1. What is the priority nursing diagnosis for a patient experiencing a migraine headache?
   a. Acute pain related to biologic and chemical factors
   b. Anxiety related to change in or threat to health status
   c. Hopelessness related to deteriorating physiological condition
   d. Risk for Side effects related to medical therapy

2. You are creating a teaching plan for a patient with newly diagnosed migraine headaches. Which key items should be included in the teaching plan? (Choose all that apply).
   a. Avoid foods that contain tyramine, such as alcohol and aged cheese.
   b. Avoid drugs such as Tagamet, nitroglycerin and Nifedipine.
   c. Abortive therapy is aimed at eliminating the pain during the aura.
   d. A potential side effect of medications is rebound headache.
   e. Complementary therapies such as relaxation may be helpful.
   f. Continue taking estrogen as prescribed by your physician.

3. The patient with migraine headaches has a seizure. After the seizure, which action can you delegate to the nursing assistant?
   a. Document the seizure.
   b. Perform neurologic checks.
   c. Take the patient’s vital signs.
   d. Restrain the patient for protection.

4. You are preparing to admit a patient with a seizure disorder. Which of the following actions can you delegate to LPN/LVN?
   a. Complete admission assessment.
   b. Set up oxygen and suction equipment.
   c. Place a padded tongue blade at bedside.
   d. Pad the side rails before patient arrives.

5. A nursing student is teaching a patient and family about epilepsy prior to the patient’s discharge. For which statement should you intervene?
   a. “You should avoid consumption of all forms of alcohol.”
   b. “Wear you medical alert bracelet at all times.”
   c. “Protect your loved one’s airway during a seizure.”
   d. “It’s OK to take over-the-counter medications.”

6. A patient with Parkinson’s disease has a nursing diagnosis of Impaired Physical Mobility related to neuromuscular impairment. You observe a nursing assistant performing all of these actions. For which action must you intervene?
   a. The NA assists the patient to ambulate to the bathroom and back to bed.
   b. The NA reminds the patient not to look at his feet when he is walking.
   c. The NA performs the patient’s complete bath and oral care.
d. The NA sets up the patient’s tray and encourages patient to feed himself.

7. The nurse is preparing to discharge a patient with chronic low back pain. Which statement by the patient indicates that additional teaching is necessary?
   a. “I will avoid exercise because the pain gets worse.”
   b. “I will use heat or ice to help control the pain.”
   c. “I will not wear high-heeled shoes at home or work.”
   d. “I will purchase a firm mattress to replace my old one.”

8. A patient with a spinal cord injury (SCI) complains about a severe throbbing headache that suddenly started a short time ago. Assessment of the patient reveals increased blood pressure (168/94) and decreased heart rate (48/minute), diaphoresis, and flushing of the face and neck. What action should you take first?
   a. Administer the ordered acetaminophen (Tylenol).
   b. Check the Foley tubing for kinks or obstruction.
   c. Adjust the temperature in the patient’s room.
   d. Notify the physician about the change in status.

9. Which patient should you, as charge nurse, assign to a new graduate RN who is orienting to the neurologic unit?
   a. A 28-year-old newly admitted patient with spinal cord injury
   b. A 67-year-old patient with stroke 3 days ago and left-sided weakness
   c. An 85-year-old dementia patient to be transferred to long-term care today
   d. A 54-year-old patient with Parkinson’s who needs assistance with bathing

10. A patient with a spinal cord injury at level C3-4 is being cared for in the ED. What is the priority assessment?
    a. Determine the level at which the patient has intact sensation.
    b. Assess the level at which the patient has retained mobility.
    c. Check blood pressure and pulse for signs of spinal shock.
    d. Monitor respiratory effort and oxygen saturation level.

11. You are pulled from the ED to the neurologic floor. Which action should you delegate to the nursing assistant when providing nursing care for a patient with SCI?
    a. Assess patient’s respiratory status every 4 hours.
    b. Take patient’s vital signs and record every 4 hours.
    c. Monitor nutritional status including calorie counts.
    d. Have patient turn, cough, and deep breathe every 3 hours.

12. You are helping the patient with an SCI to establish a bladder-retraining program. What strategies may stimulate the patient to void? (Choose all that apply).
    a. Stroke the patient’s inner thigh.
    b. Pull on the patient’s pubic hair.
    c. Initiate intermittent straight catheterization.
    d. Pour warm water over the perineum.
    e. Tap the bladder to stimulate detrusor muscle.
13. The patient with a cervical SCI has been placed in fixed skeletal traction with a halo fixation device. When caring for this patient the nurse may delegate which action(s) to the LPN/LVN? (Choose all that apply).
   a. Check the patient’s skin for pressure form device.
   b. Assess the patient’s neurologic status for changes.
   c. Observe the halo insertion sites for signs of infection.
   d. Clean the halo insertion sites with hydrogen peroxide.

14. You are preparing a nursing care plan for the patient with SCI including the nursing diagnoses Impaired Physical Mobility and Self-Care Deficit. The patient tells you, “I don’t know why we’re doing all this. My life’s over.” What additional nursing diagnosis takes priority based on this statement?
   a. Risk for Injury related to altered mobility
   b. Imbalanced Nutrition, Less Than Body Requirements
   c. Impaired Adjustment to Spinal Cord Injury
   d. Poor Body Image related to immobilization

15. Which patient should be assigned to the traveling nurse, new to neurologic nursing care, who has been on the neurologic unit for 1 week?
   a. A 34-year-old patient newly diagnosed with multiple sclerosis (MS)
   b. A 68-year-old patient with chronic amyotrophic lateral sclerosis (ALS)
   c. A 56-year-old patient with Guillain-Barre syndrome (GBS) in respiratory distress
   d. A 25-year-old patient admitted with CA level spinal cord injury (SCI)

16. The patient with multiple sclerosis tells the nursing assistant that after physical therapy she is too tired to take a bath. What is your priority nursing diagnosis at this time?
   a. Fatigue related to disease state
   b. Activity Intolerance due to generalized weakness
   c. Impaired Physical Mobility related to neuromuscular impairment
   d. Self-care Deficit related to fatigue and neuromuscular weakness

17. The LPN/LVN, under your supervision, is providing nursing care for a patient with GBS. What observation would you instruct the LPN/LVN to report immediately?
   a. Complaints of numbness and tingling
   b. Facial weakness and difficulty speaking
   c. Rapid heart rate of 102 beats per minute
   d. Shallow respirations and decreased breath sounds

18. The nursing assistant reports to you, the RN, that the patient with myasthenia gravis (MG) has an elevated temperature (102.2°F), heart rate of 120/minute, rise in blood pressure (158/94), and was incontinent off urine and stool. What is your best first action at this time?
   a. Administer an acetaminophen suppository.
   b. Notify the physician immediately.
   c. Recheck vital signs in 1 hour.
d. Reschedule patient’s physical therapy.

19. You are providing care for a patient with an acute hemorrhage stroke. The patient’s husband has been reading a lot about strokes and asks why his wife did not receive alteplase. What is your best response?
   a. “Your wife was not admitted within the time frame that alteplase is usually given.”
   b. “This drug is used primarily for patients who experience an acute heart attack.”
   c. “Alteplase dissolves clots and may cause more bleeding into your wife’s brain.”
   d. “Your wife had gallbladder surgery just 6 months ago and this prevents the use of alteplase.”

20. You are supervising a senior nursing student who is caring for a patient with a right hemisphere stroke. Which action by the student nurse requires that you intervene?
   a. The student instructs the patient to sit up straight, resulting in the patient’s puzzled expression.
   b. The student moves the patient’s tray to the right side of her over-bed tray.
   c. The student assists the patient with passive range-of-motion (ROM) exercises.
   d. The student combs the left side of the patient’s hair when the patient combs only the right side.

21. Which action(s) should you delegate to the experienced nursing assistant when caring for a patient with a thrombotic stroke with residual left-sided weakness? (Choose all that apply).
   a. Assist patient to reposition every 2 hours.
   b. Reapply pneumatic compression boots.
   c. Remind patient to perform active ROM.
   d. Check extremities for redness and edema.

22. The patient who had a stroke needs to be fed. What instruction should you give to the nursing assistant who will feed the patient?
   a. Position the patient sitting up in bed before you feed her.
   b. Check the patient’s gag and swallowing reflexes.
   c. Feed the patient quickly because there are three more waiting.
   d. Suction the patient’s secretions between bites of food.

23. You have just admitted a patient with bacterial meningitis to the medical-surgical unit. The patient complains of a severe headache with photophobia and has a temperature of 102.6°F orally. Which collaborative intervention must be accomplished first?
   a. Administer codeine 15 mg orally for the patient’s headache.
   b. Infuse ceftriaxone (Rocephin) 2000 mg IV to treat the infection.
   c. Give acetaminophen (Tylenol) 650 mg orally to reduce the fever.
   d. Give furosemide (Lasix) 40 mg IV to decrease intracranial pressure.

24. You are mentoring a student nurse in the intensive care unit (ICU) while caring for a patient with meningococcal meningitis. Which action by the student requires that you intervene immediately?
a. The student enters the room without putting on a mask and gown.
b. The student instructs the family that visits are restricted to 10 minutes.
c. The student gives the patient a warm blanket when he says he feels cold.
d. The student checks the patient’s pupil response to light every 30 minutes.

25. A 23-year-old patient with a recent history of encephalitis is admitted to the medical unit with new onset generalized tonic-clonic seizures. Which nursing activities included in the patient’s care will be best to delegate to an LPN/LVN whom you are supervising? (Choose all that apply).
   a. Document the onset time, nature of seizure activity, and postictal behaviors for all seizures.
   b. Administer phenytoin (Dilantin) 200 mg PO daily.
   c. Teach patient about the need for good oral hygiene.
   d. Develop a discharge plan, including physician visits and referral to the Epilepsy Foundation.

26. While working in the ICU, you are assigned to care for a patient with a seizure disorder. Which of these nursing actions will you implement first if the patient has a seizure?
   a. Place the patient on a non-rebreather mask with the oxygen at 15 L/minute.
   b. Administer lorazepam (Ativan) 1 mg IV.
   c. Turn the patient to the side and protect airway.
   d. Assess level of consciousness during and immediately after the seizure.

27. A patient recently started on phenytoin (Dilantin) to control simple complex seizures is seen in the outpatient clinic. Which information obtained during his chart review and assessment will be of greatest concern?
   a. The gums appear enlarged and inflamed.
   b. The white blood cell count is 2300/mm3.
   c. Patient occasionally forgets to take the phenytoin until after lunch.
   d. Patient wants to renew his driver’s license in the next month.

28. After receiving a change-of-shift report at 7:00 AM, which of these patients will you assess first?
   a. A 23-year-old with a migraine headache who is complaining of severe nausea associated with retching
   b. A 45-year-old who is scheduled for a craniotomy in 30 minutes and needs preoperative teaching
   c. A 59-year-old with Parkinson’s disease who will need a swallowing assessment before breakfast
   d. A 63-year-old with multiple sclerosis who has an oral temperature of 101.8°F and flank pain

29. All of these nursing activities are included in the care plan for a 78-year-old man with Parkinson’s disease who has been referred to your home health agency. Which ones will you delegate to a nursing assistant (NA)? (Choose all that apply).
   a. Check for orthostatic changes in pulse and bloods pressure.
b. Monitor for improvement in tremor after levodopa (L-dopa) is given.
c. Remind the patient to allow adequate time for meals.
d. Monitor for abnormal involuntary jerky movements of extremities.
e. Assist the patient with prescribed strengthening exercises.
f. Adapt the patient’s preferred activities to his level of function.

30. As the manager in a long-term-care (LTC) facility, you are in charge of developing a standard plan of care for residents with Alzheimer’s disease. Which of these nursing tasks is best to delegate to the LPN team leaders working in the facility?
   a. Check for improvement in resident memory after medication therapy is initiated.
   b. Use the Mini-Mental State Examination to assess residents every 6 months.
   c. Assist residents to toilet every 2 hours to decrease risk for urinary intolerance.
   d. Develop individualized activity plans after consulting with residents and family.

31. A patient who has been admitted to the medical unit with new-onset angina also has a diagnosis of Alzheimer’s disease. Her husband tells you that he rarely gets a good night’s sleep because he needs to be sure she does not wander during the night. He insists on checking each of the medications you give her to be sure they are the same as the ones she takes at home. Based on this information, which nursing diagnosis is not appropriate for this patient?
   a. Decreased Cardiac Output related to poor myocardial contractility
   b. Caregiver Role Strain related to continuous need for providing care
   c. Ineffective Therapeutic Regimen Management related to poor patient memory
   d. Risk for Falls related to patient wandering behavior during the night

32. You are caring for a patient with a recurrent glioblastoma who is receiving dexamethasone (Decadron) 4 mg IV every 6 hours to relieve symptoms of right arm weakness and headache. Which assessment information concerns you the most?
   a. The patient does not recognize family members.
   b. The blood glucose level is 234 mg/dL.
   c. The patient complains of a continued headache.
   d. The daily weight has increased 1 kg.

33. A 70-year-old alcoholic patient with acute lethargy, confusion, and incontinence is admitted to the hospital ED. His wife tells you that he fell down the stairs about a month ago, but “he didn’t have a scratch afterward.” She feels that he has become gradually less active and sleepier over the last 10 days or so. Which of the following collaborative interventions will you implement first?
   a. Place on the hospital alcohol withdrawal protocol.
   b. Transfer to radiology for a CT scan.
   c. Insert a retention catheter to straight drainage.
   d. Give phenytoin (Dilantin) 100 mg PO.
34. Which of these patients in the neurologic ICU will be best to assign to an RN who has floated from the medical unit?
   a. A 26-year-old patient with a basilar skull structure who has clear drainage coming out of the nose
   b. A 42-year-old patient admitted several hours ago with a headache and diagnosed with a ruptured berry aneurysm.
   c. A 46-year-old patient who was admitted 48 hours ago with bacterial meningitis and has an antibiotic dose due
   d. A 65-year-old patient with a astrocytoma who has just returned to the unit after having a craniotomy
RATIONALE
NEUROLOGIC PROBLEMS

1. **ANSWER A** – The priority for interdisciplinary care for the patient experiencing a migraine headache is pain management. All of the other nursing diagnoses are accurate, but none of them is as urgent as the issue of pain, which is often incapacitating. **Focus:** Prioritization

2. **ANSWERS A, B, C, D & E** – Medications such as estrogen supplements may actually trigger a migraine headache attack. All of the other statements are accurate. **Focus:** Prioritization

3. **ANSWER C** – Taking vital signs is within the education and scope of practice for a nursing assistant. The nurse should perform neurologic checks and document the seizure. Patients with seizures should not be restrained; however, the nurse may guide the patient’s movements as necessary. **Focus:** Delegation/supervision

4. **ANSWER B** – The LPN/LVN can set up the equipment for oxygen and suctioning. The RN should perform the complete initial assessment. Padded side rails are controversial in terms of whether they actually provide safety and not embarrass the patient and family. Tongue blades should not be at the bedside and should never be inserted into the patient’s mouth after a seizure begins. **Focus:** Delegation/supervision.

5. **ANSWER D** – A patient with a seizure disorder should not take over-the-counter medications without consulting with the physician first. The other three statements are appropriate teaching points for patients with seizures disorders and their families. **Focus:** Delegation/supervision

6. **ANSWER C** – The nursing assistant should assist the patient with morning care as needed, but the goal is to keep this patient as independent and mobile as possible. Assisting the patient to ambulate, reminding the patient not to look at his feet (to prevent falls), and encouraging the patient to feed himself are all appropriate to goal of maintaining independence. **Focus:** Delegation/supervision

7. **ANSWER A** – Exercises are used to strengthen the back, relieve pressure on compressed nerves and protect the back from re-injury. Ice, heat, and firm mattresses are appropriate interventions for back pain. People with chronic back pain should avoid wearing high-heeled shoes at all times. **Focus:** Prioritization

8. **ANSWER B** – These signs and symptoms are characteristic of autonomic dysreflexia, a neurologic emergency that must be promptly treated to prevent a hypertensive stroke. The cause of this syndrome is noxious stimuli, most often a distended bladder or constipation, so checking for poor catheter drainage, bladder distention, or fecal impaction is the first action that should be taken. Adjusting the room temperature may be helpful, since too cool a temperature in the room may contribute to the problem. Tylenol will not decrease the autonomic dysreflexia that is causing the patient’s headache. Notification of the physician may be necessary if nursing actions do not resolve symptoms. **Focus:** Prioritization
9. **Answer B** – The new graduate RN who is oriented to the unit should be assigned stable, non-complex patients, such as the patient with stroke. The patient with Parkinson’s disease needs assistance with bathing, which is best delegated to the nursing assistant. The patient being transferred to the nursing home and the newly admitted SCI should be assigned to experienced nurses. **Focus: Assignment**

10. **Answer D** – The first priority for the patient with an SCI is assessing respiratory patterns and ensuring an adequate airway. The patient with a high cervical injury is at risk for respiratory compromise because the spinal nerves (C3 – 5) innervate the phrenic nerve, which controls the diaphragm. The other assessments are also necessary, but not as high priority. **Focus: Prioritization**

11. **Answer B** – The nursing assistant’s training and education include taking and recording patient’s vital signs. The nursing assistant may assist with turning and repositioning the patient and may remind the patient to cough and deep breathe but does not teach the patient how to perform these actions. Assessing and monitoring patients require additional education and are appropriate to the scope of practice for professional nurses. **Focus: Delegation/supervision**

12. **Answers A, B, D & E** – All of the strategies, except straight catheterization, may stimulate voiding in patients with SCI. Intermittent bladder catheterization can be used to empty the patient’s bladder, but it will not stimulate voiding. **Focus: Prioritization**

13. **Answers A, C & D** – Checking and observing for signs of pressure or infection are within the scope of practice of the LPN/LVN. The LPN/LVN also has the appropriate skills for cleaning the halo insertion sites with hydrogen peroxide. Neurologic examination requires additional education and skill appropriate to the professional RN. **Focus: Delegation/supervision**

14. **Answer C** – The patient’s statement indicates impairment of adjustment to the limitations of the injury and indicates the need for additional counseling, teaching, and support. The other three nursing diagnoses may be appropriate to the patient with SCI, but they are not related to the patient’s statement. **Focus: Prioritization**

15. **Answer B** – The traveling is relatively new to neurologic nursing and should be assigned patients whose conditions are stable and not complex. The newly diagnosed patient will need to be transferred to the ICU. The patient with C4 SCI is at risk for respiratory arrest. All three of these patients should be assigned to nurses experienced in neurologic nursing care. **Focus: Assignment**

16. **Answer D** – At this time, based on the patient’s statement, the priority is Self-Care Deficit related to fatigue after physical therapy. The other three nursing diagnoses are appropriate to a patient with MS, but they are not related to the patient’s statement. **Focus: Prioritization**

17. **Answer D** – The priority interventions for the patient with GBS are aimed at maintaining adequate respiratory function. These patients are risk for respiratory failure, which is urgent. The other findings are important and should be reported to the nurse, but they are not life-threatening. **Focus: Prioritization, delegation/supervision**
18. **ANSWER B** – The changes that the nursing assistant is reporting are characteristics of myasthenia crisis, which often follows some type of infection. The patient is at risk for inadequate respiratory function. In addition to notifying the physician, the nurse should carefully monitor the patient’s respiratory status. The patient may need incubation and mechanical ventilation. The nurse would notify the physician before giving the suppository because there may be orders for cultures before giving acetaminophen. This patient’s vital signs need to be re-checked sooner than 1 hour. Rescheduling the physical therapy can be delegated to the unit clerk and is not urgent. **Focus:** Prioritization

19. **ANSWER C** – Alteplase is a clot buster. With patient who has experienced hemorrhagic stroke, there is already bleeding into the brain. A drug like alteplase can worsen the bleeding. The other statements are also accurate about use of alteplase, but they are not pertinent to this patient’s diagnosis. **Focus:** Prioritization

20. **ANSWER A** – Patients with right cerebral hemisphere stroke often present with neglect syndrome. They lean to the left and when asked, respond that they believe they are sitting up straight. They often neglect the left side of their bodies and ignore food on the left side of their food trays. The nurse would need to remind the student of this phenomenon and discuss the appropriate interventions. **Focus:** Delegation/supervision

21. **ANSWER A, B and C** – The experienced nursing assistant would know how to reposition the patient and how to reapply compression boots, and would remind the patient to perform activities he has been taught to perform. Assessing for redness and swelling (signs of deep venous thrombosis {DVT}) requires additional education and still appropriate to the professional nurse. **Focus:** Delegation/supervision

22. **ANSWER A** – Positioning the patient in a sitting position decreases the risk of aspiration. The nursing assistant is not trained to assess gag or swallowing reflexes. The patient should not be rushed during feeding. A patient who needs to be suctioned between bites of food is not handling secretions and is at risk for aspiration. This patient should be assessed further before feeding. **Focus:** Delegation/supervision

23. **ANSWER A** – Untreated bacterial meningitis has a mortality rate approaching 100%, so rapid antibiotic treatment is essential. The other interventions will help reduce CNS stimulation and irritation, and should be implemented as soon as possible. **Focus:** Prioritization

24. **ANSWER A** – Meningococcal meningitis is spread through contact with respiratory secretions so use of a mask and gown is required to prevent spread of the infection to staff members or other patients. The other actions may not be appropriate but they do not require intervention as rapidly. The presence of a family member at the bedside may decrease patient confusion and agitation. Patients with hyperthermia frequently complain of feeling chilled, but warming the patient is not an appropriate intervention. Checking the pupil response to light is appropriate, but it is not needed every 30 minutes and is uncomfortable for a patient with photophobia. **Focus:** Prioritization
25. ANSWER B – Administration of medications is included in LPN education and scope of practice. Collection of data about the seizure activity may be accomplished by an LPN/LVN who observes initial seizure activity. An LPN/LVN would know to call the supervising RN immediately if a patient started to seize. Documentation of the seizure, patient teaching, and planning of care are complex activities that require RN level education and scope of practice. Focus: Delegation

26. ANSWER C – The priority action during a generalized tonic-clonic seizure is to protect the airway. Administration of lorazepam should be the next action, since it will act rapidly to control the seizure. Although oxygen may be useful during the postictal phase, the hypoxemia during tonic-clonic seizures is caused by apnea. Checking the level of consciousness is not appropriate during the seizure, because generalized tonic-clonic seizures are associated with a loss of consciousness. Focus: Prioritization

27. ANSWER B – Leukopenia is a serious adverse effect of phenytoin and would require discontinuation of the medication. The other data indicate a need for further assessment and/or patient teaching, but will not require a change in medical treatment for the seizures. Focus: Prioritization

28. ANSWER D – Urinary tract infections are a frequent complication in patient with multiple sclerosis because of the effect on bladder function. The elevated temperature and decreased breath sounds suggest that this patient may have pyelonephritis. The physician should be notified immediately so that antibiotic therapy can be started quickly. The other patients should be assessed soon, but do not have needs as urgent and this patient. Focus: Prioritization

29. ANSWERS A, C and E – NA education and scope of practice includes taking pulse and blood pressure measurements. In addition, NAs can reinforce previous teaching or skills taught by the RN or other disciplines, such as speech or physical therapists. Evaluation of patient response to medication and development and individualizing the plan of care require RN-level education and scope of practice. Focus: Prioritization

30. ANSWER A – LPN education and team leader responsibilities include checking for the therapeutic and adverse effects of medications. Changes in the residents’ memory would be communicated to the RN supervisor, who is responsible for overseeing the plan of care for each resident. Assessment for changes on the Mini-Mental State Examination and developing the plan of care are RN responsibilities. Assisting residents with personal care and hygiene would be delegated to nursing assistants working the LTC facility. Focus: Delegation

31. ANSWER B – The husband’s statement about lack of sleep and anxiety over whether the patient is receiving the correct medications are behaviors that support this diagnosis. There is no evidence that the patient’s cardiac output is decreased. The husband’s statements about how he monitors the patient and his concern with medication administration indicate that the Risk for Ineffective Therapeutic Regimen Management and falls are not priorities at this time. Focus: Prioritization

32. ANSWER A – The inability to recognize a family member is a new neurologic deficit for this patient, and indicates a possible increase in intracranial pressure (ICP). This change should be communicated to the physician immediately so that
treatment can be initiated. The continued headache also indicates that the ICP may be elevated, but it is not a new problem. The glucose elevation and weight gain are common adverse effects of dexamethasone that may require treatment, but they are not emergencies. Focus: Prioritization

33. **ANSWER B** – The patient’s history and assessment data indicate that he may have a chronic subdural hematoma. The priority goal is to obtain a rapid diagnosis and send the patient to surgery to have the hematoma evacuated. The other interventions also should be implemented as soon as possible, but the initial nursing activities should be directed toward treatment of any intracranial lesion. Focus: Prioritization

34. **ANSWER C** – This patient is the most stable of the patients listed. An RN from the medical unit would be familiar with administration of IV antibiotics. The other patients require assessments and care from RNs more experienced in caring for patients with neurologic diagnoses. Focus: Assignment