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| **Association of Standardized Patient Educators** |
| Case Development Template |
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*This template is intended to be comprehensive in nature, but may not contain every element necessary for an activity or scenario. Conversely, not every activity or scenario will require each part of this template. SP educators may exercise their judgment when selecting which parts of this template are applicable to their activities or scenarios.*

# Part 1 – Administrative Details

**Patient (SP) Name:**

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Patient’s Reason for the Visit (e.g. why is the patient coming to the doctor today?):

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**Patient’s Chief complaint:**

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**Differential Diagnosis:**

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**Actual Diagnosis:**

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**Case Purpose or Goal: (e.g. formative, summative, teaching, learner practice, assessment, lecture, demonstration)**

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**Level of the learner and discipline: (e.g. 3rd year Nursing Learner)**

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**Learner’s prerequisite knowledge and skills:**

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**Case authors:**

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**Date of case development:**

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**Summary of patient story:**

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**Learning/Case objectives:**

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**List of learner assessment instruments used: (e.g. SP checklist, post-encounter note, quiz)**

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**Event format: (e.g. formative, summative, small group, individual, multi-station OSCE, duration)**

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**Demographics of patient/recruitment guidelines: (e.g. age range, gender, body type, ethnicity, other)**

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**List of special supplies needed for encounter: (e.g. additional materials *see part 6*, moulage, props, SP attire, physical exam equipment, etc.)**

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**Recommended SP training agenda:**

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**SP Training materials needed: (e.g. documents, video, physical exam equipment, references, images, websites)**

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**Instructions for additional staff: (e.g. sim tech, proctor, sim educator)**

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# Part 2 – Door Chart/Note & Learner Instruction

**Setting (place/time)**

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**Patient Name:**

**Age:**

**Gender:**

**Chief Complaint:**

**Vital Signs: (if applicable)**

 Blood Pressure

 Temperature

 Respiratory Rate

 Heart Rate

 BMI

**Lab Results: (if applicable)**

**Image Results: (if applicable)**

**Instructions to Learners:**

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| * Tasks to be completed (e.g. elicit an appropriate history, conduct a focused physical exam)
* Patient encounter length (10 minutes, 20 minutes, 30 minutes, etc.)
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# Part 3 – Content for SPs

**Presentation and Resulting Behaviors (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples:**

**Affect: pleasant and cooperative**

**Body language: relaxed**

**Facial expression: relaxed**

**Eye contact: natural**

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**Opening Statement**

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**Dealing with Open-Ended Questions and Guidelines for Disclosure**

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| * Information offered spontaneously (what the patient can disclose after an open-ended question)
* Information hidden until asked directly (what the patient should withhold until specific questioning)
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**History of Present Illness (HPI): (consider the following)**

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| **Quality/Character** |
| **Onset** |
| **Duration** |
| **Location** |
| **Radiation** |
| **Intensity** |
| **Aggravating** **Factors (what makes it worse)** |
| **Alleviating** **Factors (what makes it better)** |
| **Precipitating** **Factors (does anything seem to bring it on)** |
| **Associated** **Symptoms** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, expectations for the visit)** |

**Review of Systems: (e.g. pertinent positives and negatives)**

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**Past Medical History (PMH): (consider the following)**

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| **Illnesses/Injuries** |
| **Hospitalizations** |
| **Surgical History** |
| **Screening/Preventive (if relevant)** |
| **Medications (Prescription, Over the Counter, Supplements)** |
| **Allergies (e.g. environmental, food, medication and reaction)** |
| **Gynecologic History (if relevant)** |

**Family Medical History: (consider the following)**

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| **Family tree (e.g. health status, age, cause of death for appropriate family members)** |
| **Relevant Conditions/Chronic Diseases (management/treatment)** |

**Social History:**

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| **Substance Use (past and present)****Drug Use (Recreational and medications prescribed to other people)****Tobacco Use****Alcohol Use** |
| **Home Environment** |
| **Social Supports** |
| **Occupation** |
| **Relationship Status** **Current sexual partners (if relevant)****Lifetime sexual partners (if relevant)****Safety in relationship (if relevant)** |
| **Leisure Activities** |
| **Diet** |
| **Exercise** |

**Physical Exam Findings: (may also include instructions on replicating findings)**

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**Prompts and Special Instructions:**

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| **Questions the patient MUST ask/ Statements patient must make (optional)** |
| **Questions the patient will ask if given the opportunity** |
| **What should the patient expect from this visit?** |

**Guidelines for Feedback: (e.g. logistics, content for feedback)**

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# Part 4 – SP Checklist

Learner Name: Date: SP:

**Grading Scale (LIKERT or Dichotomous):**

*Please describe the scale to be used for each item in this section (e.g. Yes/No, Done/Not Done, etc.).*

*Include the point values for each. (e.g. Yes = 1, No=0)*

Insert checklist here:

# Part 5 – Checklist Guidelines

Checklist guidelines are a description of the intent of a checklist item. Not all items on a checklist must be included; however clarification of certain items may be useful for rater/SPs.

This includes specifics of what raters/SPs should be looking for in order to receive credit for an item. Include examples of questions or approaches a student might take and the appropriate response.

Examples *(note these are institution specific, authors do not intend example criteria to serve as recommendations for a specific technique)*

**History**

* **#3. Learner asks about shortness of breath**

 **Yes**

 **No**

*note to scorers: Any questions about trouble breathing, difficulty breathing or trouble catching your breath would warrant credit for this item.*

*note to scorers: Questions about “lung problems” would not warrant credit for this item*.

**Physical**

* **#7. Learner palpated the area of pain.**

 DONE:  The learner will place his hand OR fingertips right over the area of pain.

DONE INCORRECTLY: The student does this maneuver over gown (or other clothing).

* **#10. Learner examined neck on ONE side while patient was lying down (head of bed elevated 15-45o).**

DONE

Not Done

Done incorrectly

-For credit: Must be done while patient is lying down at an angle of 15-45 degrees.  The learner should turn your head to one side to see if the veins in neck are distended (sticking out).

-Criteria for DONE INCORRECTLY:

* If the learner attempts this maneuver while patient is lying flat OR sitting upright.
* If the learner does not have the patient turn head.

# Part 6 – Additional Learner Materials

(e.g. laboratory results/readings, images, physical exam results cards)

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# Part 7 – Post-Encounter Activities

**Describe the type of activity the student will engage after the SP Encounter.**

*(Write a SOAP Note, Order Labs, Answer Multiple choice questions, etc.)*

*\*note – debriefing may also be a post-encounter activity*

# Part 8 – Note Rubric or Answer Key for Post-Encounter Activities

(Insert here – criteria that make explicit for raters how learners earn credit sections/items)

# Part 9 – Briefing/Learner Orientation

**Format and timing:**

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**Session objectives: (as applicable)**

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**Special instructions: (e.g. special equipment)**

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# Part 10 - Debriefing

**Technique to be used: (e.g. Plus-Delta, Advocacy-Inquiry, Debriefing with Good Judgment)**

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**Discussion questions/topics:**

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