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1.0 Descriptive summary of station:

In this station, the candidate is expected to evaluate and manage new onset psychotic symptoms in a 76-year-old man referred from a nursing home. The candidate is asked to outline the process of consultation, and then to describe how to address the presentation to reach a diagnosis, and management of Lewy Body dementia which needs to be considered in the context of possible delirium.

1.1 The main assessment aims are to:

- Describe the procedural and operational processes involved in a nursing home consultation.
- Outline the psychiatric evaluation to assess a patient living in a nursing home with visual hallucinations and aggression.
- Justify appropriate diagnoses and differential diagnoses.
- Provide a brief management plan for the most likely diagnosis.

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

- Ensure communication with the nursing home staff, the General Practitioner and the family.
- Explore the chronic nature of the visual perceptual abnormalities.
- Justify the prioritisation of a diagnosis of Lewy Body dementia.
- Recommend that the family does not move the patient from the facility.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Psychiatry of Old Age
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Data Gathering Content; Diagnosis; Management – Initial Plan), Communicator (Patient Communication – Disclosure)

References:

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- Shin KS, Teodorczuk A, Watson R. Dementia with Lewy bodies: Challenges in the diagnosis and management. *Aust N Z J Psychiatry.* 2019;53(4):291-303.

Committee for Examinations
Objective Structured Clinical Examination
Station 4
Perth September 2019



1.4 Station requirements:

- Standard consulting room.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

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

This is a **VIVA** station: there is no role player in the examination room.

You are working as a junior consultant psychiatrist along with your registrar in the division of Psychiatry of Old Age. A team member approaches you to discuss a referral that was forwarded from a nursing home overnight.

Allan Appleton, a 76-year-old man, was admitted to the nursing home two years ago. Despite having no psychiatric history, he has developed visual hallucinations of 'people wearing hats and standing under a tree', and they have been present on and off for the past nine months, and associated with confusion, agitation and aggression.

Family members of Mr Appleton have asked for him to be relocated from the nursing home.

Your tasks are to:

- Briefly describe the process of how you would manage this referral with the nursing home.
- Explain the key areas you would focus on in your history taking and assessment.
- At **four (4) minutes**, you will receive further psychiatric history, mental state examination findings, and investigation results to justify your diagnosis / differential diagnoses and short-term management plan to the examiner.

Station 4 - 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).

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 you are to provide further information to the candidate at **four (4) minutes**.
- DO NOT redirect or prompt the candidate unless scripted.
- 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 **four (4) minutes** into the station, the examiners hand over the final task to the candidate and say:
'Please review this information obtained by your registrar.'
- 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 the 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.

There is no role player as this is a VIVA station.

At **four (4) minutes** into the station, you are to provide further information to the candidate. You are to say the following:

'Please review this information obtained by your registrar.'

You are to justify your diagnosis / differential diagnoses and short-term management plan to the examiner.

Additional Relevant History

- Inability to remember his way around the nursing home; used to play piano but not anymore; progressive loss of planning and spatial orientation.
- Slowed down movements and repeated falls.
- No alcohol or other substance use.
- No vomiting, incontinence, seizures.

Mental state examination: 14/09/19 at 08:20

Engaged; good rapport; speech: unremarkable; mood 'fine'; affect: euthymic; no delusions. Alert and orientated.

Progress notes: 10/09/19 to 13/09/19

Patient agitated; demanding to leave nursing home; varying level of alertness; confused at times says he is in a 'railway station'; other times alert and orientated.

Blood examination: No abnormality detected (NAD)

Urine and blood culture: No abnormality detected (NAD)

CT scan head: generalised atrophy otherwise no abnormality detected.

3.2 Background information for examiners

This is a viva station where the candidate is expected to describe the procedural and operational issues involved in responding to a nursing home referral to the Psychiatric Services for Older Persons. The patient referred is a 76-year-old man living in residential care with a nine-month history of visual hallucinations and aggression.

The candidate is then required to outline the psychiatric evaluation to assess his presentation, and outline appropriate diagnoses / differential diagnoses. Based on this, the candidate then should provide a brief management plan for the most likely diagnosis.

In general, the candidate is expected to address:

1. The processes involved in a nursing home consultation for an elderly patient presenting with late-onset psychotic symptoms.
2. The diagnostic evaluation of psychotic symptoms followed by the most likely diagnosis of Lewy Body dementia.
3. The short-term management including the management of family's request for removing the patient from the nursing home.

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

- Ensure communication with the nursing home staff, the General Practitioner and the family.
- Explore the chronic nature of the visual perceptual abnormalities.
- Justify the prioritisation of a diagnosis of Lewy Body dementia.
- Recommend that the family does not move the patient from the facility.

A **surpassing candidate** may demonstrate the awareness of practical difficulties in providing care to the patient and conducting this examination; articulate the need for repeated examinations of orientation to time, place and person because of possible fluctuation in presentation; demonstrate comprehensive knowledge of advanced diagnostic modalities for dementia, such as ¹⁸F-fluorodeoxyglucose PET scan; appropriately identify the limitations of diagnostic classification systems to guide treatment; describes the complex relationship between delirium and dementia; negotiate with the staff and family; and confidently discuss the changing classification of hallucinations / pseudohallucinations. They may offer education programs to the clinical staff; and quote evidence related to treatment options.

The consultative process:

Nursing home consultation is a part of Psychiatry of Old Age service. As a junior consultant, the candidate must articulate the processes involved in a nursing home consultation. It is largely a multidisciplinary process. In this context, the candidate should discuss with the team member and depending on the urgency, recommend an initial assessment by the clinician or the registrar, and then a review by the consultant.

Communication with the nursing home staff, family members and the general practitioner, and review of the nursing home notes are essential components of a nursing home consultation. The candidate must deal with a complex task of supporting the team colleagues, and nursing home staff, and addressing the demand from the family in a sensitive manner. A balanced approach of considering further evaluation of behavioural problems, severity of psychotic symptoms, risks and safety issues, pharmacological management (see below), and resources in the nursing home (e.g. dementia unit; staff trained to manage delirium and dementia symptoms) to manage the presentation against the benefits and risks of psychiatric inpatient admission is appropriate in addressing family's demand. The candidate may have to negotiate with the nursing home staff in deciding management setting, and educate the staff for a collaborative care. Support for the nursing home staff, and the family distressed by the patient's aggressive behaviour is integral part of this consultation.

Diagnostic evaluation:

The candidates must describe the set of diagnostic enquiries in the given situation. They should articulate the aspects of history enquired regardless of who conducts the assessment. The expectation is that candidates screen for symptoms of delirium specifically assessing orientation to time, place and person and attention. The line of enquiries should cover previous psychiatric and medical history, screening for common conditions that can lead to delirium, viz., infections, electrolyte derangements, drugs particularly with anticholinergic toxicity, alcohol withdrawal state, head injury, stroke and other cerebral pathologies like tumours.

The patient in this station is 76-year-old, and therefore better candidates will consider dementia as a predisposing factor for delirium. Given the chronic nature of visual hallucinations, it is appropriate for the candidates to consider chronic organic syndromes, such as dementia, and explain the screening questions for this syndrome as well.

Further information is provided **at four minutes** into the station. The visual hallucinations have a chronic onset over at least nine months. They are vivid and associated with worsening memory deficits, as well as impaired visuospatial orientation, a feature supportive of dementia with Lewy Bodies. In addition, the patient has had repeated falls and slowed movements which are indicative of Parkinsonian symptoms. In the history, there was no previous psychiatric episode. These features, specifically hallucinations exclusively in the visual modality and onset in late age, support psychotic symptoms secondary to an organic or medical condition, and stand against functional psychiatric disorders like schizophrenia and bipolar disorder.

There is no history of substance misuse, and therefore alcohol withdrawal can be excluded. Mental state examination does not show any abnormalities or features of disorientation. The candidates must take this as a fluctuating nature of delirium rather than dismiss delirium. Investigation results, except generalised atrophy in the CT scan, show no abnormality, a scenario that is not uncommon when psychotic symptoms and delirium occur in the context of dementia. The accepted differential diagnoses in this scenario are delirium, Lewy Body dementia, Parkinson's syndrome with dementia, Alzheimer's disease, vascular dementia and psychosis secondary to a medical condition. Diagnosis of a primary psychiatric disorder like schizophrenia, mood disorder or similar conditions falls well below the standard.

Diagnosis

Dementia with Lewy Bodies:

The patient in this station has delirium, but as part of dementia with Lewy Bodies (DLB). DLB accounts for 15%–20% dementia cases at autopsy. DLB arises from accumulation of a synaptic protein α -synuclein as Lewy Bodies in the brainstem, limbic cortex and neocortical regions. It is characterised by fluctuating but progressive deficits in multiple cognitive domains. This is the central and essential feature of Lewy Body dementia syndrome which often manifests as delirium in the beginning. Visual hallucinations and aggression of the patient in this scenario warrants a differential diagnosis of delirium, arguably the most common syndrome to be considered in such a situation. The candidates, however, should consider other features in the history, such as chronic progressive course, vivid visual hallucinations, extrapyramidal symptoms, and falls in arriving at the most likely diagnosis – Lewy Body dementia. In general, clinical features that support the diagnosis include repeated falls, syncope, transient loss of consciousness, severe autonomic dysfunction, depression, systematised delusions, or hallucinations in other sensory and perceptual modalities. They lack diagnostic specificity however, and can be seen in other neurodegenerative disorders.

Delirium:

Affecting attention and consciousness, delirium is the most severe form of mental disturbance. It is a syndrome that can arise from diverse aetiology, varying from medical diseases to alcohol withdrawal through Lewy Body dementia. Delirium is common, but often unidentified. Key diagnostic features include an acute onset and fluctuating course of symptoms, inattention, impaired level of consciousness, and disturbance of cognition, such as disorientation, memory impairment and alteration in language. Supportive features include disturbance in sleep-wake cycle, perceptual disturbances (hallucinations or illusions), delusions, psychomotor disturbance (hypo- or hyper-activity), inappropriate behaviour, and emotional lability. The challenges in delirium diagnosis are fluctuating nature of the symptoms, the lucid interval, lack of knowledge, and the notion that normal routine medical investigations exclude delirium. Diagnosis of delirium is clinical, and based on the syndrome. Visual hallucinations with no perceptual disturbances in other modalities, as the patient in this scenario reports, are uncommon in primary ('functional') psychiatric disorders like schizophrenia, and should rise high index of suspicion of an organic syndrome.

Other dementia syndromes, for instance, dementia arising from Alzheimer's disease can also present with psychotic symptoms. Candidates must commit this as a differential diagnosis because it is the most common form of dementia.

Management plan:

Initial plan may include further cognitive evaluation including a neuropsychological assessment. This can be bedside cognitive assessment, for instance using Montreal Cognitive Assessment (MoCA). It is not necessary that the candidates mention any particular method of cognitive evaluation.

Additional neuroimaging investigations, such as MRI scan is worth considering in order to exclude other neurological conditions, as well as support Lewy Body dementia. If available, occipital hypometabolism on ^{18}F -flurodeoxyglucose Positron Emission Tomography (PET) is suggestive of Lewy Body dementia.

Dementia with Lewy Bodies:

The management of Lewy Body dementia is essentially symptomatic, focussing on the control of distressing psychotic symptoms, addressing behavioural problems and psychosocial interventions. Evidence supports the use of cholinesterase inhibitors, such as donepezil in slowing down the progress of cognitive symptoms, as well as behavioural symptoms especially with early and assertive treatment. In fact, cholinesterase inhibitors, such as donepezil are more beneficial in Lewy Body dementia than in Alzheimer's dementia presumably because of extensive cholinergic impairment in the former. From a funding perspective, New Zealand candidates may comment that cholinesterase inhibitors are funded by the government for use in dementia. In Australia, they are only subsidised for use in Alzheimer's disease. Off label use of medications (e.g. cholinesterase inhibitors) will vary as per local practices.

In addition, certain medications need to be avoided as they can aggravate the clinical picture; for example, first generation antipsychotics which are likely to lead to exaggerated extrapyramidal signs, sedation, immobility, or neuroleptic malignant syndrome (NMS) with fever, generalised rigidity and muscle breakdown. This is an essential and integral part of the management of Lewy Body dementia in view of its serious risk. If at all used, then second generation antipsychotic medications like quetiapine are to be considered. The role of memantine is less clear.

There is also an absence of effective treatment except for medications that offer modest control of the cognitive and behavioural symptoms. There are no therapies that have proven to be curative or stop the disease progression. Physical exercise and cognitive training are, however, shown to be beneficial and recommended for patients with dementia.

Early diagnosis will also allow families and caregivers the time to plan for the expected decline. Preventive steps to improve safety in the nursing home environment should be taken, given the tendency to recurrent falls and rapid attentional fluctuations. Families will also have time to develop a better understanding of their role in patient care, including assistance with daily activities, and provision of social and cognitive stimulation. More educated candidates may talk about referral to specific dementia services, such as Dementia Behaviour Management Advisory Services (DBMAS).

Delirium:

The definitive management of delirium is the treatment of the underlying medical condition. But in this station, the patient has irreversible degenerating condition – Lewy Body disease. Symptomatic management of delirium largely relies on pharmacological and behavioural strategies. Behavioural management is an essential component of delirium treatment. Re-orientating the patient with calendar, clock and labels or signs are common strategies. Presence of family members and / or familiar people are also beneficial. Night light, low stimulus environment and reassurance are other interventions. It is vital to implement falls prevention strategies particularly when sedating medications are used. Commitment to ongoing review of improvement and / or side effects (e.g. postural hypotension); and monitoring of vital signs, hydration and mobility is also critical. Physical restraint is the last resort, and this will require the candidate discuss about legislative provisions in states and territories. Consideration of Advanced Health Directives, Power of Attorney, Guardianship under Civil and Administrative Tribunal or similar authorities is imperative.

As part of collaborative care, the candidate should address the family's request for change in management setting (inpatient admission, psychogeriatric nursing home etc.), and justify leaving the patient in his current nursing home at this time, as it is an environment with which he is familiar. The candidates must also offer supportive measures to the family with interventions that include but not restricted to referral to Dementia support program. Better candidates shall mention explanation of the patient's condition to family members, and education programs about delirium in dementia to the nursing home staff.

DMS-5 Diagnostic criteria for Delirium.

- A. Disturbance in *attention* (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced *orientation to the environment*).
- B. The disturbance develops over a short period of time (usually hours to a few days), *represents an acute change from baseline attention and awareness*, and tends to fluctuate in severity during the course of a day.
- C. An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception).
- D. *The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.*
- E. There is evidence from the history, physical examination or laboratory findings that the disturbance is *a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e. due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple aetiologies.*

ICD-10 Diagnostic Criteria for Delirium, not induced by alcohol and other psychoactive substances

An etiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

Include:

Acute or subacute:

- brain syndrome
- confusional state (nonalcoholic)
- infective psychosis
- organic reaction
- psycho-organic syndrome

Exclude:

- F10.4 Delirium tremens, alcohol-induced or unspecified.
- F05.0 Delirium not superimposed on dementia, so described.
- F05.1 Delirium superimposed on dementia
Conditions meeting the above criteria but developing in the course of a dementia (F00-F03).
- F05.8 Other delirium
 - Delirium of mixed origin
 - Postoperative delirium.
- F05.9 Delirium, unspecified.

DSM-5: Dementia with Lewy Bodies Diagnostic Criteria

The diagnostic criteria for *probable DLB* require:

- The presence of dementia.
- At least two of three core features:
 - fluctuating cognition with pronounced variations in attention and alertness,
 - recurrent visual hallucinations that are typically well formed and detailed, and
 - spontaneous Parkinsonian (motor signs) with onset at least one year later than cognitive impairment.

Suggestive clinical features include:

- Rapid eye movement (REM) sleep behaviour disorder,
- Severe neuroleptic sensitivity, and
- Low dopamine transporter uptake in basal ganglia demonstrated by SPECT or PET imaging.

In the absence of two core features, the diagnosis of probable DLB can also be made if dementia plus at least one suggestive feature is present with one core feature.

Possible DLB can be diagnosed with the presence of dementia plus one core or suggestive feature.

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

- 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).
- they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- they can **collaborate** effectively within a healthcare team to optimise patient care.
- 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.
- they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- 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.
- 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 most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

STATION 4 – MARKING DOMAINS

The main assessment aims are to:

- Describe the procedural and operational processes involved in a nursing home consultation.
- Outline the psychiatric evaluation to assess a patient living in a nursing home with visual hallucination and aggression.
- Justify appropriate diagnoses and differential diagnoses.
- Provide a brief management plan for the most likely diagnosis.

Level of Observed Competence:

2.0 COMMUNICATOR

2.2. Did the candidate appropriately and adequately demonstrate their leadership role in the assessment and treatment? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

comprehensively applies the principles of working closely with patient / colleagues including other specialists / families, and show the awareness of ensuring respectful and open communication; demonstrates awareness of practical difficulties in providing care to the patient and conducting this examination.

Achieves the Standard by:

providing a clear and appropriate explanation of consultation in a nursing home; outlining the psychiatrist role in managing stress levels of colleagues, staffs, and family; collecting historical and collateral data; reviewing nursing home records for clarity; committing to ongoing explanation regarding features of dementia and delirium; balancing statutory obligations around management while ensuring patient's rights; seeking advice about local dementia services; reviewing current supports for the family.

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

- Ensure communication with the nursing home staff, General Practitioner and family.

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; approach is disrespectful; explanation of diagnosis and management is unclear or inadequate to meet the needs of the referral or family members.

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

2.2. Category: PATIENT COMMUNICATION - Disclosure	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"/>

1.0 MEDICAL EXPERT

1.2 Did the candidate describe how they would undertake an appropriately detailed and focussed assessment? (Proportionate value - enter value 20%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior explanation in a range of areas; demonstrates prioritisation and sophistication in how they would proceed; articulates advanced diagnostic modalities for dementia such as ¹⁸F-fluorodeoxyglucose PET scan.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; assessment process is hypothesis-driven; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; seeking previous psychiatric / medical history and presentation; repeated examinations of orientation because of possible fluctuation in presentation; identifying relevant investigations; demonstrating ability to prioritise assessment of risk and safety (e.g. absconding risk; 'sun downing'); screening for delirium and dementia syndrome; and outlining the key issues including cognitive examination.

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

- Explore the chronic nature of the visual perceptual abnormalities.

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; omissions adversely impact on the proposed content to be obtained; significant deficiencies such as substantial omissions in history or assessment process.

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"/>

1.9 Did the candidate justify a diagnosis and differential diagnoses based on the available information? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; conducts presentation at a sophisticated level; appropriately identifies the limitations of diagnostic systems; describes the complex relationship between delirium and dementia including predisposing and precipitating factors, and the low threshold for onset of delirium in dementia.

Achieves the Standard by:

demonstrating capacity to accurately integrate available information from history taking and mental state assessment; organising findings with emphasis on conditions that cause late-onset psychosis; recognising delirium syndrome as likely comorbidity; demonstrating understanding that delirium can be a manifestation of Lewy Body dementia.

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

- a. Justify the prioritisation of a diagnosis of Lewy Body 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; deficits in history and examination; inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions; does not consider hallucinations in other modalities; does not consider delirium; or Diagnosis of schizophrenia.

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

1.9 Category: DIAGNOSIS	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"/>	

1.13 Did the candidate describe a relevant initial management plan? (Proportionate value - 30%)

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; quotes evidence and nature of evidence (e.g. randomised controlled trials for cholinesterase inhibitors).

Achieves the Standard by:

demonstrating the ability to: prioritise and implement evidence-based care; integrating available information to formulate a treatment plan for delirium and Lewy Body dementia; planning for risk management including absconding and the impact of aggression; considering stimulus / environmental strategies; recommending judicious use of specific medications and other specific environmental and nursing interventions; articulating favourable evidence for cholinesterase inhibitors for Lewy Body dementia; stating that first generation antipsychotics should be avoided in Lewy Body dementia as a general principle; consideration of involuntary / guardianship options; record keeping and communicating to necessary others; identifying potential barriers.

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

- a. Recommend that that the family do not move the patient from the facility.

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; errors or omissions in the plan will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

1.13 Category: MANAGEMENT – Initial Plan	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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