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SP CASE SCENARIO OVERVIEW

|  |  |
| --- | --- |
| **Course Number – Name Scenario Title**  |  |
| **SP Educator(s) and Case Author(s)** |  |
| **Date(s) the event will occur** |  |
| **Past Event Date(s)** |  |
| **Last Updated/Approved by** |  |
|  |  |
| **Description***Synopsis of the simulation structure.* | [ ] One-On-One Encounter (1 Learner, SP)[ ] Deconstructed Small Group (Facilitator, SP, 6 – 12 Learners) [ ]Telehealth [ ] In Person [ ] Hybrid (SP/Manikin) [ ] Other  |
| **Primary Challenges Presented by Patient/Family member***Summarize the case to easily understand the purpose and focus for the simulation.* |  |

Classification of Case

|  |  |
| --- | --- |
| **Assessment Level** | [ ] Formative [ ] Summative [ ] High Stakes |
| **Assessment Grading***Completing the assessment* | [ ] Faculty Grading [ ] Live Grading [ ] Remote Grading [ ] None |
| **School(s)/Department(s)/Discipline***Medicine, Pharmacy, Nursing, Dental, PA, OT, PT*  |  |
| **Learner Level/Year***1st year, Resident, Practicing Provider*  |  |
| **Patient Group to be Portrayed***Peds, Adolescent, Adult, Geriatric* |  |
| **Organ System Focus***Cardiac, Respiratory, Neurological etc.* |  |
| **Intended Differential Diagnosis** *Potential diagnoses the Learner should identify.* |  |
| **Intended Working Diagnosis***Diagnosis you want the Learner to select/pursue.* |  |

Learner Needs Assessment
*Why is this scenario needed? For more guidance see* [*Healthcare Simulation SOBP – Simulation Design – Criterion 2*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900096-7/fulltext)

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Learning Objectives
*Objectives are specific and measurable: (1) Who will do, ( 2) How much/ well, (3) Of what, ( 4) By when? For more guidance and to access a list of potential objective verbs, see the following links: (1)* [*Healthcare Simulation SOBP – Simulation Design – Criterion 3*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900096-7/fulltext)*; (2)*[*Healthcare Simulation SOBP – Outcomes & Objectives*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900100-6/fulltext) *; (3)* [*https://uthsc.edu/simulation/documents/simulation-based-learning-objectives.pdf*](https://uthsc.edu/simulation/documents/simulation-based-learning-objectives.pdf)

|  |
| --- |
| **Following this activity, learners will be able to…** |
| 1.2.3. |

# EVENT LOGISTICS

*Capture the overall format of the event, example: small group, or one on one. Timing of the event, example: 10-minute Prebrief, 20-minute History and Physical with the SP including 5 minutes remain time warning. 10-minute Post Encounter with 2 minutes remain time warning: Learner - SOAP note, SP - MIRS Checklist, 5-minute round reset/break etc.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Session Item** | **Session Description** | **Time** | **Resources/Instructions** |
| Prebrief |  |  |  |
| SP Encounter |  |  | Time Announcement: |
| Post Encounter Task*Describe for Learner and SP*   | [ ] None [ ] SP MIRS[ ] Learner  |  | Time Announcement: |
| SP Verbal Feedback with Learner |  |  | Time Announcement: |
| Round Reset/Break |  |  |  |
| Learner Debrief  |  |  |  |
| SP De-roling Debrief Post Event |  |  |  |

|  |
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| **Event Flow Notes**:  |

# LEARNER BRIEFING INFORMATION – Door Note Instructions

*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.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name**: **Reason for visit/Chief Complaint**: **Setting (place/time)**: **Vital Signs**:

|  |  |
| --- | --- |
| Blood Pressure |  |
| Temperature |  |
| Respiratory Rate |   |
| Heart Rate |   |

**Tasks:** *You have \_\_\_ minutes to:**Obtain a history pertinent to this patient’s problem. Perform a relevant physical examination.**Explain your clinical impression and workup plan to the patient.**You will then have \_\_ minutes to complete your patient note.* |

Faculty/Proctor Prebrief 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. See the link* [*Healthcare Simulation SOBP Prebriefing: Preparation and Briefing*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900095-5/fulltext) *for more. Below are the essential components to include in the Prebrief Script:*

|  |
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| * *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”.)*
* *Safe learning environment (Basic Assumption Philosophy™ “We believe that everyone participating in this simulation is intelligent, capable, cares about doing their best, and wants to improve©”)*
* *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)*
 |

# SP ROLE BRIEFING INFORMATION

*Cases include components that reflect the different users of the case, such as SP Educators, SPs, Learners, and Operations staff. The development of these materials is optimized when utilizing a set of best practice guidelines. See the* [*ASPE SOBP*](https://advancesinsimulation.biomedcentral.com/articles/10.1186/s41077-017-0043-4) *for more.*

|  |
| --- |
| 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 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.
 |
| **Simulated Patient Objectives** | Your challenge as the **Simulated Patient** is multifold:  * To appropriately and accurately reveal information 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.
 |

# PRESENTATION & BEHAVIOR

*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.*

|  |  |
| --- | --- |
| **General Appearance** | Hygiene: [ ] clean [ ] slightly unkempt [ ] poor hygiene/appears uncleanHair: [ ] neatly styled [ ] clean/combed but not styled [ ] unkemptMakeup: [ ] none [ ] limited/lipstick only [ ] full makeupClothes: [ ] hospital gown [ ] casual [ ] professionalClothes: [ ] clean/good repair [ ] clean but worn [ ] tattered/uncleanClothes: [ ] appropriate fit [ ] tight fit [ ] loosely fitting  |
| **Body Language** | Body Language: [ ] relaxed [ ] withdrawn [ ] defensive [ ] uncomfortable [ ] anxious [ ] fearful [ ] nervous [ ] neutral [ ] otherFacial Expression: [ ] relaxed [ ] tense [ ] happy [ ] worried [ ] irritated [ ] neutral [ ] otherEye Contact: [ ] normal [ ] looks away frequently [ ] no eye contact  |
| **Mood/Affect** | [ ] relaxed [ ] cooperative [ ] pleasant [ ] happy [ ] confident [ ] sad [ ] uncooperative [ ] hostile [ ] demanding [ ] preoccupied [ ] anxious [ ] fearful [ ] apprehensive [ ] listless [ ] withdrawn [ ] other |
| **Communication** | Voice Level: [ ] normal [ ] soft spoken [ ] loud/ boisterousVoice Tone: [ ] normal [ ] hostile/angry [ ] sad/depressed [ ] uneasyVoice Clarity: [ ] clear/easy to understand [ ] garbledGrammar: [ ] correct word choices [ ] slang/grammar incorrectResponsiveness: [ ] responds to open ended/direct questions with information [ ] responds to questions primarily yes/no answers [ ] other |
| **Portrayal Spectrum Level***Description of how the role would feel/act mentally/physically for each point on the scale.* ***This is a guide for acting, not medical aspects like severity!*** | Portrayal Level: None --------Low----------Medium----------High    |
| Low = Mind: Body:  |
| Medium = Mind: Body:  |
| High =  Mind:  Body:   |

# SP SCRIPT NOTES

*Any special instructions or reference material the SP needs to know for this case. Links, pictures etc.*

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|  |

# OPENING STATEMENT

*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. This content can be volunteered freely by the role.*

|  |  |
| --- | --- |
| **Opening Statement** *What brings you in today?* | “I … ” |
| **Answer to Second Open-ended question:***Can you tell me more about that?* | “I … ” |
| **Answer to Third Open-ended question:***Can you say more about that?* | “I … ” |

## What Should the Patient/Family Member Expect from this Visit?

*Include instructions to the SP about expectations they should have and could/should reflect to the Learner regarding this visit.*

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# Guidelines for Information to be Shared/Withheld

*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.*

|  |
| --- |
| **WHAT INFORMATION SHOULD THEY NOT VOLUNTEER UNLESS SPECIFICALLY ASKED A QUESTION?** |
| **Question Asked by Learner or Other Triggers/Actions**  | **Patient Response/Actions** |
| How to react to unexpected/unscripted questions:  | Answers should NOT add symptoms/history or findings that are not in the case.If asked something medical that is not in the case: You answer “No,” “I don’t know,” “Not that I’ve noticed,” etc. If asked something about your life in general that is not in the case: Improvise an answer that fits but does not distract, confuse, or cause the learner to waste time. |
| If specifically asked: what does the patient think is going on with their health: |  |
| If specifically asked: what is the patient’s primary concern about the problem: |  |
| **WHAT INFORMATION SHOULD THEY OFFER FREELY?** |
| **Question Asked by Learner or Other Triggers/Actions**  | **Patient Response/Actions** |
| After the Learner greets you:  | Give the opening statement exactly as written.  |
| The Challenge Question: | Give the Challenge question exactly as written.  |
| If they do not ask 2nd and/or 3rd open ended questions:  | Work this content into the conversation. |

## 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.*

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## 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 ...”*

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| --- |
| *At the time warning SP will ask:*  |

# HISTORY OF PRESENT ILLNESS

 *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.*

|  |  |  |
| --- | --- | --- |
| **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  | *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?”* |  |

# Review of Body Systems (ROS)

*In the pertinent information for the review of each body system – circulatory, digestive, endocrine, musculoskeletal, lymph, nervous, renal, reproductive, respiratory, skin- are there any changes the SP should share when asked about each system?*

|  |  |
| --- | --- |
| Pertinent Positives  | You **DO** have:  |
| Pertinent Negatives | You **do NOT** have: |

# Impact on Patient/Family Member

*Capture the impact the illness/condition is having on the role’s life their beliefs about where and when the problem originated any underlying concerns/fears they have about the symptoms.*

|  |
| --- |
| **How would the SP answer these questions?***BATHE (acronym for Background, Affect, Trouble, Handling, and Empathy)* |
| **Learner BATHE questions:** | **SP Answer** |
| *What* ***B****rings you in/What has been going on?* |  |
| *How is it* ***A****ffecting you/How do you feel about it?* |  |
| *What is most* ***T****roubling about this?* |  |
| *How are you* ***H****andling this?* |  |
| Learner uses techniques that demonstrate empathy/acknowledges patient cues. e.g., “NURS”***N****aming emotion: “It must be hard to....”**Express****U****nderstanding [Goal is to normalize or validate feelings or experience]: "That is difficult, I’d feel that way too.”**Showing****R****espect: “I know it is difficult for you to talk about this.”**Offering****S****upport [partnering/assistance, showing concern/sensitivity]: “I’ll be working with you each step of the way.”* |

# PAST MEDICAL HISTORY (PMH)

*Include the elements that the SP can provide when responding to questions about their medical history and current medications.*

|  |  |
| --- | --- |
| **Illnesses & Injuries** | Adult illness: Childhood illnesses:  |
| **Hospitalizations & Surgeries**  | Hospitalizations: Surgical History: |
| **Screening, Preventive, Health Care Maintenance** | **Screening/Preventive Care***Specify how often this occurs (including never) and most recent visit* |
| **Provider** | **Most Recent** | **How Often** |
| Primary Care |  |  |
| Eye Doctor |  |  |
| Other: |
| **Health Care Maintenance** |
| **Test** | **Most Recent** | **Outcome** |
| Pap smear (Women) |  | [ ] Normal [ ] Abnormal |
| Mammogram (Women 40+) |  | [ ] Normal [ ] Abnormal |
| Prostate exam (Men 50+) |  | [ ] Normal [ ] Abnormal |
| Cholesterol check |  | [ ] Normal [ ] Abnormal |
| Colonoscopy (45+) |  | [ ] Normal [ ] Abnormal |
| Other: |
| **Immunizations***Vaccinations received* | Covid vaccination/Boosters: [ ] Yes [ ] No  [ ] Maybe willing[ ] Flu shot [ ] Hepatitis [ ] Pneumovax [ ] Tetanus vaccination [ ]  None [ ] Other: |
| **Medications: Prescription, Over the Counter, Herbal Supplements***Include how to say drug name, reason for taking, dose, schedule and how long the patient has been on the medication. (SPs will have med info written on a card.)**SP Note: You must have the med card with you and keep it out of sight. When asked about Meds you say, “I made a list.” DO NOT hand over the list - they need to ask each question. If they ask to see the list, use the excuse, “I’ll read it to you, my handwriting is messy.”* | **Prescriptions** |
| Name & Pronunciation | Reason for taking | Dose | Schedule of use | How long? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Over the Counter/Herbal Supplements** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Allergies & Reaction** | [ ] None [ ] Other[ ] Medication - Specify Type and Reaction: [ ] Food - Specify Type and Reaction: [ ] Environmental - Specify Type and Reaction:  |
| **Gynecologic History** *If relevant include birth control in prescription medications.* | 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: [ ] pill [ ] shot [ ] condoms [ ] IUD [ ] vaginal ring [ ] diaphragm [ ] none [ ] other  |
| **Sexual History***“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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Psychiatric/Mental Health** *“What mental health conditions have you been told you have, if any?”* | Past:Current: |

# FAMILY MEDICAL HISTORY & EARLY LIFE DETAILS

*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.*

|  |  |
| --- | --- |
| **Early Life Details** | Birthplace: Family situation growing up:Father’s Occupation: Mother’s Occupation: Any other pertinent details: |
| **Family Member:** | **Mother** |
|  | [ ] Alive [ ] Deceased Age (or age at death): \_\_\_\_ [ ] SP can adjust this age to match their own ageMedical conditions:[ ] Healthy, no major medical problems [ ] Unknown [ ] Hypertension[ ] Asthma [ ] Depression [ ] Diabetes [ ] Alcoholism [ ] Heart disease [ ] Emphysema [ ] Cancer (specify type: ) [ ] Other |
| **Family Member:** | **Father** |
|  | [ ] Alive [ ] Deceased Age (or age at death): \_\_\_\_ [ ] SP can adjust this age to match their own ageMedical conditions:[ ] Healthy, no major medical problems [ ] Unknown [ ] Hypertension[ ] Asthma [ ] Depression [ ] Diabetes [ ] Alcoholism [ ] Heart disease [ ] Emphysema [ ] Cancer (specify type: ) [ ] Other |
| **Family Member:** | **[ ] Sister [ ] Brother** |
|  | [ ] Alive [ ] Deceased Age (or age at death): \_\_\_\_ [ ] SP can adjust this age to match their own ageMedical conditions:[ ] Healthy, no major medical problems [ ] Unknown [ ] Hypertension[ ] Asthma [ ] Depression [ ] Diabetes [ ] Alcoholism [ ] Heart disease [ ] Emphysema [ ] Cancer (specify type: ) [ ] Other |
| **Family Member:** | **[ ] Children [ ] Spouse [ ] Maternal Grandparents** |
|  | [ ] Alive [ ] Deceased Age (or age at death): \_\_\_\_ [ ] SP can adjust this age to match their own ageMedical conditions:[ ] Healthy, no major medical problems [ ] Unknown [ ] Hypertension[ ] Asthma [ ] Depression [ ] Diabetes [ ] Alcoholism [ ] Heart disease [ ] Emphysema [ ] Cancer (specify type: ) [ ] Other |

# SOCIAL HISTORY

*Consider the elements that the SP can use to answer questions about their personal habits and life history.*

|  |
| --- |
| **Tobacco/Nicotine Products***“Do you use any tobacco products? 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?** |
| Cigarettes  |  |   |  |  |
| Vape/e-cigarette |  |  |   |   |
| Cigar |  |  |  |  |
| Pipe |  |  |  |  |
| Chewing tobacco |  |  |  |  |
| **Alcohol** *“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?** |
| Beer |  |   |  |  |
| Wine |  |  |   |   |
| Liquor |  |  |  |  |
| **CAGE Alcohol Questionnaire (CAGE)** |
| *Have you ever felt you needed to* ***C****ut down on your drinking?* |  [ ] Yes [ ] No [ ] N/A |
| *Have people* ***A****nnoyed you by criticizing your drinking?* |  [ ] Yes [ ] No [ ] N/A |
| *Have you ever felt* ***G****uilty about drinking?* |  [ ] Yes [ ] No [ ] N/A |
| *Have you ever felt you needed a drink first thing in the morning (****E****ye-opener) to steady your nerves or to get rid of a hangover?* |  [ ] Yes [ ] No [ ] N/A |
| **Drugs/Illicit Substances** *“Do you use recreational drugs or “street drugs”? 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?** |
| Marijuana |  |   |  |  |
| Cocaine |  |  |   |   |
| Inhalants |  |  |  |  |
| IV drugs |  |  |  |  |
| Medications not prescribed to you? |  |  |  |  |

Social Determinants of Health (SDoH)

*Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.*

|  |  |
| --- | --- |
| **Home Environment** | Location (Town) of Home: Type of Dwelling: [ ] House [ ] Apartment/Condo [ ] Mobile Home [ ] Other Length of time living in area: Number of people living with patient: |
| **Level of Education** | [ ] Did not complete high school [ ] High school graduate [ ] College graduate [ ] Attended college [ ] Attended vocational school [ ] Graduate school attended/completed |
| **Relationship Status** | [ ] Married [ ] Long-term Partner [ ] Engaged [ ] Single [ ] Divorced [ ] Separated [ ] WidowedNumber of prior marriages (list any important details): |
| **Social Supports**  | Describe means of social, and emotional support: [ ] Family [ ] Friends [ ] Co-workers [ ] OtherRelevant details: |
| **Occupation** | Type of work: Employed: [ ] Full Time [ ] Part Time [ ] Retired [ ] Unemployed |
| **Financial Status** | [ ] Financially Comfortable [ ] Okay, but nothing to spare [ ] Inconsistent Income (Depends on ability to find work) [ ] Fixed Income (pension/government) Relevant details: |
| **Health Care Access** | Access to Insurance Coverage: [ ] Full Health Insurance [ ] Underinsured [ ] No Health Insurance [ ] Other  |
| **Religion** | Religious Affiliation: [ ] None [ ] Catholic [ ] Methodist [ ] Protestant [ ] Episcopalian [ ] Lutheran [ ] Baptist [ ] Jewish [ ] Buddhist [ ]Muslim [ ] Presbyterian [ ] Unitarian [ ] Atheism [ ] Agnostic [ ] Other Level of Participation: [ ] Actively participates/ religion very important [ ] Occasionally participates [ ] Inactive [ ] OtherRelevant details: |
| **Leisure Activities** |  |
| **Life Stressors** | [ ] Minimal Stress [ ] Moderate Stress [ ] Extreme Stress Key stressors: |
| **Diet/Caffeine** | Diet:[ ] Regular, well-balanced diet – three meals a day[ ] Lots of snack foods[ ] Pick up “fast foods” frequently[ ] Eat out frequently (restaurants) [ ] Limits diet (specify what and why– salt, sugar, fat etc.) Relevant details:Caffeine: [ ] None[ ] Minimal (1-2 cups of coffee or cola per day) [ ] Moderate [ ] Heavy (6-8 caffeinated drinks per day) Relevant details: |
| **Exercise** | [ ] Sedentary[ ] Minimal (walk a lot throughout the day)[ ] Formal exercise 1-2 times per week[ ] Formal exercise 3-4 times per week[ ] Daily exercise Type of exercise:  |
| **Sleep Habits** | [ ] Less than 6 hours per night[ ] 6-8 hours per night[ ] More than 8 hours per nightHas sleep pattern changed recently? [ ] Yes [ ] NoHas current medical issue(s) impacted sleep? [ ] Yes [ ] NoRelevant details:  |

# 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. lnclude instructions on replicating findings.*

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# MASTER INTERVIEW RATING SCALE (MIRS) – SP EVALUATION & FEEDBACK TO LEARNERS

*SP evaluation of Learners is optional. A case will not use every item, a selection of provided items is used. SPs need approximately 1 minute per item, plus 1 - 2 minutes for written comments. Access the complete* [*Master Interview Rating Scale here*](https://www.dropbox.com/scl/fi/z2fz5fjw276rb4gbikrfz/MIRS-SP-Full-Communication-Rating-Scale.docx?dl=0&rlkey=nm8nvqsxawvvtbhdx7nh6e6u4)*.*

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| **SELECTED MIRS ITEM NUMBERS FOR THIS CASE:** |
| **SP Written Comment Box Instructions:***"Please provide one or two specific strengths and one or two specific suggestions for improvement about the Learners performance in the space below. Your written feedback will be provided directly to the Learner."* |

# SCENARIO SETUP – SUPPLIES, EQUIPMENT, MEDICATIONS, PROPS

*The materials the Learners and/or SPs need during the scenario. Capture the supplies needed to make the scenario realistic such as Props, Moulage, Equipment etc. Example: BP Cuff, Reflex Hammer, Phone. Makeup special effects to be applied. Be specific to allow the application in the correct site and with correct specifications.*

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| **Props & Equipment Needed – Results, Setup, SP Props, Etc. Special Supplies Needed** |
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| **Moulage Effect Needed** (ATTACH PHOTO) |
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DEBRIEFING LEARNERS

*Technique used in Debriefing: Capture any framework or technique used, for example,* [*Plus-Delta*](https://rdcu.be/cBpq8)*,* [*Advocacy-Inquiry*](https://harvardmedsim.org/blog/paail-a-conversational-strategy/)*,* [*PEARLS*](https://debrief2learn.org/pearls-debriefing-tool/)*.*

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| **Technique to be Used with the Learners:** |
| **Discussion Questions/Topics** *Whatever debriefing framework you are using, ensure that key learning objectives are reflected in the structured debrief of the scenario. See (1)* [*The PEARLS Healthcare Debriefing Tool*](https://debrief2learn.org/wp-content/uploads/2017/12/PEARLS-Small-Poster-8.5x11-PDF-EN.pdf)*; (2)* [*Healthcare Simulation SOBP - The Debriefing Process*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900098-0/fulltext) *for more.* |
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CASE RESOURCES & REFERENCES

*Provide any references, guidelines, best practices and/or content clinical standards utilized in developing this scenario to support the clinical context. Materials for setup and/or which are provided to the learners. If providing as an attachment in an email, capture the filename below for CHIPS OneDrive. See the Healthcare Simulation SOBP for guidance on Facilitation of sessions:* [*Healthcare Simulation SOBP - Facilitation*](https://www.nursingsimulation.org/article/S1876-1399%2821%2900097-9/fulltext)*.*

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| **Case Resources and References** |
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| **OTHER LOGISTICS *(FOR OFFICE USE ONLY)*** |
| Event flow |  |
| Number of learners |  | Room type & quantity: |  |
| Number of Cases |  | How will the cases run: | [ ] Simultaneous [ ] Separate |
| Number of Rooms per case |  | Number of Rounds |  |
| Round Times |  |
| Number of SPs Needed? |  | Number of Backups Needed? |  |
| Proctor(s) Needed? | [ ] Yes [ ] No | If Yes, how many? |  |
| A/V Capture | [ ] Yes [ ] No | Learner Video Access | [ ] Yes [ ] No Date Range? |
| Recording Capture for | [ ] Prebrief [ ] Encounter [ ] Post-Encounter [ ] Debrief |
| B-Line Reports | [ ] Yes [ ] No | Report Type? |  |
|  Research IRB# and title of project |  |
| Action Item Follow-UpsFaculty Logistics Operations Education  |