Student Name: Kirsten Taylor

Medical Diagnosis/Disease: UTI

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

Anatomy and Physiology
Normal Structures

-The upper urinary system consists of two kidneys and 2 ureters. The lower urinary system consists of a urinary bladder and the urethra. Urine is formed in the kidneys and drains through the ureters to be stored in the bladder, and then passes out of the body through the urethra.

-The kidneys are the principal organs of the urinary system. The primary function of the kidneys is to regulate the volume and composition of extracellular fluid and excrete waste products from the body.

-The kidneys also help control blood pressure and make erythropoietin protein, activate vitamin D, and regulate acid-base balance.

-The kidneys are bean-shaped and they are located behind the peritoneum on either side of the vertebral column.

- Each kidney weighs 4-6 Oz. It is about 5 inches long and the adrenal glands are on top of each kidney.

-Each kidney is surrounded by fat and connective tissue that cushions and supports it.

-The nephron is the functional unit of the kidney in which each kidney has 1 million nephrons.

-Blood flow to the kidneys is around 1200 ml per minute and accounts for 20 to 25 % of cardiac output

Pathophysiology of Disease

-The urinary tract above the urethra is normally sterile. The defense mechanisms include complete emptying of the bladder, ureterovesical junction competence, ureteral peristaltic activity, and antibacterial characteristics.

-These antibacterial characteristics include having an acidic pH which is less than 6.0, high urea concentration, and abundant glycoproteins.

-If any of the above things are changed it can increase the chance of an infection.

- Organisms are introduced via the ascending route from the urethra and originate in the perineum. Other less common routes include the bloodstream and lymphatics.

- Gram-negative bacilli are normally found in the GI tract (E.coli).

NCLEX IV *(7)*: Reduction of Risk

Anticipated Diagnostics

Labs

Dipstick urinalysis- + nitrates, WBC, leukocyte

Urine for culture and sensitivity- determines bacteria susceptibility

Additional Diagnostics

Ultrasound

CT scan

CT urogram to rule out obstruction

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

Contributing Risk Factors

Factors increasing urinary stasis- BPH, tumors, neurogenic bladder.

Foreign bodies- catheters, calculi, instrumentation.

Anatomic factors- obesity, congenital defects, fistula

Compromising immune response factors- age, HIV, diabetes

Functional disorders- constipation

Other factors- pregnancy, multiple sex partners

CAUTI- Catheter associated Urinary Tract Infection

Signs and Symptoms

Painful urination (uncomplicated)

Abdominal or back pain, fever, sepsis, and decreased kidney function (systemic)

Flank pain, chills, fever (upper tract infection)

Older adults- symptoms are often absent, non-localized abdominal discomfort rather than dysuria, cognitive impairment, and fever less likely

NCLEX IV *(7)*: Reduction of Risk

Possible Therapeutic Procedures

Non-surgical

Empty bladder regularly and completely

Surgical

Recurrent- Maybe a TURP

Also reconstruction of urinary tract

Prevention of Complications

(What are some potential complications associated with this disease process)

Pyelonephritis

Urosepsis

Renal Damage

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

Anticipated Medication Management

Antibiotics (prophylactic or suppressive)

Trimethoprim/sulfamethoxazole

Nitrofurantoin

Ampicillin, amoxicillin, cephalosporin

Antifungals

Urinary analgesic (phenazopyridine)

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

Non-Pharmacologic Care Measures

Cranberry juice

Adequate fluids

OVERALL prevent CAUTI's by following CHORUS

Heating pad

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

What stressors might a patient with this diagnosis be experiencing?

- Being in the hospital
- Anxiety
- Could this progress to a systemic infection (death?)
- Financial stressors

Client/Family Education

List 3 potential teaching topics/areas

- Knowing the signs and symptoms of a UTI
- Proper perineal care (Front to back wiping)
- Making sure to finish the full length of antibiotics even if they are feeling better

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

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

Registered Nurse

Urologist

Lab

CNA

Pharmacy

Nephrologist

Spiritual team

Potential Patient Problems (Nursing Diagnoses) based on Research

List two potential patient problems you will be addressing as part of your nurse's notes, along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order.

Problem # 1: Acute Pain
Clinical Reasoning: The patient is diagnosed with a UTI. A UTI is known to cause pain while urinating and if severe a UTI can cause abdominal, back, and flank pain.

Goal/EO: The patient will report pain of less than or equal to 3 on a scale of 1-10 during my time of care.

Ongoing Assessments:
Assess pain characteristics using the 6 P's q4hrs.
Assess Sx/S of pain q4hrs.
Assess pain using the pain scale q4hrs.
Assess HR, BP, RR, Sp02, and Temp q4hrs.
Assess the pts expectations for pain relief q4hrs.

NI: 1. Provide rest periods to facilitate comfort, sleep, and relaxation during my time of care.

2. Educate on care channel and guided imagery during my time of care.

3. Apply a heating pad to the lower back or suprapubic area q2hrs.

4. Ensure the use of the pain scale to help manage pain q2hrs.

5. Educate the use of a sitz bath and that it may reduce perineal pain q8hrs.

6. Educate the importance of the administration of analgesics and antispasmodics to decrease pain q12hrs.

Problem # 2 Deficient Knowledge : UTI
Clinical Reasoning: The patient is diagnosed with a UTI. The patient may have never had one before and they may be uneducated on what a UTI is and ways to prevent it.

Goal/EO: The patient will verbalize understanding and do the teach-back method about what a UTI is, ways to prevent UTIs, and knowing the signs and symptoms for future UTIs.

Ongoing Assessments:
Assess the level of education and barriers to learning q12hrs.
Assess the motivation and willingness to learn qshift.
Assess the knowledge of UTI risk factors qshift.
Assess the knowledge of UTI prevention qshift.
Assess the knowledge of UTI treatment qshift.
Assess the understanding of signs and symptoms of a UTI q12hrs.

NI: 1. Educate the importance of drinking 2 to 3 liters of fluid daily q12hrs.

2. Educate why wiping front to back is important q12hrs.

3. Educate on the signs and symptoms of a UTI qshift.

4. Educate on the importance of completing the full course of antibiotic therapy, even if the symptoms have resolved.

5. Educate on the need for frequent bladder emptying qshift.

6. Educate the importance of changing underwear daily and avoiding tight-fitting or constricting underwear or pants qshift.

C- Benzo, antianxiety, sedative- Hypnotic, antiemetic, muscle relaxant, amnesiac, antitremor, anticonvulsant
A- TE- produces anxiolytic, anticonvulsant, muscle relaxant, antiemetic effects
Uses- manage anxiety PO, manage status epilepticus and preanesthesia IV
Action- Enhances action of inhibitory neurotransmitter gamma-aminobutyric acid
D- PO Anxiety 0.5-2mg q 4-6hrs prn up to 10mg/day- max 2g. Status epilepticus- IV 4mg max of 2mg/min, may repeat in 2-5min, Max 4mg
S- dizziness, drowsiness, weakness, ataxia, h/a, hypotension, N/V. AE- Abruptor rapid withdrawl may result in restlessness, irritability, insomnia, tremor, abd cramps
C- hypersen. to med (Benzos), glaucoma, respiratory depression, Caution with neonates, hepatic/renal impairment, compromised pulmonary function, depression
A- A= GI M= liver E= urine
N- Monitor BP, RR, HR. Assess motor responses, offer emotional support, Moinitor for Suicidal ideation / worsening of anxiety. Avoid task that require alertness, motor skills (Drug is established wait), Do not smoke or use ETOH

*Lorazepam (Ativan)

C- Antibiotic
A- TE- Bactericidal, Uses → Tx of susceptible infections due to many bacterias, bronchitis, sinusitis, PNA, UTI, pyelonepharits, SKin infection. Actions- Inhibits DNA enzyme gyrase in susceptible microorganisms interfering w/ cell replication and repair
D- PO, IV 250-500mg q24hrs, 750mg q24hrs for complicated/severe infections
S- Diarrhea, Nausea, abd pain, drowsiness, dizziness, h/a. AE- abx associated colitis, neuropathy superinfections, tendonitis, tendon rupture,
C- Hypersen to med (fluoroquinolones). Caution with Known or suspected CNS disorders, Seizure disorders, RA, elderly, renal impairment, bradycardia, MG
A- A= bloodstream M- E- urine, hemodialysis
N- Monitor glucose, renal function, Ask if hypersent. to med. LFT, Monitor Bowel activity, Assess for rash, urticaria, pruritis, photosensitivity, superinfection
Teach- complete full tx, report diarrhea, report nervous system problems

*Levofloxain (Levaquin)

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:

   a. **_____Craig Registered Nurse_____**

   b. **_____Ashley Assistive Personnel_____**

2) Did your patient have any abnormal blood work (lab)? If so, *select a priority finding* and discuss why that value is concerning.

   a. **A priority finding from the blood work ordered would be the patient's ABGs. They came back as pH (7.28), PaCO2 (35), and HCO3 (20). These results mean that the patient is in metabolic acidosis and the patient is heading towards distributive shock.**

3) Did your patient have any abnormal clinical diagnostic tests? If so, what were they and what was the abnormal finding? What can that indicate?

   a. **Abnormal clinical diagnostic tests include the x-ray of the patient's hip which showed a hip fracture. The urinalysis showed that the urine was a slight amber color and cloudy. The leukocytes esterase and RBC casts were positive.**

4) What were some of the teaching topics covered in the scenario? Why were they important to the care of this patient?

   a. **Teaching why the patient can not have surgery to fix her hip fraction and what they will be doing instead of the surgery.**

   b. **Always making sure to repeat any medication orders that were given over the phone, this provides safety to the patient and decreases the risk of having a medication error that may result in major problems for the patient.**

   c. **Called the doctor to teach the patient about traction because she was concerned that she didn't know what was going on.**

5) What were some steps the nursing team demonstrated that promoted patient safety?

   a. **The communication throughout the healthcare team and how they notified each other promptly and effectively to prevent any problems with the patient.**

   b. **Patients bed in the lowest position.**

   c. **Repeating the medication phone order back to the doctor to prevent a medication error.**

6) Do you feel the nurse and medical team utilized therapeutic communication techniques when interacting with individuals, families, and health team members of all cultural backgrounds?

   a. If **yes**, describe:

      Yes, I believe the medical team utilized therapeutic communication because the team communicated if there were any important things the nurse should know. The nurses had great communication and always made sure that they knew what they were doing and all their questions were answered. The nurse told the doctor the important information that helped decide new orders for the patient.

   b. If **no**, describe:

      _____

      _____

Reflection

1) Go back to your Preconference Template:

   a. Indicate (circle, star, highlight, etc.) the components of your preconference template that you saw applied to the care of this virtual patient.

2) Review your Nursing Process Form: Did you select a correct priority nursing problem?

   a. If **yes,** write it here: _____

   b. If **no,** write what you now understand the priority nursing problem to be:

   Decreased cardiac output

3) Review your Nursing Process Form: Did you see many of your anticipated nursing assessments and interventions used?

   a. Indicate (circle, star, highlight) the ones you saw utilized during the scenario.

   b. Were there interventions you included that *were not* used in the scenario that could help this patient?

      i. If **yes,** describe:

      _____

      _____

      ii. If **no,** describe:

      No, there were no interventions that were included on my nursing process form that could have helped this patient because overall my nursing diagnosis didn't pertain to the patient's main concerns at the time. The patient's main problems were her low sp02, fever, and all the cardiac medication that the patient was on.

4) Often patient care will take a different direction than we anticipated at the beginning of our shift. Did that happen here? Yes

   a. How did that impact the nursing care delivered?

   This impacted the nursing care delivered because, from her admitting diagnosis, I was prepared to educate the patient on how to prevent future UTIs, the importance of finishing the full course of antibiotic therapy, proper wiping, and emptying their bladder frequently. I was now focused more on the patient's breathing following the ABC method when I first walked into the room. Also with the patient's new hip fracture, I had to watch out for that specific extremity and any new complications that followed such as the patient's new pressure injury that she got from being in bed so long.

   b. Did it create a new priority nursing problem (diagnosis)? (Refer to your NANDA list)

      i. Write it here: Decreased Cardiac Output

5) What was your biggest "take-away" from participating in the care of this patient? How did this impact your nursing practice?

   The biggest takeaway from participating in the care of this patient is that the admitting diagnosis may not be the main problem for your patient. Before you do anything you need to take a look at your patient and see what their problem is at that exact moment. I was very surprised that someone with a UTI could have so many more things going for them while they are at the hospital. Overall, doing a full assessment is one of the most important things to do for your patient before continuing with your day.

Module Report

Tutorial: **Real Life RN Medical Surgical 3.0**

Module: **Urinary Tract Infection**

Individual Name: **Kirsten Taylor**

Institution: **Margaret H Rollins SON at Beebe Medical Center**

Program Type: **Diploma**

Standard Use Time and Score

	Date/Time	Time Use	Score
Urinary Tract Infection	4/12/2022 6:36:01 PM	43 min	Strong

Reasoning Scenario Details
Urinary Tract Infection - Use on 4/12/2022 5:52:56 PM

Reasoning Scenario Performance Related to Outcomes:

*See Score Explanation and Interpretation below for additional details.

Body Function	Strong	Satisfactory	Needs Improvement
Cardiac Output and Tissue Perfusion	100%		
Cognition and Sensation	100%		
Immunity	100%		
Integument	100%		
Mobility	100%		
Oxygenation	100%		
Regulation and Metabolism	100%		

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Management of Care	100%		
RN Safety and Infection Control	100%		
RN Psychosocial Integrity	100%		
RN Pharmacological and Parenteral Therapies	100%		

RN Physiological Adaptation	100%		

QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	100%		
Evidence Based Practice	100%		
Teamwork and Collaboration	100%		

Decision Log:

Scenario	Question Fill In the Blank Essay (Not Scored)
Question	What additional information would assist Nurse Craig in preparing to care for Mrs. Jordan? List 5 additional pieces of information that should have been included in the report.
Selected Option	5 additional pieces of information that should have been included would be how much her first dose of levofloxacin was, her vital signs from the last time they were done, any abnormal lab valves, the pts pain level, any specific diet the pt may be one, and anything recommendations the leaving nurse recommends the new nurse to do.
Rationale	1. Levofloxacin (Levaquin) – How much was given and when is the next dose? 2. Agitation – The client's baseline level of orientation. Is this agitation new or getting worse? How do you know she is tired? Did she tell you that or is she sleeping on and off? 3. Probable discharge in next 24 hr – Is there a discharge order or plan? 4. Output – Amount, color and characteristic of urine.5. IV – The type and amount of IV solution given since arrival in the emergency department. The type and rate of IV solution that is currently infusing. Location of IV site and size of catheter.6. Vital signs – Range of vital signs, including O2 saturation. Current vital signs. 7. Blood glucose – Results of blood glucose and time obtained. 8. Social status – Any significant others that are with her. Individuals who should be contacted about hospitalization. 9. Medical history – Pre-existing conditions, allergies, and home medications and adherence. 10. Other – Normal level of activity, history of falls, and diet at home.

	Optimal Decision
Scenario	Nurse Craig just entered Mrs. Jordan's room to do his assessment.
Question	Nurse Craig is assessing Mrs. Jordan. Which of the following actions should the nurse take next?
Selected Option	Apply oxygen per nasal cannula at 2 L/min.
Rationale	According to the airway, breathing, and circulation (ABC) priority-setting framework, this is the first intervention the nurse should take to address the client's difficulty breathing.

Optimal Decision	
Scenario	Nurse Craig finds Mrs. Jordan restless and having increased difficulty breathing.
Question	Nurse Craig observes that Mrs. Jordan is restless and having increased difficulty breathing. Which of the following assessments is appropriate for Mrs. Jordan's needs at this time?
Selected Option	Rapid focused assessment
Rationale	The client is experiencing an acute episode of dyspnea. A rapid focused assessment will allow the nurse to determine the underlying cause of the dyspnea and to intervene quickly. Therefore, this is the correct assessment at this time.

Optimal Decision	
Scenario	Nurse Craig completes a rapid focused assessment.
Question	Based on the findings from the rapid focused assessment, which of the following actions should Nurse Craig perform first?
Selected Option	Increase oxygen to 4 L/min.
Rationale	The client is demonstrating clinical manifestations of heart failure and hypoxemia. Using the priority-setting framework of ABCs, increasing the rate of oxygen administration is the priority action because this promotes improved oxygenation.

Optimal Decision	
Scenario	Nurse Craig has received a bag of medications from Mrs. Jordan's home.
Question	Nurse Craig has received a bag of medications from Mrs. Jordan's home. He reviews each of the medications. Which of the following is the best action for Nurse Craig to take at this time?
Selected Option	Request medication reconciliation with pharmacy.
Rationale	The client's preadmission medications should be compared to the current medications prescribed by the provider upon admission.

Optimal Decision	
Scenario	Nurse Craig is discussing Mrs. Jordan's medications with the pharmacist.
Question	Nurse Craig has reviewed Mrs. Jordan's medications received from her home. Nurse Craig labels the medication bag and locks the medications in a cabinet. Based on events so far, which of the following best describes Mrs. Jordan's priority underlying medical condition?
Selected Option	Cardiac
Rationale	Based on the client's home medications and the events that have occurred, the client's cardiac condition is the priority at this time. Digoxin (Lanoxin), furosemide (Lasix), potassium chloride, and isosorbide (Imdur) are medications prescribed for heart failure. The client is experiencing shortness of breath and difficulty breathing related to fluid overload.

Optimal Decision	
Scenario	Mrs. Jordan is demonstrating exacerbation of heart failure.
Question	Mrs. Jordan has experienced increased respiratory distress during the past 2 hr. Since admission, she has received 2,550 mL IV and 100 mL orally. Her urinary output since admission to the medical-surgical unit has been 100 mL. Which of the following clinical manifestations indicates exacerbation of heart failure and should be reported to the provider? (Select all that apply.)
Selected Ordering	Dependant pitting edema Crackles in the lungs
Rationale	Pitting edema is a clinical manifestation of heart failure. Weak peripheral pulses is a clinical manifestation of heart failure. Dark amber urine is typically seen in a client who has fluid volume deficit. Therefore, this finding does not indicate heart failure.Neck vein distension is a typical clinical manifestation for a client who has heart failure. Crackles in the lungs is a clinical manifestation of heart failure.

Optimal Decision	
Scenario	The provider just explained to Mrs. Jordan that she is not a candidate for surgery and needs to be placed in Buck's traction. Mrs. Jordan is tearful and has a frightened look on face.
Question	The provider has just informed Mrs. Jordan that due to her cardiac condition she is not a candidate for surgery. Mrs. Jordan is tearful and has a frightened look on her face. Which of the following is an appropriate statement by Nurse Craig?
Selected Option	"Tell me about the concerns you have."
Rationale	This is a therapeutic statement by the nurse to the client.

Optimal Decision	
Scenario	Mrs. Jordan is in Buck's traction and needs a bed bath.
Question	Nurse Debbie is preparing to provide a bed bath for Mrs. Jordan, who is in Buck's traction. Which of the following is the appropriate action for Nurse Debbie to take?
Selected Option	Leave the traction in place.
Rationale	Buck's traction is to remain in place to keep the extremity immobilized to decrease muscle spasms until surgery is performed on the fractured hip.

Optimal Decision	
Scenario	Nurse Stephanie has inspected Mrs. Jordan's back for skin breakdown.
Question	Image|RN_AMS_UTI_22_stem_800px.png|Mrs. Jordan is at risk for skin breakdown due to her age, her cardiac condition and her mobility that is restricted due to the placement of Buck's traction. Nurse Stephanie assesses the client for skin breakdown. Based on the photograph, Nurse Stephanie should classify the skin breakdown as which of the following?
Selected Option	Stage 2
Rationale	In stage 2, there is partial thickness skin loss involving the dermis with a shallow pink ulcer that has a red pink bed without sloughing. It also can appear as an intact blister.

Optimal Decision	
Scenario	Nurse Debbie is planning care for Mrs. Jordan
Question	Which of the following should Nurse Debbie include in the plan of care for Mrs. Jordan, who has a fractured hip and is in Buck's traction?
Selected Option	Monitor Mrs. Jordan's ability to move her toes on the affected leg.
Rationale	The nurse should monitor the client's ability to move her toes on the affected extremity to assess for circulatory compromise.

Optimal Decision	
Scenario	Mrs. Jordan tells Nurse Debbie that she is short of breath. Mrs. Jordan's SaO2 saturation is 85%. Nurse Debbie increased the oxygen flow rate to 6 L/min.
Question	Mrs. Jordan reports that she is short of breath. Her SaO2 is 85%, and the oxygen flow rate has been increased to 6 L/min. Nurse Debbie reassesses the client. Which of the following clinical findings is an early indicator of shock?
Selected Option	Restlessness
Rationale	Restlessness is due to decreased cerebral perfusion and can be a clinical finding in the early stages of shock.

Optimal Decision	
Scenario	Nurse Debbie completes an assessment of Mrs. Jordan.
Question	Nurse Debbie assessed Mrs. Jordan and determined that Mrs. Jordan is at risk for shock. Which of the following types of shock is Mrs. Jordan at risk for?
Selected Option	Distributive shock
Rationale	The client is becoming septic. Sepsis is a widespread infection that triggers a whole-body inflammatory response. It leads to distributive shock when infectious micro-organisms are present in the blood.

Optimal Decision	
Scenario	Nurse Debbie has received the laboratory reports.
Question	Nurse Debbie is reviewing the laboratory report. Which of the following arterial blood gases (ABGs) indicate that Mrs. Jordan is experiencing metabolic acidosis?
Selected Option	pH 7.28, PaCO2 35, HCO3 20
Rationale	The client is at risk for metabolic acidosis. In the presence of metabolic acidosis, the pH is less than 7.35, the HCO3 is less than 22, and the PaCO2 is within the expected reference range.

Score Explanation and Interpretation
Individual Performance Profile

REASONING SCENARIO INFORMATION

Reasoning Scenario Information provides the date, time and amount of time use, along with the score earned for each attempt. The percentage of students earning a Scenario Performance of Strong, Satisfactory, or Needs Improvement is provided. In addition, the Scenario Performance for each student is provided, along with date, time, and time use for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

If a detrimental decision is made during a Real Life scenario, the scenario will diverge from the optimal path and potentially end prematurely, in which case an indicator will appear on the score report.

REASONING SCENARIO PERFORMANCE SCORES

Strong	Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems.
Satisfactory	Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems.
Needs Improvement	Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems.

REASONING SCENARIO PERFORMANCE RELATED TO NURSING COMPETENCY OUTCOMES

A performance indicator is provided for each outcome listed within the nursing competency outcome categories. Percentages are based on the number of questions answered correctly out of the total number of questions that were assigned to the given outcome. Outcomes have varying numbers of questions assigned to them. Also, due to divergent paths within the branching simulation, the outcomes encountered and the number of questions for each outcome can vary. The above factors cause limitations related to comparing scores across students or groups of students.

NCLEX® CLIENT NEED CATEGORIES

Management of Care	Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team.
Safety and Infection Control	Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team.
Health Promotion and Maintenance	Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health.
Psychosocial Integrity	Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care.
Basic Care and Comfort	Promoting comfort while helping clients perform activities of daily living.
Pharmacological and Parenteral Therapies	Providing and directing administration of medication, including parenteral therapy.
Reduction of Risk Potential	Providing nursing care that decreases the risk of clients developing health-related complications.
Physiological Adaptation	Providing and directing nursing care for clients experiencing physical illness.

Score Explanation and Interpretation
Individual Performance Profile

QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)

Safety	The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others.
Patient-Centered Care	The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values.
Evidence Based Practice	The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based.
Informatics	The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice.
Quality Improvement	Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients.
Teamwork and Collaboration	The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes.

BODY FUNCTION

Cardiac Output and Tissue Perfusion	The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues.
Cognition and Sensation	The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli.
Excretion	The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance.
Immunity	The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth.
Ingestion, Digestion, Absorption, and Elimination	The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body.
Integument	The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury.
Mobility	The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement.
Oxygenation	The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide.
Regulation and Metabolism	The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment.
Reproduction	The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions.

DECISION LOG

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

If a detrimental decision that could result in grave harm to the client is made during a Real Life scenario, the scenario ends immediately and an indicator that a detrimental decision has been made appears in the score report.
A detrimental decision indicates the need to remediate the related topic area to prevent detrimental outcomes in the future.