SIMULATION SCENARIO DEVELOPMENT TEMPLATE

Scenario name: Depression in Primary Care
Date submitted: 07/10/2011
Submitted by: Sharon J. Wilson
Institution: University of Washington
Target audience: Undergrad ☐ Grad ☑ Other: Novice clinicians
Goal/Purpose: Identification of depressive symptoms in primary care

Lab Set-up

Patient simulator/Task trainer: Standardized Patient or student role-playing
Patient characteristics: Any age or gender
Vital parameters, beginning: Normal range BP, Pulse, RR. Weight 184 lbs. Height 5'5"
Environment/setting/location: Primary care clinic
Lab staff needed day of simulation: None
Equipment, supplies & prop list: Stethoscope; Penlight; Tongue blade

Learning Objectives

Learner will be able to:

1. elicit a complete history of present illness, including relevant past medical history, review of systems and social history.
2. perform a brief, focused physical exam.
3. demonstrate clinical reasoning in the formulation of a diagnosis and basic management plan.
4. demonstrate ability to communicate findings, diagnosis and plan in a post-visit chart note.
5. counsel patient regarding natural history of depression and treatment plan.

Student Preparation

Pre-requisite knowledge/activities:

Knowledge of DSM IV criteria for depression and initial treatment depression.
Knowledge of natural history depression and depression screening tools.
Knowledge of medications commonly used to treat depression and how to take these medications including potential side effects.

Clinical Case Information

Case description/Patient history (HPI, PMH, Social Hx, FH):

Chris King is a 36 year old male or female patient that presents with c/o 20 lb. weight gain in last 3 months. Weight 3 months ago was 162 lbs. Wanting to eat all the time and doesn't ever seem to feel full. Craving high calorie foods. Lost job 6 months ago and no prospect for finding one soon. Physical exam 4 months ago was normal except never came back for fasting lab. ROS: recent difficulty getting to sleep due to worrying; fatigue/no energy; no fever/chills; temp. intolerance, increased thirst or urination. PMH: no diabetes, anemia cancer or CAD. FH: Father dying of cirrhosis of the liver and he lives nearby; only child. Habits: non-smoker; 6 beers a day, increase last 6 months from weekends only; never used recreational drugs; used to bike without any energy recently so not doing. SH: married with no children. No marital problems.

Medications and Allergies (MAR):

NKDA
Multivitamin one a day. No herbals or OTCs.

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Actor Roles and Behavior Overview

Actor/Role – Brief overview of behavior during scenario

Clinician - performs H&P and develops treatment plan.
Standardized patient or student role-playing of patient - Poor eye contact and flat affect; wringing hands.

Scenario Events and Expected Actions

Events in chronological order – Expected actions

1. Patient sitting on exam table - reluctant to talk. Short answers to questions.
2. If clinician starts to ask questions related to depressive symptoms - patient speaks more freely, starts to get weepy. Completes HPI.
3. If clinician asks patient to fill out depression screening tool - fill out to indicate severe depression but NOT suicidal.
4. Clinician performs physical exam - patient does not have any positive findings.
5. Clinician presents treatment plan - patient accepts plan and asks questions prn.
6. Clinician completes documentation post-visit.

Debriefing Points

What went well?
What would you do differently next time?
What was your differential diagnosis for this patient?

References

Evidenced-based practice guidelines, protocols or algorithms used in creating scenario:

DSM IV reference for depression criteria.
Uphold, C.R., Graham, M.V. (2003). "Clinical Guidelines in Family Practice", 4th Ed.
Bickley, Lynn S. (2009). Bates' Guide to Physical Examination and History Taking, 10th ed., page 78. Philadelphia: Lippincott.

Key Words:

Depression; Outpatient setting; APN novice; H&P; focused visit; standardized patient

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