Proctored ATI Remediation Template

Student Name:
Assessment Name:
Semester:

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 Evaluating Performance of a Wound Irrigation Procedure

- Patient wounds should be moist so that the wound can heal avoiding excessive ecudate which can lead to maceration.
- Documentation should be well written with patient response and the condition of the wound.
- Braden scale helps assess patients' risk for developing pressure injuries, the wound should be evaluated for improvements in patients with

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Subcategory: Concepts of Management

Topic: Therapeutic communication Responding to Staff Conflict

- The most effective way to communicate therapeutic is short and simple.
- The patient should have plenty of time to respond back.
- When the nurse is asking a patient question, the nurse must make sure that the questions are not irrelevant personal questions.

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Subcategory: Informed Consent

Topic: Legal Responsibility Completing an Informed Consent Document

- The nurse should act in the best of the patient's interest ensuring their right and preferences are respected.
- A nurse practicing outside your scope can lead to legal liability.
- When a patient is giving voluntary consent a nurse should make sure the patient is mentally competent to give their consent.

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Subcategory: Referrals

Topic: The interprofessional Team Referral for a Client Who Has a Traumatic Brain Injury

- The nurse should maintain communication with the patient's specialist to make sure the care of the patient is progressing.
- To better know how to help the patient the team members should share what they know about the patient.
- Delays in critical rehabilitation or intervention can have an impact on the recovery outcome.

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Main Category: Safety and Infection Control

Subcategory: Accident/Error/Injury Prevention

Topic: Client Safety Nursing Action When a Client Falls

- The clients with more than one risk factor are at the greater risk for falls.
- The nurse should do a fall risk assessment for each patient at admission.
- A patient who has orthostatic hypotension should be instructed to not to stand up to quickly, they should sit on the side of the bed for a few seconds before they stand and should stand on the side of the bed for a few seconds before walking.

Topic: Home safety Identifying Fall Risks in the Home

- Place the bed low when the toddler starts to climb.
- Keep the floors clear of cords, shoes, toys so no can trip, and fall make sure there are no loose rugs.
- Have bars installed in the bathroom and on the stairs to keep the patient's balance.

Topic: Nursing Process

- Throughout the provision of care the nurse will be performing an ongoing plan to make sure the patient is well taken care., nurse will set priorities to determines the client outcome.
- The nursing process provides a framework throughout which nurses can apply knowledge, experience, judgment, and skills, as well as established standards of nursing practice to formulate a plan of nursing care.
- The nursing process is a dynamic, continuous, client-centered, problem-solving, and decision-making framework that is foundational to nursing practice.

Subcategory: Ergonomic Principles

Topic: Ergonomic Principles

- Ergonomics is a science that focuses on the factors or qualities in an object's design or use that contribute to comfort, safety, efficiency, and ease of use.
- Good body mechanics reduces the risk of injury.
- Evaluate each situation and use an algorithm to determine the safest method to transfer or move the client.

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Subcategory: Hone safety

Topic: Client Safety

- Use current evidence to promote a culture of safety, while using the National Patient Safety Goals as a guide.
- Older adult clients can be at an increased risk for falls due to decreased strength, impaired mobility and balance, improper use of mobility aids, unsafe clothing, environmental hazards, endurance limitations, and decreased sensory perception.
- Inspect the client's environment for items that could cause injury during a seizure and remove items that are not necessary for current treatment.
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Subcategory: Safe Use of Equipment

Topic: Mobility and Immobility

- Movement depends on an intact skeletal system, skeletal muscles, and nervous system.
- Assessment focuses on mobility, range of motion (ROM), gait, exercise status, activity tolerance, and body alignment while standing, sitting, and lying
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Subcategory: Standard Precautions/Transmission Based Precautions/Surgical Asepsis

Topic: Infection Control

- A nurse should assess each client for the risks of infection specific to the client, the disease or injury, and the environment.
- Inflammation is the body's local response to injury or infection.
- X-rays, CT scan, magnetic resonance imaging (MRI), and biopsies to determine the presence of

infection, abscesses, and lesions

Topic: Urinary Elimination

- The nurse should monitor and increase fluid intake during the day and decrease fluid intake prior to bedtime.
- The patient should do Kegel exercises 3 to 4 times a day, which tighten the pelvic muscles for 10 seconds, relax the pelvic slowly for 10 seconds instruct the patient to repeat in sequence of 15 either lying down sitting or standing
- Urinary habit training helps clients who have limited cognitive ability to establish a predictable pattern of bladder emptying.

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Subcategory: Use of Restraints/Safety Devices

Topic: Client Safety

- Nurses must know and follow federal, state, and facility policies for the use of restraints.
- Nurses must know and follow federal, state, and facility policies for the use of restraints.
- Explain the need for the restraints to the client and family, emphasizing that the restraints keep the client safe and are temporary.

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Main Category: Health Promotion and Maintenance

Subcategory: Developmental Stages and Transition

Topic: Coping

- Be empathetic in communication, and encourage the client to verbalize feelings.
- Control the environment to reduce the number of external stressors, including noise and breaks in the continuity of care.
- The optimal time to teach a client about stress-management skills is after coping with crisis successfully.
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Subcategory:Health Promotion/Disease Prevention

Topic: Health Promotion and Disease Prevention

- Assist the client to recognize their personal perceived barriers that can hinder commitment to adopting and maintaining the plan for a healthy lifestyle change.
- Improve awareness and understanding of the progress involving health, disease, and disability.
- Heredity creates a predisposition for various disorders such as heart disease, cancers, mental illnesses.

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Subcategory: High Risk Behaviors

Topic: Older Adults (65 years and Older)

- Increase intake of vitamins D, B_{12}, E, folate, fiber, and calcium.
- Educate patient on weight bearing exercises such as walking, dancing or light weightlifting to help strengthen bones and to help maintain bone density.
- Let patient know to limit their smoking and alcohol intake.
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Subcategory: Techniques of Physical Assessment

Topic: Head and Neck

- This examination includes the skull, face, hair, neck, shoulders, lymph nodes, thyroid gland, trachea position, carotid arteries, and jugular veins.
- Use the techniques of inspection, palpation, and auscultation to examine the head and neck.
- If the client's head size appears abnormal, compare the circumference to a chart, considering the client's gender, age, and race.

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Main Category: Psychosocial Integrity

Subcategory: Stress management

Topic: Coping

- Be empathetic in communication, and encourage the client to verbalize feelings.
- Allow the client to give input into the treatment regimen.
- Coping behavior that describes how an individual handles demands imposed by the environment

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Main Category: Basic Care and Comfort

Subcategory: Assisitve Devices

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

- Promote regular movement to the patient to help keep muscles strong and prevents stiffness.
- Helping the patient change position while on bed rest helps with the blood flow and reduces the risk of pressure injury and blood clots.
- Patients in crutches should fit 2-3 fingers width below the armpit and handgrips at wrist level this will help prevent nerve damage and help with good support.

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Subcategory: Elimination

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

- When caring for a client ensure a quiet private environment and make sure the client is comfortable to make sure that they are relaxed.
- Using a warm compress on the lower abdomen or the use of a bedside commode helps encourage urination before considering catheterization.
- The nurse should maintain a good hygiene during catheter use to reduce the risk of urinary tract infections.

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Subcategory: Mobility/Immobility

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

- A patient with skin integrity issues a nurse should check for signs of pressure injuries especially over bony areas.
- A nurse should monitor the patient for reduced lung function or secretions which can be the increase risk for pneumonia.
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Topic: Mobility and Immobility: Teaching a Client About Logrolling While in Bed

- To prevent injury or pain logrolling keeps the spine straight.
- Client should have a bedrail to ensure safety and to also avoid strain during the process.
- A nurse should encourage the patient to do regular movement and repositioning to help with the joint flexibility and muscle strength while in bed.

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Subcategory: Nonpharmacological Comfort Intervention

Topic: Pain Management: Identifying Findings Related to Chronic Pain

- The nurse should look for signs like muscle tension, reduced mobility and changes in posture it can result from long term pain.
- Idiopathic pain is a form of chronic pain without a known cause, or pain that exceeds typical pain levels associated with the client's condition.
- Management aims at symptomatic relief. Pain does not always respond to interventions.

Topic: Pain Management: Nonpharmacological Methods for Pain Relief

- The nurse should not require the client to use nonpharmacological strategies in place of pharmacological pain measures, although the client has the right to choose whether to use both types.
- Heat/cold therapy, massage and physical therapy can help reduce muscle tension and improve a patient circulation.
- The way the client think can have reframe negative thoughts about their pain.

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Subcategory: Nutrition and Oral Hydration

Topic: Fluid imbalances Assessment Findings of Extracellular Fluid Volume

- Assessment of skin turgor in the older adult might not provide reliable findings due to a natural loss of skin elasticity.
- The nurse should monitor and document edema, I&O, circulation and shortness of breath and dyspnea during the client care.
- A client who has excess fluid and water (fluid volume excess) will require sodium restriction.

Topic: Nutrition and Oral Hydration Assisting a Client Who Has Dysphagia

- A client with dysphagia should be watched for coughing or choking while eating, if it continue to occur stop feeding and notify the healthcare provider immediately.
- The patient food should be modified and liquid consistency to help with choking during eating.
- Sit the client upright at a 90-degree angle during meals and for 30-60 minutes afterward.

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Main Category: Pharmacological and Parenteral Therapies

Subcategory: Dosage calculation

Topic: Dosage calculation

- Nurses are responsible for administering the correct amount of medication by calculating the precise amount of medication to give.
- Nurses can use three different methods for dosage calculation: ratio and proportion, formula (desired over have), and dimensional analysis.
- There are 5 different types of calculations, solid oral medication, liquid oral medication, injectable medication, correct doses by weight and IV infusion rates.

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Subcategory: Medication Administration

Topic: Safe medication administration and error reduction

- Determine if the medication prescription is complete: with the client's name, date and time, name of medication, dosage, route of administration, time and frequency, and signature of the prescribing provider.
- 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.
- Notify the provider of all errors and implement corrective measures immediately.

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Subcategory: Pharmacological Pain management

Topic: Adverse Effect, Interactions and Contraindications

- Undertreatment of pain is a serious complication and can lead to increased anxiety with acute pain and depression with chronic pain.
- The nurse should consider an age specific contraindication, some medications are not recommended for children or older adults due to increased sensitivity.
- There are some medications should be taken with specific foods.

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Main Category: Reduction of Risk Potential

Subcategory: Potential for Alterations in Body Systems

Topic: Complementary and Alternative Therapies

- Assist with evaluating the safety of herbal and natural products the client can be using. Provide the client with reliable information and determine possible interactions with prescription medicines and therapies.
- Alternative therapies are treatment approaches that become the primary treatment and replace allopathic medical care.
- Implementing complementary or alternative therapies depends upon the client's acceptance of and involvement in the therapeutic intervention.

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

Topic: Fluid imbalances

- Overhydration: Osmolarity less than 280 mOsm/kg
- Older adults have an increased risk for dehydration due to multiple physiological factors including a decrease in total body mass, which includes total body water content and a decrease in the ability to detect thirst.
- Increased in both hypovolemia and dehydration unless the fluid volume deficit is due to hemorrhage.

Topic: Mobility and immobility

- **Measure the calf and/or thigh circumference and the length of the leg to select the correct size stockings.**
- Remove the stockings every 8 hr to assess for redness, warmth, or tenderness.
- Make sure the stockings are not too tight over the toes.

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Subcategory: Therapeutic Procedures

Topic: Bowel elimination: Discharge Teaching About Ostomy Care

- Encourage the client to set aside time to defecate. Sometimes, after a meal works best.
- Educate clients on the signs of complications and advise them to seek media help if they see discoloration, swelling or unusual discharge.
- The nurse should encourage a high fiber diet and stay hydrated to help with regular bowel movements.

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Main Category: Physiological Adapation

Subcategory: Alternations in Body Systems

Topic: Pressure Injury Wounds and wound management

- Inflammation is a localized protective response to injury or destruction of tissue.
- Document the location and type of wound and incision, the status of the wound and type of drainage, the type of dressing and materials, client teaching, and how the client tolerated the procedure.
- The inflammation begins with the injury and lasts 3 to 6 days.
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Subcategory: Fluid and Electrolytes

Topic: Fluid and electrolyte imbalances

- The expected ranges for Na+ is 136 to 145 mEq/L, K+ 3.5 to 5 mEq/L.
- Administer oral or IV calcium supplements and vitamin D supplements.
- The nurse should encourage foods in high calcium, including dairy products and dark green vegetables.

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Main Category: Clinical Judgement

Subcategory: Analyze Cue

Topic: Nutrition and oral hydration identifying Complications for a Client Who Is in a Rehabilitation Facility

- The nurse should assess the patient regularly for their weight, appetite and any changes in the patients eating habits to identify malnutrition or dehydration.
- Dysphagia can happen due to the muscle weakness or neurological conditions.
- To help detect and address electrolytes imbalance nurses should do regular labs and monitor the patients.

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

- The client should understand the purpose and effect of the preoperative medications that will be administered.
- Avoid smoking, alcohol, or illicit drug use, which can interfere with surgical medications and increase the risk for surgical complications.
- Administer preoperative medications (prophylactic antimicrobials, antiemetics, sedatives) as prescribed.

Topic: Nutrition and Oral Hydration: Reviewing the Medical Record of a Client Who Is Receiving Parenteral Nutrition

- A nurse should regularly check for signs of dehydration or fluid overload, being that parental

nutritional can affect hydration and the levels of electrolytes.

- Administer and monitor parenteral nutrition to clients who are unable to use their gastrointestinal tract to acquire nutrients.
- Parenteral nutrients include lipids, electrolytes, minerals, vitamins, dextrose, and amino acids.

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