

Committee for Examinations Objective Structured Clinical Examination

Station 10
Melbourne April 2016



1.0 Descriptive summary of station:

The candidate is to undertake an assessment with the spouse of a 70-year-old man suffering from Alzheimer's disease. He has displayed a recent episode of verbal aggression. The candidate will then present their understanding of the situation and outline the general principles of early management to the spouse.

1.1 The main assessment aims are to:

- Assess an episode of verbal aggression in a patient with dementia by demonstrating skill in undertaking a biopsychosocial assessment with a spouse.
- Outline the general principles of early management that advocate for multi-disciplinary team involvement utilising non-pharmacological strategies and not recommending psychotropic medication as first line treatment.

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

- Exploration of the aggressive episode OR the risk.
- Check for a medication induced disorder OR symptoms of depression, hallucinations, delusions.
- Explain the concept of Behavioural and Psychological Symptoms of Dementia.
- Recommend further assessment involving members of a Multi-Disciplinary Team.
- Counsel about referral to community support services and / or Alzheimer's Association / Alzheimer's NZ.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
Other Disorders - Neuropsychiatric Disorders
- **Area of Practice:**
Psychiatry of Old Age
- **CanMEDS Domains of:**
Medical Expert, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
Medical Expert (Assessment, Formulation), Collaborator (Teamwork, External Relationships)

References:

- Dementia Collaborative Research Centres (2012) (Authors: Burns K, Jayasingha R, Tsang R, Brodaty H) "Management of behavioural and psychological symptoms of dementia":
 1. "Behaviour management: a guide to good practice"
 2. "A clinician's field guide to good practice"
 3. "A guide for family carers"

<http://www.dementiaresearch.org.au/images/dcrc/pdf/A_Clinicians_Field_Guide_to_Good_Practice_Managing_Behavioural_and_Psychological_Symptoms_of_Dementia_2014.pdf>
- RANZCP & NSW Ministry of Health (2013) "Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW health clinicians",
<https://www.ranzcp.org/Files/Publications/A-Handbook-for-NSW-Health-Clinicians-PSD_June13_W.aspx>
- Best Practice Advocacy Centre New Zealand (2014) "Antipsychotics in dementia"
<<http://www.bpac.org.nz/a4d/resources/guide/guide.asp>>
- Alexopoulos GS, Jeste DV et al (2005) "The expert consensus guideline series: Management of dementia and its behavioural disturbances", Post grad Med: Jan 2001 Spec No: 1-111.

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 – woman in her 60s, in semi-smart dress.
- 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 working as a junior consultant psychiatrist in a community mental health clinic. You are about to interview Maria, a 66-year-old who lives with her 70-year-old husband Antonio. Antonio was diagnosed with moderate Alzheimer's disease by a neurologist one year ago.

Maria has been referred by her local general practitioner after an episode last week when Antonio did not recognise Maria, shouted at her for the first time and loudly threatened to have her "taken away". The GP noted that when reviewed that day, Antonio's mental state was stable and unchanged from his previous assessment.

Your tasks are to:

- Undertake a focussed assessment of the aggressive incident.
- Feedback to Maria your understanding / formulation of the situation.
- Present the general principles of early management to Maria.

You will not receive any time prompts.

Station 10 - 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:
 - Duplicate copy of 'Instructions to Candidate'.
 - Any other candidate material specific to the station e.g. investigation results.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

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 or time prompts for you to give.
- DO NOT redirect or prompt the candidate – the simulated patient 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:

- 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.

You have no opening statement or prompts.

The role player opens with the following statement:

"I'm at my wits' end, but I don't know how you can help."

3.2 Background information for examiners

In this station the candidate is to complete a biopsychosocial assessment with Maria, the spouse of Antonio who is a 70-year-old man suffering from Alzheimer's disease. This is in the specific context of an incident when he displayed a recent episode of verbal aggression. The candidate then needs to present their understanding of the situation and explain the general principles of early management to the spouse.

The candidate needs to demonstrate their skill in undertaking a behavioural assessment of agitation and verbal aggression. When specifically assessing the aggressive behaviour, the candidate could work through a problem-solving process to define the seriousness of Antonio's behaviour. A review of how much of a problem the aggression is, including assessment of whether other behaviours are also a problem, and whether any of them are related to the environment or interactions with others. The next step is to consider the situation and look at the circumstances contributing to the aggression: when and where the behaviour occurred or did not occur, and if he has possibly behaved in the same way in the same place. Finally, assessment needs to be made of Antonio in the situation and whether he seemed to be in pain or discomfort, or unwell; if he was tired, overstimulated, bored, lacking in social contact or anxious, embarrassed, ignored or misunderstood. He could also have been responding to an unpleasant incident, a change or a provocation or even been hallucinating, delusional or depressed.

Through their history taking the candidate should demonstrate their ability to assess risk in this setting and to apply their knowledge of the potential contributions of concurrent psychiatric illness, medical factors and medication side effects.

The candidate is expected to accurately communicate their findings and demonstrate skill in formulating and negotiating an initial management plan which should involve multidisciplinary community team assessment in the home and an awareness that psychotropic medications are NOT recommended as a first line management strategy.

It is important that while the candidate provides options and suggestions to Maria, they do not give a false sense that interventions can prevent the symptoms from progressing.

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

- Demonstrate exploration of the aggressive episode OR the risk;
- Check for a medication induced disorder OR symptoms of depression, hallucinations, delusions;
- Explain the concept of Behavioural and Psychological Symptoms of Dementia (BPSD);
- Recommend further assessment involving members of a multi-disciplinary team;
- Counsel about referral to community support services and / or Alzheimer's Association.

A better candidate may:

- Show an awareness of literature and College guidelines on management of BPSD;
- Make mention of scales and rating instruments for BPSD: agitation, aggression, wandering;
- Involve a bi-cultural clinician or consider involving a language and cultural interpreter.

Alzheimer's disease typically presents with two overlapping syndromes, one cognitive, the other behavioural. Almost all patients experience the behavioural syndrome which is characterised by psychosis, aggression, depression, anxiety, agitation, and other common but less well-defined symptoms included in the term "behavioural and psychological symptoms of dementia" (BPSD); like circadian rhythm (sleep / wake) disturbance. BPSD impacts on care providers and tends to ultimately precipitate the chain of events resulting in long-term institutional care.

Symptoms of Moderate Alzheimer's disease: As a progressively degenerative condition, Alzheimer's disease affects each person differently and symptoms do not appear suddenly. There are three major stages (mild, moderate and severe) even though there is no specific timeframe of progression. People can have both good, clear days and bad days (where they can become agitated, confused or angry).

The moderate (confused) phase of Alzheimer's disease often lasts the longest (between 2 to 10 years) and presents with severe memory and cognitive decline, motor skill changes and behavioural changes. Noticeable gaps in memory and thinking and, while they tend to be able to distinguish familiar from unfamiliar faces, people with Alzheimer's disease can have trouble remembering the name of their spouse. People can become disoriented to time and place. They also lose awareness of recent experiences and may not be able to express themselves effectively because of a reduction or confusion of words.

Behavioural and Psychological Symptoms of Dementia (BPSD) are also known as neuropsychiatric symptoms. They are a heterogeneous group of non-cognitive symptoms and behaviours that form a major component of the dementia syndrome irrespective of its subtype. They are as important as cognitive symptoms because they strongly correlate with the degree of functional and cognitive impairment. Symptoms include agitation, abnormal motor behaviour, anxiety, elation, irritability, depression, apathy, disinhibition, suspiciousness / delusions, and hallucinations. People can become easily frustrated, especially as their skills decline or in response to demands of carers and the environment.

As part of BPSD people can have trouble losing bladder or bowel control as well as experiencing changes in sleep patterns or appetite. It is estimated that BPSD affects up to 90% of all dementia patients over the course of their illness.

BPSD is thought to be independently associated with poor outcomes, including distress among patients and caregivers, long-term hospitalisation and misuse of medication.

These symptoms most commonly present simultaneously in the patient. A high degree of clinical expertise is crucial to appropriately recognise and manage the neuropsychiatric symptoms in a patient with dementia. Combination of non-pharmacological and careful use of pharmacological interventions is the recommended therapeutic for managing BPSD.

Tests / Instruments:

There are more than 75 different instruments that have been used in BPSD.

- Brief Psychiatric Rating Scale (Overall and Gorham, 1962),
- Sandoz Clinical Assessment Geriatric (Shader et al., 1974),
- Alzheimer's Disease Assessment Scale (Mohs et al., 1983),
- Cambridge Examination for Mental Disorders (Roth et al., 1986),
- Behavioural Pathology in Alzheimer's Disease Scale (BEHAVE-AD) (Reisberg et al., 1987).

In addition, psychiatric instruments initially developed for use in adults or to measure single BPSD have been used in demented and older populations, include the Hamilton Depression Rating Scale (Hamilton, 1960) and the Beck Depression Inventory (Beck et al., 1961).

The diagnosis of BPSD is based on obtaining a clinical history, direct observation, psychiatric and physical examinations, and reports by care providers; exclusion of physical problems (e.g. an infection, pain, constipation or poor eyesight or hearing) or mental illnesses such as depression. Laboratory tests can assess for the presence of medical conditions that can trigger or exacerbate the clinical presentation of BPSD. It is important to exclude unmet medical needs.

Tools for assessing BPSD are the clinician-administered Neuropsychiatric Inventory (NPI) which assesses ten behaviours as well as appetite and sleep in the person with dementia. It can help to distinguish between the different types of dementia. Recent versions also include a Caregiver Distress Scale.

The Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD) measures BPSD and is generally clinician rated in Acute, Primary, Community and Residential Care settings and can be used to measure change as a result of interventions.

There are also tools to assess particular BPSD areas and pain:

- 1) Aggression (RAGE=Rating Scale for Aggressive Behaviour in the Elderly)
- 2) Agitation (CMAI=Cohen-Mansfield Agitation Inventory; PAS=Pittsburgh Agitation Scale)
- 3) Depression (CSDD=Cornell Scale for Depression in Dementia; GDS=Geriatric Depression Scale)
- 4) Pain (PAINAD=Pain Assessment in Advanced Dementia; the Abbey Pain Scale; PACSLAC=Pain Assessment Checklist for seniors with Limited Ability to Communicate) agitation).

Generic principles of management include engaging the person in enjoyable and meaningful activities, which could range from making music to exercising, spending quality time with the person, like chatting or sharing a task together, developing a structured daily routine, trying to ensure continued social relationships, encouraging the person to engage in past pleasurable activities, reducing unnecessary noise and clutter, providing people with familiar personal items and maintaining a comfortable sleeping environment.

Principles of Management. The key principle in caring for a person with dementia is the involvement of a multidisciplinary team using a “person-centred care” approach which aims to develop an understanding of the person as an individual (RANZCP & NSW Health, 2013). This focuses on identifying and meeting the specific needs of the individual. Forming a working partnership between the person, the carer and the clinical team assists in developing shared goals based on the person’s values and experience. Clinicians need to focus on establishing rapport with both the carer and person to properly assess and prioritise physical, psychological and social goals. Factors guiding assessment and treatment include: 1) the person’s response to their past and current environments; 2) their personal history, culture and religious background; 3) personal likes and dislikes; 4) interpretation of precipitants to behaviours; and 5) unmet needs (RANZCP & NSW Health, 2013).

Management priorities should include 1) managing physical care needs (investigating physical problems such as pain, infection, constipation, poor eyesight or hearing and possible mental disorders such as delirium or depression); 2) behavioural and environmental strategies; 3) psychological engagement; 4) maximising residual strengths in the person; and 5) caring for the carer. Cautious consideration of psychotropic medication is only indicated if there are risk issues or psychosocial strategies have not relieved the situation (e.g. not as a first line choice in the present case).

Communication is a key in working with a person with dementia, including attention to body language and tone of voice. Strategies to improve verbal communication include: 1) minimising background noise; 2) speaking in a gentle voice; 3) using simple, calm hand gestures and facial expressions; 4) explaining tasks slowly in simple terms; 5) allowing time to be understood; 6) clarifying by repeating or rewording; and 7) using personal reference where available (person’s or relative’s name).

“Top 5 Strategies” One useful intervention in the RANZCP & NSW Health booklet on BPSD management is to identify with the carer the “Top 5 Strategies” they have found useful in reassuring the person with cognitive impairment. These top 5 strategies include developing a list of: 1) things that cause distress; 2) things that settle distress; 3) established reassuring routines; 4) repeated anxieties or questions; and 5) triggers indicating an unmet need. Composing such a list acknowledges the expertise of the carer and may assist them to take a step back from troublesome behavioural interactions.

Psychosocial management includes: 1) maintaining safety; 2) modifying the environment; 3) sleep hygiene; 4) modifying or revising the timing of activities. Specific non-pharmacological treatments include: 1) behavioural assessment and management = ABC (identification of Antecedent events, Behaviour and Consequences); 2) music therapy; 3) aromatherapy and hand massage (particularly for agitation); and 4) psychological interventions including reminiscence, validation and orientation therapies.

Working with the carer is a basic intervention that should be mentioned by candidates. Acknowledging Maria’s experience and knowledge of Antonio is an important step in establishing rapport and gaining her cooperation. She needs specific information / education about Alzheimer’s disease and the common occurrence of otherwise inexplicable behaviours (BPSD). Alzheimer’s Australia / NZ are important sources of information and education. It is important to emphasise that BPSD behaviours are due to the disorder, are often transient and can be understood and managed with a calm, reassuring presence.

Carer Support. Candidates should mention the need to assess Maria's stress levels, mental well-being and current coping, as well as to screen for the development of a treatable mental disorder. Providing her with practical support may improve her ability to continue caring for Antonio at home. Specific attention should be paid to 1) mobilising and engaging established social network; 2) arranging domestic assistance, home maintenance, in-home respite and home care; 3) referral to community services; 4) financial, legal, and guardianship matters; and 5) encouraging contact with Alzheimer's organisations for information and social support.

Any intervention should be positive and incorporate person-centred principles:

- Valuing the person with dementia and treating them as individuals.
- Looking from the perspective of the person with dementia.
- Creating a positive social environment to foster a sense of well-being.
- Trying to ensure continued social relationships, encouraging the person to engage in meaningful activities and maintaining a comfortable sleeping environment.
- Reducing unnecessary noise and clutter, providing people with familiar personal items.

It is important to obtain a comprehensive understanding of the behaviour by assessing:

- behaviour: onset, triggers, frequency, occurrence of the behaviour and when does it not occur. It is usually best to record the behaviour, what happened before and afterwards.
- person: characteristics, life history, dementia diagnosis and severity, mood, support needs.
- Caregiver(s): characteristics, carer's own health, communication approach, relationship factors, stress threshold.
- environment: physical, social, cultural, emotional, spiritual.

Non-pharmacologic interventions are now considered the foundation of BPSD treatment. Problem behaviours can be seen as meaningful responses to unmet needs in the therapeutic milieu. Because the progression and impact of BPSD varies between patients, interventions must be designed, implemented, and reviewed on an individual basis. They include: family support and education, psychotherapy reality orientation, validation therapy, reminiscence and life review, behavioural interventions, therapeutic activities and creative arts therapies, environmental considerations (including restraint-free facilities), behavioural intensive care units, and workplace design and practices that aid the ongoing management of caregiver stress.

Although pharmacological management is a commonly used option, it is often limited in its effects and can be associated with a substantial risk of side-effects.

Social supports need to be put in place for both the person with Alzheimer's disease and the carers. This includes home help, day care and access to other community services. There is a wide range of literature and web-based information about Alzheimer's disease. Consideration of a nursing home has to be approached at some time.

Resources:

Books, DVDs, Help sheets

Online – www.alzheimers.org.au

www.dementiacareaustralia.com

www.dasinternational.org (Dementia Advocacy and Support Network for people with dementia)

www.careraustralia.com.au

www.dbmas.org.au (Dementia Behaviour Management Advisory Services)

www.alzheimers.org.nz

ilearn.careerforce.org.nz/mod/book/view

3.3 The Standard Required

In order to:

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

Achieve 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 medico-legal 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 well-being 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.

Does Not Achieve the Standard – the candidate demonstrates significant defects in most 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:

Background information

You are Maria, a 66-year-old lady, married to Antonio, age 70. You have been married for 46 years and have 3 grown children (Paola age 45 living nearby, Marco age 43 living in Rome, and Andrea age 41 living interstate). You live in the home Antonio built for the family 40 years ago. Antonio was a builder until he sold the business and retired 5 years ago. You stayed home to raise the children, then worked as a childcare assistant at the local day care centre. You retired 3 years ago, when you noticed Antonio having trouble coping with retirement.

Diagnosis of dementia

A few years ago, you noticed Antonio's memory was slipping. Then he had trouble paying the bills. When he turned into a one way street two years ago, you decided to do all the driving and Antonio agreed. Last year your GP, Dr Jones, did tests and scans. He said Antonio was suffering from dementia and referred you to a private nerve specialist. After two appointments, the neurologist said Antonio had Alzheimer's disease. He prescribed a memory tablet called Aricept but Antonio just seemed to get worse. After four months you stopped the tablets and have not seen the neurologist since.

Antonio has no other medical problems. He takes no medications and does not like tablets or going to the doctor.

Living with dementia

You sometimes argue with Antonio when he does not remember things. You get particularly frustrated when Antonio just sits in his lounge chair for hours, staring at the television. If you shout at him "*Why don't you say something?*" he just says "*I'm okay. Leave me alone.*"

At other times Antonio follows you wherever you go and does not let you out of his sight. He even stands by the door when you go to the toilet. He still goes shopping with you, but stays close by your side. You take him to the beach a couple of times a week, but these days he doesn't want to get out of the car. At home, he repeatedly asks "*When are we going to eat?*" but when a meal is served you have to encourage him to eat the food.

While he seems to understand everything you say, he never starts a conversation anymore. You feel like his head is empty and miss being able to talk about things with him. Because of his condition, you never visit friends and no one, other than your daughter Paola, comes to visit you at home.

You do not have any home help. You have never been offered any community services. You have not read anything about Alzheimer's disease because it might make you cry. You live day by day, fearing what will happen as Antonio's illness gets worse. You feel it is your duty to care for Antonio and would never consider him going into a nursing home. That is the way both of you have been raised.

Concerning symptoms

Risk: Antonio is a gentle man and has never abused you or the children. You do not think Antonio could ever hurt himself or anyone else. You are not afraid of him and he has never threatened to harm you or himself. You do worry how he would cope if anything ever happened to you. Your main worry is about his safety and what might happen if he got out of the house or the fenced backyard. You are frightened that if he wandered about the neighbourhood, he could not find his way home again.

Agitation: Late in the afternoon, Antonio gets restless and walks about the house from room to room. At night he will go to the front or back door and rattle the doorknob, trying to get outside. You can easily distract him from the door and reassure him with comforting words or a hug.

You help Antonio in the shower every morning. For 10 minutes before showering, Antonio is irritable, restless and fidgets at the breakfast table. He can resist washing and does complain when you wet his hair, occasionally pushing you away. You do not feel there is any danger when he is in the shower. Once showered, Antonio calmly sits at the table reading the paper. When you ask him what he is reading, he just says "*the news*", but never makes any other comment.

Aggression: Antonio raised his voice to you last week for the first time in your marriage, when he did not recognise you. He asked "*Where is Maria? What have you done with her?*". You burst into tears and ran from the room when he said "*Who are you? What are you doing in my house?*", and told you that he would "*have the police take you out of my house*". When you returned in half an hour, Antonio asked "*Where have you been, Maria? I've been so worried.*" When you told Dr Jones about this incident, he immediately referred you to the Community Mental Health Clinic.

Relevant negatives

Delirium (acute change in mental state): Other than the one occasion of not recognising you last week, Antonio has not seemed much different over the past month. He is able to focus his attention on a task, concentrate on it for a short time and is not easily distracted. His awareness does not change rapidly throughout the day. He does not see things or hear voices.

Depression: Antonio does not appear to be down, sad or depressed. He does not dwell on negative thoughts or express guilt. His sleep is undisturbed, retiring at 9 pm, arising to toilet once but returning to sleep readily, and awakens at 7 am. He is often muddled and uncertain where he is on awakening, but this settles with reassurance. His appetite is good and weight steady. He has few interests and spends much of the day sitting in the lounge room staring blankly at the television. He does potter about the back garden in good weather, moving pot plants from place to place on the patio in an aimless manner. He has never spoken of wishing to die. You do not think he would contemplate suicide as he always considered it a sin.

Psychosis: Antonio has never accused you of being unfaithful or expressed any ideas of being persecuted, followed, spied upon or interfered with in any way. He does not seem to be responding to unseen things or talk to others when no one is present. He does not speak of hearing voices and does not appear to see things or have visions of unshared occurrences.

Attitude to future management

Further assessment: You are happy to go along with seeing anyone the doctor / candidate suggests.

Home help: You are willing to accept help in the home but are not keen on anything like "day care" for Antonio.

Medications: You do not want Antonio to be drugged or sedated.

4.2 How to play the role:

You are feeling the strain of caring single-hand for your husband over the past year. You feel isolated, yet unable to ask for assistance believing that it is your fate to care for Antonio. You have mixed feelings about getting help. You find it hard to see the man you love, your life partner, disappear before your eyes. You are stressed by the worry and constant care needs, but reluctant to let others do any caring. You are lonely, but are too embarrassed to talk to friends and worry that Antonio might "say something silly".

4.3 Opening statement:

"I'm at my wits' end, but I don't know how you can help."

4.4 What to expect from the candidate:

After asking for some background about you and Antonio, candidates may explore how the diagnosis of Alzheimer's disease was made, what you know about Alzheimer's and whether you have received any education, assistance or home help.

Candidates might then move on to explore Antonio's symptoms of restless pacing, trying to leave the house and the episode of not recognising you. The candidate may ask about risk of harm or concerns you might have about your safety. They should explore whether Antonio experiences depression, hallucinations, unusual fixed but false beliefs or sudden changes in alertness, awareness and attention.

The candidates should tell you about the "behaviour and psychiatric symptoms of dementia" (if they say "BPSD", ask them what that means).

They should then propose an action plan involving further assessment in your home with members of a multidisciplinary community team (social worker, community nurse, occupational therapist, and psychologist). They may discuss further interventions to assist you in caring for Antonio. They may suggest contacting community help, elder care support services or support groups such as the Alzheimer's Association (Australia) or Alzheimer's New Zealand.

4.5 Responses you MUST make:

Nil

4.6 Responses you MIGHT make:

If the candidate recommends medication, say:

"I don't want Antonio drugged or sedated."

If the candidate suggests that others might help care for Antonio, say:

"No one loves Antonio like I do ... Nobody could care for him as I do."

4.7 Medications:

Currently not on regular medication. Tried Aricept for 4 months (started on one tablet at night and increased to one tablet in the morning and one at night after a month). This was ceased as Antonio seemed to be getting worse. You are not keen for him to have any tablets like this again.

STATION 10 – MARKING DOMAINS

The main assessment aims are to:

- Assess an episode of verbal aggression in a patient with dementia by demonstrating skill in undertaking a biopsychosocial assessment with a spouse.
- Outline the general principles of early management that advocate for multi-disciplinary team involvement utilising non-pharmacological strategies and not recommending psychotropic medication as first line treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of assessment areas; demonstrates prioritisation and sophistication.

Achieves the Standard if:

demonstrated use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; integrating key sociocultural issues relevant to the assessment; clarifying important positive and negative features.

To score 3 or above the candidate **MUST:**

- demonstrate exploration of the aggressive episode OR the risk.
- check for a medication induced disorder OR symptoms of depression, hallucinations, delusions.

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 or 1) if:

scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in the history.

1.2 Category: ASSESSMENT – data gathering content	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

Achieves a score of at least 4 *and* provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history and observations; integrating medical, psychological and sociological information including possible contributions of delirium or other psychiatric conditions (depression, psychosis); developing hypotheses to make sense of the patient's predicament using a biopsychosocial framework.

To score 3 or above the candidate **MUST:**

- explain the concept of Behavioural and Psychological Symptoms of Dementia.

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 or 1) if:

Scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; Significant omissions affecting quality score 1.

Does Not Achieve the Standard (scores 0) if:

significant deficiencies including inability to synthesise information obtained; providing an inadequate formulation or diagnostic statement.

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

3.0 COLLABORATOR

3.2 Did the candidate appropriately involve treatment teams in developing management plans? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 and takes a leadership role in treatment planning; provides a sophisticated link between the plan and key issues identified; addresses difficulties in the application of the plan.

Achieves the Standard if:

discusses the need to assess psychological issues relevant to patient; offers strategies to deal with problematic behaviours; acknowledges carer's expert knowledge of patient; usefulness of social worker to explore social referral or interventions; psychologist to assess capacities and retain of functions; occupational therapist to assess home safety and functional capacity; community nurse to provide practical support; GP to oversee management plan.

To score 3 or above the candidate **MUST:**

a. recommend further assessment involving members of a Multi-Disciplinary Team.

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 or 1) if:

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

recommends medication as a first line treatment; recommends hospital admission; plan not tailored to carer and patient needs or circumstances; errors or omissions impact adversely on the finalised plan.

3.2. Category: TEAMWORK – Treatment Planning	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

3.3 Did the candidate demonstrate an appropriately skilled approach to carer? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 and recognises the complexity of liaison; readily contributes to engagement of other agencies.

Achieves the Standard if:

offers to liaise directly with relevant agencies; identifying appropriate techniques to enhance engagement; outlining plans to maintain an effective working alliance.

To score 3 or above the candidate **MUST:**

a. counsel about referral to community support services and / or Alzheimer's Association.

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 or 1) if:

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

lack of consideration of individual perception of roles, capabilities or preference; any errors or omissions adversely impact on alliance.

3.3. Category: EXTERNAL RELATIONSHIPS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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