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321 Proctored ATI Remediation

Management of Care (2)

- Critical thinking and clinical judgement: Caring for a client who has nausea
  - When critically thinking and making decision's regarding a client who has nausea, the nurse will use the nursing process – assessment, planning, diagnosis, implementation, and evaluation.
  - In the assessment phase, the nurse will observe the patient, and ask question's pertaining to the client's nausea.
  - In the implementation phase, the nurse will use a nursing intervention aimed at treating the clients nausea; like administering an anti-nausea medication, for example.
- Therapeutic communication: Providing written materials in a client's primary language
  - Communication is key in the nurse-client relationship, and providing written materials in a client's primary language establishes a trusting relationship.
  - It is important to provide written materials that are appropriate for the client's educational and developmental level.
  - Providing written materials and instructions in a client's primary language is also a step towards being a culturally competent nurse.

Safety and Infection Control (2)

- Infection control: Caring for a client who is immunocompromised
  - When a client is immunocompromised, they are at higher risk for developing infection or disease.
  - It is necessary to use standard precautions when working with the client, as well as any additional precautions the facility may have in place (contact, droplet, etc.)
  - The immunocompromised client may also be put into a protective environment, such as a private room or positive airflow room, for additional protection.
- Medical and surgical asepsis: Preparing a sterile field
  - Sterile technique refers to the practice of eliminating all micro-organisms from an object/area/procedure to prevent contamination.
  - When preparing a sterile field, one key concept is that only sterile items should be within the sterile field.
  - When pouring a sterile solution, the solution bottle should be held with the label in the palm of the hand so the solution does not run down the label.

Health Promotion and Maintenance (2)

- Head and neck: Assessing visual acuity using a Snellen chart
  - The Snellen chart is used to screen a client's far vision.
  - When performing the screen, the client should stand 20 feet away from the Snellen chart.

    - The client should start by reading the chart with both eyes, and then with each eye separately, with and without correction.
- Hygiene: Bathing a client who has dementia
    - If the client with dementia cannot tolerate a full bath, a partial bath may be more appropriate for the client.
    - When performing the bath, frequent rest periods and clarification on the nurse's actions may help keep the client from becoming confused.
    - May client's with dementia are older adults, and it is important to consider that older adult's skin may not tolerate frequent bathing as much as younger adults.

Basic Care and Comfort (1)

- Urinary elimination: Application of a condom catheter
    - Condom catheters are a non-invasive method used to help with urinary incontinence.
    - Condom catheters are used on male patients, and sit on the outside of the genitals.
    - It is important to apply the condom catheter correctly, and explain the procedure fully to the client.

Pharmacological and Parenteral Therapies (2)

- Intravenous therapy: Promoting vein dilation prior to inserting a peripheral IV catheter
    - One method of promoting vein dilation prior to IV insertion is having the client make a fist after the tourniquet has been applied.
    - Another method is using smooth friction when applying cleaning solution to the area where the IV will be inserted.
    - Another method for vein dilation is to use heat to promote relaxation of the vein and surrounding area.
- Pharmacokinetics and routes of administration: Teaching about self-administration of clotrimazole suppositories
    - When preparing to insert a vaginal suppository like clotrimazole, the client patient should lay on their back with knees bent and feet flat, close to the hips.
    - The suppository should be lubricated before insertion.
    - After insertion, the client should remain supine and retain the suppository for at least 5 minutes.

Reduction of Risk Potential (2)

- Intravenous therapy: Action to take for fluid overload
    - Signs of fluid overload when using IV fluids include distended neck veins, tachycardia, shortness of breath, crackles, and edema.
    - If fluid overload is suspected, the IV infusion should be stopped immediately.
    - The patient should then have vital signs and oxygen level assessed, and diuretics administered if indicated.

- Vital signs: Palpating systolic blood pressure
    - Palpating the systolic blood pressure provides the nurse with the correct range to inflate the blood pressure cuff to when taking a manual blood pressure.
    - The nurse should palpate the radial pulse on the arm where the cuff is being inflated, and inflate the cuff until the pulse cannot be palpated any longer.
    - Note the pressure at which the pulse was no longer palpated, and inflate the cuff 20-30 mm Hg past that mark when taking a manual blood pressure.

Physiological Adaptation (1)

- Pressure injury, wounds, and wound management: Performing a dressing change
    - Wound dressing changes are important, as they provide an opportunity to assess the wound and also protect from infection.
    - When performing a dressing change, aseptic technique should be used to minimize infection risk.
    - If dressing a pressure injury, the type of dressing depends on the severity and stage of the pressure injury.