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

Student Name: Jocelyn Holden

ATI Scenario: Schizophrenia (ATI 1)

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

The function of the brain is to control everything we do, our, movements our thoughts, etc. The brain has four lobes: frontal lobe, occipital lobe, temporal lobes, and parietal lobe. The frontal lobe is responsible for thinking, planning, decision making and personality. The frontal lobe is the last to develop and that's by the age of 25. That is why rationale decisions may be incorrect or inappropriate before the age of 25. The temporal lobe is responsible for hearing, memory, and language. The limbic system consists of two structures, the amygdala and hippocampus. The amygdala controls anger, aggression, and pleasure. The hippocampus controls memory formation. In other words, turns short-term memory into long-term memory. The brain has numerous neurotransmitters. Includes dopamine, histamine, serotonin, norepinephrine, glutamate, GABA, and acetylcholine. Dopamine controls fine muscle movements, integration of emotions and thoughts, decision making, and stimulates hypothalamus to release hormones. Histamine is responsible for alertness, inflammatory response, and stimulates gastric secretion. Norepinephrine is responsible for mood, attention and arousal, and fight or flight response to stress. Serotonin is responsible for mood, sleep regulation, hunger, pain perception, aggression and libido. Glutamate is responsible for learning & memory. GABA is responsible for reducing anxiety, aggression, pain perception, anticonvulsant and muscle-relaxing properties.

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Schizophrenia

Schizophrenia is characterized by altered cognition, altered perception and inability to determine what is real or not. Schizophrenia is usually diagnosed between 15 and 25 years old. There is a severe deterioration of social and occupational functioning. Comorbidities consist of substance use, anxiety, depression, suicide, and polydipsia. Biological influences include increased dopamine, increased serotonin, and increase C4 activity. Prolonged synaptic pruning led to the symptoms of schizophrenia. Schizophrenia presents with positive symptoms, negative symptoms, cognitive symptoms & associated features. Positive symptoms include hallucinations, delusions, illusion, & disturbed form of thought. Negative symptoms include anhedonia, avolition, affective blunting, apathy, alogia, social isolation, effected affect, & effected interpersonal functioning. Cognitive symptoms include wavy flexibility, posturing, pacing and rocking, regression, and eye movement abnormalities. DSM-5 Criteria: 2+ of the following (must have one of the first three) delusions, hallucinations, disorganized speech, catatonic behavior, or negative symptoms. Must persist for at least 6 months. The course of illness: prodromal phase, acute/active phase, stabilization phase, maintenance phase, and stabilization and maintenance phase. Typically, antipsychotics (conventional or atypical) are prescribed.

To Be Completed Before the Simulation

Anticipated Patient Problem: **Disturbed Thought Process**

Goal 1: **Patient will adhere to antipsychotic medication 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?
Establish a therapeutic relationship, PRN communication w/ patient	Establish trust and rapport to allow the patient to be comfortable and compliant PRN, distrust
Assess episodes of hallucinations PRN, cues of hallucinations	Encourage verbalization of hallucinations to describe what the voices are saying. Provide a safe environment to refrain my harm PRN, hallucinations
Assess orientation Q2H	Reorient with reality (clock, calendar, and reintroductions) PRN, disorientation
Assess distractibility techniques Q8H	Provide music, drawing, or specific activities for distraction PRN, distracted
Preform Mental Status Exam BID	Provide a safe environment, acknowledge feelings, and monitor changes within MSE exams PRN, abnormal MSE
Assess knowledge on Schizophrenia diagnosis BID	Educated on physiology of Schizophrenia & signs and symptoms (hallucinations, delusions, confusion, etc.)

Goal 2: **Patient will identify signs and symptoms of Schizophrenia during my time of care**

To Be Completed Before the Simulation

Anticipated Patient Problem: **Ineffective Coping**

Goal 1: **Patient will verbalize two healthy coping strategies 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 current coping skills BID	Identify healthy coping skills (meditations, journaling, walking, etc.) and implement new skills PRN, ineffective coping
Assess readiness to participate in group activities BID	Encourage social interaction to form connections/support reducing isolation PRN, incompliance
Assess daily personal goals every morning	Help create daily personal goals PRN, no goals Ex. Today I hope to stay happy and avoid being depressed
Identify triggers causing stress, anxiety, decreased function PRN, ineffective coping	Educate on how to avoid triggers to then avoid negative behavior PRN, triggers
Assess mood and affect along with suicidal ideation TID	Maintain a safe environment, encourage to explain thoughts and feeling and intervene PRN, depressed mood, flat affect or suicidal ideation
Assess self-care BID	Provide assistance with basic needs to improve well-being PRN, poor hygiene

Goal 2: **Patient will set two person goals each day during my time of care**

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed Thought Process
Goal: Pt will adhere to antipsychotic medication during my time of care Met: ■ Unmet:☐
Goal: Patient will identify signs and symptoms of Schizophrenia during my time of care Met: ☐ Unmet:■

Actual Patient Problem #2: Impaired Coping
Goal: Pt will verbalize adherence to positive coping skills during my time of care Met: ■ Unmet:☐
Goal: Pt will verbalize current negative coping skills during my time of care Met: ■ Unmet:☐

Additional Patient Problems:
#3 Self-care Deficit
#4 Anxiety
#5 Impaired Coping
#6 Deficient Knowledge

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	"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."	0805	Noted loose associations. Provided redirection and maintain calm environment.	0805	No additional loose associations noted
Anxiety	0800	Ken is expressing signs of anxiety. Ex. pumping his fist	0805	Established a therapeutic relationship, maintaining a low stimuli environment	0810	Ken expressed a decrease in anxiety symptoms throughout the conversation
Self-care Deficit	0810	Sister expresses concern about Ken's weight. Wt. 190lb	0810	RN educated wt. has decreased 20lb. in 6mo.	0840	MD expressed no concern with wt. loss. "I want you to eat three times a day, even if you're not hungry."
Disturbed Thought Process	0815	Ken missed worked with decreasing energy "… watching a bird show on TV. Can't mow the yard without a car."	0820	RN expresses symptoms may be worsening	0820	Educated on positive symptoms of schizophrenia. "Hallucinations, delusions, and motor agitation"
Disturbed	0815	Ken states he has	0820	Educated on		Ken is

Thought Process		not been following medication regimen or appointments		Risperidone.		experiencing delusion of persecution. “The pharmacist is poisoning my pills.”
Disturbed Thought Process	0820	Ken confirmed he often hears voices in his head	0825	“Do you often hear words tell you to hurt yourself or others”	0825	Ken states, “No just mumbling.”
Disturbed Thought Process	0820	SAFE-T: Low risk level → Moderate risk factors, + support system, & denies SI	0825	Provided resources for episodes of hallucinations	Post one week 0820	Hallucinations have decreased and no suicidal ideation
Deficient Knowledge	0825	Sister verbalized episodes of dizziness & trouble swallowing	0825	Educated on symptoms of schizophrenia	Post week 0820	No verbalized complaints of dizziness or trouble swallowing
Deficient Knowledge	0830	One to two beers weekly. Uses Cocaine	0835	Educated on the purpose of a urine test. Along with psychosis caused by cocaine	One week later 0820	Urine Test: - for cocaine but + for marijuana
Anxiety	0830	Sister expressed concern about anxiety and social isolation	0830	Educated on the purpose of visiting and talking on a regular basis.”	0900	Emily continued to support Ken, along with verbalizing concerns showing interest in support
Deficient Knowledge	0840	Poor medication regimen	0845	NP recommended IM injection Paliperidone at the clinic	0845	Ken expresses he’d feel better getting medication by known staff members
Impaired Coping	0900	Emily states, “Should Ken be in addition therapy.”	0900	RN states, “Yes group therapy is a great choice.”	0900	Will continue to monitor Ken’s effort to addition therapy & outcomes
Disturbed Thought Process	One week later 0800	Ken is hearing voices and music. “I can’t make out what their saying. Like background music at a restaurant.”	0800	Provided a safe environment and showed empathy toward Kens feelings	0840	Maintained a safe environment, close monitoring and distraction from hallucinations/delusions
Disturbed Thought Process	0810	Assessed ability to self-distract from hallucinations	0815	“You can try listening to music or even talking to your sister during hallucinations.”	0815	“Sometimes it makes it better listening to music with my headphones in.”

Disturbed Thought Process	0815	One week post first Paliperidone injection. Voices have decreased & social interaction increased	0815	Educated that Paliperidone takes up to two weeks to reach its peak. So, symptoms will continue to improve	0815	Sister states, “Oh, that’s great!”
Impaired Coping	0820	Positive Urine Test: Marijuana	0825	Educated that marijuana can worsen the symptoms of schizophrenia. Recommended deep breathing, meditation or journaling.	0830	Ken states, “Yeah, I will give those a try.”
Disturbed Thought Process	0830	Emily expresses concern for continuation of paranoia. Ken won’t go near the pharmacy.”	0835	Educated on avoiding whispering to decrease Ken’s paranoia	0840	Emily will continue to avoid paranoia triggers for Ken
Deficient Knowledge	0835	Emily is concerned about Ken’s relapse	0835	Educated schizophrenia is a chronic disorder. Relapse includes difficulty sleeping, social withdrawal, hallucinations, disturbed thought disturbances.”	0835	Emily states, “I will try my best to watch out for these things.”

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
AIMS: 0 = none
Urine Test (+) Marijuana, (-) Cocaine
Base line prior to initiating Paliperidone therapy: Cholesterol 162, FBS 98, Prolactin 7, HDL 54, & LDL 108

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

Signs and Symptoms
(+) Auditory hallucinations, delusions (persecutory), & loose association,
(-) Social isolation, flat affect, avolition, & apathy

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

Contributing Risk Factors
Marijuana Use
Age of 21
Mild Anxiety
Social Withdrawal
Nonadherence of Medication

Therapeutic Procedures
Non-surgical
Cognitive Behavioral Therapy (CBT)
Support Systems

Surgical
N/A

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)
Incompliance of Medication → leading to increasing symptoms

Delusions of Persecution → leading to medication incompliance

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

Medication Management
Risperidone (uncompliant)
IM Paliperidone

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

Non-Pharmacologic Care Measures
Group therapy
Healthy coping mechanisms (meditation, deep breathing, journaling, walking, etc.)
Support systems

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

Stressors the client experienced?
Delusions of Persecution
Work

Client/Family Education

Document 3 teaching topics specific for this client.
- If experiencing hallucinations, call the clinic immediately or notify Emily.
- Medication regimen is very important to decrease episodes of hallucinations
- Signs and symptoms of schizophrenia relapse

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

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
Mental Health Registered Nurse
Mental Health NP

Patient Resources
Crisis and Emergency
Durable Power of Attorney for Health Care

Reflection Questions

Directions: Write reflection including the following:

1. What was your biggest "take away" from participating in the care of this client?
   Participating in the care of Ken was able to give an insight for a patient with schizophrenia. Especially, since individuals which schizophrenia are specifically taken care of by mental health nurses and medical doctors. I now feel more comfortable when conversating with a individual experiencing positive and negative symptoms of schizophrenia.

2. What was something that surprised you in the care of this patient?
   Throughout the care of Ken, I was surprised by the support system he had. Being able to see how certain points of care were directed by his sister, changed his plan of care. Having a concerned support system allows for questions to be answered and to keep track of the diagnosis and plan.

3. What is something you would do differently with the care of this client?
   Throughout the care of Ken, I feel like I would have established a more developed connection. Ken was clearly experiencing anxiety. Ken did not elaborate on questions and possibly if a more developed therapeutic communication could have allowed for Ken to voice his concerns a little more than he did.

4. How will this simulation experience impact your nursing practice?
   The simulation provided a good background for an individual with schizophrenia, including medications, symptoms, and recommendations. By that I feel more comfortable taking care of an individual with schizophrenia.

5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.
   Ken was 21 years old. He was in Erikson's stage of Intimacy vs. Isolation. Normal findings include desire to form close relationships and independence in work settings. During the simulation Ken did not mention having a very strong support group other than his sister, Emily. Often a strong friend group is developed. Later in the simulation Emily mentioned Ken had gone out with his friends and spent time together.