Committee for Examinations
Objective Structured Clinical Examination
Station 1
Auckland September 2018

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

This is a station that tests the candidate's ability to analyse clinical performance data on seclusion in four local hospitals, identify that there are variations in the numbers of people being secluded across the hospitals, and provide explanations as to why this may have occurred. The candidate is then provided with more specific information on which to provide an opinion.

1.1 The main assessment aims are to:

- Review and interpret the clinical performance data that has been provided.
- Identify that there has been an increase in the seclusion figures in one of the local hospitals.
- Outline the factors that may explain the variation in seclusion rates both between sites and throughout the year.
- Identify strategies to reduce seclusion rates.
- Provide opinion on specific data related to individuals.

1.2 The candidate MUST demonstrate the following to achieve the required standard:

- Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.
- Outline at least three (3) factors to explain the variation between sites.
- Propose at least three (3) appropriate explanations for the trend throughout the year.
- Provide at least three (3) evidence-based strategies to reduce seclusion rates.
- Provide at least three (3) explanations why these multiple seclusions may be happening.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Governance Skills, Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Marking Domains Covered**: Medical Expert, Health Advocate, Scholar.
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Management – Therapy), Health Advocate (Addressing Disparity), Scholar (Teaching & Presenting; Application of Knowledge), Manager (Governance)

References:

- Gaskin, C.J, Elsom S.J and Happell B. (2007) Interventions for reducing the use of seclusion in psychiatric facilities. British Journal of Psychiatry 191: 298-303.
- Oster C. et al. (2015) Seclusion and restraint use in adult inpatient mental health care: An Australian perspective. Collegian 23: 183-190.
- The Royal Australian and New Zealand College of Psychiatrists Position Statement 61: Minimising the use of seclusion and restraint in people with mental illness.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

This is a **VIVA** station. In this **VIVA,** there is no role player.

You are working as a junior consultant psychiatrist in an inpatient unit of a large city hospital, and have been asked by your clinical director to analyse the seclusion figures for the last year for the hospitals in your district. She has asked you to examine the raw data she has provided, and prepare a presentation for the next medical meeting. If any of the hospitals are found to be outliers in terms of their seclusion rates, she has also asked you to consider and propose possible reasons why this may be so.

Your tasks are to:

- Review data and provide a basic graphical representation that is suitable to identify trends and will support a discussion around these.
- Explain how the seclusion figures are trending across the hospitals.
- Explain the hospitals' overall performance throughout the year.
- Provide possible reasons for these trends and any unexpected results.
- Identify interventions or strategies that could reduce the rates of seclusion within this hospital.

At ten (10) minutes, you will be given the final task by the examiner.

Station 1 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues are available for candidate use.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / times for any scripted prompt.
- DO NOT redirect or prompt the candidate unless scripted.
- If the candidate asks you for information or clarification say:
  'Your information is in front of you – you are to do the best you can.'
- **At ten (10) minutes, you are to give the final task to the candidate.**
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your co-examiner's and your mark sheet in **one** envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you must remain in the room and NOT proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

This is a VIVA station so there is no role-player**.** Your role is to keep to time and to mark the candidate.

At ten (10) minutes, you are to give the final task to the candidate. The final task is:

You are the consultant of this acute 20 bed psychiatric unit.

The following are last month's data.

Two patients, Mr AB & Ms SR, have both been secluded multiple times over the month.

Based on likely causes of the seclusion patterns, please outline your approach to the management of reducing these seclusions.

August 2018

Patient	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion
Mr AB	4 hours 3.05pm	3 hours 1.55pm	2 hours 3.50pm	1.5 hours 2.00pm	4.5 hours 3.12pm	1.5 hours 2.10pm
Ms SR	3 hours 6.30am	1.5 hours 6.00am	1.5 hours 5.42am	1.0 hours 5.15am	1.5 hours 6.00am	1.5 hours 2.15pm

3.2 Background information for examiners

In this station the candidate is expected to demonstrate skills at analysing clinical data on seclusion rates, including presenting their analysis in a simple graphical form from which they can then identify an increase in seclusion figures in Western Hospital. The candidate is then expected to postulate on factors that may explain the variation between sites as well as the trend over the year. Finally, the candidate is expected to present strategies that will assist in reducing seclusion rates.

In order to 'Achieve' this station, the candidate **MUST**:

- Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.
- Outline at least three (3) factors to explain the variation between sites.
- Propose at least three (3) appropriate explanations for the trend throughout the year.
- Provide at least three (3) evidence-based strategies to reduce seclusion rates.
- Provide at least three (3) explanations why these multiple seclusions may be happening.

Royal Australian and New Zealand College of Psychiatrists Position Statement 61:

The RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way that supports good clinical practice and provides safe and improved care for consumers. Reducing the use of seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.

Background

In recent years, there have been a number of Australian reviews in relation to seclusion and restraint, including:

- *In 2005, Australian Health Ministers endorsed the National Safety Priorities in Mental Health: a National plan for reducing harm. The Plan identified four priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion' (National Mental Health Working Group, 2005).*

- *The National Mental Health Seclusion and Restraint Project (2007 – 2009), also known as the Beacon Project, was developed as a collaborative initiative to establish demonstration sites as centres of excellence aimed towards reducing seclusion and restraint in public mental health facilities. The Beacon Project published a suite of national documentation in September 2009 (Mental Health Standing Committee, 2009), which was endorsed by the Mental Health Standing Committee (MHSC) for use by Australian mental health services.*
- *The National Mental Health Consumer and Carer Forum's 2009 position statement on Ending Seclusion and Restraint in Australian Mental Health Services (National Mental Health Consumer and Carer Forum, 2009).*
- *In its 2012 Report Card on Mental Health and Suicide Prevention, the National Mental Health Commission recommended that action must be taken to eliminate the use of seclusion and restraint in mental health services. In order to carry out this recommendation, the Commission called on all states and territories 'to contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013' (National Mental Health Commission, 2013).*
- *In 2015, the National Mental Health Commission published A Case for Change: Position Paper on seclusion, restraint and restrictive practice in mental health services to help identify best practice as well as the barriers to reducing or eliminating seclusion and restraint in mental health settings (National Mental Health Commission, 2015).*
- *All Australian jurisdictions have introduced laws, policies or guidelines, focussing on reducing seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.*

In New Zealand, Te Pou o Te Whakaaro Nui (Te Pou) released a report in 2008, Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change (O'Hagan et al., 2008).

The standards governing the use of seclusion and restraint in the Health and disability services (restraint minimisation and safe practice) standards were also revised in 2008 (Standards New Zealand, 2008). The intent of the standards is to 'reduce the use of restraint in all its forms and to encourage the use of least restrictive practices'.

In 2010, the New Zealand Ministry of Health developed guidelines to identify best practice methods for using seclusion in mental health acute inpatient units in alignment with the specifications set out in the Health and Disability Services Standards to, over time, limit the use of seclusion and restraint on mental health patients. In addition, reducing (and eventually eliminating) seclusion is one of the goals of the Ministry's service development plan 'Rising to the Challenge' (Ministry of Health, 2012).

Subsequently, Te Pou has developed an evidence - based Six Core Strategies Checklist for reducing the use of seclusion and restraint practices. As research also shows that Tangata whai i te ora are over - represented in reporting of seclusion and restraint events, Te Pou has also developed recommendations to support better outcomes when working with Māori people using services. The work is drawn from Te Pou's work with services and from the study Strategies to reduce seclusion and restraint for tangata whai i t e ora (Wharawera - Mika et al., 2013).

Over the past decade, Trauma - Informed Care has emerged and encompasses strategies aimed at reducing coercive practices, including restraint and seclusion as a way of creating therapeutic environments that prevent retraumatising or traumatising consumers. The majority of consumers in inpatient settings have had past trauma experiences and as such 'universal trauma precautions' and nursing practices that are growth - promoting and recovery - focussed are recommended to prevent further harm. Restraint and seclusion are experienced by consumers as emotionally unsafe and disempowering practices and, therefore, can be re-traumatising (Muskett, 2014).

Recent data shows that the seclusion and restraint rate in mental health services in both Australia and New Zealand is declining. In Australia, there were eight seclusion events per 1 000 bed days in 2013 – 14, an average annual reduction of 12.2% since 2009 – 10. The highest rate of seclusion was for child and adolescent and general services with 9.6 and 9.5 seclusion events per 1000 bed days respectively. Older person services had the lowest rate of seclusion events (0.5), a reduction of 34.4 % in five years (Australian Institute of Health and Welfare, 2014). In New Zealand, the use of seclusion in adult inpatient units is also in decline, with the number of people secluded decreasing by 29% since 2009 and the total number of hours spent in seclusion reducing by 50% since 2009. However, Māori people remain over - represented in the seclusion figures. In 2013, Māori people were 3.7 times more likely to be secluded than non - Māori in an adult inpatient setting (per 100,000 population; Ministry of Health, 2014).

<u>Definition</u>

Both seclusion and restraint have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. The primary aim is to reduce risk of traumatic experience and / or injury for both consumers and staff involved.

- ***Seclusion** is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.*

- ***Restraint*** *is the restriction of an individual's freedom of movement by physical, chemical or mechanical means. Here, 'physical' means bodily force that controls a person's freedom of movement, 'chemical' means medication given primarily to restrict a person's movement not to treat a mental illness or physical condition and 'mechanical' means a device that controls a person's freedom of movement.*

While this position statement applies to the use of seclusion and restraint in mental health settings, it should also be used to inform policy in all other health, welfare or disability settings. This includes the use of seclusion and restraint on individuals with intellectual disability and in aged care settings and those presenting in emergency departments.

Evidence

Seclusion and restraint are generally used in the hope of preventing injury and reducing agitation, but studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994).

It is acknowledged that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer. Seclusion and restraint are not a substitute for inadequate resources (such as lack of trained nursing staff). They should never be used as a method of punishment.

There is considerable variation in the clinical standards governing the use of seclusion and restraint in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The aim is to reduce the use of these interventions and the adverse events that accompany them. Reduction of seclusion and restraint is possible, as demonstrated in studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). Evidence also shows that de - escalation and debriefing strategies can help minimise the use of seclusion and restraint. It requires leadership, commitment and motivation, and a change culture underpinned by recovery with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.

The main barriers to reducing seclusion and restraint are:

- *lack of identified good practice / agreed clinical standards for the use of seclusion and restraint.*
- *lack of quality improvement activity and clinical review – i.e. poor governance.*
- *inappropriate use of interventions and variation in practice – e.g. using threat of restraint or seclusion to coerce particular behaviour.*
- *lack of staff knowledge or skills to prevent , identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations.*
- *lack of staff knowledge or skills regarding appropriate triaging of mental health presentations.*
- *lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint.*
- *lack of staff education and training, particularly in non-mental health care settings.*
- *lack of resources and poor facilities.*

Many of the barriers above are being addressed through the MHSC initiatives in Australia and the recent updates by Te Pou and Standards New Zealand. Common themes developed in all strategies for the reduction of seclusion and restraint include:

- *national direction and appropriate funding.*
- *leadership towards organisational, clinical and cultural change.*
- *use of data to inform practice.*
- *improved governance and review.*
- *workforce development, including de-escalation and debriefing strategies.*
- *use of practical and evidence - based seclusion and restraint prevention tools.*
- *service user development and participation.*
- *better care planning.*
- *consumer roles in inpatient settings.*
- *debriefing techniques.*
- *review of relevant mental health legislation.*

The RANZCP supports the development of these strategies and believes that an increased focus on developing good clinical care, governance, research and education will help reduce the use of seclusion and restraint in practice.

The RANZCP also supports measures to improve the environment and physical layout of mental health services to help consumers to feel as safe and secure as possible. These measures can, in turn, help services to reduce the need to utilise seclusion and / or restraint practices. Potential examples include having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed and enabling doors to the to the main wards to be unlocked (National Mental Health Commission, 2015).

Issues which could specifically explain why sites within the same district could have different seclusion utilisation include disparity in staffing numbers and stability; different levels of comfort on assertive medication management for aggression; allocation of resources (including access to security staff or lack thereof; size of the site / grounds; locked facility or not; ward culture; demographics of the hospital catchment area (population size, density and stability, metropolitan vs regional setting).

Increasing trends could occur for a range of reasons, for instance, changes in staff expertise such as registrar term change or recruitment of new nursing graduates; commencement of a new consultant who has different training / opinion around seclusion; tendencies to under medicate leading to episodes of seclusion.

The candidate may elaborate on the role and attitudes of the Nurse-in-Charge / Nurse Unit Manager (NUM), and other shift leaders and their impact on the culture of the ward. They could postulate on issues related to the training and attitude of all members of the MDT; the specific leadership of consultants; the availability of medical staff to de-escalate prior to seclusion; that there may be training gaps – both on policies and procedures (and whether they are being followed) and of de-escalation strategies and training in the management of occupational violence.

In the station the candidate will be given a set of data at ten (10) minutes to consider about their own ward. This is to test their ability to consider the role of a consultant to be a manager of unusual trends of seclusion. They are expected to be able to consider the multiple stakeholders to be consulted before developing a quality improvement plan. Explanations for the multiple seclusion incidents could be broken down to considering specific patient factors that could explain each of the patient's patterns of seclusion: whether this is early in the admission or throughout the admission; whether the patient is known to the staff or new to the service; diagnoses, treatment plans, adequate medication management, extenuating psychosocial factors confounding the inpatient management (*for example, does the patient have a diagnosis of a personality disorder leading to later use of effective sedating medications*); impact of personality structure and interactions with staff; transference and countertransference factors and cognitive biases.

The candidate should provide a range of actions to address the change in their hospital. This could include plans to meet with all stakeholders (nursing staff, medical staff, patient advocates), and prepare a strategy to aim to reduce seclusion rates for each patient. They should effectively consult around complex governance issues of occupational violence and aggression versus Human Rights versus the goal of seclusion; lead change management. There may be mention of a review of the timing of medications; or making transparent the role of cognitive bias to a particular patient. The candidate could focus on the role that shift change and handover takes in this process – are the nurses finding it difficult to manage highly aroused patients when there is a handover process being prepared and / or occurring.

The better candidate may:

- consider a quality project for their ward around better implementing the hospital de-escalation policy, and trying to actively reduce seclusion rates.
- want to investigate whether there are person specific factors, for instance, the same shift leader each time.
- recommend an external review.
- include consumer and carers in any review.
- consider local culture and interventions that include the entire ward.

3.3 The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).

ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.

iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.

iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.

v. they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations.

vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.

vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- Review and interpret the clinical performance data that has been provided.
- Identify that there has been an increase in the seclusion figures in one of the local hospitals.
- Outline the factors that may explain the variation in seclusion rates both between sites and throughout the year.
- Identify strategies to reduce seclusion rates.
- Provide opinion on specific data related to individuals.

Level of Observed Competence:

6.0 SCHOLAR

6.3 Did the candidate demonstrate an appropriately skilled approach to applying principles of presenting? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:
provides a well-structured and clear visual representation; recognises the opportunity that presenting offers; prioritises the learning needs of peers; provides carefully tailored feedback strategies.

Achieves the Standard by:
demonstrating the capacity to: identify requirements to portray the main points for the presentation; organising the data in a simple manner; appropriately labelling key aspects of the graph to ensure a successful outcome; accurately interpreting data at a level relevant to the consultant audience; clearly seeing their role in the delivery of findings; identifying additional information that may be required.

To achieve the standard ***(scores 3)*** the candidate **MUST:**

a. Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; does not apply any structure to their graphical representation; does not demonstrate an increasing trend; does not see presenting as part of their role.

Does Not Address the Task of This Domain (scores 0).

6.3. Category: TEACHING & PRESENTING	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature / research / clinical experience? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
candidate acknowledges that information provided is not comprehensive but is the subject of debate; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:
commenting on the voracity of the available evidence; discussing major strengths and limitations of information provided and their visual interpretation; specifying the key proponents of current knowledge base; describing the relevant applicability of theory to the scenario.

To achieve the standard ***(scores 3)*** the candidate **MUST:**

a. Outline at least three (3) factors to explain the variation between sites.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; unable to demonstrate ability to analyse data; inadequate knowledge of the literature or evidence relevant to the scenario; inaccurately identifies or applies evidence provided.

Does Not Address the Task of This Domain (scores 0).

6.4. Category: APPLICATION OF KNOWLEDGE	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

5.0 HEALTH ADVOCATE

5.1 Did the candidate appropriately attempt to address disparity in the seclusion rates over time? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
actively seeks to evaluate local hospital data; considers impact of differences of local settings.

Achieves the Standard by:
demonstrating the capacity to: describe strategies to reduce inequalities and disparities in the clinical setting; use expertise and influence to advocate on behalf of patients; promote primary and secondary prevention strategies within individuals / communities; engage with minority groups to enhance delivery of care; actively link with relevant advocacy groups; mobilise additional resources when needed.

To achieve the standard ***(scores 3)*** the candidate **MUST:**

a. Propose at least three (3) appropriate explanations for the trend throughout the year.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; limited recognition of health inequalities and disparities; unable to explain or advocate for rational explanations across time; unsophisticated approach to explaining differences.

Does Not Address the Task of This Domain (scores 0).

5.1. Category: ADDRESSING DISPARITY	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological and / or psychological / social intervention strategies? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options; clarifies the role of other health professionals; considers sensitively barriers to implementation; identifies most strategies.

Achieves the Standard by:
demonstrating the following: the understanding of evidence-based least restrictive interventions; identification of specific options; appropriate selection of and rationale for specific strategies; including benefits / risks, application and monitoring.

To achieve the standard ***(scores 3)*** the candidate **MUST:**

a. Provide at least three (3) evidence-based strategies to reduce seclusion rates.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; errors or omissions impact adversely on patient care and seclusion outcomes; options lack evidence base and / or are inaccurate; plan not tailored to reducing seclusion or circumstances relating to seclusion.

Does Not Address the Task of This Domain (scores 0).

1.14. Category: MANAGEMENT - Therapy	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

4.0 MANAGER

4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
presents a considered systems approach to their answer including demonstrating willingness take responsibility for their role in this situation and in leading change; considers effectiveness of audit, review and feedback processes; incorporates significance of upholding human rights in the context of risk mitigation.

Achieves the Standard by:
identifying principles of clinical governance and standards, applying governance within organisational structures; demonstrating capacity to distinguish between leadership and management; contributing to principles of change management and change processes; considering a suitable range of options that explain the data; presenting a range of relevant and practical approaches to reducing seclusion rates in the two patients.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Provide at least three (3) explanations why these multiple seclusions may be happening.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; lacks clarity about clinical governance and standards; poorly defines own scope of practice and responsibilities.

Does Not Address the Task of This Domain (scores 0).

4.1. Category: GOVERNANCE	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the level of a junior consultant psychiatrist?

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**