N321 Adult Health I
Proctored ATI Remediation Template

Student Name: Tracy Donaldson
Assessment Name: RN Fundamentals 2023
Semester: Spring 2024

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: : Collaboration with Multidisciplinary Team

Topic: pressure injury, wounds, wound management- wound irrigation

- If irrigating, use a piston syringe or a sterile straight catheter for deep wounds with small openings. Apply 5 to 8 psi of pressure. A 30 to 60 mL syringe with a 19-gauge needle provides approximately 8 psi. Use normal saline, lactated Ringer's, or an antibiotic/antimicrobial solution. Hold the tip 2.5 cm (1 in) above the wound. Use continuous pressure to flush the wound, repeating the procedure until the irrigant flowing out of the wound is clear.
- Never use the same gauze to cleanse across an incision or wound more than once.
- Although the provider might prescribe other mild cleansing agents, isotonic solutions remain the preferred cleansing agents.

Subcategory: Legal Rights and Responsibilities

Topic: legal responsibilities: identifying negligence

- ***Unintentional torts*** **Negligence:** A nurse fails to implement safety measures for a client at risk for falls. **Malpractice (professional negligence):** A nurse administers a large dose of medication due to a calculation error. The client has a cardiac arrest and dies.
- Intentional tort- Assault The conduct of one person makes another person fearful and apprehensive

Example: A nurse threatens to place an NG tube in a client who is refusing to eat.

- Intentional tort- Battery: Intentional and wrongful physical contact with a person that involves an injury or offensive contact.

Example: A nurse restrains a client and administers an injection against their wishes.

Main Category: Safety and Infection Control

Subcategory: Accident/Error/Injury Prevention

Topic: pressure injury, wounds, and wound management- preventing pressure injuries

- Keep skin clean, dry, and intact. Provide a firm, wrinkle-free foundation with wrinkle-free linens.
- Keep the head of the bed at or below a 30° angle (or flat), unless contraindicated, to relieve pressure on the sacrum, buttocks, and heels.
- Raise heels off of the bed to prevent pressure
- Lift, rather than pull, clients up in bed or in a chair, because pulling creates friction that can damage the outer layer of skin (epidermis

Subcategory: Home Safety

Topic: evaluating client understanding of home safety teaching

- Ensure that lighting is adequate inside and outside the home and remove clutter
- Monitor gait and balance, and provide aids as needed.
- Remove items that could cause the client to trip (throw rugs and loose carpets).

Topic: evaluating discharge teaching for an older adult

- Place electrical cords and extension cords against a wall behind furniture.
- Make sure that steps and sidewalks are in good repair.
- Ensure that lighting is adequate inside and outside the home and remove clutter.

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

Topic: infection control: isolation precautions for a client who has influenza

- A private room or a room with other clients who have the same infectious disease. Ensure that clients have their own equipment.
- Masks for providers and visitors.
- Clients who have a droplet infection should wear a mask while outside of the room/home.

Topic: infection control: removal of personal protective equipment

- **Remove gown and gloves**
- **Remove mask without touching**
- **Wash hands**

Topic: medical and surgical asepsis: technique for setting up a sterile field

- The outer wrappings and 1-inch edges of packaging that contains sterile items are not sterile. The inner surface of the sterile drape or kit, except for that 1-inch border around the edges, is the sterile field to which other sterile items can be added. To position the field on the table surface, grasp the 1-inch border before donning sterile gloves. Discard any object that comes into contact with the 1-inch border. QS
- Touch sterile materials only with sterile gloves.
- Consider any object held below the waist or above the chest contaminated.
- 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.

Subcategory: Use of restraintsf/Safety Devices

Topic: client safety: planning care for a client who has a prescription for restraints

- Nurses must know and follow federal, state, and facility policies for the use of restraints.
- Some clients require seclusion rooms and/or restraints.
- In general, use seclusion or restraints for the shortest duration necessary and only if less restrictive measures are not sufficient. They are for the physical protection of the client or the protection of other clients or staff.

Main Category: Psychosocial Integrity

Subcategory: Coping Mechanisms

Topic: coping: evaluating client adaptation to a role change

- Make sure rescue equipment is at the bedside, including oxygen, an oral airway, suction equipment, and padding for the side rails. Clients at high risk for generalized seizures should have a saline lock in place for immediate IV access.
- Ensure rapid intervention to maintain airway patency.
- Inspect the client's environment for items that could cause injury during a seizure and remove items that are not necessary for current treatment.
- Assist clients at risk for seizures with ambulation and transferring to reduce the risk of injury.
- Advise all caregivers and family not to put anything in the client's mouth (except an airway for status epilepticus) during a seizure.
- Advise all caregivers and family not to restrain the client during a seizure but to lower the client to the floor or bed, protect their head, remove nearby furniture, provide privacy, put them on one side with the head flexed slightly forward if possible, and loosen their clothing.

Main Category: Basic Care and Comfort

Subcategory: Mobility/Immobility

Topic: planning care for a client who is immobile

- identify clients at risk for pressure injury development.
- Position using corrective devices (pillows, foot boots, trochanter rolls, splints, wedge pillows).
- Turn every 1 to 2 hr, and use devices for support or per protocol.

- Teach clients who can move independently to turn at least every 15 mins.
- Provide clients who are sitting in a chair with a device to decrease pressure.
- Limit sitting in a chair to 1 hr. Instruct clients to shift their weight every 15 mins.
- Use a therapeutic bed or mattress for clients in bed for an extended time.
- Ensure adequate intake of calories, proteins, and other essential nutrients.
- Provide skin and perineal care.

Topic: teaching about reducing the adverse effect of immobility

- Maintain hydration (at least 2,000 mL/day unless fluid is restricted).
- Make sure clients change position in bed at least every 2 hr, and perform weight shifts in the wheelchair every 15 mins.
- **Four-point gait** requires the client to bear weight on both legs. The client alternates each leg with the opposite crutch so three points of support are on the floor at all times.
- **Three-point gait** requires the client to bear all weight on one foot while using both crutches. The affected leg should never bear weight or touch the ground.
- **Two-point gait** requires the client to have partial weight bearing on both feet. The client moves a crutch while moving the opposite leg at the same time. This is to mirror the movements of normal arm and leg motion during walking.
-
-

Subcategory: Nutrition and Oral Hydration

Topic: assisting a client who has dysphagia

- **Dysphagia:** pureed food and thickened liquids
- Assist with preventing aspiration. QS
    - Position in high Fowler's position or in a chair.
    - Support the upper back, neck, and head.
    - Have clients tuck their chins when swallowing to help propel food down the esophagus.
    - Avoid the use of a straw.
    - Observe for aspiration and pocketing of food in the cheeks or other areas of the mouth.
    - Observe for indications of dysphagia (coughing, choking, gagging, and drooling of food).
    - Keep clients in semi-Fowler's position for at least 1 hr after meals.

- Provide oral hygiene after meals and snacks.

Topic: the interprofessional team: requesting a referral for a client who has dysphagia

- Occupational therapist
- Speech-language therapist
- The RN is the lead team member, soliciting input from all nursing team members and setting priorities for the coordination of client care.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: Expected Actions/Outcomes

Topic: safe medication admin and error reduction

- Avoid distractions during medication preparation (poor lighting, phones). Interruptions increase the risk of error.

- Prepare medications for one client at a time.
- Check the labels for the medication's name and concentration. Read labels carefully. Measure doses accurately and double-check dosages of high-alert medications (insulin and heparin) with a colleague. Check the medication's expiration date.
- Doses are usually one to two tablets or one single-dose vial. Question multiple tablets or vials for a single dose.
- Follow the rights of medication administration consistently. Take the MAR to the bedside.
- Only give medications that you have prepared. Do not administer a medication prepared by someone else.
- Encourage clients to become part of the safety net, teaching them about medications and the importance of proper identification before medication administration. Omit or delay a dose when clients question the size of the dose or the appearance of the medication.
- Follow correct procedures for all routes of administration.
- Communicate clearly both in writing and speaking.
- Use verbal prescriptions only for emergencies and follow the facility's protocol for telephone prescriptions. Nursing students cannot accept verbal or telephone orders.
- Follow all laws and regulations for preparing and administering controlled substances. Keep them in a secure area. Have another nurse witness the discarding of controlled substances.
- Do not leave medications at the bedside. Some facilities' policies allow exceptions (for topical medications).
- Document each medication after administration. Include the name of the medication, dosage, time, route, and assessment data prior to and following medication administration. Document if the client refuses to take a medication or if a medication was not administered

Subcategory: Medication Administration

Topic: pharmacokinetics and routes of administration: enteral admin of meds

- eye drops-- “I will gently apply pressure with my finger to the front part of my ear after putting in the drops.”
- For liquids, suspension, and elixirs, follow directions for dilution and shaking. To prepare the medication, place a medicine cup on a flat surface before pouring, and ensure the base of the meniscus (lowest fluid line) is at the level of the dose.
- Contraindications for oral medication administration include vomiting, decreased GI motility, absence of a gag reflex, difficulty swallowing, and a decreased level of consciousness.
- Have clients sit upright at a 90° angle to facilitate swallowing. QS
- Administer medications, such as analgesics, that irritate the gastric mucosa with small amounts of food if not contraindicated.
- Do not mix with large amounts of food or beverages in case clients cannot consume the entire quantity.
- Avoid administration with interacting foods or beverages (grapefruit juice decreases the metabolism of certain medications increasing the risk of toxicity).
- Administer oral medications as prescribed and follow directions for whether medication is to be taken on an empty stomach (30 min to 1 hr before meals, 2 hr after meals) or with food.
- Follow the manufacturer’s directions for crushing, cutting, and diluting medications. Break or cut scored tablets only.
- Make sure clients swallow enteric-coated or time-release medications whole. These medications should not be crushed or chewed because time-released medications are intended to release slowly and enteric-coated are made to protect the gastric lining.
- Use a liquid form of the medication to facilitate swallowing whenever possible
- **Enteral- do not mix medications- observe aspirate and check PH**

Main Category: Reduction of Risk Potential

Subcategory: Changes/Abnormalities in Vital Signs

Topic: vital signs: nursing actions for elevated blood pressure

- **Blood pressure** (BP) reflects the force the blood exerts against the walls of the arteries during cardiac muscle contraction (systole) and relaxation (diastole). Systolic blood pressure (SBP) occurs during ventricular systole, when the ventricles force blood into the aorta and pulmonary artery, and it represents the maximum amount of pressure exerted on the arteries when ejection occurs. Diastolic blood pressure (DBP) occurs during ventricular diastole, when the ventricles relax and exert minimal pressure against arterial walls, and represents the minimum amount of pressure exerted on the arteries.
- Assess orthostatic changes by taking the client’s BP and heart rate (HR) after the client has been in the supine position for

3 to 10 min. Next, have the client change to the sitting or standing position and immediately reassess BP and HR. Wait an additional 3 min and repeat BP and HR. The client has orthostatic hypotension if the SBP decreases more than 20 mm Hg and/or the DBP decreases 10 mm Hg or more with an increase in HR. Do not delegate this procedure to an assistive personnel.

- Orthostatic hypotension Have the client sit at the edge of the bed for at least 1 min before standing up, and move slowly when changing position.

Subcategory: Potential for Alterations in Body Systems

Topic: administering meds to a client who has dysphagia

- Thicken medication with applesauce
- Alternative formulation
- Different route

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

Topic: airway management: changing tracheostomy ties

- Replace tracheostomy ties if they are wet or soiled. Secure the new ties before removing the soiled ones to prevent accidental decannulation.
- Provide tracheostomy care every 8 hr to reduce the risk of infection and skin breakdown.
- Suction the tracheostomy tube, if necessary, using sterile suctioning supplies.
- Apply the oxygen source loosely if the client's SpO_2 decreases during the procedure.
- Use surgical asepsis to remove and clean the inner cannula (with the facility-approved solution). Use a new inner cannula if it is disposable.
- Remove soiled dressings and excess secretions.
- Clean the stoma site and then the tracheostomy plate.
- Place a fresh split-gauze tracheostomy dressing of nonraveling material under and around the tracheostomy holder and plate.
-
    - if a knot is needed, tie a square knot that is visible on the side of the neck. Check that one or two fingers fit between the tie and the neck.
- Change nondisposable tracheostomy tubes every 6 to 8 weeks or per protocol.

- Reposition the client every 2 hr to prevent atelectasis and pneumonia.
- Minimize dust in the room. Do not shake bedding.
- If the client is permitted to eat, position them upright and tip the chin to the chest to enable swallowing. Assess for aspiration.

Topic: intravenous therapy: actions to take for fluid overload

- **Daily weighing**
- **diuretics**
- **Semi-fowlers position**

Subcategory: Therapeutic Procedures

Topic: repositioning a client with a lower back injury

- Reposition every 1-2 hours
- Increased risk for blood clots if not moving
- Watch for pressure injuries

Main Category: Physiological Adaptation

Subcategory: Alterations in Body Systems

Topic: priority action when caring for a client who is experiencing a seizure

- Stay with the client, and call for help.
- Maintain airway patency and suction PRN. QS
- Administer medications.
- Note the duration of the seizure and the sequence and type of movements.
- After a seizure, determine mental status and measure oxygenation saturation and vital signs. Explain what happened, and provide comfort, understanding, and a quiet environment for recovery.
- Document the seizure with any precipitating behavior and a description of the event (movements, injuries, duration of seizures, aura, postictal state), and report it to the provider.

Subcategory: Pathophysiology

Topic: identifying manifestations of an anaphylactic reaction

- Initial manifestations of anaphylaxis include GI cramping and apprehension, with generalized itching and hives following, progressing to angioedema and intensely large, itchy hives.
- Respiratory manifestations following inflammation and mucous production include lung crackles, wheezing, decreased

breath sounds, a feeling of a lump in the throat, hoarseness, and stridor. The client can develop respiratory failure and death.

- Cardiovascular manifestations include weak, thready pulse, tachycardia, and hypotension.
- Allergic asthma can have a similar progression following exposure to an allergen and can become life-threatening.

Subcategory:

Clinical Judgment

Subcategory: Prioritize Hypotheses

Topic: nasogastric intubation and enteral feeding: recognizing postoperative complications

- Apply water-soluble lubricant to the nares as necessary.
- Assess the color of the drainage. Report dark, coffee-ground, or blood-streaked drainage immediately.
- Consider switching the tube to the other naris.

Subcategory: Analyze Cues

Topic: caring for a client who is receiving antibiotics

- When combining two or more medications that are hepatotoxic, the risk for liver damage increases.
- Liver function tests are essential when a client starts taking a hepatotoxic medication and periodically thereafter.
- Monitor client for abdominal pain, jaundice, dark urine, and fatigue.

Topic: identifying risks for delayed wound healing

Age: Increased age delays healing.

- Loss of skin turgor
- Skin fragility
- Decrease in peripheral circulation and oxygenation
- Slower tissue regeneration
- Decrease in absorption of nutrients
- Decrease in collagen
- Impaired immune system function
- Dehydration due to decreased thirst sensation
- Overall wellness

Subcategory: Take Actions

Topic: providing discharge teaching for a client recovering from pneumonia

- Increase fluids
- Rest when tired
- spirometer use