

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

Student Name: **Olivia Creamer, SNB**

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

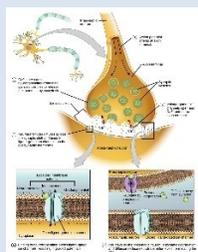
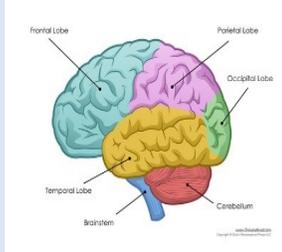
A&P of Normal Structures

Limbic system: The “emotional nervous system”

- Comprised of the hypothalamus, amygdala, thalamus, & hippocampus
 - Hypothalamus: Regulates the ANS (*i.e. Fight or flight versus rest & digest response*)
 - Influences the release of hormones from the anterior pituitary gland
 - Amygdala: Responsible for fear & aggression
 - *If stimulated:* Anger; violence; anxiety; fear
 - *If destroyed:* Mellow affect
 - Thalamus: “Sensory-relay station”
 - Hippocampus: Responsible for the formation of new memories
 - Converts short-term memory to long-term memory
 - Long-term stress causes atrophy
 - *If destroyed:* Long-term memory remains intact

Central nervous system (CNS): Brain & spinal cord

- Cerebrum: Largest part of the brain. Responsible for memory & reasoning
- Frontal lobe: Responsible for memory, higher cognitive functioning, & voluntary gross movement
- Broca’s area: Responsible for expressive aphasia
- Wernicke’s area: Responsible for receptive aphasia
- Occipital lobe: Responsible for vision & visual association



Peripheral nervous system (PNS): 12 pairs of cranial nerves; 31 pairs of spinal nerves

- Peripheral components of the autonomic nervous system
- **Autonomic nervous system (ANS):** Responsible for involuntary functions of cardiac and smooth muscle, as well as glands
 - Sympathetic ANS: Fight or flight
 - Parasympathetic ANS: Rest & digest

Neurotransmission: A nerve impulse begins with the generation of an action potential. When the impulse reaches the end of a nerve fiber, a neurotransmitter is released & crosses the synapse. The neurotransmitter then binds to (a) receptor(s) on the postsynaptic cell, either stimulating or inhibiting it

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

Schizophrenia is a mental disorder characterized by psychosis with a clinical picture of:

- Altered cognition & altered perception
- Inability to determine what is or is not real
- Severe deterioration of social & occupational functioning

Predisposing factors:

- Biochemical:
 - ↑ dopamine; ↑ serotonin
 - ↑ C4 activity which contributes to prolonged synaptic pruning
 - Synaptic pruning is the process of “cutting” unnecessary nerve connections and *normally* occurs during adolescence
- Psychological influences:
 - Viral infection(s)
 - Anatomical abnormalities
 - Shrunken limbic system; enlarged ventricles; ↓ gray matter
 - Head injury in adulthood
- Genetic influences:
 - **STRONG** genetic component
 - Genetic markers
 - Chromosomes (?)

Manifestations:

- (+) symptoms: Added experiences
 - *E.g. Delusions; hallucinations; delusions*
- (-) symptoms: Absence of essential human qualities
 - *E.g. Anhedonia; avolition; affective blunting; apathy; alolia*
- Cognitive symptoms: Concrete thinking; impaired memory; impaired information processing; impaired executive functioning

DSM-5 criteria:

- 2+ of the following symptoms for > 6 months:
 - Delusions (*MUST be present*)
 - Hallucinations (*MUST be present*)
 - Disorganized speech (*MUST be present*)
 - Catatonic behavior
 - (-) symptoms
 - Affected level of functioning
- Typically diagnosed around 15-25 years of age

<ul style="list-style-type: none"> • Functional unit of the nervous system: Neuron <ul style="list-style-type: none"> ○ Consists of the cell body, dendrites (receive impulses), & an axon (carries nerve impulses) • <i>Insufficient</i>: ↓ receptors; deficient release of neurotransmitters from the presynaptic cell • <i>Excessive</i>: Excessive release of transmitters; ↑ receptor responsiveness <p>Neurotransmitters:</p> <ul style="list-style-type: none"> • Dopamine: Fine muscle movement; integration of emotions & thoughts; decision making; stimulates the hypothalamus to release hormones • Norepinephrine: Mood; fight or flight response to stress; attention & arousal • Histamine: Alertness; inflammatory response; stimulates gastric secretions • Serotonin: Mood; sleep regulation; hunger; pain perception; aggression & libido • Gamma-amino butyric acid (GABA): ↓ anxiety, aggression, & pain perception; anticonvulsant & muscle-relaxing properties • Glutamate: Responsible for learning & memory • Acetylcholine: Learning & memory; mood regulation; mania; sexual aggression; stimulation of the PNS 	<ul style="list-style-type: none"> ○ The earlier the disorder presents, the “worse it is” <p>Course of illness:</p> <ul style="list-style-type: none"> • Prodromal phase: May appear 1 month – 1 year before the 1st psychotic break <ul style="list-style-type: none"> ○ Deterioration in role functioning & social withdrawal ○ Sleep disturbances; anxiety; irritability ○ Depressed mood; poor concentration; fatigue • Acute phase: Prominence of psychotic symptoms (<i>Positive; negative; cognitive; and mood</i>) • Stabilization phase: Symptoms diminish <ul style="list-style-type: none"> ○ Focus is shifted to understanding the illness <ul style="list-style-type: none"> ▪ Controlling/ coping with symptoms ▪ Reduction of (-) symptoms • Maintenance phase: Maintaining & increasing symptom control <ul style="list-style-type: none"> ○ ↑ independence ○ Improving quality of life
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To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed sensory perception

Goal 1: Will identify at least 2 effective coping strategies (e.g. Listening to music; art therapy; journaling; deep breathing exercises) to manage hallucinations (Auditory and/ or visual) by the end of my care.

Goal 2: Will recognize and verbalize that hallucinations are not based in reality by the end of my care.

<p align="center">Relevant Assessments</p> <p>(Prewrite) What assessments pertain to your patient's problem? Include timeframes</p>	<p align="center">Multidisciplinary Team Intervention</p> <p>(Prewrite) What will you do if your assessment is abnormal?</p>
<p>Assess for the presence and content of hallucinations Q2H and PRN.</p>	<p>Administer olanzapine (<i>Atypical, 2nd generation antipsychotic[s]</i>) ____ mg PO as prescribed. Provide distraction PRN (e.g. Take for a walk). Maintain eye contact.</p>
<p>Explore previously successful & unsuccessful coping strategies Q shift and PRN.</p>	<p>Educate on and encourage use of healthy coping mechanisms (e.g. <i>Deep breathing; mindfulness; guided imagery; journaling; music & art therapy; walking</i>) Q shift & PRN.</p>
<p>Assess for environmental factors and stressors that may precipitate hallucinations Q4H and PRN. Monitor for S/Sx's of anxiety including, irritability, restlessness, tachypnea, & sweating.</p>	<p>Maintain a low-stimuli environment Q shift & establish a structured daily routine. Encourage avoidance of external stressors if possible PRN.</p>
<p>Monitor for self-harm, harm to others, and command hallucinations Q2H and PRN.</p>	<p>Initiate suicide precautions STAT (1:1 sitter; removal of ligature risks). Encourage verbalization of self-harm or homicidal thoughts Q2H and report to HCP STAT.</p>
<p>Assess ability to differentiate hallucinations from real external stimuli Q2H and PRN.</p>	<p>Acknowledge hallucination(s) but reinforce/ reassure that they are not based in reality PRN. Reorient to present reality PRN.</p>
<p>Monitor patterns and quality of sleep Q shift & PRN (<i>Are hallucinations interfering with sleep?</i>)</p>	<p>Maintain a quiet, low-stimuli environment during night hours and establish consistent sleep-wake cycles. Encourage participation in daytime activities and limit caffeine consumption Q shift.</p>

To Be Completed Before the Simulation

Anticipated Patient Problem: Disturbed thought processes

Goal 1: Will be AOx4 (Person, place, time, and situation) during my time of care.

Goal 2: Will engage in appropriate conversation with > 1 staff member with no evidence of loose association or magical thinking during my time of care.

<p align="center">Relevant Assessments</p> <p>(Prewrite) What assessments pertain to your patient's problem? Include timeframes</p>	<p align="center">Multidisciplinary Team Intervention</p> <p>(Prewrite) What will you do if your assessment is abnormal?</p>
<p>Assess for grandiose, somatic, persecutory, and paranoid delusions Q2H and PRN.</p>	<p>Acknowledge delusions without reinforcing them PRN. Clarify misinterpretations and utilize therapeutic communication Q shift (<i>e.g. Active listening; restating; exploring</i>)</p>
<p>Perform a mental status examination (MSE) Q4H and PRN.</p> <ul style="list-style-type: none"> • Behavior; mood; affect • Speech • Thought processes; thought content; judgement • Perception • Orientation; concentration 	<p>Encourage participation in simple, reality-based activities Q shift.</p> <ul style="list-style-type: none"> • Avoid competitive activities <p>Reorient to time, person, place, & situation PRN. Provide consistency & keep promises (If made) Q shift.</p>
<p>Monitor responses to external stimuli and communication with peers and/ or staff Q2H and PRN.</p>	<p>Model calm, appropriate responses (Communication) Q shift and redirect conversations PRN. Encourage brief, structured interactions in a safe environment Q shift.</p>
<p>Assess for and identify stressors that may precipitate delusions and/ or disorders of thought form Q4H and PRN.</p> <ul style="list-style-type: none"> • Assess for recurring topics & themes 	<p>Encourage verbalization of emotions Q2H and collaborate in developing a plan to manage anxiety-provoking situations (<i>i.e. Effective coping strategies</i>) Assist the client in identifying early signs of stress</p>
<p>Assess available support systems (or lack of) and accessibility to local resources Q shift and PRN.</p>	<p>Provide with information on local community resources Q shift and PRN. Provide with physical handouts and assist in developing a plan to access and attend such services.</p>
<p>Assess for self-care deficits (<i>i.e.</i> Poor hygiene; inadequate nutrition; lack of sleep) Q8H and PRN.</p>	<p>Provide pre-packaged foods if paranoid & refuses to eat Q4-6H and PRN. Encourage active participation (While providing assistance) in self-care activities Q shift and PRN.</p>

To Be Completed During the Simulation:

<p>Actual Patient Problem #1: Disturbed sensory perception <i>Goal:</i> Will identify ≥ 1 effective coping strategy to manage hallucinations by the end of my care. Met: ☐ Unmet:☐ <i>Goal:</i> Will recognize and verbalize that hallucinations are not based in reality by the end of my care. Met: ☐ Unmet:☐</p> <p>Actual Patient Problem #2: Disturbed thought processes <i>Goal:</i> Will engage in conversation with ≥ 1 staff member without exhibiting disorders of thought form by the end of my care. Met: ☐ Unmet:☐ <i>Goal:</i> Will be free of delusions (Grandiose; somatic; persecutory; paranoid) by the end of my care. Met: ☐ Unmet:☐</p> <p>Additional Patient Problems: #3: Social isolation #4: Ineffective coping #5: R/F injury</p>

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
R/F injury/ Disturbed sensory perception	0900	Exhibiting irritability/ fidgeting and facial twitching. Unable to maintain eye contact.	0900	Maintained an open posture, sitting/ standing off to the side more than 1 arms reach away.	1115	No harm to self or others during my time of care. Sitting quietly in chair; fidgeting with hands.
Self-care deficit(s)	0910	Weight: 190 lbs. Decrease of 20 lbs. from previous office visit. Sister, Emily, states, “He only ate a few bites at lunch the other day.”	0950	NP, Nicole, encouraged consuming 3 meals/ day even when not hungry.	0950	States, “All right, I’ll eat 3 meals/ day.”
Disturbed thought processes.	0915	Responds, “no” when asked if he has been taking his risperidone as prescribed. States, “The pharmacist is poisoning the pills.”	0955	NP, Nicole, validated hallucinations. Discussed possibly ordering paliperidone via IM injection. Advised that injections would be given weekly.	0955	States, “I would feel more comfortable coming to the clinic to receive antipsychotic injections.”
Disturbed sensory perception	0925	Reports hearing “mumbles” and “a quiet little song” intermittently.	1000	NP, Nicole, advised to call the clinic STAT if experiencing command hallucinations (Harm to self or others)	1000	States, “Ok. I will call here if I experience those thoughts.”
R/F injury	0935	SAFE-T – Low risk <ul style="list-style-type: none"> Strong relationship with sister No thoughts of self-harm 	1110	Provided information on emergency & crisis resources & offered printed instructions/ pamphlets. Referred to group therapy.	1110	Sister, Emily, states, “You both have given us a lot of good information. If Ken or I have any questions, we will call later.” Established a plan for long-term commitment to attending therapy.
Disturbed sensory perception	0935	Reports previous cocaine use but denies recent use of cocaine or other substances.	0935	Educated on the effects of cocaine use (e.g. Psychosis)	0938	States, “Yeah, I understand that cocaine can cause hallucinations. I don’t want it to get worse.”
Social isolation	0940	Sister, Emily, reports, “I’ve been concerned about Ken not wanting to do as much with me or his friends. He seems more restless & anxious as well.”	0942	Advised that anxiety and social isolation are common comorbidities of schizophrenia. Encouraged visiting & communicating with Ken on a regular basis.	0945	Sister, Emily, states, “I don’t have any questions” when asked.

Disturbed thought processes	0955	States, "I would feel more comfortable coming to the clinic to receive antipsychotic (Paliperidone) injections."	1005	Paliperidone prescribed. Advised to call the clinic if experiencing any abnormal body movements. Provided with a pamphlet. Educated that the 1 st 2 injections are given one week apart, then once a month after the 3 rd month.	1005	States, "Ok. I can come into the clinic next week. I understand that the medication will reach peak effectiveness in about 13 days."
One week later						
Disturbed sensory perception	0900	Exhibiting fidgeting, limited eye contact, irritability, and mumbling. States, "Can't make out what they are saying. Like background noise in a restaurant." Command hallucinations noted	0905	Validated that hallucinations are frightening. Reassured safety and encouraged verbalization of fears/emotions. Encouraged talking to sister, Emily, and listening to music.	0905	States, "Sometimes it helps when I listen to music with my headphones." States, "Yes, the hallucinations are going away."
Disturbed sensory perception	0910	First dose of paliperidone 1 week ago. States, "I still here voices sometimes, but not as often." Denies tremors, restlessness, or muscle spasms.	0910	Educated on the possible S/E's of paliperidone and advised that they would be assessed at each visit.	0910	Sister, Emily, states, "I'll be sure to call the office if we notice anything like that starting."
Ineffective coping	0915	(+) drug screen for marijuana. States, "I use weed because it is relaxing."	0915	Encouraged use of other forms of relaxation, including, deep breathing exercises, meditation, and yoga.	0918	States, "Yeah. I can give those things a try."
Disturbed thought processes	0920	Sister, Emily, states, "Ken's paranoia has improved, but he still won't go to the store where we used to get his medications because he is afraid the pharmacist might do something."	0925	Advised that paliperidone has yet to reach it's peak effect(s). Symptoms should continue to improve by then. Advised to avoid whispering when in the same room as Ken.	0925	No delusions noted during the remainder of my 2 nd day of care.
R/F self-care deficit(s)	0930	Sister, Emily, states, "What if Ken ends up so sick that he can't make his own decisions about his care?"	0935	Provided with a pamphlet that explains how a durable POA can help.	0940	States, "Thank you for going over that with us."
Disturbed sensory perception & thought processes	0945	Sister, Emily, states, "What can we do to help reduce the incidence of relapse?"	0950	Educated that group therapy & learning new coping skills can help prevent relapse. Advised that substance use may precipitate relapse. Encouraged to notify trusted people if there is a desire for social withdrawal.	0955	Stated, "Thank you for going over everything with us. I will try and keep an eye on him. I do not have any questions."

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

Drug screen:

- (+) Marijuana
- All other screens (-)

Fasting blood glucose (BG): 98 mg/dL ✓
 Prolactin: 7 ng/mL ✓

Lipid profile:

- Total cholesterol: 162 mg/dL ✓
- HDL: 54 mg/dL ↓
- LDL: 108 mg/dL ↑
- Triglycerides: 98 mg/dL ✓

CBC:

- RBC: 5.7
- Hgb: 16 g/dL
- Hct: 48%
- Platelets: 310,000 ✓
- WBC: 6,200 ✓

AIMS testing – 0 for all movements
 SAFE-T – Low-risk
 Weight loss of 20 lbs. (190 lbs.)(BMI of 29.8)

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms

- Associative looseness
- Anergia; anhedonia (**Social isolation**)
- Minimal eye contact
- Motor agitation
- Auditory hallucination(s)
- Associative looseness
- Delusions of persecution
- Mood: Flat, bland affect; mildly withdrawn
- Clenches fists; paces; anxiety

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors

- Social use of alcohol
- Previous cocaine use; current marijuana use
- 2 pack-year history
 - Quit > 2 years ago
- ACEs – Parents divorced when client was 6 years old
- 21 years of age (Typically diagnosed between 15-25 years)

Therapeutic Procedures

Non-surgical

- 2nd generation (Atypical) antipsychotics (Paliperidone; risperidone)

Surgical

- N/A

NCLEX IV (7): Reduction of Risk

Prevention of Complications

- Metabolic syndrome
- Extrapyramidal symptoms (Less common with 2nd generation antipsychotics, but risk is still present)
- Social withdrawal/ isolation – Depression; R/F suicide; self-care deficits
- Substance abuse with use of marijuana and previous use of cocaine

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management

- Risperidone 2 mg PO BID
- Paliperidone (Invega Sustenna) 234 mg IM x1 dose
 - Once/ week for the 1st two doses, then Q month.

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures

- Group therapy referral
- Deep breathing exercises; listening to music; journaling; meditation; yoga
- Validation of hallucinations &/ or delusions, but redirection PRN.
- Educated on the risks associated with substance use; alternative coping mechanisms suggested
- Open communication with sister & other trusted individuals
- Crisis & emergency resources
- Pamphlets on durable POA's

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?

- Hallucinations; delusions
- Incompliance with medications
- Inability to attend appointments when sister is out of town
- Independent living

Document 3 teaching topics specific for this client.

- Educated that positive symptoms of schizophrenia include hallucinations, delusions, & motor agitation
- Educated on the S/E's of 2nd generation and danger signs to report (e.g. Abnormal body movements)
- Risks associated with substance use, specifically marijuana and cocaine.

Multidisciplinary Team Involvement

- RN
- Nurse practitioner (Who specializes in mental health)
- Receptionist for appointment maintenance

Patient Resources

- Emergency & crisis resources for thoughts of self-harm & harm to others (Initiated after a low-risk SAFE-T assessment)
 - 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 “take away” from caring for this client was the importance of involving the family or support person(s) throughout the course of care. I feel as though it is instinctual to want to focus assessments, interventions, and education on the client directly, but this simulation highlighted how valuable it is to also include those who support them, specifically, his sister, Emily.
2. What was something that surprised you in the care of this patient?
It was interesting to see a client with schizophrenia primarily exhibit negative symptoms. Although he experienced hallucinations, delusions, and restlessness, his presentation was not the exaggerated, “media-drive” depiction often portrayed. When I attended DBH, I primarily saw positive symptoms, so observing the anhedonia, anergia, and flat affect helped me better understand the full clinical picture.
3. What is something you would do differently with the care of this client?
Something I would do differently in caring for this client is to encourage more active involvement. While his sister was very involved and often led the conversation(s), I believe it would have been beneficial for the client to practice his communication skills with staff in a structured, therapeutic environment. I also believe that it would have assisted in the collection of subjective data.
4. How will this simulation experience impact your nursing practice?
This simulation experience influences my future nursing practice by enhancing my understanding of effective, therapeutic communication with clients who have schizophrenia, as well as the outpatient treatments (interdisciplinary team involvement) involved in managing this disorder.
5. Discuss norms/ deviations of G&D that were experienced during the simulation, including developmental stage.
Deviations in G&D were primarily related to the client’s diagnosis of schizophrenia. He demonstrated both (+) & (-) symptoms, but also demonstrated periods of appropriate cognitive functioning, including goal-directed thinking. While living independently is promising for a young adult his age, he has seemingly struggled to establish and maintain romantic relationships and peer friendships (Major developmental task of adults his age), which may contribute to social isolation. From a moral development perspective (Kohlberg’s theory), he appears to function appropriately for his age.