

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

Student Name: Ayanna Williams

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

Central nervous system: brain, spinal cord, cranial nerves I and II.

- **Cerebrum:** right and left cerebral hemispheres
 - **Frontal lobe:** higher cognitive function, memory retention, voluntary eye movements, voluntary motor movement, motor function involved in speech production
 - **Temporal lobe:** hearing and language comprehension
 - **Parietal lobe:** spacial awareness and tactile sensations
 - **Occipital lobe:** vision
 - **Basal ganglia:** initiation, execution, and completion of voluntary movements associated with skeletal muscle activity (blinking, swinging arms while walking)
 - **Thalamus:** relay center for sensory input from the body, face, retina, and cochlear and taste receptors
 - **Hypothalamus:** exerts a direct influence on the release of hormones from the anterior pituitary gland (TSH, GH, LH, prolactin-releasing hormone)
 - **Limbic system:** concerned with emotion, aggression, feeding behavior, and sexual response
- **Skull:** protects the brain from external trauma
- **Vertebral Column:** protects the spinal cord, supports the head, provides flexibility

Peripheral nervous system (PNS): cranial nerves III-XII, spinal nerves, and the peripheral components of the **autonomic nervous system** (sympathetic and parasympatic)

Neurons: the main functional unit of the nervous system that consists of a cell body, multiple dendrites (receive impulses), and an axon (carries nerve impulses)

- The initiation of a nerve impulse starts with the generation of an action potential. As the impulse receiving the end of the nerve fiber, a **neurotransmitter** is released crossing the **synapse** (junction between 2 neurons) to attach to receptors on the postsynaptic cell to inhibit or excite it
 - **Insufficient transmission:** deficient release of neurotransmitters or a decrease in receptors
 - **Excessive transmission:** excessive release of a transmitter or an increase receptor response
- **Myelinated axons** allow for a faster conduction of action potential
- **Neurotransmitters:** major components in the brain's chemical makeup
 - **Dopamine:** helps with fine muscle movement, integration of emotions and thoughts, decision making, and stimulates the hypothalamus to release hormones
 - **Norepinephrine:** helps with mood regulation, attention and arousal, fight or flight response to stress
 - **Histamine:** helps with alertness, inflammatory response, and stimulates gastric secretions
 - **Serotonin:** helps with mood regulation, hunger, pain perception, aggression, and libido
 - **GABA:** reduces anxiety, aggression, pain perception, and anticonvulsant and muscle-relaxing properties
 - **Glutamate:** learning and memory
 - **Acetylcholine:** learning and memory, regulates mood, mania, sexual aggression, stimulates the parasympathetic nervous system

Glial Cells: provide support, nourishment, and protection to the neurons

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

Schizophrenia is characterized by psychosis, which is determined by an alteration in cognition, perception, and the impaired ability to determine what is real or not real. It can be caused by the increase of C4 activity, which causes prolonged synaptic pruning. Synaptic pruning typically happens in adolescents where unnecessary nerve connections are snipped. It can also be caused by neurotoxic viruses, anatomical abnormalities (enlarged ventricles), or a head injury in adulthood. There is also a strong genetic connection that can increase the risk of offspring inheriting schizophrenia. Schizophrenia is characterized by positive and negative symptoms. Positive symptoms add to behavior that is not “typical” and are an addition to reality, such as hallucinations or delusions. Negative symptoms involve an absence of essential human qualities, such as social withdrawal, lack of motivation, poor hygiene practices, and loss of interest.

Courses of Illness:

- **Prodromal phase:** precedes the acute phase (about 1 month-a year before), symptoms include: deterioration in role functioning and social withdrawal, sleep disturbances, anxiety, irritability, depressed mood, poor concentration, and fatigue
- **Acute phase:** psychotic symptoms are prominent (positive, negative, cognitive, and mood symptoms)
- **Stabilization phase:** symptoms diminished and the focus is shifted to understanding the illness through medication and treatment regimen, controlling or coping with symptoms, and reducing negative symptoms
- **Maintenance phase:** maintaining and increasing symptoms control

To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed Sensory Perception (auditory and visual)

Goal 1: will recognize the distortions of reality by the end of my shift

Goal 2: will identify and modify external factors (anxiety, stress) that contribute to alterations in perception by the end of my shift

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess for the risk of harm to oneself or others Q4hrs	Establish 1:1 supervision and remove harmful items in reach during my time of care
Assess the contents of hallucinations Q4hrs/PRN	If they are not a danger to oneself or others, acknowledge that they are real to them but also state that I am not able to see/hear anything during my time of care
Assess medication adherence Q4hrS/PRN	Educate on the method of action of antipsychotics and possible signs and symptoms that may ensue (first generation - EPS vs second generation – metabolic syndrome) during my time of care)
Assess for increasing agitation or anxiety Q2hrs/PRN	Provide a calm and low-stimuli environment with reduced sound and lighting during my time of care
Assess the ability to recognize triggers of positive symptoms behaviors Q4hrs/PRN	Educate on positive coping mechanisms (physical activity, deep breathing) to use during a time of intense stress or anxiety during my time of care
Assess for actions of associative looseness Q4hrs/PRN	Provide simple reality-based activities such as a newspaper with the date on it or a clock with the time on it during my time of care

To Be Completed Before the Simulation

Anticipated Patient Problem: Social isolation

Goal 1: will build a trusting relationship with at least one staff member by the end of my shift

Goal 2: will be able to provide eye contact during a conversation by the end of my shift

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess if a support system is present at the onset of my shift	Establish a therapeutic relationship through active listening, a calm tone, and a nonjudgmental attitude at the onset of my shift
Assess verbal speech (disorganized, slow) and nonverbal body language (lack eye contact) Q4hrs/PRN	Utilize simple/clear language and allot time for the patient to respond during my time of care
Assess for paranoia Q4hrs/PRN	Provide food that is prepackaged, such as giving them an opportunity to go to the vending machine, during my time of care
Assess self-esteem and self-perception Q4hrs/PRN	Provide positive reinforcement for small successes (talking with a peer/eye contact) during my time of care
Assess for participation in social/leisure activities during my time of care	Gradually increase exposure to social environments, such watching a movie or doing a puzzle to attending group sessions with peers during my time of care
Assess for positive behaviors (hallucinations/delusions) that may affect social behavior Q4hrs/PRN	Administer antipsychotics as ordered

To Be Completed During the Simulation:

Actual Patient Problem #1: disturbed sensory perception (auditory)
Goal: will recognize the distortions of reality by the end of my shift Met: Unmet:
Goal: will identify and modify external factors (anxiety, stress) that contribute to alterations in perception by the end of my shift Met: Unmet:

Actual Patient Problem #2: risk for violence
Goal: will not cause harm to self or others during my time of care Met: Unmet:
Goal: will acknowledge to report if any suicidal/harmful ideations come about Met: Unmet:

Additional Patient Problems:
 #3 deficient knowledge
 #4 social isolation
 #5 self-care deficit

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
Risk for violence/ Disturbed sensory perception	0800	Exhibits associative looseness: “it had birds in it, birds can fly, I don’t like when birds get in the house, how can I clean the house when the sun doesn’t shine, increased anxiety	0805	Nurse Anne stood off to the side Ken with more arm’s reach away with a direct path to the door	0810	Ken did not show any signs of violence, continues to fidget with his armband
Self-care deficit	0810	Sister concerned because he has lost 20lbs in 6 month and has not had an appetite, lack of energy	1130	NP encourages his to eat 3 meals even if he does not feel hungry	1130	Responds with “All right I will”, returned to fidgeting
Disturbed Sensory Perception	0815	Has not been taking medications for 4 months, missed his appointment in February	0816	Nurse Anne educated the positive and negative signs of schizophrenia, asked	0820	Shows signs of paranoia; thinks the pharmacist has poisoned his risperidone medication, continues to fidget and plays with his arm band during conversation
Disturbed Sensory Perception	0820	Delusion of persecution	0821	Nurse Anne acknowledges that it must be scary to think that someone is trying to hurt Ken; offers to talk to the provider to see if	0830	Ken continues to lack eye contact during the conversation and continued to fidget with his armband;

				there are any other medication options		sister appreciative of her efforts
Risk for violence	0830	Auditory hallucinations of voices and music	0835	Nurse Anne asked Ken what the voices are saying to prevent risk of harm of self/others, used the safe-t tracking tool questionnaire, emergency and crisis resources provided	0840	Denies hearing voices to hurt himself, safe t is at a low risk level d/t to the strong relationship with his sister and denying any thoughts of self-harm, accepts the resources
Deficient knowledge	0900	Experiencing dizziness and difficulty swallowing	0905	Provides education that these can be symptoms of schizophrenia	0910	Just responds with "ok", sister engages more in the conversation
Deficient knowledge	0925	History of cocaine use, quit smoking 2 years ago, drinks one or two beers at bingo every week	1000	Urine tested for cocaine or other substance use, educated on the effects of cocaine intoxication (psychosis)	1005	Ken explained that he does not want his symptoms to get worse, urine screening positive for marijuana
Social isolation	1020	Increased anxiety and does not want to do much with his family or friends, restless	1025	Educated on ways Ken can decrease his anxiety and increased his socializations (Emily visiting him and talking on a regular basis for a brief time, then gradually increase), established a long-term commitment to attend group therapy	1230 (next appointment a week later)	Has gone out with his friends since the last visit, does not hear voices as often after the start of his new medication
Disturbed sensory perception/risk for violence	1100	NP performs an assessment, delusions of persecution about pharmacist	1105	NP offered Ken to receive paliperidone injections from staff members that he knows/informed him to call the clinic right away if he experiences any command hallucinations	1115	Accepted the offer to receive injections every week for 2 weeks and then once a month, received information on the medication; states "I will"
Deficient knowledge	1115	New medication, injections every week instead of pills	1120	Educated on the adverse effects of paliperidone (EPS), explained that it takes 2 weeks for its peak effect	1120	States that he will be able to come to the clinic next month to receive the next injection, denies any signs of tremors, restlessness, or muscle spasms since starting the medication

Disturbed sensory perception/risk for violence	1200 (next appointment a week later)	Week since last visit, increased anxiety and agitation, hearing voices	1205	Encourages Ken to focus on her voice and to tell her what he is hearing; provides empathy and claims that hearing voices must be frightening, but he is safe	1215	States that he cannot understand what they are saying, sounds like “background noise in a restaurant”, denies hearing command hallucinations, voices start to go away and he becomes less anxious, says it helps when he listens to music during hallucinations
Deficient knowledge	1215	Urine drug test positive for marijuana, states that it helps him relax	1216	Educated on how marijuana can increase the symptoms of schizophrenia, encouraged the use of other methods of relaxation such as deep breathing, meditation, or journaling	1220	Acknowledges and claims that he will give these methods a try instead of using marijuana
Disturbed Sensory Perception/ Deficient Knowledge	1220	Sister concerns of Ken’s feelings of paranoia, explains that he will not go to the store where he used to get his medications, Ken continues to state that the pharmacist is trying to poison him, but shows trust in his sister	1225	Educated on ways Emily decrease Ken’s paranoia at home (avoid whispering or talking quietly to others when in the same room as Ken)	1230	Emily was very appreciative and receptive of the education provided by Nurse Anne
Deficient Knowledge	1245	Emily expresses concern about if Ken ever becomes sick enough to not make decisions for himself about his care, Ken denies that it will happen, expresses concern about relapses	1255	Provided a pamphlet about a durable power of attorney (chosen by the client, and retains the right to terminate the DPAHC relationship), educated on relapse prevention	1300	Emily claims that she will do whatever care that Ken needs

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

- 190 lbs – lost 20 lbs in 6 months
- Cholesterol: 162
- Fasting blood glucose: 98
- AIMS testing: 0 for all movements
- Triglycerides: 98
- Prolactin level: 7
- Positive marijuana in urine
- Safe T- low score
- BMI: 29.8
- Temp: 37.3, Pulse: 88bpm, RR: 18, BP: 126/72 sitting, O2: 98% RA

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms

- Associative looseness
- Flat affect
- Lack of eye contact
- Lack of an appetite/weight loss
- Increased anxiety
- Lack of energy
- Delusion of persecution
- Decline of self-care
- Flat affect
- Auditory hallucinations
- Social isolation

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors

- 21 yrs old (usually diagnosed between 15-25)
- Cocaine
- Marijuana
- Smoking cigarettes
- Beer

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures

Non-surgical

- Medication: second-generation antipsychotics
- AIMS/SAFE-T

Surgical

- No surgical interventions were present

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

- Substance use
- EPS with medications
- Suicidal ideations
- Change in family dynamics
- Lack of social interactions

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management

- Risperidone 2 mg BID
- Paliperidone injections 234mg IM
 - Once a week for the first 2 doses then once a month

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures

- Nurse Anne redirected his thoughts
- Reduce environmental stimuli
- Support system present
- Deep breathing
- Journaling
- Therapeutic communication

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?

- Hallucinations
- Delusions/paranoia
- Not taking medications/going to appointments
- Not being able to eat properly

Client/Family Education

Document 3 teaching topics specific for this client.

- Medication adherence/side effects
- Importance of a support system

NCLEX I (1): Safe and Effective Care Environment

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

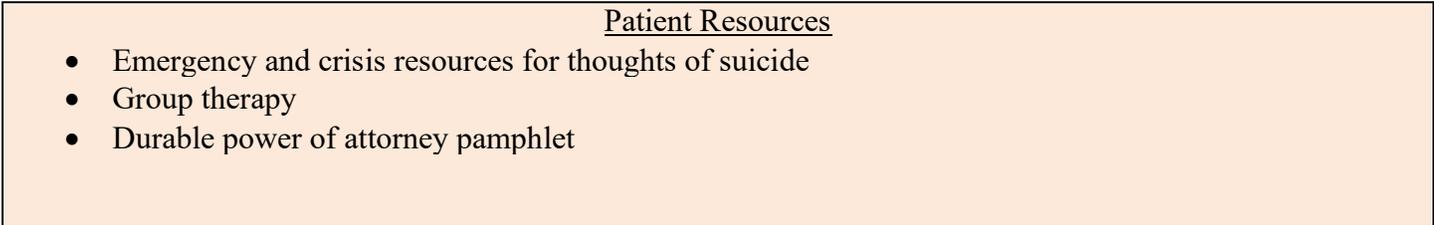
- Nurse
- NP

- Identifying triggers that cause symptoms (marijuana)



Patient Resources

- Emergency and crisis resources for thoughts of suicide
- Group therapy
- Durable power of attorney pamphlet



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 participating in the care of this client is that their symptoms are real to them. Ken truly believed that the pharmacist was out to get him, which negatively impacted his lifestyle. He did not attend his appointments and did not take his medication, which causes an exacerbation of his symptoms. As nurses, we cannot hear or see what they are saying, and it is important to acknowledge that. It is also important to understand what they are hearing because it can cause harm to themselves or others.

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

Something that surprised me in the care of this patient is how involved the sister was with his care. She was very receptive when it came to education about the symptoms, meds, coping strategies, etc. She just wanted the best for her brother, which is very admirable, especially because of how harmful schizophrenia could possibly be in family situations.

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

Something that I would do differently with the care of this client providing teaching back methods for Ken. During a lot of the education scenes, Ken would just respond with simply “ok”. I would like to ensure that he understands the information provided. For example, I could ask him if he could name 1 positive and 1 negative symptoms of schizophrenia.

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

This simulation experience impacted my nursing practice by acknowledging that this is a condition that can be extreme. It helps solidify that safety is a priority when it comes to this condition. It is important to assess command hallucinations or thoughts of self-harm directly. A safe tracking tool was also used to screen Ken for any of these thoughts/actions.

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

Ken is a 21-year-old male, which puts him in the young adult developmental stage. During this time, people start to form intense relationships and commitment, have higher cognitive/abstract thinking, and differentiate themselves from the nuclear family they grew up in (starting a family). If they are unable to form an impactful relationship, this could lead to social isolation and withdrawal. Social isolation and withdrawal are symptoms that Ken has exhibited. He also had paranoia from his pharmacist, which prevented him from going out to the store that he once did. It is also normal to have clear communication with a purpose in this developmental stage. However, Ken starts to engage in loose association, and his statements do not connect with one another. Instead of having abstract thinking, Ken would have disorganized thinking with his hallucinations.