**“3 Critical Concepts - Remediation Document”**

Upon completion of the required Practice Assessment, conduct a focused review, by downloading the “**ATI Individual Performance Profile”** Report. Complete **the “3 Critical Concepts – Remediation Document” by using each NCLEX Client Need Category, listed under the “Topics to Review Section” in the report to identify 3 Critical Concepts learned and or understand better about the missed concept.** Use reliable evidence-based resources to remediate each topic (ATI Focused Review, ATI eBook, Course textbook per Syllabus). Cite your sources (APA formatting not required).

**8 NCLEX Client Need Categories**

1) Management of Care, 2) Safety and Infection Control, 3) Basic Care and comfort, 4) Health Promotion and Maintenance, 5) Psychosocial Integrity, 6) Pharmacological and Parenteral Therapies, 7) Reduction of Risk Potential, and 8) Physiological Adaptation

**Reflection Section – Include one of the 6 Cognitive Functions listed below**

*Reflect on how the 3 critical concepts you learned, helped you gain a better understanding of the* ***6 Cognitive Functions of the National Council for State Boards of Nursing (NCSBN) - Clinical Judgement Measurement Model (NCJMM) - which follows the Nursing Process:***

* + ***Recognize Cues* (Assessment)** - Filter information from different sources (i.e., signs, symptoms, health history, environment).
	+ **Analyze Cues (Analysis)** - Link recognized cues to a client’s clinical presentation and establishing probable client needs, concerns, or problems.
	+ **Prioritize Hypotheses (Analysis)** - Establish priorities of care based on the client’s health problems (i.e. environmental factors, risk assessment, urgency, signs/ symptoms, diagnostic test, lab values, etc.)
	+ **Generate Solutions (Planning)** - Identify expected outcomes and related nursing interventions to ensure clients’ needs are met.
	+ **Take Actions (Implementation)** - Implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client’s health.
	+ **Evaluate Outcomes (Evaluation)** - Evaluate a client’s response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met.

**Topics To Review**

Management of Care (1 item)
**Collaboration with Interdisciplinary Team (1 item)**
Priority Findings to Report to the Provider

Safety and Infection Control (1 item)
**Use of Restraints/Safety Devices (1 item)**Caring for a Client Who Is in Restraints

Psychosocial Integrity (6 items)
**Mental Health Concepts (5 items)**Distinguishing Between Therapies for Dementia, Obsessive Compulsive Disorder, and Borderline Personality Disorder
Identifying Findings That Indicate an Improvement in a Client Who Has Anorexia Nervosa
Identifying Risk Factors of Delirium
Interventions for a Client Who Is Aggressive
Nursing Actions for a Client Who Is Experiencing Delirium
**Behavioral Interventions (1 item)**Evaluating Responses of Client Who Is in Seclusion and Restraints

Reduction of Risk Potential (2 items)
**Changes/Abnormalities in Vital Signs (1 item)**Identifying Potential Prescriptions from the Provider for a Client Who Has Delirium

**Potential for Complications of Diagnostic Tests/Treatments/Procedures (1 Item)**Evaluating a Client's Condition

**Pharmacological and Parenteral Therapies (1 Item)**Expected Actions/Outcomes **(1 item)**

Medications for Depressive Disorders: Expected Outcomes of Amitriptyline

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| **Date** | **12/2/2022** |
| **Student Name** | **Diamond JewelStar** |
| **Instructor Name** | **Dr. Candace James-Marrast** |
| **Assessment Name** | **RN Mental Health Online Practice Assessment 2019 B with NGN** |
| **# of Topics to Review** | **11** |  |  |
| **NCLEX Client Need Category**  |
| **Management of Care (1 item)** |
| **Topic** | **Concept** | **3 Critical Concepts (I learned, and/or understand better about this topic)** | **Reflection – Address 1 of the 6 Cognitive Functions** |
| **Collaboration with Interdisciplinary Team** **(1 item)** | **Priority Findings to Report to the Provider** | 1. The importance of ensuring the client has adequate fluid intake because delirium can result in electrolyte imbalance
2. Monitor vital signs is a key component of nursing care because - tachycardia, elevated b/p, sweating, dilated pupils, can be associated with delirium. These are findings I will need to report to the provider
3. Perceptual disturbances can be present, such as hallucination and illusion for a client with delirium.
 | **Take Actions (Implementation)**I need to make sure to identify the priority findings and required findings to report to the provider. I need more practice on identifying the priority. I also need to make sure that I practice knowing which client is priority by using Acute vs Chronic, Urgent vs Nonurgent, and Stable vs Unstable patients. Professor I can improve by reviewing the nurse logic priority setting framework.  |
| **Safety and Infection Control (1 item)** |
| **Topic** | **Concept** | **3 Critical Concepts (I learned, and/or understand better about this topic)** | **Reflection – Address 1 of the 6 Cognitive Functions** |
| **Use of Restraints/ Safety Devices** **(1 item)** | **Caring for client who is in restraints** | 1. Clients with restraints need frequent assessments.
2. The importance of discussing ways for clients to keep control during the aggression cycle.
3. Encouraging the client to talk about the incident, what triggered and escalated the aggression from the client’s perspective.

• Conduct on going evaluation of theClient.• Determine the need for restraints.• Check facility protocol when times for application of restraints. | **Take Actions (Implementation)** I need to remember that clients with restraints need ongoing evaluations. (Every 15 minutes – not 30 minutes until the restraints are no longer necessary). Professor, I will review the nursing care for clients with restraints.I need to properly read the question becauseI remembered after clicking the continuethat you assess every hour and notefindings. I will include more test takingquestions to build my understanding |
| **Psychosocial Integrity (6 items)** |
| **Topic** | **Concept** | **3 Critical Concepts (I learned, and/or understand better about this topic)** | **Reflection – Address 1 of the 6 Cognitive Functions** |
| **Mental Health Concepts (5 items)** | **Distinguishing Between Therapies for Dementia, Obsessive Compulsive Disorder, and Borderline Personality Disorder**  | 1. Dialectical behavior therapy is for clients who have a personality disorder who exhibits self-harm behavior. Systematic desensitization is for clients with OCD. Fluoxetine can be used for both OCD and borderline personality disorder.
2. SSRIs can be used for MDD, OCD, Bulimia Nervosa, PDD, Panic disorders, PTSD, social anxiety disorder, GAD, and bipolar disorder.
3. Validation Therapy is used for clients with dementia

• It is important to identify the systemicdesterilization• Another Important one is dialectalbehaviors because it focuses ongradual changes• It is important to use validation therapy | **Recognize Cues (Assessment)**I mixed up which disorder isused for each therapy. I will need to review the psychotherapyand the various therapies for each intended disorder. I will also need to practice more questions on these topics.Distinguishing different disorders is not my topic so I will continue doing practice questions and flash cards to properly distinguish disorders. |
|  | **Identifying Findings That Indicate an Improvement in a Client Who Has Anorexia Nervosa**  | 1. Anorexia Nervosa will have electrolyte imbalance, including hypokalemia, Hyponatremia, Hypochloremia hypomagnesemia, hypophosphatemia, decreased estrogen, and decreased testosterone.
2. Clients who have anorexia nervosa have a body weight that is less than 85%. of the expected normal weight.
3. Decrease pulse and temperature
 | **Analyze Cues (Analysis)** I need to make sure to read theexhibit data more closely. Ithought because the glucose levelwas less than the initial readingIt was included, but because it wasstill within normal limits.Looking back at the question I thought Itwas referring to the key things that showanorexia is not improving. I will review my assessment skills. |
|  | **Identifying Risk Factors of Delirium** | 1. Risk factors for delirium Include physiological changes- neurologic (Parkinson + Huntington disease)-metabolic, cardiovascular, and respiratorydisease2. Infections such as HIV/ADs, surgery, and substance use or withdrawal can also put the client at risk for Delirium.3. Other risk factors are older age, multiple comorbidities, the severity of disease, polypharmacy, and the client’s environment**.** | **Recognize Cues (Assessment)**I will review my assessment skills to identify the factors that contributed to the client’s diagnosis and to properly assure my client receives all the help they need in order to get all the help.The reason why I got this wrong wasbecause I did not know all the factors. |
|  | **Interventions for a Client Who Is Aggressive** | 1. I learned that when the patient is

showing aggression can go throughare positive inotropic andchronotropic.2. The reactions client can experience with receiving second line medication3. Communication with clients calmly and direct instructions on what they must do in a particular situation. | **Take Actions (Implementation)** When administering second line medications, it is important to note the client’s reaction such as (aFIB), Low HR & and Myocardialinfraction. I did not know this before and I will review my nursing care for clients with aggression. |
|  | **Nursing Actions for a Client****Who Is Experiencing****Delirium** | 1. I learned to approach slowly and fromthe front.1. I also learned ways to promote sleep

for the client1. As well as providing a low-level

stimuli room for the client | **Take Actions (Implementation)** I misread the question. I thought the question was asking for ways to promote sleep, not actions to implement for a client with delirium. I will review the management of care for a client with delirium. |
| **Behavioral Interventions (1 item)**  | **Evaluating Responses of Client Who Is in Seclusion and Restraints**  | 1. Restraints or seclusion must be discontinued when the client in exhibiting behavior that is safer and quieter.2. Regularly determine the need to continue using the restraints.3. Remove the restraints when the client is feeling better but assess the client prior to removal.4. The importance of documenting at all phases of the episode. The reason for restraints, less restrictive methods used and the outcome, when the client was placed, time the provider written by the provider, any medications prescribed, the client’s response to the treatment provider.  | **Evaluate Outcomes (Evaluation)** I realize I did not remember a lot about restraints/seclusion and the client’s expected behavior. I will review this topic in my ATI and textbook.  |
| **Reduction of Risk Potential (2 item)** |
| **Topic** | **Concept** | **3 Critical Concepts (I learned, and/or understand better about this topic)** | **Reflection – Address 1 of the 6 Cognitive Functions** |
| **Changes/Abnormalities in Vital Signs** **(1 item)**  | **Identifying Potential Prescriptions from the Provider for a Client Who Has Delirium**  | 1. Consult the provider about trying sleep-promoting OTC products (melatonin, valerian,chamomile).2. Urine analysis and culture and sensitivity can indicate bacteria and sediment. WBC + RBC, and positive leukocyte esteraseand nitrates (68% to 88%. Positive results indicate UTI.)3. Ensure adequate food and fluid Intake. The underlying cause of delirium can result in electrolyte Imbalance. | **Generating solution**Collaborating with the provider to promote sleep is pertinent for clients with delirium to prevent risk reduction. Also, have to recognize that electrolyte imbalance puts theclient at risk for delirium. |
| **Potential for Complications of Diagnostic Tests/Treatments/Procedures (1 item)**  | **Evaluating a Client's Condition**  | 1. 4 types of delirium* Hyperactive with agitation and restlessness.
* Hypoactive Empathy and quietness
* Mixed, having a combination of hyper and hypo manifestation.
* Unclassified for those whose manifestations do not classify into the other categories

2. Level of consciousness is usually altered and can rapidly fluctuate.3. Restless, anxiety, motor agitation, and fluctuating moods are common. Personality change is rapid. | **Prioritize Hypothesis**I did not fully know all this topic and the information need to answer this question. I know I must review this topic particularly the complications the client can experience based on the types of tests prescribed by the provider. I also need to practice my assessment skills so I can recognize the manifestation of delirium and differentiate itfrom manifestation of neurocognitive disorders. |
| **Pharmacological and Parenteral Therapies (1 items)** |
| **Topic** | **Concept** | **3 Critical Concepts (I learned, and/or understand better about this topic)** | **Reflection – Address 1 of the 6 Cognitive Functions** |
| **Expected Actions/Outcomes (1 item)** | **Medications for Depressive Disorders: Expected Outcomes of Amitriptyline** | 1. Antidepressants can increase the risk ofsuicide.2. Antidepressant-induced suicide is mainlyassociated with clients under the age of 25.3. Suicide prevention is facilitated byprescribing only 1 week of medication foracutely ill client. | **Evaluate Outcomes (Evaluation)**Antidepressants have many associated risks and I need to become familiar with these risks to better my nursing judgment. |

**References:**

Halter, M. J. (2022). Varcarolis' Foundations of Psychiatric Mental Health Nursing9th ed. Publisher: Saunders/Elsevier. St. Louis, Missouri.

ATI Content Mastery Series Review Module: RN Mental Health 11.0 ed.