BNURS506 Quiz Answering

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

#:	Your Answer	Feedback from Grader	Score
2	Yes, the child could have cerebral palsy (CP). The child's history of premature birth, substance exposure while in utero, and requiring mechanical ventilation after birth all put the child at a higher risk of having CP (Barkoudah & Aravamuthan, 2025a). Additionally, CP causes delays in developmental milestones and can cause those with the condition to require the use of tube feedings, either due to poor nutritional intake or aspiration with PO intake, both of which are seen in this child. According to Barkoudah and Aravamuthan (2024), the presence of any of the following motor milestone delays indicates a need for evaluation of CP: (* = demonstrated by child in scenario) ● Development of a hand preference before 12 months old ● Sustained fist posture or clenching of hands after 4 months old ● Tightness or stiffness in the legs from 6-12 months old ● Head lag presence after 4 months old ● Inability to sit without support after 9 months old* ● Consistent asymmetry of movements and posture after 4 months old* Additionally, CP can cause changes in developmental reflexes, in addition to abnormal posture and motor tone. The child in the scenario also has abnormal motor tone AEB visibly decreased muscle tone in the lower extremities. When assessing someone for a CP diagnosis, Barkoudah and Aravamuthan (2025b) recommend: ● A detailed patient medical history and family medical history ○ Generally focuses on risk factors for CP, hearing tests on patient, ophthalmologic evaluations of patients, and any potential genetic causes of CP ● Physical assessment and evaluation of development	Good job answering all parts of the question. You did a great job giving enough detail to each question. I liked your format to the second question and the different milestones that you wrote for cerebral palsy. Thanks for your feedback. The reason I took off 0.25 points was due to citations at the end. Those need to be edited and the retrieved part needs to be taken out.	9.75 / 10

- Patient's growth
- Evaluation of coordination, posture, and motor tone
- Motor development assessment
- Screening for cognitive, attention, behavioral, and/or communication concerns
- Evaluation of functional status using a standardized measurement

- Neuroimaging
  - Brain MRI (abnormal in 85-90% of CP cases)
    - If the child has more mild clinical findings, may not be done until age 2 to limit risk of missing subtle findings
  - Head CT (less sensitive than brain MRI)
  - Cranial ultrasound (performed on those with an open anterior fontanel)
- Metabolic and genetic testing
  - Recommended when assessment indicates a potential genetic, metabolic, or infectious cause of CP

References:

Barkoudah, E. & Aravamuthan, B. (2024). Cerebral palsy: Classification and clinical features. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/cerebral-palsy-classification-and-clinical-features?search=cerebral%20palsy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H16408839

Barkoudah, E. & Aravamuthan, B. (2025). Cerebral palsy: Epidemiology, etiology, and prevention. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/cerebral-palsy-epidemiology-etiology-and-prevention?search=cerebral%20palsy&topicRef=6169&source=see_link#H1

Barkoudah, E. & Aravamuthan, B. (2025). Cerebral palsy: Evaluation and diagnosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/cerebral-palsy-evaluation-and-di

	agnosis?search=cerebral%20palsy&topicRef=6167&source=see_link#H3780353938 Feedback: This question was extremely thorough! An image could have helped add a little pizazz, but overall great question.		
4	Toby most likely has Guillain-Barré syndrome (GBS). I would explain this to Toby by saying, “Based on your symptoms, you most likely have a condition called Guillain-Barré syndrome. This condition is caused by your immune system, the system in your body that fights off infections, attacking your nervous system, and people can develop it after having an infection, like COVID (Chandrashekhar & Dimachkie, 2025). Things may get worse before they get better, and recovery can take weeks or months Luckily, though, with proper treatment, most people with this condition experience complete recovery with no long-lasting muscle weakness (Ashok Muley, 2024). I know this is a lot to take in, but what questions do you have?” Given that Toby’s symptoms started less than 4 weeks ago, and he is unable to walk, he should receive immunomodulatory therapy in the form of either IVIG or plasma exchange (Ashok Muley, 2024). Early treatment of the condition is important due to the risk of the condition progressing to respiratory failure and/or death. One potential complication of the disease is the development of a cardiac arrythmia, with the most common being sinus tachycardia (Ashok Muley, 2024). Patients should have their BP checked at least q4h and be on continuous telemetry until they stabilize or begin to improve. Additionally, an ECG should be done if the patient has any cardiac symptoms or abnormalities on telemetry. References: Ashok Muley, S. (2024). Guillain-Barré syndrome in adults: Treatment and prognosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adult	1. Yes, Toby has Guillain-Barre Syndrome! Your answer included the pathophysiology, timeline, and prognosis in a simplified way for the patient to understand. I like that you included asking if the patient has any questions. In my professional experience, patients with GBS are often younger, mostly healthy individuals and this diagnosis, although curable, can be tough to process. My key answer also included informing the patient that they will likely need physical therapy. (2.5/3 pts) 2. Excellent! I would have either accepted PLEX or IVIG as correct answers but thank you for including both. Early treatment is essential to prevent respiratory failure. (3/3 pts) 3. Cardiac arrhythmias can be a result of autonomic dysfunction which is a major complication of GBS! BP monitoring and continuous tele are excellent choices to monitor cardiac function! (3/3 pts)	10 / 10

	s-treatment-and-prognosis?search=guillain%20barre%20syndrome%20adult&topicRef=5137&source=see_link#H1276909542 Chandrashekhar, S. & Dimachkie, M. (2025). Guillain-Barré syndrome in adults: Pathogenesis, clinical features, and diagnosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-pathogenesis-clinical-features-and-diagnosis?search=guillain%20barre%20syndrome%20adult&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H829093397 Feedback: I honestly haven't thought about GBS since nursing school, thank you for giving me the chance to do a deep dive on it. The question was super thorough, and even though there were multiple parts, it was easy to find all of the information needed on the same sources (which is greatly appreciated).	+1 pt citation Thank you for your feedback! Excellent job!	
6	Based on Rufino's symptoms in the context of recent stomach flu 1 week ago, he most likely has Guillain-Barré syndrome (GBS). My immediate concerns are that Rufino is going to experience respiratory failure as a result of descending paralysis reaching his diaphragm, aspirate if he attempts to consume food/fluids PO due to his impaired gag reflex, and/or generally not be able to protect his airway. While all patients with GBS should receive serial neuro checks daily, Rufino is at a higher risk of deterioration and should therefore get them more frequently, like every 4-8 hours. Given his impaired gag reflex, I would want to ensure that Rufino doesn't take in anything by mouth until fully assessed by SLP to limit risk of aspiration and assess him for signs of aspirating on his saliva (including wet sounding cough, wheezing/stridor, and reported difficulty breathing). Given that GBS can lead to rapidly occurring respiratory failure, Ashok Muley (2024) recommends the following respiratory assessments and interventions: ● Monitor respiratory rate, oxygen saturation, FVC, and maximum inspiratory/expiratory pressure	Amazing response. You correctly listed all my grading criteria, diagnosis, priority concern, assessment and intervention. You also went above and listed other assessments such as FVC and NIF.	10/ 10

	○ Should be done q2-4h ○ Can be reduced to q6-8h for patients with mild weakness once clinically stable for 2-3 days ● Intubation if experiencing SOB at rest or while talking, using accessory respiratory muscles, unable to count to 15 in one breath, demonstrate cranial nerve impairment with impaired swallowing, or meet the following parameters: ○ Sustained RR above 30 breaths/min ○ SpO2 <92% ○ PaCO2 > 50 mmHg ○ FVC < 20 mL/kg (or reduction of more than 30% in between measurements) ○ NIF reduction below -30 cm H2O ○ MEP < 40 cm H20 Based on these criteria, I would also want to immediately notify the provider and prepare for Rufino to require intubation. Once immediately stabilized, Rufino should be admitted to the ICU as soon as possible. References: Ashok Muley, S. (2024). Guillain-Barré syndrome in adults: Treatment and prognosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/guillain-barre-syndrome-in-adults-treatment-and-prognosis?search=guillain%20barre%20syndrome%20adult&topicRef=5137&source=see_link#H1276909542 Feedback: I love that your question focused on the nursing care aspects of GBS and how to ensure the patient's safety!		
8	When looking at how the nurse should approach Mrs. James' care, it's important to remember that the principles of trauma-informed care are safety, peer support, trustworthiness and transparency, collaboration and mutuality, empowerment, and attention to cultural/historical/gender issues affecting health (Weil, 2024). Ways in which Mrs. Jame's nurse could incorporate these principles into Mrs. Jame's care include:	Great job focusing on trauma informed care for this patient AND I LIKE HOW YOU INCLUDE CULTURE AS WELL! I recognize the question I asked was very broad so I am grading this question based on detailed	9.5/ 10

	● Ensuring that Mrs. James has as much privacy as possible during care
	● Allowing Mrs. James to set her goals for the day and assisting her in meeting those goals
	● Having Mrs. James decide the order in which necessary care tasks are done
	● If possible, creating a timeline for the day with Mrs. James' and sticking to that timeline
	  ○ If something comes up and the nurse is not able to stick to that timeline, they should communicate this with Mrs. James as soon as possible to limit the risk of re-traumatization given her history of neglect
	● Clarifying their role and the role of any other staff that assist in Mrs. James' care
	● Asking for Mrs. James' permission before touching her or performing any care tasks
	● Encouraging Mrs. James to voice if anything being done makes her feel uncomfortable
	● Inquiring about whether Mrs. James has any religious or cultural preferences that she would like to be incorporated into her care
	● Giving Mrs. James as many choices as possible and honoring those choices
	● Verbalizing to Mrs. James that the nurse is there to work with her, not do things to her
	● If Mrs. James declines any care, honoring the refusal but still educating on the potential outcomes related to the refusal
	  ○ Can be phrased as, "I completely understand that you don't want to do "a", and that is your choice. I do want to let you know that if we don't do "a", then "b" could happen. I just wanted to make sure that you were aware of this so that you can make an informed choice. If you change your mind and decide you would like to do "a", please let me know."
	● Asking Mrs. James if she would like to set designated check-in times with the nurse and honoring those check-in times
	  ○ The nurse could also ask Mrs. James if she would prefer to have another staff check-in with her or push back the check in
		explanations as opposed to the correct answer. Only missing being consistent with pain meds in answer, OVER GREAT WORK AND DETAILED ANSWERS	

	time if her nurse gets caught up doing care tasks with another patient during their set check in time ● Asking Mrs. James if she would like to work with the nurse to develop a care plan that outlines her care preferences so that when she has new staff working with her they can know her preferences References: Weil, A. (2024). Trauma-informed care in adults. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/trauma-informed-care-in-adults?search=trauma%20informed%20care&source=search_result&selectedTitle=1~28&usage_type=default&display_rank=1#H556055798 Feedback: I absolutely love that your question is focused on patient care! I would have appreciated would have been some information on how many ways the nurse can integrate the principles of trauma-informed care you were looking for and how specific you wanted us to be (sorry if I went a bit overboard).		
10	You should consult with the anesthesia provider before administering an additional dose of local anesthetic (LA). I would be concerned about local anesthetic system toxicity (LAST). Some potential symptoms of LAST that could be seen in the OR are changes in HR and BP (could be tachycardia and hypertension or bradycardia and hypotension) and muscle twitching (Warren & Pak, 2024). Patient risk factors: older age & lower body weight Treatment: IV lipid emulsion works by either binding to the LA and therefore removing it from the tissue, or by transporting the LA from the heart/brain to the organs that store it and break it down (Warren & Pak, 2024).	1. Correct, 2 points 2. Correct, 1 point 3. Correct, 2 points - thank you for your concise answer and for symptoms that are observable in the OR setting (ie patient draped and anesthetized). 4. Correct, 2 points - nice work identifying the factors specific to this patient! 5. Correct, 1 point References & citations - 1 point BONUS - Exactly correct! 1 point	10 / 10

	Bonus: Epinephrine slows the absorption of LA and reduces the peak plasma levels (Warren & Pak, 2025). This lowers the risk of LAST, especially when higher doses of LA are needed. References: Warren, L. & Pak, A. (2024) Local anesthetic systemic toxicity. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/local-anesthetic-systemic-toxicity?search=local%20anesthetic%20systemic%20toxicity&source=search_result&selectedTitle=1~49&usage_type=default&display_rank=1#H2872791588 Feedback: As someone who has never stepped foot in an OR outside of being a patient, I really struggled with this question and would have appreciated some contextual information about what all is used to monitor patients while they're in the OR. Otherwise, I appreciated that the answer expectations and point layout were very clear and that there was a bonus opportunity	Thank you for your specific feedback, that's super helpful. I will definitely think of this going forward.	
12	Jason most likely has adolescent idiopathic scoliosis (AIS), given that the key signs of the condition are a positive Adams forward bend test (seen in Jason by the increased prominence of his right scapula), waist tilting, and uneven waist creases (Scherl & Hasley, 2024a). The condition is due to a lateral curvature in the spine which causes rotation of the spinal column. The next steps in evaluation would be to use a scoliometer to determine the degree of ATR and to evaluate Jason for the presence of unequal leg lengths, as this can cause the development of spinal curvature. Jason should also be referred to a neurologist and to get a standing, full-length x-rays of his spine from posteroanterior and lateral views to confirm the presence of AIS, measure the Cobb angle, determine the pattern of the curve, evaluate the etiology, and evaluate skeletal maturity (Scherl & Hasley, 2024a). Given that Jason hasn't started puberty yet, there is a high risk of rapidly progressing AIS, as puberty is a time of rapid growth. This, in combination with hi	You provided a clinically sound and thoughtful approach. I appreciated your mention of the Adams test and imaging specifics. You also tied Jason's pubertal stage to progression risk appropriately. The neurologist referral seems a bit unnecessary without neurologic symptoms, still, this was a strong answer overall!	9/ 10

	s Cobb angle will help determine whether observation, bracing, or surgical intervention is the best course of treatment for Jason (Scherl & Hasley, 2024b). References: Scherl, S. & Hasley, B. (2024). Adolescent idiopathic scoliosis: Clinical features, evaluation, and diagnosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/adolescent-idiopathic-scoliosis-clinical-features-evaluation-and-diagnosis?search=scoliosis&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H12 Scherl, S. & Hasley, B. (2024). Adolescent idiopathic scoliosis: Management and prognosis. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/adolescent-idiopathic-scoliosis-management-and-prognosis?sectionName=APPROACH%20TO%20SURVEILLANCE%20AND%20MANAGEMENT&search=scoliosis&topicRef=6286&anchor=H14797078&source=see_link#H790748256 Feedback: You did a fantastic job with this question!!! You gave just enough background and clinical data to ensure that we had all of the information we needed to answer the question, without adding too much to make anything confusing. Also, the addition of the picture was extremely nice and gave a great visual for what you were describing!		
14	Kernig sign (Hasbun, 2024) ● Test: have patient supine with hip flexed to 90 degrees and attempt to move lower leg by extending the knee ● Positive result: pain in anterior thigh/low back or resistance to knee extension >135 degrees Brudzinski sign (Hasbun, 2024)	Your description of the assessments is correct (2 pts). Your priorities are mostly correct; however, I was also looking for placement of seizure pads to prevent injury, but I still awarded full points (3 pts). You gave a very nice, concise, SBAR (2 pts). The interventions would realistically happen very quickly and	10 / 10

	● Test: have the patient supine and flex the patient's head to their chest (make sure to tell them not to try to move their head for you to ensure its passive motion) ● Positive result: patient's knees and hips flex Prioritizes for Samantha's Seizure 1. Position Samantha on her side a. Rationale: positioning on the side helps prevent aspiration and protects the airway 2. Call the doctor to the bedside and provide medication per protocol or as ordered to stop seizure activity a. Rationale: we want to get the seizure activity to stop as soon as possible to limit the risk of lasting neurological deficits 3. Monitor VS, specifically oxygen saturation a. Rationale: seizure activity can result in hypoxia SBAR S- Samantha is a 27-year-old female who has been seizing since 12:03 B- She presented with worsening 9/10 headache pain, photophobia, and lethargy. AAO x1 and GCS 13 on arrival with nuchal rigidity, positive Kernig and Brudzinski signs, hypotension at 91/42, tachycardic at 124, and temp 39.8 C. A- I'm concerned that she may lose her airway if we can't get her seizure to stop. R- Can we please give her IV Ativan to stop the seizure activity Intervention order: 1. Prepare to assist with endotracheal intubation 2. Insert 2 large-bore IVs, or an IO if unable to obtain venous access 3. Administer 1500 mg of Levetiracetam 4. Administer 1L of Lactated Ringer's 5. Start a propofol drip at 50 mcg/kg/min 6. Obtain a BMP, CBC, LFTs, and 2 sets of blood cultures 7. Call the EEG tech for a STAT EEG	close together, however the correct answer is 4 (airway), 2 (access), 6 (propofol has anticonvulsant properties and will sedate her for intubation), 5 (volume / circulation), 1 (antiepileptic), 3 (labs), and 7 (EEG). I still awarded full points (1 pt). I really appreciated your answer to Charlotte and that you gave her the opportunity to ask questions (2 pts). Thank you very much for your feedback. I did realize this question was lengthy and I appreciate the time you took to provide a thorough answer. Great work!	

	Explanation: “While we’re going to have to wait on some test results to be sure, we’re worried that Samantha has a condition called bacterial meningitis. It’s caused by a bacterial infection in the brain and spinal cord and would explain all of her symptoms, even the seizure. Luckily, we were able to get the seizure to stop, but she’s going to need to be in the hospital for a while so we can monitor and treat her. It is possible that she may have some lasting neurological side effects, but we won’t know for sure until she starts responding to treatment. Would you like me to ask the doctor to come talk to you so they can try to give you more information?” References: Hasbun, R. (2024). Clinical features and diagnosis of acute bacterial meningitis in adults. *UpToDate*. Retrieved May 15, 2025, from https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-acute-bacterial-meningitis-in-adults?search=meningitis&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H4 Feedback: This question was extremely in depth, and I really like how it focused on nursing interventions.		
16	The patient most likely has gout. Pathophysiology: Gout occurs because of the formation of monosodium urate (MSU) crystals in the soft tissue, joints, and/or bones. For the MSU crystals to be able to form, the person must have hyperuricemia (high serum urate concentration), which can be caused by the body over producing urate, extrarenal underexcretion of urate, and renal underexcretion of urate (Merriman, 2024). While not everyone with hyperuricemia will develop gout, the risk factors for developing gout seem to promote the saturation of extracellular fluid urate levels. I would suspect that the patient would be put on a xanthine oxidase inhibitor, such as allopurinol, to lower their serum urate concentration	Your answer is very clear and touches on all of the components I was looking for. I liked how you also pointed out that not everyone with hyperuricemia will develop gout automatically; instead, specific risk factors are involved. Good work!	10/ 10

	(Perez-Ruiz, 2025). Reducing the consumption of animal proteins high in purine (red meats & organ meats), alcohol, high-fructose corn syrup, and sugar sweetened beverages can help lower serum urate levels and reduce the risk of gout flare ups. References: Merriman, T. (2024). Gout: Pathophysiology. *UpToDate*. Retrieved May 16, 2025, from https://www.uptodate.com/contents/gout-pathophysiology?search=gout&topicRef=1667&source=see_link Perez-Ruiz, F. (2025). Gout: Pharmacologic urate-lowering therapy and treatment of tophi. *UpToDate*. Retrieved May 16, 2025, from https://www.uptodate.com/contents/gout-pharmacologic-urate-lowering-therapy-and-treatment-of-tophi?sectionName=Indications&search=gout&topicRef=1666&anchor=H7&source=see_link#H7 Feedback: Your question was super clear, and I really liked that you included the part about dietary/nonpharmacological management of the condition.		
18	Given the fibula fracture and drilling into the talus, the patient could develop acute compartment syndrome (ACS), a deep vein thrombosis (DVT), or avascular necrosis (AVN) of the talus (Howe, 2025). Long bone fractures put patients at a notably higher risk of developing ACS (Hammerberg, 2025). Additionally, if the patient's cast is overly constricting or the patient's LLE has significant swelling after the cast is applied, he would be at an even higher risk of developing ACS. While removing the casting material and normalizing extremity perfusion through fluid resuscitation could help if the patient developed ACS (aligning the fracture can also help but that was already done surgically), the only definitive treatment for ACS is a fasciotomy. This would be done if the compartment pressure is within 30 mmHg of the patient's diastolic pressure and would involve cutting into the four compartments of the LLE through 1 or 2 incisions to relieve the pressure.	Despite being a difficult scenario, you did a great job answering the question with accurate information. You did go kind of overboard which is to my benefit. I didn't even think about avascular necrosis when I created this scenario. Appreciate the feedback!	10/ 10

	Patient would be at a higher risk of developing a DVT after surgical repair of his injuries d/t immobility reducing blood flow and injury to the vessels in the area r/t the injury and surgical repair. If this occurs, the interventions utilized would depend on the location of the DVT, the severity of the patient's symptoms, and the presence of any contraindications for anticoagulant therapy. Lip and Stevens (2025) recommend the following treatment: ● Proximal DVT = anticoagulation for most patients ○ Those at high risk of bleeding may receive unfractionated heparin due to the ability to reverse the effects of the medication quickly if bleeding occurs ○ Absolute contraindications for anticoagulation = retrievable IVC ● Distal DVT ○ Low risk of proximal extension and embolization = serial ultrasound and surveillance ▪ If it extends towards the proximal veins but stays in the calf, would indicate need for anticoagulation therapy assuming pt doesn't have any absolute contraindications ○ High risk of proximal extension & low bleeding risk = anticoagulation therapy ○ High risk of proximal extension & bleeding = serial ultrasound and surveillance Trauma to the talus, even that done for surgical repair, puts the patient at risk of developing AVN of the talus because of injury to the vasculature of the bone. If this occurs, Dhillon et al. (2018) recommend that MRI and x-ray are used to stage the AVN and the following interventions are utilized for cases of traumatic AVN: (of note, the list is structured such that if the first listed intervention doesn't work you move to the next listed intervention) ● Early AVN (stage 1 or 2) ○ Conservative management ▪ Non-weight bearing until union which is then progressed to protective weight bearing ▪ Extracorporeal shockwave therapy		

- Monitor for signs of collapse or progression
  - Core decompression
  - Bone grafting
  - Salvage operation
- Early Stage 3 (< 1mm collapse)
  - Trial of core decompression and limited fusion
  - Salvage operation
- Late Stage 3 or Stage 4
  - If feasible, talar replacement and total ankle replacement
  - Salvage operation

Given that the patient had a serious fibula fracture that required surgical correction, they could be back to playing baseball in 4 months, but it may take longer, especially if they have any complications (Fields, 2023). Additionally, they need to wait for provider clearance before returning to baseball due to the risk of reinjuring the bone if they return before it's fully healed.

References:

Dhillon, M. S., Rana, B., Panda, I., Patel, S., & Kumar, P. (2018). Management Options in Avascular Necrosis of Talus. *Indian journal of orthopaedics*, *52*(3), 284–296. https://doi.org/10.4103/ortho.IJOrtho_608_17

Fields, K. (2023). Fibula fractures. *UpToDate*. Retrieved May 17, 2025, from https://www.uptodate.com/contents/fibula-fractures?search=fibula%20fracture%20treatment&source=search_result&selectedTitle=1~44&usage_type=default&display_rank=1#H9

Hammerberg, E. (2025). Acute compartment syndrome of the extremities. *UpToDate*. Retrieved May 17, 2025, from https://www.uptodate.com/contents/acute-compartment-syndrome-of-the-extremities?search=maisonneuve%20fracture&topicRef=13798&source=see_link#H3

Howe, A. (2025). General principles of fracture management: Early and

	late complications. *UpToDate*. Retrieved May 16, 2025, from https://www.uptodate.com/contents/general-principles-of-fracture-management-early-and-late-complications?search=maisonneuve%20fracture&topicRef=237&source=related_link#H66786309 Lip, G. & Stevens, S. (2025). Overview of the treatment of lower extremity deep vein thrombosis (DVT). *UpToDate*. Retrieved May 17, 2025, from https://www.uptodate.com/contents/overview-of-the-treatment-of-lower-extremity-deep-vein-thrombosis-dvt?search=post%20operation%20dvt%20management&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H505990327 Feedback: I realize I may have gone a bit overboard with my answer, but I had a difficult time finding concise answers to complication management. Overall, though, I really enjoyed how thorough the question was and that it focused on things a nurse would be monitoring for post-op and educating the patient/their family on.		
20	The assessments that I would want to do for this patient would be: ● assessing the circulation in the lower extremities through cap refill, skin color and temperature, and strength of pulses to ensure that the RLE is equal to the LLE and has adequate blood flow ● assessing the peripheral nervous system in the lower extremities by having the pt wiggle their toes and reporting whether they can feel me touching their feet and if it feels the same on both feet ● assessing the surgical site and note the amount/type of drainage while keeping an eye out for increased bleeding (given that the patient has just finished surgery, I wouldn't expect any signs of infection to be present yet, but I would also note them if present) ○ If there is a dressing on the surgical incision, I would ensure to check the orders and consult with the surgeon to determine whether the dressing can be removed at this time for a full assessment of the surgical site	1.3/3 That's awesome you mention all the good points. 2.3/3 you list more than 3 pieces of information!!! 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

	○ If I am unable to remove the dressing, I would make sure to note that in my charting, in addition to if there is any drainage that can be seen soaking through the dressing ● have the pt rate their pain from 1-10 so that it can be monitored more effectively ● assess all line, drains, and tubes to ensure they're patent/not kinked and properly connected to the patient and their associated devices (e.g., that the PIV tubing is running from the IV bag, through the pump, and into the pt's PIV site) ● ensure that the LR is running at the rate that is ordered Nursing management interventions: ● Provide pain medications as ordered to prevent breakthrough pain and help reduce risk of patient refusing to ambulate due to pain ● Encourage and facilitate ambulation as ordered and tolerated (may also ask PT to help/provide mobility aids if needed or ask them to be present for when the pt ambulates for the first time) ● Re-enforce importance of prescribed ROM restrictions and facilitate compliance by ensuring that the pt's bed is at the correct height and their toilet has an elevated seat if needed Discharge Education ● Continuing to move and remain active, as allowed by the provider, is important and can help reduce the risk of post-surgical complications such as DVTs, or blood clots in the legs (Erens & Crowley, 2025) ● "If you notice that the skin around your incision becomes red, swollen, increasingly painful, or hot to touch, or if you notice any foul swelling discharge coming out of your incision, notify your provider immediately, as these can all be signs of infection." ● Avoid high impact activity, such as running, or contact sports until they are approved by your provider to limit your risk of complications ● If the provider has told the pt to limit hip ROM to ≦ 90 degrees, "Until you are told otherwise, your provider wants you to not extend your hip past 90 degrees. You can think of this as not bringing your right leg further than it would be if you were sitting on a flat surface with your leg out straight in front of you. The reason that the provider doesn't want		

	you to bend your hip more than this is it can cause your hip to dislocate. To help avoid this, you'll want to avoid sitting on low couches/chairs and, if you can, getting in and out of low seated cars. If you can't avoid these things, you can use pillows or firm cushions to raise the seat to an appropriate height. You'll also want to be mindful of the height of your toilet at home, and if it's low, you'll want to consider getting a raised toilet seat. Would you like me to pull up some pictures of either of these things?" References: Erens, G. & Crowley, M. (2025). Total hip arthroplasty. *UpToDate*. Retrieved May 17, 2025, from https://www.uptodate.com/contents/total-hip-arthroplasty?search=total%20hip%20arthroplasty&source=search_result&selectedTitle=1~145&usage_type=default&display_rank=1#H3453959869 Feedback: I absolutely love that your question focused on the nursing specific aspects of this patients care. You also did a great job making the question extremely clear.		