Station 2

Instructions for Standardized Client

OPENING STATEMENT *Note: To be said verbatim at the start of the station.*
I've been short of breath lately.
INFORMATION PROVIDED TO EXAMINEE
69-year-old Wayne Porter is at the community health clinic. Wayne is concerned about an increased shortness of breath.
AIM FOR EXAMINEE
Examinee is to obtain a history of the health concern, complete a focused respiratory assessment and respond to the client's concerns.
KEY CONCEPTS FOR STANDARDIZED CLIENT
• SC to listen carefully to the examinee's question and only answer that question. • SC to portray consistently all day (i.e., stay "fresh" & standardized in the delivery of answers).
DETAILS FOR STANDARDIZED CLIENT
You are 69-year-old Wayne Porter, a client visiting the community health clinic. You are here today as you have worsening shortness of breath since yesterday.
BACKGROUND
Behaviour, Demeanor, and Appearance
• You are cooperative
Attire
• Hospital gown and regular pants that can roll up to the knees
• Slippers
• Loose fitting socks
Starting Position, Framing
• Sitting on a chair, sideways so back is exposed, one arm resting on back of chair
HISTORY OF PRESENT ILLNESS/PROBLEM

Client's Concerns

- Some shortness of breath since yesterday, that has been getting a little worse today

Current Symptoms

- You are short of breath even when lying down and you had to sleep using 3 pillows last night (you usually use one).
- Your shortness of breath gets worse when you try to walk. You can go about ½ a block and then you must stop. You usually do not have to stop when you walk.
- Yesterday, you noticed that you were short of breath after climbing a flight of stairs and this happened again today after you walked from your car to the clinic.
- You haven't had any recent infections, colds, or illnesses.
- You have not traveled recently.
- You do not have chest pain.
- It is harder to breath in than out.

PAST MEDICAL HISTORY

- If asked about any medical/health conditions, you **must** offer history of Congestive Heart Failure (CHF) immediately. . SC should use full term (vs. abbreviation) when first mentioning it.
- You were diagnosed with high blood pressure 10 years ago.
  - You had a heart attack 5 years ago.
  - Within a few months after your heart attack, you experienced shortness of breath (SOB) a few times, and when you were first diagnosed with congestive heart failure (5 years ago). You have not been hospitalized since your heart attack 5 years ago.
- There have been no changes to your medications since your heart attack
- You take your meds directly out of the bottles; you do not use a dosette or a blister pack.
- You have not missed taking any medication.
- You do not monitor your fluid intake. You have never been told to do this.
- You weigh yourself regularly and noticed that you have gained about 3 pounds in past 2 days.
- If asked directly for weight, give your own weight.
- You see your doctor at the clinic once a year for regular check-ups and prescription renewals. Your last visit was 8 months ago.
- You cannot remember the exact date of your last ECG, stress test or angiogram; it was probably 5 years ago after your heart attack.
- You do not have angina.
- You did not have cardiac surgery or angioplasty after your heart attack.
- You have had both the flu vaccine and the pneumonia vaccine this year.

ALLERGIES

None

MEDICATIONS

- Blood pressure pill – Capoten (captopril) 10 mg (daily in am) x 10 years
- A pill for my heart – Lopressor (metoprolol) 25 mg (daily in am) x 5 years
- A pill to lower cholesterol – Crestor (rosuvastatin) 10 mg (daily at supper with food) x 5 years
- A pill to remove water – Lasix (furosemide) 20mg (daily in am) x 5 years
- A pill to prevent heart attack - coated baby Aspirin (acetylsalicylic acid) 81mg (daily at supper) x 5 years

Notes:

- Do not explain what the medications are for, but if asked, you do know what each one is for and the reason you take it.
- If the candidate sees Crestor on the med list and asks if you have high cholesterol, say *"not that I'm aware of"* (Your doctor may have prescribed this preventatively, but you don't need to know this).

Note: Hand the medication list over to the examinee when asked about medications.

FAMILY MEDICAL HISTORY

- Your father died of a heart attack at age 76.
- Your mother died from a stroke at age 69.

SOCIAL/PERSONAL HISTORY

Occupation	You are a retired car salesman.
Relationship Status	You are divorced.
Children	3 children and 4 grandchildren
Social Support	3 children
Living Arrangements	1 floor apartment with elevator access
Alcohol	You drink 4 beers on the weekend. This is normal for you.
Smoking	No
Recreational Drugs	None
Diet	You try to follow a balanced diet, however in the past week you haven't. Instead, you have eaten a lot of canned food and soups. You have also been eating out for a few meals like chicken wings, french fries and burgers.
Exercise	You walk daily for 15 minutes.
Other	None

“MUST ASK” QUESTIONS
None
“MAY ASK” QUESTIONS
None
PHYSICAL EXAM
• Physical respiratory assessment - the examinee **will** touch you. • The examinee may ask you to remove your gown to conduct a chest assessment. • They may put their hands on your chest and back, place a stethoscope on your chest and back to listen to your breathing, put their fingers on top of your foot or behind your ankles to check pedal pulses or assess edema, and push on your fingernails to check capillary refill.
NOTE: If the examinee actually causes you pain when conducting the physical assessment, loudly say "*Please stop. You are hurting me*." The examiner will then prompt the examinee to move on to the next step.
ADDITIONAL NOTES FOR STANDARDIZED CLIENT
None
STANDARDIZED CLIENT RESPONSES

If the examinee…	**Respond by saying**
Asks for consent to complete a health history and/or physical assessment	*Yes.*