

ATI Real Life Student Packet
N201 Nursing Care of Special Populations
2024

Student Name: Ryan Clagett

ATI Scenario: Schizophrenia

To Be Completed Before the Simulation

Blue boxes should be completed using textbook information. What do you expect to find? This information should be collected before you start the ATI simulation

Medical Diagnosis: Schizophrenia

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures

Brain:

- cerebrum = has 4 lobes: frontal, temporal, parietal, and occipital
- frontal controls higher cognitive function, memory retention, voluntary motor movement, speech
- the temporal lobe integrates somatic, visual, and auditory data and contains Wernicke receptive speech area
- the parietal interprets spatial info, sensory cortex
- occipital is where processing of sight takes place
- the basal ganglia, thalamus, hypothalamus, and limbic systems are specific groups of neuron clusters in the cerebrum
- brainstem = includes midbrain, pons, and medulla; vital centers concerned w/ respiratory, vasomotor, and heart function are in the medulla; contains centers for sneezing, coughing, hiccupping, vomiting, sucking, and swallowing
- the reticular formation relays sensory info, influences excitatory and inhibitory control of spinal motor neurons, and controls vasomotor and respiratory activity
- cerebellum = coordinates voluntary movement and maintains trunk stability and equilibrium
- cerebrospinal fluid made in choroid plexuses of the brain w/n the ventricles; it circulates w/n the subarachnoid space that surrounds the brain, brainstem, and spinal cord and flows from the cranial cavity to the spinal cavity; CSF cushions the brain and spinal cord and carries nutrients through passive diffusion and active transport; make about 500 mL/day; filled w/ about 150 mL

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

- mental disorder in which there are disturbances in thought content and form, perception, affect, language, social activity, sense of self, volition, interpersonal relationships, and psychomotor behavior
- results from excessive activity at dopaminergic synapses, leading to active psychotic S/Sx
- a decrease in prefrontal activity of dopaminergic pathways leads to negative and cognitive symptoms
- other neurotransmitters may also contribute to schizophrenic S/Sx, such as norepinephrine, serotonin, glutamate involving the N-methyl-D-aspartate receptor, and gamma-aminobutyric acid transmission
- structural abnormalities of the intraventricular system, temporal lobe abnormalities, decreased volume of the amygdala and hippocampus of the limbic system
- structural changes in prefrontal white matter; increased volume of the basal ganglia has been found
- altered brain structure and function may also result from overactivity of the immune system
- exact cause unknown
- may result from a combination of genetic biological, cultural, and psychological factors
- affects about 1% of the world's adult population
- onset typically occurs in the late teens to mid-30s, w/ major deterioration occurring during the first 5-10 years of the disorder
- males and females are affected equally (males tend to have earlier onset and more severe S/Sx)
- the risk for suicide in people w/ schizophrenia averages about 5%

at any given time; too much CSF results in hydrocephalus

- has meninges (dura mater, subarachnoid, and pia mater) to protect the brain and spinal cord
- the skull protects the brain from trauma
- the internal carotid arteries supply blood to the brain (the circle of Willis is formed by communicating arteries that join the basilar and internal carotid arteries)

Cellular Composition (Neurotransmitters):

- neurons have excitability, conductivity, and can influence other neurons, muscles, or glandular cells
- cell body, dendrite, and axon
- glial cells provide support, nourishment, and protection to neurons (microglia have phagocytosis, macroglia are astrocytes, oligodendrocytes, and ependymal cells)
- neurotransmitters are chemicals that affect the transmission of impulses across the synaptic cleft: excitatory activate postsynaptic receptors and increase action potential; inhibitory activate postsynaptic receptors to decrease change of action potential (drugs and toxins can affect neurotransmitters by changing their function or blocking their attachment or receptor sites on the postsynaptic membrane)

Synaptic Transmission:

- neuron initiates, receives, and processes messages w/n and outside the body
- the nerve impulse (initiation) involves the generation of an action potential (a series of action potentials travel the axon, a chemical interaction w/ a neurotransmitter transfers the impulse across the junction (synapse) b/t nerve cells, generating more APs until the destination)
- nodes of Ranvier (gaps in myelin sheath)
- saltatory conduction jumps signals faster
- synapse is junction b/t 2 neurons (presynaptic terminal, synaptic cleft, postsynaptic cell)

-substance use disorders occur in more than 50% of individuals w/ schizophrenia (particularly tobacco)

-the clinical course frequently includes recurrent, acute exacerbations of psychosis w/ periods of full or partial remission of symptoms

-genetic component (having parents w/ schizophrenia significantly increases the risk for children to be diagnosed w/ schizophrenia)

-other factors that have been implicated include viral infections, anatomical abnormalities, and head injuries in adulthood

-DSM-5 Criteria: ≥ 2 of the following (must have 1, 2, or 3), whereby the level of functioning is affected, and continuous signs persist for ≥ 6 months

--Delusions

--Hallucinations

--Disorganized speech

--Catatonic Behavior

--Negative Symptoms

-course of illness includes prodromal phase, acute phase, stabilization phase, and maintenance phase

--prodromal: precedes acute phase, deterioration in role functioning and social withdrawal; sleep disturbance, anxiety, irritability; depressed mood, poor concentration, fatigue; may appear 1 month-1 year before first psychotic break

--acute: psychotic symptoms are prominent

--stabilization: symptoms diminish, focus is shifted to understanding the illness

(controlling/coping w/ symptoms, reducing negative symptoms)

--maintenance: maintaining and increasing symptom control, adherence to medication and tx regimen, improving quality of life, [relapse prevention, developing a plan in stabilization and maintenance phases]

To Be Completed Before the SimulationAnticipated Patient Problem: **Disturbed Sensory Perception: Auditory and Visual**

Goal 1: The pt. will recognize distortions of reality by the end of my care.

Goal 2: The pt. will recognize and verbalize command hallucinations during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess for command hallucinations and S/Sx of other positive symptoms PRN.	Ensure patient, family, and staff safety (1:1 sitter, restraints, PRN antipsychotics/benzodiazepines) at all times.
Assess for suicidal ideation and behavior (using SAD PERSONS) upon admission and PRN.	Initiate suicide precautions (1:1 sitter, q15min checks, paper scrubs, safe meal trays, remove all harmful objects) STAT.
Assess for delusions PRN.	Acknowledge the pt's feelings, clarify misinterpretations, and reorient to reality (w/o arguing or proving the delusion is incorrect) PRN.
Assess for ability to perform ADLs and self-care activities PRN.	Educate and encourage the performance of ADLs and self-care activities independently PRN.
Assess the pt and family's knowledge of the stabilization and maintenance phases of schizophrenia PRN.	Educate on relapse prevention by recognizing the S/Sx of a relapse (hallucinations, delusions, not taking medications) and who to contact PRN.
Assess the pt and family's knowledge of following their medication regimen PRN.	Educate on medication reconciliation, purpose of medications, and side effects of medications PRN.

To Be Completed Before the SimulationAnticipated Patient Problem: **Risk for Violence**

Goal 1: The pt. will not harm themselves or others during my time of care.

Goal 2: The pt. will participate in a structured therapeutic milieu during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess for safety concerns (command hallucinations, violence, escalation behavior) at all times.	Ensure patient, family, and staff safety (1:1 sitter, restraints, PRN antipsychotics/benzodiazepines) at all times.
Assess for positive and negative symptoms and anxiety levels PRN.	Provide a structured therapeutic milieu w/ consistent rules and limits at all times.
Assess for suicidal ideation and behavior (using SAD PERSONS) PRN.	Initiate suicide precautions (1:1 sitter, q15min checks, paper scrubs, safe meal trays, remove all harmful objects) STAT.
Assess environmental factors (overstimulation, lack of privacy) PRN.	Create a low-stimulation environment (reducing noise, limiting visitors, private room near the nursing station) PRN.
Assess the pt's current coping mechanisms and ability to manage anger or frustration PRN.	Educate pt. on anger management techniques, healthy coping mechanisms, and collaborate w/ the psychiatrist to introduce CBT PRN.
Assess the pt's hx of violent, aggressive, or anxious behavior, including frequency, severity, and triggers PRN.	Establish a therapeutic relationship w/ the pt. based on trust and respect at all times.

To Be Completed During the Simulation:

Actual Patient Problem #1: **Disturbed Sensory Perception: Auditory and Visual**
 Goal: KJ will recognize distortions of reality by the end of my care. Met: Unmet:
 Goal: KJ will recognize and verbalize command hallucinations during my time of care. Met: Unmet:

Actual Patient Problem #2: **Ineffective Coping**
 Goal: KJ will teach back appropriate coping strategies by the end of my care. Met: Unmet:
 Goal: KJ will teach back about not using illicit substances by the end of my care. Met: Unmet:

Additional Patient Problems:
 #3: Ineffective Health Management
 #4: Deficient Knowledge: Schizophrenia

Below will be your notes, add more lines as needed. **Relevant Assessments:** Indicate pertinent assessment findings. **Multidisciplinary Team Intervention:** What interventions were done in response to your abnormal assessments? **Reassessment/Evaluation:** What was your patient’s response to the intervention?

Patient Problem (#)	Time	Relevant Assessments	Time	Multidisciplinary Team Intervention	Time	Reassessment/Evaluation
1	Day 1 at 1300	Exhibited an altered speech pattern of associative looseness (“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”) when responding to sister’s question “Did you end up going to see the movie you’ve been wanting to see?”	Day 1 at 1305	Collaborated w/ NP about associative looseness; established rapport	Day 1 at 1307	Brought from the waiting room w/ sister to the exam room; avoided eye contact when talking, hand fidgeting
2	Day 1 at 1308	Height/weight taken (5’ 7” and 190lbs); 20 lbs lighter from hospital admission 6 months prior; sister mentioned, “It doesn’t seem like he is eating much lately”; VS WNL (BP 120/72,	Day 1 at 1310	Explained that height and weight are WNL; notified NP; sat down off to the side, more than an arm’s reach away; NP educated on eating three meals a day, even if not hungry	Day 1 at 1311	Reassured about recent weight loss and VS; verbalized understanding that “I will” regarding eating three meals a day

		HR 76, RR 16, T 37 C, SpO2 98% RA); became increasingly anxious				
1	Day 1 at 1315	“Yeah, miss work but watching a bird show on TV. Can’t mow the yard without a car”; “the pharmacist poisoned the pills”; sister mentioned symptoms of dizziness and trouble swallowing	Day 1 at 1316	Educated that delusions, hallucinations, and motor agitation are positive symptoms of schizophrenia; asked about command hallucinations and educated to seek help via sister or anyone on the healthcare team if experiencing command hallucinations; educated that dizziness and trouble swallowing are symptoms of schizophrenia; used SAFE-T tool (low-risk level resulted) and educated on reaching out if thoughts of suicide or harming others are present	Day 1 at 1318	No command hallucinations were heard; “I only hear mumbling. No words anymore”; verbalized understanding that “I will” regarding reaching out when having thoughts of suicide or harming others
2	Day 1 at 1315	Sister mentioned, “Ken has missed his last two shifts at work and seems to have very little energy lately. He seems confused when he’s talking. He only ate a few bites when we went to lunch a couple days ago”; missed scheduled February appointment; denied smoking; claimed drinking in moderation (1-2 beers a week); claimed hx of	Day 1 at 1319	Educated that psychosis is a manifestation of cocaine intoxication; collaborated w/ NP about obtaining a urine drug screen; educated that social isolation can occur w/ schizophrenia and that visiting and talking regularly will help maintain social interactions	Day 1 at 1320	Verbalized understanding that the urine drug screen is beneficial (“I don’t want it to get worse”); sister verbalized, “That will be helpful” regarding ways of maintaining social interactions and preventing social isolation

		cocaine use; sister mentioned symptoms of anxiety and social isolation				
3	Day 1 at 1315	Denied taking prescribed risperidone as scheduled	Day 1 at 1321	Collaborated w/ NP about different medication options; NP educated on injectable antipsychotic medication alternatives	Day 1 at 1324	Verbalized understanding that "I think so" regarding receiving injectable medications instead of pills
1	Day 1 at 1420	Order placed for paliperidone 234 mg IM once	Day 1 at 1435	Educated to notify the provider if experiencing abnormal body movements; pamphlet provided on paliperidone; educated that first two doses of paliperidone are given 1 week apart and then monthly starting w/ the third injection; educated that paliperidone reaches peak effectiveness in about 13 days; administered paliperidone 234 mg IM in L deltoid; receptionist scheduled appointment for next week	Day 1 at 1440	Verbalized understanding that "I can" regarding going to the clinic next week for the second dose of paliperidone and monthly after that to receive subsequent injections
2, 4	Day 1 at 1440	Sister mentioned, "Should Ken be in therapy of some sort so he's not just relying on his medication?"	Day 1 at 1442	Educated on establishing a goal for long-term commitment to attending group therapy; provided information on specific groups in the area for group therapy and on emergency and crisis resources	Day 1 at 1443	Verbalized understanding that attending group therapy regularly will help prevent relapse and social isolation; sister said, "You have given us a lot of good information. If Ken or I have any questions later, we will call"

2	Day 1 at 1441	NP ordered a urine drug screen	Day 1 at 1443	Escorted to the bathroom for urine collection	Day 1 at 1445	Results revealed positive marijuana use
1, 2	Day 2 at 1015	“I can’t make out what the voices are saying. It’s like background noise at a restaurant”; hand fidgeting, limited eye contact; AIMS score of 0	Day 2 at 1016	Acknowledged fears using therapeutic communication and reassured on safety; educated on listening to music during hallucinations; asked about medication effectiveness	Day 2 at 1017	“The voices are going away”; reported feeling less anxious; “I still hear voices sometimes, but not as often”; sister mentioned, “He’s gone out w/ his friends a couple of times”; denied side effects (tremors, restlessness, muscle spasms) of paliperidone
2	Day 2 at 1018	“Yeah. So what?” after revealing positive marijuana results on the urine drug screen	Day 2 at 1019	Used therapeutic communication; educated on using other forms of relaxation and coping strategies (deep breathing, meditation, journaling) instead of marijuana	Day 2 at 1020	“I use weed because it’s relaxing”; verbalized understanding and taught back that “I’ll give those things a try” regarding other relaxation techniques and coping strategies instead of marijuana
1, 3	Day 2 at 1021	Sister verbalized concern for continued paranoia and durable power of attorney	Day 2 at 1022	Educated on avoiding whispering or talking quietly to others when in the same room; provided pamphlet on a durable power of attorney for healthcare; educated that the client can terminate a durable power of attorney for healthcare	Day 2 at 1023	Verbalized understanding that “thanks for going over that with us” regarding the paranoia and durable power of attorney for healthcare
1, 2, 3, 4	Day 2 at 1025	Sister mentioned, “What can we do to prevent Ken from	Day 2 at 1026	Educated that schizophrenia is a chronic illness, relapses can occur,	Day 2 at 1030	No additional questions; verbalized understanding of

		<p>having a relapse of his symptoms?”</p>		<p>group therapy can help prevent relapse, learning new coping skills can help prevent relapse, substance use can cause a relapse, and to notify trusted people if there is a desire for social withdrawal</p>		<p>the teaching; VS, physical assessment, lipid panel, and CBC WNL</p> <p>[Scenario ends]</p>
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To Be Completed After the Simulation

The orange boxes should be filled out with your simulation patient's actual results, assessments, medications, and recommendations

NCLEX IV (7): Reduction of Risk

Actual Labs/Diagnostics
 -Urinalysis (positive for marijuana use; negative for other illicit drug use)
 -[Lipid: WNL]
 -[CBC: WNL]
 -[CMP, if indicated]

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms
 -Delusions (of persecution)
 -Hallucinations (background voices)
 -Associative looseness
 -Social isolation
 -[Other positive symptoms: word salad, echolalia, tangentiality, illusions, clang associations, neologisms]
 -[Other negative symptoms: anhedonia, avolition; flat, blunted, inappropriate affect; impaired social interaction]

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
 -Substance use disorder (tobacco, cocaine, marijuana)
 -[Inherited genetic factors]
 -[Disruptions in dopamine, glutamate, norepinephrine, serotonin, NDMA]

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures
Non-surgical
 -[ECT]
Surgical
 -N/A

Prevention of Complications
 (Any complications associated with the client's disease process? If not, what are some complications you anticipate)
 -Relapse due to noncompliance with medication therapy (prevention due to monthly administration of IM paliperidone)
 -[Risk for self-care deficits (prevention due to paliperidone, support from sister, group therapy)]

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management
 -Paliperidone 234 mg IM once monthly (first two doses one week apart)
 -Risperidone (stopped taking due to delusions of persecution)
 -[Antipsychotics: first-gen (conventional-EPS), second-gen (atypical-metabolic)]

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
 -Therapeutic communication
 -Group therapy
 -Support group from sister
 -[Assistance w/ ADLs]
 -[Quiet room w/ low-stimuli environment]

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?
 -Living independently (worrying about too much sister involvement)
 -Dropping out of school and picking up an odd job
 -Ineffective coping w/ substance use and social isolation

Client/Family Education

Document 3 teaching topics specific for this client.
 • Adhering to medication regimen.
 • Knowing about command hallucinations and who to contact when experiencing them.
 • Learning effective coping strategies and relaxation techniques (besides marijuana).

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement
 (Which other disciplines were involved in caring for this client?)
 RN, PMHNP, receptionist, [social worker, PT/OT, case management, registered dietician, pharmacist, psychiatrist]

Patient Resources

Group therapy, emergency and crisis resources contacts, pamphlets/attorneys for durable power of attorney for healthcare

Reflection Questions

Directions: Write a reflection including the following:

1. What was your biggest “takeaway” from participating in the care of this client?

Caring for a patient with schizophrenia can be different depending on the patient. For this patient, there was an emphasis on providing education to the patient and sister regarding medication adherence, relapse recognition and prevention, and seeking out group therapy. Caring for a patient also differs from caring for a patient in the hospital setting. There is more time to answer questions that the patient or family may have, and there is a greater chance of establishing rapport and connecting with the patient and family on a deeper level.

2. What was something that surprised you in the care of this patient?

Something that surprised me about the patient's care was how supportive KJ's sister was throughout the scenario. Typically, with the ATI real-life scenarios, the care is centered around the patient. Since the sister was involved in KJ's care throughout, she became another member of the healthcare team, acting as his support system. It was beneficial for me to see how the nurse would interact with the patient and his sister and how the therapeutic communication would accommodate more than one person. The scenario showed that establishing trust and rapport early in the care of a patient can lead them to follow through on a treatment plan successfully. This was especially true for KJ, who had a loving and supportive sister who made sure he made it to his appointments and understood and took part in his plan of care.

3. What is something you would do differently with the care of this client?

Something I would do differently with the care of this patient is to provide more information on group therapy and durable power of attorney for healthcare instead of just handing out pamphlets. There is an incredible amount of information on those pamphlets, and it can be overwhelming for patients and their families to cipher through what is essential. To the best of my knowledge, I would provide what I know about group therapy, for example, how it has helped other patients or some hurdles that other patients had to go through to participate in group therapy. For the durable power of attorney, I would follow the same process and get in contact with an available attorney on-site or via phone so that KJ and his sister would have up-to-date information readily available so that they can make an informed decision.

4. How will this simulation experience impact your nursing practice?

This simulation experience will impact my nursing practice by giving me strategies for communicating with schizophrenic patients and how to participate in their care. I will utilize therapeutic communication to establish trust and rapport with the patient before performing any assessments, tests, or medication therapy unless contraindicated or in an emergency. In this simulation, KJ relapsed due to having a delusion of persecution that his pharmacist was poisoning his medications, which resulted in him stopping his treatment. It was through the actions of the nurse that trust was established, thus resulting in KJ receiving an injectable medication and hopefully resolving some of his symptoms. Ultimately, I want to incorporate this therapeutic communication aspect of the simulation into my daily nursing practice.

5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.

Since KJ is 21 years old, he falls into the formal operation (Piaget), young adulthood with intimacy vs. isolation (Erikson), and stage 4 conventional level (law and order orientation; Kohlberg) developmental stages. KJ displayed concrete thinking, hallucinations, and delusions, which are deviations from the formal operation developmental stage. He displayed a conventional level at stage 4, the norm for a young adult. For the Erikson developmental stage, KJ is showing signs of non-achievement for intimacy vs. isolation due to being withdrawn and socially isolated. Since he is working on his life living with schizophrenia, it would be difficult for him to develop the capacity for giving mutual love, respect, and himself to another person at this point in his life.