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

Student Name: Katelyn Milligan

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

Normal structures:
Cerebral cortex- responsible for cognitive functioning, decision making, judgement, problem solving, and organization.

Frontal lobe- Controls executive functioning, impulses, planning, and socializing.

Temporal lobe- Auditory processing, speech, and memory

Limbic system: controls emotional responses known as the “emotional brain”. Consists of the amygdala (fear, anger, aggression), hippocampus (emotions and memories), Thalmus (senses except smell), Hypothalamus (maintains homeostasis and nervous system responses).

Basal Ganglia: Motor activity and behavior

Neurotransmitters:

Dopamine: Regulates reward, pleasure, thought process

Serotonin: Mood, anxiety and sleep-wake regulation

Glutamate: Excitatory important for cognition, memory, and learning

GABA: Calming, controls excitability and anxiety

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Chronic brain disorder that affects a persons thought processes, perception, affect, and behaviors.

Excess dopamine in the brain can contribute to behaviors of positive symptoms including hallucinations, delusions, and disorganized thinking.

Not enough dopamine leads to negative symptoms including flat affect, poor motivation, social withdrawal

Glutamate hypofunction is related to cognitive deficits and thought disorganization

Serotonin hyperactivity leads to hallucinations and negative symptoms.

Decreased GABA leads to high excitability causing disorganized thoughts and perception.

Structural abnormalities include enlarged ventricles, reduced gray matter, hippocampus atrophy, abnormal thalamus activity, and decreased cerebral blood flow

Influences include genetic predisposition as first-degree relatives and twins have a higher risk of developing schizophrenia, maternal malnutrition viral infections during pregnancy and birth complications, psychosocial stress as a child and trauma, brain insults at an early age

Phases:

Normal functioning includes perceiving reality accurately, logical thought patterns, regulates emotions, has social interaction and can maintain relationships.		Prodromal phase: Early warning phase that occurs before the psychotic episode 1 month or 1 year before. Manifestations include deteriation in role functioning, social withdrawal, sleep disturbances, anxiety, depressed mood, and poor concentration. Early recognition is important. Acute phase: The active stage where psychotic symptoms present the most. Shows as positive symptoms (hallucinations, delusions, bizarre behavior), negative symptoms (flat blunt affect, apathy, poor self-care), cognitive symptoms (impaired memory, poor executive functioning) and mood symptoms (anxiety, irritability, depression). Safety is important in this phase. Stabilization phase: period following the acute episode where the symptoms begin to fade. Here is where we understand the illness, identify coping skills, and build trust. Maintenance phase: Long term focused on stability, preventing relapse, and improving quality of life. Shows as symptoms may persist of the negative and positive. The patient may though gain independence. Reinforce medication adherence is important, teaching relapse warning signs and prevention strategies, along with encouraging therapies.

To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed sensory perception

Goal 1: Will demonstrate coping mechanisms to stop the hallucinations like deep breathing, closing eyes, talking to someone, journaling 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?
Hallucinations contents, frequency, and duration by asking what the voices are saying/doing PRN	Apply safety measures like removing external stimuli, ask for staff assistance if gets extreme, and use de-escalation techniques, remove hazards, PRN.
Body language during assessment like fidgeting, rocking, facing away from others	Provide deep breathing techniques to reduce anxiety levels PRN
Mood during hallucinations (Yelling, smiling, scared)	Acknowledge hallucinations and reorient back to reality to deescalate.
Medication adherence at times ordered	Educate on importance of taking medications as prescribed to ultimately help them feel better and to prevent dangerous side effects at times ordered.
Attendance of therapies provided at behavior health as scheduled	Attend group therapies with them and participate in things like gym time, or art to encourage them to feel comfortable participating as they are scheduled.
Social interaction and engagement during common area time.	Encourage to talk to others and make friends to lean on during difficult times as that could be a good coping mechanism PRN.

Goal 2: Will maintain safety before, during, and after hallucinations during my time of care.

To Be Completed Before the Simulation

Anticipated Patient Problem: Impaired social interaction

Goal 1: Will engage in conversation with another patient 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?
Eye contact during conversations either with myself, staff, or peers Q2	Develop a RAPPORT so that they feel comfortable to make eye contact during conversations Q2
Body language around others (fidgeting, facing them or opposite way, looking down) during group time	Teach ways to promote healthy communication with others like that sitting towards someone shows interest and active listening to facilitate companionship during group time.
Hallucinations time, frequency, duration and contents PRN	Provide coping mechanisms when hallucinations occur like journaling, watching a show they may like, reading, etc. PRN
Participation in group activities and if they attend at all or stay back during scheduled times	Encourage to participate and educate that leaning on peers who have similar backgrounds is a good coping mechanism PRN
Mood like anxiety, agitation, withdrawal Q1	Remove loud stimuli, talk in a calm manner, ask open ended questions to facilitate conversation on how they feel Q1
Their perception of their barriers to social interactions Q4 like fears, suspicions of others, low-self esteem	Provide reassurance that they are worthy of healthy relationships and that not everyone wants to hurt them Q4

Goal 2: Will participate in group activities like gym time or art therapy with peers and work in a group during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed Sensory Perception (Auditory)
Goal: Will communicate coping strategies during times of hallucinations like deep breathing, talking to sister or staff, journaling. Met: ☐ Unmet: ☐
Goal: Will score in the no risk range on the suicide risk screening form during my time of care Met: ☐ Unmet: ☐

Actual Patient Problem #2: Ineffective Health Maintenance
Goal: Will communicate understanding of medication adherence and accept a different route of administration during my time of care Met: ☐ Unmet: ☐
Goal: Will attend and participate in doctors visit during my time of care by answering questions and accepting new resources Met: ☐ Unmet: ☐

Additional Patient Problems:
#3 Anxiety
#4
#5
#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
Anxiety	8:30	Fidgeting with fingers, talking to self, looking down avoiding eye contact while checks in as sister talks to receptionist for him.	8:30	Receptionist made eye contact with Jackson, smiled, and asked for his name, age, and birthday	8:30	Responded to receptionist oriented to name and DOB, did not make eye contact and fidgeted.
Disturbed Sensory Perception (Auditory)	8:35	Change in speech pattern while talking to sister in the waiting room exhibited associative looseness. Exhibited anxiousness by making a fits with his hands, mumbling, and looking around while the RN took his weight. Lost 20lb in 6 months.	8:35	RN Notified Nurse Practitioner. Sat down to the side of Ken to alleviate anxiety and "get on his level". Documented the weight loss of 20lb.	8:35	Continued to look down, fidget with bracelet, not talk unless spoken to, and will not make eye contact.
Disturbed Sensory Perception (Auditory)	8:40	Fumbiling with bracelet, looking down, saying phrases that do not make sense like "cannot mow the grass without a car." While sister speaks for him and says he's not himself lately and has not been eating.	8:40	Looks directly at Ken and speaks to him instead of sister while facing him and making eye contact.	8:40	Fumbling, looking down, avoiding eye contact and admits he has not been taking his medication.

Ineffective Health Maintenance	0900	Stated “I did not feel a need to take my medication, or come here, or to my last appointment”. Sister shocked about this information.	0900	RN restated that he is no longer taking the Risperidone and asked what caused him to stop taking the medication using therapeutic communication.	0900	Stated “The pharmacist poisoned the pills, I am no longer taking them”. Fumbling, looking down, no eye contact. Having delusions of persecution.
Disturbed Sensory Perception (Auditory)	0915	During mental status assessment denied hearing command hallucinations but admitted to hearing mumbling. Hears songs. Assessed SAFE-T score and scored well.	0915	Restated what he said to confirm. Provided information about who to contact like the healthcare team or Emily during times of harming self or others. Provided sister Emily handouts on resources for when suicidal ideations occur.	0915	Understood teaching by agreeing to contact people during suicidal ideations. Remained looking down, fidgeting, avoiding eye contact.
Ineffective Health Maintenance	0930	During drug screening questionnaire admitted to drinking once a week at bingo 2 beers, using cocaine but did not remember the last time. Sister asked what side effects can Cocaine cause.	0930	Educated sister on side effects of Cocaine causing psychosis. Educated Ken on Cocaine worsening effects of Schizophrenia.	0930	Stated “I do not want it to get worse” and understood the teaching by the RN. Rubbing hands, looking to the side, biting lip.
Anxiety	0935	Sister notified RN that Ken has not been as social as before and does not want to spend time with her or his friends and has been more anxious lately.	0935	RN educated Sister Emily and Ken on coping mechanisms to help reduce anxiety and help maintain social relationships like Ken talking to his sister everyday to maintain social ability.	0935	Rubbing hands, looks up and makes eye contact briefly with RN, does not have any other questions for her.
Disturbed Sensory Perception (Auditory)	0945	Provider comes in and asks questions about medication compliance, schizophrenia symptoms, weight loss, and thoughts of hurting self or others. Sister mentioned him thinking the pharmacist was putting poison in his pills.	0945	Educated on eating 3 meals a day. Validated Ken’s feelings of paranoia about poison in the pills, offered him the option to get injections of Paliperidone by staff members he knows so he doesn’t have to take pills.	0945	Agreed to getting injections and informing someone of suicidal ideations, rubbing hands, twitching eye, looking to side, making eye contact briefly.
Ineffective Health Maintenance	1000	RN and provider came in to provide information and side effects on Paliperidone injection along with handout. Sister Emily had questions on adjunctive therapies along with the medication.	1000	RN educated Ken and sister Emily on group therapy, long term goals for care, handouts for resources and the hotline for crisis.	1000	No questions, fidgeting, made brief eye contact. Sister Emily smiled and thanked them for the information.
Disturbed Sensory	Next week	Came back the next week for appointment,	Next week	RN confirms that he is not hearing command	Next week	Less anxious, fidgeting less, not grabbing ears

Perception (Auditory)	0830	mumbling worse, grabbing ears, fumbling with bracelet, did not respond to RN questions. Stated “I cannot make out what you’re saying I hear background noises like at a restaurant”	0830	hallucinations to harm himself or others and validates that it must be scary, but he is safe. Provided coping resources like listening to music, talking to someone he trusts like his sister, or do something he enjoys.	0830	or face, not mumbling, responding to RN. Stated “Yes they are going away now”. Shared that listening to music with his headphones sometimes helps.
Disturbed Sensory Perception (Auditory)	0935	RN asked about how new prescription of Paliperidone is working. Stated that he still hears voices but not as often. Sister shared that he has gone out with his friends too.	0935	Educated that it may take 2 weeks for full effect of medication and about the side effects of tremors or trouble sleeping. Informed Ken that his drug test was positive for Marijuana. Used open ended questions and asked why he uses marijuana. Provided other relaxing techniques like journaling.	0935	Stated “yeah so what”. Stated that Marijuana relaxes him. Fidgeting, looking down at bracelet. Agreed to giving other healthier coping mechanisms a try.
Disturbed Sensory Perception (Auditory)	0940	Sister expressed concern about Ken not wanting to go to his usual pharmacy because he still believes the pharmacist is going to poison him. Stated “I don’t trust him, he tried to poison me”.	0940	RN reassured that hopefully once the medication reaches its peak that the paranoia will stop. Provided education on making Ken feel more relaxed by avoiding whispering around him.	0940	Fidgeting slightly, looking down. Sister Emily expressed gratitude for education by smiling and nodding.
Ineffective Health Maintenance	0945	Sister Emily expressed concern for long term care of Ken. Ken reassured Emily that he will never need assistance with ADL.	0945	Provided reassurance that that is a valid concern. Provided Ken and Emily with a pamphlet on power of attorney and explained it to them. Also provided education on relapses with Schizophrenia and preventing them.	0945	Ken expressed gratitude by thanking the RN for the information on power of attorney. Ready for provider to come in.

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 positive for Marijuana
CBC w differential WNL
Prolactin level Elevated
Fasting blood glucose
Lipid panel- Elevated

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

Signs and Symptoms
Auditory Hallucinations, delusions, disorganized speech, decline in self-care, grades, withdrawal from personal relationships, quit attending classes
Did not attend last Dr. Visit
Sleeping less around 5-6 hours a night.
Minimal eye contact, clenched fists, pacing
Flat bland affect
Weight loss, with decreased appetite, trouble swallowing
Not taking prescribed medication

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

Contributing Risk Factors
Parents divorcing when 10
Sister only support person
Substance use of Cocaine, alcohol, Marijuana
Not attending doctor visits or medication adherence

NCLEX IV *(7)*: Reduction of Risk

Therapeutic Procedures
Non-surgical
Referral to group therapy
IM of Paliperidone
Referral to substance abuse therapy

Surgical
None

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

Risk of suicide or self-harm, impairment of daily functioning, worsening psychosis, metabolic syndrome from hx of stopping medication.

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

Medication Management
Acetaminophen 325 mg 1-2 PO PRN for pain relief
Cetirizine 10 mg PO daily for allergies
Paliperidone 234 mg IM 1 dose now for schizophrenia

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

Non-Pharmacologic Care Measures

Teaching on schizophrenia signs and symptoms, relapse prevention, and outpatient therapy. Pamphlet on medication. Encourage use of coping skills.

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

Stressors the client experienced?
Failing class and not attending
Social withdrawal and isolation
Not much support-only sister
Parent's divorce
Substance use

Client/Family Education

Document 3 teaching topics specific for this client.
• Importance of taking prescribed medications and not just stopping
• Effects of drugs such as Marijuana on schizophrenia along with cocaine or alcohol.
• Coping mechanisms for hallucinations like talking with sister, or journaling.

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

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
Nurse practitioner, RN, social workers, therapists, pharmacy

Patient Resources
Counselors nearby that specialize in Schizophrenia, Substance abuse programs, Crisis hotline numbers,

support groups for people with Schizophrenia so they can lean on each other

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 was that schizophrenia can affect a person's whole life including their relationships, career, goals, and even just ADL's can be affected. It can be a debilitating disorder.

2. What was something that surprised you in the care of this patient?
   Something that surprised me was when he admitted to having used cocaine and then his drug test came back positive for marijuana. I don't think I really related substance abuse to schizophrenia but now I can understand how this goes hand in hand and how this can be really dangerous for the patient.

3. What is something you would do differently with the care of this client?
   Something I would do differently would just to be incorporate more therapeutic communication with him while also incorporating the medical side. I felt like most of the appointments were focused on his medication and his compliance and while that is important it is also just as important to focus on how he is feeling mentally. I would have focused way more on his mental status and asked more open ended questions. I also think that from the beginning he should have had the resources he was offered, I don't think he should have been offered those because he was going through a hard time, I think they should have been offered at his initial diagnosis.

4. How will this simulation experience impact your nursing practice?
   This simulation impacted my nursing practice by opening up my insight into how much this diagnosis not just affects the patient but their family. I also did not realize too that some people with schizophrenia really need that one support person to kind of take charge of their healthcare because of how hard it is for the patient to be consistent with their appointments. I also know that everyone isn't in that same position where they have that one support person so it is important as the nurse to provide as many resources as possible for the patient and to also be an listening ear.

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

   The client was at the age where he should have been in the intimacy vs isolation stage. A normal part of this stage would be for the individual to establish relationships not only friends but intimate relationships, have college or a job going on steady, and completing ADL's independently and starting their life. For this client, he had trouble with his relationships as he lost a lot of friends and withdrawal from socialization and going out, he also was getting bad grades at college and ultimately dropped out of that as well, along with that his sister took a lot of control of his ADL and life choices as he was not in the mental state to make them alone.