Standardized Patient Form

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| ***Role Player****: Asking someone to imagine that they are either themselves or another person in a particular situation. ​Role Players behave exactly as they feel that person would, thus would not need a case developed.*  ***Structured Role Play:*** *A person who has been provided a prepared script on one element of a scenario which articulates a learning objective.​ Improvisation meets structure.​*  ***Embedded Participant​:*** *An individual who is trained or scripted to play a role in a simulation encounter in order to guide the scenario based on the objectives.​*  ***Simulated Patient:*** *A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the SP presents the ‘Gestalt’ of the patient being simulated; not just the history, but the body language, the physical findings and the emotional and personality characteristics as well.*  ***Standardized Patient:*** *Individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies based only on learner performance are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance.*  *\*Please consider the lines between the six applications as porous and not as hard lines that prevent movement between applications . Source: Comprehensive Healthcare Simulation; Implementing Best Practices in Standardized Patient Methodology, Chapter 5 The Human Simulation Continuum: Integration and Application.* | |
| **Level of Standardization** | [ ] Standardized Patient  [√] Simulated Patient |
| **Standardized Patient Objectives** | Your challenge as the **Standardized Patient** is multifold:   * To appropriately and accurately reveal the facts about the role being portrayed. * To improvise only when necessary and in a manner that is consistent with the overall tone/content of the case. * Maintain the realism of the simulation i.e., stay in character. * Evaluate learners fairly based on how they performed in this encounter. * Provide patient perspective in feedback. |

**Patient Name: Johnathan "John" Smith**

**Age: 58**

**Gender: Male**

**Chief Complaint: Sudden shortness of breath and chest pain**

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

**Examples:**

**Affect: pleasant/cooperative/irritated**

**Speech: verbose/terse/limited**

***Note: include any changes to presentation as case progresses***

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| **Affect: Anxious, visibly distressed**  **Speech: Rapid, slightly panicked**  **Body Language: Clutching chest, sweating, restless movements**  **Non-Verbal Communication: Frequent shallow breathing, pacing, occasional clutching of stomach**  **Verbal Characteristics: Occasionally breathless, using short sentences, expresses fear and confusion** |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

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| **Opening Statement(s)** | **A**  **"I've been feeling really short of breath all of a sudden, and my chest hurts a lot."**  **"I don't know what's happening to me, everything feels so heavy."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"I was just walking to my car when this started."**  **"I feel like my heart is racing."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **"I've been having some chest discomfort over the past few weeks, but I thought it was just stress."**  **"My wife noticed I was breathing faster last night."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **"I have a history of heart disease." (only disclosed if asked about medical history)**  **"I've been skipping my medications recently because I felt better."** |

**Sample Healthcare Interview & Physical Exam Format:**

**History of Present Illness (HPI):**

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| **Quality/Character** | **Pressure-like chest discomfort, tightness** |
| **Onset** | **Acute, started 20 minutes ago** |
| **Duration/Frequency** | **Continuous since onset** |
| **Location** | **Central chest, radiating to both arms and back** |
| **Radiation** | **To left arm, both shoulders, and upper back** |
| **Intensity (e.g. 1-10 scale for pain)** | **8/10 in pain scale** |
| **Treatment (what has been tried, what were the results)** | **Took sublingual nitroglycerin 10 minutes ago with no significant relief** |
| **Aggravating** **Factors (what makes it worse)** | **Movement, deep breaths, lying down** |
| **Alleviating** **Factors (what makes it better)** | **Sitting upright provides slight relief** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Recent heavy lifting at home, increased stress** |
| **Associated** **Symptoms** | **Severe shortness of breath, profuse sweating, nausea, dizziness, palpitations** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Feels life-threatening, fears imminent death, concerned about family and responsibilities** |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

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| Constitutional: Recent weight gain (8 lbs in 2 months), increased fatigue  Cardiovascular: Chest pain, palpitations, irregular heartbeat  Respiratory: Shortness of breath, no cough  Gastrointestinal: Nausea, no vomiting, decreased appetite  Neurologic: Dizziness, no syncope, mild confusion  Musculoskeletal: Generalized weakness, no joint pain  Psychiatric/Behavioral: High anxiety, panic |

**Past Medical History (PMH): (fill in any relevant fields)**

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Chronic Heart Failure (NYHA Class III), Hypertension, Type 2 Diabetes Mellitus** |
| **Hospitalizations** | **Hospitalized twice in the past year for heart failure exacerbations** |
| **Surgical History** | **Coronary artery bypass graft (CABG) 5 years ago** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual influenza vaccine, last colonoscopy 3 years ago** |
| **Medications (Prescription, Over the Counter, Herbal/Dietary Supplements)**  **Include: medication name, dosage strength, dosage form, route of administration, frequency of administration, duration of therapy, indication** | **Furosemide 40 mg daily**  **Metoprolol 50 mg twice daily**  **Lisinopril 20 mg daily**  **Aspirin 81 mg daily** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medications: None**  **Food: Shellfish (causes hives)**  **Environmental: None**  **Date of Allergy Diagnosis: Identified at age 45** |
| **Gynecologic History** | **N/A** |

**Family Medical History: (fill in any relevant fields)**

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| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | **Father: Deceased at 70 from myocardial infarction**  **Mother: Alive, age 88, with hypertension and osteoarthritis**  **Siblings: Two sisters, ages 65 and 60, both healthy** |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | **do not add any additional family members, any other family is alive and well, unsure about paternal grandparents** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Father had angioplasty and stent placement** |

**Social History: (fill in any relevant fields)**

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| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | **No recreational drug use** |
| **Tobacco Use** | **Smoked 1 pack per day for 40 years, quit 5 years ago** |
| **Alcohol Use** | **Drinks occasionally, about 2-3 drinks per week** |
| **Home Environment** | **Home type** | **Two-story house** |
| **Home Location** | **Urban area** |
| **Co-habitants** | **Lives with wife and one adult son** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Supportive spouse, good relationship with son** |
| **Financial** | **Retired, fixed income with Medicare and supplemental insurance** |
| **Health care access and insurance** | **Adequate access through Medicare** |
| **Religious or Community Groups** | **Attends local church services regularly** |
| **Education and Occupation** | **Level of Education** | **High school diploma** |
| **Occupation** | **Retired electrician** |
| **Health Literacy** | **Moderate, can understand basic medical instructions** |
| **Sexual History:** | **Relationship Status** | **Married for 35 years** |
| **Current sexual partners** | **Wife** |
| **Lifetime sexual partners** | **Monogamous** |
| **Safety in relationship** | **Stable, no concerns** |
| **Sexual orientation** | **Heterosexual** |
| **Gender identity** | **Pronouns** | **He/Him** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender Male** |
| **Sex assigned at birth** | **Male** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Casual attire, no indicators of gender non-conformity** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys gardening, watching sports, and woodworking** |
| **Recent travel** | **None in the past year** |
| **Diet** | **Typical day’s meals** | **Low-sodium, diabetic diet** |
| **Recent meals** | **Ate dinner 1 hour ago, no recent changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Limits salt intake, avoids fatty foods** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Diabetic and low-sodium diet** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Light walking daily, no structured exercise** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced activity due to worsening heart failure symptoms** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Sleeps 5-6 hours per night, interrupted by breathing difficulties, recent increase in fatigue** |
| **Stressors** | **Work** | **Retired, no current work-related stress** |
| **Home** | **Managing household with limited mobility due to heart condition** |
| **Financial** | **Fixed income, occasionally concerned about medical expenses** |
| **Other** | **Fear of sudden health deteriorations** |

**Physical Exam Findings: (may also include instructions on simulating/replicating/reporting findings, e.g., physical simulations, verbal prompts, findings cards, moulage, hybrid technology)**

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| General: Distressed, anxious, diaphoretic, pale  Vital Signs: (Learner may have access to symptomatic vitals)  Blood Pressure: 80/50 mmHg  Heart Rate: 130 bpm, irregularly irregular  Respiratory Rate: 35 breaths per minute  Temperature: 98.4°F  Oxygen Saturation: 85% on room air  HEENT: Pupils equal, reactive to light; no jugular venous distension (JVD)  Cardiovascular: Tachycardia, irregular rhythm, weak and thready peripheral pulses  Respiratory: Rapid, shallow breathing, use of accessory muscles, decreased breath sounds bilaterally  Abdomen: Soft, non-tender, no hepatosplenomegaly  Extremities: Cool, clammy skin, mild peripheral edema in lower extremities  Neurologic: Alert but anxious, oriented to person, place, and time; slight confusion noted  Skin: Pale, diaphoretic, no rashes |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Is everything okay?"**  **"Why am I feeling like this?"**  **"Can you help me? I feel like I'm dying."**  **"I need to get to the hospital right away.** |
| **Questions the SP will ask if given the opportunity** | **"What do you think is causing my symptoms?"**  **"How serious is my condition?"**  **"What treatments are available for me?"**  **"Will I need to stay in the hospital?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis of cardiogenic shock.**  **Initiation of emergency interventions such as IV fluids, vasopressors, and possibly inotropic support.**  **Consideration for advanced cardiac life support measures.**  **Reassurance through communication about the steps being taken to stabilize his condition.** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Yes, the SP is unaware of specific laboratory results (e.g., elevated lactate levels, troponin levels) and imaging findings (e.g., echocardiogram results) unless the learner directly inquires about them.**  **The SP does not know detailed aspects of the treatment plan that the learner may propose unless it is explained during the encounter.** |