BNURS506 Quiz Answering

Term: Spring 2025
Module 4: Musculoskeletal & Neurologic Systems
Name: Student M

#:	Your Answer	Feedback from Grader	Score
1			/ 10
2	1. Yes, given the developmental delays and complex medical history, it is possible the patient has Cerebral palsy. Cerebral palsy is a disorder of movement and posture, caused by disturbances to the developing brain. It is characterized by several symptoms demonstrated by this patient including delays in developmental milestones, asymmetry of function, and/or atypical tone or posture (Davis et al., 2023) 2. Common motor abnormalities in CP include spasticity, dyskinesia, and ataxia. Weakness, hypotonia, and sensory abnormalities may also accompany these features in some individuals. Signs and symptoms suggestive of the diagnosis of CP may be present in infancy. This may include abnormalities in motor tone, significant delays in achieving motor milestones, abnormal developmental reflexes, or the presence of associated conditions such feeding difficulties, growth failure, or epilepsy (Barkoudah, 2024) The patient demonstrates delayed motor milestones, asymmetry in function, low muscle tone in lower extremities, and occasional delayed response to his name. 3. Additional assessments to rule out CP could include: MRI (to identify brain abnormalities affiliated with CP), standardized neurologic and motor assessments such as Such as the Hammersmith Infant Neurological Examination and the Prechtl Qualitative Assessment of General Movements (which are highly	Good job answering all parts of the questions! I really liked your answer to the first question, it looked perfect. It has enough detail and answers the question perfectly. Overall you did a great job with the answers. The reason I took off 0.5 points was due to your apa citations. There are some extra numbers in your last citation that need to be taken out and the other two citations are following different format. Thanks for your feedback!	9.5 / 10

	predictive of CP), and developmental evaluations of motor and cognitive functions. (Bosanquet et al., 2013) References: Barkoudah, E. (2024). *Cerebral palsy: Classification and clinical features*. UpToDate. Retrieved May 17, 2025, from https://www.uptodate.com/contents/cerebral-palsy-classification-and-clinical-features Bosanquet, M., Copeland, L., Ware, R., & Boyd, R. (2013). A systematic review of tests to predict cerebral palsy in young children. *Developmental Medicine & Child Neurology, 55*(5), 418–426. https://doi.org/10.1111/dmcn.12140 Davis, B. E., Leppert, M. O., German, K., Lehmann, C. U., & Adams-Chapman, I. (2023). Primary care framework to monitor preterm infants for neurodevelopmental outcomes in early childhood. *Pediatrics, 152*(1), e2023062511. https://doi.org/10.1542/peds.2023-062511 Feedback: Thanks for getting me to think about the early signs, symptoms and causes of cerebral palsy, I learned about the assessments that can be used to diagnose CP, which I was not familiar with before.		
3			/ 10
4	1. Tony's symptoms are suggestive of Guillain-Barre Syndrome which can be triggered by an antecedent infection (in this case, COVID-19) and leads to rapid progression of weakness and numbness in both legs, ascending from the feet to the thighs, and	1. You correctly identified that Toby has Guillain-Barre Syndrome! Your answer provided a simplified explanation of his diagnosis. The question also asked to explain the prognosis	9 / 10

	the absence of deep tendon reflexes in the lower extremities (Chandrashekhar & Dimachkie, 2025). 2. Standard first-line treatment for GBS includes intravenous immunoglobulin (IVIG) or plasma exchange. Early treatment is crucial as it can significantly improve outcomes and reduce the risk of complications such as respiratory failure. (Chandrashekhar & Dimachkie, 2024). 3. One potential complication of GBS is respiratory failure, which can occur due to involvement of respiratory muscles. Signs and symptoms include dyspnea, reduced oxygen saturation, and difficulty breathing. Monitoring interventions include regular assessment of respiratory function, including spirometry and blood gas analysis, to detect early signs of respiratory compromise (Chandrashekhar & Dimachkie, 2024). References: Chandrashekhar, S., & Dimachkie, M. M. (2025). *Guillain-Barré syndrome in adults: Pathogenesis, clinical features, and diagnosis*. UpToDate. Retrieved May 17, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-pathogenesis-clinical-features-and-diagnosis Chandrashekhar, S., & Dimachkie, M. M. (2024). *Guillain-Barré syndrome in adults: Treatment and prognosis*. UpToDate. Retrieved May 17, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-treatment-and-prognosis Feedback: This was interesting question because I had heard about GBS, but was really unfamiliar with it. Thanks for helping me learn something new!	which included that most people fully recover from GBS although it may take weeks to months and will likely require physical therapy even after discharge. (2/3 pts) 2. I would've accepted IVIG or PLEX as answers but thank you for including both! Yes, early treatment is important to prevent respiratory compromise. (3/3 pts) 3. Respiratory compromise is a major complication of GBS. Difficulty breathing is a common sign of worsening GBS and may indicate that they need to be intubated. Thank you for including both s/s and monitoring interventions! (3/3 pts) +1 citation Thank you for your feedback! I'm glad you enjoyed learning about GBS!	
5			/ 10

6	Rufino's neurologic deficits combined with his history of recent infection suggests they may have Guillain-Barre Syndrome (GBS) (Chandrashekhar & Dimachkie, 2025) however, I would want to rule out the possibility of a stroke with an MRI. My immediate concerns are for respiratory failure, a serious and common complication of GBS. Priority assessments should include frequent respiratory function tests, continuous pulse oximetry, and close monitoring of vital signs (and ABCs). Early intervention should include IVIG or plasma exchange. (Chandrashekhar & Dimachkie, 2024). References: Chandrashekhar, S., & Dimachkie, M. M. (2025). *Guillain-Barré syndrome in adults: Pathogenesis, clinical features, and diagnosis*. UpToDate. Retrieved May 17, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-pathogenesis-clinical-features-and-diagnosis Chandrashekhar, S., & Dimachkie, M. M. (2024). *Guillain-Barré syndrome in adults: Treatment and prognosis*. UpToDate. Retrieved May 17, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-treatment-and-prognosis Feedback: Good question! The symptoms had me thinking about a stroke initially, but the neurology category, and the fact that I had just learned about GBS in question 4 corrected my course. The question is simple yet thought provoking.	Correct identification of illness, GBS. Initaly, his provider did an MRI to rule out a stroke. Respiratory failure is the main concern. The patient would ultimately need intubation ICU monitoring. You identified the correct medication that GBS patients are started on, IVIG. Other interventions/assessments that could have been listed is DVT prevention, patient/family education, neuro and cardiac monitoring.	9/ 10
7			/ 10

8	TIC can be implemented by creating a safe and supportive environment. This includes clear communication, transparency about procedures, and offering choices whenever possible to empower James and respect their autonomy. Nurses should also respect the individuality of James by recognizing the importance of environmental circumstances and building a meaningful relationship that fosters trust and collaboration. Addressing James' resistance to care requires a compassionate and empathetic approach. Acknowledge their feelings and provide reassurance. For example, using statements like "I can see that you are upset" can help de-escalate situations and build rapport. Peer support groups may also be helpful for James to navigate the challenges of living with MS. (Forkey et al., 2021) Some of the key components of TIC include consistency, transparency, respect, trust, empowerment, choice, and a calm atmosphere (de la Parrelle et al., 2022) References: de la Perrelle, L., Klinge, N., Windsor, T., Field, R., & Koder, D. (2022). Characterising trauma-informed aged care: An appreciative inquiry approach. *International Journal of Geriatric Psychiatry, 37*(9), e5802. https://doi.org/10.1002/gps.5802 Forkey, H., Szilagyi, M., Kelly, E. T., & Duffee, J. (2021). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580 Feedback: This was a good question about Trauma Informed Care, but did not advance my knowledge of pathophysiology, pharmacology, or physical assessments related to Multiple Sclerosis. Important content, but not really relevant to this class.	Great job focusing on trauma informed care for this patient. I recognize the question I asked was very broad so I am grading this question based on detailed explanations as opposed to the correct answer. Only missing being consistent with pain meds in answer, but overall good work	9/ 10

9			/ 10
10	1. I would consult the anesthesiologist to confirm the dose and avoid toxicity 2. I am concerned about Local Anesthetic Systemic Toxicity (LAST) 3. LAST can cause seizures and/or cardiac arrhythmias (Pak & Weinberg, 2023) 4. - The age of the patient: “In older adult patients, clearance of local anesthetics may be reduced due to deterioration of hepatic function and perfusion. Thus they may be at increased risk for LAST with repeat dosing or continuous infusion of local anesthetics. In addition, nerves are more sensitive to local anesthetics in older adults, and lower doses of local anesthetics are necessary for adequate block than in younger patients” (Pak & Weinberg, 2023) - total dose per body weight – patient has a relatively low body weight which may affect the availability of the anastatic and increase risk for toxicity. (Pak & Weinberg, 2023) Bonus: “Addition of epinephrine to local anesthetic solutions can slow the rate of absorption and reduce peak plasma levels and may act as a marker for intravascular injection. Epinephrine reduces the absorption of LA by 20 to 50 percent, depending on the site of injection and the LA” (Pak & Weinberg, 2023) Epinephrine slows the absorption of local anesthetic via vaso constriction References: Pak, A., & Weinberg, G. L. (2023). Local anesthetic systemic toxicity. In J. E. Arens (Ed.), *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/local-anesthetic-systemic-toxicity:contentReference[oaicite:3]{index=3} Feedback:	1. Correct, 2 points 2. Correct, 1 point 3. Correct, 2 points 4. Correct, 2 points - especially nice work identifying the risk factors for this specific patient! 5. Missing, 0 References and citations - 1 point BONUS - correct, 1 point Thank you for the feedback. I hadn’t thought of it but I think that’s true - not many pharmacology questions up to this point.	9 / 10

	I have never heard of LAST before this question, thanks! This is a good pharmacology question, which there have not been too many of. I like the clear guidance for scoring expectations.		
11			/ 10
12	I suspect scoliosis, likely idiopathic adolescent scoliosis (AIS) given Jasons age(>12 years) and onset of symptoms. The asymmetry in the waist and hips suggests a curve in the spine. An X-ray and a scoliometer can be used to measure the cobb angle which is necessary for diagnosis, to evaluate extent of the disease, and determine treatment. Treatment of AIS is individualized and based on the age of the patient (anticipated growth remaining), the extent of the Cobb angle, and the functional impact of scoliosis. Minor scoliosis may be treated with observation and/or bracing, while severe scoliosis may require surgical intervention (posterior spinal fusion). The severity of the scoliosis will increase as Jason starts having pubertal growth spurts. (Scherl & Yaszay, 2023) References: Scherl, S. A., & Yaszay, B. (2023). *Adolescent idiopathic scoliosis: Management and prognosis*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/adolescent-idiopathic-scoliosis-management-and-prognosis Feedback: Nice question! This brought me back to nursing school. I got to observe an 8-hour posterior spinal fusion surgery. It was a great experience. It also confirmed to me that I do not have interest in becoming an OR nurse.	Your response covers the main points well, including scoliosis identification, need for imaging, and general treatment tiers. The growth risk aspect was mentioned but could be more clearly tied to Jason's pubertal status and your pathophysiology explanation was a bit brief and could include more specific details about the structural changes involved in AIS. Nice job though!	9/ 10

13			/ 10
14	- Protect airway and postioning (easily compromised during seizure) - Place in side-laying position (in case of emesis) - Administer anti-seizure medication – If IV access, Ativan, if no IV access, Intranasal midazolam - Monitor respiratory status, vital signs and provide oxygen as needed – patient may require bagging if not breathing spontaneously S: Samantha is a 27-year-old with who came to the ER w HA, photophobia and lethargy, altered mental status with a GCS of 13, positive Kernigs and Brudzinskis sign; seizure lasting 6 minutes B: attended a music festival last night, symptoms progressed over the past few hours and getting worse A: Patient likely has meningitis R: Monitoring and management of ABCs; insert 2 large bore IV catheters, prepare for possibility of continued seizure activity and intubation. Prioritize empirical abx to treat bacterial infection, and dexamethasone to reduce intracranial inflammation Order of interventions based on priority: 2, 1, 4, 6, 5, 3, 7 - However, I would likely draw the labs with the insertion the PIVs, and I would start the propofol before intubating (if available and not delaying intubation significantly) “Samantha likely has condition called meningitis which has caused her to have some swelling in her brain. That swelling is causing the changes you saw in her today. This is a serious condition and she needs help from us to support her bodies breathing and circulation while we treat the infection. The tube we put in to help her breathing can be very uncomfortable so she will be sedated until it is safe to remove it. We will be transferring her to a specialty unit where she can receive attentive care until her condition starts to improve”	I am not sure if it got cut off but your description of kernig/brudzinski signs was missing. I assume that was the case and will award half credit (1 pts). Your priorities are correct; however, I was also looking for seizure pads to prevent injury, but I still awarded full points (3 pts). I really liked your SBAR and thank you for your feedback about how this question could be eliminated to make the quiz shorter (2 pts). The interventions would likely occur relatively quickly and close together, and your point about drawing labs with the IV is a smart way to cluster care. The correct order is 4 (airway), 2 (access), 6 (propofol also has anticonvulsant properties and will also sedate her for intubation), 5 (volume / circulation), 1 (antiepileptic), 3 (labs), and 7 (EEG) and I still awarded full points (1 pt). You gave a really great explanation to Charlotte (2 pts). Thank you very much for your constructive feedback, and I realize the question was too long. Thank you for the time you spent providing a thorough answer, and great work!	9 / 10

	References: Hasbun, R. (2024). *Clinical features and diagnosis of acute bacterial meningitis in adults*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-acute-bacterial-meningitis-in-adults Hasbun, R. (2024). *Treatment of bacterial meningitis caused by specific pathogens in adults*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/treatment-of-bacterial-meningitis-caused-by-specific-pathogens-in-adults Feedback: You have painted a great clinical picture. There is just a lot going on here, you have asked so many questions. I think the question(s) could be simplified and/or reduced without sacrificing the learning (ie. SBAR is not necessary).		
15			/ 10
16	1. I suspect the diagnosis to be Gout 2. Gout is caused by tissue deposition of monosodium urate (MSU) crystals. It is characterized by hyperuricemia and is a necessary precondition for the development of gout. Patients develop symptomatic arthritis during flares and over time can accumulate joint damage from crystal deposition and chronic inflammation. (Gaffo, 2025) 3. “The prevention of recurrent gout flares, tophi, and progressive structural joint damage generally requires the long-term use of drugs that reduce the serum urate concentration either by enhancing renal excretion of uric acid or by decreasing urate	You did a good job identifying gout, describing its pathophysiology, and discussing how allopurinol is the preferred urate-lowering medication for patients with recurrent gout flares. One thing to note is that the 3rd question also asked you to describe how diet could impact the occurrence of gout, so I had to take points off there. Uric acid is a waste product of purine	8.5/ 10

	synthesis"; "Allopurinol is the preferred urate lowering agent for most patients" (Perez-Ruiz, 2025) References: Gaffo, A. (2025). *Clinical manifestations and diagnosis of gout*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/gout-clinical-manifestations-and-diagnosis Perez-Ruiz, F. (2025). *Pharmacologic urate-lowering therapy and treatment of tophi in patients with gout*. In R. F. Connor (Ed.), *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/gout-pharmacologic-urate-lowering-therapy-and-treatment-of-tophi Feedback: Good question, it was straight forward and thought provoking.	metabolism; therefore, it's recommended that patients decrease their intake of purine-rich foods such as organ meats, red meat, and seafood. Consuming alcohol, especially beer, can also cause hyperuricemia. Overall, you did a great job of concisely identifying and describing the components related to gout and its treatment.	
17			/ 10
18	1. The patient is at risk for developing compartment syndrome, deep vein thrombosis, and infection 2. A - Compartment syndrome: and emergent fasciotomy in which an incision is made to the fascia to relieve the pressure that has built up, restricting blood flow and neurologic function without this pressure relief, tissue necrosis can occur (Osborn, 2020) B- Deep vein thrombosis – treated with LMWH injections, likely enoxaparin to break down the clot. It is important to monitor for signs and symptoms of stroke and pulmonary embolism as the patient is at risk for the clot embolizing (Lip & Stevens, 2023). C- Infection: treated with antibiotics. Patient may be placed on prophylactic abx after the surgery – these abx would need to be	I appreciate the answers about post op complications after a surgery. what as a nurse we need to assess our patient for. I really appreciate your feedback. I will try to improve my questions and scenarios next time :).	9.5/ 10

	reevaluated if signs and symptoms (fever, redness, swelling, discharge) emerged. Swab of surgical signs and blood cultures could be used to determine the sensitivities for abx selection. 3. Return to baseball would depend on rate of healing and presence of any of the above complications. Since this was a complex fracture that required surgery, I anticipate the patient would not return to baseball for at least 4 months. “While many athletes and laborers with minor fibular fractures may return to activity in as little as four to six weeks, more complex injuries require substantially longer. Proximal, distal, and complex fractures that require surgery require four months or longer for adequate healing.” (Fields, 2023) References: Fields, K. (2023). *Fibula fractures*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/fibula-fractures Lip, G., & Stevens, S. (2023). *Overview of the treatment of lower extremity deep vein thrombosis (DVT)*. *UpToDate*. Wolters Kluwer. Retrieved May 17, 2025, from https://www.uptodate.com/contents/overview-of-the-treatment-of-lower-extremity-deep-vein-thrombosis-dvt Osborn, C. P. M., & Schmidt, A. H. (2020). Management of acute compartment syndrome. *Journal of the American Academy of Orthopaedic Surgeons, 28*(3), e108–e114. https://doi.org/10.5435/JAAOS-D-19-00270 Feedback:		
19			/ 10

20	1. A) Pain – verbal score from 1-10 B) Neurovascualar – circulation, sensation, and movement (looking for signs/symptoms of compartment syndrome (pulses, cap refill, color, motor function and sensation) C) Surgical site assessment: ensure the site is clean, dry and intact, no excessive bleeding or discharge, no redness or swelling (Erens & Crowley, 2025). 2. A) Administer pain management (scheduled and PRN); likely analgesics(Tylenol), NSAIDS (ibuprofen) to reduce reliance on opioids – consider starting patient on bowel regimen if opiods are being used to prevent constipation (Erens & Crowley, 2025) B) Mobilization and physical therapy are initiated as soon as possible to facilitate recovery of function and to help prevent deep vein thrombosis (DVT). Exercises to restore normal hip motion and strength and a gradual return to everyday activities are initiated in the hospital and continued upon discharge (Erens & Crowley 2025). The patient should be on fall precautions and assisted with movement using a gait belt C) Complete a post-void bladder scan to evaluate need for catheterization 3. A) Medications for Pain management and to prevent DVT and constipation B) The importance of safe movement and physical activity c) Possible complications: blood clots, infection, joint stiffness (Erens, 2023) References:	1.3/3 That's good you mention pain, neurovascular and surgical cites. 2.3/3 Awesome, you pointed out the most of the good points. 3.4/4 You got it. However, it's also important to educate the safety instruction on assistive devices and narcotic pain management.	10/ 10

	Erens, G. A. (2023). *Total hip replacement: Beyond the basics*. UpToDate. https://www.uptodate.com/contents/total-hip-replacement-beyond-the-basics Erens, G. A., & Crowley, M. (2025). *Total hip arthroplasty*. UpToDate. https://www.uptodate.com/contents/total-hip-arthroplasty Feedback: Good question, I like that it got me to think about nursig priorities, interventions, complications, and patient education related to hip replacement.		