

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

Student Name: Riley Osborne

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

CNS: brain, spinal cord, cranial nerves

PNS: cranial nerves, spinal nerves, autonomic nervous system

Neurons are the main function of the nervous system and they create nerve impulses when excitability.

Glial cells provide support, nourishment, and protection to the neurons.

The brain: has the cerebrum which is the left and right hemispheres, which then have four lobes which are the parietal, temporal, occipital, frontal. The brainstem, and cerebellum.

The thalamus is the major relay center for sensory input from the body, face, retina, and cochlear receptors.

The hypothalamus influences the release of hormones from the anterior pituitary gland, it also helps regulate appetite, body temp, water balance, and emotion expression.

The limbic system controls emotion, feeding, behavior, and sexual response.

The brainstem has centers for things such as sneezing, vomiting, hiccupping, sucking, coughing, swallowing.

The medulla effects the respiratory, vasomotor, and heart function.

The cerebellum coordinates voluntary movement and maintains trunk stability

The cerebrospinal fluid is used as a cushion for the brain and spinal cord

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

Schizophrenia affects thoughts, feelings, and behavior. It is characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions. There is a genetic prevalence in this disorder, or there are individuals who are exposed to environmental insult during a critical period of neurodevelopment.

Adults with this disease have abnormal levels of neurotransmitters such as dopamine, serotonin, alpha-adrenergic, gamma-Aminobutyric acid, and glutamate levels.

The brain scans typically have anatomical differences in the brain including volume, activity, ventricle size, and alterations in the surface of the cortex.

Usually diagnosed between 15-25 years old.

s/s can be positive or negative, positive signs are things like hallucinations, delusions, or anything that adds to a person's behavior. Negative signs would be depression, abnormal behavior, withdrawing, or anything that takes away from a person's normal behavior.

There is no current prevention strategies to prevent schizophrenia.

According to **DSM 5** you have to have 2+ of the following s/s: delusions, hallucinations, disorganized speech, catatonic behavior, negative symptoms, level of functioning affected, s/s persist for at least 6 months.

Course of illness:

Prodromal phase: precedes the acute phase, deterioration in role functioning and social withdrawal, sleep disturbances, anxiety, irritability, depressed mood, poor concentration,

fatigue, can appear one month to one year before the first psychotic break.

Acute phase: the active phase where positive, negative, cognitive, and mood s/s occur.

Hospitalization may be required during this phase.

The goal is safety and stabilization.

Stabilization phase: s/s diminish

Maintenance phase: maintaining and increasing symptom control, pt should be taking medication and treatments

To Be Completed Before the Simulation

Anticipated Patient Problem: disturbed thought process

Goal 1: will recognize distortion of reality during my time of care

Goal 2: will use appropriate verbal communication for situation during my time of care

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 support system q shift	Encourage and educate support system during care so they have the knowledge and confidence to partake in helping with care outside of the hospital q shift
Assess behavior status for increasing anxiety, agitation, or depression q 2 hours	Administer PRN medications for increased agitation
Assess for hallucinations and delusions q 2 hours	Acknowledge the hallucinations and delusions are real and scary for the patient but also acknowledge that you don't see or hear them prn
Assess knowledge of effective coping strategies q shift	Educate on proper coping strategies they can do at home such as finding new hobbies, hanging out with friends or family, etc. prn and q shift
Assess for waxy flexibility, posturing, pacing, rocking, regression, and eye movement abnormalities q 4 hours	Encourage activities such as walking, coloring, group activities, to decrease abnormal movement and redirecting abnormal behaviors prn
Assess for deterioration in appearance q shift	Encourage self-care activities and offer consistent guidance and instruction prn

To Be Completed Before the Simulation

Anticipated Patient Problem: RF violence

Goal 1: will not harm self or others during my time of care

Goal 2: will have a safe plan for discharge developed during my time of care

Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include timeframes	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Assess for self-harm ideation at least q 6 hours	Contact provider and initiate 1:1 suicide precaution
Assess for negative s/s of schizophrenia q shift	Encourage collaboration with peers, personal hygiene, outdoor activities if possible prn
Assess for medication adherence q shift	Re educate on the importance of medication adherence and the importance of taking them consistently even if feeling "ok" prn
Assess for ideation of harming others or auditory hallucinations q 6 hours	Clarify what the auditory hallucinations are saying and if they are telling them to harm anyone, ensure a sitter is in the room with them and safety for the sitter is maintained prn
Assess for participation levels in group activities and interaction types q shift	Encourage participation in group activities if socially isolated, encourage alone activities if agitated and increased mood prn
Assess for hx of suicide attempts or past reports of violence q shift	Ensure proper safety precautions are in place for patient and sitter, build a rapport and establish trust q shift

To Be Completed During the Simulation:

Actual Patient Problem #1: disturbed thought process
 Goal: will recognize distortion of reality during my time of care **Met:** **Unmet:**
 Goal: will use appropriate verbal communication for situation during my time of care **Met:** **Unmet:**
 Actual Patient Problem #2: ineffective coping
 Goal: will promote knowledge of self-care activities like eating, hanging out with friends, going to appointments, etc., during my time of care **Met:** **Unmet:**
 Goal: will demonstrate knowledge of new and healthy coping strategies for dealing with auditory hallucinations during my time of care **Met:** **Unmet:**

Additional Patient Problems:
 #3 decreased nutrition
 #4 self care deficit
 #5 RF social withdraw
 #6 Deficient knowledge of disease

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
#1	0745	Change in speech pattern noted; when his sister asked about the movie he was supposed to see and he went from the movie to birds, to flys, to the house, to the sun shining.	0750	Nurse anne brought her concern of the altered speech pattern to the provider	0755	The provider and the nurse noted that Ken was experiencing associative looseness at that time. Ken was able to communicate and answer questions with the help of his sister through the rest of the visit with some more episodes of associative looseness
#2, #3, #4	0800	Ken has lost 20 pounds since the last video about 6 months ago. His sister expressed that he only takes a few bites of his	0910	The provider Nicole educated on eating 3 meals a day even if not feeling hungry to decrease the	0915	Ken agreed and stated willingness to eat 3 meals a day

		food and says that he has not really been hungry.		constant trend of losing weight		
#2	0810	Ken has been exhibiting increasingly anxious behaviors such as fidgeting with his hands and pacing/rocking while in the room	0815	Nurse anne ensures she stands off to the side of ken and keeps more then an arm's reach away for safety	0930	Ken was able to sit and limit fidgeting during the rest of the visit.
#1, #4	0815	When asked if he has been taking his medication that he was prescribed when he was last at the office Ken says no he has not. When asked why he said that the pills are poisoned by the pharmacist.	0910	The provider offered for Ken to come into the office and get injectable medication to help with the auditory hallucinations	0915	Ken verbalized feeling better coming into the clinic to take the medications vs getting it from the pharmacist
#2, #4	0820	Ken had missed his last appointment in February while his sister Emily was away. Emily expresses that he has missed his last two shifts at work and has had low energy.	0823	Nurse Anne clarified with Ken why he did not come to his appointment	0825	When asked why he did not go he said he "didn't need to come. Didn't need the medicine".
#1	0830	Ken expresses that he does not have any auditory hallucinations that tell him to harm himself or others. Nurse Anne uses the SAFE-T screening tool to ensure Ken is safe for himself and others	0835	Nurse Anne educated on the importance of reaching out to someone such as Emily or anyone on the healthcare team if experiencing hallucinations telling him to harm himself or others	0840	Ken verbalized understanding
#2, #6	0830	Ken admits to drinking 1-2 beers every week at bingo. As well as having used cocaine and	0840	Educated on the effects of cocaine use on causing psychosis when intoxicated. As well as that this substance can	0845	Ken verbalized understanding that cocaine can worsen s/s of schizophrenia

		cigarettes in the past.		worsen signs of schizophrenia.		
#2, #5	0845	Emily verbalized a concern of withdraw from her and the rest of kens friends as well as an increase of anxiety and restlessness	0850	Educated Emily that visiting and talking to ken frequently and regularly can help decrease his social isolation	0900	Emily verbalized understanding of how to help and eagerness to want to help Ken
#1, #6	0930	Nurse Anne asks if there are any questions about Paliperidone before she gives the medication	0935	Nicole provides pamphlets about the medication and nurse Anne explains the dosing frequency to Emily.	0940	Ken agrees to come back for each medication injection and he has no further questions.
#2, #6	0945	Emily asked about Nurse Annes opinion on if the medication for Ken was enough or if he should also be going to therapy	0950	Recommended group therapy for Ken and helping him with his social withdraw	0955	Ken and Emily verbalize agreeing to looking into the group therapy for the future
#1, #2, #5	A WEEK LATER 1000	A week after the injection Ken states that his auditory hallucinations are getting better and Emily states, she noticed ken has started to go out with his friends more.	1005	Nurse Anne acknowledges that hearing voices can be frightening but he is safe	1020	Ken states that he listens to music with his headphones to help his auditory hallucinations as an effective way to cope.
#2, #4	1030	Urine drug screen positive for marijuana but negative for cocaine	1035	Nurse Anne uses open ended questions like “tell me some of your reasons for using marijuana” to get a good conversation with Ken going and not make him feel judged	1045	Ken states “I use weed because it is relaxing”. But he verbalizes understanding the importance of trying other forms of relaxation that are not marijuana
#1, #6	1045	Emily expresses concern about Kens paranoia with Ken not going to the store where he used to go get his medications	1050	Nurse Anne suggests avoiding whispering or talking quietly to others when in the same room as Ken	1055	Emily states she has no further questions

		because he thinks the pharmacist will do something				
#6	1100	Emily expresses concern about what would happen if Ken gets so sick he can not make his own decisions	1110	Nurse Anne gives a pamphlet on POA in health care and goes over it with them so they can make their own decision	1120	Ken expresses thankfulness for going over this with Emily and easing her anxiety
#6	1125	Emily asks what they can do to prevent relapse	1130	Nurse Anne educates that relapse is normal in the disease process but avoiding substance use, going to therapy, and learning new coping skills can help prevent relapse	1135	Emily and Ken express not having any more questions or concerns

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
 Vital signs
 CBC
 Prolactin level
 Blood glucose
 Lipid profile

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms
 Auditory delusions, trouble swallowing, not eating, social withdraw, anxiety, dizziness, associative looseness speech, persecutory delusions

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
 Hx of substance use (tabaco, cocaine, marijuana)
 Divorced parents as a child
 Male
 Age 21

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures
Non-surgical
 Group therapy
 Listening to music

Surgical
 N/A

Prevention of Complications
 (Any complications associated with the client's disease process? If not what are some complications you anticipate)
Depression
Anxiety
Suicide
Withdraw
Harmful voices to self or others

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 234mg IM once a month after first two injections

Non-Pharmacologic Care Measures

Group therapy
Listening to music
Watching movies
Emily (support system)
Friends

Stressors the client experienced?

Divorce of parents
Substance abuse
Only sleeping 5-6 hours a night

Client/Family Education

Document 3 teaching topics specific for this client.

- POA importance and definition
- Group therapy importance
- telling Emily or any of his health care team members if thoughts of harming himself or others arise

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement

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

Nurse, provider, support system

Patient Resources

POA 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 this client was the importance of support systems for clients with mental illnesses. A lot of the information came from the client’s sister and without her there we may not have known that the client was not taking his medication or hanging out with his friends as much as normal. She was also asking a lot of important educational questions opening the opportunity for the nurse to give pamphlets and explanations to her questions.
2. What was something that surprised you in the care of this patient?
I was surprised that this patient was taking drugs especially ones like cocaine, I just did not think that was going to be an issue that was going to come up or must be addressed but it gave me a good insight into how to respond to that type of situation. I think that I was also not expecting that his sister would not know that he was doing the drugs considering it seemed she had a good insight to most of what was going on with him.
3. What is something you would do differently with the care of this client?
I think I would have found a better way to include Ken in the discussion and have him open more. I feel as though Emily took the lead with most of the conversations and most of the education was towards her and helping her understanding how to take care of Ken. Especially since Ken lives alone and he needs to know how to take care of himself and his own illness.
4. How will this simulation experience impact your nursing practice?
This simulation has impacted my nursing practice by helping me to not form any stigma or bias against patients with mental health disorders especially schizophrenia. It showed me that there are many ways that mental illnesses can present and that what I have in mind may not be correct for all mental illnesses. It also taught me that these clients are no different from anyone else and deserve the same care as everyone else.
5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.
Ken is a young adult and during this stage Erikson focuses on intimacy vs. isolation with a focus on forming close relationships with others. Young adults are also at the stage of trying to develop independence in all aspects of life. In some ways Ken is doing great like him living on his own, having a job, and having some friends. But in other ways he is not doing that great because he is becoming socially withdrawn, and he dropped out of school. But he also has a close relationship with his sister and he seems to be doing good with maintaining their relationship.