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

Student Name: Alex Brzozowski

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

The brain is divided into different section:

Cerebrum: largest part of the brain (lobes: frontal, parietal, temporal, occipital)

Cerebellum: two hemispheres, used for coordination, balance

Brainstem: connects the brain to the spinal cord, controls reflexes, maintains HR, BP and RR

Neurotransmitters of the brain:
Dopamine: fine muscle movement, emotions and thoughts, stimulates hypothalamus to release hormones
Norepinephrine: fight or flight, mood, attention, arousal
Serotonin: mood, sleep, appetite, pain perception
Glutamate: memory
Histamine: alertness, inflammatory response, stimulates gastric secretion
GABA: helps to decrease anxiety
Acetylcholine: plays a role in learning and memory, regulates mood, mania, sexual aggression, stimulates the PNS

Neurons in the brain activity: Once an electrical impulse reaches the end of a neuron, a neurotransmitter is released, crossing a synapse to attach the receptors on the postsynaptic cell to excite it

Amygdala: Aggression center, stimulates and can have feelings of anger, violence as well as fear and anxiety
Thalamus: Functions as the sensory relay station, all our senses go through here except scent
Hypothalamus: fight or flight and rest and digest
Hippocampus: forms new memories, converts short term memory into your long-term memory

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

During schizophrenia there is an increase in dopamine. During this time, you can have positive and negative symptoms. Some examples of positive symptoms include hallucinations, delusions, and disorganized speech. Some examples of negative symptoms include having a flat affect, and self-isolation. There is also a theory that there are structural changes that occur in the brain when you have schizophrenia including enlarged ventricles, a decrease in gray matter, abnormal hippocampus size. Schizophrenia also has a large genetic component linked explaining how if they have a family member that has it, they are more likely to get it.

To Be Completed Before the Simulation

Anticipated Patient Problem:Disturbed Sensory Perception

Goal 1: Will be able to verbalize one coping strategy to manage hallucinations during my time of 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 or delusions Q2hrs and PRN	Validate feelings, but state now you are not able to see the hallucination
Assess thought content Q2hrs and PRN	Redirect conversation, redirect to a different activity
Assess orientation PRN	Reorient to where they are using clear simple sentences
Assess speech pattern when talking and PRN	Use clear, simple phrases, speak slowly and calmly
Assess affect and behavior PRN	Monitor for medication effectiveness
Assess ability to perform ADLs daily and PRN	Give step by step instructions in a clear, simple tone, do not rush them

Goal 2: Will be able to verbalize a decrease in intensity of hallucinations during my time of care.

To Be Completed Before the Simulation

Anticipated Patient Problem: Risk for Violence

Goal 1: Will remain free from physical harm during my time of 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 history of aggression PRN	Remove harmful objects from the room
Assess for command hallucinations Q2hrs and PRN	Speak in a calm, non-threatening manner and ask what the voices are telling them
Assess for violent behaviors PRN	Set clear boundaries and limits
Assess judgement and impulses Q2hrs and PRN	Offer PRN medications as ordered
Assess for harmful objects in room Q2hrs and PRN	Remove harmful objects, keep a calm milieu
Assess verbal cues and social interactions Q2hrs and PRN	Provide an arm's length between you and patient, keep a calm environment, and speak in a calm tone

Goal 2: Will show no signs of command hallucinations during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem #1: Disturbed Sensory Perception
Goal: Will be able to verbalize one coping strategy to manage hallucinations during my time of care. Met: ☐ Unmet:☐

Goal: Will be able to verbalize a decrease in intensity of hallucinations during my time of care. Met: ☐ Unmet:☐

Actual Patient Problem #2: Risk for Violence
Goal: Will remain free from physical harm during my time of care. Met: ☐ Unmet:☐

Goal: Will show no signs of command hallucinations during my time of care Met: ☐ Unmet:☐

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 Sensory Perception	0900	Nurse heard a change in speech pattern, and has lost some weight	0910	Nurse asks if Ken has been taking his medication (Risperidone)	0930	Provider asks Ken if he would prefer an injection
Risk for Violence	0905	Ken is becoming very anxious	0910	Nurse stands off to the side more than one arms reach away from him	0915	Ken is sitting in the chair, looking down at the floor, feeling anxious
Disturbed Sensory Perception	0910	Ken no longer taking medication, states that the pharmacist is poisoning the medication, he is experiencing paranoia	0915	Nurse tells Ken she will talk to the provider about switching his medication, so he does not feel like someone is poisoning him	0935	Ken agreed to get an injectable form of his antipsychotic called Paliperidone
Disturbed Sensory Perception	0915	Ken hears mumbling and a quiet song during his hallucinations, dizziness when standing up and trouble swallowing his food	0915	The nurse completes a SAFE-T screening tool	0920	Educated the importance if he ever has thoughts of harming himself to let the HCP know, gave information on crisis resources
Disturbed Sensory Perception and Risk for Violence	0920	Ken states drinking beer and doing cocaine-doesn't remember the last time doing it	0920	Nurse educated that cocaine and other substances can cause psychosis and worsen signs of schizophrenia	0925	The nurse went over different resources to help with social isolation and anxiety
Disturbed Sensory Perception	0925	Provider states, Ken having weight loss, hearing voices and music no words, stopped taking risperidone 4 months ago	0930	Provider educates that there are antipsychotics that can be given by the pharmacist by injection by staff members Ken knows	0930	Ken will receive an injectable medication called Paliperidone, and will come back in a week to receive next injection
Disturbed Sensory Perception	0940	Ken has an order for Paliperidone	0940	Nurse explains that he will come to the clinic monthly for an injection	0945	Nurse recommended group therapy to go along with Kens medication, Nurse gave different handouts

						regarding group therapy
Disturbed Sensory Perception	Next Week 0900	Follow up appointment- he hears noises that sound like background music at a restaurant, no signs of self-harm	0905	The nurse educates when he is hearing the voices to talk to someone he trusts, or to do an activity such as listening to music to help drown out the hallucinations	0910	Ken verbalizes that he listens to music to help with the hallucinations
Disturbed Sensory Perception	0915	Week since first Paliperidone injection, Ken states still being able to hear noises, he has gone and hung out with his friends	0915	Nurse educates that the medication can take up to 2 weeks to take full effects, and the nurse explains that Ken can experience EPS symptoms		Ken states he will notify provider if he has any EPS symptoms
Disturbed sensory perception	0920	Positive drug test for marijuana, states it makes me feel calm	0925	Nurse educated instead of marijuana he could make try other methods such a deep breathing	0925	He states he could give some of these other methods a try
Risk for Violence and Disturbed sensory perception	0925	Sister concerned about Kens paranoia	0930	Nurse educates that with the medication it will help decrease some of the symptoms of paranoia	0930	Educating to help with the paranoia you can avoid whispering around Ken

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

Positive drug screen for marijuana

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

Signs and Symptoms

Showing Signs of Paranoia
Auditory hallucinations
Delusions
Disorganized Speech
Sister reported decline in self-care, and a withdrawal from personal relationships

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

Contributing Risk Factors

History of smoking cigarettes, 2 pack-year history

Social use of alcohol

Has used cocaine but no other substances

Therapeutic Procedures

Non-surgical

Medications-Risperidone
Helping to reorient to reality
Putting on headphones to help him when he is hearing voices
Calm environment
Good support system-he has his sister who helped him

Surgical

N/|A

NCLEX IV *(7)*: Reduction of Risk

Prevention of Complications

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

Suicide Ideation
Violence
Substance use disorder
EPS

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Medication Management

Risperidone 2mg PO 2x daily
Acetaminophen 235mg 1-2 tab PO PRN general discomfort

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

Non-Pharmacologic Care Measures

During hallucinations he can put his headphones on and listen to music to distract himself

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

Stressors the client experienced?

Hearing sounds that sound like background music at a restaurant

Client/Family Education

Document 3 teaching topics specific for this client.

•Educated the importance that if he ever had thoughts of harming himself to let the HCP know.
• Educated the use of cocaine can worsen the symptoms of psychosis and schizophrenia
•Educate the importance taking his medications as prescribed, do not discontinue abruptly

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

Multidisciplinary Team Involvement

(Which other disciplines were involved in caring for this client?)
Provider
Nurse
Could also include a psychiatrist.

Patient Resources

Different group therapies that the patient can attend to talk about schizophrenia with others with same condition
Nurse went over resources to help with social isolation and anxiety

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 participating in the care of this client is that everyone who has schizophrenia may be experiencing it a little differently. I learned that it is always important to ask questions, for example if the nurse would have not asked about him taking his medication, she would have never learned that he was not taking it due to the fact that the thought the pharmacist was poisoning him. I also learned from this that it is very important to have a family member or someone you trust involved in your care. Having someone who can look after you and that you can go to goes a long way.

2. **What was something that surprised you in the care of this patient?**
   Something that surprised me during my care is that even though someone has schizophrenia people often think of them as being "different". During this simulation I saw how people can have these mental heath disorders can still live at home and live a normal life which is amazing. He is still able to go out and hangout with his friends even though he is struggling with a mental health condition.

3. **What is something you would do differently with the care of this client?**
   Something that I would do differently during this simulation would be to offer more resources and just doing a better job explaining parts of his condition. It is very important he is following his medication regimen so I think more education on that would be important. I also think trying to gain more trust to understand more about his auditory hallucinations would be a good idea.

4. **How will this simulation experience impact your nursing practice?**
   This simulation impacts my nursing practice because I find it really important to be communicating with these patients and building trust with them. Trust is the most important aspect to build with patients. They will be more willing to open you up. I think also just understanding medications, and really understanding that keeping up with the medication regimen is so important and that is a good teaching point to educate my patients on.

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

Some norms of growth and development I saw during this simulation is that he has friends and can go out and hangout with his friends, able to do ALDs independently, maintains relationships with friends, able to express emotions. Tends to have a hard time with though process due to his paranoia-thinks that his medications are being poisoned by the pharmacist. He is in the developmental stage of Intimacy vs Isolation: he has a hard time with relationships due to his paranoia which can lead to isolation.

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