

## Proctored ATI Remediation Template

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Assessment Name: ATI Remediation: Proctored Assessment for end of semester

Semester: Fall 2024 - Danville

### 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 à these will be the content areas you will be remediating on
        - a. Provide three (3) critical points to remember for each topic à 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" à 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: Pharmacological and Parenteral Therapies (3)

### Subcategory: Medication Administration (2)

#### Topic: Pharmacokinetics and Routes of Administration: Administering Ophthalmic Drops

- This method of medication administration necessitates aseptic technique.
- The patient should tilt their head back, and the nurse should administer from a distance of 1-2cm from the conjunctival sac of the eye, without touching.
- If administering more than one Ophthalmic medication, provide a 5-minute minimum lapse of time between medications.

#### Topic: Safe Medication Administration and Error Reduction: Comparing the Medication Administration Record to the Medication Container

- Always verify the patient ID via 2 or more sources, such as: Name, DOB, ID#.
- Remember the Patient “RIGHTS” - Such as Right: client, medication, dose, time, route, documentation, education, assessment, evaluation, and patient right to refuse.
- Use only approved abbreviations, as this is one error that is responsible for a high number of medication errors.

### Subcategory: Dosage Calculations (1)

#### Topic: Dosage Calculation: Calculating a Dose of Cefoxitin by Weight

- Remember to properly set up all dimensional analysis equations.
- Apply a common-sense check – “Does this amount make logical sense?”
- The abbreviation “gtt” stands for guttae, which is the drop factor in an IV, or the amount of drops an IV infuses at per a given minute time span. I.e. “drops per minute.”

## Main Category: Basic Care and Comfort (3)

### Subcategory: Assistive Devices (1)

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

- Crutch gait: 4-point: Requires weightbearing in both legs. Three points are maintained on the floor at all times by alternating each leg with the opposing crutch.
- Crutch gait: 3-point: Requires all weightbearing to be on one foot while utilizing both crutches. Affected leg will swing through consistently, never touching the ground.
- Crutch gait: 2-point: Requires partial weightbearing on both feet. Each and every step is accompanied by an advancement of the crutch on the opposite side in order to keep weight reduced on both legs at all times.

### Subcategory: Elimination (1)

#### Topic: Urinary Elimination: Interventions to Promote Voiding in a Client Who Is Postoperative

- Provide the patient with appropriate means for voiding within their given limitations. Bed bound patients may need to utilize bed pans or fracture pans. Patients who can sit at the edge of bed safely may utilize a urinal. Patients who can at least perform pivots between seating surfaces may utilize bedside commodes. Ambulatory patients should be encouraged to utilize the bathroom as normal, with the appropriate amount of adequate assistance provided by the medical team.
- Always encourage patients of this demographic to drink plenty of fluids and provide rationale/education associated as needed.
- Make sure incontinent patients feel well taken care of and can void with dignity and adequate assistance whenever the need arises. This will prevent patients unsafely attempting this on their own and falling. It will also prevent patients soiling themselves or outright refusing adequate fluid intake in an effort to forestall or minimize the frequency of voiding.

### Subcategory: Mobility/Immobility (1)

#### Topic: Mobility and Immobility: Priority Finding for a Client Who Is Immobile

- Monitor the patient for swelling/redness/pain/and warmth onsets in the lower extremities. Homans sign testing should be performed. Utilize compression devices or staking on the lower extremities. These are to reduce the potential for immobility associated DVT's, and/or detect them early.
- Encourage use of incentive spirometer and monitor patients breathing/secretions/and coughing.

Immobility can deteriorate the respiratory system and lead to the onset of illnesses such as pneumonia. Use of this activity, and close monitoring can reduce the likelihood of this, as well as alert you early on to the onset of potential complications.

- Monitor patients emotional and psychosocial tolerance to the impact of prolonged immobility. Clients who are immobile in a medical setting for long periods of time, and confined to bed rest can develop depression, anxiety, withdrawal, and altered sleep patterns. Emotional impacts can influence client behavior.

### **Main Category: Management of Care (3)**

#### **Subcategory: Collaboration with Multidisciplinary Team (1)**

##### **Topic: Pressure Injury, Wounds, and Wound Management: Evaluating Performance of a Wound Irrigation Procedure**

- For clean wounds (surgical) work from the least contaminated to the most contaminated areas.
- Isotonic solutions are the standard tonicity of solution utilized for this procedure unless otherwise specifically stated/ordered. Administering analgesics beforehand is advised.
- The ideal irrigating pressure is between 5-8 PSI, and the tip of the irrigating device should be approximately 1” from the wound.

#### **Subcategory: Continuity of Care (1)**

##### **Topic: Continuity of Care (1 item) Information Technology: Approved Abbreviations for Use in Documentation**

- The Joint Commission is the body who determines which abbreviations are accepted and which are not. There is some variance in this by a given organizations preferred policies.
- Documentation should be succinct, but clear and thorough never-the-less. Use of appropriate abbreviations only will facilitate this.
- Documentation should reflect assessments, interventions, and evaluations – not personal opinions or criticisms about the client or other health care professionals.

#### **Subcategory: Informed Consent (1)**

##### **Topic: Legal Responsibilities: Completing an Informed Consent Document**

- Informed consent is the legal process for a patient or their lawfully appointed designate provides a written and legally binding form of consent for a given treatment or procedure.
- It is only considered informed if the patient has been provided with a thorough understanding of the nature of the procedure and its treatments, including the risks, benefits, side effects, and ramifications.
- The client's nurse must visibly witness the signing of this document by the appropriate individual, as governed by a given state's laws (which the nurse is required to be familiar with).

### **Main Category: Reduction of Risk Potential (2)**

#### **Subcategory: Therapeutic Procedures (1)**

##### **Topic: Bowel Elimination: Discharge Teaching About Ostomy Care**

- The stoma's normal appearance should be moist, shiny, and pink.
- Mild soap and water are used to cleanse the skin, and then it should be dried completely. Moisturizing soaps can interfere with the adherence of the collection pouch.
- Once applied, the bottom of the pouch should be folded, with a closure clamp in place. Used pouches should be disposed of in the proper receptacle with gloves and consideration to hand hygiene utilized.

#### **Subcategory: Laboratory Values (1)**

##### **Topic: Airway Management: Collecting a Sputum Specimen**

- Sputum samples are collected to identify aberrant cells/cancer, as well as identify and diagnose respiratory diseases. Culture and sensitivities can be performed to ID micro-organisms and inform as to the appropriate antibiotic to select for treatment<sup>4</sup>.
- Specimens should be collected early in the morning, and a 2-hour window after consuming any food/fluids should be applied before collections – these in an effort to reduce tampering of the samples from the presence of gastric fluids/aspirate/other.
- If the patient is unable to effective cough or expectorate sputum, the collection can be acquired by endotracheal suctioning.

## Main Category: Physiological Adaptation (1)

### Subcategory: Pathophysiology (1)

#### Topic: Adverse Effects, Interactions, and Contraindications: Assessing for an Allergic Reaction to Antibiotics

- Hypersensitivities can range from simple superficial reactions to airway obstruction, anaphylactic shock, and angioedema.
- The first presentations of anaphylaxis can include stomach cramps, itching, hives, and progress to severe angioedema.
- The respiratory system can be overcome with inflammation and mucus production, leading to adventitious lung sounds, and may progress rapidly in severity to respiratory failure and death.

## Main Category: Safety and Infection Control (2)

### Subcategory: Use of Restraints/Safety Devices (1)

#### Topic: Client Safety: Action to Take Prior to the Use of Restraints

- Restraints necessitate a physician's order, often requiring additional justifications/rationale (as determined state-by-state), and must be prescribed for the shortest duration needed.
- Restraints can be physical or chemical in nature. Physical can take the form of gloves, straps, ties, chair alarms, and other devices. Chemical restraints are related to medications that make a patient more sedate or pacified.
- Restraints should be a last resort only, and after other efforts have been exhausted unsuccessfully (such as attempts to verbally de-escalate, distract, or change the environment.) Once a restraint is in place, regular checks of the patients' skin/vitals/etc must be maintained, and the patient should be regularly questioned as to voiding or repositioning needs if the restraint interferes with their independent ability to manage these aspects.

### Subcategory: Home Safety (1)

#### Topic: Client Safety: Teaching About Home Safety

- Clients at risk for falls should be educated that their home should have appropriate lighting, no throw rugs, and all wires should avoid crossing common footpaths.
- Additionally, the client should have appropriate footwear, assistive devices, and rails where needed (bathrooms and stairways being areas of emphasis)
- Nurses should identify individual client fall risks such as: advanced age, impaired mobility or sight, medications that contribute to alterations in LOC, coordination, or blood pressure.

## Main Category: Health Promotion and Maintenance (1)

### Subcategory: High-Risk Behaviors (1)

#### Topic: Older Adults (65 years and Older): Reducing the Risk for Osteoporosis

- Clients at-risk for osteoporosis should be encouraged to partake regularly in weight-bearing exercises, get sunlight exposure, and take vitamin D & calcium supplements.
- An annual DEXA scan is advised to monitor for changes in bone density.
- Advise clients to monitor caffeine, sodium, alcohol, and cigarette use. All of these have been linked to disrupting cellular function directly responsible for maintaining adequate bone density.

## Main Category: Clinical Judgement (3)

### Subcategory: Analyze Cues (1)

#### Topic: Preoperative Nursing Care: Findings Requiring Follow-Up Prior to Surgery

- Patient allergies should be given paramount consideration prior to any surgical intervention. The patient may be at risk from any number of medications, latex, contrast agents, or other elements that could complicate the operation in a critical way.
- A patient with bleeding or clotting disorders needs extra consideration as these can have profound implications when performing a surgery, as patient bleeding is to be anticipated, and for a period after there will be a high presence of all elements within Virchow's Triad, which relate to high clot/DVT/PE risks.
- A standard of pre-operative care is the analysis of the patient urine, clotting factors, overall chemistry, vitals, and CBC. Patients with an existing infection would likely require waiting until the

infection had cleared prior to surgery, and any number of organ dysfunctions observed could also preclude the patient's eligibility to a given operation out of safety concerns.

### **Subcategory: Prioritize Hypotheses (1)**

#### **Topic: Mobility and Immobility: Priority Risk for a Client Who Has Impaired Mobility**

- Musculoskeletal & Integumentary: Patients with immobility are at an increased risk of skin breakdown, muscle atrophy, pressure wounds, and contractures.
- Metabolic: Patients with immobility are at increased risk of urinary stasis, constipation & fecal impaction, digestive dysfunction, and nutritional deficits.
- Cardiovascular & Respiratory: Patients with immobility are at an increased risk for developing pneumonia, thrombotic or embolitic events, development of orthostatic hypertension, circulatory complications & edema, and onset of heart failure.

### **Subcategory: Take Actions (1)**

#### **Topic: Urinary Elimination: Reviewing the Medical Record of a Client Who Has a Urinary Tract Infection**

- Patients at risk for a UTI, or seeking to prevent a subsequent event, should be advised of the following: Clean genitals front to back, drink 2-3L of fluid daily unless told otherwise, avoid tight-fitting clothing, wear cotton fabric underwear, urinate after intercourse, and take showers instead of baths.
- Patients recovering from a UTI should be educated on the proper usage of their antibiotics and educated on signs and symptoms to notify their provider about if observed: foul smelling urine. Urine that is dark or cloudy. Painful or burning sensations with urination. Difficulty voiding, or incomplete emptying. Increased frequency or urge.
- Additionally, clients may benefit from education on other potential risk factors for a UTI – females having a shorter urethra, and men having potential prostatic complications. Patients utilizing a catheter or who have diabetes also possess a significantly higher risk. As well as immunodeficient patients, or pregnant patients.