

Student Name: May Helen Waltjen
 Medical Diagnosis/Disease: UTI

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures
 glomerulus → Bowman's capsule →
 tubules → reabsorption by
 convoluted tubules → loop of
 Henle → distal tubule → collecting
 ducts → renal pyramid →
 calyx → ureter → bladder →
 urethra → excretion

Pathophysiology of Disease
 - urinary tract is usually sterile
 - tract may become defenseless
 and compromised by GI bacteria
 - usually gram-negative bacilli
 - instruments like cath. can
 cause infection
 - can be caused by hematogenous
 transmission
 - previous trauma from kidney
 stones or renal scars

NCLEX IV (7): Reduction of Risk

Anticipated Diagnostics
Labs
 - urine culture
 - WBC / CBC
 - urinalysis
 - clean catch sample
Additional Diagnostics
 - ultrasound

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
 - Hygiene - Age
 - Obesity - void
 dysfunction
 - Chronic - anatomy
 (women)
 - STI / STD
 - pregnancy
 - obstruction

Signs and Symptoms
 - Painful urination
 - confusion
 - fever - fatigue
 - back pain - anorexia
 - sepsis - chills
 - dysuria
 - frequency / urgency
 - hematuria
 - flank pain

NCLEX IV (7): Reduction of Risk

Possible Therapeutic Procedures
Non-surgical
 - catheter to
 relieve bladder
Surgical
 - remove obstruction

Prevention of Complications
 (What are some potential complications associated with this disease process?)
 - age / mobility
 - could lead to kidney injury if
 it progresses

NCLEX IV (6): Pharmacological and Parenteral Therapies

Anticipated Medication Management
 - Antibiotics (specific based
 on culture results)
 - analgesics
 - phenazopyridine

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
 - hydration
 - analgesic admin
 - ambulation

NCLEX III (4): Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?
 - constant infection
 - inability to care for
 oneself

Client/Family Education

List 3 potential teaching topics/areas
 • Proper hydration
 • Take full course of antibiotics
 • ways to prevent another infection
 (hygiene)
 - empty bladder fully
 - void regularly to avoid back up

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?)
 - urologist - PCP
 - Home health
 - Nutritionist
 - PT / OT

Potential Patient Problems (Nursing Diagnoses)

Mary Helen

List two potential patient problems you will be addressing along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order.

Problem #1: Impaired urinary system function

Clinical Reasoning: frequency, urgency, hesitancy

Goal/EO: client will have normal urinary elimination during my time of care

Ongoing Assessments: urinary output ($\geq 30\text{ml/hr}$), pattern of elimination, burning, incontinence
Palpate bladder for distention

- NI:
1. Encourage adequate fluid intake (2-4L/day) unless contraindicated during my time of care
 2. Encourage ambulation every hour as tolerated during my time of care
 3. Teach proper perineal care (based on gender appropriate practice) [women = front to back] and hygiene during my time of care
 4. ~~Palpate bladder~~ Encourage voiding q 2-3hr while awake and to empty bladder completely during my time of care
 5. Encourage reporting of signs/symptoms of frequency, urgency, hesitancy
 6. Teach proper use of antispasmodics to reduce symptoms during my time of care
-

Problem #2 Acute Pain

Clinical Reasoning: Confirmed UTI, pain using pain scale, change in BP, HR, RR

Goal/EO: client will have pain level less than 3/10 during my time of care

Ongoing Assessments: HR, BP, RR q 4h, PQRST of pain before and after meds

- NI:
1. Apply heating pad to suprapubic or back during my shift
 2. Instruct/teach client about sitz bath during my shift
 3. Encourage use of analgesics during my time of care as prescribed
 4. Encourage use of antispasmodics during my time of care as prescribed
 5. Use diversional techniques such as guided imagery or massage during my shift
 6. Encourage client to verbalize pain or discomfort during my time of care.

ACTIVE LEARNING TEMPLATE: Medication

STUDENT NAME Mary Helen

MEDICATION Lorazepam (Ativan)

REVIEW MODULE CHAPTER _____

CATEGORY CLASS Benzodiazepine (anti anxiety)

PURPOSE OF MEDICATION

Expected Pharmacological Action

Enhances action of inhibitory neurotransmitter gamma-aminobutyric acid in CNS. Anti anxiety, anti convulsant muscle relaxant

Therapeutic Use

- Management of anxiety disorders
- Short term relief of symptoms

Complications

- Abruptly stopping ↑ restlessness
- overdose = confusion, coma, diminished reflexes

Medication Administration

PO: give with food. Tabs may be crushed or diluted

Dose: 0.5 - 2mg q 4-6hr
up to 10mg/day

Max dose: 2mg

Contraindications/Precautions

- Sensitivity to benzodiazepines
- Acute narrow angle glaucoma
- Respiratory depression

Nursing Interventions

- monitor respirations
- Signs of dizziness or drowsiness
- motor response evaluated
- Assess for drug seeking behaviors | RISK drug abuse

* Antidote: Flumazenil

Interactions

Valproic acid, alcohol or other depressants may increase CNS depression

Client Education

- Don't stop abruptly
- Don't drive
- Don't smoke
- No alcohol
- Birth control recommended
- may cause thoughts of suicide/mood changes

Evaluation of Medication Effectiveness

- calm facial expressions
- decreased restlessness
- decreased insomnia

ACTIVE LEARNING TEMPLATE: Medication

STUDENT NAME Mary Helen

MEDICATION Levofloxacin (Levaquin)

REVIEW MODULE CHAPTER _____

CATEGORY CLASS Antibiotic

PURPOSE OF MEDICATION

Expected Pharmacological Action

Treatment of susceptible infections due to: Pneumoniae, aureus, influenzae, E. coli, pneumoniae, UTI, chronic bronchitis

Therapeutic Use

Treat infections by interfering with bacterial cell replication

Complications

- Hypersensitivity to fluoroquinolones
- Do not use w/ suspected CNS disorders organ transplant pts, RA, elderly,
- Diarrhea, Nausea, abdominal pain, dizziness, headache or drowsiness

Contraindications/Precautions

- colitis, super infections
- may increase photosensitivity
- may cause tendonitis, hallucinations or vertigo

Interactions

- Do not use w/ antacids, zinc, NSAIDs
- may increase risk of arrhythmias
- may increase anticoagulation effect of Warfarin

Evaluation of Medication Effectiveness

- symptoms of anxiety relieved

Medication Administration

IVPB (10ml = 250mg)
reconstitute in 40ml
0.9% NaCl, D5W
- concentration 5 mg/ml
± 60 mins for 250 mg or 500
± 90 mins for 750 mg

Nursing Interventions

- med history
- Baseline ECG
- serum glucose
- bowel activity

Client Education

- SIS of reaction
- SIS of infection (temp)
- muscle weakness
- complete full course
- tendon inflammation may happen
- No antacids
- Hydrate

Not compatible

- Furosemide
- heparin
- insulin
- niro
- propofol

Rate

60 mins 250mg or 500mg

90 min 750mg

Storage

Safe @ room temp

Priority Patient Problem #1: Decreased cardiac output

<p>Subjective:</p> <p><i>This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.</i></p>	<p>History Present Illness (HPI): 28 yo female came in through ED @ 0500 diagnosed w/ Urrosepsis She has some agitation and is restless. Currently has \textcircled{L} Hip fracture and is in Bucks traction - not surgical candidate because of CHF exacerbation</p> <p>PMH: CHF, DM</p> <p>Allergies: none</p> <p>NKA</p> <p>Current Medications: Lev ofloxacin 250mg IV q 12hr Furosimide 20mg IV bolus Glyburide 2.5mg PO w/ Breakfast Digoxin 0.25mg po</p>
<p>Objective:</p> <p><i>This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.</i></p>	<p>Vital Signs: T 38.3 HR: 98 RR 24 BP: 128/82 O2: 85% (L400)</p> <p>Labs: CBC, BMP CBC, BMP elevated on 4/2 NC</p> <p>Diagnostics: CBC, BMP Chest X Ray - Shows enlarged heart hypertrophy L vent.</p>
<p>Assessment:</p> <p><i>Focused assessments on your priority problem.</i></p>	<p>lung sounds, edema present?, LOC, Capillary refill, pulses, HR, BP, RR, JVD present</p> <p>I+O q 6hr:</p> <p>at 0600</p>
<p>Plan</p> <p>*Based on priority problem only</p> <p><i>Include what your plan is for the client. What treatments or medications are needed? You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?</i></p>	<p>Plan: Monitor I+O, maintain furosimide, elevate HOB to degree to provide relief but maintain traction. Consult w/ cardiology to ensure Furosimide is appropriate. Administer Digoxin as prescribed. Monitor CBC, BMP. Maintain O2 @ 4L NC. If CHF exacerbation improves, may be able to get surgery on hip + be discharged order troponin level + procalcitonin prior to discharge.</p> <p>Teaching & Resources: Cardiologist, PCP, Home health</p>

Mary Helen

ATI Virtual Clinical Questions and Reflection:

- 1) Identify two members of the healthcare team collaborating in the care of this patient:
 - a. Craig, RN
 - b. Dr. Baxter
- 2) What were some steps the nursing team demonstrated that promoted patient safety?
 - a. communicated about findings related to CHF
 - b. skin breakdown treatment/prevention
 - c. update provider upon condition changes
- 3) 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:
communication between day/night shift, utilization of charge nurse, tried to reorient pt; was not dismissive (read back orders)
 - 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 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; shock
- 3) Review your Patient Problem Form: Did you see many of your anticipated nursing assessments and interventions used?
 - a. Were there interventions you included that *were not* used in the scenario that could help this patient?
 - i. If yes, describe:
Acute pain - administered Tylenol
 - ii. If no, describe:
no, I picked Impaired urinary. Should have picked cardiac output
- 4) After completing the scenario, what is your patient at risk for developing?
 - a. Infection, septic shock, exacerbation of CHF
 - b. Why? _____

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

Understanding that an initial diagnosis may not be the real priority. Because of Mrs. Jordan's confusion, she became a fall risk. Anticipating what could happen in terms of agitation and anxiety. Mrs. Jordan's fall may have been preventable.

Module Report

Tutorial: Real Life RN Medical Surgical 4.0

Module: Urinary Tract Infection



Individual Name: Mary Helen Waltjen

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	2/28/2023 11:07:55 AM	40 min	Satisfactory

Reasoning Scenario Details

Urinary Tract Infection - Use on 2/28/2023 10:28:12 AM

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	66.7%	33.3%	
Cognition and Sensation	100%		
Immunity		100%	
Integument	100%		
Mobility	50%	50%	
Oxygenation	66.7%	33.3%	
Regulation and Metabolism	50%		50%

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Management of Care	66.7%	33.3%	
RN Safety and Infection Control	100%		
RN Psychosocial Integrity	100%		
RN Pharmacological and Parenteral Therapies	100%		

RN Physiological Adaptation	42.9%	42.9%	14.3%
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QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	62.5%	25%	12.5%
Evidence Based Practice	50%	50%	
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	What was her glucose before breakfast, was she given anything for the agitation, does she have a case manager, is she on anything for the CHF, what type of diet is she on, any fluid restrictions?
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.

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	Administer acetaminophen (Tylenol) 325 mg PO.
Rationale	Acetaminophen (Tylenol) can reduce pain associated with dyspnea, but this is not the priority action.

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.

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	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.

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	Remove the boot daily to inspect the skin under the device.

Rationale	The nurse should remove the boot every 8 hr to inspect the skin under the device.
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Optimal Decision	
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Scenario	Mrs. Jordan tells Nurse Debbie that she is short of breath. Mrs. Jordan's SaO ₂ 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 SaO ₂ 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.

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	Cardiogenic shock
Rationale	Cardiogenic shock occurs when the actual heart muscle is unhealthy and pumping is directly impaired. Myocardial infarction is typically the common cause of direct pump failure, not congestive heart failure.

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, PaCO ₂ 49, HCO ₃ 26
Rationale	These blood gases exhibit respiratory acidosis. This can be determined by the pH, which is less than 7.35, the PaCO ₂ , which is greater than 45, and the HCO ₃ , which 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.

