STANDARDIZED/SIMULATED PATIENT

CASE WRITING OUTLINE

**How to use this outline:**

* Open document in Desktop version of Word, not web, for sections to work properly.
* This is a simplified version of the Upstate Simulation Department SP Case Development Template.
  + The outline is meant to be used by content experts while developing new cases.
  + Once the outline is complete, a development meeting will be scheduled between you (the content expert) and a simulation educator to complete and review other sections needed to finalize your activity and complete the Upstate Simulation Department SP Case Template.
* The outline follows ASPE Standards of Best Practice and is designed to help consistently build robust cases that promote inclusion. We ask that you consider the breadth of people who are actual and standardized patients in creating your case. If elements are not essential to the objectives of the case, we propose that SPs provide responses based on their ability, experience and comfort in sharing, rather than reporting details that may exclude some.
  + For example: Activities -- patient plays tennis and walks (response can be open) allows a patient who uses a wheelchair to answer, 'plays adaptive tennis and does upper body exercise', or a patient with limited mobility to answer 'does water exercise at the local community center' or similar.

Questions can be addressed to [SIMULATE@Upstate.edu](mailto:SIMULATE@Upstate.edu)

**Last Reviewed and Edited By**: Erin Marie Graham, 8/2024

**References:** This template is adapted from peer reviewed templates such as Association of Standardized Patient Educators, MedEd Portal, UMASS iCELS, CHIPS SP Case Template by [Center for Healthcare Improvement and Patient Simulation](https://www.uthsc.edu/simulation/) is licensed under a [Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License](http://creativecommons.org/licenses/by-nc-nd/4.0/)

## **AUTHORS:**

### Scenario Overview

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| 1. **Name of Case**   Consider descriptive title that considers main topic or purpose of encounter |  |
| 1. **Length of Patient Encounter**   How long learner is 1:1 with patient. For OSCE/SPE Assessments, this is usually 20 minutes. |  |
| 1. **Learner Objectives/Purpose and goals of the case**   All objectives should be learner-centered and SMART (Specific, Measurable, Action-oriented, Relevant/Realistic, Timely/Time-bound. | By the end of the activity, learners will be able to: |
| 1. **Target learner level:** |  |
| 1. **Assessment level** | Teaching only, no assessment  Formative Assessment  Summative Assessment  Other: |
| 1. **Type of case**   More than one option can be checked | Communication  History Only  Physical Exam Only  History and Physical Exam  Teaching and post encounter debrief  Other |
| 1. **Case Evaluation and Guides**   What assessments will be used for the session?  More than one option can be checked | **Standardized Patient:**  SP GAP Kalamazoo Communication Checklist  SP Verbal Feedback  SP Oral Feedback  SP H&P Checklist  Other:  **Learner**  Post- Encounter Written Note (Enter time allotted)  Post- Encounter Oral Presentation (Enter time allotted)  Pre/Post Session Evaluation Survey  Other:  **Faculty**  Monitor Checklist (Used live during Learner encounter)  Faculty Scoring Rubric (Used after Learner encounter has been completed)  Faculty Debrief Discussion Guide  Other: |
| 1. **Special Needs/ Equipment**   Video needed for telehealth encounter, List of equipment needed to be out for learner, etc. |  |

### SP DEMOGRAPHICS

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| * This information will be used to help “cast” SPs. * Items that are not relevant to case, leave blank or write “N/A” | |
| 1. **Gender** | Female Male  Any |
| 1. **Age**   Using an age range (e.g., 25-65) instead of a precise age is easier to case and more realistic. SPs will give their own age within the acceptable age range provided. All SPs are legally 18+ | SP needs to give specific age:  SPs can give their own age within the acceptable range of: |
| 1. **Race and/or ethnicity**   Leaving this unspecified tends to be easier to cast. |  |
| 1. **Attire**   Hospital gown, socks on/off, dressed casually, business casual, disheveled |  |
| 1. **Makeup or moulage**   Location and size. Include pictures if trying to mimic a bruise or rash |  |

### CASE OVERVIEW

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| 1. **SETTING:**   Outpatient PCP, ED, Rehab, Office Lounge |  |
| 1. **CHIEF CONCERN/OPENING STATEMENT:**   What the SP is saying when greeted by the learner. For patient encounters this is their primary reason for seeking medical care, stated in first person his/her own words. Short 1-2 sentences. |  |
| 1. **OTHER CONCERNS:**   Leave blank if no other concerns, could be other symptoms, requests, questions, patient has |  |
| 1. **ACTUAL DIAGNOSIS:**   List the diagnosis(es) you want the learner to potentially make. |  |
| 1. **PATIENT PRESENTATION/ EMOTIONAL TONE**   What are the patients’ traits or emotions? Example: Are they calm, tired, depressed, anxious? |  |
| 1. **HISTORY OF PRESENT ILLNESS**   Edit categories based on specific encounter needs | * ONSET: * LOCATION: * DURATION: * CHARACTERISTICS: * AGGRAVATING: * ALLEVIATING: * RADIATION: * PROGRESSION: * RELATED SYMPTOMS: * TREATMENT: * SIGNIFICANCE: |
| 1. **PAST MEDICAL HISTORY**   Describe past medical history |  |
| 1. **PAST SURGICAL HISTORY**   Describe past surgical history |  |
| 1. **MEDICATIONS**   Prescribed and over the counter. Reason for taking med, how long they have been taking it, dose of med |  |
| 1. **ALLERGIES** |  |
| 1. **SOCIAL HISTORY**   Edit categories based on specific encounter needs. | * LIVING SITUATION: * RELATIONSHIP STATUS: * CHILDREN: * EMPLOYMENT: * SEXUAL HISTORY: * CAFFEINE: * ALCOHOL: * DRUGS: * TOBACCO: * DIET: * EXERCISE: * STRESSORS: * SLEEP HABITS: |
| 1. **PHYSICAL EXAM/ HEENT EXAM RESULTS**   SPs can be trained to simulate physical findings. Describe and list findings for encounter and provide instructions or procedures.  *Example:* Pain in lower back. Pain is a 4:10 on pain scale. It hurts more when pressing down on area and when bending over. SP cant reach feet, they are too stiff and not able to bend all the way over. |  |
| 1. **FAMILY MEDICAL HISTORY** |  |
| 1. **CONCERNS** |  |
| 1. **OPEN-ENDED QUESTIONS**   How you want the SP to answer to questions likely asked by the learner   * Should write in IF/Then format   If Learner asks X, SP should share or say Y   * Anything medical not mentioned in the script is a negative * Anything personal not mentioned in the script should have an answer consistent with the patient for this encounter. |  |
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| **REFERENCES OR POLICIES**  List references used to create case |
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| **CASE EVALUATION & GUIDES**  Can be entered below or sent as separate document.  SP/Faculty Checklists, Surveys, Debriefing Guides |
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