ATI Real Life Student Packet
N201 Nursing Care of Special Populations
2025

Student Name: _Lillian Maslauskas _____

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

Function unit of the nervous system:

- Neurons that transmit singles, dendrites that receive impulses, axons that send the impulses, and the synapse is the connection point where neurotransmitters cross. Gray matter is also located in the brain that is found deep within the brain and is composed of neuron cell bodies, dendrites, and synapses.

Chemical signaling- Neurotransmitters
Dopamine, acetylcholine, serotonin, and GABA are your chemical signals that allow communication across the synapses.

- *Synapses:* Place where neurons connect and communicate with each other

BRAIN: Central organ of the nervous system that is responsible for controlling and coordinating all bodily functions. It receives sensory information and then processes it to initiate responses. It also is in control of your consciousness, thought emotion, and memory. Uses up 20% of the body's oxygen and glucose. The C*ircle of Willis* is part of the cerebral blood flow

- 3 main parts:
  Cerebrum- the largest part of the brain, it is responsible for functions such as thought (ability to think, plan and make decisions), language, movement, and sensory perception (sight, hearing, touch, taste and smell).
  - Frontal lobe: planning, judgement
  - Parietal lobe: senses
  - Temporal lobe: hearing, memory,

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Schizophrenia is chronic with and overactivity of serotonin and dopamine within the brain. It is characterized by psychosis. Typically diagnosed around 15-25 years old but the younger you are when diagnosed the worse it is. It is a lifelong condition with no cure. Treatment and medications are done for quality of life.

Brain imaging:

- Enlarged ventricles
- Reduced gray matter
- Smaller brain size
- Decrease lymphatic
- Abnormal synaptic pruning typically found durin`g adolescents (excessive loss of connection).

There is a very strong genetic factor (1st degree relative).

Positive Symptoms: Additions to normal behavior.

- Hallucinations
- Delusions
- Disorganized speech and behavior.

Negative Symptoms: Loss of normal functions

- Alogia
- Anhedonia
- Avolition
- Affective flattening
- Social withdrawal
- Poor self-care

language comprehension. o Occipital lobe: Vision o Thalamus (sensory), hypothalamus (hunger, thirst, hormones), pineal gland (melatonin) are located beneath. *Cerebellum*- located in the back of the brain. It coordinates your balance, posture, and fine motor skills. *Brainstem*- Connects the brain to the spinal cord and controls your breathing and all your vital signs. o Midbrain, pons and medulla oblongata.		

To Be Completed Before the Simulation

Anticipated Patient Problem: Disrupted sensory precipitation. (auditory and visual hallucinations). **(1)**

Goal 1: Pt. will identify at least one coping strategy when hallucinations occur during my time of care. (listening to music, coloring, going for a walk, playing a game).

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Identify what the voices are saying or what they are seeing when s/s of hallucinations start to occur.	Acknowledge when the hallucinations occur that I understand the hallucinations are real to them but that I do not see them
Assess the ability to distinguish reality from hallucinations PRN.	Provide a calm environment with minimal stimulation to ensure there is no increase in anxiety that could further hallucinations during my entire time of care.
Assess coping strategies at begin of my care and PRN.	Establish rapport and trust while providing a calm environment and offer new/possible options. (exercising mindfulness, going for a walk/run, group therapy)
Assess level of anxiety or agitation PRN and throughout my time of care.	Encourage going for a walk, playing a game in a quiet room, listening to music.
Assess any risk for self harm or of others during my entire time of care.	Provide a safe environment and collaborate with team members and/or providers for possible need of suicide precautions.
Assess sleep patterns in relation to hallucinations during my time of care.	Promote and educate importance of sleep to help decrease the stress and intensity of hallucination frequency.

Goal 2: Pt. will recognize distortions of reality during my time of care.

To Be Completed Before the Simulation

Anticipated Patient Problem: Disrupted thought process **(2)**

Goal 1: Pt. will use appropriate verbal communication during my time of care.

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Assess subject of thought throughout my time of care (grandiosity, persecutory, paranoia).	Emphasize what is happening in the here and now.
Assess speech patterns when talking to staff and others. (tangentiality, word salad, clang associations).	Redirect conversation and explain how I am having a difficult time understanding.
Assess for thought blocking during entire time of care.	Provide distraction with a game, drawing or walking. As the thought block could be due to a hallucination.
Assess for concrete thinking when speaking to pt.	Repeat information PRN while using clear, consistent and simple communication.
Assess response to external stimuli during activities.	Provide short interactions to prevent becoming overwhelmed and provide small step by step instructions during activities.
Assess orientation to person, place, time and situation at beginning of my care and PRN.	Provide reorientation PRN. Show a schedule, clock, or calendar to reenforce.

Goal 2: Pt. will only go off topic 3 times when talking to staff or another client during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem #1: Disrupted sensory precipitation **(1)**

Goal: Pt. will identify at least one coping strategy when hallucinations occur during my time of care. (listening to music, coloring, going for a walk, playing a game). Met: ☒ Unmet: ☐

Goal: Pt. will recognize distortions of reality during my time of care. Met: ☒ Unmet: ☐

Actual Patient Problem #2: Disrupted thought process **(2)**

Goal: Pt. will use appropriate verbal communication during my time of care. Met: ☒ Unmet: ☐

Goal: Pt. will only go off topic 3 or less times when talking to staff or another client during my time of care. Met: ☒ Unmet: ☐

Additional Patient Problems:
#3- Disorganized speech
#4- Self care deficit
#5- Social Isolation
#6

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
2 and 3	0900	Prior to calling Ken back RN overheard him talking with his sister.	0905	RN informed NP about his speech change and stated it will be looked into when assessing Ken.	0915	RN spoke with Ken regarding how he is doing/feeling. Ken stated "Can't mow yard without car".
4	0910	On scale Ken weighed 190 lbs. 20 lbs down from last visit. Emily felt a concern In his weight. Stated " he has not been feeling hungry or eating when we go out to lunch".	1010	NP informed both Ken and Emily that his weight is not of concern but she would like him to eat at least 3 meals a day even if he is not hungry.	1015	Ken verbalized understanding and stated "Alright, I will". Ken avoiding eye contact and continued fidgeting with wrist band.
1,2 and 4	0920	RN reviewed meds with Ken and Ken stated he has not been taking his Risperidone and	0923	RN asked Ken why he stopped taking his medication.	0925	Ken became fidgety and anxious. Stated "They poison pills. The pharmacist".

		had missed his last visit when his sister was out of town.				
1	0930	Ken was silent and fidgety in the chair when continuing conversation about meds.	0931	RN stated “I will talk to your provider about maybe starting a new medication so you do not feel like someone is trying to hurt you”.	0932	Ken remained silent and played with his wrist band. Sister responded “Thank you!”.
1	0940	In Kens medical chart it stated that he experiences hearing music and voices.	0942	RN asked Ken what exactly he hears and what is being said. Also explained importance of asking this to ensure no risk for self harm.	0945	Ken stated “ Just mumbling sometimes, no words. It’s a quiet little song”.
5	0952	Sister Emily stated she is worried about Ken not wanting to spend time with his friends or family as much anymore.	0955	RN stated “Anxiety and social isolation can occur with schizophrenia”. RN also offered to go over certain things to help reduce anxiety and help Ken maintain his social relationships.	1000	Sister Emily appreciated the information and was interested in discussing methods to help Ken. Ken remained fidgeting in his chair with his wrist band.
1 and 4	1020	NP in room and reviewing Ken stopping his Risperidone.	1025	NP educated that could be why Ken is hallucinating more and becoming more isolated from others.	1027	Ken remained silent and sister expressed concern.
4	1030	Sister stated “I am very concerned with him not taking his pills anymore due to him thinking the pharmacist is poisoning him”.	1035	NP stated “That is a valid concern and there are other options such as injections for your antipsychotic med”	1037	Both Ken and his sister agree on injections rather than oral med.
4	1045	New medication order placed for Paliperidone injection.	1050	NP and RN reviewed effects of medication with Emily and Ken and when the next time to come back. RN administered injection.	NEXT WEEK (0910)	Ken stated “I still have hallucinations just not as often.” Emily also stated that he has been hanging out with family and friends more too.

(NEXT WEEK) 1	0900	Ken very fidgeted and mumbling under his breathe upon arrival to outpatient center.	0905	RN asked Ken what exactly he was hearing and what the voices were saying.	0906	Ken stated “I cant hear what they are saying. Background noise at restaurant”
1	0915	Ken less fidgety and anxious. Stated “voices went away”.	0920	RN educated Ken about when he does hear voices that he can talk to his sister or listen to calm music to help cancel out the voices.	0922	Ken stated “Sometimes it helps to listen to music with my headphones”.
4	0925	Kens drug screen from last time was all negative except for marijuana use.	0926	RN stated “Your urine drug screen showed positive for marijuana. Using this can increase your risk for hallucinations”.	0928	Ken stated “ It helps me relax”.
1 and 2	0935	Sister stated she was still concerned regarding Kens Paranoia. Stated “We wont go to the store where we used tog etnhis medications. He still think the pharmacist will harm him.”	0940	RN stated “The paranoia should decrease once the medication peaks.” RN educated on ways to help Ken feel safe and less paranoid.	0950	Sister verbalized understanding and used her resources provided.
4	1000	Sister stated “ I am concerned if Ken gets worse who will take care of him if I can’t” Ken stated “ That wont happen, I can take care of myself”	1005	RN provided them with a pamphlet of durable POA for health care and explained information inside.	1010	Sister was very thankful for the informative pamphlet and information. Ken was relaxed and listening.

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

SAFE – T: Low risk level due to strong relationship with sister and denies any thoughts of self harm.

Urine drug screening : Positive for Marijuana. Everything else was negative.

Fasting blood glucose- 98 mg/dL
Prolactin- 7 ng/mL

Lipid Panel:
Cholesterol- 162
HDL- 54
LDL- 108
Triglyceride- 98

CBC:
RBC- 5.7
Hbg-16
Hct-48%
Platlet-310K
WBC-6200
Neutrophils-60%
Lymphocytes-30%
Monocytes-6%
Eosinophils-3%
Basophils- 1%

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

Signs and Symptoms

- Associative looseness
- Social isolation
- Hallucinations (music and voices mumbling)
- Paranoia
- Word salad
- Disruptive thought process
- Disrupted sensory perception

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

Contributing Risk Factors

- 21 years old
- Stopped taking Risperidone
- Smokes marijuana
- Drinks ETOH
- In the past has done cocaine

Therapeutic Procedures

Non-surgical

- CBT

Surgical

- Deep brain stimulation
- ECT

NCLEX IV *(7)*: Reduction of Risk

Prevention of Complications

(Any complications associated with the client's disease process? If not what are some complications you anticipate)

- R/f substance abuse
- Anxiety and depression
- OCD
- R/f self harm and suicide

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

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

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

Medication Management
- Risperidone 2 mg PO/ BID
- Paliperidone 234 IM injection

Non-Pharmacologic Care Measures
- Group therapy
- Social support
- Listening to soft music
- Drawing
- Exercise

Stressors the client experienced?
- Paranoia of pharmacist
- Anxious

Client/Family Education

Document 3 teaching topics specific for this client.
• Effects of cocaine and marijuana usage. How they can actually worsen hallucinations.
• How to prevent relapse from happening and signs to look out for.
• Information regarding new injection medication and when it will take affect.

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

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
- MH RN
- MH NP
- Family member-sister
- Receptionist to schedule upcoming appt.

Patient Resources
- Emergency crisis resources for both patient and family member
- Paliperidone med info packet
- Pamphlet on group therapy recommendations
- Pamphlet on POA

Reflection Questions

Directions: Write reflection including the following:

1. What was your biggest "take away" from participating in the care of this client?
   My biggest take away from participating in the care of this client is that having family support is SO crucial. Having someone there with you especially during times of hallucinations or paranoia, is so important to reassure or distract from the situation. Another thing is being patient with clients with schizophrenia because you never know what is going on in their brain.

2. What was something that surprised you in the care of this patient?
   Something that surprised me was how overall calm this patient was and how much he listened to the nurse and his sister,

3. What is something you would do differently with the care of this client?
   Something I would do differently for this client is I would try to get the client more involved. Yes the sister was there but I still think it is so important to inform the client just as much in the care and show them all the resources and pamphlets.

4. How will this simulation experience impact your nursing practice?
   This simulation will impact my nursing practice by helping me better understand how to care of a schizophrenic patient, The different types of techniques to use when they have a hallucination episode and just overall care of the patient.

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

   Over all during this simulation the patient's developmental stage was within normal limits. The patient was at the young adult stage and was well kept, dressed nicely, acted his age and developmental area was within normal range. Only deviation would be during periods of hallucinations the patient did not want to hang out with friends or family, which at this stage in development that is a big thing that usually occurs, is both friends and family time