

N321 Adult Health I  
Proctored ATI Remediation Template

Student Name: Nick Alford

Assessment Name: N321 Adult Health ATI Proctored Exam Remediation

Semester: Spring 2025

**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.

1. 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: Informed Consent**

**Topic: Legal Responsibilities: Action to Take When Witnessing Informed Consent**

- Consent is informed when a provider explains, and the client understands:
  - The reason the client needs the treatment/procedure.
  - How the treatment/procedure will benefit them.
  - The risks of the treatment/procedure.
  - Alternative options to treat the problem, including not treating the problem.
- The nurse's role is to provide the form, witness the clients signature, and give the provider the signed form.
- Nurses should confirm with the client that they understand the information and are competent to provide informed consent. Additionally, they should relay any questions the client has to the provider.

**Subcategory: Legal Rights and Responsibilities**

**Topic: Legal Responsibilities: Teaching About Examples of Negligence**

- Negligence is an unintentional tort and occurs when a nurse breaches duty by failing to follow established protocols/standards.
- It also includes malpractice, a form of professional negligence, such as omitting information or administering an incorrect medication dosage.
- Negligence generally results in harm to the patient, either physically, emotionally, or financially.

**Main Category: Safety and Infection Control**

**Subcategory: Accident/Error/Injury Prevention**

**Topic: Mobility and Immobility: Planning Care for a Client Who Has Hemiplegia**

- Clients with hemiplegia are by their nature a much higher fall risk due to their impairment. Home environments should be modified to accommodate for reduction of aspects potentiating a fall. Risk avoidance is likewise important in clinical settings as well. Keen awareness of trip points and keeping walkways wide and visible are key.
- In acute cases, clients should be regularly assisted to reposition for optimal comfort and to minimize onset of tone related contractures. They should also be aided for transfers and ambulation as needed, both for rehabilitative benefit, but to ensure dignity and motivation. This will also prevent potential skin breakdown from laying on regions of the body with impaired sensation or capacity to be

independently repositioned.

- Assistive devices provide patients with increased independence and safety when mobilizing. Therapy staff are able to provide appropriate devices based on the client's current level of function and prospective functional goals and size these devices to the client.

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

##### **Topic: Infection Control: Identifying When to Use a Face Shield for Performing Client Care**

- Masks, eye protection, and face shields are required when care might cause splashing or spraying of body fluids.
- Donning of a face shield should come toward the end of PPE donning, right before putting gloves on. They should be removed toward the end as well, with removal of face mask coming last right after.
- Facemasks that are to be reused routinely in each patient's room should be cleaned off with the appropriate disinfectant for the precautions/conditions involved whenever visibly soiled, and at least once a day.

##### **Topic: Infection Control: Teaching About Protective Environment**

- For immobile clients, pulmonary hygiene is important. Aspects of promoting this include regular turning, coughing, deep breathing, and use of incentive spirometry. These should be done every 2 hr, or as prescribed. This will reduce the potential growth of micro-organisms and the development of pneumonia by preventing stasis of pulmonary excretions, stimulating ciliary movement and clearance, and expanding the lungs.
- Negative pressure airflow exchange in the room of at least six to 12 exchanges per hour, depending on the age of the structure. These are for airborne respiratory illnesses.
- However, with immunocompromised patients they should be in a POSITIVE\* airflow room, with 12+ air exchanges per hour and HEPA filtration for incoming air.

#### **Subcategory: Home Safety**

##### **Topic: Home Safety: Teaching a Client About Fire Safety at Home**

- Houses should have an appropriate number and placement of fire extinguishers and smoke alarms, that are functional, for their given size. Family members should understand how to operate them. With older models of smoke detectors utilizing household batteries that must be swapped out, these should be changed approx. every 6 months.
- Clients on home oxygen should avoid smoking in the home. Keep devices away from open flames. Store tanks according to manufacturer's recommendations. Replace bedding with cotton options as other textiles may generate static electricity potentiating ignition of oxygen. Keep electrical equipment in good repair and grounded.
- Have an emergency action plan with your family for what to do in the event of a home fire. Likewise, know your workplace's emergency action plans, fire related or otherwise.

### **Main Category: Health Promotion and Maintenance**

#### **Subcategory: Health Promotion/Disease Prevention**

##### **Topic: Urinary Elimination: Effects of Aging on Urinary Infections**

- Older adult clients suffer a range of age-related urological deteriorations, many of which potentiate an increased risk for UTIs: Fewer nephrons, loss of bladder muscle tone, increased frequency, inefficient bladder emptying, increased nocturia, decreased bladder capacity.
- Older adults often have poorer fluid intake due to some of these issues as well, hoping to counteract urgency or nocturia, but cause an increased potential for a UTI to occur in doing so.
- As we age our immune system becomes less potent in its level of response to infectious vectors. As a result, symptoms associated with a UTI can change as the inflammatory response is less pronounced. As a result, older adults are less aware of the presence/onset of a UTI, and the infection may progress further before detection, potentially resulting in confusion/delirium states.

#### **Subcategory: Health Screening**

##### **Topic: Data Collection and General Survey: Completing a Client Health History**

- A thorough health history includes many demographic related items, including: name, address, contact info (including emergency contacts), birth date & age, gender at birth & gender identity/pronouns, race & ethnicity, relationship status, occupation & employment status, insurance, family/others living in home, social elements, and any advanced directives that exist.
- It will also include the history of present illness, and all medical history prior. This includes hospitalizations, immunizations/vaccinations, surgeries, etc. As well as relevant familial health considerations that influence the client's health or health risks.
- When performing a health history, the client may also be educated on health promotion strategies and preventative measures. This may also include a review of systems where the client is assessed physically.

### **Main Category: Basic Care and Comfort**

#### **Subcategory: Elimination**

##### **Topic: Urinary Elimination: Techniques for Promoting Urination**

- Clients should adequately hydrate, averaging 2L of intake a day, predominately water, and demonstrate a relatively similar (but smaller) amount of output. Output should be clear to yellow and relatively odorless. This value can be higher if there is significant exertion or high environmental temperatures involved. Pregnant or ill patients will also require an increase in baseline levels of hydration.
- High sodium diets will lead to a decrease in urinary output due to fluid retention, as will antihistamines and anticholinergics. Inversely, caffeine and alcohol can act in a similar fashion to antihypertensives and diuretic medications and increase urinary output.
- For clients with mobility issues, adaptive equipment should be brought to bear to ensure the client maintains regular voiding. This can be bedside commodes or use of a urinal.

#### **Subcategory: Personal Hygiene**

##### **Topic: Older Adults (65 Years and Older): Planning Care for a Client Who Has Dementia**

- Clients with dementia have reduced overall balance, spatial awareness deficits, decreased reaction times, and poorer night vision. For these reasons, keeping a source of light in a client's room at night can prevent a fall.
- Dementia clients may not adequately attend to their fluid and meal intake on their own or have difficulty doing so. Make sure clients are making it to their dining halls or having trays delivered. Check to make sure they have consumed said meal. Offer snacks as needed throughout the day. Assist them to eat if needed, and ensure they have what they need to do so – like having glasses and dentures donned.
- Similarly to this, self-care may also be lacking in clients with dementia. Make sure clients are able to attend to their ADL's and provide assistance where necessary.

### **Main Category: Pharmacological and Parenteral Therapies**

#### **Subcategory: Medication Administration**

##### **Topic: Blood and Blood Product Transfusions: Administering a Blood Transfusion Via IV Access**

- Plasma provided by IV must be thawed from its frozen storage state before administering and should be administered immediately after thawing is complete.
- Nurses should remain with clients during the first 15-30 min of a transfusion and monitor vitals to ensure that there are no severe reactions occur to the transfusion.
- Large-bore IV access is required for blood products, usually utilizing 18-gauge or 20-gauge diameters. Blood transfusions are among the IV products that require x2 nurses to confirm before administration.

### **Main Category: Reduction of Risk Potential**

#### **Subcategory: Potential for Complications of Diagnostic Tests/Treatments/Procedure**

**Topic:** Intravenous Therapy: Actions To Take for Fluid Overload

- To minimize the potential for fluid overload the nurse should use an IV pump, and it is generally advised to never go above a rate of 125 mL/hour for most applications, unless there is a special case. Likewise, monitor all I&O if there is a concern for potential fluid overload.
- Treatment of a fluid overload may start with the notification of the provider, followed by decreasing the IV rate, raising the head of the bed, and administering diuretics.
- Closely monitor vitals and auscultate heart and lung sounds to observe for pulmonary or cardiac effects of fluid overload.

**Subcategory:** System-Specific Assessments

**Topic:** Head and Neck: Assessment of the Thyroid Gland

- Abnormal thyroid findings during a physical assessment include: a palpable and/or visible mass, limited range of motion of the neck, and enlarged lymph nodes.
- The client should hyperextend the neck to make the skin taut and aid in detection of the thyroid and any potential abnormalities. If a bruit is auscultated on the thyroid, it could be suggestive of hyperthyroidism.
- The client can all take sips of water while the thyroid is palpable so the nurse can confirm that the thyroid moves normally with the trachea during this.

**Subcategory:** Therapeutic Procedures

**Topic:** Chronic Obstructive Pulmonary Disease: Preoperative Teaching About Using an Incentive Spirometer

- Clients should be encouraged to use incentive spirometry, particularly after operations or respiratory illness. It should be performed sitting up and is recommended to be used ten consecutive times every hour on the hour. Clients should be instructed to breathe in for several seconds through the device and then hold for several seconds with each inhale.
- Clients will often need repeat reminders, frequently attempting to blow into the device as opposed to sucking air in through it to expand the lungs.
- Education should be provided as to the benefits it supports – such as aiding in the elimination of remnant congestive material in the lungs from anesthetics, stretching the lung fields out to improve capacity, and reinflating collapsed alveoli responsible for absorbing oxygen. All this largely in an effort to prevent pneumonia.

## Main Category: Physiological Adaptation

### Subcategory: Alterations in Body Systems

#### Topic: Airway Management: Nasotracheal Suctioning Technique

- It is necessary to maintain surgical asepsis when performing any form of tracheal suctioning to avoid bacterial contamination of the airway. Medical asepsis can be practiced for oral suctioning, however.
- Limit individual suction attempts to 10-15 seconds apiece to avoid hypoxemia or vagal response. Repeat if needed. Limit total suctioning time to 5 min.
- Suction should be off while the catheter is being inserted, advance 6-8", and apply intermittent suction by using your thumb to cover the suction port. Rotate and withdraw during suction to prevent "grabbing" tissue. No more than 2 passes per suction event and allow 1 min to pass between them for ventilation.

## Main Category: Clinical Judgement

### Subcategory: Analyze Cues

#### Topic: Postoperative Nursing Care: Caring for a Client Who is Postoperative

- Patients who are postoperative potentiate a number of considerable risks, including: infection, bleeding, pneumonia, thromboembolic events, vomiting, hypovolemia, and respiratory compromise.
- Clients in a PACU may need warming blankets and fluids to prevent hypothermia, as well as supplemental oxygen to support O<sub>2</sub> values.
- Maintain side lying positions in clients who have not yet woken from procedures to reduce risks of aspiration and reposition to supine with a semi-fowler's elevator to the bed once they begin to respond to verbal stimuli. Patients can be placed in reverse Trendelenburg if experiencing hypotensive episodes or hypovolemic shock.

### Subcategory: Take Actions

#### Topic: Fluid Imbalances: Nursing Actions for a Client Who Reports Abdominal Pain

- Perform abdominal assessment in the following procession: inspection, auscultation, percussion, and palpation.
- Observe for abdominal distention. Listen for bowel sound activity. Note any tenderness or guarding by the patient and the location where it occurred.
- Ascites is an excess of fluid accumulation within the peritoneal cavity that expands the abdominal wall and places surrounding structures under significant pressure. This can contribute to peritonitis, where the cavity becomes inflamed and results in abdominal pain.

### Subcategory: Recognize Cues

#### Topic: Airway Management: Priority Concerns for a Postoperative Client

- Maintain continuous monitoring of blood oxygen saturation levels and respond accordingly.
- Place clients on an appropriate supplemental O<sub>2</sub> device and titrate supplemental oxygen to an adequate level to support these values in a health range of the mid to high 90's%
- Be aware of the client's lip color, reported dyspnea, visible work of breathing, and respiratory rate & rhythm. As well as their level of consciousness, positioning, presence of coughing, any productivity with a cough, and auscultate breathing sounds.

#### Topic: Client Safety: Recognizing Risk Factors for an Older Adult Client

- Due to age and health related impacts in the older adult client, they will be at a higher risk level for a fall due to decreased strength and balance, slower reaction times, mobility deficits, use of mobility aids, and poorer spatial and proprioceptive awareness.
- For similar reasons, these clients may be at a higher risk for pressure related ulcers due to a decreased capacity to independently reposition. Clients who are incontinent as well possess a very high potential to develop pressure sores from the added impact of skin-damaging bodily waste pressing into these pressurized regions of the body.
- In client rooms – floors should be clear of clutter, without throw rugs, and possess night lighting in key locations. Bed wheels, wheelchairs, and carts should be locked by default. For clients who are

sedated, unconscious, or otherwise compromised, all bed rails should be up and the bed in the lowest position.

**Subcategory: Evaluate Outcomes**

**Topic: Pain Management: Evaluating Client Response to Morphine**

- Pain is subjective and the most reliable way to evaluate pain control efficacy is through the clients' own reports.
- Nonverbal cues can include facial expressions, moaning, guarding, and withdrawal. Heart and respirations rates may be elevated in clients with pain, and they may demonstrate increased anxiety and agitation.
- When assessing a client's pain, it is important to acquire information regarding its location, onset, qualities, severity, duration and frequency, as well as aggravating and alleviating factors. OLDCART it!