Foundations ATI Exam Remediation

Management of Care

Continuity of Care

Information Technology: Approved abbreviations for use in documentation

1. Some error prone abbreviations that should NOT be used in a clinical setting or for documentation include things like: U, IU, trailing zeros, cc, q.d, HS, IJ, D/C, TIW and more
2. Using abbreviations can easily lead to errors in medication dosage, frequency, and more. It is important to be familar with your facilities unique policy on abbrevations as well.
3. The best way to document is to right things out clearly so say “daily”, “3 times a week” and “injection” for example and always spell out the full names of medications.

Safety and Infection Control

Accident/Error/Injury Prevention

Home Safety: Identifying fall risks in the home

1. The age and developmental status of a client create safety risks that are specific to each client.
2. Specific changes in older adults that place them more at risk for falls at home include things like impaired vision and hearing, getting up at night to use the bathroom, changes in musculoskeletal strength and mobility, and decreases in tactile sensitivity.
3. To reduce the risk of falls in the home clients should remove throw rugs and loose material, secure electrical/extension cords to the walls and behind furniture, placing grab bars in the shower, and ensuring adequate lighting.

Nursing Process: Priority action following a missed provider prescription

1. An incident is the occurrence of an accident or an unusual event. Examples of incidents are medication errors, falls, omission of prescription, and needlesticks.
2. If a prescription is missed the priority action is to tell the provider and fill out an incident report.
3. Do not refer to an incident report in a client’s medical record.

Basic Care and Comfort

Mobility/Immobility

Mobility/Immobility: Priority finding for a client who is immobile

1. Mobility is defined as freedom and independence in purposeful movement and many factors can affect how mobile a person is. Such factors include health status, age, musculoskeletal or nervous system injury, posture and more.

2. For clients who are immobile or who have imparied immobility it is vital to perform very frequent assessments of their skin, respiratory, cardiovascular, musculokskeletal and urinary systems. For example, nurses should look for things such as signs of skin breakdown, redness or pallor, breathing effort, edema, decreased ROM of joints which can all be caused by immobility.
3. Nurses should also work to consistently and frequently provide interventions to avoid complications of immobility such as frequently turning/re-positioning clients, instructing them to deep breath and cough, providing passive ROM, encouraging fluid intake and a healthy diet, and promptly cleaning up any incontience events to help keep clients clean and dry.

Mobility/Immobility: Teaching a client about log rolling while in bed

1. The purpose of logrolling is to maintain alignment of the clients spine to prevent inury to the back and spine.
2. While logrolling a patient, the nurse should cross the patient's arms on the chest to prevent injury to their arms.
3. The head of the bed should always be flat when log rolling a client.

Pharmacological and Parenteral Therapies

Medication Administration

Safe Medication Administration & Error Reduction: Comparing the MAR to the medication container

1. Nurses have a responsibility to maintain up-to-date knowledge of medications as well as how to properly prepare, administer, and safeguard them.
2. A nurse should read medication labels and compare them to the MAR three separate times. First, before removing the medication container from where ever it is stored, next when removing the specified amount of medication from the container, and lastly in the presence of the client before administering the medication.
3. Nurses should always follow through with the rights of medication administration for each medication to be given. These rights include: right client, right dose, right time, right route, right documentation, right client education, right to refuse, right assessment, and right evaluation.

Reduction of Risk Potential

Therapeutic Procedures

Bowel Elimination: Discharge teaching about ostomy care

1. The type of equipment needed to provide ostomy care includes the pouch system, gloves, wash cloths, wash cloths, scissors, a pen, warm water and an optional barrier paste.
2. A person should wash their hands and put on gloves before removing the ostomy pouch. They should then inspect the stoma to make sure it is pink

and moist and look for any signs of irritation on the skin around the stoma. The person should also use mild soap and warm water to clean the stoma and the area surrounding it.

3. Cut an opening for the stoma on the new pouch that is about ⅛ an inch larger than the stoma, apply the skin barrier and pouch, and secure the pouch clamp. Follow with disposing the old pouch and gloves and wash hands.

Clinical Judgement

Analyze Clues

Preoperative Nursing Care: Findings requiring follow up prior to surgery

1. Preoperative care takes place from the time a client is scheduled for surgery until care is transferred to the operating suite and includes a thorough assessment of the client's physical, emotional, and psychosocial status prior to surgery.
2. Before a surgery a nurse should verify that the informed consent is accurately completed, signed, and witnessed. The nurse should also make suer that the client is legally able to consent to the procedure.
3. The nurse should also ensure that the client remains NPO for at least 6 hr for solid foods and 2 hr for clear liquids before surgery, help perform skin preparation and ensure that jewelry, dentures, prosthetics, makeup, nail polish, and glasses are removed.

Take Action

Urinary Elimination: Reviewing the medical record of a client who has a UTI

1. For a client who has a UTI it is important for the nurse to promptly administer all medications, especially antibiotics and ensure that the client finishes their antibiotic regime.
2. The nurse should also trend vital signs and lab results such as a urinalysis to assess if signs of infection are improving, worsening, or not changing at all.
3. Nurses should also measure intake and output and document that in a client's medical record as well as describe the quality of the client's urine.