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

Student Name: Olivia Morales

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:
CNS: brain, spinal cord, and cranial nerves.
PNS: cranial nerves III to XII, spinal nerves, and peripheral components of the autonomic nervous system.
Neurons: main functional unit of nervous system.
Excitability of neurons: ability to generate a nerve impulse.
Conductivity: ability to transmit an impulse.
Glial cells: provide support, nourishment, and protection to neurons. Make up about half of the brain and spinal cord mass.
Brain: composed into cerebrum, brainstem, and cerebellum.
Cerebrum: has right and left hemispheres. Divided into 4 lobes: frontal, temporal, parietal, and occipital.
Frontal lobe: controls higher cognitive function, memory retention, voluntary eye movements, voluntary motor movement, and motor functions involved in speech production.
Temporal lobe: integrates somatic, visual, and auditory data.
Parietal lobe: interprets spatial information, contains sensory cortex.
Occipital lobe: process of sight.
Gray matter: makes up outer layer or cerebral hemispheres.
Basal ganglia, thalamus, hypothalamus, and limbic system are groups of neuron clusters in the cerebrum.
Basal ganglia: found centrally in the cerebrum and midbrain. Function: initiation/execution/ completion of voluntary movements, learning, emotional response, and automatic movements

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

-The exact cause of schizophrenia is unknown, but it is believed to be a complex combination of genetics and environmental factors.
-It is thought to occur in susceptible individuals who are exposed to environmental insult during a critical period of neurodevelopment
-With schizophrenia there is a **severe deterioration of social and occupational functioning.**
-It is **characterized by** psychosis seen as altered cognition, perception, and ability to determine what's real/what's not real.
-Usually **diagnosed** between **15 to 25 years old**.
-Of all mental illnesses it causes more lengthy hospitalizations, chaos in family life, costs to people/governments, and fears.
-Comorbidities: substance use disorders, anxiety, depression, suicide, and polydipsia.
Predisposing factors:
Biological influences:
-increased dopamine
-increased serotonin
-increased C4 activity (prolonged synaptic pruning leads to symptoms)
Physiological influences:
-viral infection transmitted to fetus from mother while pregnant
-anatomical abnormalities
-head injury in adulthood
Genetic influences:
-strong genetic component, but how it is inherited is uncertain.
DSM-5 criteria:
2+ of these (but MUST have either 1, 2, or 3)

1. Delusions
2. Hallucinations
3. Disorganized speech

associated with skeletal muscle activity ex: swallowing.
Thalamus: major relay center for sensory input from the body, face, retina, and cochlear and taste receptors.
Hypothalamus: influences the release of hormones from the anterior pituitary gland. With input from the limbic system, it also regulates appetite, body temp, water balance, circadian rhythm, and expression of emotion.
Limbic system: emotion, feeding, behavior, and sexual response.
Brainstem: includes midbrain, pons, and medulla. Has centers for sneezing, coughing, hiccupping, vomiting, sucking, and swallowing.
Medulla: respiratory, vasomotor, and heart function.
Cerebellum: coordinates voluntary movement and maintains trunk stability/equilibrium. Receives info from cerebral cortex, muscles, joints, and inner ear.
Cerebrospinal fluid: cushions the brain/spinal cord and carries nutrients through passive diffusion and active transport.

4. Catatonic behavior
5. Negative symptoms

**Must be continuously for at least 6 months
Positive symptoms: delusions, concrete thinking, echolalia, loose association, neologisms, clang associations, word salad, circumstantiality, tangentiality, mutism, magical thinking, thought blocking, hallucinations, illusions, etc.
Negative symptoms: anhedonia, avolition, affective blunting, apathy, alogia, flat affect, impaired social interaction, social isolation, etc.
Prodromal phase:
-precedes acute phase
-sleep disturbance, anxiety irritability, depressed mood, poor concentration, fatigue
-may appear 1 month to 1 year before first psychotic break
Acute phase:
-psychotic symptoms are present
-goal: safety and stabilization
-hospitalization may be required
Stabilization phase:
-symptoms diminish
-focus is shifted to understanding the illness
-controlling/coping with the symptoms
Maintenance phase:
-maintaining and increasing symptom control
-adherence to medication regimen
-improving quality of life
-relapse prevention

To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed thought process.

Goal 1: Will communicate clearly with others during my time of care.

Goal 2: Will use coping strategies to effectively deal with hallucinations/delusions.

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 for any hallucinations/delusions and their content q2hrs.	Acknowledge the hallucinations/delusions but do not agree that they are reality prn.
Assess for disorganized speech, loose associations, word salad, neologisms, or pressured speech q2hrs.	Use clear, simple, and concise language when communicating with patient prn.
Assess for overall grooming and personal hygiene q shift.	Encourage self-care and hygiene activities q shift.
Monitor for increasing agitation or anxiety q2hrs.	Promote putting energy into other activities such as gym time, walking, or art prn.
Assess for effective coping strategies q shift.	Assist in identifying and practicing effective coping strategies to manage stress/triggers q shift.
Assess orientation, memory, concentration, and focus q2hrs.	Frequently reorient to time, date, location, and current situation as well as promoting a low stimuli environment q shift.

To Be Completed Before the Simulation

Anticipated Patient Problem: Risk for suicide.

Goal 1: Will not successfully complete suicide during my time of care.

Goal 2: Will express feelings, concerns, and suicidal ideations 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 for negative symptoms q2hrs.	Encourage self-care and hygiene activities q4hrs.
Assess participation in group activities/social interaction q 2hrs.	Encourage participation in different therapies and social interaction q2hrs.
Assess risk factors such as age, gender, employment, etc. q shift.	Help develop a strong support system q shift.
Assess medication/treatment adherence q shift.	Encourage involvement in treatment plans to boost adherence q shift.
Assess for ideation, plan, intent, and access to means q 2hrs.	Implement suicide precautions until they are no longer a risk to themselves q shift.
Assess for history of suicide attempts q shift.	Build a strong rapport and establish trust q shift.

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed thought process.
Goal: Will communicate clearly with others during my time of care. Met: ☐ Unmet:☐
Goal: Will adhere to medication regimen during my time of care. Met: ☐ Unmet:☐

Actual Patient Problem #2: Ineffective coping.
Goal: Will demonstrate effective coping strategies to deal with hallucinations/delusions during my time of care. Met: ☐ Unmet:☐
Goal:Will promote self-care activities such as eating, sleeping, etc. during my time of care. Met: ☐ Unmet:☐

Additional Patient Problems:
#3 Impaired self-care
#4 Risk for social withdrawal
#5 Deficient knowledge of disease management.

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.	0745	Exhibiting a change in his speech pattern in the waiting room. "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."	0750	Nurse Anne brings up her concern about his speech to Nicole the provider.	0755	Nurse Anne and Nicole identify the change as associative looseness together. Ken was able to communicate clearly and answer questions throughout the visit.
Ineffective coping.	0800	Exhibiting anxious behavior. Showing motor agitation and fidgeting.	0815	Nurse Anne stands off to the side of ken, more than an arm's reach away.	0930	Ken was able to sit down and remain calm for the rest of the visit.
Impaired self-care.	0800	Down 20 lbs. since last visit 6 months ago.	0900	Nicole tells Ken she wants him to eat 3 meals a day even if he doesn't feel hungry to prevent further weight loss.	0905	Ken agrees to this plan by saying "All right, I will."
Ineffective coping.	0815	Missed his appointment in February while sister was out of town. Missed last two shifts at work,	0820	Nurse Anne asks clarifying questions about why he did not come to his appointment.	0830	Ken states "No, I didn't need to come here. Didn't need the medicine." Nurse Anne states it

		seems confused when talking.				seems that he is experiencing worsening symptoms.
Ineffective coping.	0830	Hasn't been adhering to his medication regimen. Experiencing persecutory delusions about his pharmacists.	0915	Nicole offers for Ken to come to the clinic for injections.	0930	Ken and Emily both agree this is something they think would be beneficial and Ken agrees to give it a try. Ken gets his first injection before leaving his visit
Disturbed thought process.	0830	Ken experiences auditory hallucinations in the form of voices and music. He only hears mumbling, no words anymore. Dizziness when standing and trouble swallowing. SAFE-T score was low risk. Ken presents low risk of harm to himself.	0915	Nurse Anne tells Ken his SAFE-T score is reassuring. Nurse Anne/Nicole both educate Ken on the importance of reaching out if any voices tell him to harm himself.	0930	Ken agrees he will reach out to the clinic and Emily if he ever has thoughts of hurting himself.
Ineffective coping.	0835	Used cocaine in the past, drinks at bingo every week. Hasn't used any substances in the past few months.	0840	Nurse Anne identifies that cocaine could also be causing psychosis. She informs him he will have to do a urine screen to rule out cocaine as the cause of his symptoms.	0845	Acknowledges he will have to do the urine screen.
Deficient knowledge of disease management.	0835	Emily asks what symptoms cocaine may cause.	0840	Nurse Anne explains that cocaine intoxication can cause psychosis as well.	0845	Emily states, "since cocaine can cause Ken to have hallucinations, I can see why it's important to do the drug screen"
Ineffective coping.	0840	Emily brings up concerns of Ken becoming socially isolated, anxious, and restless. Ken	0845	Nurse Anne states "Emily, visiting and talking with Ken on a regular basic will help him	0900	Emily has no more questions about how to help Ken with reducing his

		has dropped out of school.		maintain his social interactions"		risk for social withdrawal.
Disturbed thought process.	0900	Nicole/Nurse Anne assess for any questions they may have about the Paliperidone.	0905	Nicole provides information pamphlets and Nurse Anne explains the dosing regimen/frequency to Emily.	0910	Ken agrees he will be able to come back every month for the injection and states he has no further questions.
Ineffective coping.	0910	Emily expresses concerns about Ken not being in therapy and only relying on medication.	0915	Nurse Anne informs them that they recommend group therapy as part of the tx plan for schizophrenic patients.	0930	Emily and Ken accept the information and seem interested in possibly implementing group therapy.
Ineffective coping.	0600	Urine drug screen was positive for marijuana.	1015	Nurse Anne uses the open-ended question "Tell me some of your reasons for using marijuana" to encourage open discussion.	1020	Ken states he uses weed because its relaxing. But he agrees to try deep breathing exercises, meditation, or journaling as other forms of relaxation.
Disturbed thought process.	1000	Been one week since last visit, still hearing voices but can't make out what they're saying. He is visibly anxious, showing motor agitation/fidgeting.	1005	Nurse Anne is reassured that the voices are not telling Ken to do anything. She acknowledges hearing voices must be frightening but he is safe.	1010	Ken states "Sometimes it helps when I listen to music with my headphones." as an effective coping mechanism when he hears voices.
Risk for social withdrawal.	1000	Has been out a couple times with friends since he got his first injection of his new medication.	1010	Nurse Anne states "It sounds like the medication is starting to help." She also touches on how it still hasn't reached its peak effect yet and even greater improvement may occur.	1015	Emily seems incredibly pleased to hear this stating "That's good to hear."
Disturbed thought process.	1020	Emily expresses concerns about Ken feeling paranoid	1030	Nurse Anne suggests avoiding whispering or talking quietly to	1030	No further teaching is needed for Emily on this subject as she states she has

		about the people in his life.		others when around Ken.		no further questions.
Deficient knowledge of disease management.	1030	Emily expresses concerns about what would happen if Ken couldn't make decisions for himself anymore.	1040	Nurse Anne provides Emily with resources/pamphlet on durable power of attorney for health care.	1045	Ken thanks Nurse Anne for going over that with him and Emily.
Deficient knowledge of disease management.	1045	Emily asks about ways to prevent relapse.	1050	Nurse Anne acknowledges it is not fully preventable but there are ways to decrease incidence such as avoiding substances and partaking in group therapy.	1100	Ken and Emily state they have no more questions for Nurse Anne.

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
-CBC with differential
-Prolactin level
-Fasting blood glucose
-Lipid profile

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

Signs and Symptoms
-Persecutory delusions
-Auditory hallucinations
-Trouble swallowing
-Dizziness with standing
-Disorganized speech
-Motor agitation.
-Social withdrawal
-Decline in self-care (not eating)
-Mild anxiety

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

Contributing Risk Factors
-History of substance abuse (cocaine/marijuana)
-Parents divorced when he was a child.
-Male

NCLEX IV *(7)*: Reduction of Risk

Therapeutic Procedures

Non-surgical
-Group therapy
-Enjoys reading and watching movies

Surgical
-Psychosurgery (last resort)

Prevention of Complications
(Any complications associated with the client's disease process? If not what are some complications you anticipate)
-Depression
-Anxiety
-Substance Use Disorders
-Risk for suicide
-Withdrawal
-Cognitive impairments

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

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

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

Medication Management
-Risperidone 2mg PO twice daily
-Paliperidone 234 mg IM

Non-Pharmacologic Care Measures
-Group therapy
-Support system (Emily)
-Reading, watching movies, listening to music.
-Setting goals.

Stressors the client experienced?
-Dropped out of school
-Parental divorce
-Substance abuse
-Recently discharged from acute mental health facility

Client/Family Education

Document 3 teaching topics specific for this client.
- Importance of medication adherence.
- Importance of reaching out if he has any thoughts about harming himself.
- Benefits of group therapy in conjunction with medication therapy.

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

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
-Nurses
-Providers
-Support system/family

Patient Resources
-Crisis resources
-Durable power of attorney for health care
-Medication pamphlet
-Group therapy resources

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 was how important support systems truly are in the care of a mental health patient. While these visits were about Ken, Emily brought a lot of valid concerns to the table and without her there they might've never gotten brought up. These concerns led us to know the true condition of how Ken was doing, and when she wasn't around he didn't go to his doctor's appointment. Emily plays a big part in Ken's life and it was very apparent through this scenario just how much her being around and paying attention to his condition positively affected the care he received, further proving how important it is for mental health patients to have a strong support system. Without a strong support system some things could go unnoticed as the patient themselves may not even notice they are occurring, and it could be detrimental to their care.

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

   I was expecting him to be in a more heavily acute phase than he was during the scenario. He was experiencing auditory hallucinations and some delusions, but he was a lot more functional and calmer than I anticipated him to be. I was expecting him to be more agitated and anxious than he was, while he had his anxious moments, he was fairly calm during both visits. He stayed open to the teaching, let Emily voice her concerns, maintained eye contact, answered many questions, and was overall engaged and concentrated for the visits. Which was a lot more than I was expecting, I feel as though schizophrenic patients are portrayed as these aggressive people who people believe they are meant to fear, but Ken was very polite and functioning during the visit.

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

   I think I would try to find a better balance between talking with Ken and Emily, I feel as though sometimes it was more focused on educating Emily/conversing with Emily than it was Ken. Which is understandable as she was the one asking the questions, but Ken also lives alone and needs to know all this information as well. So, I think asking him more questions to make sure he was understanding the material and implementing some teach back techniques during the visit could've been really beneficial to his care to make sure he wasn't just agreeing he understood when in reality maybe he didn't.

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

   This simulation experience will impact my nursing practice by helping me prevent forming any bias and stigma against patients who suffer from schizophrenia. As I talked about earlier, I expected Ken to be in a much worse state than he was during this simulation and it just proved that schizophrenia can come in all shapes and forms, and that it is nothing to fear. These patients deserve the same care, respect, and compassion no matter what diagnosis they have in their chart. I think this simulation was a very good reminder that people with schizophrenia are people just like us trying to enjoy their lives and that they have family like Emily who care for them very much, just like our families care for us. Their diagnosis makes them no different from anybody else and I think that is a very good lesson for me to carry into my nursing practice in the future.

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

   Ken is in the young adult developmental stage of his life. During the young adult stage Erikson focuses on Intimacy vs. Isolation, there is a heavy focus on forming close/committed relationships

and preventing loneliness. Young adults are also expected to become more independent, focus on careers, higher education, starting families, and having financial independence. In some ways Ken is doing very well, and in some ways he is not. For example, he was originally in college which would've been good for pursuing higher education, but he recently dropped out, yet he is still living on his own and still has a stable job. So, while he is not currently pursuing higher education he still has independence. There was no mention of any romantic partnership during the simulation, but he is very close with his sister and is working on keeping close relationships with his friends so while not the most conventional, he is still preventing loneliness which is important for his development. Overall while he is not taking the conventional developmental route for his age, he is still focusing preventing loneliness and promoting independence which is important for him and a big step for him which his diagnosis.