Student Name: Addie Baunchalk
Medical Diagnosis/Disease: Schizophrenia

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation

Anatomy and Physiology Normal Structures

Frontal lobe – voluntary body movements such as speaking, thinking, judgement, and expression of feelings.
Parietal lobe – perception and interpretation of sensory info
Occipital lobe – visual reception and interpretation
Temporal lobe – hearing, short term memory, smell, expression of emotions through connection with limbic system
Hypothalamus: controls ANS, regulates pituitary gland, regulates appetite and temperature, visceral response to emotional situations and body rhythms.
Limbic system: emotional brain
Medulla: regulates BP, HR, RR and reflexes
Cerebellum: involuntary movements such as coordination and posture
Pons: sleeping and dreaming, as well as transmitting messages between the nervous systems
SNS: fight or flight
PNS: rest and digest

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Schizophrenia is a disorder which causes disturbances in thought processes, perception, and affect which is categorized by four phases. It is associated with increased levels of dopamine, norepinephrine, GABA, and serotonin as well as a severe deterioration of social and occupational functioning. A return to full premorbid functioning is not common.
Premorbid phase: signs that occur before there are any clear signs of disease – shy and withdrawn, poor peer relationships, poor school performance, antisocial behavior.
Prodromal phase: extends until the onset of psychotic symptoms – can last weeks to years. Deterioration in role functioning and social withdrawal. Substantial functional impairment. Beginning of negative symptoms – depressed mood, poor concentration, fatigue. Sleep disturbances, anxiety, and irritability present. Sudden onset of obsessive-compulsive behavior.
Acute schizophrenic episode: chronic illness with acute exacerbations of prominent psychotic symptoms. Delusions, hallucinations, impairment in work, social relations, and self-care.
Residual phase: characterized by remission and exacerbations. No psychosis is present, negative symptoms remain. Flat affect and impairment in role functioning are prominent.

NCLEX IV *(7)*: Reduction of Risk

Anticipated Diagnostics Labs

CBC
Drug screen
UA

Additional Diagnostics

EEG
MRI/CT
H&P

DSM-5: will show at least one sign of delusions, hallucinations or disorganized speech that is continuous for at least 6 months

NCLEX II *(3)*: Health Promotion and Maintenance

Contributing Risk Factors

Excess dopamine
Abnormalities w/ serotonin, GABA, or norepinephrine
Increased C4 activity
Viral infections
Ventricular enlargement
Decreased grey matter
Head injury in adulthood
Genetics
Childhood trauma

Signs and Symptoms

Positive symptoms:
Delusions (persecutory, grandiose, somatic, paranoid)
Hallucinations
Disturbances in thought (neologisms, word salad, magical thinking)
Illusions, Echopraxia, Concrete thinking, Loose associations
Negative symptoms:
inappropriate, flat, or weak affect
Apathy, avolition, poor self-care, impaired social interaction, isolation, anergia, anhedonia

NCLEX IV *(7)*: Reduction of Risk

Possible Therapeutic Procedures

Non-surgical

Individual psychotherapy
Group therapy
Behavior therapy
Family therapy
RAISE

Surgical

N/A

Prevention of Complications

(What are some potential complications associated with this disease process)
Homelessness
Substance abuse
Suicide
Impaired nutrition
Anxiety, depression, OCD
Inability to work or attend school
Social isolation

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Anticipated Medication Management

Antipsychotics
Conventional – Chlorpromazine, Fluphenazine, Haloperidol, Prochlorperazine
Atypical – Clozapine, Olanzapine, Risperidone, Paliperidone
Antidepressants - Paroxetine, Fluoxetine, Sertraline
Lithium
Benzodiazepines – Clonazepam, Lorazepam, Diazepam

NCLEX IV *(5)*: Basic Care and Comfort

Non-Pharmacologic Care Measures

Low stimuli environment
Reality based activities
Healthy coping mechanisms
Thought stopping techniques
Distraction
Safety measures
Do not argue
Do not leave alone with hallucinations
Sit beside client and avoid eye contact

NCLEX III *(4)*: Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?

Stress of symptoms
Depression
Substance use
Social isolation
Side effects of medications
Stigmas
Financial stress/homelessness

Client/Family Education

List 3 potential teaching topics/areas

- Do not stop medications abruptly – continue full medication therapy
- Importance of family support throughout illness
- Importance of identifying stressors for relapse (exacerbation of symptoms)

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)
Primary care physician
Psychologist
Psychiatrist
Social worker
Mental health nurse
Support groups
Case management

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 R/T panic anxiety 2º Schizophrenia AEB mumbling to self, withdrawal, flat affect, fidgeting, tilting of head to one side, "I hear voices mumbling but I can't make out their words"

EO: K.J will discuss content of hallucinations at least once or as necessary during my time of care.
EO: K.J will identify at least one stress trigger that precipitates anxiety and hallucinations once during my time of care.

Ongoing Assessments: Assess for signs of hallucinations PRN, Assess vital signs (BP, HR, RR) q4h, Assess for suicidal thoughts q2h, Assess for thoughts of harming others q2h, Assess signs of increasing anxiety q2h, Monitor for SE of antipsychotics 1hr after admin., Review drug screen results PRN

NI: 1. Identify self and establish trust and rapport at all times during my care.

2. Maintain low stimuli, safe environment with suicide precautions – all medical equipment outside the room, no plastic bags or cords, special food trays, dimmed lights, minimal noise at all times during my time of care.

3. Accept voices are real to K.J while reassuring reality and safety PRN hallucinations during my time of care.

4. Assist in identifying times of increased stress and their triggers at all times during my time of care.

5. Use distraction techniques such as reality-based activities PRN hallucinations during my time of care.

6. Explain what I am going to do and warn K.J prior to touching at all times during my time of care.

NDx # 2 Social Isolation R/T inability to trust and delusional thinking 2º Schizophrenia AEB no longer hanging out with peers, unable to maintain eye contact, withdrawal, appears increasingly anxious when approached, "The pharmacist is trying to poison me"

EO: K.J will engage in at least one social activity with the nurse during my time of care.
EO: K.J will verbalize understanding related to the importance of social interaction in preventing relapse once during my time of care.

Ongoing Assessments: Assess anxiety level q2h, assess participation in social interaction PRN, assess triggers and relieving factors PRN, Assess for changes in behavior with social interaction at all times

NI: 1. Identify self and establish trust and rapport at all times during my care.

2. Assist K.J in identifying s/sx of increased anxiety related to social interaction as necessary during my care.

3. Provide opportunities for K.J to learn adaptive coping mechanisms for social settings in a non-threatening environment at all times during my time of care.

4. Structure activities related to K. J's pace, activity level, and interests as necessary during my care.

5. Give recognition and positive reinforcement for voluntary interaction with others PRN during my care.

6. Maintain a low stimuli environment – no loud noises, no crowding at all times during my care.

Directions: Initials/ Signature AB *Addie Baunchalk*

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 #
0800	E	21 y/o male recently diagnosed with schizophrenia. Sister present. Mumbling to self. Fidgeting with hands. Presents with clothing appropriate for weather. Clean, no odor noted. Hair combed. Mood is appropriate. Alert and oriented. "Yeah it had birds in it. Birds can fly. I don't like when flies get in the house. How can I clean the house when the sun doesn't shine" ---------- AB	1,2,4
0805	E	Sister stated, "It doesn't seem like he's eating much lately." Current weight 190 lbs. – 20 lb. weight loss in the last six months. ---------- AB	5
0810	I	Stood off to the side more than an arm's reach away. Reassured sister I would report weight loss to Nicole, but he is still within the expected reference range for his height.---------- AB	1,2,5
0815	E	Sister stated, "Ken has missed his last two shifts at works and seems to have very little energy lately… and he seems confused when he's talking. He only ate a few bites when we went to lunch a couple days ago." "Yeah, miss work but watching a bird show on TV. Can't move the yard without a car." Admits to not taking medication. Unable to maintain eye contact, fidgeting in seat, appears anxious when responding to questions. ---------- AB	3,4
0815	I	Educated on positive and negative s/sx of Schizophrenia. Delusions, hallucinations, motor agitation, alterations in speech, decrease in functioning, apathy, anhedonia, alogia, avolition, and flat affect - AB	1,2,3,4,6
0820	E	Missed appointment in February. "Didn't go. Didn't need to go. Didn't need the medicine… they poisoned the pills." ---------- AB	2,3
0820	I	Used restating – "You think that someone is trying to poison you?" ---------- AB	2
0820	E	"The pharmacist is." Sister stated, "You think the pharmacist is trying to poison you?" "Yes they're poisoned. I'm not going to take them." ---------- AB	2
0830	I	Documented delusions of persecution in chart. Explained I will talk to the provider about another medication option. ---------- AB	2,6
0835	E	Ken and sister acknowledge understanding. Sister stated, "Thank you" ---------- AB	6
0840	E	Confirmed auditory hallucinations of voices mumbling and music – not specific words. Denied hearing command hallucinations. Admits to dizziness when standing and trouble swallowing some bites of lunch the other day. ---------- AB	1,6
0845	I	Educated auditory hallucinations, dizziness, and trouble swallowing are all symptoms of schizophrenia. Performed SAFE-T screening. ---------- AB	1,6
0900	E	SAFE-T screening tool: risk factors – schizophrenia, mild anxiety, occasional social withdrawal, no adherence to med. Therapy. Protective factors – positive, supportive relationships with sister and friends. Conduct suicide injury – denies suicidal ideation, plan, or intent. No suicidal behaviors noted. Risk level- low. ---------- AB	1,2,3
0915	I	Explained screening score was reassuring and explained/emphasized the importance of reporting any thoughts of harming oneself to a healthcare provider. ---------- AB	6
0930	E	Quit smoking two years ago. Drinks one-two beers a week at bingo. Confirms use of cocaine – unable to recall last use. "Don't remember. It was too long ago" Denies any other substances. ---------- AB	5
0935	I	Educated on cocaine causing psychosis and potentially worsening s/sx of schizophrenia. Also taught the other s/sx of cocaine use – exhilaration, panic, anger, increased desire for socialization, HTN, Tachycardia, decreased appetite, and dilated pupils. Emphasized need for drug screening. -------- AB	5,6
0945	E	Sister verbalized understanding, "Since cocaine can cause hallucinations, I can see why it's important to do the screen." ---------- AB	5,6
1000	E	Sister stated, "I've been concerned about K.J not wanting to do as much with me or his friends. And he seemed more restless and anxious too lately." ---------- AB	3
1005	I	Encouraged sister to visit and talk to ken on a regular basis for a brief amount of time about topics that don't cause him anxiety to help maintain social interaction. Emphasized gradual increase in length and number of interactions as he get's more comfortable. ---------- AB	3
1010	E	K.J and sister verbalized understanding and report no further questions. ---------- AB	other
1015	I	Emphasized importance of eating three meals a day even when you don't feel hungry. ---------- AB	5
1020	E	"Alright, I will." ---------- AB	5
1030	E	Sister stated, "K.J thought the pharmacist was putting poison in his pills. I'm worried he won't take his medication anymore." ---------- AB	2

1040	I	Validated sister's concern. Offered alternative medication given by injection by staff members Ken knows. ---------- AB	2,6
1045	E	Sister stated, "Ken I think that sounds like a great option." Accepts new medication plan. --------- AB	2,6
1100	I	Educated on SE of Paliperidone and to report any abnormal body movements to the provider ------ AB	6
1115	E	No more questions at this time. Ready to receive injection. ---------- AB	6
1130	I	Administered Paliperidone 234 mg IM in left deltoid. Educated on peak of medication. ---------- AB	6
1145	E	Injection tolerated well. Sister stated, "Should ken be in therapy of some sort so he's not just relying on his medication?" ---------- AB	6
1200	I	Educated on group therapy as a part of the treatment plan. Emphasized establishing a goal for long term commitment to attending group therapy. ---------- AB	6
1215	E	No further questions. Sister stated, "You have given us a lot of good information. If Ken or I have any questions later, we will call. ---------- AB	other
1230	E	(Next week's follow up appointment) Confirms auditory hallucinations. "Can't make out what they are saying, like background noise in a restaurant." Anxious movements, flat affect, reports no command hallucinations, minimal eye contact, negative AIMS scale ----------AB	1
1235	I	Educated on distraction techniques for hallucinations/ social support when hearing voices ---------- AB	1
1240	E	"Sometimes it helps when I listen to music with my headphones." Confirmed auditory hallucinations are getting better, denies any adverse effects of medication, Sister reports "He has gone to hangout with his friends a couple of times too" ---------- AB	1
1240	E	Urine drug screen negative for all substances except marijuana ---------- AB	5
1245	I	Used therapeutic communication, "Tell me some of your reasons for using marijuana" ---------- AB	5
1245	E	"I used weed since its relaxing" ---------- AB	5
1250	I	Educated on alternative forms of relaxation such as deep breathing or meditation ---------- AB	6
1250	E	"Yeah I can give those a try." Sister states concern with K. J's paranoia. ---------- AB	6,1,2,3
1255	I	Educated sister to avoid whispering or talking quietly to others when in the same room as K.J ----- AB	6,1,2,3
1255	E	Shook head. "I want to do whatever I can to help Ken so that he keeps getting better. But what if he ends up getting so sick someday that he can't make his own decisions about his care?" ---------- AB	6
1300	I	Educated of DPAHC and guardians. ---------- AB	6
1300	E	"Thanks for going over that with us" Sister states, "What can we do to prevent Ken from having a relapse of symptoms?" ---------- AB	6
1305	I	Educated on relapse prevention – group therapy, learning new coping skills, and notifying trusted people if there is a desire for social withdrawal ---------- AB	6
1305	E	No further questions at this time. ---------- AB	other

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: Auditory R/T panic anxiety 2º Schizophrenia AEB mumbling to self, fidgeting, tilting head to the side, flat affect, poor concentration, "I hear mumbling, but I can't make out their words.", hears faint music in background
2.	Disturbed thought processes: delusional thinking R/T inability to trust, panic anxiety 2º schizophrenia AEB "The pharmacist is trying to poison me", not taking medications, anxious movements, unable to make eye contact
3.	Social isolation R/T inability to trust and delusional thinking 2º Schizophrenia AEB sister states "no longer wants to hangout with friends", missing work, quit attending school, unable to maintain eye contact, persecutory delusions, increasingly anxious when approached
4.	Impaired verbal communication R/T panic anxiety and disordered unrealistic thinking 2º Schizophrenia AEB loose associations, "Yeah miss work but watching a bird show on TV. Can't mow lawn the yard without a car", mumbling
5.	Imbalanced nutrition: less than body requirements R/T insufficient dietary intake 2º Schizophrenia AEB loss of 20 lbs. in 6 months, "He took two bites of food", substance use
6.	Readiness for enhanced health management R/T identifying own healthcare needs 2º Schizophrenia AEB attending follow up appointments, compliance with medication, asking various questions concerning healthcare needs/schizophrenia

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?

An "aha" moment I experienced during this learning experience was definitely early in the simulation. Having no previous experience with a patient with Schizophrenia I knew textbooks definitions but was not familiar with the physical presentation of symptoms as well. My "aha" moment was the initial question asking about K.J's speech. I had to listen to the audio clips to identify the loose associations. This took a few minutes for me to correlate my memorized textbook definition with what exactly I was hearing. Once I realized that the clip stating "It had birds in it. Bird's can fly. I don't like when flies get in the house. How can I clean the house when the sun doesn't shine?" was demonstrating the shift in one idea to another my light bulb went off in my head. It was definitely an "aha" that's what that sounds like moment. I think the most important aspects of this simulation were being able to correlate risks and behaviors with interventions as well as communication and trust with the patient. First, I think being able to correlate how K.J was presenting in the clinic with identified risks and behaviors I knew from lecture guided me in how I could answer the questions to treat K.J properly. In some instances, there was more correlation than others. I think this taught me the importance of knowing your patient's full story and having preparation of research or knowledge prior to trying to treat them. Secondly, I think this simulation with K.J having delusional thinking, auditory hallucinations, impaired communication, and anxiety really painted a picture as to why it is so important to develop that trust with your patient and be able to keep an open line of communication. For example, because I was able to develop trust with K.J we were able to understand why he wasn't taking his medication as prescribed and find a treatment option that would alleviate the stress and help with medication adherence ultimately helping with his symptoms. I also found it was important to use therapeutic communication to really understand what he was saying at times. For example, focusing in on why specifically he was using the marijuana that showed up on his drug screen rather than just accepting him saying, "yeah so". Overall, I believe this simulation helped me prepare to care for mental health patients in my future. I feel more confident with identifying symptoms of schizophrenia and anxiety as well as

how to approach someone dealing with those disorders. I think I have gained a better appreciation for how we manage and treat mental illness patients holistically. Looking at K.J you may notice his anxious behaviors, lack of eye contact, or fidgeting but until you dig deeper and develop an understanding of what he is experiencing in his head as well as during his day to day life we wouldn't be able to treat the full K.J. For instance, one may be likely to narrow in on his hallucinations and delusional thinking and forget the importance of nutrition in a mental health patient. At the end of the day, I believe this simulation was a good experience to prepare me for my future.

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