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

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ATI Scenario: Schizophrenia (ATI real life 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 nervous system is one of the most complex systems that controls the bodies functions.
Nervous systems:
Central Nervous System (CNS): Brain, spinal cord, cranial nerves I & II. Peripheral Nervous System (PNS): Cranial nerves III–XII, spinal nerves, autonomic components. Autonomic Nervous System (ANS): Sympathetic (fight/flight) & parasympathetic (rest/digest).
Cells:
Neurons: Functional unit; properties include excitability, conductivity, and ability to influence other cells. Cell body (soma): metabolic center. Dendrites: receive impulses. Axon: transmits impulses to neurons, muscles, or glands. Myelin sheath: insulates and speeds conduction. Glial Cells (support cells): Astrocytes: support, form blood-brain barrier, repair, gliosis. Oligodendrocytes: produce myelin in CNS. Schwann cells: produce myelin in PNS, support regeneration. Microglia: phagocytic defense. Ependymal cells: line ventricles, aid in CSF secretion.
Neurophysiology:
Nerve impulse: Electrical (action potential) → chemical (neurotransmitter) → electrical in next neuron. Saltatory conduction: Action potential "jumps" between nodes of Ranvier, speeding transmission. Synapse: Presynaptic terminal → synaptic cleft → postsynaptic receptor.
Neurotransmitters:
Excitatory: epinephrine, norepinephrine, glutamate. Inhibitory: serotonin, GABA, dopamine. Special roles: endorphins (block pain), substance P (enhances pain).
CNS:
Spinal cord: continuous w/ brain stem, exits through cranial cavity through foramen magnum. Gray matter: neuron cell bodies (motor, autonomic,

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease
Biochemical:
Increased dopamine, serotonin, & C4 activity (causes increased synaptic pruning)
Physiological:
Viral infections, anatomic abnormalities, head injury in adulthood
Genetics:
Strong genetic component, 1st degree relatives increased risk
Prevalence:
In US ~1% population, dx usually between age 15-25
Commodities:
SUD, anxiety, depression, suicide, polydipsia
Characteristics:
Psychosis, altered cognition, perception, ability to determine what's real. Alter social, occupational, and daily function
Phases:
Prodromal phase, acute phase, stabilization phases, maintenance phase
Positive symptoms:
Added to person (should not be there). Hallucinations (false sensory perception w/ no external stimuli) delusions (false personal beliefs), illusions (misinterpretations of real external stimuli). Form of thought: concrete think (literal interpretations), echolalia (repeating words), loose association (shift ideas from unrelated topic), neologism (made up words), clang associations (rhyming words), word salad (random words), circumstantiality (delay in reaching the point), tangentiality (never reaching point), mutism (not speaking), magical thinking (idea that thought control things), thought blocking (stoppage of thought)
Negative:

interneurons). White matter: ascending sensory & descending motor tracts. Ascending tracts: carry sensation (pain, touch, vibration, proprioception). Descending tracts: motor control (pyramidal for voluntary movement; extrapyramidal for posture & coordination). Reflex arc: receptor → afferent neuron → interneuron → efferent neuron → effector (muscle/gland).

Brain:

3 major components (cerebrum, brainstem, cerebellum). Cerebrum (lobes): Frontal: motor, cognition, speech (Broca). Parietal: sensory, spatial orientation. Temporal: auditory, language comprehension (Wernicke). Occipital: vision. Basal ganglia: refine movements, automatic motor control. Thalamus: sensory relay station. Hypothalamus: autonomic & endocrine regulation, homeostasis, circadian rhythm. Limbic system: emotions, memory, drives. Cerebellum: coordination, balance, posture. Brainstem (midbrain, pons, medulla): cranial nerves III–XII, vital centers (respiratory, cardiac), reticular activating system (arousal, sleep-wake cycle).

Ventricles & CSF:

4 ventricles produce & circulate CSF (~500 mL/day; ~150 mL at any time). Cushions, nourishes brain & spinal cord. Absorbed via arachnoid villi into venous circulation. Imbalance → hydrocephalus or increased ICP.

PNS:

Spinal nerves: 31 pairs; each has dorsal (sensory) & ventral (motor) roots. Dermatome: skin region supplied by one spinal nerve. Myotome: muscle group supplied by one spinal nerve. Cranial nerves (CN I–XII): some sensory, some motor, some mixed.

ANS:

Sympathetic (SNS): Fight-or-flight → ↑HR, dilates bronchi, dilates pupils, ↓GI motility, ↑glucose. Parasympathetic (PSNS): rest-and-digest → ↓HR, constricts pupils, ↑GI motility, stimulates urination & digestion. SNS: norepinephrine (postganglionic), acetylcholine (preganglionic). PSNS: acetylcholine at both synapses.

Cerebral circulation:

Blood supply: Anterior circulation: internal carotids. Posterior circulation: vertebral → basilar artery. Circle of Willis provides collateral flow. Blood-brain barrier: selective permeability; lipid-soluble drugs pass easily, water-soluble slowly. Meninges: dura, arachnoid, pia → protect & support brain. Skull & vertebral column: physical protection.

Anhedonia (decreased pleasure or joy), avolition (lack of motivation), affect blunting (decreased showing of emotions), apathy (lack of interest), alogia (lack of speech), decreased affect, impaired interpersonal skills. Impaired memory, information processing, executive function.

DSM-5:

2+ of the following for at least 6 months
Delusions, hallucinations, disorganized speech, catatonic behavior, negative s/sx. Level of function is impaired

To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed sensory perception

Goal 1: Will accurately interpret reality during time of care

Goal 2: Will recognize distortions of reality and identity potential triggers during 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 any hallucinations (visual, auditory, tactile) q1 hr & prn	Ask what hallucination (auditory), then convey empathy, suggest reality, distract prn
Assess for self-harm or suicide risk q1 & prn	Place on 1:1 observation, remove harm risks, chart q15 min
Assess for delusions and illusions q1 & prn	Don't argue or play into delusion or illusion, suggest reality, convey empathy prn
Assess for form of thought (positive symptoms) q1 & prn	Use reality-based activities, ask for clarity if not understanding, look & identity themes, use clear communications prn
Assess for trigger of impaired sensory perception q1 & prn	Document, look for recurrent themes, talk to client about it q1 & prn
Assess milieu is therapeutic and safe q1	Set limits, reinforce positive behavior, calm & quite, avoid competition q1 & prn

To Be Completed Before the Simulation

Anticipated Patient Problem: Ineffective health maintenance

Goal 1: Maintain med compliance & management during time of care

Goal 2: Get proper amount for fluid and nutritional intake recommended per day during time of care

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframe	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Assess for negative symptoms q1 & prn	Give second gen antipsychotics as scheduled & prn
Assess med compliance q2 & prn	Educated on reasons to take meds, side effects, importance of staying on meds prn
Assess for lack of self care q4 & prn	Give positive reinforcement when completed, assist as needed, encourage independent with care q4 & prn
Assess nutritional & hydration status q2 & prn	Give high calorie, high protein foods, give in sealed containers if paranoid, offer food frequently q2 & prn
Assess support system q daily	Involve support system in care, provide education, teach what to monitor q daily & prn
Assess for social isolation and withdrawal q2 & prn	Use therapeutic communication, spend time with client, encourage participation in milieu (if appropriate) q2 & prn

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed thought perceptions
Goal: Will successfully recognize distortions of reality Met: ☐ Unmet:☐
Goal: Will use at least one coping strategy (such as distraction) when hearing voices Met: ☐ Unmet:☐

Actual Patient Problem #2: Ineffective health maintenance
Goal: Will eat 3 meals a day to prevent further weight loss Met: ☐ Unmet:☐
Goal: Show up for all appointments & follow med compliance Met: ☐ Unmet:☐

Additional Patient Problems:
#3 Social isolation
#4 Interrupted family process
#5 Disturbed sensory process
#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	0945	Associative looseness speech pattern when talking to sister	0946 1st appt	RN notified NP about loose association speech pattern	0946 1st appt	Continued with loose association and clang association in first part of appointment
Ineffective health maintenance	0946 1st appt	sister said "doesn't' seem like he's eating much", weight 190 lbs (20 lbs less than 6 months ago), said not feeling hungry	0950 1st appt	Brought up weight loss up to NP. NP want Ken to eat 3 meals a day	0952 1st appt	Ken agreed to eating 3 meals a day ("Okay I will), even when not hungry
Social isolation	0950 1st appt	"Has missed last 2 shifts at work and having very little energy" & missed last appointment Sister brought up increasing anxiety level & social isolation	0955 1st appt	Administered 1st dose of IM paliperidone	1000 2nd appt	Came back for 2nd appt 1 week later and sister reported he has gone out with friends
Ineffective health maintenance/ Disturbed thought process	0950 1st appt	Denied taking medication he was prescribed last time he was here ("they poison the pills) (delusion of persecution)	0954 1st appt	NP discusses injectable antipsychotics and prescribed paliperidone for Ken	0955 1st appt	1st dose given, second dose scheduled for 1 week later

Disturbed sensory perceptions	0951 1st appt	Admitted to having auditory hallucination (hearing mumbling or music)	0956 1st appt	Nurse asked if he hears words that tell him to hurt himself or others Tell him to reach out to healthcare provider if it changes Administered 1st dose of IM paliperidone	1001 2nd appt	Agreed if hearing command hallucinations to tell sister and call clinic Reported still hearing voices sometimes, but are better
Ineffective health maintenance	0957 1st appt	Urine drug test negative for cocaine, positive for marijuana	0957 1st appt	Nurse asked "tell me some reasons for using marijuana", Ken says it helps him relax	0958 1st appt	Educated that marijuana can worse symptoms, gave alternative relaxation techniques
Ineffective health maintenance	0958 1st appt	Sister asked if Ken should also be in therapy along with medication management	0958 1st appt	Nurse educated about the positive effects of group therapy	0958 1st appt	Verbalized understanding of positive effects of group therapy in conjunction with medication
Disturbed sensory perceptions	1001 2nd appt	Ken appeared restless, and admits to hearing voices like "background noise at restaurant" no command hallucinations	1002 2nd appt	Use therapeutic communication to convey empathy and reassure "hearing voices must be fighting, but you are safe" Educated on use of distraction when hearing voices . Gave crisis resources if developed command hallucinations	1003 2nd appt	Ken verbalized that listen to music with his headphones helps with the auditory hallucinations
Disturbed though process	1003 2nd appt	Sister brings up that Ken is still paranoid about the pharmacist	1005 2nd appt	Nurse expanded methods to reduce paranoia such as not whispering in same room as Ken	1007 2nd appt	Sister had not further questions at the time
Interrupted family process	1009 2nd appt	Sister brought up up concerns about what if Ken gets so sick he can't make his own decisions	1010 2nd appt	Nurse gave pamphlet on (DPAHC) if that ever happened	1011 2nd appt	Sister and Ken read over pamphlet, asked follow up questions, and said they would look into it

Interrupted family process	1013 2nd appt	Sister brought up concerns about what would happen if Ken relapsed	1013 2nd appt	Nurse educated that this is part of illness and gave ways to manage it	1015 2nd appt	Sister and client verbalized understanding of relapse recognition and what to do

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 (+ for marijuana)
SAFE-T screening
MSE
CBC
RBC: 5.7
Hgb: 16
Hct: 48%
Platelet: 310,000
WBC: 6200
Lipid panel
Total cholesterol: 162
HDL: 54
LDLD: 108
Triglycerides: 98

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

Signs and Symptoms
Associative looseness
SUD
Delusions of persecution
Auditory hallucinations
Flat affect
Weight loss & decreased appetite
Social withdrawal
Decline in self-care

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

Contributing Risk Factors
Male
Age 21
Past use of cocaine & current use of ETOH & marijuana
ACE 1/10
Parental divorce
Increased stress (college)

NCLEX IV *(7)*: Reduction of Risk

Therapeutic Procedures
Non-surgical
Talk therapy
Group therapy
Psychopharmacology

Surgical
Deep brain stimulation
ECT
Spinal cord stimulator

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)
Substance use
Psychosis
Malnutrition
Dehydration
Polydipsia
Self harm
Suicide
Violence towards others

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

Medication Management
Risperidone PO (discontinued)
Paliperidone IM injection

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

Non-Pharmacologic Care Measures
Group therapy
Distraction techniques

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

Stressors the client experienced?
Family stress
Paranoia
Hearing voices
Job & daily function
Medication side effects
Relapse

Client/Family Education

Document 3 teaching topics specific for this client.

- Medication (paliperidone) side effect & importance
- Family/support system signs to monitor
- When to contact the HCP (auditory hallucinations)

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

Multidisciplinary Team Involvement

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

Psychiatrist
Nurse
Therapist
Peer support (group)
Support system/family

Patient Resources

Group therapy
Family support group
Online and printed reference and education materials

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 this was not everyone with schizophrenia has the same presentation. Also, how key the family or support system plays a role in the treatment of this.

2. **What was something that surprised you in the care of this patient?**
   Something that surprised me in caring for this patient was how crucial his sister played in his care. She was the one primary asking questions and bring up concerns about the client. In my experience I have usually gone directly to the patient with questions & education. It was interesting see how having a good support system is so important for those with mental illness.

3. **What is something you would do differently with the care of this client?**
   Something I would most likely do differently would be trying to get the client more involved in his treatment. Most of the concerns and questions were raised by his sister. I would try to get the client more engaged in his care, this might not be very successful, but I think that it would be worth a try getting him more involved along with having his sister participate.

4. **How will this simulation experience impact your nursing practice?**
   This will impact my nursing practice by better helping me understand how to engage with clients with schizophrenia or any other mental illness. I had not cared for this population yet & I think that this gave me an idea on how to approach client care as well as involving the family or support system. I also remined me how important it is to have a support person in a person with mental illness.

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

   Ken is in the young adult stage the normal Erickson for this stage is intimacy vs isolation. This stage focuses on the importance of building strong lasting relationships and the transition from adolescent into adulthood. From my understanding Ken has not been able to form these lasting meaningful connections with people other than his sister. This could lead to isolation if not completed, during the simulation his sister mentioned that he cares be socially isolated sometimes, but that since the first dose of paliperidone was given he had hung out with his friends. In order to successfully complete this stage Ken will need to form last connections with a person, cause, institution, or creative effort.