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

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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

Nervous System (Central Nervous System [CNS]): Consists of the brain and spinal cord. Key regions in the brain include:
-Frontal Lobe: responsible for decision-making, planning, reasoning, and social behavior.
-Temporal Lobe: includes the hippocampus (memory) and the amygdala (emotion) and plays a role in perception and interpretation of sensory input, particularly auditory info.
-Parietal Lobe: involved in processing sensory info and spatial awareness.
-Basal Ganglia: coordinates movement and links emotion with motivation and cognition.
-Thalamus: acts as a relay station, filters directing sensory signals to appropriate brain regions.
Neurotransmitters are . Some neurotransmitters include:
-Dopamine: regulates reward, motivation, and movement.
-Glutamate: main excitatory neurotransmitter, supports learning and MEMORY*
-Serotonin: Influences mood, sleep, and anxiety.
-GABA (Gamma-aminobutyric Acid): Main inhibitory neurotransmitter, helps calm brain activity.

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

-Schizophrenia is a chronic brain disorder that involves disruptions of thought, perception, emotion, and behavior. The pathophysiology is essentially neurochemical imbalances and structural abnormalities, while there is also a genetic link.
-Neurochemical Imbalance: It is thought that there is a hypoactivity of dopamine, leading to the negative symptoms (take away from person) of schizophrenia. These symptoms include but are not limited to flat affect, apathy, and depression. On the opposite end, there can also be a hyperactivity of dopamine, leading to the positive symptoms (adding onto the person) of schizophrenia, which include hallucinations and delusions. Glutamate is also involved; with a decreased activity it causes cognitive deficits and the psychotic symptoms that are seen clinically. Serotonin is also altered, which interacts with dopamine systems and influences mood and perception.
-Structural Abnormality: Enlarged ventricles can be seen and are indicative of loss of brain tissue volume. There is a decreased amount of grey matter, especially in the prefrontal cortex, temporal lobe, and hippocampus. Reduced brain connectivity between key regions that are responsible for emotion and cognition. There is also hypoactivity of the frontal lobe during cognitive activities seen on imaging.

To Be Completed Before the Simulation

Anticipated Patient Problem: **Risk for Violence (To Self or Others)**

Goal 1: Will verbalize feelings of anger or fear appropriately during my care.
Goal 2: Will remain free from harm to self/others during my 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 for command hallucinations (voices telling to harm self/others) Q2 hours and PRN if behavior changes.	Maintain a calm, non-threatening demeanor, using a low, steady voice.
Assess for level of agitation or anxiety by looking at body language (tone/posture) upon hourly rounding and continuously if escalating.	Activate safety protocols if risk escalates (call for help, initiate seclusion/restraint per protocol).
Assess history or expression of violent/aggressive thoughts Qshift and before group activities.	Set firm, consistent behavior limits.
Assess environment for potential objects that can cause harm Qshift and PRN after visitors or activity changes.	Ensure a safe environment; remove hazards and maintain clear exit access.
Assess substance use or withdrawal symptoms on admission, Qshift, and PRN if symptoms emerge.	Offer prescribes PRN medications (haloperidol, lorazepam) for agitation.
Assess coping mechanisms and ability to verbalize feelings Qshift.	Use de-escalation strategies: deep breathing, walking, or talking with staff.

To Be Completed Before the Simulation

Anticipated Patient Problem: **Disturbed Thought Processes**

Goal 1: Will verbalize at least one reality-based statement during interactions in my 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 for hallucinations/delusions (type and content of them) Qshift and PRN if behavior changes.	Do not argue or challenge delusions, focus on reality-based communication.
Assess speech patterns (loose associations, flight of ideas, word salad) each interaction and Qshift.	Use short, clear, simple communication to minimize confusion.
Assess orientation to person, place, and time Q8 hours and PRN if confusion increases.	Engage in gentle reality orientation (time, date, events).
Assess insight and judgment about illness daily during nursing assessment.	Encourage participation in structured, reality-based activities as tolerated.
Assess triggers or stressors that worsen symptoms Qshift or after an episode of anxiety/agitation.	Provide a structured and predictable environment with consistent staff.
Assess medication adherence and side effects (EP, sedation) Qshift and 30-60 minutes post medication administration.	Administer and monitor effects of prescribed antipsychotics.

Goal 2: Will demonstrate improved thought organization as evidenced by decreased frequency of delusional/hallucinatory statements by the end of my care.

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed Thought Process
Goal: Will verbalize at least one reality-based statement during my care. Met: ☑ Unmet:☐
Goal: Will demonstrate improved thought organization as evidenced by decreased frequency of delusional/hallucinatory statements by the end of my care. Met: ☑ Unmet:☐

Actual Patient Problem #2: Ineffective Coping Mechanisms
Goal: Will demonstrate at least one effective coping mechanism (deep breathing) during my care. Met: ☑ Unmet:☐
Goal: Will verbalize effective coping/de-escalation techniques to use at home. Met: ☑ Unmet:☐

Additional Patient Problems:
#3 Impaired Social Interaction
#4 Excessive Anxiety

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 Thought Process	1100	He is confused, has not eaten and claims to not be hungry.	1120	Performed a Suicide Assessment and Five-step Evaluation and Triage (SAFE-T) screen.	1125	Result of screen was low risk for suicide.
Excessive Anxiety and Disturbed Thought Process	1105	Having delusions of persecution and not taking meds. States "didn't need the med" and "they poisoned the pills"	1110	Used therapeutic communication and offered alternative medication. Injection by staff members he knows in the clinic.	1150	Accepts paliperidone injection in clinic and verbalizes will come next week for it, and then monthly.
Impaired Coping Mechanisms	1130	Drinks one or two beers every week at bingo. Used to do cocaine.	1135	Educated that cocaine can cause hallucinations.	1135	Verbalized understanding and stated, "cannot remember last time he used it."
Impaired Social Interaction	1140	Sister states he has been withdrawn socially.	1145	Educated family member to visit and talk with him a regular basis to help maintain social interaction.	1150	Verbalized will do this and will avoid whispering around him to prevent paranoia.
Ineffective Coping Mechanisms	1210	Sister asks about benefits therapy and if they should get him involved in it.	1210	Recommends group therapy and inform that long term commitment is best for ideal outcomes.	1220	Verbalized no further questions, verbalized feeling educated, verbalized understanding.
Disturbed Thought Process and Excessive Anxiety	**Next Appt.** 1100	Still hearing voices, anxiety increasing.	1110	Asks what voices are saying, engaged in reality-based communication. Provided quiet environment. De-escalation techniques used-deep breaths together.	1115	Verbalizes "I know they're not real, I feel better."
Ineffective Coping Mechanisms	1130	"Sometimes it helps when I listen to music with my headphones."	1135	Reinforces that this de-escalation technique is very beneficial.	1140	Still hears voices sometimes but not as often.
Ineffective Coping Mechanisms	1150	Urine negative for cocaine, positive for marijuana. States it is "relaxing."	1155	Deep breathing, meditation, journaling suggested as alternative relaxation techniques.	1200	Verbalizes will try those.

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 specimen: negative for cocaine, but positive for marijuana.

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

Signs and Symptoms
-Anxiety, fidgeting.
-Associative looseness.
-Hallucinations (voices mumbling, soft music).
-Delusions of persecution (pharmacists are poisoning him).

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

Contributing Risk Factors
-Alcohol use.
-Previous cocaine use.
-Current marijuana use.

NCLEX IV *(7)*: Reduction of Risk

Therapeutic Procedures (According to Textbook)

Non-surgical
-Cognitive-behavioral therapy (CBT)
-Electroconvulsive therapy
-Occupational therapy.

Surgical
-Prefrontal lobotomy (HISTORICAL – NOT USED TODAY)
-Deep brain stimulation (experimental).

Prevention of Complications
(Any complications associated with the client's disease process? If not what are some complications you anticipate)
-EPS of meds
-Neuroleptic Malignant Syndrome
-Metabolic Syndrome
-Cardiovascular Disease
-Substance Use Disorders
-Poor self-care
-Malnutrition
-Relapse/acute psychotic episodes
-depression
-Anxiety
-Suicidal ideation/behavior
-Social withdrawal.

NCLEX IV *(6)*: Pharmacological and

Medication Management
-Paliperidone IM once monthly in clinic.
-Acetaminophen 325 mg 1-2 PO PRN for general discomfort.
-Risperidone 2 mg PO twice daily.

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

Non-Pharmacologic Care Measures
-Therapeutic milieu
-Therapeutic communication
-Group therapy
-Journaling, meditation, deep breathing exercises.

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

Stressors the client experienced?
-Hearing voices
-Paranoia
-Anxiety
-Cannot relax
-Not hungry, won't eat.

Client/Family Education

Document 3 teaching topics specific for this client.
• Eat 3 meals a day even when not hungry.
• Develop effective coping mechanisms (deep breathing, journaling, meditation).
• Call provider as soon as signs of relapse start.

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

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
RN, NP, neurologist, pharmacist, therapist.

Patient Resources
Group therapy, Crisis Text Line (Text HELLO to 741741), 988 suicide hotline, psychosocial rehab programs, National Alliance on Mental Illness (NAMI) and the NAMI app.

Reflection Questions

Directions: Write reflection including the following:

1. What was your biggest "take away" from participating in the care of this client?
   Therapeutic communication is of utmost importance when speaking to a client with schizophrenia who is experiencing anxiety, paranoia, and hallucinations. Speaking calmly, while addressing and validating their feelings goes a long way in these interactions.

2. What was something that surprised you in the care of this patient?
   He was well groomed, and at first glance he seemed completely normal, it was not until he started talking that you can tell he had something going on in his head. It taught me to never judge a book by it's cover and the importance of having deep, open-ended communication with my clients.

3. What is something you would do differently with the care of this client?
   I would make sure I am educated better on de-escalation techniques and what to say when a client is agitated so that I can remain free from harm as well as helping my client remain free from harm.

4. How will this simulation experience impact your nursing practice?
   I will always use therapeutic communication and I will make sure I am educated on effective de-escalation techniques to help the patient calm down and to keep myself and the patient safe and free from harm.

5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.
   He is 21, so social drinking is to be expected in this stage of development. He lives independently and he can perform his ADLs by himself which is ideal for his age. Deviations in his development include excessive anxiety and paranoia, hallucinations, social withdraw, and malnutrition. He is in the developmental stage Early Adulthood, and in Erikson's stage of Intimacy vs. Isolation. He should involve himself in group therapy and social interactions to prevent isolation.