

N323 Mental Health
Proctored ATI Remediation Template

Student Name: Ngoc Trinh
Assessment Name: Mental Health
Semester: Fall 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 Sick 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.
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: Assignment, Delegation and Supervision

Topic: Delegation and Supervision: Delegating to Assistive Personnel

- The nurse should delegate only tasks that are within the assistive personnel’s scope of practice, such as bathing, ambulating, vital signs, and basic hygiene care.
- The nurse must provide clear instructions about the task, expected outcomes, and when to report changes or concerns back to the nurse.
- The nurse remains responsible for evaluating the client’s response to the delegated task and must follow up to ensure it was completed safely and correctly.

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Main Category: Safety and Infection Control

Subcategory: Accident/Error/Injury Prevention

Topic: Neurocognitive Disorders: Identifying Clients at Greatest Risk of Accident and Injury

- Clients with neurocognitive disorders are at high risk for accidents because confusion and poor judgment make it difficult for them to recognize danger.
- Clients who wander, forget instructions, or have impaired memory are especially vulnerable to falls, medication errors, and getting lost.
- Clients who experience agitation or altered perception may accidentally harm themselves, so they require close supervision and a safe, clutter-free environment.

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Subcategory: Security Plan

Topic: Crisis and Anger Management: Prioritizing Nursing Actions for a Client Who Is Becoming Increasingly Angry

- The nurse should remain calm, use a non-threatening posture, and speak in a soft, clear voice to help de-escalate the client's anger.
- The nurse should ensure safety by removing other clients from the area, keeping a safe distance, and identifying exits and staff who can help if needed.
- The nurse should set clear, respectful limits about acceptable behavior and offer choices, such as taking a walk or moving to a quieter room, to help the client regain control.

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Main Category: Health Promotion and Maintenance

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Main Category: Psychosocial Integrity

Subcategory: Abuse or Neglect

Topic: Family and Community Violence: Identifying Risk Factors for Child Maltreatment

- Children are at higher risk for maltreatment when caregivers have high stress levels, poor coping skills, or a history of being abused themselves.
- Families with limited financial resources, social isolation, or unstable living conditions have an increased risk of child neglect.
- Children with disabilities, chronic illness, or behavioral challenges are more vulnerable because caregivers may feel overwhelmed or frustrated.

Topic: Family and Community Violence: Priority Intervention for a Client Experiencing Intimate Partner Violence

- The nurse's priority is to ensure the client's immediate safety by assessing for life-threatening injuries and determining if they are in immediate danger.
- The nurse should validate the client's feelings, listen without judgment, and provide emotional support to reduce fear and shame.
- The nurse should help the client develop a personalized safety plan and offer resources such as shelters, hotlines, and legal support, without pressuring the client to leave the relationship.

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Subcategory: Family Dynamics

Topic: Group and Family Therapy: Identifying Characteristics of a Family Who Has Rigid Boundaries

- A family with rigid boundaries does not easily allow others to share thoughts or feelings, and communication is often closed or limited.
- Family members may follow strict rules and roles, with little flexibility or change allowed.
- These families often discourage outside relationships or help, which can lead to isolation and poor coping when stress occurs.

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Subcategory: Mental Health Concepts

Topic: Anxiety Disorders: Expected Findings of Posttraumatic Stress Disorder

- A client with PTSD may re-experience the trauma through nightmares, flashbacks, or intrusive memories.
- The client often avoids places, people, or situations that remind them of the event and may feel emotionally numb or detached.
- The client may be easily startled, have trouble sleeping, feel irritable, and show signs of hypervigilance or always "being on guard."

Topic: Care of Clients Who are Dying and/or Grieving: Supporting a Client Who Is Experiencing Anticipatory Grief

- The nurse should encourage the client to talk about their feelings, fears, and hopes as they begin to grieve before the loss occurs.
- The nurse should validate the client's emotions and reassure them that sadness, anger, or guilt are normal responses.
- The nurse should offer spiritual care, counseling, or support group referrals and involve family or

significant others if the client desires.

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Subcategory: Therapeutic Communication

Topic: Eating Disorders: Communicating With a Client Who Has Anorexia Nervosa

- The nurse should use a calm, nonjudgmental tone and focus on the client's feelings rather than arguing about food or weight.
- The nurse should avoid comments about appearance and instead emphasize health, safety, and how the client is coping.
- The nurse should build trust by being consistent, setting clear but supportive limits, and involving the client in treatment decisions as much as possible.

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Main Category: Basic Care and Comfort

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Main Category: Pharmacological and Parenteral Therapies

Subcategory: Adverse Effects/Contraindications/Side Effects/Interactions

Topic: Psychotic Disorders: Identifying an Adverse Effect of Clozapine

- Clozapine can cause agranulocytosis, a dangerous drop in white blood cells that greatly increases the risk for infection.
- The nurse must monitor the client's WBC and ANC regularly and hold the medication if counts are too low.
- The client should report signs of infection such as fever, sore throat, or flu-like symptoms immediately because they may indicate agranulocytosis.

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Main Category: Reduction of Risk Potential

Subcategory: Changes/Abnormalities in Vital Signs

Topic: Vital Signs: Factors Influencing False Blood Pressure Readings

- Using the wrong cuff size, such as a cuff that is too small or too large, can cause blood pressure readings to be falsely high or low.
- Taking blood pressure with the arm unsupported, hanging down, or above heart level can give an inaccurate reading
- Talking, moving, crossing legs, or not resting for a few minutes before the measurement can also lead to false blood pressure readings.

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Main Category: Physiological Adaptation

Subcategory: Recognize Cues

Topic: Substance Use and Addictive Disorders: Caring for a Client Who Is Experiencing Intoxication

- The nurse should first assess airway, breathing, circulation, level of consciousness, and vital signs to detect life-threatening effects of intoxication.
- The nurse should maintain client safety by preventing falls, reducing environmental stimuli, and using close observation or a sitter if needed
- The nurse should monitor for complications such as respiratory depression, aspiration, or risk of withdrawal and notify the provider of any worsening status.

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Subcategory: Analyze Cues

Topic: Depressive Disorders: Caring for a Client Who Has Depression

- The nurse should assess for changes in sleep, appetite, energy level, and daily functioning to determine the severity of depression.
- The nurse should watch for suicidal thoughts, self-harm behaviors, or sudden mood improvement that may signal increased suicide risk.
- The nurse should observe how the client responds to treatment and note any worsening symptoms, withdrawal, or lack of engagement.

Topic: Personality Disorders: Identifying Manifestations

- Clients may show patterns of unstable relationships, intense emotions, or difficulty controlling impulses depending on the type of personality disorder.
- Some clients may display manipulative behaviors, rigid thinking, or extreme sensitivity to criticism.
- The nurse should note behaviors that disrupt functioning, such as self-harm, aggression, or poor coping during stress.

Topic: Psychotic Disorders: Contraindications for Medication Administration

- The nurse should avoid giving antipsychotics if the client has a history of severe medication reactions such as neuroleptic malignant syndrome.
- Antipsychotics may be contraindicated for clients with certain cardiac conditions, such as prolonged QT interval.
- The nurse must check for drug interactions and avoid giving antipsychotics when the client is severely intoxicated or medically unstable.

Topic: Substance Use and Addictive Disorders: Identifying Manifestations of Intoxication

- Intoxication may cause slurred speech, impaired coordination, confusion, or slowed reaction time.
- The nurse should watch for vital sign changes such as low blood pressure, slow respirations, or altered level of consciousness.
- Behavioral signs may include mood swings, poor judgment, aggression, or sedation.

Topic: Suicide: Identifying Verbal and Nonverbal Behavioral Cues

- Verbal cues include statements about hopelessness, wanting to die, or being a burden.
- Nonverbal cues include withdrawing from others, giving away belongings, or sudden calmness after deep depression.
- The nurse should recognize high-risk behaviors such as researching methods, writing goodbye notes, or putting affairs in order.

Subcategory: Prioritize Hypotheses

Topic: Substance Use and Addictive Disorders: Manifestations of Opioid and Stimulant Withdrawal

- Opioid withdrawal commonly causes nausea, vomiting, sweating, muscle aches, diarrhea, anxiety, and yawning, but it is not usually life-threatening.
- Stimulant withdrawal often presents with fatigue, depression, increased sleep, irritability, and strong cravings for the drug.
- The nurse should prioritize safety by assessing for severe depression or suicidal thoughts during stimulant withdrawal and monitoring fluid status and comfort during opioid withdrawal.

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Subcategory: Generate Solutions

Topic: Substance Use and Addictive Disorders: Caring for a Client Who Is Experiencing Manifestations of Withdrawal

- The nurse should provide a quiet, low-stimulus environment and offer reassurance to help reduce anxiety and agitation during withdrawal.
- The nurse should administer prescribed medications—such as methadone for opioid withdrawal or benzodiazepines for alcohol withdrawal—to ease symptoms and prevent complications.
- The nurse should monitor vital signs, hydration status, and mental status closely to detect worsening withdrawal or the need for emergency intervention.

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Subcategory: Take Actions

Topic: Psychotic Disorders: Caring for a Client Who Is Hearing Voices

- The nurse should acknowledge the client's experience without agreeing with the voices, such as saying, "I understand you are hearing something, but I do not hear it."
- The nurse should help the client feel safe by staying with them, reducing environmental stimuli, and using a calm, supportive tone.
- The nurse should encourage coping strategies—like listening to music, deep breathing, or engaging in activities—and administer prescribed antipsychotic medication as ordered.

Topic: Substance Use and Addictive Disorders: Caring for a Client Who Has a substance use disorder

- The nurse should use a nonjudgmental, empathetic approach to build trust and encourage honest communication about substance use.
- The nurse should assess the client for withdrawal symptoms, medical complications, and co-occurring mental health concerns.
- The nurse should collaborate with the healthcare team to provide treatment options such as detox services, counseling, medication-assisted therapy, and relapse-prevention resources.

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Subcategory: Evaluate Outcomes

Topic: Substance Use and Addictive Disorders: Evaluating a Client's Progress

- The nurse should evaluate progress by noting decreased substance use, fewer cravings, and improved ability to cope without drugs or alcohol
- The nurse should assess whether the client is attending therapy, support groups, or treatment programs consistently.
- The nurse should look for improvements in mood, relationships, work or school performance, and overall health as signs of positive progress.

Topic: Trauma- and Stressor-related Disorders: Providing Care for a Client Who Has Posttraumatic Stress Disorder

- The nurse should create a safe, calm environment and avoid sudden movements or triggers that may remind the client of the trauma.
- The nurse should encourage the client to use grounding techniques, relaxation exercises, and coping skills to manage flashbacks and anxiety.
- The nurse should support adherence to therapy and medications, and monitor for worsening symptoms such as severe anxiety, depression, or suicidal thoughts.

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