N321 Adult Health I
Proctored ATI Remediation Template

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Assessment Name: RN Fundamentals 2019
Semester: 2

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: Client Rights

Topic: Ethical Responsibilities: Responding to a client's need for information about treatment

- #1. The nurse should advocate for the client, meaning the nurse will support/defend the client's health, wellness, safety, wishes, and personal rights, including privacy.
- #2. The nurse should abide by the ethical principle of veracity and be truthful with the patient about the treatment.
- #3. The nurse needs to understand and respect that the client has autonomy and can make their own decisions even if it isn't in their best interest.

Subcategory: Establishing Priorities

Topic: Critical Thinking and Clinical Judgment: Caring for a client who has nausea

- #1. Nurses must apply knowledge, experience, attitudes, and intellectual and professional standards to develop their critical thinking skills fully.
- #2. There are three different types of critical thinking a nurse could utilize, basic, commitment, and complex.
- #3. A nurse caring for a client with nausea should specifically use the commitment category of critical thinking by interpreting the assessment data, identifying the pros and cons of interventions, realizing potential problems, creating goals and outcomes for the client, setting priorities, and evaluating the outcome.

Subcategory: Information Technology

Topic: Information technology: Action to take when receiving a telephone prescription

- #1. Have a second nurse listen to the phone conversation involving a telephone prescription.
- #2. Read it back to the provider, verifying the medication name, dosage, time/frequency, and route.
- #3. Verify the provider signs the prescription in person within the allotted time frame of that facility.

Main Category: Safety and Infection Control

Subcategory: Accident/Error/Injury Prevention

Topic: Safe Medication Administration and Error Reduction: Client identifiers

- #1. Two client identifiers are required before administering medication to a client.
- #2. Acceptable patient identifiers include the client's name, assigned ID #, telephone number, date of birth, or an ID with a patient photo.
- #3. Nurses can also use the client's bracelet by scanning its bar-code.

Subcategory: Ergonomic Principles

Topic: Ergonomic Principles: Teaching a caregiver how to avoid injury when repositioning a client

- #1. Before attempting to position or move a client, perform a mobility assessment. Begin with the easiest movements (range of motion) and progress as long as the client tolerates it (balance, gait, exercise).
- #2. Keep your head and neck in a straight line with your pelvis to avoid neck flexion and hunched shoulders, which can cause impingement of nerves in your neck.
- #3. Avoid twisting your spine or bending at the waist (flexion) to minimize the risk for injury.

Subcategory: Reporting of Incident/Event/Irregular Occurrence/Variance

Topic: Information Technology: Action to take when a visitor reports a fall

- #1. An incident is the occurrence of an accident or an unusual event. Examples of incidents include medication errors, falls, omission of prescription, and needlesticks.
- #2. Document facts without judgement.
- #3. Do not refer to an incident report in a client's medical record.

Subcategory: Safe Use of Equipment

Topic: Home Safety: Client teaching about electrical equipment safety

- #1. The nurse must identify risk factors using a risk assessment tool and complete a nursing history, physical examination, and home hazard appraisal.
- #2. Place electrical cords and extension cords against a wall behind furniture.
- #3. Burns can result from electrical currents, chemicals, radiation, or flames. Home hazards that can causes these include pot/pan handles the protrude over the stove, hot bath water, and electrical appliances. Remove these agents, meaning the electrical current, radiation source, or chemical.

Subcategory: Standard Precautions/Transmission-Based Precautions/Surgical Asepsis

Topic: Infection Control: Caring for a client who is immunocompromised

- #1. A nurse uses infection control practices such as medical asepsis, surgical asepsis, and standard precautions to break the chain and thus stop the spread of infection.
- #2. A client who is immunocompromised should be placed in a protective environment as an intervention to protect clients.
- #3. A protective environment requires a private room, positive airflow that has 12 or more air exchanges and hour, HEPA filtration for incoming air, and a mask be placed on the client when leaving the room.

Topic: Medical and Surgical Asepsis: Preparing a sterile field

- #1. Avoid coughing, sneezing, and talking directly over a sterile field.
- #2. Hold items to add to a sterile field at a minimum of 6 inches above the field.
- #3. Sterile materials can touch other sterile surfaces or materials; however, contact with non-sterile materials at any time contaminates a sterile area, no matter how short the contact.

Main Category: Health Promotion and Maintenance

Subcategory: Health Screening

Topic: Head and Neck: Assessing visual acuity using a Snellen chart

- #1. Have the client stand 20 feet from the Snellen chart. Evaluate both eyes and then each eye separately with and without correction.
- #2. For each eye, have the client cover the opposite eye.
- #3. Ask the client to read the smallest line of print that is visible. Make a note of the smallest line the client can read correctly.

Subcategory: Techniques of Physical Assessment

Topic: Vital Signs: Assessing a client's blood pressure

- #1. A normal blood pressure reading shows a systolic number less than 120 and a diastolic number less than 80. An elevated blood pressure reading shows a systolic number of 120 – 129 and a diastolic number less than 80. Stage 1 hypertension would show a systolic number 130 – 139 and a diastolic number 80 – 89. Stage 2 hypertension would show a systolic number of 140 or higher and a diastolic number of 90 or higher.
- #2. The width of the cuff should be 40% of the arm circumference at the point where the cuff is wrapped.
- #3. The bladder (inside the cuff) should surround 80% of the arm circumference of an adult and the whole arm for a child.

Main Category: Psychosocial Integrity

Subcategory: End-of-Life Care

Topic: Grief, Loss, and Palliative Care: Providing end-of-life care

- #1. Administer medication such as morphine that manages pain, anxiety, and air hunger.
- #2. Reposition the client to maintain airway patency and comfort.
- #3. Encourage the client to use relaxation techniques such as guided imagery and music if applicable.

Main Category: Basic Care and Comfort

Subcategory: Assistive Devices

Topic: Mobility and Immobility: Evaluating a client's use of a walker

- #1. Have the client push up from the armrest of the chair or from the bed to a standing position.
- #2. Place a firm grip on both sides of the walker with your hands. Move the walker forward a short distance.
- #3. Step forward with your injured or weaker leg first, putting weight on the palms of your hands. Then take a step with your stronger leg.

Subcategory: Elimination

Topic: Urinary Elimination: Application of a condom catheter

- #1. To apply the condom catheter, the nurse should hold the client's penis tightly along its shaft with the non-dominant hand. Then, smoothly roll the condom sheath onto the penis using your dominant hand.
- #2. Allow 2.5 – 5 cm, or 1 – 2 inches, between the tip of the glans penis and the end of the condom catheter.
- #3. Equipment needed for the application of a condom catheter includes gloves, a condom catheter, elastic tape, and a leg or standard collection bag.

Subcategory: Mobility/Immobility

Topic: Pressure Injury, Wounds, and Wound Management: Actions to prevent skin breakdown

- #1. Position using corrective devices such as pillows, foot boots, wedge pillows, trochanter rolls, splints, or alternating air-pressure mattress pads.
- #2. Turn clients every 1 to 2 hours, and use devices for support. Educate clients who are capable of moving independently to turn themselves at least every 15 minutes.
- #3. Provide skin and perineal care.

Subcategory: Non-Pharmacological Comfort Interventions

Topic: Complementary and Alternative Therapies: Contraindications for receiving acupuncture

- #1. Acupuncture is contraindicated for clients who have bleeding disorders such as hemophilia and clients who are on anticoagulant medications.
- #2. Acupuncture is contraindicated in clients who have open or infected skin.
- #3. Acupuncture is contraindicated in clients who may be pregnant.

Subcategory: Rest and Sleep

Topic: Rest and Sleep: Identifying findings that indicate sleep deprivation

- #1. Clients may exhibit excessive daytime sleepiness if they are experiencing sleep deprivation.
- #2. Clients may experience moodiness or poor concentration if they are sleep-deprived.
- #3. Clients may be using substances that could be a factor causing their sleep deprivation.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: Medication Administration

Topic: Pharmacokinetics and Routes of Administration: Self-administration of ophthalmic solutions

- #1. Teach the client to sit upright or lie supine, tilt their head slightly, and look up at the ceiling.
- #2. After the client administers drops, tell them to apply gentle pressure with their finger and a clean

facial tissue on the nasolacrimal duct for 30 – 60 seconds to prevent systemic absorption of the medication.
- #3. If the client needs to instill more than one medication in the same eye, tell them to wait at least 5 minutes between them.

Topic: Pharmacokinetics and Routes of Administration: Teaching about self-administration of Clotrimazole suppositories
- #1. Position clients in the left lateral or Sim's position.
- #2. Insert the suppository just beyond the internal sphincter.
- #3. Instruct the client to remain flat or in the left lateral position for at least 5 minutes after insertion to retain the suppository.

Topic: Safe Medication Administration and Error Reduction: Confirming a client's identity
- #1. Two client identifiers are required before administering medication to a client.
- #2. Acceptable patient identifiers include the client's name, assigned ID #, telephone number, date of birth, or an ID with a patient photo.
- #3. Nurses can also use the client's bracelet by scanning its bar code.

Subcategory: Parenteral/Intravenous Therapies

Topic: Intravenous Therapy: Promoting vein dilation prior to inserting a peripheral IV catheter
- #1. Select the vein by using visualization, gravity, fist clenching, friction with the cleaning solution, or heat, and choose from the following, distal veins first on the nondominant hand, a site that is not painful or bruised and will not interfere with activity, and a vein that is resilient with a soft, bouncy sensation.
- #2. Avoid using varicose veins that are permanently dilated and tortuous or veins that are sclerosed or hard.
- #3. Avoid using veins in the inner wrist with bifurcations, in flexion areas, near valves, in lower extremities, and in the antecubital fossa.

Main Category: Reduction of Risk Potential

Subcategory: Changes/Abnormalities in Vital Signs

Topic: Vital Signs: Palpating systolic blood pressure
- #1. Estimate systolic pressure by palpating the radial pulse and inflating the cuff until the pulse disappears. Inflate the cuff another 30 mm Hg, and slowly release the pressure to note when the pulse is palpable again (the estimated systolic pressure).
- #2. Deflate the cuff and wait one minute. Place the stethoscope over the brachial artery. Close the pressure bulb by turning the valve clockwise until tight. Quickly inflate the cuff to 30 mm Hg above the palpated systolic pressure.
- #3. Release the pressure no faster than 2 – 3 mm Hg per second. The level at which you hear the first clear sounds is the systolic pressure.

Subcategory: Potential for Complications of Diagnostic Tests/Treatments/Procedures

Topic: Nasogastric Intubation and Enteral Feedings: Preparing to administer feedings
- #1. Feedings need to be at room temperature.
- #2. Before administering verify if the feeding needs mixed or shaken.
- #3. After feeding is instilled in the bag you need to flush the tubing with at least 30 mL of water to prevent clogging.

Subcategory: Therapeutic Procedures

Topic: Preoperative Nursing Care: Providing preoperative teaching to a client
- #1. Adhere to preoperative instructions regarding medications.
- #2. Avoid smoking, alcohol, or illicit drug use, which can interfere with surgical medications and

increase the risk for surgical complications.

- #3. Ensuring that the client understand the care and restrictions that are required associated to the surgical procedure being performed.

Main Category: Physiological Adaptation

Subcategory: Alterations in Body Systems

Topic: Pressure Injury, Wounds, and Wound Management: Performing a dressing change

- #1. The dressing protects the wound from microbes.
- #2. Use gentle friction when cleansing or applying solutions to the skin to avoid bleeding or further injury to the wound.
- #3. Never use the same gauze to cleanse across an incision or wound more than once. Do not use cotton balls and other products that can leave fibers behind. Use a syringe or straight catheter to irrigate deeper wounds.