

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

Student Name: Morgan Taylor

ATI Scenario: 1

**To Be Completed Before the Simulation**

Medical Diagnosis: Schizophrenia

NCLEX IV (8): **Physiological Integrity/Physiological Adaptation**

Anatomy and Physiology  
Normal Structures

**Anatomy: Brain:** Cerebrum (L&R) largest part of the brain. Controls thinking, learning, emotion, memory & functions. Home of the limbic system (amygdala – emotion and fear, hippocampus – memory formation and retrieval, hypothalamus – homeostasis temp, hunger, thirst) that regulates emotions, motivation, and memory. Thalamus – relays sensory information to the cerebrum. **Lobes:** Parietal– sensory & language Frontal- executive functions and movement Temporal– hearing, memory and language Occipital – vision. Brainstem: connects the cerebrum to the spinal cord and controls RR, HR, digestion. (Midbrain – eye movement, visual and auditory processing. Pons – facial sensation and hearing. Medulla oblongata- RR, HR) Cerebellum – behind the brainstem – muscle coordination and balance. Basal Ganglia- regulates movement and posture. **Physiology:** The brain controls functions and oversees structure and focus of the body. The brain is the central organ of the nervous system. Neurons and synapses are the functional units that send, receive, and process electrical signals through dendrites, cell body, and axons. Neurotransmitters: Serotonin: Mood regulation, sleep & appetite. Dopamine: reward & motivation. GABA: Calming and inhibitory effects. Glutamate: learning and memory. Within the brain the neurons will relay signals throughout to ensure that the body is maintaining homeostasis.

NCLEX IV (7): **Reduction of Risk**

Pathophysiology of Disease

Schizophrenia has multiple factors that contribute to the disease. There is a strong genetic factor, along with neurotransmitter abnormalities. There is an increase in dopamine (+ symptoms – hallucinations and delusions) Reduced glutamate (- symptom – apathy) Dysregulated GABA which can disrupt the brains homeostasis and alterations in serotonin. There is also a reduction in gray matter volume corresponding to a schizophrenia diagnosis. Contributions to schizophrenia could be ACEs and drug use.

**To Be Completed Before the Simulation**

Anticipated Patient Problem: Disturbed sensory perception (auditory and visual)

Goal 1: Client will not harm self or others and remain safe during my time of care.

<b>Relevant Assessments</b>  (Prewrite) What assessments pertain to your patient's problem? Include timeframes	<b>Multidisciplinary Team Intervention</b>  (Prewrite) What will you do if your assessment is abnormal?
Assess mood & affect q2h	Administer prescribed medication (antipsychotics, antidepressants), identify risks associated with possible SI.
Assess risk for suicide ideations q2h	Notify provider, 1:1 sitter, keep client within sight (do not leave alone) SI precautions in place
Assess vital signs q4h	If elevated HR/RR coach relaxation techniques, administer PRN antianxiety if ordered
Assess knowledge on relaxation techniques BID	Provide teaching on different coping techniques, help to identify stressors and triggers BID.
Assess for hallucinations and what they are saying/doing q4h	Maintain safety for client and others, stay with client, distract from hallucinations PRN
Assess mental status and orientation q4h	Orient person to time and place if indicated, maintain safety constant

Goal 2: Client will recognize distortions of reality during my time of care.

**To Be Completed Before the Simulation**

Anticipated Patient Problem: Self Care Deficit

Goal 1: Client preforms self-care ADLs independently once during my time of care.

<b>Relevant Assessments</b>	<b>Multidisciplinary Team Intervention</b>
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess knowledge of current medications daily	Education on importance of medication adherence (involve support system) daily
Assess for stressors and environment BID	Maintain a low stimulus, calm environment, help identify and remove stressors, relaxation techniques
Assess for relapse daily	Provide education that this is part of illness – develop a plan with client daily
Assess hygiene daily	Encourage daily shower and oral hygiene, provide new clothes and linen (within suicide precaution)
Assess for support system daily	Help develop a support system, education (relapse may be a normal process of illness and s/s) daily
Assess mood & affect q2h	Administer antipsychotics and antidepressants per order

Goal 2: Client verbalizes self-perception realistically during my time of care.

**To Be Completed During the Simulation:**

Actual Patient Problem #1: Disturbed sensory perception - auditory
Goal: Client will not harm self during my time of care. Met: X Unmet:
Goal: Client will recognize distortions of reality during my time of care Met: X Unmet:
Actual Patient Problem #2: Knowledge deficit
Goal: Verbalizes understanding of new medication during my time of care. Met: X Unmet:
Goal: Verbalizes understanding of crisis intervention and when to seek emergency care. Met: X Unmet:

Additional Patient Problems:
#3 Self-care deficit
#4 Risk for suicidal ideations
#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
Disturbed sensory perception	0900	Hands clenched, jittery, appearing anxious	0900	Maintain a safe distance away from client	1100	Staff and client remained safe during visit
Self-care deficit	0920	190 pounds (20lbs less over last 6 months) relay isn’t eating	0925	Reassured still WNL but will bring to providers attention	0945	Verbalizes will eat 3 meals a day even when not hungry
Self-care deficit/ Disturbed sensory perception	0935	Missing work, non-compliant with medication delusion of medication being “poisoned”	0940	Notify provider – new medication ordered, provided education on new medication (paliperidone)	0945	Accepts new medication, verbalizes understanding & receives first dosage in office
Disturbed sensory perception/ Risk for suicidal ideations	1000	Denies hearing command hallucinations (just music and words) Denies SI	1015	SAFE-T screening questionnaire, provided emergency and crisis resources	1015	SAFE-T score – reassuring for no SI
Knowledge deficit/self-care deficit	1015	Denies recent substance use	1020	Education on cocaine symptoms, UDS	1025	Verbalizes understanding of education
Self-care deficit	1030	Sister relays concern for social isolation	1035	Education on ways to remain involved	1040	Pamphlet on group therapy given, acknowledged by client and sister
Disturbed	1040	Fidgety at follow	1045	Reassures kens	1050	Verbalizes coping

sensory perception		up appointment		safety & acknowledges he is hearing things		techniques like listening to music
Disturbed sensory perception	1050	+ TCH in USD	1055	Education on other coping techniques – deep breathing	1100	Verbalizes understanding of symptoms with drug usage while having a mental illness
Knowledge deficit	1100	Sister asks questions about progression of illness/ POA	1105	Provided pamphlet and education on POA	1110	Verbalizes understanding of possible relapse of disease

**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  
  
UDS  
BGL  
Cholesterol

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

Signs and Symptoms  
  
Hallucinations (hearing mumbling)  
Delusions (persecution)  
Anxiety/Restless  
Social isolation  
Paranoia

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

Contributing Risk Factors  
  
History of cocaine use and current  
ETOH 1-2drinks/week, THC

**NCLEX IV (7): Reduction of Risk**

Therapeutic Procedures  
  
Non-surgical  
  
Relaxation techniques  
  
Surgical

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

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

Medication Management  
  
Risperidone  
Paliperidone

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

Non-Pharmacologic Care Measures  
  
Group therapy  
Meditation  
Journal  
Deep breathing  
Calming music

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

Stressors the client experienced?  
  
Anxiety  
Social isolation

**Client/Family Education**

Document 3 teaching topics specific for this client.  
•Medication education on paliperidone  
•Signs and symptoms of relapse of schizophrenia  
•What to do in crisis, or if experiencing SI/HI

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

Multidisciplinary Team Involvement  
(Which other disciplines were involved in caring for this client?)  
  
Practitioner, Lab, Pharmacy

Patient Resources

Pamphlet on new medication paliperidone  
Group therapy handouts  
Crisis information  
Pamphlet on POA

## 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 this ATI sim was that there is so much teaching involved in clients who are diagnosed with mental illness. The teaching does not stop at just the client – but family or support persons should also be involved and encouraged to ask questions.
2. What was something that surprised you in the care of this patient?  
I was surprised with how “calm and cooperative” the client was. With the client being anxious, paranoid, and fidgety I was expecting him to possibly “lash out” at the nurse for asking so many questions but he did not. I was expecting safety to be a big concern for the staff.
3. What is something you would do differently with the care of this client?  
For the care of this client, I would have maybe made the environment a little more low stimuli, dimmer lights, the nurse was mainly open other than turning her back to chart in the computer in the middle of their conversation. That may be a potential safety hazards or make the client more paranoid.
4. How will this simulation experience impact your nursing practice?  
This sim will help me in my practice to remind me to remain nonjudgmental, and to include the support persons along with the client. After watching our video in class and completing this lesson it made me realize how much strain mental illness has on family members, and it is very important to include and involve them in the care. Education in extremely important.
5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.  
Developmental stage – intimacy vs. isolation. This client is experiencing isolation. The sister brings up multiple times how he is experiencing social isolation and voices her concern. His paranoia may contribute to that, and if not resolved he may not be able to develop intimacy throughout his life.