The Royal Australian & New Zealand College of Psychiatrists

**1.0    Descriptive summary of station:**

This station tests the candidate's knowledge of current expectations in Australia and New Zealand regarding seclusion, and ongoing government direction towards reduction of this practice which is regarded as a form of restraint. In this station the nurse-in-charge of an inpatient ward has raised concerns about seclusion practices on the ward. The candidate should be able to demonstrate knowledge of recovery oriented practices, and an understanding of trauma-informed care. The candidate is also expected to negotiate the team dynamics sensitively as would be expected at the level of a junior consultant.

**1.1    The main assessment aims are to:**

- Evaluate knowledge of policy and underlying theory behind current thinking on use of seclusion in Australia and New Zealand.
- Evaluate ability of candidate to recognise and negotiate a change within a complex team dynamic.

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

- Outline three accepted strategies likely to contribute to reduction in use of seclusion.
- Describe the key principles of trauma-informed care.
- Identify three leadership / change management factors relevant to this situation.

**1.3    Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Governance Skills
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Manager, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Manager (Policy usage; Governance), Scholar (Application of knowledge).

*References:*

- A Case for Change Position Statement on seclusion, restraint and restrictive practices in mental health services. Australian Government May 2015.
- Department of Health and Social Care England. Positive and Proactive Care: Reducing the Need for Restrictive Interventions. Policy Paper April 2014, UK, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf>.
- Health Quality and Safety Commission New Zealand: Zero Seclusion 2020 Project, 27 February 2018 blog, <https://www.hqsc.govt.nz/blog/why-eliminating-seclusion-by-2020-is-an-aspirational-goal/>.
- Health Quality and Safety Commission New Zealand: Zero Seclusion 2020 Project. 14 March 2018 blog, <https://www.hqsc.govt.nz/blog/zero-seclusion-its-about-teamwork/>.
- Hinings, C.R. and R. Greenwood, The dynamics of strategic change. 1989: B. Blackwell.
- National Mental Health (Aust) Consumer and Carer Forum. Ending seclusion and restraint in Australian Mental Health Services Position statement 2009.
- National Mental Health Commission (Aust) Seclusion and Restraint Declaration 2013, <http://www.mentalhealthcommission.gov.au/media/97455/NMHC_Seclusion_and_Restraint_Dec.pdf>.
- RANZCP Position Statement 61: Minimising the use of Seclusion and Restraint in people with Mental Illness.
- Reducing and Eliminating Seclusion in Mental Health Inpatient Services. An Evidence Review for the Health Quality and Safety Commission New Zealand. Te Pou o Te Whakaaro Nui June 2018.
- Safewards: <http://www.safewards.net>.
- Six core Strategies to Reduce Seclusion and Restraint Use NASMHPD Publications. (National Association of State Mental Health Directors), 2008, <https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use>.
- Six Core Strategies New Zealand Adaption Te Pou O Te Whakaaro Nui. 2013.
- Tobin, M. and J. Wells, Psychiatrists managing change: lost control or at a loss. Australasian Psychiatry, 1999. 7(4): p. 194-198.

Committee for Examinations
Objective Structured Clinical Examination

Station 11
Gold Coast  April 2019

The Royal
Australian &
New Zealand
College of
Psychiatrists

### 1.4    Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in his 30's, confident, neatly dressed.
- Pen for candidate.
- Timer and batteries for examiner.

## 2.0    Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are a newly appointed junior consultant in an acute inpatient service. You are approached by Tony, the nurse-in-charge, who had observed a recent seclusion event, and has raised concerns about the unit's use of seclusion practices which he feels are not in line with current government policies. You have agreed to give some time to Tony now to discuss your stand point on the use of seclusion, and how you see the unit moving forward in the approach to, and use of seclusion.

Your tasks are to:

- Outline relevant policies and methods guiding efforts towards reducing the use of seclusion in inpatient mental health settings.

- Explain the current theories which justify reduction in the use of seclusion.

- Identify important issues that could impact on efforts to change the use of seclusion in this ward environment.


**You will not receive any time prompts.**

**Station 11 - 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 (available for candidate use).
- Do a final rehearsal with your role player.

**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 there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the role player has prompts to use to keep to the aims.
- 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 **eight (8) 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 mark sheet in an 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 <u>must</u> remain in the room and <u>NOT</u> 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.

The role player opens with the following statement:

> *'Thanks for giving me this time to discuss seclusion as I'm hoping we can make some changes around here.'*

### 3.2 Background information for examiners

In this station, the candidate is expected to demonstrate knowledge of current goverment policy regarding seclusion, and ongoing direction towards reduction and eventual elimination of this practice which is regarded as a form of restraint. The theoretical background including trauma-informed care is expected to be covered by the candidate. The candidate is also expected to sensitively negotiate the team dynamics with a new nurse-in-charge. This question is focussed primarily on demonstrating understanding of policy and theory which is similar across all Australian states and NZ, rather than the applciation of Mental Health Acts or other legislation affecting the legalities of seclusion which differs across jurisdictions.

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

- Outline three accepted strategies likely to contribute to reduction in use of seclusion.
- Describe key principles of trauma-informed care.
- Identify three leadership / change management factors relevant to this situation.

A surpassing candidate will be able to demonstrate that they have clearly considered these issues, and have more than a basic theoretical understanding of both seclusion related issues, and of change management which they can apply to the scenario.

Since the early 2000s there has been increasing concern about potential overuse of seclusion and restraint in inpatient mental health units. The following are examples of how seclusion and restraint impact on people's human rights:

- Being confined in a space of which someone cannot freely exit.
- Reduction of personal space and taking away freedom.
- Humiliating and disempowering.
- Punishment and abandonment.
- Dehumanised by having your freedom taken away.

**Trauma-informed Care**

There is considerable discussion and concern that use of seclusion can be traumatic for patients and for staff. This is linked to the theories of trauma-informed care and recovery-focussed practice. The former is based on the theory that past traumatic experiences are very common in mental health patients, and frightening emotions can be very easily retriggered by experiences in a mental health ward if patients are placed in a situation where they feel vunerable and powerless. Trauma-informed care aims to reduce or eliminate these situations, improve recognition by staff of the signs and symptoms of trauma, and build a patient's sense of safety, control and empowerment. The consumer advocacy movement and increasing 'patient voice' has been closely involved in the development of policies stemming from these theories and issues.

Generally, the following five primary trauma-informed care principles can form a strong foundation for change in practice (Roger D. Fallot and Maxine Harris, 2006):

- Safety – which includes creating spaces where people feel culturally, emotionally, and physically safe as well as an awareness of an individual's discomfort or unease.
- Transparency and trustworthiness.
- Choice.
- Collaboration and mutuality.
- Empowerment.

An awareness of cultural, historical and gender issues are also identified as important factors.

Along with a set of principles, four key elements for a trauma-informed approach are outlined below (Cieslak et al., 2014; Isobel & Edwards, 2017).

1. Realisation of the widespread impact of trauma on people, families, groups, organisations, and communities; an understanding of pathways to wellbeing.
2. Recognition of the signs and symptoms of trauma through understanding the profound neurological, biological, psychological, and social effects of trauma and violence on people; coupled with an ability to recognise the signs and symptoms of trauma in people accessing services, staff, and others.
3. Responding by integrating trauma knowledge into policies, procedures, programmes, and practice.
4. Avoiding the re-traumatisation of people accessing services, and the workforce.

Trauma-informed care acknowledges the need for services to address the safety and wellbeing of staff who may experience indirect trauma or organisational or hierarchical disempowerment. In countries impacted by colonisation research indicates trauma-informed care needs to include an additional element. In order to fully engage with the impacts of colonisation on the wellbeing of people, the impact of historical trauma events and their contribution to negative health disparities, needs to be included.

**Recovery-focussed / based / oriented Practice** includes principles as follows: uniqueness of the individual, real choices, attitudes and rights, dignity and respect, partnership and communication, and evaluating recovery. The unwell individual is regarded as the expert on their own personal distress.

> '*From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services.'* (Jacobson and Greenley, 2001 p.482).

## Policy

With regard to changing practice and influencing better outcomes, there has been publication of position statements by government and state bodies in USA, Australia, UK and NZ on the practices of seclusion and restraint, and the need to reduce their use. This has lead to data collection, trial 'beacon' projects, and publication of guidelines and strategies to encourage healthboards and hospitals to try to reduce their rates of seclusion and restraint. Common to these documents are ideas expressed as the 'Six Core / Key Strategies to Reduce Seclusion and Restraint.'

In Australia, the National Mental Health Consumer and Carer Forum's (NMHCCF) lists the following strategies:

- Better Accountability.
- Implementation of Evidence Based Approaches to Ending Seclusion and Restraint.
- Adherence to Standards and Public Reporting.
- Support for Mental Health Professionals Towards Cultural and Clinical Practice Change.
- Better Care Planning.
- Review Relevant Mental Health Legislation.

In New Zealand Te Pou (national centre of evidence based workforce development for the mental health, addiction and disability sectors) have produced another version (Te Pou NZ):

- 'Leadership towards organisational change' – outlining a philosophy of care that targets seclusion and restraint reductions.
- 'Consumer roles in inpatient settings' – having an inclusive approach which involves consumers, carers and other advocates in seclusion and restraint reduction initiatives.
- 'Using data to inform practice' – using data in an empirical, non-punitive way to review, analyse and monitor patterns of seclusion and restraint.
- 'Workforce' – developing procedures, practices and education that promote mental health recovery.
- 'Use of seclusion and restraint reduction tools' – using assessments and other resources to develop individual aggression prevention approaches.
- 'Debriefing techniques' – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.

The RANZCP recognises these common themes in documents aiming to reduce seclusion and restraint 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 – minimising the use of seclusion and restraint in people with mental illness
- service user development and participation
- better care planning
- consumer roles in inpatient settings
- debriefing techniques
- review of relevant mental health legislation.

Specific non-pharmacological strategies that encompass the functioning of staff as a whole are available and more popular options currently include *Safewards*, beacon sites*. *Safewards* originated in the UK from a broad body of evidence and many services are implementing it locally. The *Safewards* model and associated interventions have been highly effective in reducing conflict and containment, and increasing a sense of safety and mutual support for staff and patients. The original model focusses on orginating factors (e.g. team strucutres and rules), flashpoints (e.g denial of a leave request) and staff modifiers (e.g. staff frustration, teamwork, or technical mastery).

---

**\* Beacon Sites** (https://meteor.aihw.gov.au/content/index.phtml/itemId/596362)

***Use of restrictive practices during admitted patient care***

*Health Ministers endorsed the National safety priorities in mental health: a national plan for reducing harm (the Plan), Australia's first national statement about safety improvement in mental health, in 2005. The Plan identified 4 national priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'.*

*In line with the Plan, the National Mental Health Seclusion and Restraint Project (2007–2009), 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. Key to this work has been translating international lessons and initiatives to the Australian environment and the development and implementation of policies, guidelines and staff training based on good practice. Project outcomes were positive, with several **Beacon sites** reporting significant reductions in the use, and / or duration of seclusion, thus providing the foundation for further change.*

---

The RANZCP position statement also discusses barriers to implementing changes to seclusion practice as below; 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.

This station also evaluates the candidate's knowledge and abilities in leadership and change management. Expectations are laid out in pre-fellowship guidelines as below:

'Leadership • Knowledge of contemporary leadership theory • Understanding the importance of organisational culture • Understanding the importance of context • Followship and near leadership • Understanding of systems theory • Analyse complex problems to discern risks and benefits of actions and plan appropriately - SWOT analysis • Adapts approach to the context • Change management theory and practice.'

**Change Management**

There are many different change management models in existence of which some are deemed more suitable for healthcare than others. Issues considered include: whether change is planned or naturally evolving, whether it is episodic or continuous, whether is it imposed from above or coming from grassroots employees / end-users, power relations within an organisation, environmental and technological factors, organisational capacity and complexity, human and financial resources, dynamic power of leaders and buy-in of staff, whether it is a closed or open system (systems theory).

SWOT analysis is a frequently used technique in health settings to evaluate the need for and process of change. It utilises the model of identifying strengths, weaknesses, opportunities and threats as a framework for the change process.

In practice, change leaders must ensure that they have resources (financial, human, and otherwise), in addition to a general appreciation of the need for change, buy-in from senior staff in the organisation, and a clear outline of how the change will transpire in order to improve their likelihood of successfully achieving change. As the end goal is to improve patient experience of care, the patient's role is critical and actions must be taken enable their input and buy in to whatever approach is taken to improve their experience. Without patient input, health providers may be misguided and waste resources in their attempts to improve patient experience.

Within psychiatry, one article, by Tobin and Wells, discusses the issue of implementing change in leadership and management to ultimately improve patient care in Australia and New Zealand. The change management model used in this article to structure the change effort aligns with Hinings and Greenwood's model of change dynamics. In their analysis of how the change initiative should be undertaken, Tobin and Wells outline situational constraints, such as a newly enacted mental health policy intended to achieve improved quality and effectiveness of service delivery. Tobin and Wells go on to describe interpretive schemes and interests through a discussion of psychiatrist-management relations and areas of tension. Dependencies of power, which include how psychiatrists can influence management and power dynamics between clinicians and non-clinical managers, are outlined. This is followed by a discussion of how management can exercise effective leadership and the importance of effective training for management. While Tobin and Wells do not explicitly state their use of Hinings and Greenwood's model of change dynamics, their analysis of change management in psychiatry employs all of Hinings and Greenwood's change management principles, (situational constraints, interpretive schemes, interests, dependence of power, and organisational capacity) thereby validating its applicability in this area of clinical practice.

In this scenario a range of leadership and change management opportunities arise, such as (but not exclusively): difficulty in immediately initiating change as a new and junior consultant in an established team; the need to form relationships; need to find out what unit policies are and if any plans in place to make changes; the importance of exploring the views of key people such as the other clinicians, consultants and managers; the importance of engaging senior staff including managers; need to collect data; methods to evaluate possible barriers to change including environmental, funding, training; recognition of the need to get a range of staff on board with idea; stressing importance of patient, family and peer advocate roles in this process, possibility of the fact they are new could be opportunity for change if others are ready but needing a catalyst; use of both top down and bottom up approaches to effect change; recognising the importance of a multi-disciplinary approach with clarification of roles and responsibilities and measures of success.

### 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.

**4.0 Instructions to the Role Player**

**4.1 This is the information you need to memorise for your role:**

You are Tony Matthews, aged 31, a senior mental health nurse. You are the nurse-in-charge on this acute mental health ward. You have asked to speak with the newly appointed psychiatrist working in the ward, as you have some concerns about whether the use of seclusion is up-to-date, and in keeping with latest evidence in the literature and with government policy.

Seclusion has been used for many years with mental health patients to manage periods of extreme violence to one's self or others when they are very unwell. Seclusion is defined as the confinement of the patient at any time of the day or night, alone in a room or area from which free exit is prevented. So seclusion means that a person is placed in this secure environment by themselves with the intent that when exposed to less stimulation they may find it easier to calm down, and gain more control over their behaviour.

Both seclusion and restraint (where an acutely unwell person is held by staff – either to enable a treatment intervention or to reduce risk of imminent harm to self or others) have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. Over the years, there has been an increasing desire from governments, policy makers and clinicians to reduce the need for, and use of these practices as it has been shown that, while imminent risk may be managed, the use of seclusion and restraint can be very traumatising for both patients and staff involved.

You have recently met the candidate who is a newly graduated psychiatrist working on the ward. You are concerned about a recent seclusion of an agitated young woman admitted who had been shouting and lashing out at staff. You feel seclusion wasn't necessary, and that it just made her more upset and traumatised.

You feel that the other psychiatrists on the ward are old fashioned in their thinking, and use the practice of seclusion too freely – and that this is not in line with how things are in some other wards, and other hospitals where you have worked.

You have tried to raise the issue with them but feel that they are not willing to listen to you. You are keen to find out if the new consultant is more in line with your beliefs that seclusion is overused on the ward, and if they are going to be willing to help you to reduce, and hopefully eventually stop, the practice.

**4.2 How to play the role:**

You are an experienced mental health nurse who has also run wards in other hospitals. You are neatly dressing in casual work clothing.

You are not wanting to get into any discussion about the specific case scenario – it is provided as a brief basis from which the conversation can arise. Your key interest is in what they can tell you about the current thinking around the use of seclusion, and then how they may be able to play an important role with you to change culture in the ward. They should tell you about current government policies to reduce and stop seclusion.

They should describe some specific strategies which can be used to reduce seclusion, but hopefully mention that it is tricky as they are new here, and do not know what has been discussed by other consultants, managers, nursing staff about this issue.

**4.3 Opening statement:**

*'Thanks for giving me this time to discuss seclusion as I'm hoping we can make some changes around here.'*

**4.4 What to expect from the candidate:**

The candidate should ask you what it is that you are worried about, and what it is you want to change, and you tell them about the young woman who was secluded, and that you want to stop this from happening.

The candidate should be able to enter into a discussion with you about the pros and cons of seclusion, and the impact of secluding people. They should then go on to identify some difficulties with making changes, and some ideas on what they can do to assist in changes occurring.

**4.5    Responses you MUST make:**

*'So what do think of seclusion and how it should be used in acute wards nowadays?'*

*'It makes people feel terrible. Do doctors know about that?'*

*'So how can you and I make some changes and stop this happening?'*

*'People are so traumatised by seclusion – it's just not okay!'*


**4.6    Responses you MIGHT make:**

If asked about what you know about the seclusion literature and policy, defer to them with suggested comments like:

Scripted response: *'I'd like to know what you think about seclusion'* or *'I'm asking for your opinion.'*

If asked about the diagnosis of the young woman:

Scripted response: *'I don't know the details – just that she was very upset and seclusion didn't help.'*

If asked what you think you should do or how do you think it should be done:

Scripted response: '*Just stop seclusion – I'm hoping you can tell me how in this ward!'*

**STATION 11 – MARKING DOMAINS**

**The main assessment aims are:**

- Evaluate knowledge of policy and underlying theory behind current thinking on use of seclusion in Australia and New Zealand.
- Evaluate ability of candidate to recognise and negotiate a change within a complex team dynamic.

**Level of Observed Competence:**

**4.0    MANAGER**

**4.5    Did the candidate demonstrate effective understanding of policy and current practice? (Proportionate value 40%)**

*Surpasses the Standard (scores 5) if:*
demonstrates a sophisticated knowledge of policy expectations; takes in a system / organisational consideration to decision making; quotes specific documents or government strategies being utilised in their region for seclusion reduction; outlines rationales for the focus on reduction of seclusion; demonstrates familiarity with interventions like Safewards, Beacon sites.

*Achieves the Standard by:*
incorporating likely service policies into decision making; identifying and applying policy expectations into practice; describing a range of accepted strategies (as outlined in the Six Core / Key strategies for seclusion reduction) e.g. use of quality improvement methodology, sensory modulation, consumer leadership, environmental changes to wards, post seclusion debriefing for staff and patients, peer support, workforce development and training.

To achieve the standard *(scores 3)* the candidate **MUST:**
a.  Outline three accepted strategies likely to contribute to reduction in use of seclusion.

*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 Address the Task of This Domain (scores 0).*

| 4.5. Category: POLICY USAGE | Surpasses Standard | Achieves Standard | | Below the Standard | | Domain Not Addressed |
|---|---|---|---|---|---|---|
| ENTER GRADE (X) IN ONE BOX ONLY | 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |

**6.0    SCHOLAR**

**6.4    Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature / research / clinical experience? (Proportionate value – 30%)**

*Surpasses the Standard (scores 5) if:*
recognises the impact of environment, people and new knowledge on current understanding; provides a comprehensive outline of trauma-informed care; acknowledges their own gaps in knowledge; outlines principles of and specific applicable factors of Recovery-focussed / based / oriented Practice; recognises how research has led to a greater understanding of how this can contribute to better patient care.

*Achieves the Standard by:*
identifying key aspects of the literature and describing the relevant applicability of theory to the scenario; describing options identified in the literature and policy; including a number of principles and factors applicable to reducing seclusion; postulating applicability of trauma-informed care to this scenario.

To achieve the standard *(scores 3)* the candidate **MUST:**
a.  Describe the key principles of trauma-informed care.

*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 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 ☐ |

## 4.0 MANAGER

**4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value - enter value 30%)**

*Surpasses the Standard (scores 5) if:*

able to tolerate and manage uncertainly; effectively describes complex governance issues and change management barriers; mentions change theory models or utilises change theory terminology.

*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; mentioning any of a broad range of leadership and change issues applicable to this scenario.

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

a. Identify three leadership / change management factors relevant to this situation.

*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 (e.g. does not acknowledge the importance of their new status on the team regarding making changes).

*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 |
|---|---|---|---|