

## **ATI Remediation**

### **1. Management of Care**

#### **a. Collaboration with Multidisciplinary Team**

- Educating patient on proper wound care to prevent from causing irritation
- Establishing a sterile field, irrigate site with saline from clean to dirty edges
- Irrigation of wounds helps to get rid of foreign pathogens by flushing them out via high pressure

#### **b. Continuity of Care**

- Prohibited abbreviations: IU, Q.D., MS, U, u
- Use of a trailing zero. Only used when showing level of precision of the value
- Standardized abbreviation is developed within the individual organization

#### **c. Informed Consent**

- A legal process in which a client(s) is given permission for a procedure or treatment
- Ensuring the client understood the information given and is alert and oriented to give proper informed consent
- The nurse's role is to witness the client signature on the informed consent and to make sure the provider receives it

### **2. Safety and Infection Control**

#### **a. Accident/Error/Injury Prevention**

- All clients must be evaluated at the health care facility for fall risk factors
- The nurse should communicate risk factors and plans of care to the client, family, and assisting staff members
- Be sure to always explain use of the call light to the client to encourage use in fall prevention
- Clients with increased fall risk may include decreased visual acuity, weakness, urinary frequency, gait/balance problems, adverse medication, and cognitive dysfunction
- Keep floor clean, dry, clutter free, bed in low position/locked, and brakes on
- Use proper PPE accordingly with plan of care and round on patients hourly

### **3. Health Promotion and Maintenance**

#### **a. Health Promotion/Disease Prevention**

- Colonoscopy every ten years, fecal occult blood test yearly when at risk
- Risk factors include colon polyps, inflammatory bowel disease, smoking, high fat/low-fiber diet
- Expected to see change in stool consistency, blood in stool, cramps, and weight loss

#### **b. Health Screening**

- Assess by inspection, auscultation, and palpation
- Nurse education to patient and family on healthy lifestyle changes to help prevent worsening of condition

- Assessing chest symmetry, irregular breathing, weak or strong pulses

**c. High-Risk Behaviors**

- Taking medications to help strengthen bones, avoiding medications that make weaken bones
- Perform routine weight-bearing exercises
- Limit alcohol use and smoking

**4. Basic Care and Comfort**

**a. Assistive Devices**

- Crutches are used to help maintain stability, decrease musculoskeletal system changes, and have optimal ROM
- Nurses to help assess patient with ROM capability, muscle tone, monitoring gait, ensuring they stand with back straight and elbows flexed at 30 degrees
- Evaluate patient by performing teach back method

**b. Mobility/Immobility**

- Factors affecting mobility may include muscle injury, poor posture, impaired CNS, or age
- Nurse to ensure patient maintains intact skin, watching for and breakdown, color change, warmth, non-blanchable areas of bony prominences
- Ensure adequate food intake to promote proper wound healing
- Keeping skin dry and clean from moisture, typically seen from incontinence
- Sit to stand lifts may be utilized to assist weight-bearing patients
- Nurse may assist in passive ROM exercises to promote muscle and joint health

**c. Nutrition and Oral Hydration**

- Excessive fluid loss may be a result of lack of proper fluid intake
- Risk factors include excessive vomiting, diarrhea, burns, hemorrhage, plasma loss
- Nurse should instruct patient to have proper intake of fluids/water daily, in addition to nutritional requirements and medications
- Nurse to emphasize small and more frequent meals if necessary
- Foods needed for energy and should be protein dense
- Proper assessment of clients for risk for dysphagia through screening

**5. Pharmacological and Parenteral Therapies**

**a. Medication Administration**

- Oral meds most effective and convenient for patients who can ingest and tolerate
- Nurse to identify patient using at least two patient identifiers, ensuring med safety, and check expiration dates
- Monitor patients' response to medications looking for possibility for any adverse reactions or irregular vital signs

**6. Reduction of Risk Potential**

**a. Potential for Alterations in Body Systems**

- Biological and natural products may have medication affects or effects on adequate diet
- Providing patient with proper education and information to determine if possible medications may cause health complications
- Focus on optimal health of the patient in a holistic approach, taking into considerations religious preferences

**b. Therapeutic Procedures**

- Replace ostomy when bag is full, leaking, or damaged
- Educate patient and family on how to inspect signs for infection, how to limit discomfort while removing adhesives
- Always allow patient to ask questions and voice concerns

**7. Physiological Adaptation**

**a. Pathophysiology**

- Symptoms of allergic reactions are not typically life-threatening; however, severe cases may cause anaphylaxis
- Monitor patient's airway, oxygen saturations, and signs of distress or discomfort
- Latex allergy may not develop in patients till after repetitive exposures

**8. Clinical Judgment**

**a. Analyzing Cues**

- In prevention of osteoporosis, it is best to consume an adequate amount of calcium and vitamin D
- Nurse should educate to avoid wet surfaces and wear rubber-bottomed shoes
- Excess caffeine consumptions may cause too much excretion of calcium in urine
- During pre-op nurse to obtain health history and perform physical examination to establish if patient qualifies for a safe procedure
- Diagnostic tests may include blood testing, x-ray, CT, MRI, urinalysis, stool sample, EKG, or tissue biopsies
- Nurse to obtain informed consent, arrange for POA or supportive family to be ride home post-surgery

**b. Prioritize Hypothesis**

- Risk for pressure ulcers, muscle weakness, orthostatic hypotension, and contracture
- Nurse to perform a Braden Scale assessment to determine risk of immobility and harm to patient
- Stage IV pressure injury is most severe, being that it is deep typically exposing muscle or bone

**c. Take Actions**

- Reviewing chart to see medications and prior instances of UTI
- Ensuring patient is clean of incontinence to prevent increased risk of infection
- Normal urine should be pale to light yellow, clear, and not foul smelling

## Module Report

Tutorial: NurseLogic 2.0

Module: Knowledge and Clinical Judgment



Individual Name: Kaleb Kelly

Institution: Lakeview CON

Program Type: BSN

### Overview Of Most Recent Use

	Date	Time Use	Score
LESSON	12/5/2023	30 min 10 sec	N/A
Beginning Test	8/27/2023	4 min	100.0%
Advanced Test	8/27/2023	9 min	100.0%

### Lesson Information:

#### Lesson - History

	Date/Time	Time Use
		Total Time Use: 2 hr 43 min
Lesson	8/27/2023 3:40:52 PM	0 min 3 sec
Lesson	8/27/2023 4:03:27 PM	22 min 19 sec
Lesson	12/5/2023 3:35:06 PM	1 min 21 sec
Lesson	12/5/2023 4:26:49 PM	12 min 1 sec
Lesson	12/5/2023 5:42:59 PM	1 hr 15 min 30 sec
Lesson	12/5/2023 6:19:14 PM	22 min 0 sec
Lesson	12/5/2023 6:56:09 PM	30 min 10 sec

### Beginning Test Information:

Total Time (12/5/23) = 2 hours 20 minutes