**CityWide ED Orientation**

**Quiz: Neuro System – Answer Key**

1. Which of the following is considered the most reliable indicator of neurological function
2. Glasgow Coma Scale
3. Pupillary reaction
4. **Level of consciousness**
5. Motor changes
6. Which of the following signs and symptoms is an early indication of increased intracranial pressure?
7. **Change in level of consciousness**
8. Papilledema
9. Respiratory depression
10. Dilated pupils
11. Which of the following totals for a Glasgow Coma Scale score would be classified as a moderate head injury?
12. 3
13. 15
14. 8
15. **11**
16. An elderly patient is admitted to the ED with progressive confusion over the past three weeks. Which of the following focal head injuries is the most likely the cause of the patient’s progressive confusion?
17. Epidural hematoma
18. **Subdural hematoma**
19. Concussion
20. Skull fractures
21. A patient presents to the ED with altered level of consciousness. You would complete all assessments except for:
22. Glasgow coma scale
23. Finger pick glucose
24. Vital signs
25. **Foley insertion**
26. A teenager presents to the ED following a car crash. He is evaluated and determined to have a closed head injury with a possible cervical fracture. The ED nurse determines the following with a Glasgow Comas Scale (GCS) evaluation: no eye opening with stimulation, no verbal response prior to intubation, and no motor response with IV insertions. Which of the following GCS scores would be appropriate for this patient?
    1. Eye: 0; Motor: 0; Verbal: 0
    2. Eye: 1; Motor: 0; Verbal: 0
    3. **Eye: 1; Motor: 1; Verbal: 1**
    4. Eye: 0; Motor: 1; Verbal: 1
27. A patient who is seizing should be placed in:
    1. Restraints
    2. A prone position
    3. A supine position
    4. **Left lateral decubitus position**
28. When preparing a patient with a suspected spinal cord injury for transport to another facility, the nurse should anticipate:
    1. Administering prophylactic anticonvulsants
    2. Assisting with endotracheal intubation
    3. **Placing the patient in spinal immobilization**
    4. Elevating the head of the bed to 30 degrees.
29. Which of the following conditions would the nurse suspect in a patient with suspected T1 spinal cord injury whose initial assessment includes BP of 80/38, HR 38, dry skin, and flaccid paralysis of the lower extremities?
    1. Autonomic dysreflexia
    2. Spinal shock
    3. **Neurogenic shock**
    4. Hypervolemia
30. Meningeal irritation is indicated by which of the following findings?
    1. Abnormal flexion
    2. Positive “Babinski” reflex
    3. Peripheral paresthesias
    4. **Nuchal rigidity**