Committee for Examinations
Objective Structured Clinical Examination
Station 8
Sydney April 2018

The Royal Australian & New Zealand College of Psychiatrists

CONTENT	PAGE
Overview - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements	2
Instructions to Candidate	3
Station Operation Summary	4
Instructions to Examiner - Your role - Background information for examiners - The Standard Required	5 5-7 7
Instructions to Role Player	8-10
Marking Domains	11-12

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

Peter, a 30-year-old male with an intellectual disability has been brought to the Emergency Department by his carer after an episode of self-harm. There has been a recent history of increasingly challenging behaviour by Peter. The candidate is to take a collateral history from the carer to identify the presence of symptoms of anxiety as a potential mental illness. The carer will ask for an explanation, and the candidate is to explain the situation in layman's terms.

1.1 The main assessment aims are to:

- Assess, via collateral history, the presence of an acute psychiatric presentation in a person presenting with challenging behaviour in the context of intellectual disability.
- Explain the presentation and possible diagnoses to the carer.
- Use effective communication skills with the carer.

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

- Elicit the precipitants of the self-injurious behaviour.
- Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.
- Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment - data gathering content, formulation); Communicator (Patient communication - carer)

References:

- Ervin Davis, Sy Atezaz Saeed, Diana J. Antonacci. Anxiety Disorders in Persons with Developmental Disabilities: Empirically Informed Diagnosis and Treatment Reviews Literature on Anxiety Disorders in DD Population with Practical Take-Home Messages for the Clinician. *Psychiatr Q (2008) 79:249–263.*
- Moss S, Emerson E, Kiernan C, Turner S, Hatton C, Alborz A. Psychiatric symptoms in adults with learning disability and challenging behaviour *Br J Psych (2000) 177: 452-456*.
- Hurley AD. Mood disorders in intellectual disability. *Curr Opin Psychiatry (2006) 19:465–469*.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female in mid-30s, dressed casually and neatly.
- 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 covering the Emergency Department.

Peter, a 30-year-old with an intellectual disability has been brought to hospital by his carer after an episode of self-harm - hitting his head against a table resulting in a laceration which needed stitches.

The Emergency Department doctor has asked you to assess Peter as his disturbed behaviour has been increasing over the last 2 months.

Peter has gone for a head CT scan, and you are about to speak with his carer, Claire.

Your tasks are to:

- Take a focussed collateral history from Peter's carer about the changes in behaviour, and the presence of any psychiatric disorder.
- Explain your understanding of the presentation to the carer.

You will not receive any time prompts.

Station 8 - 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'
  - Pens.
  - Water and tissues (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 / scripted prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
  'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

If a candidate elects to finish early after the <u>final task</u>:

- You are to state the following:
  'Are you satisfied you have completed the task(s)?
  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings'.

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room, briefly check ID number.

There is no opening statement or scripted prompt for you to give.

The role player opens with the following statement:

'Peter hit his head on the table. There was blood everywhere!'

3.2 Background information for examiners

The aims of this station are to assess the candidate's ability to elicit a collateral history about recent onset of increasingly challenging behaviour in a man with intellectual disability. The candidate is to also assess for the presence of a psychiatric disorder then explain the presentation to the carer.

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

- Elicit the precipitants of the self-injurious behaviour.
- Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.
- Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

A surpassing candidate may: identify the similarity between this episode and his past episode (father's death and mother being in hospital); inquire about the patient's risk or abuse history whilst at his day program; indicate how using a psychometric scale may be helpful to identify the presence of a psychiatric disorder.

Anxiety and self-injurious behaviour associated with intellectual disability

According to the American Association on Intellectual and Developmental Disabilities, Intellectual Disability (ID) starts before the age of 18. People with ID can present with significant limitations in both intellectual functioning, and in how they adapt and behave to their environment, including having problems with everyday social and practical skills. *Intellectual function* is also called *intelligence* and refers to general mental capacity, such as learning, reasoning and problem solving. A way to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 to 75 indicates a limitation in intellectual functioning. ID can range in levels from being mild, moderate, severe to profound.

In the small number of available studies mental retardation has been associated with higher levels of self-reported fears in children and adults. Cognitive deficits experienced by people with intellectual disability can affect their ability to interpret and deal with life's challenges. Increasing support for people with intellectual disability to live and work in the broader community may expose them to potentially fearful stimuli.

Self-injury or aggressive behaviour is common amongst those with intellectual disability (17%). This can be caused or exacerbated by underlying psychiatric morbidity, and is a frequent reason for referral for psychiatric assessment. These behaviours can occur at any age but peak in the 15-34-year age group. The prevalence of disturbed behaviours increases with severity of intellectual impairment, and is more likely with people with little to no speech. There is also a notable sex difference, as disturbed behaviour is more likely to occur in males. Self-injurious behaviour is more likely to be associated with anxiety than mood disorders, and overall, behavioural disturbance increases with increased psychiatric symptoms.

Anxiety symptoms most commonly associated with self-injury include both phobic anxiety and non-situational anxiety. Typical features that may be present will include increased stress, increased anxiety, panic, agoraphobia, OCD, and GAD symptoms. Higher rates of sleep disturbance and selective mutism can also occur. Anxiety is particularly prevalent in those with autism or autism spectrum disorder (14%).

People with intellectual disability are often sensitive to change in their environment; adjustment disorders are, therefore, a relatively common presentation in this population. Adjustment disorders occur in the context of a stressor or life event and involve extreme emotions, such as depression and anxiety and actions that cause problems in work and at home.

Adjustment disorder is a stress-related, short-term, non-psychotic disturbance. The discomfort, distress, turmoil, and anguish to the patient are significant, and the consequences (e.g., suicidal potential) are extremely important.

Signs and symptoms

As the term adjustment disorder implies, symptoms develop when the person is responding to a particular event or situation, for example a loss, a problem in a close relationship, an unwanted move, a disappointment, or a failure. The pathogenic stressors may be single events, or persistently stressful circumstances. They may be recurrent or continuous. Typical stressors include disruptions of close relationships (except bereavement), events that disrupt general adaptation (emergencies or disasters), and occupational failures or losses. Characteristic symptoms include the following:

- Low mood
- Sadness
- Worry
- Anxiety
- Insomnia
- Poor concentration
- Anger, disruptive behaviour
- Other typical manifestations - loss of self-esteem, hopelessness, feeling trapped, having no good options, and feeling isolated or cut off from others.

Diagnosis

The specific **DSM-5** diagnostic criteria for adjustment disorder are as follows:

- Emotional or behavioural symptoms develop in response to an identifiable stressor or stressors within 3 months of the onset of the stressor(s) plus either or both of (1) marked distress that is out of proportion to the severity or intensity of the stressor, even when external context and cultural factors that might influence symptom severity and presentation are taken into account and / or (2) significant impairment in social, occupational, or other areas of functioning.
- The stress-related disturbance does not meet criteria for another mental disorder, and is not merely an exacerbation of a pre-existing mental disorder.
- The symptoms do not represent normal bereavement.
- After the termination of the stressor (or its consequences), the symptoms persist for no longer than an additional 6 months.

The following 6 specifiers are used to identify subtypes of adjustment disorder:

- With depressed mood
- With anxious mood
- With mixed anxiety and depressed mood
- With disturbance of conduct
- With mixed disturbance of emotions and conduct
- Unspecified.

ICD 10 diagnostic criteria for adjustment disorder differ in that the symptoms develop within 1 month of the identified stressor. Further symptoms include: subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event.

The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

Conduct Disorders may be an associated feature of ID, particularly in adolescents. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions and conduct. Anxiety Disorders are common in people with intellectual disability. There can be difficulty in making a diagnosis especially in view of communication difficulties and the presence of behaviours not necessarily related to mental illness. It can be difficult for individuals with intellectual disability to describe internalising symptoms of anxiety because of deficits in communication, social skills, and intellectual functioning. Invariably, significant clinical collateral must be obtained from interviews with carers and other key stakeholders to assist with diagnostic clarification of Anxiety Disorder in all such cases.

Psychometric instruments have been used to assist in the identification of Anxiety Disorders in this population; these include the Mood and Anxiety Semi-Structured Interview (MASS), and the Fear Survey for Adults with Mental Retardation (FSAMR). For instance, the MASS asks adults with moderate to severe intellectual disability to identify the occurrence of 'behavioural descriptions', which correspond to symptoms of Mood Disorders (including anxiety, worry, depressed mood and anhedonia).

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 Claire. You work as a disability support worker (see below for role description) at a supported housing unit in the city. You have been working in your role for just under six months, and feel relatively inexperienced. The supported house is the home to 5 residents with intellectual disability (see below for a description).

You have brought one of the residents, whose name is Peter, to the Emergency Department (ED) today. He is a 30-year-old man with intellectual disability and has been a resident at the home for about 5 years.

This morning Peter hit his head on the table in the kitchen on purpose. He had a large cut on his forehead, and you brought him to the ED for treatment. The cut will need stitching up. They have sent him for a brain scan just as a precaution. The doctors in the ED have seen him, and have told you that he will be okay.

Background to today's event:

For the last 2 months, Peter has been doing things to himself that have been causing him harm (called self-injurious behaviour). He has been banging his head, also pinching and scratching himself. He has numerous scars and bruises upon his arms and hands from past actions. There have been times when he has become agitated and damaged property - breaking a cup and throwing a chair against a wall. He has not threatened or made an attempt to injure anyone else.

Peter has appeared aware of his surrounding before, during and after his episodes of self-harm; and he has not appeared confused or disoriented. You are not aware of him collapsing or having any fits (you know about these as some of the other residents have them).

This kind of behaviour has apparently occurred intermittently over the years in Peter. The last time though, was a few years ago following the death of his father. To the best of your knowledge it settled within a few weeks, without any treatment.

Peter's intellectual disability (abbreviated to ID):

ID starts before the age of 18. People with ID present with significant problems in both intellectual functioning and in how they adapt and behave to their environment. They can have problems with everyday social and practical skills. *Intellectual function* is also called *intelligence* and refers to general mental capacity, such as learning, reasoning and problem solving. An IQ test can measure intellectual function: normal or average range is 90-100 and scores of around 70 to 75 indicate limitations in intellectual functioning. ID can range in levels from being mild, moderate, severe to profound.

You are not sure what Peter's IQ is, but you are able to describe his level of functioning. Peter has simple communication / language skills: identifying basic feelings of being well or unwell, whether he is too hot or too cold, when he needs help with something and, so he can communicate simple needs. He has no problems with his mobility. He will often need prompting for complicated activities but can dress himself and prepare simple foods such as a chocolate spread sandwich. He does need supervision when showering but only to make sure that he washes himself well. He is able to toilet himself with minimal assistance.

During the day he attends a supported program that includes working in a flower nursery, car washing, a walking group and participating in a games club. Every week he visits his elderly mother for the afternoon: he usually looks forward to this.

Peter's physical health:

If asked, Peter did not lose consciousness, vomit or appear confused after the injury today.

He has not suffered from any physical health problems that you know of. He has not complained of physical discomfort or headache, and you are not aware of any urinary or bowel disorder. There is no history of Peter having seizures / epilepsy.

Peter's psychological health:

Peter can sometimes talk to himself, and it will often involve him describing what he is doing. This has been a lifelong mannerism (habitual gesture or way of speaking or behaving), and this has not escalated during the last 2 months. He does not appear to be hearing voices or responding to voices no one else can hear. Although he can be quiet and more withdrawn at times he has not appeared depressed. He can still enjoy simple activities (like listening to music), and still enjoys some of his day program.

Recent changes in Peter's life:

If asked what has been going on in Peter's life; a new resident, called Angus, has moved into the home about 3 months ago. He is a large young man who will shout, and bang on the walls and table. He does this for fun and often laughs loudly. Angus does not actively seek to threaten or hurt anyone but he can be disruptive. Peter has taken to staying in his room when this resident is about. At meal times Peter will stay in his room until encouraged to come out. This can precipitate agitation, and he will try to find excuses to stay away - such as playing with his cars or reading his magazines (looking at the pictures). When he does sit at the table he will sit as far away from Angus as he can.

His visits to his mother have only recently restarted: he is taken to see her weekly for an hour at her home. Last month, she had to have a hospital admission and rehabilitation after she had a hip replacement. Peter was distressed when his mother went into hospital. As he was so distressed after the first hospital visit, the staff decided not to take him back to there. He would rock and pinch himself and frequently say '*Don't like it*', and when he got home he was more withdrawn and less interested in activities. At other times he would be his normal self.

Peter has become more disturbed when attending the nursery for his day program. He has become resistant to leaving the house on those mornings. He has shut himself in his room, run around the house and thrown things, and needed redirecting and distracting by staff. He can be more agitated in the evening or before the day program, and the self-harm behaviours have occurred at this time. At other times he will rock and again say, '*Don't like it'* repeatedly. The staff at the day program report no major problems with Peter once he is there except that he is quieter than his normal self, is less involved in the activities at the nursery, and is more likely to be found with one of the staff members.

Overall, in the last couple of months Peter has been varied in how he presents himself. He can be worried and fretful. At such times he can be distracted by staff through simple measures or taken out for a walk. If this does not settle his state the anxiety will increase, and he will pace, rock, scratch or even bang his head.

Although he usually sleeps well, his sleep has been more unsettled. He can sometimes be restless a night, and will rummage and move clothes from his drawers and wardrobe. The GP recently prescribed a medication called quetiapine XR which Peter takes every night, and this has helped settled him for much of the time but there are times when this does not calm him down, and the staff have to try their best to contain his agitation. He is now anxious and agitated most days in the week but he can still often be his old self, interacting in a friendly manner.

Peter does not use any alcohol or drugs.

He was treated with a medication called fluoxetine a few years ago for depressed mood after his father's death.

You don't know of any family history of mental illness.

Given that you are quite new at the service you do not know a lot about his past or early history.

About supported housing

Community service organisations (non-government organisations) are usually funded to provide a range of supported accommodation services including group homes and community residential units for people with a disability. The support is based on the individual's needs and promotes community participation, relationship building, skill development and maintenance.

Accommodation is usually offered in shared housing with the residents supported by a team of staff who usually work according to a roster. Supported accommodation facilities aim to provide a safe, stable community environments for people with various life challenges. Essentially, clients require assistance with daily living skills which is provided in an environment that should be respectful and caring.

4.2 How to play the role:

You are to dress casually but neatly. You work as a disability support worker and provide personal, physical and emotional support to disabled people who require assistance with daily living. Disability support workers can provide assistance with showering, dressing and eating, and basic household chores, and often facilitate or assist with outings and other social activities.

You are concerned about Peter's worsening behaviour, and are interested in trying to find out what is causing it. You will take a helpful interaction style with the candidate.

4.3 Opening statement:

'Peter hit his head on the table. There was blood everywhere!'

4.4 What to expect from the candidate:

The candidate is expected to explore the nature of Peter's behaviour, and work to see if they can identify the cause. The candidate will also ask questions to assess for the presence and nature of any symptoms that would indicate that Peter may have a psychiatric disorder. The candidate will then explain the diagnosis and findings to you.

4.5 Responses you MUST make:

'I don't know what set off this behaviour today.'

'There have been a number of changes in Peter's life in the last few months.'

'It's now been harder to get him out of his room sometimes.'

4.6 Responses you MIGHT make:

If asked any question that is not in the script reply:

'I am not able to answer that. Sorry.'

4.7 Medication and dosage that you need to remember:

Quetiapine (KWET-I-APINE) XR 50 milligrams at night.

STATION 8 – MARKING DOMAINS

The main assessment aims are:

- Assess, via collateral history, the presence of an acute psychiatric presentation in a person presenting with challenging behaviour in the context of intellectual disability.
- Explain the presentation and possible diagnoses to the carer.
- Use effective communication skills with the carer.

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; explores possibly changes in the staff, clients and environment at the nursery day program; explores past losses and grief.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking hypothesis-driven history; integrating key social issues relevant to the assessment; demonstrating ability to prioritise; eliciting precipitants for self-injurious behaviour; completing a risk assessment relevant to the individual case; assessing for phenomenology; clarifying important positive and negative features; eliciting the history of avoidance behaviours in the patient.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Elicit the precipitants for the self-injurious 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 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:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; indicates the usefulness in using psychometric tools in diagnosing anxiety disorders in those with intellectual disability.

Achieves the Standard by:
identifying and succinctly summarising relevant aspects of the presentation; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; identifying relevant predisposing, precipitating perpetuating and protective factors; demonstrating good judgment when providing appropriate detail to the carer; accurately linking limited coping repertoire in the formulation of events; identifying differential diagnoses: anxiety disorder, depressive episode, adjustment disorder, or behavioural disorder.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.

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:
significant deficiencies including inability to synthesise information obtained; providing an inadequate formulation or diagnostic statement; errors or omissions are significant and do materially adversely affect conclusions.

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNCATOR

2.1 Did the candidate demonstrate an appropriate professional approach to communicating with the carer? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport; provides succinct and professional information.

Achieves the Standard by:
demonstrating ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the carer; recognising confidentiality and bias; prioritising and synthesising information; providing accurate and structured verbal report / feedback; demonstrating discernment in selection of content.

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

a. Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

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 provided; unable to maintain rapport.

2.1. Category: PATIENT COMMUNCATION - Carer	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5 ☐**	**4 ☐**	**3 ☐**	**2 ☐**	**1 ☐**	**0 ☐**

GLOBAL PROFICIENCY RATING

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

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