**(Reproductive system)**

A nurse is conducting a prenatal teaching class. A number of questions were raised by clients, what is:

1. The function of the Fallopian tubes (FT)?
   a. Estrogens and progesterone are secreted from the FT.
   b. FT is the passage way for the fetus
   c. Fetus develops in the Fallopian tube
   **d. Fertilization occurs in the FT.**

2. The function of the placenta?
   a. Prevents antibodies and viruses from passing to the fetus
   b. Cushions and protects the fetus
   **c. Facilitates exchange of nutrients and wastes products between mother and fetus**
   d. Maintains body temperature of the fetus.

3. The presence of the following hormone in the blood confirms pregnancy?
   **a. Beta HCG (Beta Human Chorionic Gonadotropin)**
   b. Progesterone
   c. Estradiol
   d. Prolactine.

4. What is The physiology related to the cessation of ovulation during pregnancy?
   **a. Estrogen and progesterone hormones are high**
   b. Estrogen and progesterone hormones are low
   c. Follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels are high
   d. FSH and LH levels are low.

5. The main role of the uterus?
   a. Production of estrogen and progesterone
   **b. Implantation of the fertilized ovum**
   c. Fertilization of the ovum
   d. Protection of ovaries from infection.

## Chemotherapy

The nurse is caring for a 42 years old female receiving chemotherapy. Her blood test revealed the following results:

- Hemoglobin 12 mg/dl,
- Platelets 50,000/$mm^3$
- White blood cells (WBC) count 1600/$mm^3$

Note that the blood group of the patient is O positive

1. When should the nurse administer antiemetic to prevent nausea and vomiting related to chemotherapy?
   **a. 30 minutes before initiation of therapy**
   b. With the administration of therapy
   c. Immediately after nausea begins
   d. Immediately after therapy.

2. Which of the following nursing actions should be implemented before administering chemotherapy?
   a. Administer antibiotics as prescribed
   **b. Inspect the insertion site**
   c. Give the patient a regular diet
   d. Provide narcotics as prescribed to induce sleep.

3. Which of the following should be included in the teaching plan for this patient who is experiencing thrombocytopenia?
   **a. Minimize use of sharp objects**
   b. Use an electric toothbrush
   c. Monitor temperature
   d. Report pain.

4. The nurse understands that the patient needs more information about the risk of bleeding and self-care as the patient states:
   a. I should avoid taking my temperature rectally
   b. I need a platelet transfusion if my platelet count is too low
   **c. I am going to take aspirin for my headache**
   d. I will count the number of pads I use when menstruation

5. The patient needs platelet transfusion. Which of the following blood groups is compatible to be administered to the patient?
   **a. O Positive**
   b. B Positive
   c. B Positive
   d. AB Positive

## Diabetes Type 2

Mrs. Mona, 38 years old, is a newly diagnosed diabetic type 2 patient, who came for her first checkup.

1. Which statement by Mrs. Mona indicates that she understands her treatment?
   a. “I take oral insulin instead of shots”
   b. “By taking these medications, I am able to eat more”
   c. “When I become ill, I need to increase the number of pills I take”
   **d. “The oral anti-diabetic medication I am taking help releases the insulin I already make”.**

2. The nurse is monitoring the patient for signs of complications. Which of the following if exhibited in Mrs. Mona would indicate hyperglycemia and warrant physician notification
   **a. Polyuria**
   b. Hypotension
   c. Hypertension
   d. Tachycardia.

3. The nurse is preparing a teaching plan regarding proper foot care. Which instruction is included in the plan?
   a. Soak feet in hot water
   b. Avoid using a mild soap on the feet
   **c. Dry between the toes**
   d. Cut nails in a circular shape every day.

4. Which statement revealed that Mrs. Mona had misconception about her disease:
   **a. “I am afraid of transmitting disease to my family by direct contact”**
   b. “I am afraid to deliver a baby with diabetes”
   c. “Getting infection could affect my health status”
   d. “I have to carry always my diabetic card”.

5. The nurse would be concerned of which finding following Mrs. Mona’s physical examination:
   a. Decreased hearing abilities
   **b. Decreased sensation in lower limbs**
   c. Decreased tasting buds
   d. Hair loss.

## Intestinal Obstruction

Mrs. Hiba is 40 years old, admitted to hospital for intestinal obstruction. She presented with acute abdominal pain, vomiting, absence of bowel elimination and flatulence

1. The main objective of naso gastric tube insertion for this patient is:
   a. Enteral alimentation
   b. Medication administration
   **c. Gastric aspiration**
   d. Parenteral administration.

2. To reduce pain for Mrs. Hiba the doctor ordered morphine sulfate S/C. The life threatening complications of this medication is:
   a. Somnolence
   **b. Respiratory distress**
   c. Confusion
   d. Hypotension.

3. The radiologic study specific for intestinal obstruction is abdominal:
   **a. CT scan**
   b. Echography
   c. Angiography
   d. MRI

4. The intestinal obstruction may lead to dehydration. The initial manifestation that indicates dehydration on Mrs. Hiba is:
   a. Hematuria
   b. Polyuria
   c. Dysuria
   **d. Oliguria**

5. Blood transfusion was ordered for Mrs. Hiba post op due to severe anemia. This needs an approval from.
   **a. Patient**
   b. Doctor
   c. Nurse
   d. Family.

**Meningitis**

A nurse is dealing with a new patient suspected to have meningitis. Upon physical examination, the nurse notes that the patient exhibits a positive "kernig's sign".

1. Which of the following observations is a characteristic of kernig's sign?
   a. Complaints of muscle and joint pain
   b. Petechial and purpuric rashes are noted on the trunk
   c. Neck flexion causes adduction and flexion of lower extremities
   **d. Difficulty to extend the leg when the thigh is flexed at the hip or knee.**

2. Based on the mode of transmission of bacterial meningitis, which type of isolation for this patient should the nurse include in the plan of care?
   a. Contact isolation
   b. Reverse isolation
   **c. Air-borne isolation**
   d. No isolation.

3. The physician performed a lumbar puncture to diagnose the type of Meningitis. Lumber puncture is performed at the level of:
   a. $L_2$ - $L_3$
   **b. $L_4$ - $L_5$**
   c. $S_1$ – $S_2$
   d. $S_3$ – $S_4$.

4. The nurse reviews the result of the specimen, which element confirms the presence of bacterial meningitis?
   a. Low protein level
   **b. Glucose <40mg/dL**
   c. Low white blood cell count
   d. High red blood cell count

5. Which of the following signs would the nurse assess if the patient develop a disseminated intravascular coagulation (DIC) as a complication of meningitis?
   a. Pitting edema
   **b. Hemorrhagic skin rash**
   c. Peripheral cyanosis
   d. Dyspnea on exertion.

## CABG

Mr. Ramzi was complaining of coronary artery disease since 6 months. He was admitted to the hospital for urgent case of severe chest pain. Cardiac catheterization had shown stenosis of two vessels. An open heart surgery was ordered to be done. Post-operatively the patient was transferred to the Cardiac Surgery Unit (CSU) for observation.

1. Which of the following arteries enriches cardiac muscle?
   **a. Coronary**
   b. Carotid
   c. Jugular
   d. Femoral

2. The nurse cares for the patient post-operatively. Which catheter monitors pulmonary pressure?
   a. Arterial line
   b. Supraclavicular line
   **c. Swan Ganz**
   d. Venous femoral line

3. Post cardiac surgery, pulmonary embolism may occur when which of the following blood vessels is used for grafting?
   a. Mammary artery
   **b. Saphenous vein**
   c. Femoral vein
   d. Popliteal artery

4. During the post-op period, the patient took a blood transfusion. Which type of shock may the patient develop?
   a. Cardiogenic
   b. Neurogenic
   **c. Anaphylactic**
   d. Hypovolemic

5. The patient died on the floor. The patient in the next bed asked about the cause of death. The nursing response should be:
   a. Explain about the pre-op treatment
   b. Inform the details of death causes
   c. Inform the responsible doctor
   **d. Respect the confidentiality of information**

## Ischemic cerebrovascular accident

A 50 year old female patient known to have uncontrolled Diabetes Mellitus, atherosclerosis, and hypertension, is presented to the Emergency Room complaining of hemiplegia, aphasia and confusion. Her son denied that she had headache or vomiting. She was diagnosed with Ischemic cerebrovascular accident (CVA).

1. The immediate nursing goal to be achieved for this patient is to maintain:
   a. Physical activity
   b. Normal skin integrity
   c. **Patent airway**
   d. Adequate Nutrition status

2. In the Emergency Room, the diagnostic test that should be performed first is:
   a. Positron Emission Tomography (PET scan)
   b. **Computed Tomography Scan**
   c. Trans Carotid Doppler
   d. Magnetic Resonance Imaging

3. The risk factor contributing to this patient's ischemic cerebrovascular accident is:
   a. Gender
   b. Age
   c. **Diabetes Mellitus**
   d. Chronic Obstructive Pulmonary Disease

4. For thrombolytic therapy to be effective, it must be given within a specific time after the onset of symptoms. Which is:
   a. **3 – 4 hours**
   b. 6 – 7 hours
   c. 8 - 9 hours
   d. 10 -14 hours

5. In aphasia, brain injury has most likely occurred in which brain lobe?
   a. **Frontal**
   b. Occipital
   c. Temporal
   d. Parietal

## Psychiatry

A client admitted to psychiatric unit 3 days ago because of psychomotor retardation, insomnia, loss of appetite, hopelessness, worthlessness and active suicidal ideations.

1. Based on above clinical presentation,The patient is most likely to have the following mental disorder:
   **a. Major depression**
   b. Bipolar disorder
   c. Schizoaffective
   d. Anxiety

2. Physician prescribed 10 mg of Paroxitine (Paxil) every morning. The nurse should monitor the client closely for the following side effect:
   a. Headache
   b. Nausea
   c. Fatigue
   **d. Agitation**

3. The patient spends most of the day lying in bed. The following approach by the nurse is considered most therapeutic:
   a. Wait for the client to begin the conversation
   **b. Initiate contact with the client frequently**
   c. Sit outside the client's room
   d. Avoid talking to the client

4. The client tells to the nurse "you are my favorite nurse; I want you to remember me when I am gone". What is the most appropriate response by the nurse?
   a. "All of the nurses are good to all clients"
   b. "Thank you, you are my favorite client too"
   c. "I don't care if you like me or not, still need to take your medication"
   **d. "Tell me more about your feelings and thoughts"**

5. Based on the patient's assessment and history, which of the following presents a priority concern?
   a. The presence of bruises on the client's body
   b. The client reports not eating or sleeping
   **c. The client report of suicidal thoughts**
   d. The client refuses to see his wife

**Community Health**

Mr. Riad is 60 years old and retired. He used to work in a factory polluted with cotton dust. He also used to smoke cigarettes 1 pack /day which he reduced to 5-6 cigarettes/day. He is now complaining of lack of appetite, difficulty breathing.
He is maintained on bronchodilator puffs, oral cortisone and antibiotics.

1. What is the priority nursing diagnosis for Mr. Riad.
   a. Altered nutrition
   b. Altered coping mechanism
   c. Social isolation
   **d. Ineffective airway clearance.**

2. What is the side effect for long-term use of cortisone?
   **a. Hyperglycemia**
   b. Delirium
   c. Meningitis
   d. Allergy.

3. One of the harmful effects of passive smoking is?
   a. Fatigue
   b. Dysuria
   **c. Lung cancer**
   d. Insomnia.

4. Mr. Riad complains that h was never informed about the consequences of pollution on his health. Which of the below is the nurses' best attitude?
   a. He does not need any information
   b. He is already a smoker
   **c. He has the right for complete information**
   d. He is maintained on cortisone.

5. The nurse teaches Mr. Riad about his nutritional status. What is an important advice related to this case?
   a. Do not skip breakfast
   b. Limit intake of spices
   **c. Limit salt intake**
   d. Does not need a special diet.

## Renal Failure

Mr. Naji a 60 years old male client, presented to the emergency department with signs of tobramycin toxicity.

1. What type of renal failure would the nurse expect to see?
   a. Prerenal.
   b. Postrenal.
   c. Extrarenal.
   **d. Intrarenal.**

2. Mr. Naji exhibits signs of early renal failure. Which of the following signs is indicative of this condition during the?
   a. Polyuria
   b. Polydypsia
   **c. Oliguria**
   d. Anuria

3. Mr. Naji's potassium level is 6 meq/L. The nurse should implement the following nursing action?
   a. Check the sodium level
   **b. Place Mr. Naji on a cardiac monitor**
   c. Increase vegetables in his diet
   d. Allow an extra 500 ml fluid intake.

4. Mr. Naji asks the nurse why he is anemic. Which of the following responses by the nurse best explains this condition?
   **a. There is a decreased production by the hormone erythropoietin**
   b. We need to augment your dietary intake of iron-rich foods
   c. It is most likely that you have hereditary predisposition for anemia
   d. Increased metabolic waste products in your body depress the Bone Marrow.

5. The most accurate indicator that Mr. Naji is recovering is the decreased level of?
   a. BUN levels
   **b. Serum Creatinine**
   c. Neutrophil count
   d. Lymphocyte count.

## Hypertension

Ms. Linda is a 50 year old patient complaining from intense headache and tinnitus, since few days and was admitted to the hospital for investigation. The doctor diagnosed the case as arterial hypertension.

1. Which of the below blood pressure values indicates hypertension?
   a. Systolic arterial pressure equal or above 120mmHg
   b. Systolic arterial pressure equal or below 130 mmHg
   **c. Systolic arterial pressure equal or above 140 mmHg**
   d. Diastolic arterial pressure equal or below 90 mmHg

2. Orthostatic hypotension is defined as a physiologic alteration in the following body system:
   **a. Neurovascular**
   b. Immunological
   c. Gastrointestinal
   d. Respiratory

3. When measuring arterial blood pressure, the patient should be placed in which position?
   **a. Sitting**
   b. Left lateral
   c. Prone
   d. Standing

4. When hypertension is diagnosed early, the initial medical treatment of choice is:
   a. Calcium channel blocker
   **b. Vasodilator**
   c. Anxiolotic
   d. Anti inflammatory

5. The patient should be instructed to follow the following diet:
   a. Low caloric
   b. High protein
   c. High lipid
   **d. Low salt**

## Hepatitis

Mr. Naji was admitted to the hospital presenting with jaundice, anorexia and malaise. The doctor prescribed laboratory studies and liver biopsy to confirm hepatitis.

1. After contaminated needle stick injury the immediate nursing action that should be taken is:
   a. Make blood tests
   b. Continue regular work
   **c. Wash hands**
   d. Take a sick report

2. Which type of Hepatitis needs an oral-fecal precaution?
   a. Hepatitis D
   b. Hepatitis C
   **c. Hepatitis A**
   d. Hepatitis B

3. Which of the following elevated blood test(s) confirms hepatitis?
   a. White blood cells
   b. Bilirubin
   c. Interferon
   **d. Liver enzymes**

4. What is the recommendation that the nurse should give for a Hepatitis B client concerning physical activity?
   **a. Limit daily activities**
   b. Encourage ambulation
   c. Sleep most of the time
   d. Maintain regular activities

5. After liver biopsy the patient developed peritonitis. The nurse's role is to assess for:
   a. Bloody diarrhea
   b. Abdominal distention
   c. Abdominal flatulence
   **d. Abdominal pain**

**Immediate Care of the Newborn**

You are a nurse assigned for the care of newborns after delivery. As part of newborn care, you assess the Apgar score, give vitamin K and apply erythromycin ointment.

1. A normal 1 minute Apgar score is:
   a. 1 to 2
   b. 5 to 9
   **c. 7 to 10**
   d. 12 -15

2. Vitamin K is routinely administered for newborns because:
   **a. Lack of vitamin K will lead to abnormal bleeding**
   b. Vitamin K is important for digestion
   c. Vitamin K is important for lung maturity
   d. Lack of Vitamin K is caused by immature pancreas action.

3. Which of the following injection sites would the nurse select to administer the vitamin K intramuscular injection (IM):
   **a. The lateral aspect of the middle third of the vastuslateralis muscle**
   b. The medial aspect of the upper third of the vastuslateralisis muscle
   c. The deltoid muscle
   d. The ventrogluteal muscle.

4. Erythromycin ointment is applied to the newborn eyes to prevent:
   **a. Neonatal conjunctivitis due to a gonococcal infection**
   b. Syphilis infection of the eyes
   c. Cataracts in the newborn
   d. Against fungal infection

5. To prevent heat loss in the newborn infant resulting from evaporation, you should:
   a. Warm the crib pad
   b. Turn on the overhead radiant warmer
   c. Close the door of the room
   **d. Dry the infant with a warm blanket**

## Scoliosis

Sarah, an 11 years old girl, was admitted to the Emergency Department accompanied by her mother for back pain. The mother is very worried because she noticed a lump on one side by examining the back of her daughter.

1. What is the screening test for scoliosis?
   a. Bucket test
   **b. Bending test**
   c. Lasegue test
   d. Homan test.

2. What is the most significant clinical finding for scoliosis?
   **a. Lateral curvature of the spine "S or C shape"**
   b. Congenital malformation of lower extremities
   c. Back pain even at rest
   d. Equality of the shoulders and the hips

3. According to principles of growth and development, what is an appropriate nursing diagnosis for this child?
   a. Impaired skin integrity
   b. Fluid volume deficit
   **c. Disturbed body image**
   d. Altered urinary elimination

4. During the post-operative period, which assessment finding is considered a priority?
   **a. Neuro-vascular deficit**
   b. Diminished peripheral pulses
   c. Pain upon coughing
   d. Hypothermia

5. Educational tips that you should give to the family upon discharge?
   a. Keep the child in supine position
   **b. Avoid bending or rotation**
   c. Avoid swimming until full recovery
   d. Allow long distance walking

**Tonsillitis**

A 3 years old child presented to the pediatric clinic with fever of 39.5°C and the mother indicated that he didn't eat his meals for the past 24h. On physical examination, the pediatrician found that he had congested tonsils and took a swab for culture.

1-The nurse teaches the mother that one of the sign of tonsillitis that she should watch for is:

a. Hyperactivity
**b. Snoring**
c. Low grade fever
d. Increased appetite

2- The nurse explains that if the infection extends to the adenoids, it may cause a serious complication:

a. Teeth infection
b. Chronic headache
c. **Acute otitis media**
d. Asthma

3-Supportive measures for management of tonsillitis include:

**a. Increase fluid intake**
b. Antibiotic therapy
c. Antiviral therapy
d. Apply warm compresses

4- The pediatrician recommended tonsillectomy for recurrent tonsillitis and formation of peritonsillar abcess. The best position for the child during immediate post- op period is:

a. Supine with head tilted to the side
b. Supine with head of bed elevated 45°
c. Lying on left side
**d. Prone with head tilted to the side**

5-After tonsillectomy, witch of the following should indicate to the nurse the presence of early
hemorrhage:

**a. Drooling bright red secretions**
b. Pulse rate of 95 beats/mn
c. Vomiting dark brown secretions
d. High grade fever

## Cardiopulmonary Arrest and CPR/BLS

Mr. Samir, a 70 years old patient, known to have Diabetes Mellitus and hyperlipidemia, was admitted to emergency department with heart failure. On examination, he was found to be pale with no visible chest movements, unresponsive to verbal command, and pulseless.

1. The priority emergency intervention indicated for Mr. Samir is:
   a. Intubation
   b. Epinephrine administration
   **c. CPR/compression**
   d. Defibrillation

2. During CPR, the appropriate dose of epinephrine should be:
   **a. 1 mg every 3 to 5 minutes**
   b. 1 mg every 1-2 minutes
   c. ½ mg every 10 minutes
   d. 1 mg after each cycle.

3. Airway patency is maintained by:
   a. Oral suction
   b. Endotracheal intubation
   c. **Head tilt and chin lift**
   d. Tracheotomy

4. Ratio of compressions to breathing per cycle of CPR for this patient is:
   a. 15 to 2
   b. 15 to 1
   c. 30 to 1
   d. **30 to 2**

5. During CPR, the nurse checks for a pulse after:
   a. Each cycle of CPR
   b. The 1st cycle of CPR
   c. 5 minutes of CPR
   d. **5 cycles of CPR**

## Anxiety

A male client known to have obsessive compulsive disorder (OCD) is admitted to the psychiatric unit for management. Upon admission the patient immediately entered the shower and washed vigorously his body for one hour with soap and water. On his way into the shower, he switched the light 44 times, after that he opened and closed the room door 44 times.

1. Which response by the nurse would be most therapeutic for this client?
   **a. Accept the client's ritualistic behavior**
   b. Challenge the client's need for rituals
   c. Express concern about harmful behavior
   d. Limit the client's rituals that are excessive

2. What is the most appropriate goal of care for this client?
   a. Omit one unacceptable behavior each day
   b. Increase the client's acceptance of therapeutic drug use
   c. Allow ample time for the client to complete all rituals everyday
   **d. Systematically decrease number of repetitions and time spent on rituals.**

3. Which statement best describes the characteristics of OCD?
   a. Compulsion is preoccupation with persistent intensive thought and ideas
   b. Obsessions are a repeated performance of certain rituals
   **c. Anxiety occurs when one resists obsessions or compulsions**
   d. Obsessions and compulsions always occur together.

4. The client was started on Clonipramine (Anafranil) to treat his symptoms. The rationale for this treatment is that Anafranil:
   a. Increases GABA levels
   **b. Increases serotonin levels**
   c. Decreases dopamine levels
   d. Decreases norepinephrine levels

5. Which of the following is the most effective non pharmacological treatment of OCD:
   a. Psychodynamic therapy
   **b. Cognitive behavioral therapy**
   c. Interpersonal therapy
   d. Group therapy

## COPD exacerbation / Acid Base Imbalance

Mr. Jaber, 73 years old, is admitted to the intensive care unit (ICU) with a diagnosis of exacerbation of chronic bronchitis. He is restless, dyspneic with a productive cough. He is a chronic smoker since 30 years and has a history of COPD.

1. The main cause of dyspnea for this patient is:
   **a. Excessive production of mucoidal sputum**
   b. Accumulation of fluid in pleura space
   c. Accumulation of fluid in alveolar spaces
   d. Increased pulmonary pressure

2. In order to facilitate maximum air exchange, the nurse should instruct Mr. Jaber to sit in the following position:
   a. Supine
   **b. Orthopneic**
   c. Low-Fowler's
   d. Semi-Fowler's

3. Mr. Jaber has the following arterial blood gas results: Ph=7.31, $PaO_2$ = 60 mmHg, $PaCO_2$ = 50 mmHg, $HC0_3$ =26 mmol/L.
   The correct interpretation of this result is:
   a. Metabolic acidosis
   b. Metabolic alkalosis
   **c. Respiratory acidosis**
   d. Respiratory alkalosis

4. The physician orders administration of 50% oxygen by face mask for Mr. Jaber. The nurse knows that this would most likely result in:
   a. Resolution of the problem
   b. A decrease in the $PCO_2$
   c. Oxygen toxicity
   **d. Hypoventilation**

5. The arterial blood gases of Mr. Jaber deteriorated, and respiratory failure is about to happen. The significant clinical indicator that the nurse should assess for is:
   a. Cyanosis
   b. Bradycardia
   **c. Mental confusion**
   d. Distended neck veins

**Pneumonia**

A one-year-old female, brought to the emergency room by her mother for difficulty in breathing, cough, runny nose, temperature= 39.4°C, respiratory rate= 40 breath/min. Blood Cell Count revealed elevated WBC, and chest X-Ray showed bilateral infiltrates. She was admitted for pneumonia management.

1- What is the main diagnostic test to confirm pneumonia?
a. ABGs (Arterial Blood Gases)
**b. Chest X-Ray**
c. Blood culture
d. Serum electrolytes

2. What is the most common micro-organism associated with pneumonia?
a. Haemophilus influenzae
b. Klebsiella pneumoniae
**c. Streptococcus pneumoniae**
d. Staphylococcus pneumonia

3. What is the immediate nursing care for a child with pneumonia?
**a. Provide fluids**
b. Provide adequate nutrition
c. Increase physical activity
d. Monitor intake/output

4. Which criteria help in the selection of the appropriate antibiotics?
a. Tolerance of the client
b. Availability of treatment
**c. Sensitivity of microorganisms**
d. Physician preference

5. What is the pathophysiologic effect on the lung parenchyma during pneumonia?
**a. Inflammation**
b. Atelectasis
c. Effusion
d. Bronchiectasis

**Burns**

The nurse is caring for a 45-year-old patient newly admitted to the burn unit. The patient has sustained a thermal burn injury of partial – thickness (second degree) burn, over 50 % of his upper body. His weight is 70 kgs and height is 170 cm. He has generalized edema and complaining of severe pain.

1. The nurse knows that partial-thickness burns involve the destruction of:
    a. Epidermis
    b. **Epidermis and part of the dermis**
    c. Epidermis, dermis and some underlying tissues
    d. All skin layers and extends to muscle.

2. The nurse knows that the priority action in this situation is:
    a. **Establish a patent airway**
    b. Insert an indwelling catheter
    c. Replace fluid
    d. Administer pain medication

3. The nurse understands that the massive systemic edema occurs because of:
    a. Catecholamine – induced vasoconstriction
    b. Decreased glomerular filtration
    c. **Increased capillary permeability**
    d. Loss of integumentary barrier

4. The nurse should anticipate that during the first 24 hours this patient is at high risk for developing the following type of shock:
    a. Septic
    b. Neurogenic
    c. Cardiogenic
    d. **Hypovolemic**

5. The nurse knows that the emergent recovery phase of burn care ends when the patient shows the following clinical finding:
    a. Healed wounds
    b. **Diuresis**
    c. Positive bowel sounds
    d. Normal vital signs.