

1.0 Descriptive summary of station:

The candidate is expected to meet with Jennifer, the mother of 19-year-old Kate who was recently admitted with first episode of mania. The candidate has not met Kate or Jennifer previously as it is Monday morning, and the events have taken place over the weekend. Kate was admitted on Saturday evening, and then overnight had been moved to the High Dependency Unit (HDU) / Psychiatric Intensive Care Unit (PICU) after which she has been injured by another patient. Jennifer was not informed of the change at the time, and was notified of these events when she arrived on the ward this morning. Jennifer has requested a meeting to discuss the incident and ongoing management. The candidate must address Jennifer's concerns, while getting some background history, provide education about manic presentations, and discuss the short-term management while providing reassurance to Jennifer.

1.1 The main assessment aims are:

- To listen to the concerns of a parent of a patient who has been injured, and address these concerns appropriately.
- To gather history about a patient with a first episode of mania.
- To provide psychoeducation regarding mania and the associated risks.
- To discuss an immediate management plan that encompasses the ongoing risk.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.
- Conduct a risk assessment specific to mania.
- Provide details of both the incident and complaint management process.
- Confirm the mother's understanding of the psychoeducation provided.
- Explain the purpose of HDU / PICU.
- Justify the current use of practice that is not least restrictive.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Manager
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Initial Plan); Communicator (Conflict Management, Patient Communication – To Patient / Family / Carer, Synthesis); Manager (Governance)

References:

- American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.) Arlington, VA: American Psychiatric Publishing.
- American Medical Association. (2017) ICD-10-CM 2017 The Complete Official Code Book (Icd-10-Cm the Complete Official Codebook) 2017 ed. Edition.
- Australian Clinical Guidelines for Early Psychosis (2nd ed). 2016 Orygen Youth Health <https://www.orygen.org.au/Campus/Expert-Network/Resources/Free/Clinical-Practice/Australian-Clinical-Guidelines-for-Early-Psychosis/Australian-Clinical-Guidelines-for-Early-Psychosis.aspx?ext=>.
- Australian Commission on Safety and Quality in Health Care (September 2011): National Safety and Quality Health Service Standards, ACSQHC, Sydney.
- Bassett, Darryl L. Risk Assessment and Management in Bipolar Disorders. MJA 2010; 193: S21–S23.
- Health Complaints Commissioner (Victoria) <https://hcc.vic.gov.au/>
- New Zealand Ministry of Health. Health and Disability Service Standards (2008). <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards>.
- Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders. Dec 2015. <https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Mood-Disorders-CPG.aspx>

Committee for Examinations
Objective Structured Clinical Examination
Station 2
Adelaide September 2017



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman in her early to mid-40s, neatly dressed in professional work attire.
- 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.

You are working as a junior consultant psychiatrist in an acute inpatient setting.

You have arrived at work on Monday morning, and have been informed that Jennifer, the mother of a 19-year-old patient called Kate, is waiting for you and that you need to see her right away as she is quite angry. You have not seen or assessed Kate, and have not had a chance to review her file either.

The nursing staff have informed you that Kate wants you to talk with her mother.

You know that Kate was admitted to the ward two days ago (on Saturday night) with first episode mania with psychotic features. Jennifer arrived on the ward today, and learnt that Kate had been moved from the open ward to HDU / PICU overnight. Jennifer was not informed of this at the time it happened. She was also told, this morning, that while in HDU / PICU, Kate has been injured by a male patient after she went into his room, and tried to lay hands on him to 'save him'. Jennifer has been told that Kate is not hurt, and only has some scratches on her arm.

Jennifer has requested an immediate meeting with you to discuss her concerns about Kate's management.

Your tasks are to:

- Listen to Jennifer's complaint and address her concerns.
- Gather relevant information about Kate's illness from Jennifer.
- Provide psychoeducation regarding the acute management of mania.
- Discuss the short-term management plan for Kate in light of Jennifer's concerns.

You will not receive any time prompts.

Station 2 - 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.
- 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 that there are no cues / 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 **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.

The role player opens with the following statement:

'What happened to Kate is unacceptable, and I want to know how this was allowed to occur.'

There are no time prompts.

3.2 Background information for examiners

This station aims to assess the candidate's ability to respond to a complaint made by the mother of a young woman admitted with a first episode of mania. Candidates are expected to be able to demonstrate that they are aware of how to manage a complaint, undertake clinical disclosure, and outline the process that takes place to investigate an incident of minor assault and associated complaint.

The candidate needs to take the mother's complaint seriously, and validate the mother's concerns. The failure of staff to notify the patient's mother about a significant change in management should be recognised and addressed. This could include a decision to discuss with the nurse-in-charge, care to avoid apportioning of blame without natural justice, as well as recognition of the impact of the incident on patient, family and staff wellbeing.

The candidate is expected to outline how they would manage the immediate situation with the individual patient including safety, and any medical response needed.

The candidate should be aware of the impact of the environment / setting on the incident: review of clinical matters (mental state, management, containment of patient), and evaluation of patient factors like illness process, substance use, or personality issues. The candidate is expected to undertake a brief risk assessment during the interview, and this should cover important aspects of the recent history, for instance:

- Any risk taking or impulsive behaviour
- Any incidences of aggression
- Any risk of self-harm or suicide.

A better candidate may also incorporate the other patients' acuity, distress, safety and de-escalation needs; the environment including staffing levels and experience, other activities etc.

The candidate should outline their plan of action to restore a safer environment. The candidate is also expected to manage the clinical situation by explaining the preference of a least restrictive environment, and associated treatment, but to recognise the risks associated with mania, and explain why least restrictive practices are not safe in this case.

Education should be provided to the mother on the reasons for utilisation of a HDU / PICU, and why the risks associated with mania might warrant such management.

It is critical that the candidates acknowledge that the mother is upset about both the incident and not being informed, and that they work in a non-judgemental, collaborative manner while recognising and acknowledging the mother's distress.

Questions about the co-patient / perpetrator should be dealt with sensitively, and with a respect for that patient's privacy.

The explanation of the initial management plan should recognise the ongoing risks associated with the patient's illness, and that ongoing management as an inpatient is required.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.
- Conduct a risk assessment specific to mania.
- Refer to both incident and complaint management.
- Confirm the mother's understanding of the psychoeducation provided.
- Explain the purpose of HDU / PICU.
- Justify the current use of practice that is not least restrictive.

A surpassing candidate may separate out the need to review the incident as well as the review of the mother's complaint, may provide information on the formal complaint process (this may include providing information about the consumer liaison officer, and accurately elaborate on open disclosure for incident management) or offer assistance from a consumer / carer worker.

Explanation about the diagnosis

DSM-5 Criteria for Mania

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalisation is necessary).
2. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree, and represent a noticeable change from usual behaviour:
 - a) Inflated self-esteem or grandiosity.
 - b) Decreased need for sleep (e.g., feels rested after only three hours of sleep).
 - c) More talkative than usual or pressure to keep talking.
 - d) Flight of ideas or subjective experience that thoughts are racing.
 - e) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 - f) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
 - g) Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
3. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.
4. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.
 - **Note:** A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

ICD 10 Criteria for Mania

F30 Manic episode

All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-).

Incl.: bipolar disorder, single manic episode

F30.2 Mania with psychotic symptoms

In addition to the clinical picture described in F30.1, delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity, and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication.

Mania with:

- mood-congruent psychotic symptoms
- mood-incongruent psychotic symptoms

Risks Associated with Mania

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) clinical practice guidelines for mood disorders states that acute mania is a medical emergency, and often necessitates use of mental health legislation. Care should be provided in a low stimulus environment with support from health professionals.

According to Darryl Bassett (MJA 2010) - the manic state carries a particular set of potential risks, which can be summarised as follows:

- Heightened risk-taking behaviour which follows a belief of being invulnerable. This may include erratic or high-speed use of a vehicle, crossing roads without due care, swimming in unsafe situations or attempting to fly by jumping from a high place.
- Excessive spending of substantial sums of money or inappropriate generosity. The direct financial impact of such behaviour can be severe, and the indirect effect on credit ratings can be significant.
- Excessive use of alcohol or other psychoactive substances.
- High levels of irritability and aggression with risks to self or others, particularly if the patient is opposed in their intentions. This is especially evident in mixed states, where heightened energy combines with dysphoric mood to produce a potentially explosive mixture.
- Disinhibited behaviour such as uncharacteristic sexual behaviour (promiscuity, unprotected sex, socially inappropriate propositions, exhibitionism) or other socially inappropriate behaviour. This can be particularly damaging in the workplace and in personal relationships, and potentially damaging to health.
- Socially disruptive behaviour derived from grandiosity, such as trying to take over piloting an aircraft that is in flight or inappropriately approaching a political leader.
- Excessive and personally offensive sarcasm and rudeness that can damage interpersonal relationships.

Least Restrictive Treatment in Early Psychosis

The recommendations from the Australian Clinical Guidelines for Early Psychosis are as follows:

- People with early psychosis should receive treatment in the least restrictive manner possible. Whenever possible, the location of the initial assessment should be community-based and at a place that is convenient to the person and their family.
- A range of treatment settings should be available to people, including home-based support, supported accommodation, rooming in, outpatient services, and inpatient care.
- The levels of risk (to self and others), the available resources (including community support) and the needs of the individual and their family should be assessed to determine whether the individual can be managed at home.
- Where hospitalisation is required, people should be admitted to a facility that can cater for, and is appropriate to, their age and stage of illness. Where streaming is not possible, a special section may be created in a general acute unit for young people with recent-onset psychosis.

Specific Issues for Families in Early Psychosis

Australian Clinical Guidelines for Early Psychosis states that the heightened emotional impact of a young person experiencing mental health difficulties for the first time, possibly maximised if the family's pathway to receiving appropriate psychiatric assistance was not straightforward, requires sensitive responses from services and clinicians.

There are special needs for information and education as families:

- Deal with possibly severe psychiatric illness for the first time
- Cope with diagnostic ambiguity and variable outcome
- Are faced with unfamiliar and often bewildering symptoms.

Complaints and Incident Management

With regard to complaint and incident management, the candidate should be able to demonstrate that they have a basic working knowledge of patient safety systems during their interaction with the mother.

Better candidates may incorporate the knowledge of these systems in their explanation to the mother, and their reassurance that the service will provide adequate care to her daughter.

Complaints management:

The Australian Charter of Health Care Rights states – 'I have a right to comment on my care and have my concerns addressed'. This is further elaborated to 'I can comment on or complain about my care and have my concerns dealt with properly and promptly'.

In New Zealand, complaints management is under the Consumer Rights Standard (Standard Number NZS 8134.1.1.13) of the Health and Disability Services Standards. The standard recognises the right of the consumer to make a complaint that is understood, respected and upheld.

The Victorian Health Complaints Commissioner provides the following recommendations for handling complaints (which are similar to other state/territory expectations):

1. Your complaint process should be easy and straightforward.
2. Complaints should be acknowledged promptly, and the complainant should be told how their complaint will be handled.
3. Complaints should be triaged appropriately.
4. Communication should be clear, using minimal jargon and technical terms. Make sure the complainant understands the information you are sharing.
5. Treat your complainants fairly, and with objectivity and respect.
6. Make sure your response to the complaint is clear and informative, and that it addresses the specific issues raised in the complaint.
7. If the complainant is not satisfied with the response, you should provide information about any available internal or external review options.
8. If the complaint highlights any systemic issues, these should be considered and acted on.

Clinical Incident Management:

In general, a clinical incident is defined as an event or circumstance resulting from health care which could have, or did lead to unintended and / or unnecessary harm to a patient. Clinical incident management is the process for effectively managing clinical incidents with a view to minimising preventable harm. It occurs in a similar manner in all health sector settings, and includes the identification and entry of an incident onto an incident management system (e.g. AIMS, IIMS, PRIME, CIMS, Riskman). Corrective actions or recommendations are actions that are then taken in the immediate, short, medium or long term to rectify or minimise the risk of harm to patients.

In Australia, the management of incidents is accredited under Standard 1 (Governance for Safety and Quality in Health Service Organisations) of the National Safety and Quality in Health Service Standards. This standard describes the quality framework required to implement safe systems; to set, monitor and improve performance of the organisation in providing quality patient care.

In New Zealand the Organisational Management Standard (NZS 8134.1.2.) of the Health and Disability Services Standards requires that the organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles and that all adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family / whanau of choice in an open manner.

Services undertake different types of formal review, and discussion and feedback to patient and family is critical, and can be done at the time (e.g. clinical disclosure) to explain what will be happening, and once the review has occurred (open disclosure). Open disclosure is the open discussion that takes place when health care does not go according to plan. The process acknowledges that an event has occurred, and provides information about what happened in an open and honest manner. It is not an admission of liability or an apportioning of blame.

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.

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:

You are Jennifer, age 45, a secondary school teacher and single parent of Kate, age 19, who is a student doing a science degree at the local university, and lives at home with you. You have asked to meet urgently with the doctor to raise concerns about your daughter's care.

Background:

Kate was admitted to a psychiatric ward two days ago on Saturday evening. You have heard that overnight she was moved to a more secure, locked area, sometimes called PICU (psychiatric intensive care unit) or HDU (high dependency unit), and you were not informed of this at the time it occurred.

It is now Monday morning. You arrived at the ward to visit, and you have been told this move took place because Kate was too unwell to be managed elsewhere in the ward. You're not clear what the exact reasons for this were, but you have been told that there were concerns about her behaviour. You find this strange as you assumed that she would get better once she was in hospital, but the nurse seemed to imply that her behaviour was getting more difficult to control.

Today you have also been informed that Kate was injured by another male patient late last night. The nursing staff have advised that Kate went into the other patient's room, and was trying to lay hands on him to save him, and she was scratched on the arm when the other patient attempted to stop her from touching him.

You've been told that Kate was examined but the doctor on duty after the incident, and that her injuries are minor but there are scratches on her arm, and you are very concerned for her safety.

You want an explanation of how this could have been allowed to happen. You are worried that Kate is not safe in hospital, and don't want to leave her there, but you are also worried that she was not safe at home either.

Kate had been depressed, and her GP started her on a medication that seems to have made things worse.

Kate has never been admitted to hospital before, and you've never visited a mental health ward before, and feel overwhelmed and distressed by the situation.

How you feel about the admission and recent events:

- You are very worried about Kate's safety – hospital is supposed to be a safe place!
- You are angry that you were not told about Kate being moved to the more secure area or about Kate being injured until you came to visit her today. And if it is a more secure area, it seems strange that she was injured there, because it should keep her safer.
- You are having difficulty coping with how quickly things have changed – Kate went from being depressed, and spending all her time in bed to acting strange like walking around naked in the yard with a knife, and saying odd things and is now in hospital.
- You are not convinced that she needs to be in the more secure, locked area of the ward, and you are not happy that you've not been clearly told the reasons why this move occurred.
- You are feeling distrustful of doctors as Kate has been injured in hospital, and it was also a doctor (your GP) who started Kate on the medication that you think might have made things worse.

If you are asked about Kate's recent history please provide this information to questions:

You were worried that she has been depressed. Kate broke up with her boyfriend, Tim, a few months ago, and she seems to have struggled with this. She had been spending most of her time in her room (mainly in bed), and she had not been attending her university classes or seeing her friends. So you encouraged her to see her GP. She was very quiet for a few weeks, and you think she would cry when she was alone (red eyes, puffy face). She had been eating poorly, and looked like she had lost some weight, but you are unsure how much. She lost interest in things she enjoyed, like spending time with friends and cooking. If asked if she was ever suicidal, deny this. She has never tried to self-harm, overdose or cut herself.

Kate was started on an antidepressant (you are unsure of the name of this) about six weeks ago, but it seemed to make little difference.

When Kate returned to see her GP, two weeks ago, the medication was increased, and you were pleased to see that Kate had started going out and seeing her friends again, and you believe she'd been attending university.

You had noticed that Kate had not been sleeping well in the last week or so – on a few occasions she'd woken you in the night playing music loudly, but she had turned this down or used her headphones when you told her it was too loud. So, you had not really thought too much further about it, as she had previously been spending so much time in bed that you were pleased to see a change.

She had started speaking quickly at times, and she decided to try out for several sporting teams. You now realise that these things were quite unusual for Kate, but at the time you were not overly concerned. It was nice to see that she was back to her normal self again.

On Saturday night, the night of admission, you were woken by Kate yelling out. You found her naked in the yard with a knife in her hand. She was talking about comets passing, and that she needed to die to save humanity. She was speaking very fast. If questioned, you will say that you have never heard her talk about having super powers, or say anything like the TV talks about her or refers to her. She has never voiced any fears about anything specific. She has not reported increases in her energy levels. You have not noticed risk-taking behaviour like driving too fast or being sexually overactive. She has not been spending excessively.

You called the ambulance and Kate was taken to hospital, and admitted under the Mental Health Act – the junior doctor who admitted her informed you of this.

You visited Kate on the ward yesterday (Sunday). You were able to spend the day with Kate, and she was not in the locked area. She did not appear any better or worse than she was the previous day. You were told that you would be able to meet the doctor who would be managing Kate on Monday, so you came to the ward to see Kate and to meet the doctor.

If you are asked about Kate's development / upbringing or home life:

Development - there were no problems with the pregnancy or delivery. There were no concerns about her development, and in fact she walked and talked earlier than many other children. She was a placid baby, and a timid child. Kate has always been a worrier. She performed well at school, and has been doing well at university. You would not describe her as outgoing, and she tends to avoid parties and larger gatherings. She is considerate and caring, and has always had a close group of good friends.

Family environment - you separated from Kate's father, John, when she was two years old, and she has had limited contact with him or his side of the family. Although you have had other relationships, you have not remarried or lived with any other partner as you were worried this would be difficult for Kate. You are close with your family, and your mother and sister assisted with looking after Kate when she was younger, and you had to work. Although Kate has no siblings, she is close with her cousins.

You worry at times that your divorce and the lack of contact with her father have been difficult for Kate, but overall you feel she has had a loving extended family. You are not aware of any other adverse events in her life (no abuse, no bullying).

Kate had a stable group of close friends through high school, and they have remained friends. Two of them are studying science with her at university. She was with her boyfriend for two years before they broke up – this was Kate's first serious relationship.

If you are asked about Kate's past psychiatric / mental health history or about use of drugs and alcohol:

You have been aware that Kate was depressed, and you have been quite worried about this. In the past she had periods of being withdrawn for a week or so at a time, but she always just seemed to "*snap out of it*". In retrospect you think she has been depressed in the past, but never as bad as she has been recently. Prior to this episode you have never seen her over-talkative or with excessive energy or needing less sleep.

You do not think Kate has been into drugs or alcohol. She has only ever had one glass of wine at dinner, and only at special family occasions. She doesn't smoke and to the best of your knowledge, Kate and her friends are against the idea of using drugs.

If you are asked about any family history of illness:

You suspect there is a history of anxiety and depression in your family (your mother's brother), but you are not aware of anyone being diagnosed with a mental illness or receiving treatment. There is also no history of substance abuse or issues with gambling.

You know little of the history of your ex-husband's family, but he did mention that his mother had had a nervous breakdown. You do not know any details regarding this.

4.2 How to play the role:

You are to be neatly dressed in professional work attire. You are angry (but not aggressive) and upset. You are worried that Kate has been injured, and have concerns about whether she will be safe if she remains in this environment. You are distrustful of doctors as Kate has been injured, and the medication her GP gave her seems to have made her worse.

However, your primary concern is for Kate, and you will become calmer if the candidate listens to your concerns in a respectful manner without trying to dismiss your concerns or down-play the incident or the fact that staff did not ring you.

You are willing to accept apologies and / or explanations, and listen to discussions regarding the reasons she was placed in the more secure, locked area. You are keen to be told about her future management, and what will be done to protect Kate. You will work with the doctor if they listen to you, and show concern and remorse over what has happened to Kate, but are not prepared to be pushed around.

4.3 Opening statement:

'What has happened to Kate is unacceptable, and I want to know how this was allowed to occur.'

4.4 What to expect from the candidate:

The candidate should listen to your complaint, and take your concerns seriously. They should be empathic and apologise for the fact that you weren't informed of events, and that Kate was injured. Explanations should be provided in non-technical language, and lots of reassurance should be given.

The candidate should be clear that Kate remains very unwell, and needs to stay in hospital but provide assurance that steps will be taken to prevent further injury. If the candidate starts to tell you about longer term treatment, you need to indicate that you are happy to discuss this at a later date, and that right now your only concern is Kate's safety in hospital.

4.5 Responses you MUST make:

'Why did Kate have to be moved?'

'I still can't believe this happened to Kate!'

'How can you be sure that Kate will be safe now?'

'What will happen to the patient who attacked her?'

'What's the hospital going to do about this?'

4.6 Responses you MIGHT make:

'Why wasn't Kate in this area earlier?'

'Well I hope he's not near her now.'

'What's wrong with the man who did this?'

'I'm not interested in the future – I want to hear about what you will do now.'

'At my school, we have procedures to follow if a student assaults anyone. What do you do?'

If told that the candidate does not have Kate's permission to talk to the mother

Scripted response: ***'When Kate came in she told the doctor that she was happy for anyone to discuss anything about her illness with me. I am sure he put it down in her notes. You can check this if you don't believe me.'***

4.7 Medication and dosage that you need to remember:

You do not know any specifics about medication; only that the GP started Kate on something for depression.

STATION 2 – MARKING DOMAINS

The main assessment aims are:

- To listen to the concerns of a parent of a patient who has been injured, and address these concerns appropriately.
- To gather history about a patient with a first episode of mania.
- To provide psychoeducation regarding mania and the associated risks.
- To discuss an immediate management plan that encompasses the ongoing risk.

Level of Observed Competence:

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

effectively de-escalates the situation; positively promotes safety for all involved; demonstrates sophisticated reflective listening skills; considers engaging a consumer / carer worker.

Achieves the Standard by:

recognising challenging communications; listening to differing views; demonstrating capacity to apply management strategies; effectively managing psychiatric emergencies with due regard for safety and risk; being aware of the responsibility to all patients and staff; being able to apologise without being defensive.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.

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):

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:

any errors or omissions impair attainment of positive outcomes; inadequate ability to reduce conflict, unable to maintain rapport or does not reflect that the mother's concerns are valid.

2.3. Category: CONFLICT MANAGEMENT	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"/>	

2.1 Did the candidate illicit information relevant to a risk assessment? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the mother taking regard to gender, background etc.; communicating plans and discussing acceptability; containing conflict or behavioural abnormalities; recognising confidentiality and bias; gathering a history of the illness as well as the incident.

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

- Conduct a risk assessment specific to mania.

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):

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:

errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport, does not explore risks related to aggression or impulsivity.

2.1. Category: PATIENT COMMUNICATION - To Patient / Family / Carer	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"/>	

4.0 MANAGER

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

Surpasses the Standard (scores 5) if:

able to tolerate and manage uncertainly; offers assistance from the consumer / complaint liaison officer or discusses the formal complaints process; respects the confidentiality of the co-patient involved and explaining this issue to the mother.

Achieves the Standard by:

identifying principles of clinical governance and standards, explaining quality assurance activities, applying governance within organisational structures; being aware that the situation involves both a critical incident and a complaint by a carer, and having an awareness of management of both these issues are separate, yet overlapping processes.

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

a. Provide details of both the incident and complaint management process.

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):

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:

lacks clarity about clinical governance and standards; poorly defines own scope of practice and responsibilities; dismisses or doesn't address concerns regarding co-patient.

4.1. Category: GOVERNANCE	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"/>

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to providing psychoeducation to a concerned family member? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

shows an understanding that the mother may be distrustful of the doctor / hospital, integrates information in a manner that can effectively be utilised by the audience; provides succinct and professional information.

Achieves the Standard by:

providing accurate and structured verbal report / feedback; prioritising and synthesising information; adapting communication style to the setting; demonstrating discernment in selection of content; uses examples of the patient's behaviour to clarify explanations

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

a. Confirm the mother's understanding of the psychoeducation provided.

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):

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:

any errors or omissions impact on the accuracy of information provided; does not explain the risks associated with mania.

2.5. Category: SYNTHESIS	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"/>

1.0 MEDICAL EXPERT

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; provides a comprehensive rationale for why least restrictive management was initially trialled (i.e. why not initially managed in ICU / HDU).

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence based acute care; explaining risk management; considering involuntary / inpatient modes; outlining medication and other specific treatments; engaging safely and skilfully appropriate treatment resources / support; having safe, realistic time frames / review of the plan; communicating to necessary others; identifying potential barriers; recognising the need for consultation.

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

- a. Explain the purpose of HDU / PICU.
- b. Justify the current use of practice that is not least restrictive.

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):

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:

does not recognise or explain why less restrictive practices are not currently possible; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	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
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