

Committee for Examinations
Objective Structured Clinical Examination

Station 6
Gold Coast April 2019



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1.0 Descriptive summary of station:

The candidate is to undertake an assessment, with the spouse, of a 71-year-old man suffering from Alzheimer's disease. The patient has displayed a recent episode of verbal aggression triggered by delusions of jealousy. 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 and a focussed risk assessment with the 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:

- Identify the delusions of infidelity as a specific risk concern of BPSD.
- Establish alcohol as a precipitant to aggressive behaviour.
- Prioritise further assessment involving a Multi-Disciplinary Team approach.
- Sensitively communicate all key aspects of BPSD in dementia.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** 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 – Data Gathering Content; Formulation), Collaborator (Teamwork - Treatment Planning; External Relationships)

References:

- Alexopoulos GS, Jeste DV et al. The expert consensus guideline series: Management of dementia and its behavioural disturbances. Introduction methods: commentary and summary. *Post grad Med: 2005 Jan: Spec No: 6-22.*
- Best Practice Advocacy Centre New Zealand (2014) Antipsychotics in dementia - Best Practice Guide <http://www.bpac.org.nz/a4d/resources/guide/guide.asp>.
- Burns K, Jayasingha R, Tsang R, Brodaty H. Dementia Collaborative Research Centres (2012). '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.
- Hashimoto M, Sakamoto S, Ikeda M. 'Clinical features of Delusional Jealousy in Elderly patients with Dementia', *J Clin Psychiatry 76(6) June 2015.*
- 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/resources/reports/a-handbook-for-nsw-health-clinicians-bpsd_june13_w.aspx
- The Brief Psychiatric Rating Scale, Overall J E & Gorham D R., *Psychol. Rep.* 10:799-812, 1962.
- The Sandoz Clinical Assessment-Geriatric (SCAG) Scale, <https://www.karger.com/Article/Abstract/213113>
- Alzheimer's Disease Assessment Scale, Rosen, W. G., Mohs, R. C., & Davis, K. L. (1984). A new rating scale for Alzheimer's disease. *The American Journal of Psychiatry, 141(11)*, 1356-1364.
- The Cambridge examination of mental disorders of the elderly, Roth M, Huppert FA, Mountjoy CQ, Tym E, Cambridge University Press, 1986.

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- The Behavior Pathology In Alzheimer's Disease Rating Scale (BEHAVE-AD), B Reisberg, S R Auer, IM Monteiro, International Psychogeriatrics, Vol 8, Suppl.3, 1996
- Hamilton, M. 1960. A rating scale for depression. J. Neurol. Neurosurg. Psychiatry 23: 56–62.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961), An inventory for measuring depression. *Archives of general psychiatry*, 4, 561-571.

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 Vicky, a 69-year-old woman, who lives with her 71-year-old husband, Kon. Kon was diagnosed with mild to moderate Alzheimer's disease by a neurologist one year ago.

Kon has been referred to you by his local general practitioner after a concerning episode last week when Kon became very angry at Vicky, and smashed their wedding photograph on the wall. He shouted at her for the first time in their marriage, and loudly threatened her with divorce. The GP noted that when reviewed the following day, Kon's mental state was stable and unchanged from his previous assessment, he dismissed the incident as a 'private matter between me and my wife', but the GP continued to have concerns for Vicky.

Vicky felt it best to come and see you alone due to not wanting to upset Kon.

Your tasks are to:

- Gather collateral from Vicky to complete a focussed assessment of the aggressive incident.
- Feedback to Vicky how you have formulated your understanding of the situation.
- Present your management plan to Vicky.

You will not receive any time prompts.

Station 6 - 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 – 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 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 and risk assessment with Vicky, the spouse of Kon, a 71-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 in response to delusions of jealousy aggravated by alcohol use. The candidate is then expected 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 an assessment of agitation, and verbal aggression in a patient with dementia. When specifically assessing the aggressive behaviour, the candidate could work through a problem-solving process to define the seriousness of Kon'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 candidate is then 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 Kon in the situation, and whether he seemed to be in pain or discomfort, or unwell; if he was possibly drinking alcohol at the time; 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, alcohol use and medical factors.

The candidate is expected to accurately communicate their findings which should include identifying underlying delusional jealousy, as well as identifying the specific risk this poses to his wife. The candidate should also identify the additional impact of alcohol use as an aggravating factor in this context.

The candidate should then 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 Vicky, they do not give a false sense that interventions can prevent the symptoms of dementia from progressing.

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

- Identify the delusions of infidelity as a specific risk concern of BPSD.
- Establish alcohol as a precipitant to aggressive behaviour.
- Prioritise further assessment involving a Multi-Disciplinary Team approach.
- Sensitively communicate all key aspects of BPSD in dementia.

A better candidate may:

- Show an ability to apply literature and College guidelines in their management of BPSD;
- Make mention of scales and rating instruments for BPSD: agitation, aggression, wandering;
- Involve a bicultural clinician or consider involving a language and cultural interpreter.

Assessment and Diagnosis

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.

Delusional jealousy (or Othello syndrome) is the fixed held belief in the infidelity of one's spouse or partner. Present rarely in a wide variety of psychiatric disorders, it has been more commonly associated with organic psychoses including post stroke and in Parkinson's disorder. In dementia, it has been associated in about 8 to 16% of cases and tends to be even more common in Lewy Body Dementia (up to 26%). Delusional jealousy has been identified as a risk factor for aggression and homicide, especially against domestic partners. It has been postulated that developing feelings of insecurity and inferiority in context of partial awareness to failing cognition underpins the evolution of delusions of infidelity. Disparities in health between patients and their spouses have also been associated as a risk factor for developing delusional jealousy.

As part of BPSD, people can have trouble with 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 the assessment of BPSD, of which the following are a few.

- 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).

Tools for assessing BPSD include 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).

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 from care providers. Exclusion of physical problems (e.g. an infection, pain, constipation or poor eyesight or hearing) or mental illnesses such as depression are critical.

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, consider medication that could aggravate confusion or cognitive issues like anticholinergic drugs or benzodiazepines, and consider whether alcohol could be an aggravating factor given that a brain affected by neurodegenerative changes tend to be more susceptible to the adverse effects of alcohol.

Management

Generic approaches 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.

The key principle of management 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 focusses 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).

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 including, in this case, restricting access to alcohol;
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 but to be considered if the symptoms continue to cause concern).

Communication is critical when 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).

The 'Top 5 Strategies' that carers have found useful in BPSD management to reassure the person with cognitive impairment (RANZCP & NSW Health) include listing:

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.

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 with a focus on person centred care approaches. 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. Evidence based approaches include possible dementia care mapping to establish patterns of behaviour and identifying underlying potential triggers which also include the use of ABC charts (identification of Antecedent events, Behaviour and Consequences).

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.

Working with the carer is a basic intervention that should be mentioned by candidates. Acknowledging Vicky's experience and knowledge of Kon 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 Vicky's stress levels, mental wellbeing 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 Kon 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 wellbeing.
- 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.

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.

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 Vicky, a 69-year-old woman, married to Kon, age 71. You live in the home Kon built for the family 40 years ago. Kon has been diagnosed with Alzheimer's disease.

You are coming to see the psychiatrist today at the request of your GP, Dr Jones, as he is concerned about the distressing incident with Kon last week. You are not sure how the psychiatrist can help.

Incident leading to GP referral

Last week you briefly left Kon at home in the afternoon to take some lemons from your garden to your long term neighbours. Upon your return, Kon was waiting for you at the door. He yelled at you, accusing you of having an affair. He then grabbed your wedding photo hanging next to the front door, and smashed it into pieces against the wall.

You got frightened but also lost your temper, and told him he was crazy and tried to reason with him that you only went to the neighbours, but then he started crying and accused you of not loving him anymore. He maintained that he knew you went to see your 'boyfriend', and said that the marriage is now finished, although he wanted to go and sort the bloke out (the neighbour). He only settled once your daughter, Maria, arrived after you called her.

This is the first time Kon has behaved like this, although you have noticed that he started to make nasty and derogatory comments about the neighbours in recent months, especially the husband; despite having been friendly with them for many years. He has made fleeting comments referring to him as 'your boyfriend' when you waved at them as they got home in the car, but you told him not to talk such nonsense and did not think more about it. Now that you recall it, he seems to be more focussed on the neighbour after a glass of ouzo. However, he has not confronted the neighbour or made specific threats.

Background information

Kon was a builder until he sold the business and retired five years ago. Since then he has been keeping himself busy by tending his vegetable garden or enjoying his Greek music.

You met each other in a small village in Greece where you grew up and after you got married, you emigrated to Australia 50 years ago in 1969. You have been married for 51 years and have three grown children (Maria age 50 living nearby, Nick age 48 living in Greece, and Helen age 45 living interstate). You stayed home to raise the children and remained a housewife.

It was a happy marriage with '*normal ups and downs like most couples*', but there was never any conflict and you were devoted to each other and your family. But Kon has become unwell recently, and his behaviour has changed.

In this station, you are about to see a psychiatrist on the recommendation of your GP. You are not sure what they can do for you and your husband Kon.

Diagnosis of dementia

About two years ago, you noticed Kon's memory was slipping. Then he had trouble paying the bills and you took over responsibility for this. When he turned into a one-way street nearly causing an accident a year ago, you decided to do all the driving and Kon reluctantly agreed. His loss of independence was difficult for him given that he loved to go for a drive. Following that incident, Dr Jones did tests and scans. He said Kon was suffering from dementia and referred you to a private nerve specialist. After two appointments, the neurologist said Kon had Alzheimer's disease. He prescribed a memory tablet called Aricept, but Kon just seemed to get worse. After four months, you stopped the tablets and have not seen the neurologist since.

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

Alcohol use

Kon never had issues with excessive alcohol use, but used to drink a glass or two of ouzo with friends when they met up at the Greek club or on a weekend whilst watching sport. This never caused concern or problems. More recently, he has taken to pouring himself some ouzo from the cabinet some afternoons, but you did not think much of it, given it did not seem excessive and never more than one or two glasses. If asked, you noticed though on the day of the incident that he seemed to have drunk more than usual, and a bottle was empty that you thought had been half full.

Living with dementia

You sometimes argue with Kon when he does not remember things as it frustrates you. You get particularly frustrated when Kon just sits in his lounge chair for hours, staring at the television. If you shout at him to say something, he just replies that he is okay and asks you to leave him alone.

At other times, Kon 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 reluctantly so and tries to convince you not to go either. You do leave him at home sometimes when you are in a hurry, and often finds him waiting just inside the door upon your return, and being quite agitated at you, sharply questioning you about where you went, and what you did and whom you saw. He also gets agitated when you are on the phone, and this has led to arguments and you avoiding calling your friends. He often repeats the same question which is frustrating to you, like 'When are we going to eat?'. He repeatedly washes any dishes found in the kitchen, and gets under your feet when you try to cook or clean. You have yelled at him in frustration, but never been violent to him.

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 Maria, 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 Kon's illness gets worse. You feel it is your duty to care for Kon, and would never consider him going into a nursing home. That is the way both of you have been raised.

Concerning symptoms

Risk: Kon is a gentle man and has never abused you or the children. You do not think Kon could ever hurt himself or anyone else. You have not been 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. He does not tend to wander off or leave the house on his own, and the yard is secure.

Agitation: Late in the afternoon, Kon 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 Kon in the shower every morning otherwise he would just not shower. For 10 minutes before showering, he 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, Kon 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: Kon raised his voice to you last week for the first time in your marriage, when he made the accusations. There has been no further conflict although he remains somewhat brooding and irritable. When you told Dr Jones about this incident, he immediately referred you to the Community Mental Health Clinic.

Delirium (acute change in alertness): Kon has NOT seemed more confused or disorientated in the past month. He is able to focus his attention on a task (like having breakfast), concentrate on it for a short time and is not easily distracted. His awareness of his surroundings does not change rapidly throughout the day. He does not see things or hear voices that others cannot.

Depression: Kon does not appear to be down, sad or depressed. He never had mental health difficulties or seen a psychiatrist in the past. He does not generally 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, and his vegetables have become neglected. He has never spoken of wishing to die. You do not think he would contemplate suicide as he always considered it a sin.

Psychosis: Other than for the above beliefs about your infidelity, Kon has never 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 Kon.

Medications: You do not want Kon 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 Kon. 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 Kon might say something silly. You do not want to burden your daughter, Maria, whom you believe has enough of her own problems.

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 Kon, 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 should explore the incident leading to the referral, and in particular the ideas about infidelity; past psychiatric issues and specific concerns about your own or Kon's safety, as well as threats to the neighbour. They should explore whether Kon experiences depression, unusual experiences, other unusual fixed but false beliefs or sudden changes in alertness, awareness and attention. They should also ask about his alcohol use as an aggravating trigger.

The candidates should tell you about something called 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 Kon. 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. They might suggest restricting his access to alcohol.

4.5 **Responses you MUST make:**

'Do I need to worry about his jealousy?'

'Can he still have his glass of ouzo doctor?'

4.6 **Responses you MIGHT make:**

If the candidate recommends medication;

Scripted statement: *'I don't want Kon drugged or sedated.'*

If the candidate suggests that others might help care for Kon;

Scripted statement: *'No one loves Kon like I do ... Nobody could care for him as I do...he won't like that.'*

4.7 **Medications:**

Currently not on regular medication.

The GP prescribed a medication called ARICEPT for four months last year (one tablet twice a day), but it was stopped as Kon seemed to be getting worse.

You are not keen for him to have any tablets like this again.

STATION 6 – 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 and a focussed risk assessment with the 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 including an assessment of risk? (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 by:

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

- Identify the delusions of infidelity as a specific risk concern of BPSD.

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).

1.2 Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
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 achieve the standard (**scores 3**) the candidate **MUST:**

- Establish alcohol as a precipitant to aggressive behaviour.

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).

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
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 by:

Discussing the need to assess psychological issues relevant to patient; offering strategies to deal with problematic behaviours; acknowledging carer's expert knowledge of patient; outlining roles 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; counselling about the importance of a referral to community support services and / or Alzheimer's Association / Alzheimer's NZ.

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

- a. Prioritise further assessment involving a Multi-Disciplinary Team approach.

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 or if the candidate *only* offers medication as a way to manage the situation. Significant omissions affecting quality scores 1.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

3.2. Category: TEAMWORK – Treatment Planning	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
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 by:

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

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

- a. Sensitively communicate all key aspects of BPSD in 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):

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).

3.3. Category: EXTERNAL RELATIONSHIPS	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
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 level of a junior consultant psychiatrist?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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