N433 Infant, Child, and Adolescent Health
Proctored ATI Remediation Template

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Assessment Name: ATI remediation AHIII
Semester: Spring 2025

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.
Proctored ATI Grading Scale –

RN Pediatric Health 2023

Level 3= 90 points

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

Level 2 = 80 points

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

Level 1 = 70 points

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

Below Level 1 = 60 points

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

6. Once the template is completed ***and*** at least the minimum remediation time has been completed within the Focused Review module(s) in ATI, upload the template to the corresponding dropbox in E360.
7.

Main Category: Management of Care

Subcategory: Case Management

Topic: Infection control: discharge teaching about preventing sepsis

- Put patients in droplet precautions. This means a private room or a room with other clients who have the same infectious disease.
- The nurse needs to educate all visitors to wear masks when visiting the patient.
- And when the patient is outside of their room, they need to wear a mask.

Subcategory: establishing priorities

Topic: head injury: priority client intervention

- Need to get diagnostic procedures done. For example, a CT and/or MRI of the head and/or neck

- The nurse also needs to get ABGs, CBC with differential, blood glucose levels, electrolyte levels, blood and urine osmolarity, and tox screen ordered.
- The nurse needs to assess the patient's respiratory status. The brain is dependent on oxygen to maintain function and has little reserve available if oxygen is deprived.

Main Category: Safety and Infection Control

Subcategory: accident/error/injury prevention

Topic: heart failure and pulmonary edema: evaluating appropriateness of prescribed medication

- An ultrasound could be done using a two-dimensional or three dimensional ultrasound to measure the systolic and diastolic functioning of the heart.
- Also need to determine the left ventricular ejection fraction by the volume of blood pumped from the left ventricle into the arteries upon each beat.
- A chest x-ray can reveal cardiomegaly and pleural effusions.

Topic: renal diagnostic procedures: identifying appropriateness of prescriptions

- Need to monitor the patient for signs of a delayed reaction to dye/contrast media (dyspnea, tachycardia, rash, hives)
- A renal scan will be done to access renal blood flow and estimate glomerular filtration rate after IV injection of radioactive material to produce a scanned image of the kidneys.
- If the patient starts experiencing hypotension, the nurse needs to increase the patient's fluid intake.

Subcategory: handling hazardous and infectious materials

Topic: cancer treatment options: caring for a client receiving radiation

- Radiation therapy is usually given as a series of divided small doses daily for a set period of time. The dose of radiation that client receives is determined by considering the duration of exposure, the intensity of the radiation, and the distance the radiation source is from the target cells.
- The patient needs to be placed in a private room and keep the door closed as much as possible.
- The nurse should make sure to keep a lead container in the client’s room if the delivery method could allow spontaneous loss of radioactive material.

Main Category: Health Promotion and Maintenance

Subcategory: aging process

Topic: middle and inner ear disorders: risk factors for hearing loss

- Environmental or workplace exposure to noise can lead to hearing loss.

- For the middle ear, risk factors could be recurrent colds and otitis media, enlarged adenoids, trauma, and changes in air pressure (scuba diving, flying)
- Inner ear disorders include viral or bacterial infection and damage due to ototoxic medications.

Main Category: Psychosocial Integrity

Subcategory: stress management

Topic: delirium and dementia: planning care for a client who has a history of dementia

- The nurse should remove contributing factors causing the client's confusion.
- The nurse should also collaborate with the interdisciplinary team regarding client's plan of care
- Nursing care should also consist of reorienting frequently, speak to patient using a calm voice, and consider the use of calming music in the patient's environment.

Main Category: Clinical Judgment

Subcategory: recognize cues

Topic: anemias: assessing a client who has anemia

- Causes of anemia include blood loss, inadequate RBC production, increased RBC destruction, deficiency of necessary components.
- Need to check for iron deficiencies, vitamin B12, folic acid deficiency, or pica
- Pay attention to age, older adult clients are at risk for nutritional-deficiency anemias (iron, vitamin B12, folate)

Topic: angina and myocardial infarction: caring for a client who has angina

- Expect for the patient to experience anxiety, feeling of impending doom
- Pt will report tight squeezing, crushing, heavy/aching pressure, or constricting feeling in the chest
- This pain can radiate to the neck, shoulder, or arm, or present as jaw pain

Subcategory: analyze cues

Topic: anemias: differentiating manifestations of types of anemias

- Patients who are pregnant or menstruating should ensure that their diet contains adequate amounts of iron-rich foods, or supplements.
- Patients that have iron-deficiency typically have elevated cholesterol levels and should integrate iron-rich foods that are not red or organ meats into their diets.
- Acute or chronic blood loss can arise from trauma, menorrhagia, GI bleed, intra or post surgical blood loss or hemorrhage, chemical or radiation exposure.

Topic: heart failure and pulmonary edema: caring for a client who has heart failure

- The nurse needs to monitor daily weight and I&O
- The patient should be assessed for shortness of breath and dyspnea on exertion
- The nurse should monitor vital signs and hemodynamic pressures

Subcategory: prioritize hypotheses

Topic: anemias: priority actions for iron deficiency anemia

- Iron supplements are used to replenish iron in the blood and iron stores. Iron is an essential component of Hgb, and subsequently, oxygen transport.
- Have hemoglobin checked in 4 to 6 weeks to determine efficacy

- Ed pt to take iron supplements between meals to increase absorption, if tolerated.

Subcategory: take actions

Topic: anemias: teaching a client who has a prescription for iron supplements

- Total iron-binding capacity reflects an indirect measurement of all proteins that bind with iron and transports it for storage.
- Oral iron supplements are used to replenish iron in the blood and iron stores. Iron is an essential component of HgB, and subsequently, oxygen transport.
- Patient should take iron supplements between meals to increase absorption, if tolerated

Topic: inflammatory bowel disease: caring for a client who has diverticulitis

- Diverticulitis is an acute onset of abdominal pain often in the left-lower quadrant with nausea and vomiting.
- Some physical assessment findings would be fever, chills, tachycardia, and abdominal distention
- The nurse should expect to see the pt hct and hgb decreased with their ESR and WBC increased

Subcategory: evaluating outcomes

Topic: Anemias: Educating a Client Who Is Taking Iron Supplements

- Parenteral iron supplements (iron dextran) are only given for severe anemia
- The patient should have their hemoglobin checked in 4 to 6 weeks to determine efficacy
- Stools can appear green to black in color while taking iron

Topic: Hepatitis and Cirrhosis: Caring for a Client Who Has Cirrhosis

- The nurse can expect for the patient to have a history of exposure to infected blood, stool, or body fluid
- The patient could also experience flu-like symptoms like fatigue, decreased appetite with nausea, abdominal pain, and joint pain.
- Some physical findings could be a fever, vomiting, dark-colored urine, clay-colored stool, and jaundice.

Topic: Hyperthyroidism: Caring for a Client Who Is Experiencing Thyroid Storm

- The nurse should minimize the client's energy expenditure by assisting with activities as necessary and by encouraging the client to alternate periods of activity with rest
- Promote a calm environment
- The nurse needs to assess the patient's mental status and decision-making ability. Intervene as needed to ensure safety

Topic: Infections of the Renal and Urinary System: Monitoring Changes in Client Status

- The needs to assess/monitor the patient's nutritional status, I&O, fluid and electrolyte balance, temperature, onset, quality, duration, and severity of pain during the nonsurgical phase.
- The nurse needs to increase intake of at least 2 L/day unless contraindicated for the patient.
- The nurse should also administer antipyretic, such as needed for fever and opioid analgesics for pain associated with pyelonephritis.

Topic: Meningitis: Identifying Manifestations of Meningitis

- Manifestations of Meningitis could be diluted blood and concentrated urine.
- The nurse should look for assessment findings of fever and chills, N&V, LOC, positive Kernig's sign, Positive Brudzinski's sign, and hyperactive deep tendon reflexes.
- Other manifestations could be tachycardia, seizures, red macular rash, and restlessness/irritability

Topic: Rheumatoid Arthritis: Caring for a Client Who Has Rheumatoid Arthritis

- The nurse can ed the client on taking acetaminophen for pain and applying ice and rest the joint for 24 hours.
- The nurse should assist with and encourage physical activity to maintain joint mobility (within the capabilities of the client)
- When doing physical therapy, the nurse needs to monitor for indications of fatigue.

Main Category: Basic Care and Comfort

Subcategory: mobility/immobility

Topic: musculoskeletal trauma: caring for a client who has skeletal traction

- When doing pin care, the nurse needs to look for any drainage and redness, loosening of pins, and tending of skin at pin site for the possible risk of infection.
- Pin care protocols (chlorhexidine) are based on provider preference and facility policy. A primary concept of pin care is that one cotton swab is designated for each pin to avoid cross-contamination
- Pin care is provided usually once a shift, 1 to 2 times a day, or per facility protocol. The nurse can increase the frequency of care if an increased amount of drainage is noted or infection is suspected.

Subcategory: non pharmacological comfort interventions

Topic: lupus erythematosus, gout, and fibromyalgia: recommendations of nonpharmacological treatment for pain

- The patient should receive education to wear a wide-brimmed hat, long-sleeve shirt, and long pants when outdoors.
- The patient should also avoid UV and prolonged sun exposure. They need to use sunscreen when outside and exposed to sunlight.
- The patient should also try to avoid stress and illnesses when possible.

Topic: postoperative nursing care: medication to address client's pain

- The nurse needs to monitor for DVTs postoperatively. Preventative measures such as sequential compression devices, anti-embolism stockings, and prescribed anticoagulants or antiplatelet medications.
- The nurse should administer prescribed anticoagulants or antiplatelet medications.
- When patients are discharged on medications, they need to be educated on the purpose of the medication, administration guidelines, and adverse effects of medications.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: blood and blood products

Topic: blood and blood product transfusions: identifying a hemolytic transfusion reaction

- This happens when blood products are incompatible with the client's blood type or Rh factor. This can occur following the transfusion of a few as 10 mL of a blood product.
- These reactions can be mild or life-threatening, resulting in disseminated IV coagulation or circulatory collapse.
- Findings of these reactions could include chills, fever, low-back pain, tachycardia, hypotension, chest tightening or pain, tachypnea, nausea, anxiety, hemoglobinuria, and an impending sense of doom.

Subcategory:central venous access devices

Topic: intravenous therapy: planning care for a client who requires a peripherally inserted central catheter

- The nurse needs to understand to change the IV site at least every 72 hours or sooner according to the facility's policy.
- Need to avoid inserting an IV into the lower extremities
- When providing care, the nurse needs to use hand hygiene and surgical aseptic technique

Subcategory: dosage calculations

Topic: dosage calculations: calculating lidocaine continuous IV infusion rate

- Infusion pumps deliver a specific amount of fluid during a specific amount of time.
- For example, if prescription rads 500 mL to infuse over 4 hours, it makes sense to administer 125 mL/hr
- The nurse needs to determine the ratio that contains the same unit as the unit being calculated (place the ratio on the right side of the equation ensuring that the unit in the numerator matches the unit being calculated)

Subcategory: medication administration

Topic: angina and myocardial infarction: teaching about sublingual nitroglycerine

- The patient needs to put the tablet under their tongue and let them dissolve completely.
- Aspirin prevents vasoconstriction. Due to this and antiplatelet effects, it should be administered with nitroglycerin at the onset of chest pain.
- Need to come straight to the hospital or call 911 if a patient has to take all three doses.

Topic: diabetes mellitus: mixing two insulins into one syringe

- Glipizide is best taken 30 min before breakfast. Withhold dose if client will not be able to eat.
- Clients taking Repaglinide need education to take the medication within 30 min of mealtime, three times per day.
- Education on metformin needs to be to take immediate release tablets two times per day with breakfast and dinner and to take sustained-release tablets once daily with dinner.

Subcategory: total parenteral nutrition

Topic: gastrointestinal therapeutic procedures: caring for a client receiving total parenteral nutrition

- TPN administration is usually through a central line (a tunneled triple lumen catheter or a single - or double - lumen peripherally inserted central line)
- TPN is used for conditions such as affects in the ability to absorb nutrition, has a prolonged recovery, creates a hypermetabolic state, and creates a chronic malnutrition
- Client will present with a weight loss greater than 10% of body weight and NPO or unable to eat or drink for more than 5 days

Main Category: Reduction of Risk Potential

Subcategory: changes/abnormalities in vital signs

Topic: pulmonary embolism: identifying manifestations

- Some expected findings would be anxiety, feelings of impending doom, sudden onset of chest pressure, pain upon inspiration and chest wall tenderness, dyspnea and air hunger, and cough.
- Some physical findings would be pleurisy, pleural friction rub, tachycardia, hypotension, tachypnea, low-grade fever, etc.
- ABG analysis would consist of a PaCO2 level to be low due to initial hyperventilation (respiratory alkalosis)

Subcategory: diagnostic tests

Topic: electrocardiography and dysrhythmia monitoring: analyzing a cardiac rhythm strip

- The nurse needs to monitor for manifestations of dysrhythmias (chest pain, decreased LOC, SOB) and hypoxia.
- The patient should remain still and breathe normally while the 12-lead ECG is performed.
- When preparing the client for a 12-lead ECG, the client should be positioned supine with chest exposed.

Subcategory: potential for complications from surgical procedures and health alterations

Topic: hyperthyroidism: findings to report following a total thyroidectomy

- Keep the client in a semi-fowler's position. support head and heck with pillows or sandbags. Avoid neck extension.
- Follow protocols, monitor vital signs typically every 15 min until stable, then every 30 min.
- The nurse needs to provide oral and tracheal suction as needed.

Subcategory: system-specific assessments

Topic: complications of diabetes mellitus: expected manifestation of diabetic ketoacidosis

- DKA is when there is a lack of sufficient insulin related to underdiagnosed or untreated type 1 diabetes mellitus or nonadherence to a diabetic regimen
- Polyuria, polydipsia, and polyphagia are the golden standard for a patient having DKA
- They will also experience metabolic acidosis which is the breakdown of stored glucose, protein, and fat to produce ketone bodies

Subcategory: therapeutic procedures

Topic: gastrointestinal diagnostic procedures: identifying expected post-procedure findings

- The nurse can expect to see an increase in the patient aspartate aminotransferase and alanine aminotransferase lab values
- After a fecal occult blood test, the nurse can expect at least three repeats of a positive guaiac FOBT to conform GI bleeding
- After an endoscopy, the nurse can expect to monitor vital signs and assess for complications

Main Category: Physiological Adaptation

Subcategory: alterations in body systems

Topic: hemodialysis and peritoneal dialysis: intervening for decreased dialysate flow rate

- To monitor for complications during dialysis, dialysis circuit clotting, air bubbles in blood tubing, temp over 37.8C, and regulation of the ultrafiltration. Need to monitor for hypotension, cramping, vomiting, bleeding at the access site, contamination of equipment
- After procedure, the nurse should compare the client's preprocedure weight with the postprocedure weight as a way to estimate the amount of fluid
- Early recognition of disequilibrium syndrome is essential. Manifestations include nausea, vomiting, changes in level of consciousness, seizures, and agitation.

Topic: seizures and epilepsy: planning interventions for care

- The nurse needs to maintain an airway, provide oxygen, establish IV access, perform ECG monitoring, and monitor vital signs, pulse oximetry, and ABG results
- The nurse should also administer diazepam or lorazepam IV push followed by IV phenytoin or fosphenytoin.
- Ed the client to wear a medical identification tag at all times

Topic: skin disorders: identifying findings related to treatment of psoriasis

- When the pt is receiving corticosteroids, the nurse should observe for thinning, striae, or hypopigmentation with high-potency corticosteroids
- For pt ed, they need to understand to apply high-potency corticosteroids as prescribed to prevent adverse effects and take periodic medication vacations
- The provider can also recommend warm, moist, occlusive dressings of plastic wrap (gloves, plastic garments, booties) after applying the topical medication. These can be left in place up to 8 hr each day.

Topic: skin disorders: monitor wounds for signs and symptoms of infection

- Atopic dermatitis manifestations include chronic rash, development of thickened areas of skin along with scaling, pruritus (intense)
- When using topical immunosuppressants, the nurse needs to instruct the client on application of medication, monitor for erythema, burning sensation, and avoid the use of occlusive dressings.
- Before using these meds, the patient needs to be educated to avoid use if infection is present, discontinue use when rash clears, and avoid sunlight and the use of tanning beds.

Subcategory: fluid and electrolyte imbalances

Topic: fluid imbalances: planning care for a client who has dehydration

- Causes for fluid imbalances would be excessive GI loss, excessive skin oss, excessive renal system losses, third spacing burns, hemorrhage or plasma loss, and altered intake.
- The nurse needs to provide oral or IV rehydration therapy, monitor I&O, monitor VS, and monitor for changes in mentation and confusion, etc.
- For pt ed, the patient needs to drink plenty of liquids to promote hydration.

Subcategory: hemodynamics

Topic: cardiovascular diagnostic and therapeutic procedures: monitoring and maintaining an arterial line

- After the procedure, the nurse should obtain a chest x-ray to confirm catheter placement
- The nurse should also continually monitor respiratory and cardiac status (vital signs, heart rhythm, O2)
- The nurse should also observe the document waveforms. Report changes in waveforms to the provider, as this can indicate catheter migration or displacement.

Topic: hemodialysis and peritoneal dialysis: findings of dialysis disequilibrium

- The findings of this would be nausea, vomiting, and headache.
- advanced age is a risk factor for this and hypotension due to rapid changes in fluid and electrolyte status.
- The nurse should use a slow dialysis exchange rate, especially for older adult clients and first-time hemodialysis.

Topic: pacemakers and implantable cardioverter/defibrillators: intervention for third-degree heart block

- These are indicated for survivors of sudden cardiac death syndrome, risk for sudden cardiac death, and spontaneous or symptomatic ventricular dysrhythmias.
- Indications for a pacemaker are symptomatic bradycardia, complete heart block, sick sinus syndrome, sinus arrest, asystole, and atrial tachydysrhythmias.
- The nurse should ed the client on understanding the type of pacemaker or ICD that is to be inserted and information about the procedure.

Subcategory: illness management

Topic: acid-base imbalances: risk factors of respiratory alkalosis

- hyperventilation due to dear, anxiety, intracerebral trauma, salicylate toxicity, or excessive mechanical ventilation
- Hypoxemia from asphyxiation, high altitudes, shock, or early-stage asthma or pneumonia
- This can result in decreased O2 and decreased or normal H+ concentration.

Subcategory: pathophysiology

Topic: pituitary disorders: manifestations of syndrome of inappropriate antidiuretic hormone

- Expected findings would be severe headache, thick lips with coarse facial structures, joint pain, muscle weakness, enlarged hands and feet, hyperglycemia. lower jaw protrusion, and bulging of forehead.
- Risk factors include age (adulthood) and benign tumors (pituitary adenoma)
- A diagnostic procedure, such as x-ray, needs to be done to identify abnormalities of the sella turcica, the location of the pituitary gland within the skull.