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

Student Name: **MaKenna Miska**

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

Nervous System

-The nervous system is divided into the central nervous system (CNS) and the peripheral nervous system (PNS). Schizophrenia primarily affects the CNS.

-The CNS is made up of the brain and spinal cord, and it controls thought, behavior, and body functions.

-The brain relies on communication between neurons, which transmit signals through neurotransmitters such as dopamine (regulates reward, motivation, and movement), serotonin (mood, sleep, and impulse control), glutamate (learning and memory), norepinephrine (alertness and arousal), GABA (inhibitory and helps calm overactivity), and lastly acetylcholine (memory, attention, and muscle activation).

- The cerebral cortex, especially the prefrontal cortex, is responsible for executive functions such as reasoning, judgment, planning, and problem-solving.

-The limbic system, which includes the hippocampus which converts short term memory into long term. The amygdala which is known as the aggression and emotional response. The thalamus is the sensory system however smell bypasses it. Lastly the hypothalamus which regulates the ANS which is the fight or flight response and rest and digest.

-The basal ganglia influence movement and behavior patterns, while the thalamus helps filter and relay sensory information to appropriate areas of the brain.

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Schizophrenia

-Schizophrenia is characterized by psychosis which includes, altered cognition and perception. Also, the impaired ability to determine what is real and what is not.
-Schizophrenia is also a chronic psychiatric disorder characterized by disruptions in thought, perception, emotion, and behavior.
-Schizophrenia usually develops in late adolescence to early adulthood, usually diagnosed between 15-25 yo.

-One of the primary mechanisms is dysregulation of dopamine pathways. In the mesolimbic pathway, an excess of dopamine activity contributes **to positive symptoms**:
**Hallucinations* which are false sensory perceptions not associated with external stimuli and those could include: (Auditory, Visual, Tactile, Gustatory, Olfactory)
**Delusions* which are false personal beliefs and those include: (Persecutory, Grandiose, Somatic, Paranoid)
**Disorganized speech* which could include: (Concrete thinking, Echolalia, Loose association, Neologisms, Clang association, Word Salad, Circumstantiality, Tangentiality, Mutism, Magical thinking, and Thought blocking)

-The mesocortical pathway, which connects the prefrontal cortex to other brain regions, often has reduced dopamine activity, resulting in **negative symptoms** which are the absence of essential human qualities.
*Which could include Anhedonia, Avolition, Affective blunting, Apathy, Alogia.
*Negative symptoms also effect *affect* which is an outward expression of a person internal emotional state and those could include: Blunted, Flat, Inappropriate, or Bizarre.

-Some other associated features include motor symptoms including immobility, purposeless movements, waxy flexibility, pacing/rocking, regression, eye movement abnormalities, or posturing.

-Individuals with schizophrenia also have impaired attention, working memory deficits, poor executive function, difficulty with problem-solving and planning. These cognitive deficits often contribute significantly to functional impairment in daily life.

-Normal balance and activity within the brain allows a person to think clearly, interpret reality correctly, and respond appropriately to the environment.		-Structurally, individuals with schizophrenia may also have reduced gray matter volume in the prefrontal cortex, temporal lobes, and hippocampus, and abnormal activity in the thalamus and limbic system (smaller limbic). These changes interfere with memory processing, emotional regulation, and the ability to filter sensory input, which may contribute to hallucinations and impaired reality testing. The amygdala and hippocampus may show altered connectivity, affecting emotional responses and memory formation. -The temporal lobes, which are for auditory processing and language comprehension, are often implicated in auditory hallucinations. -Environmental stressors, genetic vulnerability, and prenatal (viral infection in mother) or early-life insults (brain injuries) can further exacerbate these neurobiological abnormalities. Dysregulation in neurotransmitter systems combined with structural brain changes results in the hallmark features of schizophrenia: positive symptoms (hallucinations, delusions), negative symptoms (apathy, social withdrawal), and cognitive deficits (impaired memory, attention, and executive function). -Schizophrenia typically develops in phases, each with distinct features that reflect disease progression. *__The prodromal stage__ often occurs 1 month to 1 year before full onset and is marked by subtle changes in thoughts, perceptions, emotions, and behaviors, such as social withdrawal, decreased motivation, depressed mood, poor concentration, fatigue, anxiety, irritability. ***The acute stage** involves prominent psychotic symptoms, including hallucinations, delusions, disorganized thinking, negative symptoms, cognitive and mood symptoms. The goal during this stage is safety & stabilization and hospitalization may be requiring. Especially if it is the first psychotic break. ***The stabilization stage**, symptoms begin to decrease in intensity due to treatment, allowing the patient to regain some functional ability and insight. ***The maintenance stage** focuses on ongoing symptom management and relapse prevention, often involving medication adherence, psychosocial support, and coping skill development to preserve functional independence. *In order to be diagnosed with schizophrenia according to the DSM-5 an individual must have 2+ of the following: Delusions, Hallucinations, Disorganized speech, Catatonic behavior, Negative symptoms. AND must have 1, 2, or 3. Level of functioning must be affected, and these should be continuous signs for at least 6 months.

To Be Completed Before the Simulation

Anticipated Patient Problem: **Risk for Suicide**

Goal 1: **During my care, the patient will remain free from self-harm.**

Goal 2: **By the end of my care, the patient will verbalize at least one coping strategy or safety plan to use when experiencing suicidal thoughts.**

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?
Observe for nonverbal cues or behaviors indicating risk, such as agitation, withdrawal, or self-injury gestures. CONTINUOUS	Remove any potentially harmful objects, maintain safe environment PRN/ Continuous
Assess mood and affect, noting depression, hopelessness, or anxiety. Q15mins/PRN	Use therapeutic communication to encourage the patient to express feelings and concerns. PRN
Monitor sleep patterns and energy levels PRN	Maintain a quiet, low-stimulation environment during rest periods PRN
Evaluate patient's support system and willingness to use coping strategies PRN	Educate/review coping techniques such as deep breathing, journaling, or calling a crisis line. PRN
Assess for recent stressors or triggers (loss, conflict, hallucinations). PRN	Educate on problem-solving and stress management techniques, such as breaking problems into small steps. PRN
Assess verbal statements for suicidal thoughts, intent, or plans. PRN	Implement suicide precautions if risk is identified (1:1 sitter) PRN

To Be Completed Before the Simulation

Anticipated Patient Problem: **Disturbed Thought Process**

Goal 1: **By the end of my care, patient will demonstrate ability to perceive the environment correctly.**

Goal 2: **During my care, patient will recognize the distortions of reality.**

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?
Observe thought content and organization (delusions, hallucinations, or disorganized speech) PRN/ q15 min	Distract from hallucinations by (offer to go on a walk, play music, draw, play a game) PRN
Monitor patient orientation to person, place, and time. PRN/ q15 min	Provide reorientation cues (clocks, calendars, verbal reminders). PRN
Assess response to reality-based stimuli (describe what they see/hear around them). PRN	Clarify misinterpretations with a calm, empathic attitude PRN
Assess patient insight and judgment, including recognition of distorted thoughts. PRN	Maintain close monitoring, help patient feel safe PRN
Monitor response to structured activities (group therapy, reality-orientation exercises, simple tasks). PRN	Provide positive reinforcement for accurate perceptions and completed tasks. PRN
Assess ability to maintain attention and focus during interactions or tasks. PRN	Provide short, clear instructions, and repeat them as needed. PRN

To Be Completed During the Simulation:

Actual Patient Problem #1: **Disturbed Sensory Perception (auditory hallucinations)**
Goal: During my care, the patient will verbalize when experiencing auditory hallucinations. **MET**
Goal: By the end of my care, the patient will identify at least one coping strategy (ex. Listening to music, talking with family) to manage hallucinations. **MET**_

Actual Patient Problem #2: **Ineffective Health Maintenance**
Goal: During my care, the patient will verbalize understanding of the importance of medication adherence. **MET**
Goal: By the end of my care, the patient will participate in one discussion about healthy daily routines (sleep, hygiene, nutrition, or stress reduction). **MET**

Additional Patient Problems:
#3 Ineffective Coping
#4 Deficient knowledge
#5 Disturbed thought process
#6 Social Isolation

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
Disturbed Thought Process	0800	Anne RN observed pt exhibiting an altered speech pattern of associative looseness. "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."	0805	Anne RN notified provider Nicole about the conversation that was overheard.	0810	Anne RN assessed pt. Pt opened up about not taking medication risperidone in last 4 months.
Ineffective Health Maintenance	0810	Pt weights 190 lbs, 20lbs less then previous appointment 1 month ago, sister addressed that pt had only eaten a few bites of food in past few days and hasn't felt hungry.	0820	Notified provider Nicole, encouraged eating 3 meals a day to help prevent any further weight loss.	0820	Pt agreed to Anne RN suggestion on 3 meals a day, "OK".
Ineffective Health Maintenance	0830	Pt stopped taking risperidone 2mg PO, "they poisoned	0835	Anne RN appropriately acknowledged pts	0840	Pt agreed to this suggestion of a new medication.

		the pills".		persecutory delusion, "it must be scary to think that", "I'll talk with the provider to see if there is other medications".		
Disturbed Sensory Perception (auditory hallucinations)	0900	Pt admitted to hearing voices and music. "Just mumbling, no words anymore and a quiet little song"	0915	Anne RN encouraged pt to reach out to healthcare team or sister Emily, "if you ever begin to hear words telling you to hurt yourself or others".	0920	Pt verbalized understanding and agreed to reach out. "OK"
Ineffective Coping	0930	Pt drinks one to two beers every week at bingo, used cocaine in past.	0935	Anne RN educated that cocaine could mimic or worsen the symptoms of schizophrenia. Urine drug screen was ordered.	0940	Pt acknowledged education and agreed to drug screen, "Yeah, I don't want it to get worse"
Social Isolation	0950	Pt sister was concerned about pt, "not wanting to do as much with me or his friends, he seems more anxious and restless."	1000	Anne RN educated on signs and symptoms of schizophrenia, "anxiety and social isolation can occur with schizophrenia." Provided ideas on how to maintain pt social relationships.	1010	Pts sister was pleased with information, "that'd be helpful".
Deficient knowledge	1020	Pt stopped taking risperidone 4 months ago, currently experiencing auditory hallucinations, agreed to new medication, IM injection of Paliperidone (Invega Sustenna) 234mg	1025	Educated pt and family, that since pt is no longer taking the medication that may explain why pt is experiencing auditory hallucinations. Anne RN administered Paliperidone 234mg IM	1030	Pt agrees to come back to clinic next week for 2nd dose of Paliperidone.
1 WEEK LATER Disturbed Sensory Perception	0800	Pt unable to concentrate, hearing voices "background noise	0810	Anne RN provides pt with reassurance that they are safe, "hearing voices	0815	Pt acknowledges a coping strategy, "sometimes it helps when I listen to

(auditory hallucinations)		in a restaurant."		must be frightening, but you are safe.", provides more education on distractions from hallucinations, "try listening to calming music."		music with my headphones."
Disturbed Sensory Perception (auditory hallucinations)	0830	Last week pt received first injection of Paliperidone, at clinic to receive 2nd dose. Still experiencing auditory hallucinations, "I hear voices sometimes, not as often."	0835	Anne RN, educated that the medication does seem to be helping, but that the med doesn't reach peak until 2 weeks "you'll notice an even greater improvement in the next week or so."	0840	Pt denied any tremors, restlessness, or muscle spasms. (possible side effects of medication)
Ineffective coping	0900	Positive urine drug screen of marijuana, pt admits to using it for relaxation.	0905	Anne RN educates that marijuana can also worsen the symptoms of schizophrenia. Suggest, "try other forms of relaxation, like deep breathing, meditation, journaling."	0915	Pt agrees to try different relaxation techniques, "yeah, I can give those a try."
Deficient Knowledge	0920	Pt sister expresses concerns about pts paranoia and possible progression of schizophrenia, "what if he gets so sick one day, he can't make his own decisions about his care."	0930	Anne RN provides information to pt family and pt, phamplets on ways to help reduce paranoia and durable power of attorney of health care.	1000	Pt states, "thanks for going over that with us."
Deficient Knowledge	1005	Pt sister expresses concerns on possible relapse, "what can we do to prevent a relapse of symptoms."	1015	Anne RN educates that schizophrenia is a chronic illness and relapse can occur. Provides pt and family with teaching about relapses. (Group therapy, learning	1030	Pt and family appreciative of information and care provided.

				new coping skills, symptoms like social withdrawal)		

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

*Urine drug screen (pos for marijuana, neg for cocaine)
*CBC with differential
*Prolactin level
*Fasting blood glucose
*Lipid profile

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

Signs and Symptoms

*Loose associations
*Auditory hallucinations (mumbling, quiet song, background noise)
*Persecutory delusions (pharmacy trying to poison)
*Mild anxiety
*Restlessness
*Paranoia
*Occasional social withdrawal

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

Contributing Risk Factors

*SIM Pt: Cocaine use, marijuana use, alcohol use, hx of cigarette smoking, 21yo male, lives alone in apartment, enrolled in college but stopped attending, parents divorced at 6 yo, no previous mental health hx.

*In general:
-Genetic predisposition (family hx or other psychotic disorders),
-Neurochemical factors: Dopamine dysregulation (excess in mesolimbic, deficit in mesocortical), serotonin, glutamate imbalances.
-Reduced gray matter in frontal & temporal lobes
-Viral infection in pregnant mother
-Head injury in adulthood

Therapeutic Procedures

Non-surgical

*SIM pt: Antipsychotics (Paliperidone), Psychoeducation for patient and family about disease process, medication adherence, relapse signs, therapeutic milieu, safety interventions.

-In general:
Adjunctive medications for mood stabilization, anxiety, or depression as needed, CBT

Surgical
*N/A for sim patient
*No real surgical procedures but possible for 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)

-Suicide risk
-Medication side effects: EPS, metabolic syndrome, weight gain, diabetes, cardiovascular disease (with second-generation antipsychotics).
-Substance abuse: Often co-occurs, worsens symptoms, and increases relapse risk.
-Nonadherence to treatment/medication
-Cognitive decline: Impaired memory, executive function, and problem-solving ability.
-Relapse & rehospitalization: Without consistent treatment and support, recurrent acute episodes may occur.

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

Medication Management

*Risperidone 2mg PO 2x daily (stopped taking 4 months ago)
*Newly prescribed Paliperidone (Invega Sustenna) 234mg IM x one dose monthly

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

Non-Pharmacologic Care Measures

*Provided education on different coping strategies (calm music, deep breathing, meditation, journaling, talking to his sister/friends)
-Reinforced use of grounding techniques during hallucinations or distressing thoughts (focusing on objects in the room, reality orientation).
-Promoted regular sleep hygiene and healthy nutrition (3 meals a day) to stabilize mood and energy.
-Open communication with staff and family to promote a sense of safety and support.

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

Stressors the client experienced?

-Social isolation and withdrawal from friends in past weeks
-Possible financial or occupational stress due to impaired functioning, (missed last two shirts of work, "watching a bird show on tv, cant mow the yard without a car")
-Internal stressors: paranoia, believes pharmacist is trying to poison his pills
-Anxiety, restlessness
-Difficulty managing daily responsibilities because of impaired concentration or disorganized thought processes.

Client/Family Education

Document 3 teaching topics specific for this client.

•Importance of new medication adherence/ signs & symptoms to watch for
•The need to immediately report any new or worsening command hallucinations.
•The importance of notifying staff or healthcare providers about any suicidal thoughts, self-harming behaviors, or early signs of relapse (social withdrawal, increased paranoia, disrupted sleep).

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

Multidisciplinary Team Involvement

(Which other disciplines were involved in caring for this client?)

*RN, Provider, possible group therapy, Psychiatrist, Psychologist/Therapist, Family/support system (sister), OT, Pharmacy

Patient Resources

-Group therapy, pamphlet for power of attorney, pamphlet for new medication, NAMI, crisis hotline number

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 takeaway from caring for this client was realizing that even though Ken has a diagnosis of schizophrenia, at the end of the day, he is still a person who needs compassion and support. As nurses, it's our responsibility to remain nonjudgmental, empathetic, and provide the best care we can. Mental illness often carries stigma, but this experience reminded me that these are individuals who deserve dignity and respect. I thought the nurses in the scenario modeled this very well by being trustworthy, empathetic, and supportive. I also noticed how important family support is, as Ken's sister played a strong role in advocating for him.

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

   -What surprised me most was how open Ken was about his past cocaine use, but at the same time, he was hesitant to admit to using marijuana. It made me reflect on how patients may share certain information more freely while holding back on other details depending on their comfort level or perceived judgment.

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

   -If I could do something differently, I would focus more on asking open-ended questions to give Ken the space to share his experiences at his own pace. I would also try to explore his coping strategies more in depth and offer additional support around building healthier routines.

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

   -This simulation reinforced the importance of approaching every patient without judgment, while maintaining empathy and trust. It reminded me that being present, actively listening, and building rapport are just as important as the medical aspects of care. I will carry this mindset into my practice by making sure patients feel safe, heard, and respected.

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

   -Ken is a 21 yo male who falls into Erikson's developmental stage of intimacy vs. isolation. At this stage, young adults typically focus on forming meaningful relationships and establishing independence. While Ken lives alone and does have friendships, his struggles with schizophrenia and substance use may make it harder for him to maintain stability in relationships and daily routines. This shows a deviation from the expected norms of this stage, but also highlights areas where support and intervention can help him grow.