

Proctored ATI Remediation Template

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Assessment Name: RN fundamentals 2023 Focused review

Semester: 1st

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 <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.

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: Basic care and comfort

Subcategory: Urinary elimination: interventions to promote voiding in a client who is postoperative

Topic: Positioning and Privacy

- Encouraging the client to assume a natural position for voiding (e.g., sitting upright) can help promote bladder emptying.
- Ensuring privacy and a calm environment is crucial as it helps reduce anxiety and promotes normal bladder function post-surgery.
- The client may need assistance with repositioning if they are unable to get out of bed, particularly after major abdominal or pelvic surgery

Topic: Fluid Intake

- Adequate hydration is important to stimulate urinary output and prevent urinary retention, unless contraindicated due to surgical complications.
- Monitoring the type and number of fluids ingested is vital to ensure balanced hydration, especially in the early postoperative period.
- Encouraging the client to drink small sips of water frequently can help avoid overloading the bladder at once, which can cause discomfort and retention.

Topic: Use of Urinary Catheters

- A urinary catheter may be necessary if the patient is unable to void due to anesthesia effects or pain; however, it should be removed as soon as possible to avoid complications like urinary tract infections (UTIs).
- In some cases, intermittent catheterization is used to ensure the bladder is emptied when the client cannot void independently.
- If the catheter is left in place, regular assessment of the catheter's patency, output, and placement is important to prevent retention or infection.

Subcategory: Fluid imbalances: assessment findings of extracellular fluid volume deficit

Topic: Dehydration and thirst

- Thirst is a symptom in fluid volume deficit, as the body triggers the sensation to encourage fluid intake.
- Dry mucous membranes are a common physical sign of extracellular fluid deficit.
- Increased urine concentration and reduced output (oliguria) are frequent findings due to the body's compensatory mechanisms.

Topic: Hypotension and Tachycardia

- A decrease in extracellular fluid can lead to hypotension (low blood pressure), particularly when the client changes position (orthostatic hypotension).
- Tachycardia (increased heart rate) occurs as a compensatory mechanism to maintain cardiac output in response to low circulating volume.
- Weak, thready pulses are often present due to decreased blood volume.

Topic: Skin and Extremity Changes

- Skin turgor can be assessed by pinching the skin on the back of the hand or abdomen; delayed recoil is indicative of dehydration.
- The client may also exhibit cold, clammy skin, particularly in the extremities, due to peripheral vasoconstriction as the body tries to preserve blood volume.
- Capillary refill may be slow, particularly in the fingers and toes, indicating poor peripheral perfusion.

Subcategory: Pain management: nonpharmacological methods for pain relief

Topic: Heat and cold therapy

- Heat therapy (e.g., heating pads) can help reduce muscle stiffness and promote blood circulation, easing pain in chronic conditions.
- Cold therapy (e.g., ice packs) is often used in the acute phase after injuries to reduce swelling, inflammation, and numb the affected area.
- Both heat and cold should be used with caution, avoiding direct contact with the skin and monitoring

for skin damage or excessive vasodilation.

Topic: Distraction Techniques

- Engaging the patient in activities such as watching TV, playing games, or engaging in conversation can help shift focus away from pain.
- Listening to music, practicing deep breathing exercises, or visualization techniques also serve as effective distractions from discomfort.
- These methods can help activate different neural pathways, reducing the perception of pain.

Topic: Relaxation techniques

- Progressive muscle relaxation and guided imagery can reduce muscle tension and promote an overall sense of well-being.
- Meditation and mindfulness practices are effective in helping the patient to focus on the present moment and manage pain-related anxiety.
- Breathing exercises, such as slow and deep breathing, can activate the parasympathetic nervous system, lowering pain perception.

Main Category: Basic care and comfort

Subcategory: Pain Management: Identifying Findings Related to Chronic Pain

Topic: Duration and Persistence of Pain

- Chronic pain is typically defined as pain lasting for more than three to six months, often with no clear cause.
- Clients may experience continuous or intermittent pain that is unrelieved by traditional pain treatments.
- Pain may not always correlate with observable physical findings, making chronic pain a challenge to assess and manage.

Topic: Impact on Physical Function

- Chronic pain often results in reduced mobility and functional limitations, leading to changes in posture, gait, or activity levels.
- The client may show signs of fatigue, weakness, and difficulty performing activities of daily living (ADLs) due to persistent discomfort.
- Muscle atrophy or joint stiffness may develop over time as a result of avoiding certain movements or activities due to pain.

Topic: Psychological and Emotional Effects

- Chronic pain is often associated with psychological symptoms, such as depression, anxiety, and irritability.
- Sleep disturbances are common as pain may interfere with the ability to fall asleep or stay asleep, exacerbating emotional distress.
- Clients may express feelings of hopelessness, frustration, or isolation, which can affect their willingness to engage in treatment or rehabilitation.

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

Topic: Risk for Pressure Injuries

- Prolonged immobility increases the risk of pressure ulcers, particularly in bony prominences (e.g.,

sacrum, heels).

- Skin should be regularly assessed for redness, warmth, or breakdown, especially in patients with limited movement.
- Frequent repositioning and use of pressure-relieving devices (e.g., special mattresses) are essential to prevent skin damage.

Topic: Respiratory Complications

- Immobility can lead to shallow breathing and inadequate lung expansion, increasing the risk for atelectasis and pneumonia.
- Encourage the patient to perform deep breathing exercises or use incentive spirometry to maintain respiratory function.
- Elevating the head of the bed and encouraging coughing can help clear secretions and prevent respiratory infections.

Topic: Cardiovascular Concerns

- Prolonged immobility can lead to orthostatic hypotension, venous stasis, and deep vein thrombosis (DVT).
- Encourage passive or active range-of-motion exercises and periodic leg elevation to promote circulation.
- Monitor vital signs closely, particularly when the patient attempts to change position, as this can exacerbate cardiovascular instability.

Subcategory:

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Main Category: Pharmacological and parental therapies

Subcategory: Pharmacokinetics and Routes of Administration: Administering Ophthalmic Drops

Topic: Absorption of Ophthalmic Medications

- Medications administered via the eye are absorbed through the conjunctiva, cornea, and sclera, which allow for direct entry into the systemic circulation.
- The bioavailability of ophthalmic drops is typically low due to the rapid drainage from the eye into the nasolacrimal duct, which can result in less systemic absorption.
- To increase absorption, it is recommended to apply gentle pressure to the lacrimal sac after administration to prevent the medication from draining into the nasal cavity.

Topic: Proper Technique for Administering Ophthalmic Drops

- The client should be instructed to tilt their head back and look upward to expose the lower conjunctival sac, ensuring the drop is placed inside the lower eyelid, avoiding direct contact with the eye to prevent contamination.
- The dropper should be held 1-2 cm above the eye to avoid accidental contact with the eye or eyelashes, which can contaminate the medication.
- After instillation, the patient should close their eyes gently without squeezing to allow the medication to spread evenly over the surface of the eye.

Topic: Side Effects and Considerations

- Common side effects of ophthalmic drops include eye irritation, stinging, burning, or redness at the site of application.
- If multiple types of eye drops are prescribed, a 5- to 10-minute wait between administering different medications is recommended to ensure full absorption of each drop.
- Ophthalmic medications, especially those containing steroids, should not be used for extended periods due to the risk of increased intraocular pressure and cataract formation.

Subcategory: Safe Medication Administration and Error Reduction: Comparing the Medication Administration Record to the Medication Container**Topic: The Importance of the "Five Rights"**

- The "Five Rights" (right patient, right drug, right dose, right route, and right time) are fundamental principles to prevent medication errors and ensure patient safety.
- Always verify the medication container against the Medication Administration Record (MAR) before administering, ensuring the medication is the correct one for the patient and that it matches the prescribed dosage.
- Checking the expiration date and storage requirements of the medication container is essential to ensure the drug's potency and safety.

Topic: Preventing Look-Alike, Sound-Alike Medication Errors

- Medications with similar names or appearances (e.g., "hydrochlorothiazide" vs. "hydroxyzine") can easily lead to errors if not carefully compared with the MAR before administration.
- Barcode scanning systems and color-coded labels can help reduce the risk of medication errors related to similar packaging or medication names.
- Always verify the drug label against the MAR and consult a pharmacist if there is any doubt about the medication.

Topic: Role of Double-Checking and Communication

- Double-checking medications with a colleague or supervisor can help prevent errors, especially when administering high-risk medications (e.g., insulin, anticoagulants).
- Clear, open communication between the healthcare team, including nurses, pharmacists, and physicians, is vital for preventing errors.
- Reporting and documenting any discrepancies between the MAR and medication container is essential for tracking and preventing future errors.

Subcategory: Dosage Calculation: Calculating a Dose of Cefoxitin by Weight**Topic: Dosage Based on Patient Weight**

- Many medications, including cefoxitin, are dosed based on the patient's weight, usually expressed in milligrams per kilogram (mg/kg).
- To calculate the dose, the patient's weight must first be converted into kilograms (if it's in pounds), and then the appropriate weight-based dosage is calculated.
- For example, if a dose of 50 mg/kg is prescribed for a patient weighing 70 kg, the dose would be $50 \text{ mg} \times 70 \text{ kg} = 3500 \text{ mg}$ (or 3.5 g).

Topic: Correct Unit Conversion

- Ensure correct unit conversions, especially between pounds and kilograms: 1 pound = 0.45 kilograms.
- When calculating dosage, it's essential to work with consistent units to avoid mistakes. For instance, if

a drug is prescribed in mg/kg, the weight must be converted to kg if it's originally provided in pounds.

- Carefully review the prescribed dosage range (e.g., 10-15 mg/kg) to ensure that the calculated dose falls within the safe and effective range.

Topic: Calculating Doses from Available Concentrations

- Once the weight-based dose is calculated, you need to determine how much of the medication to administer based on the concentration available in the medication container (e.g., mg/mL).
- For example, if the available cefoxitin concentration is 1 g (1000 mg) per 5 mL, and the required dose is 3500 mg, the volume to be administered would be calculated as follows:
$$\frac{3500 \text{ mg}}{1000 \text{ mg}/5 \text{ mL}} = 17.5 \text{ mL}$$
- Always check that the calculated volume matches the available dosage form and that the patient can tolerate the required volume.

Main topic: Psychosocial integrity

Subcategory: Grief, Loss, and Palliative Care: Identifying a Family Who Is Experiencing a Maturational Loss

Topic: Definition of Maturational Loss

- Maturational loss refers to the loss associated with developmental changes or transitions, such as children leaving home for college or the aging process.
- It is considered a natural part of life and often involves feelings of sadness or a sense of identity shift as family members adapt to new roles.
- Unlike situational loss (such as death or trauma), maturational loss is typically gradual and occurs within expected life stages, such as retirement or becoming an empty-nester.

Topic: Impact on Family Dynamics

- Maturational loss can create changes in family dynamics, leading to shifts in roles, responsibilities, and relationships. For example, a mother may experience a sense of loss when her children grow up and leave for school or work.
- The family may face difficulty in adjusting to these transitions, especially if one member feels a loss of purpose or relevance.
- It can lead to stress and emotional conflict if family members do not communicate openly or process the changes together.

Topic: Coping Strategies

- Families experiencing maturational loss can benefit from open communication, where members share their feelings and acknowledge the changes.
- Therapy or counseling, such as family therapy, can be helpful in guiding families through these changes and providing tools for coping with the emotional aspects of transition.
- Engaging in new routines or hobbies and redefining roles within the family can help members find new meaning and strengthen relationships during this period of transition.

Subcategory: Complementary and Alternative Therapies: Discussing Alternative Treatments With a Client

Topic: Definition and Distinction Between Complementary and Alternative Medicine

- Complementary medicine refers to therapies used alongside conventional treatments (e.g., using acupuncture in conjunction with chemotherapy), while alternative medicine replaces conventional treatments (e.g., using herbal remedies instead of prescription medication).
- Patients may choose complementary and alternative therapies (CAM) to manage symptoms, reduce stress, or improve overall well-being.
CAM practices include treatments like acupuncture, massage therapy, herbal supplements, chiropractic care, yoga, and mindfulness practices.

Topic: Benefits and Risks of Alternative Treatments

- Some alternative therapies, such as acupuncture or massage, may help alleviate symptoms like pain or stress and improve quality of life, particularly in chronic conditions or palliative care settings.
- Many alternative treatments are unregulated, so there can be risks related to safety, efficacy, and interactions with conventional medications.
- It is important to educate clients about the potential benefits and risks of CAM and emphasize the importance of informing their healthcare provider about any alternative treatments they are considering avoiding harmful interactions.

Topic: Discussing Alternative Treatments with Clients

- When discussing alternative treatments, it's essential to approach the conversation with respect, understanding, and without judgment, as patients may have personal or cultural reasons for seeking CAM therapies.
- Open communication should focus on understanding the client's goals and concerns, ensuring they feel heard and supported in their decision-making process regarding alternative treatments.
- Encourage patients to ask about the evidence supporting the effectiveness of the treatment, such as

scientific research or clinical trials, to help them make an informed decision.

Main category: reduction of risk potential

Subcategory: Purpose and Benefits of Antiembolic Stockings

Topic: Prevention of Deep Vein Thrombosis (DVT)

- Antiembolic stockings (also known as compression stockings) are primarily used to prevent DVT by promoting venous return and reducing the risk of blood pooling in the lower extremities.
- By applying pressure to the lower legs, these stockings help improve blood circulation and prevent the formation of blood clots in veins, especially in immobile or post-surgical patients.
- DVT can lead to serious complications such as pulmonary embolism, so using antiembolic stockings is an essential part of preventing these risks, particularly in postoperative patients.

Topic: Enhanced Circulation and Reduced Swelling

- These stockings are designed to apply graduated compression, meaning the pressure is highest at the ankle and gradually decreases up the leg. This helps facilitate blood flow back to the heart.
- By reducing venous pressure, antiembolic stockings also help reduce swelling (edema) in the lower legs and feet, which can occur in patients with poor mobility or who are bedridden.
- Enhanced circulation can also reduce the feeling of heaviness and discomfort in the legs, improving overall comfort for patients with limited movement.

Topic: Role in Postoperative Care

- Antiembolic stockings are commonly used in postoperative care to prevent complications associated with immobility, such as blood clots and edema.
- In addition to their physical benefits, they can contribute to a quicker recovery by promoting better circulation and reducing the risk of complications like venous stasis.
- The stockings should be applied immediately after surgery or when immobility is expected to persist, and they may be worn until the patient regains mobility and is no longer at risk.

Subcategory: Complementary and Alternative Therapies: Evaluating Appropriate Use of Herbal Supplements

Topic: Safety and Efficacy of Herbal Supplements

- Herbal supplements are not regulated by the FDA in the same way as pharmaceutical drugs, meaning their safety and efficacy may not be well-established.
- Some herbal supplements may interact with prescription medications, either diminishing their effects or causing harmful side effects (e.g., St. John's Wort can interfere with antidepressants).
- It's essential to evaluate the scientific evidence supporting the herbal supplement's use, including clinical trials and peer-reviewed studies, to ensure it is both safe and effective for the intended purpose.

Topic: Dosage and Quality Control

- The quality and concentration of active ingredients in herbal supplements can vary significantly between brands and batches, potentially leading to inconsistent therapeutic effects.
- A proper dosage is crucial, as excessive use of some herbal supplements (e.g., echinacea or ginseng) can lead to adverse effects such as liver damage or increased heart rate.
- Some herbal products may contain contaminants such as heavy metals, pesticides, or other harmful substances, so it is important to choose supplements from reputable sources with proper quality control measures.

Topic: Patient Education and Informed Decision-Making

- When recommending or evaluating herbal supplements, it is crucial to educate patients on the potential risks and benefits, as well as the importance of discussing any supplements with their healthcare provider to avoid interactions.
- Clients should be encouraged to report all herbal supplements they are taking, especially if they have

chronic conditions or are undergoing surgery, as these could impact anesthesia or recovery.

- Patients should be made aware that herbal remedies are not a substitute for conventional medical treatment and should be used in conjunction with, rather than in place of, prescribed therapies unless advised otherwise by a healthcare professional.

Subcategory: Bowel Elimination: Discharge Teaching About Ostomy Care

Topic: Caring for the Ostomy Site

- After surgery, the ostomy site should be regularly cleaned with mild soap and water, and the skin around the ostomy should be kept dry and free of irritation.
- The ostomy appliance (bag) should be checked frequently for leakage or skin irritation; the adhesive should be replaced regularly to ensure a secure fit and prevent skin breakdown.
- The client should be instructed to avoid using lotions or oils around the ostomy site, as these can interfere with the adhesive on the ostomy pouch.

Topic: Managing Diet and Hydration

- Patients with an ostomy should be advised to eat a well-balanced diet, avoiding foods that may cause gas, odor, or blockages, such as beans, cabbage, and high-fiber foods in the early post-operative period.
- Drinking adequate fluids is crucial to prevent dehydration, as the colon will no longer absorb water efficiently, especially in cases of ileostomies.
- Some patients may experience changes in stool consistency or frequency, so they should be educated on adjusting their diet to manage these changes effectively, such as by increasing or decreasing fiber intake.

Topic: Emotional and Psychological Support

- Adjusting to life with an ostomy can be challenging, and patients may experience emotional difficulties such as embarrassment or body image concerns. Counseling or support groups may be helpful.
- Providing clear, empathetic communication and encouraging patients to express any concerns about their ostomy can promote better self-care and confidence.
- Patients should be encouraged to join support groups or seek professional mental health support if they are struggling with the emotional aspects of living with an ostomy.

Subcategory: Airway Management: Collecting a Sputum Specimen

Topic: Indications for Sputum Collection

- Sputum specimens are often collected to diagnose respiratory infections, such as pneumonia, tuberculosis, or bronchitis, and to identify the presence of pathogens.
- A sputum specimen can also be used to assess the effectiveness of treatment (e.g., checking for the presence of bacteria after antibiotic therapy) or to monitor chronic respiratory conditions like chronic obstructive pulmonary disease (COPD).
- The specimen is usually obtained from the lower respiratory tract, where the pathogen or abnormal cell presence is most likely to be found.

Topic: Proper Collection Technique

- The patient should be instructed to take a deep breath and cough forcefully to bring up sputum from the lungs, as the goal is to collect a specimen from the lower respiratory tract rather than saliva.
- A sterile container should be used to prevent contamination, and care should be taken not to touch the inside of the container or lid with your hands or other surfaces.
- It is important for the patient to be positioned comfortably, typically sitting up or leaning forward, to facilitate effective coughing and collection of the specimen.

Topic: Analyzing the Sputum Specimen

- Once the specimen is collected, it should be sent to the lab as soon as possible to ensure accurate results, as sputum can degrade over time, affecting the analysis.
- The lab will analyze the sputum for signs of infection (e.g., bacteria, viruses), abnormal cells (e.g., in

the case of lung cancer), or other substances (e.g., blood or mucus consistency).

- Results from the sputum specimen can guide appropriate treatment, such as prescribing antibiotics for bacterial infections or further testing if cancer is suspected.

Main category: Management of care

Subcategory: Legal Responsibilities: Responding to a Client's Refusal of Surgery

Topic: Patient's Right to Refuse Treatment

- Informed consent includes the right of a patient to refuse any form of treatment, including surgery, even if it may be lifesaving or medically necessary.
- The nurse should ensure the patient fully understands the potential risks of refusing surgery, including possible complications or death, but the final decision rests with the patient.
- It is crucial to document the refusal thoroughly in the patient's chart, including the patient's statement, the risks explained, and any alternative treatments discussed.

Topic: Ethical Considerations

- Nurses must balance the ethical principles of autonomy (respecting the patient's decision) and beneficence (acting in the patient's best interest) when responding to refusal of surgery.
- The nurse should ensure that the patient is making the decision voluntarily, without undue pressure, and that they are competent to make that decision (e.g., not under the influence of medications or mental distress).
- It may be appropriate to involve other healthcare professionals, such as a counselor, social worker, or ethicist, to help the patient understand the consequences of their refusal.

Topic: Legal Implications

- Refusing surgery may have legal consequences, such as issues related to malpractice or negligence, especially if the patient later suffers harm that could have been prevented by surgery.
- In certain cases, if a patient is deemed legally incompetent (due to age, mental health issues, or cognitive impairment), a legal guardian or court order may be needed to proceed with surgery.
- The nurse should also ensure that the refusal is documented in a way that protects both the patient's rights and the healthcare team's legal interests.

Subcategory: Pressure Injury, Wounds, and Wound Management: Evaluating Performance of a Wound Irrigation Procedure

Topic: Importance of Proper Wound Irrigation

- Wound irrigation is crucial for cleaning the wound site, removing debris, and reducing bacterial load, which helps prevent infection and promotes healing.
- The pressure used in irrigation should be sufficient to clean the wound without causing tissue damage. Typically, a pressure of 4-15 psi (pounds per square inch) is recommended for most wounds.
- The choice of irrigation solution (e.g., saline, antiseptic solution) depends on the wound type and clinician preference, but saline is generally preferred for its neutral pH and non-toxicity to tissues.

Topic: Techniques and Best Practices

- The nurse should wear appropriate protective equipment (e.g., gloves, gown) when performing wound irrigation to prevent contamination and maintain a sterile field.
- The procedure should be done in a way that avoids splashing or spreading contaminants, using a syringe to direct the irrigation solution into the wound.
- After irrigation, the wound should be assessed for signs of healing (e.g., reduced redness, absence of pus) or any signs of complications (e.g., infection).

Topic: Evaluation of Procedure Performance

- The nurse should assess the effectiveness of wound irrigation by observing whether the wound is adequately cleaned and whether any remaining debris or foreign material is removed.
- The nurse should monitor for any adverse reactions post-procedure, such as excessive pain, bleeding, or signs of infection (e.g., increased redness, warmth).
- Documentation should include the irrigation solution used, the amount of fluid used, the condition of the wound after irrigation, and any patient responses to the procedure.

Subcategory: Information Technology: Approved Abbreviations for Use in Documentation

- **Topic: Importance of Standardizing Abbreviations**
- Standardized abbreviations help ensure clear and consistent communication between healthcare

providers, reducing the risk of errors due to misinterpretation.

- The use of non-standard abbreviations can result in confusion or miscommunication, leading to potential patient harm. Therefore, many institutions have approved lists of abbreviations.
- The Joint Commission and other regulatory bodies often provide guidelines on approved abbreviations to be used in healthcare documentation.

Topic: Commonly Approved Abbreviations

- Examples of approved abbreviations include "BP" (blood pressure), "HR" (heart rate), and "PO" (by mouth).
- Some abbreviations, such as "NPO" (nothing by mouth), are universally understood and accepted in healthcare settings.
- Approved abbreviations are usually common terms that have been vetted for clarity and safety across healthcare disciplines.

Topic: Risks of Non-Approved Abbreviations

- Using unapproved abbreviations can result in unclear documentation that may delay care or lead to medication errors. For example, "QD" (once a day) could be mistaken for "QID" (four times a day).
- Commonly misinterpreted abbreviations, such as "U" (for unit), which can be mistaken for "0" (zero), pose a significant risk for medication dosing errors.
- It is important for healthcare providers to stay current with institutional and regulatory guidelines on approved abbreviations to ensure safety and avoid legal implications.

Subcategory: Legal Responsibilities: Completing an Informed Consent Document

Topic: Role of the Nurse in Informed Consent

- Nurses may assist in the informed consent process by verifying that the patient understands the procedure and ensuring that consent is obtained before any surgery or invasive procedure.
- The nurse's role is not to provide detailed medical information about the procedure (which is the responsibility of the physician), but to ensure that the patient feels informed and has the opportunity to ask questions.
- The nurse should ensure that the consent form is signed voluntarily, without any coercion or influence from others, and that the patient's questions have been answered.

Topic: Legal and Ethical Aspects of Informed Consent

- Informed consent is a legal requirement in healthcare and ensures the patient's autonomy by allowing them to make an informed decision about their treatment.
- The document should include a description of the procedure, risks, benefits, and alternatives, ensuring that the patient understands the potential outcomes of their decision.
- If a patient is unable to provide consent (e.g., due to age, mental status, or language barrier), a legal guardian or proxy may provide consent, or an interpreter may be used.

Topic: Documentation and Compliance

- The informed consent document should be thoroughly documented in the patient's medical record, including the date and time of signing and any discussions that took place prior to obtaining consent.
- Nurses should confirm that the patient signed the form voluntarily and should witness the signature if appropriate.

- If a patient revokes consent or has further questions at any point, the nurse should ensure that the healthcare team is informed and that the situation is handled appropriately.

Subcategory: Legal Responsibilities: Teaching About Guidelines for Nursing Standards of Care

Topic: Understanding the Legal Scope of Nursing Practice

- Nursing standards of care define the minimum level of care that should be provided to patients based on established guidelines, research, and legal precedent.
- The nurse has a legal and ethical obligation to provide care that aligns with professional standards, ensuring patient safety and quality outcomes.
- These standards are set by professional organizations, regulatory bodies, and healthcare institutions and serve as a basis for assessing whether a nurse's actions are appropriate in a given situation.

Topic: Documentation and Compliance

- Nurses must ensure that their actions align with the standards of care, which includes documenting all nursing interventions accurately and thoroughly to show compliance with best practices.
- In cases of malpractice or legal action, documentation can serve as evidence to demonstrate that the nurse followed the appropriate standard of care.
- It is crucial for nurses to stay informed about updates to nursing standards, as these guidelines may evolve based on new research, clinical guidelines, or regulatory changes.

Topic: Continuing Education and Professional Development

- Nurses should engage in ongoing education and training to remain current with changes in nursing practice and standards of care, which is vital for both personal growth and patient safety.
- Participation in professional organizations and certification programs helps nurses stay updated on best practices and guidelines specific to their area of care (e.g., pediatrics, critical care, geriatrics).
- Nurses should seek out educational resources, attend workshops, and participate in peer reviews to continually improve their understanding and application of nursing standards.

Subcategory: The Interprofessional Team: Referral for a Client Who Has a Traumatic Brain Injury

Topic: Importance of Early and Comprehensive Referral

- Traumatic brain injuries (TBI) require timely and comprehensive referral to a variety of specialists, including neurologists, rehabilitation therapists, and psychologists, to ensure optimal care.
- Early referral to physical and occupational therapists is crucial for addressing motor skills, cognitive impairments, and activities of daily living after TBI.
- Referral to mental health professionals, such as a psychologist or psychiatrist, is essential to address potential psychological impacts of TBI, including depression, anxiety, and post-traumatic stress disorder (PTSD).

Topic: Role of the Multidisciplinary Team

- The interprofessional team approach ensures that all aspects of the patient's care, including physical, cognitive, emotional, and social needs, are addressed, improving overall recovery outcomes.
- Team members, including doctors, nurses, therapists, and social workers, should communicate regularly to ensure a coordinated plan of care that meets the patient's evolving needs.
- Family members should also be involved in the referral process and included in discussions to ensure they understand the patient's rehabilitation goals and progress.

Topic: Rehabilitation and Long-Term Support

- Patients with TBI often require long-term rehabilitation services, including speech therapy, neuropsychological support, and vocational therapy, depending on the severity of the injury.
- Support groups and community resources can be valuable in assisting patients and families in coping with the long-term impacts of TBI, such as adjusting to disability or finding employment.
- Referral to case managers or social workers can help facilitate access to financial assistance, home care services, and adaptive equipment necessary for recovery and reintegration into daily life.

Subcategory:

Main category: Physiological adaptation

Subcategory: Pressure Injury, Wounds, and Wound Management: Wound Care Following an Open Cholecystectomy

Topic: Postoperative Wound Care

- After an open cholecystectomy (removal of the gallbladder through an abdominal incision), wound care is essential to prevent infection and promote healing. The nurse should monitor the surgical site for signs of infection, including redness, warmth, swelling, or discharge.
- The wound should be cleaned regularly with sterile saline or as prescribed by the healthcare provider. A sterile dressing should be applied to prevent contamination, and it should be changed according to the provider's instructions or if it becomes soiled or wet.
- Pain management is critical during wound care. The patient should be provided with analgesia as prescribed to ensure comfort when cleaning the wound or changing the dressing.

Topic: Risk of Infection and Prevention Strategies

- Patients who undergo an open cholecystectomy are at risk for developing wound infections due to the nature of the surgery and the potential for bile leakage. The nurse should closely monitor for any signs of infection or leakage of bile from the wound.
- Infection prevention strategies include ensuring strict aseptic technique when handling the wound and surgical dressings, educating the patient about proper hand hygiene, and ensuring that the patient is compliant with post-surgical instructions.
- Antibiotics may be prescribed if there is concern for infection, and wound cultures may be taken if an infection is suspected.

Topic: Managing Drainage and Monitoring for Complications

- Following an open cholecystectomy, some patients may have drains (e.g., Jackson-Pratt or Penrose) in place to remove excess fluid and prevent fluid buildup in the abdomen. These drains should be monitored for the amount, color, and consistency of drainage.
- Any significant changes in drainage, such as increased volume, sudden onset of bright red blood, or foul-smelling drainage, should be promptly reported to the healthcare provider.
- Complications like wound dehiscence (wound opening) or abscess formation can occur, particularly if the surgical site is not properly cared for. The nurse should educate the patient on how to care for the drain and wound site to prevent these issues.

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

Topic: Identifying Signs of an Allergic Reaction

- Common signs of an allergic reaction to antibiotics include skin rashes (e.g., hives), itching, swelling (particularly of the face, lips, or throat), and difficulty breathing. These symptoms may indicate anaphylaxis, a severe allergic reaction.
- An allergic reaction can also manifest as gastrointestinal symptoms such as nausea, vomiting, or diarrhea, though these are often less severe than an anaphylactic reaction.
- If a patient shows any signs of an allergic reaction, the nurse should stop the antibiotic immediately, notify the healthcare provider, and prepare to administer emergency treatments (e.g., antihistamines, epinephrine) as needed.

Topic: Understanding Cross-Reactivity and Sensitivities

- Certain classes of antibiotics, such as penicillin, can cause allergic reactions, and patients with an allergy to one antibiotic may be at risk for cross-reactivity to other antibiotics in the same class. For example, a patient allergic to penicillin may also be allergic to cephalosporins.
- Patients with a history of allergies to other substances (e.g., foods, pollen, latex) may have a higher risk of developing an allergic reaction to antibiotics.
- It is important for healthcare providers to review the patient's allergy history before prescribing antibiotics and to select medications that are less likely to trigger an allergic response.

Topic: Management of Allergic Reactions to Antibiotics

- When an allergic reaction is suspected, the healthcare provider may recommend switching to a different class of antibiotics that the patient has not previously reacted to.
- If an allergic reaction occurs, treatment may include antihistamines for mild reactions, corticosteroids for more severe symptoms, or epinephrine for anaphylactic reactions. The patient should be closely monitored for respiratory distress or signs of shock.
- Nurses should educate patients on the signs of allergic reactions, the importance of reporting any allergies to their healthcare providers, and the need to wear a medical alert bracelet if they have a known antibiotic allergy.

Main: Safety and infection control**Subcategory: Nursing Process: Priority Action Following a Missed Provider Prescription****Topic: Identifying the Missed Prescription**

- The first step when a provider's prescription is missed is to identify which prescription has been missed and when it was due. This could include medications, treatments, or tests that were prescribed but not administered or performed on time.
- The nurse should verify the missed prescription by reviewing the patient's medical record and any communication from the provider or pharmacy to ensure it was truly missed and not a result of another issue, such as a transcription error.
- It is essential to assess the clinical significance of the missed prescription, including whether the omission poses an immediate risk to the patient's health or treatment outcomes.

Topic: Communicating with the Healthcare Team

- Once the missed prescription is identified, the nurse should promptly notify the provider about the missed dose, explaining the situation and seeking guidance on how to proceed. If necessary, a decision will be made regarding whether to administer the medication or treatment as soon as possible.
- If the provider is unavailable, the nurse should follow established protocols or escalate the issue to the next available healthcare provider to ensure patient safety.
- Documentation of the missed prescription, including the actions taken and any provider communication, should be carefully recorded in the patient's medical chart to ensure transparency and accountability.

Topic: Corrective Actions and Patient Monitoring

- The nurse should assess the patient for any potential negative effects from the missed prescription, especially if the medication or treatment is critical to managing a condition (e.g., antibiotics for an infection, insulin for diabetes).
- In some cases, a double dose or an adjusted dose may be recommended. The nurse should verify the proper dose with the provider and monitor the patient for any signs of overdose or adverse effects.
- The patient should be informed about the missed prescription and any additional steps needed to ensure their treatment continues safely, including rescheduling medications or treatments as needed.

Subcategory: Mobility and Immobility: Using a Wheelchair for Client Transfer**Topic: Assessing the Patient's Mobility**

- Before transferring a patient using a wheelchair, it is crucial to assess their mobility status and determine if they can assist in the transfer or if they require full support.

- The nurse should evaluate the patient's ability to bear weight, move limbs, and follow directions, as this will affect how the transfer is executed.
- If the patient is unable to move independently or bear weight, a transfer assist device (e.g., a Hoyer lift) may be needed, and the nurse should ensure proper equipment is available.

Topic: Preparing for the Transfer

- Ensure the wheelchair is in good working condition before use, with properly functioning footrests, brakes, and wheels.
- Position the wheelchair properly relative to the patient (e.g., parallel to the bed or chair, with brakes locked) to allow for a smooth and safe transfer.
- The nurse should also ensure that the environment is clear of obstacles, and the floor is dry and free of tripping hazards to minimize the risk of falls or accidents during the transfer.

Topic: Correct Transfer Techniques

- Use proper body mechanics when performing the transfer to prevent injury to both the nurse and the patient. This includes bending at the knees, not the waist, and using the legs to lift, not the back.
- During the transfer, maintain stability by keeping the patient's body close to the nurse's body and using a secure grip to help the patient move safely from one location to the other.
- If the patient is unable to assist with the transfer, the nurse should use a two-person or team lift for support, ensuring the patient is properly supported throughout the movement.

Subcategory: Client Safety: Action to Take Prior to the Use of Restraints

Topic: Assessing the Need for Restraints

- Restraints should only be used after all less restrictive options have been considered and tried. The nurse should assess the patient's behavior and determine if alternative interventions (e.g., verbal de-escalation, environmental modifications) can be used to ensure safety.
- Restraints should be considered if a patient poses a significant risk to themselves or others, and no other means are effective in preventing harm.
- The healthcare team must be involved in evaluating the patient's condition and determining whether restraints are warranted, considering factors like the patient's physical and mental health.

Topic: Legal and Ethical Considerations

- Before applying restraints, the nurse should ensure that there is a physician's order for their use. The order should specify the type of restraint, the reason for use, and the duration for which they will be applied.
- The use of restraints must comply with legal and ethical standards, which include ensuring the patient's dignity, using the least restrictive option, and monitoring the patient frequently while restrained.
- The nurse must document the reason for using restraints, the type of restraint applied, and the patient's response to the restraint, as well as any efforts to remove the restraint once the immediate risk is resolved.

Topic: Safety Protocols and Monitoring

- Prior to the application of restraints, the nurse should ensure that the patient's physical needs (e.g., hydration, toileting, comfort) are addressed to minimize discomfort and stress during restraint use.
- Restraints should be applied in a way that allows for proper circulation and does not cause injury. The nurse should check the restraint regularly to ensure it is not too tight and that it does not impair circulation.
- The patient should be monitored continuously, and their safety should be reassessed frequently to determine if the restraint is still necessary, ensuring that the restraint is released periodically for comfort, repositioning, and monitoring.

Subcategory: Client Safety: Teaching About Home Safety

Topic: Fall Prevention

- Teaching clients about fall prevention at home is essential, especially for elderly patients or those with mobility issues. Common strategies include removing clutter, securing loose rugs, and installing grab bars in the bathroom.
- Ensure the client has proper lighting in hallways, stairways, and bedrooms to prevent accidents caused by poor visibility, especially at night.
- Recommend non-slip mats in the bathroom and encourage the use of sturdy, well-fitting footwear to reduce the risk of slipping.

Topic: Medication Safety

- Clients should be educated on how to store medications safely to prevent accidental ingestion, particularly in households with children or pets. Medications should be kept in their original containers and stored in a dry, cool place out of reach.
- Teach the patient to keep an up-to-date medication list and to communicate with their healthcare provider about any changes in medications, including over-the-counter drugs and supplements.
- Clients should be instructed on the proper dosage and timing for their medications, as well as the importance of taking medications as prescribed and not sharing them with others.

Topic: Emergency Preparedness

- Clients should have an emergency plan in place that includes knowing when to seek medical help. For example, a list of emergency contacts, an accessible phone, and any necessary emergency supplies (e.g., medical equipment, medications) should be readily available.
- Teach clients to recognize and respond to signs of an emergency, such as chest pain, difficulty breathing, or signs of a stroke, and to seek help immediately when necessary.
- Encourage clients to have a first aid kit at home, stocked with basic supplies, and to be familiar with its contents and how to use them in case of injury.

Main: Clinical judgment

Subcategory: Nutrition and Oral Hydration: Identifying Complications for a Client Who Is in a Rehabilitation Facility

Topic: Risk of Malnutrition

- Clients in a rehabilitation facility are at risk for malnutrition due to limited physical activity, changes in appetite, or difficulty swallowing (dysphagia). The nurse should assess the patient's nutritional intake and help with feeding as needed.
- Malnutrition can lead to delayed wound healing, weakened immune function, and increased risk of infections. It's important to monitor the client's weight regularly and provide supplements or altered textures of food if needed.
- In some cases, enteral feeding (via a tube) or parenteral nutrition (via IV) may be necessary if the client is unable to meet their nutritional needs through oral intake.

Topic: Dehydration and Oral Hydration Issues

- Dehydration is a common complication in rehabilitation settings, especially if the client has mobility issues, cognitive impairment, or difficulty accessing water independently. Nurses should ensure that fluids are offered regularly and that the client is encouraged to drink.
- Dehydration can cause confusion, decreased urine output, and electrolyte imbalances, potentially exacerbating the client's underlying condition.
- Oral rehydration solutions or IV fluids may be necessary for clients who show signs of severe dehydration.

Topic: Gastrointestinal Complications

- Clients in rehabilitation may experience constipation or diarrhea due to medications, changes in diet, or reduced mobility. Constipation can be alleviated by increasing fiber intake, hydration, and physical activity.
- Nurses should monitor bowel movements and report any changes in pattern, such as abdominal distension or pain, which could indicate more serious issues like bowel obstruction.
- A regular schedule for meals and snacks should be maintained to help regulate the client's digestive system.

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

Topic: Abnormal Laboratory Results

- Prior to surgery, abnormal laboratory values, such as elevated white blood cell counts, abnormal electrolytes, or abnormal liver/kidney function tests, should be addressed. These findings could indicate infections, organ dysfunction, or electrolyte imbalances that need correction before surgery.
- Abnormal blood clotting studies (e.g., PT, INR, or aPTT) should also be addressed, as these could increase the risk of bleeding during the surgery.
- The nurse should communicate these findings to the surgeon or anesthesiologist for further evaluation and management.

Topic: Medication History and Allergies

- A thorough medication history is essential to identify drugs that may affect anesthesia or surgical outcomes, such as anticoagulants, steroids, or herbal supplements. Some medications may need to be held or adjusted prior to surgery.
- It is important to confirm the patient's allergy history, especially to medications, latex, or anesthesia agents, to prevent serious allergic reactions during surgery.
- The nurse should verify that the patient has received instructions about which medications to take or withhold prior to surgery.

Topic: Risk of Infection or Chronic Conditions

- If the patient has an active infection, such as a cold or urinary tract infection (UTI), surgery may need to be postponed due to increased risks of complications, including wound infection and poor healing.
- Chronic conditions, such as diabetes or hypertension, must be well-controlled before surgery to minimize the risk of complications such as poor wound healing, infection, or cardiac events.
- The nurse should ensure that all necessary preoperative tests are conducted to assess the client's baseline health status.

Subcategory: Urinary Elimination: Caring for a Client Who Has an Ileostomy

Topic: Stoma Care

- After the creation of an ileostomy (a surgically created opening in the ileum for waste removal), proper stoma care is crucial to prevent skin irritation and ensure that the ostomy bag remains securely in place.
- The nurse should assess the stoma regularly for any signs of irritation, infection, or necrosis. The stoma should be pink and moist. Any changes in color or size should be reported to the healthcare provider.
- The patient should be educated on how to properly clean and care for the stoma, as well as how to empty and change the ostomy bag.

Topic: Complications of Ileostomy

- Common complications associated with an ileostomy include dehydration, electrolyte imbalances, and skin irritation. Clients with ileostomies are at higher risk for dehydration due to the loss of water and electrolytes through the stoma.
- Clients should be encouraged to drink plenty of fluids and may need electrolyte supplementation if signs of dehydration (e.g., dry mouth, decreased urine output) occur.

- Skin around the stoma may become irritated if the ostomy appliance is not fitted properly, which can cause pain or infection. Nurses should ensure the correct fitting of the ostomy bag and provide skincare recommendations to the patient.

Topic: Diet and Fluid Intake

- Clients with ileostomies may need dietary modifications to prevent blockages or discomfort. High-fiber foods or foods that may cause gas or odor should be avoided initially after surgery.
- The nurse should educate the patient about foods that can lead to ileostomy complications, such as nuts, seeds, and popcorn, which may block the stoma.
- Fluid intake should be increased to prevent dehydration, and the patient should be advised to avoid caffeinated beverages or alcohol, which can contribute to fluid loss.

Subcategory: Mobility and Immobility: Priority Risk for a Client Who Has Impaired Mobility

Topic: Risk for Pressure Injuries

- Clients with impaired mobility are at a high risk for developing pressure injuries, especially if they are unable to change positions frequently. Pressure injuries can develop on bony prominences such as the sacrum, heels, and elbows.
- The nurse should assess the skin regularly, especially over areas of pressure, and use pressure-relieving devices such as specialized mattresses or cushions.
- Turning and repositioning the client every two hours and ensuring proper nutrition (with adequate protein and hydration) are important prevention strategies.

Topic: Risk for Deep Vein Thrombosis (DVT)

- Impaired mobility increases the risk of deep vein thrombosis (DVT) due to reduced circulation in the legs. The nurse should assess for signs of DVT, such as swelling, redness, warmth, or pain in the legs.
- Preventive measures include encouraging passive or active range-of-motion exercises, using compression stockings, and administering anticoagulant medications if prescribed.
- Early ambulation and adequate hydration are essential strategies for preventing DVT in immobile clients.

Topic: Risk for Contractures and Muscle Atrophy

- Clients with impaired mobility are at risk for contractures, a condition where muscles shorten and lose their range of motion due to prolonged immobility.
- The nurse should incorporate range-of-motion exercises into the client's care plan to maintain joint flexibility and prevent contractures.
- The use of supportive devices like splints or braces may be recommended to prevent joint deformities and muscle atrophy.

Subcategory: Urinary Elimination: Reviewing the Medical Record of a Client Who Has a Urinary Tract Infection (UTI)

Topic: Symptoms and Diagnosis of UTI

- Symptoms of a urinary tract infection (UTI) may include dysuria (painful urination), frequency, urgency, cloudy or foul-smelling urine, and hematuria (blood in the urine).
- A urinalysis or urine culture may be performed to confirm the diagnosis and identify the causative organism. Sensitivity testing can help determine the most effective antibiotic for treatment.
- The nurse should assess for signs of a more severe infection, such as fever, chills, or back pain, which could indicate pyelonephritis or kidney involvement.

Topic: Risk Factors for UTI

- Risk factors for UTIs include urinary retention, catheterization, diabetes mellitus, poor hygiene, and sexual activity. The nurse should assess these factors when reviewing the patient's history and help prevent recurrence through education.
- Female patients are at higher risk due to the short length of the female urethra, which allows bacteria to reach the bladder more easily.
- The nurse should assess if the client has risk factors for recurrent infections and recommend appropriate interventions, such as proper perineal care, hydration, and urinary tract prophylaxis if indicated.

Topic: Treatment and Prevention

- UTIs are typically treated with antibiotics, and the nurse should ensure that the patient completes the full course of treatment even if symptoms resolve before finishing the medication.
- Encouraging increased fluid intake is important to help flush bacteria from the urinary tract, and the nurse should educate the patient on the importance of hydration.
- Proper hygiene and the use of cotton underwear are preventive measures that can help reduce the risk of future infections.

Main: Health promotion and maintenance

Subcategory: Coping: Evaluating Ego-Defense Mechanisms of a Client

Topic: Understanding Ego-Defense Mechanisms

- Ego-defense mechanisms are unconscious psychological strategies used by individuals to cope with anxiety, stress, or unacceptable emotions. These mechanisms help maintain psychological balance but can be maladaptive if overused.
- Common ego-defense mechanisms include repression (pushing distressing thoughts from consciousness), denial (refusing to accept reality), projection (attributing one's own unacceptable thoughts to others), and rationalization (creating logical reasons to justify behavior).
- Nurses assess these mechanisms to understand how clients manage their emotional stress and help identify any potential barriers to effective coping or therapeutic interventions.

Topic: Assessing Adaptive vs. Maladaptive Coping

- Adaptive coping mechanisms (such as problem-solving or seeking social support) are healthy ways to manage stress and are encouraged in therapeutic settings. In contrast, maladaptive coping mechanisms (like substance abuse or self-isolation) can worsen mental health conditions and hinder progress.
- Nurses should evaluate whether the client's coping mechanisms are helping them adjust to current life stressors or if they need support in learning healthier ways to manage stress.
- When assessing ego-defense mechanisms, it is important to understand the context in which they are used, as they can be helpful in the short term but may need to be addressed if they interfere with long-term coping or recovery.

Topic: Role of the Nurse in Supporting Healthy Coping

- Nurses can help clients recognize and understand their ego-defense mechanisms through therapeutic communication and reflective techniques, encouraging self-awareness and insight into how these mechanisms may affect their emotional and psychological well-being.
- The nurse should provide a safe environment where the client feels comfortable discussing difficult emotions or stressful life events. This environment facilitates the exploration of more adaptive coping strategies.
- Educating clients on effective stress-management techniques, such as mindfulness, deep breathing, and cognitive-behavioral therapy (CBT) strategies, can help them develop healthier coping mechanisms.

Subcategory: Older Adults (65 Years and Older): Reducing the Risk for Osteoporosis

Topic: Importance of Calcium and Vitamin D

- Calcium and vitamin D play crucial roles in maintaining bone density. Adequate intake of both nutrients helps prevent bone loss, which is critical for older adults at risk of osteoporosis.
- The recommended daily intake of calcium for older adults is about 1,200 mg, and vitamin D intake is about 800–1,000 IU, though individual needs may vary depending on health status and dietary habits.
- Nurses should encourage clients to include calcium-rich foods (such as dairy products, leafy greens, and fortified cereals) and vitamin D-rich foods (like fatty fish, fortified milk, and sunlight exposure) in their diet.

Topic: Weight-Bearing Exercise and Physical Activity

Regular weight-bearing exercises, such as walking, jogging, or strength training, help stimulate bone formation and maintain bone density. These activities are particularly important for older adults to reduce the risk of osteoporosis.

The nurse should encourage older adults to engage in at least 30 minutes of physical activity most days of the week, with a focus on exercises that improve balance, flexibility, and strength to prevent falls and fractures.

Exercise programs should be tailored to the individual's capabilities, and the nurse should assess for any limitations that may need to be addressed before starting an exercise regimen (e.g., joint pain, history of falls).

Topic: Medication and Monitoring

Bisphosphonates, selective estrogen receptor modulators (SERMs), and other medications may be prescribed to reduce the risk of bone loss and fractures in individuals with osteoporosis or at high risk for it.

- Nurses should monitor for side effects of osteoporosis medications, such as gastrointestinal irritation from bisphosphonates, and educate clients on how to properly take these medications (e.g., taking bisphosphonates with a full glass of water and remaining upright for 30 minutes afterward).
- Regular bone density testing (DEXA scans) is recommended to assess bone health and determine the need for pharmacological intervention. Nurses should educate clients on the importance of regular monitoring to catch osteoporosis early.