ATI Real Life Student Packet
N202 Advanced Concepts of Nursing
2022

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ATI Scenario: CKD

To Be Completed Before the Simulation

****** Blue boxes should be completed using textbook information. What do you expect to find? This information should be collected before you start the ATI simulation.

Medical Diagnosis: CKD

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures

Consist of two kidneys, two ureters, urinary bladder, and a urethra. The kidneys produce urine and other components of the urinary system allows for temporary storage for the urine or serve as transportation channels to carry the urine. The two kidneys are bean shaped organs. In addition to producing urine, they filter blood before sending it back to the heart. This is made possible due to the nephrons in the kidneys. Nephrons metabolize the nutrients and excrete the waste products.
Functions include:

- Filter/waste production
- Elimination
- Renin production
- Regulate fluid volume
- Regulate BP
- Transform vitamin D into its active form (making it usable by the body)
- Assist to produce hormones to aid in RBC production

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

CKD is progressive and irreversible. A patient with CKD may not display symptoms unless under stress (physical, mental, emotional). With a decrease in kidney function, patient will begin to show symptoms.
CKD has 5 stages:
Stage 1: Minimal kidney damage when GFR within expected reference range (greater than 90mL/min)

Stage 2: Mild kidney damage with mildly decreased GFR (60-89 mL/min)

Stage 3: Moderate kidney damage with moderate decrease in GFR (30-59 mL/min)

Stage 4: Severe kidney damage with severe decrease in GFR (15-29mL/min)

Stage 5: Kidney failure and end- stage renal disease with little or no glomerular filtration (less than 15mL/min)

Anticipated Patient Problems, Goals, & Interventions Based on Medical Diagnosis

** This worksheet should be completed before you begin the ATI simulation.

Problem #1: Excess fluid volume

Patient Goals:

1. ___ will not have weight gain >/= 3lbs and will not have +2 pitting edema daily.
2. ___ will have a heart rate between 60 and 100, no SOB or crackles during my care.

Assessments:

- HR, Spo2, BP q4hrs, bilateral lung sounds q4hrs, extremities for edema q8hrs, strict I&O q4hrs, weight daily, BUN, creatinine, and electrolytes daily

Interventions (In priority order):

1. Elevate HOB to 60˚ when feeling SOB.
2. Apply oxygen as needed.
3. Encourage lower extremity elevation while sitting.
4. Administer antihypertension medication at prescribed time.
5. Provide renal diet each meal.
6. Teach about sodium and fluid restrictions each shift.

Problem #2: risk for decreased cardiac output

Patient Goals:

1. ___ will have BP within 20mm Hg of baseline and a HR between 60 and 100 during my care.
2. ___ will have strong peripheral pulses, warm dry skin, absence of crackles during my care.

Assessments:

- HR, temp, SpO2 and BP q4hrs, electrolyte, BUN and creatinine levels daily, telemetry constantly, LOC q4hrs, orthostatic VS q12hrs

Interventions (In priority order):

1. Administer IV fluids at prescribed rate.
2. Administer oxygen as needed.
3. Administer sodium bicarbonate as prescribed.
4. Administer antihypertensives as prescribed.
5. Assist with hemodialysis preparation as needed.
6. Administer digoxin as prescribed.

To Be Completed During the Simulation

Nursing Notes

Time	*I Or E*	Notes	Specify Problem #
2330	E	Report from ED: Increased SOB and weakness, BP 80/62, respirations 30, HR 164 in afib. Given 1,000ml NS bolus in ED. Smokes one pack a day, alcohol 3-5 drinks a week. Difficulty adhering to diabetic management plan. Sodium 128, BUN 44, creatinine 3.0, GFR 25, potassium 5.1, calcium 8.7, total bilirubin 2.8, WBC 16.1, Hgb 9.3, Hct 28.2. CXR shows opacities greater in right lung. 2L NC with O_2 91%. ---------- JTSNB	1,2
0000	E	C/O SOB upon waking, HR is 158 and irregular, RR 34 with crackles in lungs, SpO2 88% on 2L NC, BP 112/70. States foot became sore during last admission, DR confirmed an infection and prescribed abx inpatient and outpatient. Stated unable to get abx until yesterday. Unable to feel sensation on foot, "especially on toes". ---------- JTSNB	1,2
0005	I	Increased oxygen to 3L. Sterile dressing changed on right heel. – JTSNB	1,2
0010	E	SpO2 88% on 3L NC, C/O feeling the same as when arrived to hospital, and states not being able to "get a deep breath". ---------- JTSNB	1,2,3
0015	I	Assisted to reposition. Called Dr Kindlebrook, received orders for and administered Furosemide 20mg IV. ---------- JTSNB	1,2
0030	E	Stated "I feel a little better." Voided 50ml of dark urine. HR 140 and irregular, BP132/45, RR 32, SpO2 85% on 3L NC. ---------- JTSNB	1,2
0050	I	Discontinued IV fluids. Decreased oxygen to 2L NC. Educated that furosemide increases UO by pulling fluid from the lungs which should help improve breathing. Bladder scan performed. ---------- JTSNB	1,2,4
0058	E	Bladder scan showed scant amount of urine. Telemetry says heartbeat is more irregular, HR 140. Stated "I am still short of breath but its not any worse. My heart is racing though." Declined chest pain, numbness, and tingling. C/O being tired. SpO2 95% on 2L NC, Potassium 6.0, BUN 52, creatinine 3.6. Elevated T wave on tele, HR 140. ---------- JTSNB	1,2,3
0105	I	Notified provider of abnormal lab results, irregular HR, and subjective data. Held Vancomycin. Administered Furosemide 20mg IV bolus. Advised to start an indwelling catheter if necessary. ---------- JTSNB	1,2
0115	E	Labored breathing stated "my heart is beating faster, and I feel like I'm going to throw up. And I'm so hot". Telemetry showed Ventricular Tachycardia. ---------- JTSNB	3
0116	I	Rapid Response called. ---------- JTSNB	1,2,3
0125	E	Amiodarone 150mg IV bolus given over 10 mins. Stabilized. Afib with a HR of 100. ---------- JTSNB	1,2,3

0135	I	Provider notified of rapid response, arrhythmia, and now in Afib with HR of 100. ---------- JTSNB	1,2
0150	I	Administered Sodium Polystyrene Sulfonate 30g PO. ---------- JTSNB	2
0155	E	Stated “I am bone tired. My provider does know I have kidney disease right? My potassium always runs high”. ---------- JTSNB	1,2,3
0200	I	Educated that Sodium Polystyrene sulfonate excretes extra potassium in the body through feces. ---------- JTSNB	2,4
0300	E	Stated “I think the medicine is really working.”, 2 bowel movements. Voided 250ml dark urine. States “It’s easier to breathe.” Potassium 5.0. ---------- JTSNB	1,2,3
0330	I	Notified provider of potassium level and UO with less difficulty breathing. Administered Furosemide 40mg IV bolus. ---------- JTSNB	1,2
0340	E	Provider added nephrology consult for possible future dialysis and to repeat labs in two hours. ---------- JTSNB	1,2
0400	E	Stated “I’ve urinated a lot since I got that medicine”. Potassium 4.8, UO 350mL. ---------- JTSNB	1,2
0420	E	Nephrologist educated about future dialysis. ---------- JTSNB	1,2,4
0445	I	Educated and reviewed chronic kidney disease information ------ JTSNB	1,2,4
0500	E	Verbalized understanding and stated “I will need to eat a low protein diet”. ---------- JTSNB	2,4
0505	E	Stated “Ouch! That hurts” when IV site touched. Site is red, swollen, and warm to touch. ---------- JTSNB	3
0515	I	Removed IV. Informed the provider requested a PICC line and provider will be in to discuss more about it. ---------- JTSNB	3,4
0525	E	Stated “I think I’ve had one of those before”. ---------- JTSNB	3.4
0600	I	Home Health notified that once discharged, scheduled to receive Cefepime 2g IV daily for two weeks. ---------- JTSNB	1,2,3,4
0625	E	No pain, pallor, drainage, erythema, or edema at PICC site. Dressing is clean, dry, and intact. ---------- JTSNB	3
0630	I	Informed that next dose of IV antibiotics is due tomorrow morning and home health will be in contact to schedule visits. ---------- JTSNB	3,4
0635	E	Stated “I do not have any questions. I just hope the medicine works. Thank you for everything!” ---------- JTSNB	3,4

Initials/ Signature: JTSNB / JTunstall

Actual Patient Problems & Goals

** This worksheet should be completed after you complete the ATI simulation.

Problem #1: **Impaired Gas Exchange**

Patient Goals:

1. RJ will have decreased SOB, RR between 12 and 20, and oriented x4 during my care. Met ✓ Unmet ☐

2. RJ will be >/= 95% on 2L NC, have no crackles, and ABG's wnl. Met ☐ Unmet ✗

Problem #2: **Excess Fluid Volume**

Patient Goals:

1. RJ will have a heart rate between 60-100, UO >/=30 ml/hr during my care. Met ☐ Unmet ✗

2. RJ will not have a weight gain >/= 3lbs in a day and will not have pitting edema +2 in extremities during my care. Met ✓ Unmet ☐

Problem #3: **Anxiety**

Patient Goals:

1. _____ Met ☐ Unmet ☐

2. _____ Met ☐ Unmet ☐

Problem #4: **deficient knowledge**

Patient Goals:

1. _____ Met ☐ Unmet ☐

2. _____ Met ☐ Unmet ☐

Problem #5: _____

Patient Goals:

1. _____ Met ☐ Unmet ☐

2. _____ Met ☐ Unmet ☐

Patient Resources: Home Health, Nutritionist

Patient Teaching: central line care, CKD management, F/U importance, action of furosemide regarding UO, and action of sodium polystyrene sulfonate as a potassium excretion through feces

To Be Completed After the Simulation

**The orange boxes should be filled out with your simulation patient's actual results, assessments, medications, and recommendations.

NCLEX IV *(7)*: **Reduction of Risk**	**NCLEX II** *(3)*: **Health Promotion and Maintenance**
Actual Labs/ Diagnostics	Signs and Symptom

Glucose K+: 4.8-6.0 BUN: 44-52 Creatinine: 3.0-3.6 WBC: 16.1 HGB: 9.3 HCT: 28.2 GFR: 25 Troponin Digoxin CXR		SOB / tachypneic (RR 30 – 34) Weakness Tachycardia / Irregular heart rhythm (HR 140) Hypotensive (112/70) Opacities in lungs / crackles Oliguria Chest Pain Nausea

NCLEX II *(3)*: Health Promotion and Maintenance

Contributing Risk Factors
age smoking alcohol consumption CAD CKD Afib PVD DM type 2

Therapeutic Procedures
Non-surgical Dialysis (in future) Bladder scan Surgical Central Line

NCLEX IV *(7)*: Reduction of Risk

Prevention of Complications (Any complications associated with the client's disease process? If not what are some complications you anticipate)
Septic shock CHF Amputation ARDS Decreased wound healing

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Medication Management
Amiodarone Furosemide Sodium Polystyrene sulfonate Antibiotics Oxygen

NCLEX IV *(5)*: Basic Care and Comfort

Non-Pharmacologic Care Measures
Diet restrictions RRT

NCLEX III *(4)*: Psychosocial/Holistic Care Needs

Stressors the client experienced?
Hospitalization Chronic disease Breathing difficulties Treatment management

Client/Family Education

Document 3 teaching topics specific for this client.
•diet restrictions •care for the central line •dialysis expectations

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement (Which other disciplines were involved in caring for this client?)	
RN	Telemetry
CNA	XRAY tech
MD	Dietary
Nephrology	
Cardiology	
Pulmonology	
Home Health	

Reflection Paper

Directions: Write a 1-page reflection paper using Times New Roman, 12 pt. font and double-spaced. Include the following:

1. Describe an "Aha" moment you experienced during this learning experience.
2. What were the most important aspects of this simulation and what did you learn?

3. How will this simulation experience impact your nursing practice?

In the first attempt of the scenario, I chose two choices that were incorrect which resulted in the simulation ending early. This definitely helped with my future nursing practice. Specifically, being unable to recognize when R.J. went from Afib to V Tach, that I needed to call a rapid response. That was ultimately detrimental to the patient. Fortunately, this was a simulation instead of real life. However, this will transfer over to my care in the real world. An "AHA" moment that I did not recognize initially was that his potassium was so high that it caused his rhythm to change. At that point, his potassium as was last reported at 6.0, the normal range is 3.5 to 5.0. Despite being 1.0 above normal, this was a drastic level. The therapeutic level is relatively narrow so with his being 6.0, this caused his heart to go from Afib to V tach. Without prior experience of this, I did not know that a level of 6.0 could cause this. I do not think there is a specific level to cause this, as it likely varies from person to person. However, this was a very good teaching point for me and I am grateful to have had this experience through a simulation instead of real life.

During the simulation I was able to determine priority assessment and care. When posed with the question of who to assess first, I chose the patient who was reporting chest pain. This was the correct choice regarding priority. This reinforced the teaching I have received and allowed me to demonstrate my knowledge. Previously, I did not know about stable versus unstable ventricular tachycardia. This simulation encouraged me to do more research and discover the difference between stable and unstable v tach. Something I found very interesting during this simulation was that the patient was prescribe antibiotics roughly two weeks ago but was unable to get them until the day before being admitted. This is extremely important and could've aided in avoiding hospitalization. This brings up a very important subject for providers and nurses. We need to not only ask what pharmacy they use but also if they need assistance getting their medications and having resources available to help them get such medications. Asking this and having those resources available could have also aided in preventing his current hospitalization.

This was a very important refresher for cardiac rhythms for me. During the first attempt, I did not know that unstable ventricular tachycardia can be fatal if not recognized immediately. This resulted in the simulation ending early and receiving an unsatisfactory. ATI provided me with the rationale that unstable ventricular tachycardia needs to be resolved within three to five minutes or it can be fatal. Hence why it was so important to call a Rapid Response once the rhythm was recognized. Throughout my nursing practice, I will recall this simulation and respond appropriately if this rhythm occurs in my patient or a fellow coworker's patient. Another very important thing I took away from this was to always prioritize your care and to not take on more than I believe I am capable of. This will allow me to provide the safest care I can for my patients while also not overwhelming myself. In the simulation I was also able to delegate care, so I was able to focus on the patient that had the most life threatening complaint. Delegation is a skill that I will continue to enhance and work on throughout my career instead of feeling like I have to complete it all without help.