N444 Concept Synthesis
Proctored ATI Remediation Template

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Assessment Name: **RN Comprehensive Predictor 2019**
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Instructions:

1. Download the report from your ATI product for the assessment you are completing this remediation template for
2. The report will be broken down into three (3) aspects:
    a. Categories
        i. These categories mimic the NCLEX-RN categories and include the following:
            1. Management of Care
            2. Safety and Infection Control
            3. Health Promotion and Maintenance
            4. Psychosocial Integrity
            5. Basic Care and Comfort
            6. Pharmacological and Parenteral Therapies
            7. Reduction of Risk Potential
            8. Physiological Adaptation
    b. Subcategories
    c. Topics
3. Complete the template on the following page by doing the following:
    a. Main Category
        i. Subcategories for each main category
            1. Topics for each subcategory → these will be the content areas you will be remediating on
                a. Provide three (3) critical points to remember for each topic → these will come from the Focused Review module(s) within your ATI product
    b. NOTE: You must remediate on all subcategories AND topics within the main categories listed under the "Topics to Review" section of the ATI report for this assessment.
4. In the event you need additional space within the table, please add rows into the table to accommodate this
    a. In the event, you need less space within the table than what is provided, you may delete those rows from the table to accommodate this OR put "N/A" → There may be main categories that you don't have to remediate on and that is OK – you can either delete the table OR put "N/A"
5. An example is provided below:

SAMPLE Main Category: Management of Care
SAMPLE Subcategory: Case Management
SAMPLE Topic: Anemias: Discharge Teaching for a Client Who is Recovering from Sickle Cell Crisis • SAMPLE Critical Point #1: Anemia is the abnormally low amount of circulation RB, Hgb concentration, or both. • SAMPLE Critical Point #2: When a patient is going through sickle crisis, the nurse should monitor oxygen saturation to determine a need for oxygen therapy. • SAMPLE Critical Point #3: A patient should have their hemoglobin checking in 4 to 6 weeks to determine efficacy.

6. Once the template is completed ***and*** at least the minimum remediation time has been completed within the Focused Review module(s) in ATI, upload the template to the corresponding dropbox in E360.

Main Category: Management of Care

Subcategory: Assignment, Delegation and Supervision

Topic: Managing Client Care: Delegating Tasks to an Assistive Personnel

- Assess which tasks can be safely delegated to assistive personnel, such as routine vital signs, assistance with ambulation and activities of daily living (ADLs), feeding and hydration, and specimen collection.
- Select an appropriately trained and competent person for the task, and provide clear instructions and guidance, such as explaining the steps for taking vital signs or demonstrating how to safely transfer a client from a bed to a chair.
- Monitor the task closely, document the process, and evaluate the outcome to ensure safe and effective client care.

Main Category: Safety and Infection Control

Subcategory: Accident/Error/Injury Prevention

Topic: Mobility and Immobility: Pressure Injuries

- The nurse must assess the client's risk factors for pressure injuries using the Norton or Braden scale, such as limited mobility, poor nutrition, incontinence, and medical conditions affecting circulation.
- The nurse should then implement preventive measures to reduce the risk of pressure injuries, such as frequent repositioning, using pressure-reducing devices, and maintaining skin hygiene and hydration.
- The nurse should monitor the client's skin regularly for signs of pressure injuries, such as redness or blisters, and take immediate action to address any identified injuries.

Subcategory: Ergonomic Principles

Topic: Mobility and Immobility: Evaluating Client Understanding of Crutch Safety

- The nurse should inform the client that the crutches must be adjusted to the proper height so that the client's arms are slightly bent at the elbow when holding onto the handgrips. The client's elbows should be flexed at 20 to 30 degrees.
- The nurse should also inform the client that when standing or resting, they should assume the tripod position by positioning the crutches about one foot in front and to the side of each foot, with the third point of the triangle being the client's body. This position provides a stable support base and reduces the risk of falls.
- The nurse should also inform the client that when they go upstairs, they should lead with their non-injured foot and the crutches, and when going downstairs, they should lead with the crutches and the injured foot.

Subcategory: Use of Restraints/Safety Devices

Topic: Client Safety: Reason for the Use of Restraints

- The nurse should know that restraints may prevent falls, self-harm, or harm to others, promote healing after surgery, or prevent dislodging medical devices.
- Nurses must follow strict guidelines and protocols when using restraints, including obtaining informed consent, assessing the client's condition regularly, and using the least restrictive type of restraint necessary.
- The nurse must remember that restraints should only be used as a last resort, and they must ensure that the client's safety and dignity are always maintained.

Topic: Gastrointestinal Structural and Inflammatory Disorders: Appropriate Use of Restraint Devices

- The nurse should know that elbow restraints may be needed for infants after surgery from repairing a cleft lip to prevent the infant from touching or rubbing the surgical site, which can cause further trauma or delay healing.
- The nurse must periodically remove the elbow restraint to assess the client's skin, allow limb movement, and provide comfort.
- The use of restraint devices should be documented in the client's medical record, including the reason for use, the type of device used, and the duration. Any adverse events or incidents related to using the restraint device should also be documented.

Main Category: Health Promotion and Maintenance

Subcategory: Health Promotion/Disease Prevention

Topic: Heart Failure and Pulmonary Edema: Risk Factors for Heart Failure

- The nurse should know that hypertension is a risk factor for heart failure because chronic hypertension can weaken the heart muscles over time.
- The nurse should also know that coronary heart disease is a risk factor for heart failure due to the narrowing of the arteries supplying the heart with blood.
- Other risk factors for heart failure include diabetes mellitus, obesity, family history of heart failure, and age.

Subcategory: High Risk Behaviors

Topic: Health Promotion and Disease Prevention: Priority Intervention When Assisting a Client With Smoking Cessation

- The nurse must assess the client's motivation and willingness to quit smoking to determine the necessary interventions and support.
- The nurse should then provide education and counseling to the client on the risks of smoking, the benefits of quitting, and strategies to quit smoking, such as nicotine replacement therapy or counseling programs.
- The nurse should refer the client to support resources and follow up to help them stay motivated and address any challenges or setbacks in their quitting journey.

Subcategory: Lifestyle Choices

Topic: Contraception: Contraindication for Oral Contraceptives

- One contraindication of oral contraceptives is a history of thromboembolic disorders because they can increase the risk of blood clots.
- Another contraindication of oral contraceptives is smoking if the client is over 35. Smoking while on oral contraceptives increases the client's risk of blood clots, acute myocardial infarction, and stroke.
- A third contraindication of oral contraceptives is uncontrolled hypertension because oral contraceptives can further increase blood pressure.

Main Category: Psychosocial Integrity

Subcategory: Abuse/Neglect

Topic: Family and Community Violence: Priority Intervention for Intimate Partner Violence

- The nurse should assess the client's safety to determine the level of risk and develop a plan to ensure their safety. The nurse can refer the client to an emergency shelter, contact law enforcement, or provide referrals to community resources.
- The nurse can reduce stress-level manifestations by using techniques to alleviate a panic attack.
- The nurse can also provide intervention to restore sleep and rest, connect the client to social support groups, and provide them with information about critical resources available.

Subcategory: Behavioral Interventions

Topic: Anxiety Disorders: Action for a Client Who Is Experiencing a Panic Level of Anxiety

- For clients with severe to panic-level anxiety, the nurse should create a safe and calming environment by turning off any unnecessary stimuli, such as loud noises or bright lights, and encourage slow and deep breathing to help the client relax.
- The nurse should be mindful that all teaching should be postponed until after the acute anxiety subsides because clients in a panic level cannot concentrate or learn.
- The nurse should also remain with the client during the worst anxiety to provide reassurance.

Topic: Personality Disorders: Caring for a Client Who Has Antisocial Personality Disorder

- The nurse must set clear boundaries with the client and consistently enforce them. It is essential to be firm and assertive while remaining professional and respectful.
- The nurse should encourage the client to develop positive coping skills, such as mindfulness meditation, deep breathing exercises, or exercise, to help manage their emotions and behaviors.

- The nurse should know that clients with antisocial personality disorder are at higher risk for engaging in risky behaviors, including substance abuse, violence, and criminal activity. Monitoring the client for any signs of dangerous behavior and implementing safety measures as needed is essential**.**

Main Category: Basic Care and Comfort

Subcategory: Non-Pharmacological Comfort Interventions

Topic: Pain Management: Caring for a Client Who Is in Active Labor

- The nurse should offer the client a variety of comfort measures, such as relaxation techniques, massage, heat, or cold therapy, and changing positions. The nurse should also encourage the client to use breathing techniques and provide support during contractions.
- The nurse should administer pain medication as ordered and monitor the client for side effects. Opioid analgesics such as meperidine or hydrochloride are administered during active labor and can help to relieve pain.
- The nurse should also inform the client that they can receive an epidural block in active labor when the client is at least 4 cm dilated. An epidural block eliminates pain from the umbilicus to the thighs helping to relieve the discomfort of uterine contractions.

Topic: Pain Management: Promoting Comfort During a Heel Stick

- The nurse can apply a warm compress or a warming device to help increase blood flow to the area, reduce pain, and promote relaxation.
- The nurse can also provide comfort measures such as swaddling, cuddling, or offering a pacifier to help comfort and soothe the infant.
- Another option is for the nurse to apply a topical anesthetic cream or solution to the heel before the procedure to help numb the area and reduce pain**.**

Subcategory: Nutrition and Oral Hydration

Topic: Cancer and Immunosuppression Disorders: Teaching a Client Who Has Anorexia

- The nurse should encourage the client to eat small amounts of high-protein foods containing calories and nutrients.
- The nurse should encourage the client to eat cool or room-temperature foods.
- The nurse should encourage the client to consume food in the morning when their appetite is the best.

Topic: Heart Failure and Pulmonary Edema: Priority Action for Fluid Overload

- One priority nursing action is administering oxygen therapy because it can help increase oxygen saturation and improve breathing.
- Another priority nursing action is to elevate the head of the bed to a semi-Fowler's position to help reduce respiratory distress and facilitate breathing.
- Another priority nursing action is administering diuretics, which help increase urine output and remove excess fluid from the body.

Topic: Sources of Nutrition: Best Source of Vitamin C

- Citrus fruits such as oranges, lemons, limes, and grapefruits are high in Vitamin C.
- Berries such as strawberries, raspberries, blueberries, and blackberries are excellent sources of Vitamin C.
- Bell peppers, especially the red and green varieties, are high in Vitamin C.

Subcategory: Personal Hygiene

Topic: Mobility and Immobility: Evaluating Use of a Walker

- The walker should be adjusted to the correct height for the client. The client should stand up straight with their arms at their sides, and the handles of the walker should be at wrist level.
- Ensure the client uses the walker safely and has appropriate accessories like wheels and glides. Check the brakes to ensure they are working correctly.
- Observe the client's gait pattern with the walker. The client should lift the walker and move it forward, then step into it with the affected leg and then the unaffected leg.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: Adverse Effects/Contraindications/Side Effects/Interactions

Topic: Antibiotics Affecting the Bacterial Cell Wall: Identifying a Medication That Causes Diarrhea

- The nurse should know that antibiotics commonly cause diarrhea. Some examples include clindamycin, amoxicillin, and cephalosporins.
- The nurse should know that laxatives can cause diarrhea. Some examples include psyllium, methylcellulose, and lactulose.
- The nurse should know that some chemotherapy drugs also cause diarrhea. Some examples include methotrexate, cisplatin, and oxaliplatin.

Topic: Medications for Depressive Disorders: Monitoring for Interactions Between Citalopram and St. John's Wort

- When St. John's Wort and Citalopram are taken together, it can increase the metabolism of Citalopram in the liver, leading to decreased blood levels of the medication.
- Therefore, taking St. John's Wort and Citalopram together can reduce the effectiveness of Citalopram and increase the client's risk of depression symptoms.
- The combination of St. John's Wort and Citalopram may increase the risk of serotonin syndrome, a potentially life-threatening condition characterized by agitation, confusion, rapid heartbeat, high blood pressure, and muscle rigidity.

Subcategory: Medication Administration

Topic: Non-Opioid Analgesics: Administering Headache Medications to a Client Who Has a History of a Peptic Ulcer

- Non-steroidal anti-inflammatory drugs (NSAIDs) such as aspirin and ibuprofen, commonly used for headaches, can irritate the stomach lining, and increase the risk of bleeding in individuals with a history of peptic ulcer disease. Therefore, acetaminophen is a safer choice for pain relief in this population.
- Triptans can also help relieve headaches in patients with a history of peptic ulcers. However, triptans such as sumatriptan are more commonly used to treat migraines.
- Ergot alkaloids can also help to relieve headaches and are considered the second-line therapy for migraines. Some examples include ergotamine and dihydroergotamine.

Topic: Therapeutic Procedures to Assist with Labor and Delivery: Indications for Increasing the Rate of Oxytocin Infusion

- If the contractions are not strong enough or frequent enough to progress the labor, increasing the oxytocin infusion rate can help stimulate stronger and regular contractions, leading to a faster progression of labor.
- When the labor has been ongoing for an extended period, and there is a risk of fetal distress or infection, increasing the oxytocin infusion rate can help speed up the process and reduce the risk of complications.
- Oxytocin infusion is commonly used to induce labor when it has not started. Increasing oxytocin infusion is done when there is a medical need for delivery, such as in cases of preeclampsia, gestational diabetes, or post-term pregnancy.

Main Category: Reduction of Risk Potential

Subcategory: Therapeutic Procedures

Topic: Gastrointestinal Therapeutic Procedures: Client Teaching for Colostomy Care

- The nurse must educate the client on proper stoma care. The stoma should be kept clean and dry to prevent skin irritation or infection. It is essential to clean the stoma with mild soap and water and to pat it dry with a soft cloth or towel. The client should avoid using harsh soaps, alcohol, or other chemicals that can irritate the skin.

- The nurse must also educate the client on managing the ostomy appliance. The ostomy appliance should be changed regularly to prevent leakage and odor. The client should empty the pouch when it is about one-third full and change it every 3-5 days or as needed.
- The nurse should also educate the client on the importance of adequate fluid intake. Maintaining adequate hydration is essential to prevent constipation and dehydration.

Main Category: Physiological Adaptation

Subcategory: Alterations in Body Systems

Topic: Medical Conditions: Hyperemesis Gravidarum

- Symptoms of hyperemesis gravidarum include persistent and severe nausea and vomiting, dehydration, weight loss, dizziness, and fainting.
- Complications of hyperemesis gravidarum include dehydration, malnutrition, electrolyte imbalances, and liver or kidney damage. It may also cause premature delivery or low birth weight in some cases.
- The treatment of hyperemesis gravidarum focuses on managing symptoms and preventing complications. Mild cases may be managed with dietary changes, rest, and anti-nausea drugs. Severe cases may require hospitalization for intravenous fluids, nutrition, and medication.

Topic: Respiratory Management and Mechanical Ventilation: Nursing Action for a Low-Pressure Alarm

- A disconnection or leak in the ventilator circuit may trigger a low-pressure alarm. The nurse should check the connections and tubing for any disconnections, kinks, or leaks.
- The nurse should assess the patient's respiratory status and vital signs, including oxygen saturation, respiratory rate, and blood pressure. If the patient's condition is stable, the nurse should adjust the ventilator settings to correct the low-pressure alarm. If the patient is unstable, the nurse should provide manual ventilation with a bag-valve mask until the issue is resolved.
- A malfunction in the ventilator may also trigger a low-pressure alarm. The nurse should check the ventilator for any error codes or malfunction indicators.