Student Name: TYLER EDDY

Medical Diagnosis/Disease: SCHIZOPHRENIA

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation **NCLEX IV *(7)*: Reduction of Risk**

Anatomy and Physiology Normal Structures

Hypothalamus: regulates autonomic nervous system. (fight vs flight) vs (Rest vs digest). Also associated with hunger, sleep, sex.
Thalamus: Sensory relay system. Hear/taste/touch come through nerves to thalamus where they are processes and relayed.
Amygdala: aggression center. Stimulating can evoke feelings such as anger/ violence, fear/anxiety.
Hippocampus: Damage to this area causes those to not be able to make memory. Making new memories and putting them into LTM. Studies show underdeveloped in people with Schizophrenia.
The limbic system: Emotional brain (emotion and memory). Includes the Hippocampus, Amygdala, Thalamus, & Hypothalamus.

Pathophysiology of Disease

Schizophrenia term- greek word "skhizo" meaning split + greek word "phren" meaning mind
Leads to disturbances in thought process, perception, and affect which can severely affect daily functioning
DSM-5 criteria: Two or more of the following present more times than not: delusions, hallucinations, disorganized speech, disorganized or catatonic behaviors, & negative symptoms. Continuous signs of disturbances for at least 6 months
Unknown cause, disease results from a combination of influences, including biological, psychological, and environmental factors.
4 Phases: Premorbid, Prodromal, Active Psychotic, and Residual phases.
No single treatment or cure, effective tx requires a multidisciplinary effort, including pharmacotherapy and various forms of psychosocial care, such as living and social training skills. Family therapy also important

Anticipated Diagnostics Labs:

n/a

Additional Diagnostics

DSM-5 criteria for diagnosis (under patho)

NCLEX II *(3)*: Health Promotion and Maintenance **NCLEX IV *(7)*: Reduction of Risk**

Contributing Risk Factors

Family hx
Childhood trauma
Childhood neglect
Viral infection
Head trauma in childhood
Anatomical abnormalities
Excess of dopamine activity in the brain
Increased C4 activity
-Prolonged synaptic pruning
Psychotropic drugs

Signs and Symptoms

Positive symptoms include: Delusions (fixed, false beliefs), Hallucinations (sensory perceptions without external stimuli), Disorganized thinking/speech, disorganized or abnormal motor behavior, etc

Negative symptoms include: Lack of emotional expression, decreased or lack of motivation to complete activities, decreased verbal communication, decreased interest in social interaction and relationships, and diminished ability of abstract thinking.

Possible Therapeutic Procedures

Non-surgical

Possible ECT

Surgical

N/A

Prevention of Complications

(What are some potential complications associated with this disease process)

Suicide (big risk)
Depression
Anxiety
Substance abuse
Social isolation (no close relationships/ inability to trust/ inability to work)
Aggressive behaviors due to fear

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies **NCLEX IV *(5)*: Basic Care and Comfort** **NCLEX III *(4)*: Psychosocial/Holistic Care Needs**

Anticipated Medication Management

Antipsychotic medications: alleviate symptoms of schizophrenia but cannot cure underlying psychotic processes.

Conventional (First Generation) Antipsychotics:
-ex: Trifluoperazine, Thiothixene (Navane) , Fluphenazine (Prolixin) , Haloperidol (Haldol) , Pimozide (Orap), Chlorpromazine (thorazine), Thioridazine (Mellaril)

Atypical (2nd Generation) Antipsychotics:
-ex: Olanzapine (Zyprexa), Quetiapine (Seroquel), Ziprasidone (Geodon), Aripiprazole (Abilify), Risperidone (Risperdal), Lurasidone (Latuda), Clozapine (Clozaril)

Non-Pharmacologic Care Measures

Stay with patient during hallucinations/delusions
Build trust (same assigned staff)
Safe, comfortable, and calm environment
Support
Family involvement
Milieu therapy
Psychosocial therapy, behavioral therapy, individual psychotherapy, community resources
Recovery model

What stressors might a patient with this diagnosis be experiencing?

Hospitalization
Cost of hospitalization/treatment
Medication costs
Loss of self
Lonely- no close relationships
Anxiety
Trying to distinguish what is real vs not real

Client/Family Education **NCLEX I *(1)*: Safe and Effective Care Environment**

List 3 potential teaching topics/areas

- Medication compliance
- Identifying Triggers
- Medication side effects (EPS symptoms for first generation) (Metabolic 2nd)

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

Therapist (Individual and family)
PCP
Psychiatrist
Nutritionist

N201: Nursing Diagnosis Form

List the two Nursing Diagnoses along with expected outcomes, assessments, and nursing interventions for each patient. The nursing diagnosis must be complete, be in priority order, use correct terminology, and include relevant related to factors and AEB statements for actual problems.

NDx # 1: Disturbed sensory perception: auditory & visual R/T withdrawal into self, panic anxiety, extreme loneliness 2° Schizophrenia AEB rapid mood swings, disorientation to reality, disordered thought sequencing.

EO: The client will recognize distortions of reality by the end of my time of care.
EO: The client will refrain from harm to self or others during my shift.

Ongoing Assessments: presence/signs of hallucinations +what they consist of, anxieties and fears, is patient at risk of harm, suicidal thoughts

NI: 1. Stay with patient during episodes of hallucinations/ delusions during my time of care.

2. Educate client on connection between increased anxiety and hallucinations by the end of my shift.

3. Distract the client from hallucinations/ delusions (activities such as games or art) during my shift.

4. Maintain a safe and calm environment during my time of care.

5. Orient to reality through use of familiar objects (pictures of family/clocks) during my time of care.

6. Encourage client to explain hallucinations/delusions (what they are hearing/visualizing) during my shift.

NDx # 2: Disturbed thought processes R/T inability to trust & panic anxiety 2° Schizophrenia AEB absence of abstract thinking, inability to concentrate, inappropriate communication, extreme suspiciousness of others.

EO: The client will use appropriate communication of reality by the time of discharge.
EO: The client will establish trust with caregiver by the end of week 2.

Ongoing Assessments: social behaviors, presence of delusions/hallucinations, emotions, fears and anxieties

NI: 1. Do not argue or deny the clients beliefs during my time of care.

2. Reinforce and orient back to reality during my time of care.

3. Do not reinforce hallucinations during my time of care.

4. Avoid touching or any physical contact without warning or permission during my time of care.

5. Maintain an attitude of acceptance during my time of care.

6. Provide activities that encourage a 1-1 relationship (between nurse and pt) during my shift.

Directions: Initials/ Signature: TE/SNB/ TYLER EDDY

Chart any and all nursing interventions done for your patient during your time of care (if nursing interventions performed by others, write as an "E" note). After each intervention, document your patient's response to the intervention (evaluation note).

Time	*I or E* (NI or Eval)	Notes	Specify NDx #
1200	E	Entrance into office with sister, avoiding eye contact, associative looseness speech pattern, flat affect, fidgeting of fingers, motor agitation, increasing anxiety---------TE	1,2
1203	E	RN introduces self, uses a calm friendly tone, sits off to side, more than an arm's length away----------TE	1,2
1205	E	Weight loss of 20lbs within 6 months, decreasing energy, speech pattern: associative looseness stating "I have missed work, I watched a bird show on tv, and I can't mow the lawn"----------TE	1,2
1207	I	Educated on positive symptoms of schizophrenia including delusions, hallucinations, and motor agitation----------TE	1,2
1209	E	States he has not been taking PO antipsychotic. Identifies delusion of persecution, believes the pharmacist may be "poisoning his pills"----------TE	2
1210	E	RN states "that is a valid concern, it must be scary thinking someone is trying to harm you". RN educates on IM injection form of medication rather than pills------TE	2
1212	E	Turning head to side, mumbling, ignoring eye contact, experiences "mumbling and music, but no specific words" hallucinations----------TE	1
1213	E	RN questions about command hallucinations, educates on importance of reporting any command to hurt oneself or others----------TE	1
1215	E	RN assessment using SAFE-T screening tool, results reassuring, encouraged to report any command hallucinations or suicidal thoughts----------TE	1,2
1217	E	RN questions on drug use, report of cocaine use in the past----------TE	4
1218	I	Education on drug use, specifically cocaine and its effects on schizophrenia and how it can cause worsening symptoms of psychosis----------TE	4
1219	E	Statement from sister "worried about his social relationships", has had decreased interactions with friends and family----------TE	3
1220	I	Educated sister to continue visiting and interacting on a daily basis to maintain social relationships---------- TE	3
1222	E	RN gives first IM injection of Paliperidone----------TE	1,2
1222	I	Educated on EPS side effects specifically abnormal body movements and encouraged to report if they are experienced while on this medication, also educated on Paliperidone taking up to two weeks to reach effects----------TE	1,2
1224	E	RN discusses other therapeutic interventions other than medication such as group therapy and offers to aid in finding those resources----------TE	1,2
1225	I	Aids in establishing a long- term goal- to attend group therapy----------TE	1,2
1225	E	Follow up visit- exhibiting anxiety, agitated motor activity, turning head to side, mumbling, reports auditory hallucinations. RN encouraging to focus----------TE	1
1226	I	Ensured that although hallucinations can be scary, the environment is safe----------TE	1
1227	E	Drug screen negative for cocaine, positive for marijuana----------TE	4
1227	I	Assessed marijuana use using a non-judgemental approach----------TE	4
1228	E	RN education on marijuana and other substances worsening symptoms of Schizophrenia and encouraged other calming resolutions such as deep breathing, distractions such as music, or journaling----------TE	4

1229	E	Sister interested in learning about what happens if schizophrenia worsens and causes inability to care for oneself, expresses concern----------TE	1,2
1229	I	Education on DPAHC and rights for client to terminate----------TE	1,2
1230	E	Sister concerns about paranoia and what to do at home to help decrease triggers, and relapse concerns----------TE	1
1230	E	RN statement "avoid speaking quietly and whispering with others", educates that relapses are common in patients with schizophrenia, and what to report to get treatment as quickly as possible (decreased sleep, hallucinations, social isolation)-TE	1
1230	E	Verbalized understanding of education of disease, identifying early warning signs of relapse, how to decrease anxiety, medication compliance and side effects, and importance of follow up visits----------TE	1

Reflective Thinking:

1) **Read over your notes**
2) Reflect on the patient problems you identified in your documentation
3) Determine appropriate nursing diagnoses for your patient based on the problems you identified
4) List your nursing diagnoses below in proper NANDA format, assigning each a number
5) Return to your notes and write the corresponding nursing diagnosis # beside each entry

1) **Disturbed sensory perception R/T withdrawal into self & anxiety 2° Schizophrenia AEB auditory hallucinations of mumbling and soft music, unable to maintain eye contact, fidgeting fingers, poor concentration**
2) **Disturbed thought processes R/T inability to trust & anxiety 2° Schizophrenia AEB stopping medications due to persecution delusions of being poisoned, statement "I have to be careful of others", extreme suspiciousness of others**
3) **Social isolation R/T anxiety, inability to trust, regression 2° Schizophrenia AEB decreased social interactions, skipping work, not seeing friends.**
4) **Ineffective coping R/T increasing anxiety, ineffective previous mechanisms AEB previous use of cocaine, positive drug screen for marijuana to "help relax"**

Reflection Paper

Directions: Write a 1-page reflection paper for each patient using Times New Roman, 12 pt. font and double-spaced. Include the following:

1. Describe an “Aha” moment you experienced during this learning experience.
2. What were the most important aspects of this simulation and what did you learn?
3. How will this simulation experience impact your nursing practice?

In the ATI MH Real Life Simulation, I was able to picture what this kind of patient would have been like in a real-life nursing situation. I felt an “Aha” moment when I was able to see the patient experiencing auditory hallucinations by recognizing the signs we had learned in class. I recognized the mumbling to self, slightly turning head, and inability to concentrate before the patient had actually verbally expressed his hallucinations. I was glad to be able to pick up on his social cues beforehand. I learned the best ways to communicate with a patient who has this diagnosis and is experiencing increasing anxiety. I watched as the nurse sat to the side of him, at a good distance, and maintained her calm tone. I think this is really important to watch because it helped her gain the trust of the patient. Trust in a one to one therapeutic relationship with this type of client is essential, and just by doing those small things, the patient was more willing to communicate and work together. An example of this was when the client was willing to allow the RN to give his IM antipsychotic. If the nurse had taken a different approach and hadn’t of built that trust, the patient may have had fears or anxiety and refused. In my nursing career, I will be implementing these interventions with my own patients and striving to build a therapeutic relationship. I really enjoyed the simulation, and although I wish we could have had this lesson in person, I was still able to learn a lot. I will now be able to confidently communicate with my mental health patients and educate them on orienting back to reality, relapse early warning signs, medication compliance, how anxiety can worsen symptoms, and effective coping techniques. I hope I can be the type of nurse my patient feels comfortable with and trusts. This simulation really showed me just how important interactions with a patient are from the very beginning and how maintaining an empathetic, but professional manner can assist the RN in every intervention he/she implements.