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

Student Name: Alexa Dolan

ATI Scenario: ATI 1 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

The central nervous system consists of the brain and the spinal cord. These two functions together to send and receive messages to and from the brain to the body.

STRUCTURES OF THE BRAIN

Cerebrum: (largest structure) in charge if thinking perception, memory and voluntary movements; includes the lobes of the brain frontal(judgement, planning, speech and personality changes), Parietal(sensory interpretation and spatial awareness), Temporal(hearing and auditory processing, memory and language comprehension), occipital(vision and visual processing) .

Diencephalon: the center that relays sensory and autonomic function: includes the Thalamus(station for sensory impulses to the cortex and regulates A&O) Hypothalamus(regulates the ans – temp, hunger, thirst, sleep, endo function, as well as controls the pituitary), Pineal gland(produces melatonin and regulates circadian rhythm)

Cerebellum: posterior to the brainstem, below the occipital lobe. Focus on balance and coordination of involuntary movements, fine motor control and muscle tone. Can cause ataxia and tremors)

Brainstem: controls life functions; breathing, HR, BP, and consciousness. Midbrain(controls visual and auditory reflexes and helps with motor movements), Pons(connects cerebellum and cerebrum, controls sleep and breathing), Medulla obligatos(controls HR, bp, swallowing, coughing and vomiting).

Spinal Cord: column of nerves running from the brain stem to the vertebral column. Functions as conducting sensory(afferent-just to brain) and motor(efferent- brain and body) impulses and controls reflexes.

Protective structures: meninges (3 layers' arachnoid, pia; protect brain and spinal cord) , CSF(cushion and protect spinal cord by removing waste and circulate nutrients) . BBB(prevents harmful substances from entering the brain) , skull/vertebral column(provide rigid protection from brain and spinal cord)

Limbic system: amygdala, hippocampus, cingulate gyrus; emotions memory, motivation, pleasure and fear)

RAS: neurons in brainstem and thalamus: controls wakefulness, alertness, and attention.

Basal ganglia: nuclei in cerebrum and midbrain that regulate movement, posture, muscle tone.

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

Considered a chronic and severe psychiatric disorder that effects thought process, emotions, perception, and behavior. Can cause distorted perceptions of reality (psychosis), impaired social functioning which could be disorganized speech or withdraw. It can be experienced with episodes of + symptoms followed by periods of remission and normalcy or – symptoms.

This disease can be caused by different factors such as Neurochemical: DOPAMINE: increase in dopamine= + symptoms, decrease in dopamine= - symptoms, blockage of dopamine can cause EPS and can increase prolactin causing sexual dysfunction. GLUTAMATE: decrease in activity can cause – symptoms (cognitive), SERETONIN: imbalance in mood, perception. GABA: decreased inhibitory control which leads to disorganized thinking and + symptoms. Structural: enlarged ventricles, reduced frontal lobe, atrophy to temporal lobe, abnormal limbic system and decreased cortical thickness. Genetics: first degree relative, prenatal infections, maternal malnutrition, hypoxia during birth and early stress on brain.

4 Phases : prodromal(early warning stage- social w/d, odd behavior and decline in functioning). Acute phase(full blown pyschosis- hallucinations, delusions and disorganized thought. USUALLY HOSPITALIZED) . stabilization phase(symptoms decrease in intensity and meds are used and adjusted to maintain a neutral level). Residual phase(absence of acute symptoms but showcases negative or cognitive symptoms).

Prognosis: iit is a chronic and lifelong disease but is manageable with consistent treatment . early interventions are best to improve long term functioning to promote independence and stabilization for the patient to participate in life long.

If untreated this can lead to suicide or self harm, harming of other people, substance use disorder, social isolation, homelessness and unemployment, and poor physical health due to lifestyle choices.

To Be Completed Before the Simulation

Anticipated Patient Problem: disturbed sensory perception

Goal 1: pt will recognize distortions of reality during my time of care.

Goal 2:pt will maintain anxiety at a manageable level 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 anxiety levels q1 hr	Use therapeutic communication and speak simply and loudly upon entering the room.
Assess behavior tendencies q 2hr prn disruptions.	Identify if pt is experiencing voices and what they are saying/telling them what to do PRN experiencing voices.
Assess LOC and orientation q 1 hr	Maintain eye contact and involve the patient with simple reality-based activities q 1hr
Assess level of paranoia q shift	Offer food and drinks at mealtime from a vending machine or prepackaged food.
Assess speech and statements made q shift	Recognize reoccurring topics and themes and reinforce clear communication making sure they understand you do not understand what is being said.
Assess s/sx of negative and/or positive symptoms q 2hr	Focus on their feelings and empathizing if negative symptoms and provide reorientation to reality frequent and often if positive symptoms.

To Be Completed Before the Simulation

Anticipated Patient Problem: Social Isolation

Goal 1: pt will establish a trusting relationship during my time of care.

Goal 2: pt was able to interact with self and others in an appropriate manner 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 pt mood and affect upon entering the room	Identify self as nurse for the day and explain in simple and clear language routine and goals for the day.
Assess support systems outside of IN/OUTpt facility q shift.	Offer resources regarding family therapy and/or PEERs prn pt request.
Assess interactions in group settings q 1 hr	Engage in hobbies that are noncompetitive and calming, avoiding laughing and whispering around client when within their presences.
Assess initial relationship with pt when on the unit q shift	Be reliable and honest – answering all questions they may have and considering continuum of care when shifts are scheduled.
Assess ADLs and appearance BID	Promote positive feedback and set small achievable goals to promote and build upon independence and self-care.
Assess social skills and interpretation of social cues q 2hr	Model appropriate social interactions such as eye contact, greeting and social skill training to practice appropriate reactions to conversations.

To Be Completed During the Simulation:

Actual Patient Problem #1: disturbed sensory/thought process
Goal: patient will recognize distortions of reality during my time of care. Met: ☑ Unmet: ☐
Goal: patient will maintain anxiety at a manageble level during my time of care. Met: ☑ Unmet: ☐
Actual Patient Problem #2: Social Isolation

Goal: patient will establish a trusting relationship during my time of care Met: ☑ Unmet: ☐
Goal: patient was able to interact w/ivf sisters appropriately during my time of care. Met: ☑ Unmet: ☐

Additional Patient Problems:
#3 Deficient knowledge
#4 R/F violence
#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/ thought process	11:00	Increasingly anxious, will not make eye contact with nurse, and observes loose associations when in the hall	11:02	Asked Ken if sister was okay to come to appointment, ken responded yes.	11:05	Was able to speak about concerns with sister in the room and was able to add further information regarding his past conditions.
Disturbed sensory/ thought process, R/F Violence	11:00	Ken is increasingly agitated and apprehensive around the nurse taking weight.	11:02	Nurse position herself off to the side more than arms reach away from ken.	11:02	Gave space when completing weight, ken remained calm and less apprehensive.
Social Isolation	11:10	Missed last two shifts of work and has low energy. Missed appt in feb "I don't need doctor" and doesn't take meds. Sister concerned about ken wellbeing.	11:20	Provides information about group therapy locally and the benefits of attending long term as well as crisis hotline. Talked about therapeutic techniques to calm. As well as maintaining conversation with ken on a regular basis.	11:30	Next week- has started visiting/ hanging out with more friends, stated "he listens to music with headphones to distract from voices".
R/F violence, social isolation	11:10	Assessed s/sx of hallucinations and delusions – could be r/f hurting self and others	11:15	Administers SAFE-T suicide screening and determine hallucinations are not command.	11:15	Ken is safe and not a risk of harming self or others. Hallucinations consist of mumbling and music.
Disturbed sensory/ thought process	11:12	Hears voices and music, " I don't take the med anymore because he is trying to poison me" " the pharmacist is trying to poison me" - risperidone	11:35	Offered injection of medication in office by a trusted faculty rather than taking pills at home. Gets Paliperidone prescription in office.	11:35	Next week-decreased anxiety and diaphoresis, still hearing voices and music" can't make out what they are saying". Not as often.
Social Isolation	11:30	Lost 20 lbs. since last visit, has had problems swallowing and has not felt hungry and cant remember what he eats.	11:30	Educated on importance of eating three meals a day to decrease weight loss and maintain current weight.	11:30	Pt Willing to eat three meals a day in order to not loose anymore weight..
Deficient knowledge, disturbed sensory/ thought process	11:45	" I only drink beer on bingo nights, I don't smoke anymore and have not done coke" – both parties unsure of side effects cocaine had on disorder	12:00	Order for urinalysis to screen for drug ands alcohol use, educated on psychosis as a side effect of cocaine and schizophrenia.	12:15	UA shown (-) for cocaine and (+) for marijuana. Admit to use marijuana for relaxation and educated on relaxation techniques such as drawing and breathing.

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Disturbed sensory/ thought process, deficient knowledge	12:10	Increasing paranoia, will not go to the pharmacy that he used to go for his medications. Sister is unable to help decrease s/sx of paranoia.	12:15	Educated on decreased paranoia with new medication as it starts to hit the peak. Educates on ways to decrease paranoia at home such as decrease whispering in the same room as ken. As well as positive and negative symptoms.	12:15	Understands that's positive symptoms such as delusions, hallucinations, motor agitation and alterations in speech can all contribute to feelings of paranoia.
Social isolation	12:30	Ken states" I can take care of myself, that will never happen" when Emily asks what happens when he cannot take care of self.	1235	Provides pamphlet on power of attorney and guardianship for ken, explains the purpose and process.	12:40	Both understand and agree the purpose and use of a DPAHC for further medical decisions.
Deficient knowledge	12:35	Unsure about relapsing of symptoms and how to handle when that happens.	12:50	Educated that relapse can occur due to chronic medical condition and ways to prevent relapse to occur.	13:00	Understands that group therapy, new coping skills and substance use can cause relapse.

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

CT/ MRI of brain
EEG /EKG

CMP, CBC, LFT, Glucose, STD testing, thyroid function test, toxicology screen

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

Signs and Symptoms

(+) = delusions, hallucinations, disorganized speech, catatonic behavior, paranoia disorganized thinking poor judgment, impulsive behavior, impaired attention, anxiety, irritability, emotional incongruity
(-) = flat/blunt affect, alogia, avolition, anhedonia, social w/d, poor hygiene/ self-care deficits, impaired memory, depression

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

Contributing Risk Factors

Genetic predisposition (1st degree relatives), neurochemical imbalances, brain structures abnormalities, prenatal/perinatal factors, ACES, life stress/trauma, socioeconomic stress, psychosocial stressors,

Therapeutic Procedures

Non-surgical
Meds(antipsychotics), CBT, supportive psychotherapy, family therapy, milieu , ECT
Surgical
Transcranial magnetic stimulation, deep brain stimulation, psychosurgery (very rare and extreme tx cases)

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)

Depression, anxiety, substance use disorder, ocd, suicide ideations

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

Medication Management

Antipsychotics – 1st gen (Haldol), 2nd gen(atypical- clozapine) partial dopamine agonists (aripiprazole), antidepressants, antianxiolytics, mood stabilizers

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

Non-Pharmacologic Care Measures

CBT, therapeutic communications, distractor activities such as walks, noncompetitive games, coloring, painting, milieu, low stimuli room

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

Stressors the client experienced?

Monetary, guilt, shame, embarrassment, relapse, avoidance of family and friends.

Client/Family Education

Document 3 teaching topics specific for this client.

- Relapse is apart of the condition
- Routine establishment
- Medication adhearance

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

Multidisciplinary Team Involvement

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

Nurse, in pt/out pt provider, case management, PEERs, behavioral health, psychiatry/psychology, pharmacy, dietician

Patient Resources

- Group therapy, take home handouts of medications/support programs that can help w/ desicions for safe medical desicions, F/U appointments w/ providors.

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 how much patience & repetition of phrases the nurse had to use with the client to establish a trusting relationship. slowing down the conversation & rewording into simple terms helped the client open up about condition

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

What surprised me is that there is so much learning to be instilled w/a patient that has schizophrenia. It made a difference that he has stable support w/ his sister & how she can reinforce learning when he is not able to comprehend by himself.

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

Something I would do differently w/ the care of the client is talk about more non-pharm techniques to sustain at a neutral level when talking about schizophrenia. I think more information on support groups & other therapies would be beneficial.

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

This will impact my nursing practice in a positive way. It made me realize having patience & compassion w/ this patient population helps establish trust in order to help them to your fullest potential

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

Ken was somewhat delayed for his developmental age since at his age most are persuing education in order to further a carrer where had to drop out of college & get a job that doesn't require a degree. He had a good relationship w/ his ~~family~~ sister which is normal and could hangout w/ friends more easily w/ help of medication to decrease any paranoia.