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ATI Proctored Remediation

1. **Management of care**
   a. Epistaxis: short, isolated occurrences of epistaxis are common in childhood. It causes anxiety for the child and child's caregivers.
   b. risk factors: trauma (picking or rubbing the nose) can cause mucous membranes in the nose, which are vascular and fragile, to tear and bleed. Humidity, allergic rhinitis, upper respiratory infection.
   c. nursing care: maintain a calm demeanor with the child and family. Have the child sit up with the head titled slightly forward to prevent aspiration of blood. Apply pressure to the lower nose with the thumb and forefinger for at least 10 min. Encourage the child to breathe through their mouth while pressure is being applied to their nose to controle bleeding.

2. **Safety and infection control: injury prevention**
a. Bodily harm: keep firearms in locked cabinets or boxes, identify safe play areas, teach stranger safety to children, teach children to wear helmets and or pads when roller skating, skateboarding, bicycling… Discuss non-violent conflict resolution strategies.
b. Burns: teach fire safety and potential burn hazards. Keep working smoke detectors in the home. Children should use sunscreen when outside. Teach safety precautions for children to take while cooking.
c. Poisoning/ substance misuse: cleaners and chemicals should be kept in locked cabinets or out of reach of younger children. Children should be taught to say "no" to substance misuse.

3. **Health promotion and maintenance**:
   a. **Immunizations**: the CDC immunization recommendations for healthy school-age children 6 to 12 years of age include: if not given between 4 and 5 years of age, children should receive the following vaccines by 6 years of age: DTaP, inactivated poliovirus, MMR, and varicella. Yearly seasonal influenza vaccine. 11 to 12 years: tetanus and diphtheria toxoids and pertussis vaccine, human papillomavirus vaccine, and meningococcal vaccine.
   b. b**. Health screenings**: scoliosis: school-age children should be screened for scoliosis by examining for a lateral curvature of the spine before and during growth spurts. Screening can take place at school or at health care facility.
   c. Nutrition: rapid growth and high metabolism require increases in quality nutrients and make adolescents unable to tolerate caloric restriction. During times of rapid growth, additional calcium, iron, protein, and are needed. Overeating and undereating

present challenges during the adolescent years. Overweight and obesity rates of particular concern: anorexia and bulimia are common in this age group as well.

4. psychosocial integrity: Depression.

a. Risk factors: family history, traumatic events.

b. Expected findings: sad facial expressions, tendency to remain alone, fatigue, feelings of worthlessness, weight loss or gain, altered sleep, lack of interest in school, drop in performance in school, low self-esteem, hopelessness, suicidal ideation, constipation.

c. Nursing care: plan care that is individualized, obtain health history and growth and development information, assess for substance use assist for coping strategies.

5. **Basic care and comfort: Fractures**

a. **Risk factors**: obesity, poor nutrition, developmental characteristics, ordinary play activities, and recreation that place children at risk for injury (falls from climbing or running, trauma to bones from skateboarding, skiing, or playing soccer or basketball).

b. **Expected findings**: pain, crepitus, deformity, edema, ecchymosis, warmth or redness. Common types of fractures in children include plastic deformation, buckle, greenstick, oblique, spinal, complete, incomplete, open or simple, complicated fracture, comminuted.

c**. Nursing care**: provide emergency care at the time of injury: obtain a history of how the injury occurred, maintain ABCs, monitor vital signs, pain, and neurologic status. Assess the neurovascular status of the injured extremity. Stabilize the injured area, avoiding unnecessary movement. Medications consist of analgesics, opioids, antibiotics. Therapeutic procedures consist of casting, traction care, surgical interventions.

6. **Pharmacology and parental therapy: congenital heart disease**

a. **Risk factors**: maternal factors: infection, alcohol or other substance use disorder during pregnancy, diabetes mellitus. Genetic factors: history of congenital heart disease in other family members, syndromes trisomy 21.

b. **Expected findings**: defects that increase pulmonary blood flow (ventricular septal defect (VSD), patent ductus arteriosus (PDA)). Obstructive defects (pulmonary stenosis, aortic stenosis, coarctation of the aorta, tricuspid atresia, tetralogy of Fallot). Mixed defects (transposition of the great arteries, truncus arteriosus, hypoplastic left heart syndrome).

c. **Therapeutic procedures**: ventricular septal defect: nonsurgical procedure, closure during cardiac catheterization, careful observation for spontaneous closure, diuretics. Atrial septal defect (closure during cardiac catheterization, diuretics, low dose aspirin 6 months after procedure, patch closure, cardiopulmonary bypass). Patent ductus arteriosus: administration of indomethacin, insertion of coils to occlude PDA during cardiac catheterization, administration of diuretics, provide extra calories for infants. Pulmonary stenosis: balloon angioplasty with cardiac catheterization. Brock procedure for infants and pulmonary valvotomy for children. Aortic stenosis: Balloon dilation with cardiac catheterization, administration of beta vlockers, calcium channel blockers.

7. **Reduction of risk potential: Physical Assessment findings: THORAX and LUNGS**

a. Chest shape: for infants, the chest shape is almost circular with anteroposterior diameter equaling the transverse or lateral diameter. Foer children and adolescents, the transverse diameter to anteroposterior diameter changes to 2:1.
b. Movement: symmetric, no retractions. In infants, irregular rhythms are common. In children younger than 7 years: more abdominal movement is seen during respirations.
c. Breasts: newborns' breasts can be enlarged during the first few days. Children and adolescents, nipples and areolas are darker pigmented and symmetric. Females: breasts develop between 10 to 14 years of age. The breast should appear asymmetric, have no masses, and be palpable. Males can develop gynecomastia, which is unilateral or bilateral breast enlargement that occurs during puberty.

8. Physiological adaptation: Iron deficiency Anemia
a. Risk factors: premature birth resulting in decreased iron stores, excessive intake of cows' milk in toddlers, malabsorption disorders, poor dietary intake of iron, increased iron requirements (blood loss). Infants: GERD, pyloric stenosis. Older children: GI polyps, colitis,
b. expected findings: tachycardia, pallor, brittle, spoon-shaped fingernails, fatigue, irritability, muscle weakness
c. laboratory tests: CBC: decreased RBC count, Hgb, and Hct.