**How to use this template:**

This template is to help standardize the process for creating simulation experiences at the SUNY Upstate Medical University Simulation Department.

* The template 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.
* Not all sections will be relevant for all learner groups. As you complete the template delete, change, and add sections that are relevant to your learner group.
* This template is intended to be comprehensive and contain all of the finalized elements needed to run an SPE activity.
* A simplified version has been created with specific sections that content expert/faculty member should complete when creating a new case. That info will then be used to complete other sections in this template.
* Please complete all sections relevant to your case and indicate where responses can be adjusted by the SP portraying this case by typing "(response can be open)” next to your entry.
	+ 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.

\*The details on how to use the template can be deleted in completed cases.

Questions about the template can be addressed to

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, 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/)

Upstate simulation
SP Case Development Template

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# CONFIRMED COURSE DETAILS (*completed by Simulation staff)*

\*\*\*If same case details are used for multiple programs, either add an additional table or add columns to the below table.\*\*\*DELETE THIS COMMENT IN COMPLETED CASES

|  |
| --- |
| ENTER PROGRAM NAME, FORMATIVE OR SUMMATIVE, TOPIC(CHIEF COMPLAINT) |
| **Clinical Setting/Room Type Needed:**  |  |
| **standardized person(s) needed**  |  |
| **Length of encounter:**  | Prebrief time  |  |
| door note /EMR time  |  |
| encounter time  (5-minute announcement)  |  |
| SP Gap (Post Encounter Time in Simcapture)  |  |
| SP VERBAL FEEDBACK  |  |
| Learner post encounter note (2-minute announcement)  |  |
| **Clipboard with paper**  | [ ] **No** [ ] **yes   notes:** |
| **Assessments**  | ENTER PROGRAM, FORMATIVE OR SUMMATIVE |
| **SP H&P**  |  |
| **SP GAPK**  |  |
| **SP WRITTEN COMMENTS**  |  |
| **SP VERBAL COMMENTS**  |  |
| **FACULTY SCORING RUBRIC**  |  |
| **Monitor scoring rubric** |  |
| **LEARNER PEN**  |  |
| **LEARNER REFLECTION**  |  |
| **FACULTY VIDEO ACCESS**  |  |
| **LEARNER VIDEO ACCESS**  |  |
| **LEARNER ASSESSMENT ACCESS**  |  |
| **Storage, length of time to keep data**  |  |

# SCENARIO OVERVIEW

|  |  |
| --- | --- |
| **SCENARIO AUTHORS**(This includes Simulation Department Educator(s)) |  |
| **DATE OF DEVELOPMENT** |  |
| **ASSESSMENT LEVEL** |
| [ ] Formative [ ]  Summative [ ] High Stakes |
| **ASSESSMENT GRADING** *Completing the assessment* |
| [ ] Faculty Grading [ ] Live Grading [ ] Remote Grading [ ] None |
| **LEARNER LEVEL/YEAR** |
|  |
| **PATIENT GROUP TO BE PORTRAYED** *Peds, Adolescent, Adult, Geriatric* |
|  |
| **ORGAN SYSTEM FOCUS** *Cardiac, Respiratory, Neurological etc.* |
|  |
| **DEMOGRAPHICS OF PATIENT/RECRUITMENT GUIDELINES***(e.g., age range, gender identity, body type, ethnicity, ability, or other and objective/reason for that demographic – note that if race is defined the objective should address impact of racism in this patient’s care)* |
|  |
| **CONTENT WARNINGS***(Any potentially triggering or uncomfortable case content that may impact SPs’ willingness or ability to portray the role while maintaining psychological safety)* |
|  |
| **DESCRIPTION** *Synopsis of the simulation structure.* |
| [ ] One-On-One Encounter (1 Learner, SP) [ ]  Small Group (Facilitator, SP, 6 – 12 Learners) [ ] In Person [ ]  Telehealth[ ] Hybrid (SP&Manikin) [ ] Other:  |
| **PRIMARY CHALLENGES PRESENTED BY PATIENT/FAMILY MEMBER***Summarize the case to easily understand the purpose and focus for the simulation.* |
|  |
| **PATIENT CHIEF COMPLAINT** *(In the patient’s words)* |
|  |
| **INTENDED DIFFERENTIAL DIAGNOSES** *Potential diagnoses the Learner should identify.* |
| [ ] None |
| **INTENDED WORKING DIAGNOSIS** *(Diagnosis you want the Learner to select/pursue.)* |
| [ ] None |
| **LEARNER PREREQUISITE KNOWLEDGE & SKILLS**  |
|  |
| **LEARNING/CASE OBJECTIVES**(Include communication, physical exam, impact of societal forces/DEI, bias and similar):* *Should apply to this specific learning experience.*
* *Learning objectives should be S.M. A. R. T. (Specific, Measurable, Achievable, Realistic, Time-bound)*
	+ *Blooms taxonomy can help with measurable language.*
	+ *Tailor your cases, too many objectives are not achievable and can lead to confusion*
 |
|  |
| **LIST OF LEARNER ASSESSMENT INSTRUMENTS REQUIRED***(e.g., results, imaging, EKG, SP checklist, post-encounter note, quiz) and modality (paper, on computer, etc.):* |
|  |
| **LIST OF PROPS NEEDED FOR ENCOUNTER***(e.g., moulage, SP attire, physical exam equipment, ice packs, etc.)* |
|  |
| **ROOM SETUP** *(e.g., equipment, furniture, sim technology, debriefing materials)* |
|  |

# DOOR CHART/NOTE & LEARNER INSTRUCTION

*What does the Learner need to know before entering the room? Setting - Where it is happening? e.g., Emergency room, Clinic, Pharmacy, Telehealth visit. If relevant, capture the Vital Signs or note “to be checked by you” Tasks and Timing Outline - e.g., 20 minutes to elicit appropriate history, and conduct a focused physical exam.*

|  |
| --- |
| **SETTING** *(patient location, in-person/telehealth)* |
|  |
| **VITAL SIGNS: Taken on intake.** Blood Pressure: Heart Rate: Temperature: Respiratory Rate: Oxygen Saturation: Pain scale:BMI:Other:  |
| **INSTRUCTIONS TO LEARNERS***(Adjust to case, include information on their tasks regarding history-taking, physical exam, patient discussion, other communications, paperwork, feedback)* |
| **You will have \_\_\_ minutes to:**1) Obtain a focused and relevant history.2) Perform a focused and relevant physical exam.Do not perform any sensitive exams (breast, pelvic, rectal). If you wish to perform a sensitive exam, simply tell the SP that you would do it.3) Discuss your initial diagnostic impressions, follow-up tests and initial management plans with the patient.**You will have \_\_\_minutes to:**4) Leave the room and complete the paperwork related to this case.**You will have 5 minutes to:**5) Return to the patient room for feedback from the Standardized Patient. |

# SP BRIEFING INFORMATION

|  |
| --- |
| **PATIENT/FAMILY MEMBER DEMOGRAPHICS** |
| **ROLE NAME***Gender neutral name preferred* |  |
| **GENDER** | [ ] Female [ ] Male [ ] Any |
| **AGE***Broad age range is preferred* | [ ] SP will give the specific age: [ ] SP may give their age within the acceptable range.Acceptable age range for this portrayal: [ ] 15-20 [ ]  21-30 [ ]  31-40 [ ]  41-50 [ ]  51-60 [ ] 61-70 [ ] 71-80 |
| **HEIGHT/WEIGHT** | [ ]  any height [ ]  any weight  |
| *The context of the event determines the degree of standardization or repeatability (consistency and accuracy) of the SP behavior. This behavior can be seen as part of a continuum, one end of the continuum, in summative assessment,* ***Standardized Patients*** *are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance. On the other end of the continuum, in formative educational settings, where standardization may not be an important part of the design, carefully trained SPs are able to respond with more authenticity and flexibility to the needs of individual learners and are referred to as* ***Simulated Patients****.* |
| **LEVEL OF STANDARDIZATION** | [ ] Standardized Patient[ ] Simulated Patient |
| **STANDARDIZED PATIENT OBJECTIVES** *.*  | *Your challenge as the* ***Standardized Patient*** *is multifold:* * *To reveal the facts appropriately and accurately 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*
 |
| **SIMULATED PATIENT OBJECTIVES** | *Your challenge as the* ***Simulated Patient*** *is multifold:* * *To reveal information appropriately and accurately about the role being portrayed.*
* *To modulate performance based on Learner needs including varying emotional response and cues.*
* *To improvise additional information in a manner that is consistent with the overall tone of the case.*
* *Evaluate learners fairly based on how they performed in this encounter.*
* *Provide the patient perspective in feedback.*
 |

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| **PATIENT AFFECT, BEHAVIOR, & RELEVANT VERBAL CHARACTERISTICS***Includes the body language, non-verbal communication, verbal characteristics etc., of the role. Describe the way in which the role is presented and is behaving, for example: Patient is shaky and confused and unable to give a clear history; Patient’s parent is muddled with answers and details. Patient is well presented and reticent to share awkward symptoms.***Example:**Affect: AnxietyBehavioral descriptor: bites fingernails, wrings hands.Body language: avoids eye contact, does not smile |
|  |
| **SP SCRIPT NOTES***Any special instructions or reference material the SP needs to know for this case. Links, pictures etc.* |
|  |

|  |
| --- |
| **OPENING STATEMENT & GUIDELINES FOR DISCLOSURE** *Opening Statement and Answers to Open Ended Questions are the scripted lines/info you would like the SP to give to start the encounter, this should be provided in the role’s words using “I” statements. Statements should match case objectives. This content can be volunteered freely by the role.* |
| Opening Statement:Follow-up Statement:  |
|  |
|  |

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| **DEALING WITH OPEN-ENDED QUESTIONS & GUIDELINES FOR DISCLOSURE** *Sharing case information**Include any prompts about responses the SP will make to questions the Learner asks. What information should the patient offer spontaneously? What information should they not volunteer unless asked directly? SPs are instructed to answer “no” if they have not been given a specific answer. To simplify the case, leave out negatives - pertinent and otherwise. This should be provided in the patient’s words using “I” statements* |
| **Information offered spontaneously (what the patient can share after an open-ended question)***Example: If specifically asked: “What do you think is going on with your health?”**Patient Response/Actions: “I don’t know.”* |
| **Information *not offered* until asked directly (what the patient should share on specific questioning)** |

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| **Questions the Role WILL Ask if Given the Opportunity***Include any prompts and special instructions for Questions the SP will ask if they are given the opportunity to do so. For example, the Learner asks the Patient if they have any questions, or there is a quiet time where the SP can ask a question.* |
|  |
| **Questions the Role MUST Ask (The Challenge Question)**Include any prompts/ instructions for Questions the SP MUST and WHEN to ask. Example, “At the time warning SP will ask ...” |
|  |

|  |
| --- |
| **HISTORY OF PRESENT ILLNESS (HPI)** Includes a detailed description of the chief complaint/reason for the visit and any associated symptoms. This should be provided in the role’s words using “I” statements and provide details to respond to typical questions included in an interview.*Consider the following* |
| **HPI CATEGORY** | **DESCRIPTION/EXAMPLE QUESTION** | **SP ANSWER: “I…”** |
| **Context** | *“What triggers the symptom?”**“What were you doing when it started?”**“What causes it to occur?”* |  |
| **Onset** | *“Date/ When did it start?”* |  |
| **Location** | *“Where is it?” “Does it radiate/move?” “Has it changed over time?”* |  |
| **Duration/Frequency**  | *Length of time present “How long has it been going on? Is this new?”* *ex. Recent/Chronic* |  |
| **Character/Quality** |  *“What does it feel like?” ex: Dull, sharp/knife‐like, achy, pressure, tightness, tingling, etc.* |  |
| **Modifying Factors** | *“What makes it better or worse?” “What treatments have you tried?”* | Aggravating/Worse:Relieving/Better: |
| **Timing/Pattern** | *“Is there a pattern? How long does it last, and how often does it occur?” ex. Constant, Intermittent* |  |
| **Severity**  | *“How bad is it?” “On a scale of 1-10 …”* |  |
| **Associated Signs& Symptoms** | *“Any other symptoms that you have noticed?”* |  |
| **Significance to Patient**  | impact on patient’s life including SDOH/ work/ family /community, patient’s beliefs about origin of problem, underlying concerns/fears, expectations for the visit, any cultural relevance, issues related to bias or racism |  |

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| **REVIEW OF SYSTEMS***Do not repeat associated symptoms: (e.g., list system and pertinent positives and negatives, i.e., GI nausea no vomiting or abdominal pain. 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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| **PAST MEDICAL HISTORY (PMH)***Include the elements that the SP can provide when responding to questions about their medical history and current medications.*Consider including the following as relevant to case objectives; N/A if not |
| **Significant illnesses/medical diagnoses** |  |
| **Injuries:** |  |
| **Hospitalizations:**  |  |
| **Surgical History:**   |  |
| **Screening/Preventive** *(list if relevant to age, gender):* |  |
| **Medications**  | **Prescriptions** |
| Name & Pronunciation | Reason for taking | Dose | Schedule of use | How long? |
|  |  |  |  |  |
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| **Over the Counter/Herbal Supplements/Vitamins** |
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| **Allergies** *(e.g., environmental, food, medication and reaction, date of allergy diagnosis if relevant):* |  |
| **Gynecologic History:**  | **Age at menopause: Age at menses:** **Cycle frequency: Cycle length: Flow:**  |
| **Number of live births: Number of vaginal deliveries:** **Number of C-sections: Number of miscarriages:** **Number of abortions: Number of pregnancies:**  |
| **Birth control method:** |

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| **FAMILY MEDICAL HISTORY***Include the medically relevant health information of close relatives. Age of family member - preferred that SP can adjust based on their age unless the family member age is medically relevant.* |
| **Family tree** *(e.g., health status, age, cause of death for appropriate family members)* |  |
| **Relevant Conditions/Chronic Diseases** |  |

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| **SOCIAL HISTORY***consider the following and include as relevant to your case – these are areas that are particularly suited to the SP answering based on their own ability, experience, comfort in sharing; please enter ‘response can be open’ where appropriate to support SP training* |
| **Substance Use/Nicotine/Alcohol***“Do you use any tobacco products? Have you ever? What type? How much? How often? How long?”**“Do you drink alcohol? Have you ever? What type? How much? How often? How long?”*  |
| **Substance** | **Current/Past****/Never** | **How much?** | **# of years** | **If quit, how long ago?** **-or- Interested in quitting?** |
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| **Sexual History & Relationship Status***“Who are you sexually active with?”* *The five Ps (partners, practices, past history of STI, prevention of STI, planning of family)* | Sexual Orientation: [ ] Lesbian/Gay [ ]  Bisexual [ ]  Queer [ ]  Questioning [ ]  Asexual  [ ]  Heterosexual [ ]  Other Currently Sexually Active: [ ]  Yes [ ]  No Number of current partners: \_\_\_\_ Number of prior partners: \_\_\_\_Past history of STD/STI: \_\_\_\_\_\_ Practices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Gender identity** *Pronouns, identifies as (e.g., transgender, cisgender, gender queer), Sex assigned at birth.**Gender presentation (any notes about body language, style, or dress that may signal gender identity)* |  |
| **Home Environment***Stability, security, transportation, co-habitants* |  |
| **Level of Education** |  |
| **Social Supports** *Friends, family, co-workers* |  |
| **Employment Status and Occupation** |  |
| **Financial Status***Comfortable, inconsistent income, fixed pension* |  |
| **Health Care Access***Full insurance, underinsured, no health insurance* |   |
| **Religion** *level of participation* |  |
| **Activities, Interests, and Recreation***Leisure Activities/hobbies/Interests:**Recent Travel:* |  |
| **Life Stressors***Minimal Stress/Moderate/Extreme**Work/ Home/ Financial/ etc.**Other:* |  |
| **Diet/Caffeine***Recent meals**Avoids eating (e.g., fried foods, seafood, etc.)**Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)* |  |
| **Exercise***Activities & Frequency**Include any recent changes to exercise/activity & reason for change* |   |
| **Sleep Habits***Pattern, length, quality, recent changes* |   |

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| --- |
| **PHYSICAL EXAM FINDINGS***Physical exam findings guide the SP on how to convey physical responses to the examination. For example, when Learner listens to your lungs, then cough as you exhale. Include number of times for each behavior in encounter. include instructions on replicating findings.* |
|  |

# ADDITIONAL LEARNER MATERIALS *(details of resources noted above)*

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

|  |
| --- |
| Examples: Pre encounter labs or images, post encounter labs or images.Please list when and where they access these. |

# POST- ENCOUNTER ACTIVITIES

|  |
| --- |
| LEARNER POST ENCOUNTER*Describe the type of activity the student will engage after the SP Encounter.*  |
| [ ] Oral Presentation |
| [ ] Post-Encounter Note  |
| [ ] Video Review/Self-Reflection  |
| [ ] Other |

|  |
| --- |
| FACULTY POST ENCOUNTER |
| [ ] Video Review  |
| [ ]  Scoring Rubric *(Include below if using rubric)* |
| Faculty Rubric: |

|  |
| --- |
| SP POST ENCOUNTER |
| [ ] Verbal Feedback  |
| [ ]  Gap-Kalamazoo Communication Skills Checklist |
| [ ] Communication Comments  |
| [ ] H&P Checklist (Include below if using)  |

|  |
| --- |
| **STANDARDIZED PATIENT H&P CHECKLIST** |
| *Questions should be related to objectives.**Please describe the scale to be used for each item in this section (e.g., Yes/No, Done/Not Done, etc.).*  |
| **STUDENT:**  | **DATE:** | **SP:** |
|  |  |  |
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# VII – BRIEFING/LEARNER ORIENTATION/CLOSURE

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| --- |
| **FACULTY/PROCTOR BRIEFING SCRIPT***Faculty/simulation educators provide orientation to Learners prior to the simulation. It outlines the goals of the experience, the underlying clinical problems and the expected actions and interventions from the Learners. It is essential to establish physical and psychological safety within the prebrief**Please consider the below essential components to include in prebriefing/orientation:* |
| * *Welcome (a basic statement to introduce the simulation activity)*
* *Objectives (can be the actual learning objectives or a least one or two broad objective statements.)*
* *Roles for participants*
* *Time limits/ process logistics (event flow, time warnings, location, including debrief.)*
* *Fiction Contract (Agreement to engage in the simulation as if working in a “real "environment.)*
* *Confidentiality (activity should be treated as a confidential event so that all participants have an equal opportunity. Remember confidentiality: “what happens in simulation stays in simulation”.)*
* *Orientation to the physical space (what supplies are provided.)*
* *Safety Phrase (“This is not a Simulation” is used if there is an actual medical or emotional emergency.*
* *Assessment (formative or summative event)*
* *Video Capture (media release form)*
 |
|  |
| **FORMAT & TIMING****Consistent orientation ppt template to be created by and reviewed with simulation staff.** |
|  |
| **SPECIAL INSTRUCTIONS** *(special equipment)* |
|  |

# CASE REFERENCES

|  |
| --- |
| **CASE RESOURCES & REFERENCES***Provide any references, guidelines, best practices and/or content clinical standards utilized in developing this scenario to support the clinical context* |
|  |