

N321 Adult Health 1
Proctored ATI Remediation Template

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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 Sick Cell Crisis <ul style="list-style-type: none">• 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.
Proctored ATI Grading Scale – RN Adult Health 1 2023

Level 3= 90 points

- **Remediation = 10 points:**
- Minimum 1-hour Focused Review
- For each topic missed, complete an active learning template and/ or identify three critical points to remember. **Must be a full sentence, not just bullet points.**

Level 2 = 80 points

- **Remediation = 10 points:**
- Minimum 2-hour Focused Review
- For each topic missed, complete an active learning template and/ or identify three critical points to remember. **Must be a full sentence, not just bullet points.**

Level 1 = 70 points

- **Remediation = 10 points:**
- Minimum 3-hour Focused Review
- For each topic missed, complete an active learning template and/ or identify three critical points to remember. **Must be a full sentence, not just bullet points.**

Below Level 1 = 60 points

- **Remediation = 10 points:**
- Minimum 4-hour Focused Review
- For each topic missed, complete an active learning template and/ or identify three critical points to remember. **Must be a full sentence, not just bullet points.**

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, and Wound Management: Evaluating Performance of a Wound Irrigation Procedure

- The nurse uses a steady flow of solution across the wound surface to remove debris.
- Normal saline or sterile water may be used; however, sterile water is preferred because normal saline does not cleanse dirty or necrotic wounds as effectively.
- Equipment may include bulb syringes, pressure canisters, irrigation fluid in a plastic container with a nozzle, or a whirlpool agitator.

Subcategory: Informed Consent

Topic: Legal Responsibilities: Obtaining Informed Consent for a Client Who Is Unconscious

- Informed consent of a patient is a legal process by which the patient's legally appointed designees has permitted for procedure or treatment.
- The nurse's role is to witness the patient's signature and to ensure the provider has obtained the informed consent.
- For an unconscious patient needing emergency surgery for life-threatening issues, two providers may sign a consent form.

Subcategory: Legal Rights and Responsibilities

Topic: Legal Responsibilities: Identifying Negligence

- Negligence occurs when the nurse fails to implement safety measures for a patient at risk.

- Professional negligence or malpractice is when a nurse administers a large dose of medication due to a calculation error, in which the patient experiences severe adverse effects.
- Failure to use equipment responsibly, document care, complete prescribed procedures, or communicate/educate effectively.

Main Category: Safety and Infection Control

Subcategory: Home Safety

Topic: Home Safety: Evaluating Client Understanding of Home Safety Teaching

- The patient states that they will keep hallways well-lit and free of clutter.
- The patient informs the nurse that they will remove throw rugs or area rugs from living spaces to minimize the risk of falling.
- The patient states they will make sure to test the temperature of bath/shower water before getting in to decrease the risk for impaired skin integrity/burns.

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

Topic: Medical and Surgical Asepsis: Technique for Setting Up a Sterile Field

- When preparing a sterile field, the nurse should allow a one-inch border surrounding it and not let anything nonsterile touch within the border.
- Objects held below the waist are nonsterile.
- The nurse should position all packages so that the flaps will open away from the body.

Subcategory: Use of Restraints/Safety Devices

Topic: Client Safety: Planning Care for a Client Who Has a Prescription for Restraints

- The nurse should have the patient assessed every 15 minutes for vital signs, fluid needs, bathroom needs, and any concerns with blood flow to restrained extremities.
- The nurse should be planning the discharge of restraints and the criteria to be met as soon as the restraints are initiated.
- The nurse should take into consideration any past surgical or medical needs of the patient before placing them in a constricted position.

Main Category: Health Promotion and Maintenance

Subcategory: Health Promotion/Disease Prevention

Topic: Middle Adults (35 to 65 Years): Identifying Risk Factors for Cardiovascular Disease

- A patient with a high BMI and psychological stressors poses a high risk for developing cardiovascular disease.
- Health issues such as cancer, type 2 diabetes, and family history can put a patient at high risk for CVD.
- Abuse of substances such as alcohol and tobacco increases risk for developing CVD.

Main Category: Psychosocial Integrity

Subcategory: Coping Mechanisms

Topic: Coping: Evaluating Client Adaptation to a Role Change

- The alarm stage of adaption is the body responding to stressors, in which hormones are released causing elevated blood pressure, heart rate, and mental alertness.
- The resistance stage involves the body functions normalizing while responding to the stressor, by

which the body attempts to cope and return to homeostasis.

- In exhaustion, the body no longer can maintain adaptation in response to the stressor, and the patient fails to adapt.

Main Category: Basic Care and Comfort

Subcategory: Assistive Devices

Topic: Mobility and Immobility: Identifying Appropriate Crutch Gait for a Client

- Do not alter crutches after fitting, support body weight at the hand grips with elbows flexed at 20 to 30 degrees and use the tripod position for a basic stance.
- The three-point stance involves the patient bearing weight on both legs, alternating each leg with the opposite crutch.
- Two-point gait requires the patient to bear all weight on one foot while using both crutches.

Subcategory: Mobility/Immobility

Topic: Mobility and Immobility: Planning Care for a Client Who Is Immobile

- The nurse should plan to have the patient checked and turned in every 2 to 4 hours to avoid skin breakdown or pressure injury.
- A mechanical lift or transfer device should be obtainable for the patient if needed.
- The nurse should monitor the airways and keep the head raised for the patient when giving oral medications or eating to ensure patency of the airway.

Topic: Mobility and Immobility: Teaching About Reducing the Adverse Effects of Immobility

- Decreased mobility can result in decreased muscle endurance, strength, mass, and impaired balance.
- Immobility has a high risk for skin breakdown, decreased skin turgor, pressure injury, and incontinence.
- Promote venous return to extremities by using SCDs, elastic stockings, and ROM exercises.

Subcategory: Nonpharmacological Comfort Interventions

Topic: Pain Management: Providing Nonpharmacological Care for a Client

- Comfort therapy may include exercise, heat/cold application, meditation, or music.
- PT or OT may be used to help with muscle tone/flexibility, in addition to the use of aqua therapy.
- Acupuncture can be utilized to help relieve pain and aid help in relaxation

Main Category: Clinical Judgment

Subcategory: Analyzing Cues

Topic: Adverse Effects, Interactions, and Contraindications: Caring for a Client Who Is Receiving Antibiotics

- Educate the patient on using a full regimen of antibiotic prescription, not to stop just when symptoms go away.
- The nurse should educate the patient that antibiotics are meant to treat bacterial infections, they do not fight against viral infections.
- Watch for signs of allergic reactions such as rash, nausea, diarrhea, or loss of airway patency.

Topic: Client Safety: Priority Risk for a Client Who Takes Multiple Medications

- The patient is at high risk for adverse effects using med-to-med interactions.
- If a nurse has already administered a medication that interacts poorly with another medication the patient is taking, the priority is to assess the patient for adverse effects, and then notify the provider.
- The nurse should consult the pharmacy with the patient's medication regimen to ensure safety with med-to-med compatibility.

Subcategory: Prioritize Hypothesis

Topic: Nasogastric Intubation and Enteral Feedings: Recognizing Postoperative Complications

- Monitor for an increase in pain or purulent discharge at the postoperative site.
- The patient should contact the provider if experiencing extreme abdominal bloating.
- Seek immediate medical attention if there is occlusion or displacement of the enteral tube.

Subcategory: Take Action

Topic: Home Safety: Providing Discharge Teaching for a Client Who Is Recovering From Pneumonia

- A cough should slowly start getting better over a 7 to 14-day span.
- Sleeping and eating can sometimes take up to a full week to return to a normal schedule.
- The patient's normal level of energy may not return for up to 2 weeks or more following discharge.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: Expected Actions/Outcomes

Topic: Safe Medication Administration and Error Reduction: Preparing To Administer a Medication for the First Time

- The nurse should follow the seven rights of medication preparation before administration.
- If needed, the nurse should consult with a pharmacy to ensure there are no interactions with other medications the patient is taking.
- The nurse should verify multiple times with the provider's order before administering the medication.

Subcategory: Medication Administration

Topic: Pharmacokinetics and Routes of Administration: Enteral Administration of Medications

- Enteral administration delivers the medication into the body through the gastrointestinal tract.
- The most common route is taken orally; however, in some cases rectal administration is necessary.
- Substances may be crushed, dissolved in a solution, chewed, taken in the food, enteric-coated, or delayed release.

Main Category: Reduction of Risk Potential

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

Topic: Airway Management: Changing Tracheostomy Ties

- The nurse should wash hands and wear gloves to ensure the cleanliness of the tracheostomy.
- Cut the ends of the ties to leave only 1 to 2 inches left.
- Make sure to change the location of the knot to avoid skin irritation.

Topic: Intravenous Therapy: Actions To Take for Fluid Overload

- The nurse should monitor strict I&O of the patient's fluids.
- Education on reducing sodium intake since water and sodium follow each other.
- Diuretics may be used to help reduce the amount of fluid in the body.

Subcategory: Therapeutic Procedures

Topic: Airway Management: Tracheostomy

- Having suction readily available and performing routine suction to promote airway patency.
- Tracheostomy tube changes should be done by the nurse or RT on a routine basis.
- Complications may include aspiration, dislodged tube, bleeding, tracheal stenosis, or acute airway obstruction.

Main Category: Physiological Adaptation

Subcategory: Alterations in Body Systems

Topic: Airway Management: Positioning for Postural Drainage

- The patient can choose a flat surface to lean forward, extend the legs, and rest elbows with arms folded.
- A wedge pillow may be utilized on a bed or flat surface by keeping the hips at a higher level than the chest.
- An exercise ball may help expel mucus from the lungs by lying the stomach over the ball so that the chest is lower than the hips.