# Module Report

**Tutorial:**   **Real Life RN Mental Health 3.0**

**Module:**   **Schizophrenia**

Individual Name:   **Kathryn Davis**

Institution:   **Lakeview CON**

Program Type:   **BSN**

## Standard Use Time and Score

| | Date/Time | Time Use | Score |
|---|---|---|---|
| Schizophrenia | 3/8/2022 10:47:26 AM | 22 min | Strong |

## Reasoning Scenario Details
## Schizophrenia  -  Use on 3/8/2022 10:25:21 AM

### Reasoning Scenario Performance Related to Outcomes:
*See Score Explanation and Interpretation below for additional details.

| Body Function | Strong | Satisfactory | Needs Improvement |
|---|---|---|---|
| Cognition and Sensation | 100% | | |
| Ingestion, Digestion, Absorption & Elimination | 100% | | |

| NCLEX RN | Strong | Satisfactory | Needs Improvement |
|---|---|---|---|
| RN Management of Care | 100% | | |
| RN Psychosocial Integrity | 100% | | |
| RN Pharmacological and Parenteral Therapies | 100% | | |

| QSEN | Strong | Satisfactory | Needs Improvement |
|---|---|---|---|
| Safety | 100% | | |
| Patient-Centered Care | 100% | | |
| Evidence Based Practice | 100% | | |

## Decision Log:

| Optimal Decision | |
|---|---|
| **Scenario** | Nurse Anne talks with NP Nicole about speech pattern change. |
| **Question** | Nurse Anne noticed that Ken is exhibiting an altered speech pattern. Which of the following responses by Ken should Nurse Anne identify as an example of associative looseness? |
| **Selected Option** | Video168d68c1e4a5a4ba6a4f68d9ffa50bf33 |
| **Rationale** | Clients who have schizophrenia may exhibit altered speech patterns. This pattern is an example of associative looseness, or shifting from one idea to another. |

| Optimal Decision | |
|---|---|
| **Scenario** | Nurse Anne positions herself in relation to Ken in the exam room. |
| **Question** | Nurse Anne observes that Ken is becoming increasingly anxious. Which of the following actions should Nurse Anne take? |
| **Selected Option** | Stand off to the side of Ken, more than an arm's reach away. |
| **Rationale** | Clients who are exhibiting anxious behaviors are at risk for violence. The nurse should stand off to the side of the client, more than an arm's reach away, to avoid increasing the client's anxiety. The nurse should have a direct path to the door in case the client becomes violent and the nurse needs to leave the room immediately. |

| Optimal Decision | |
|---|---|
| **Scenario** | Nurse Anne teaches Ken and Emily about positive and negative symptoms of schizophrenia. |
| **Question** | Nurse Anne is teaching Ken and Emily about positive and negative symptoms of schizophrenia. Which of the following manifestations should Nurse Anne include as positive symptoms? (Select all that apply.) |
| **Selected Ordering** | DelusionsHallucinationsMotor agitation |
| **Rationale** | Positive symptoms of schizophrenia are manifestations of altered mental functioning. Positive symptoms include delusions, hallucinations (visual, auditory, gustatory, olfactory), motor agitation, and alterations in speech (echolalia, clang association, associative looseness). Negative symptoms of schizophrenia are manifestations of decreased physical and mental functioning. Negative symptoms include flat affect, anhedonia, alogia, apathy, and avolition. |

| Optimal Decision | |
|---|---|
| **Scenario** | Nurse Anne evaluates Ken's delusion. |
| **Question** | Nurse Anne identifies that Ken is experiencing a delusion. Which of the following types of delusions should she document in Ken's medical record? |
| **Selected Option** | Delusion of persecution |

| Rationale | Nurse Anne should document Ken's belief that his medication is being poisoned by the pharmacist as a delusion of persecution. A delusion of persecution is the client's false belief that others are trying to harm or persecute them in some way. |
|---|---|

| **Optimal Decision** | |
|---|---|
| **Scenario** | Nurse Anne continues to assess Ken. |
| **Question** | Nurse Anne is continuing to assess Ken. Which of the following manifestations should Anne assess for first? |
| **Selected Option** | Command hallucinations |
| **Rationale** | The greatest risk for a client experiencing auditory hallucinations is the risk for self- or other-directed harm due to command hallucinations. Therefore, this assessment is the priority. Anne should continue to assess Ken to determine exactly what the voices are commanding him to do. |

| **Optimal Decision** | |
|---|---|
| **Scenario** | Nurse Anne selects a screening tool for Ken. |
| **Question** | Nurse Anne is continuing to assess Ken. Which of the following assessment tools should Anne use? |
| **Selected Option** | The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) |
| **Rationale** | Anne should use the SAFE-T, which is a tool comprised of five steps that assess a client's risk for suicide. This tool identifies both risk and protective factors related to suicide risk. Ken may be at an increased risk for suicide due to psychosis or depression. |

| **Optimal Decision** | |
|---|---|
| **Scenario** | Nurse Anne is teaching Emily and Ken about manifestations of cocaine intoxication. |
| **Question** | Nurse Anne is teaching Emily and Ken about the effects of cocaine use. Which of the following findings should Nurse Anne identify as a manifestation of cocaine intoxication? |
| **Selected Option** | Psychosis |
| **Rationale** | Nurse Anne should identify that cocaine is s stimulant that can cause psychosis during intoxication. Other manifestations of intoxication include feelings of exhilaration, anxiety, panic, and anger as well as an increased desire for socialization. Physical manifestations of intoxication include hypertension, tachycardia, decreased appetite, and dilated pupils. |

| **Optimal Decision** | |
|---|---|
| **Scenario** | Nurse Anne teaches Ken and Emily how to decrease anxiety and increase socialization. |
| **Question** | Nurse Anne is teaching Ken and Emily about actions that can decrease Ken's anxiety and increase his socialization. Which of the following statements should Anne make? |

| Selected Option | "Emily, visiting and talking with Ken on a regular basis will help him maintain his social interactions." |
|---|---|
| Rationale | Emily should visit and talk with Ken on a regular basis to interact with him for a brief time about topics that do not cause him anxiety. She should then gradually increase the length and number of these interactions as Ken becomes more comfortable. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne teaches Ken and Emily about adverse effects of paliperidone injection. |
| Question | Nurse Anne is teaching Ken and Emily about the adverse effects of paliperidone. Which of the following statements should Anne include? |
| Selected Option | "You should let your provider know if you experience abnormal body movements." |
| Rationale | Paliperidone can cause extrapyramidal effects, such as unusual body movements, tremors, or muscle contractions. Anne should instruct Ken to notify his provider if he experiences this adverse effect. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne prepares to administer Ken's first injection of paliperidone. |
| Question | Nurse Anne is preparing to administer Ken's first injection of paliperidone. Which of the following statements should she make? |
| Selected Option | "The medication will reach peak effectiveness in about 13 days." |
| Rationale | The onset of action of paliperidone is unknown, but it peaks about 13 days following administration. Paliperidone effects last approximately one month following administration. |

| Optimal Decision | |
|---|---|
| Scenario | Anne discusses outpatient therapy with Ken and Emily. |
| Question | Nurse Anne is discussing group therapy with Ken and Emily. Which of the following recommendations should Nurse Anne make? |
| Selected Option | Establish a goal for long-term commitment to attending group therapy. |
| Rationale | Nurse Anne should inform Emily and Ken that group therapy has the greatest effectiveness when it is attended on a long-term basis. This commitment to group therapy can provide Ken with a sense of belonging, improved social skills, and increased ability to manage schizophrenia. Nurse Anne should therefore recommend that Ken establish a goal to make a long-term commitment to attend group therapy. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne is communicating with Ken about his auditory hallucination. |
| Question | Nurse Anne confirms that Ken is not experiencing command hallucinations. Which of the following responses should Nurse Anne make when further communicating with Ken about his auditory hallucinations? |

| Selected Option | "Hearing voices must be frightening, but you are safe." |
|---|---|
| Rationale | After Nurse Anne confirms that Ken is not experiencing command hallucinations, she should reassure him that he is safe and show empathy for his feelings. Providing reassurance can decrease Ken's anxiety, which further decreases the risk for self and other-directed harm. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne talks to Ken about substance use. |
| Question | Nurse Anne is talking with Ken about substance use and the results of his drug screen. Which of the following statements should Nurse Anne say when discussing this topic with Ken? |
| Selected Option | "Tell me some of your reasons for using marijuana." |
| Rationale | This statement by Nurse Anne uses the therapeutic communication technique of a broad opening and an open-ended question. These techniques encourage the client to openly discuss the topic so that the nurse can gain information and insight into the situation. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne provides information about decreasing Ken's paranoia. |
| Question | Nurse Anne is teaching Emily about ways to decrease Ken's paranoia at home. Which of the following actions should Nurse Anne recommend? |
| Selected Option | Avoid whispering or talking quietly to others when in the same room as Ken. |
| Rationale | Nurse Anne should recommend that Emily avoid whispering or talking quietly to others when in the same room as Ken. Ensuring that Ken is able to overhear conversations decreases the possible belief that others are talking about him. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne provides information about durable power of attorney for health care. |
| Question | Nurse Anne is providing information to Ken and Emily about a durable power of attorney for health care (DPAHC). Which of the following information should Nurse Anne include in the teaching? |
| Selected Option | A DPAHC can be terminated by the client. |
| Rationale | Nurse Anne should inform Ken and Emily that a DPAHC is a designation by the client appointing a trusted individual to make healthcare related decisions on his behalf if he is unable to do so. Because this designation is of the client's choosing, he retains the right to terminate the DPAHC relationship. |

| Optimal Decision | |
|---|---|
| Scenario | Nurse Anne discusses schizophrenia relapse. |
| Question | Nurse Anne is teaching Ken and Emily about relapses of schizophrenia. Which of the following information should Nurse Anne include? (Select all that apply.) |

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|---|---|
| **Selected Ordering** | Group therapy can help prevent relapse. Learning new coping skills can help prevent relapse.Substance use can cause a relapse.Notify trusted people if there is a desire for social withdrawal. |
| **Rationale** | Nurse Anne should inform Ken that participating in therapy, whether it be family, group, or individual can help prevent relapse by increasing his knowledge about the illness and skills for schizophrenia management. Learning and practicing coping skills can help prevent relapse by improving Ken's ability to manage stressful situations that could trigger relapse. Ken should avoid the use of marijuana and other substances as they can cause a relapse to occur. Ken should notify people that he trusts if he starts to have a desire for social withdrawal as this is a possible indication of a relapse. Nurse Anne should instruct Ken to notify his provider right away if any indications of relapse occur so that treatment is not delayed. Nurse Anne should ensure that Ken is aware of early warning signs of relapse which include decreased sleep, social withdrawal, and thought disturbances. |

# Score Explanation and Interpretation
## Individual Performance Profile

## REASONING SCENARIO INFORMATION

Reasoning Scenario Information provides the date, time and amount of time use, along with the score earned for each attempt. The percentage of students earning a Scenario Performance of Strong, Satisfactory, or Needs Improvement is provided. In addition, the Scenario Performance for each student is provided, along with date, time, and time use for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

If a detrimental decision is made during a Real Life scenario, the scenario will diverge from the optimal path and potentially end prematurely, in which case an indicator will appear on the score report.

## REASONING SCENARIO PERFORMANCE SCORES

| | |
|---|---|
| Strong | Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems. |
| Satisfactory | Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems. |
| Needs Improvement | Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems. |

## REASONING SCENARIO PERFORMANCE RELATED TO NURSING COMPETENCY OUTCOMES

A performance indicator is provided for each outcome listed within the nursing competency outcome categories. Percentages are based on the number of questions answered correctly out of the total number of questions that were assigned to the given outcome. Outcomes have varying numbers of questions assigned to them. Also, due to divergent paths within the branching simulation, the outcomes encountered and the number of questions for each outcome can vary. The above factors cause limitations related to comparing scores across students or groups of students.

## NCLEX® CLIENT NEED CATEGORIES

| | |
|---|---|
| Management of Care | Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team. |
| Safety and Infection Control | Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team. |
| Health Promotion and Maintenance | Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health. |
| Psychosocial Integrity | Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care. |
| Basic Care and Comfort | Promoting comfort while helping clients perform activities of daily living. |
| Pharmacological and Parenteral Therapies | Providing and directing administration of medication, including parenteral therapy. |
| Reduction of Risk Potential | Providing nursing care that decreases the risk of clients developing health-related complications. |
| Physiological Adaptation | Providing and directing nursing care for clients experiencing physical illness. |

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# Score Explanation and Interpretation
## Individual Performance Profile

## QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)

| | |
|---|---|
| **Safety** | The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others. |
| **Patient-Centered Care** | The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values. |
| **Evidence Based Practice** | The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based. |
| **Informatics** | The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice. |
| **Quality Improvement** | Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients. |
| **Teamwork and Collaboration** | The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes. |

## BODY FUNCTION

| | |
|---|---|
| **Cardiac Output and Tissue Perfusion** | The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues. |
| **Cognition and Sensation** | The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli. |
| **Excretion** | The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance. |
| **Immunity** | The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth. |
| **Ingestion, Digestion, Absorption, and Elimination** | The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body. |
| **Integument** | The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury. |
| **Mobility** | The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement. |
| **Oxygenation** | The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide. |
| **Regulation and Metabolism** | The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment. |
| **Reproduction** | The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions. |

## DECISION LOG

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

If a detrimental decision that could result in grave harm to the client is made during a Real Life scenario, the scenario ends immediately and an indicator that a detrimental decision has been made appears in the score report.
A detrimental decision indicates the need to remediate the related topic area to prevent detrimental outcomes in the future.

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