

**1.0 Descriptive summary of station:**

The aim of the station is to assess the candidate's ability to provide advice to a midwife who is concerned about a patient who has a history of Anorexia Nervosa who is due to deliver her second child at a regional hospital where the midwife works.

**1.1 The main assessment aims are:**

- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the late antenatal period.
- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the early post-natal period.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.
- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the post-natal period.
- Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:** Other Disorders (eating disorder)
- **Area of Practice:** Consultation Liaison
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation – Communication; Management – Initial Plan; Management – Long-term, Preventative)

**References:**

- Eating Disorders and Obesity, Second Edition: A Comprehensive Handbook, edited by Christopher G. Fairburn DM FMedSci FRCPsych, Kelly D. Brownell PhD, 2002 Guilford Press.
- Abraham, M.D (1999) Disordered Eating and Pregnancy. Eating Disorders Review. Vol 10, Number 1. Accessed [http://eatingdisordersreview.com/nl/nl\\_edr\\_10\\_1\\_1.html](http://eatingdisordersreview.com/nl/nl_edr_10_1_1.html)
- National eating disorders collaboration "Pregnancy and eating disorders: a professional's guide to assessment and referral" nedc.com 2015

**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: neatly and professionally dressed woman in 30s.
- 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.

You are working as a junior consultant psychiatrist in a consultation liaison service at the metropolitan hospital with a tertiary referral maternity service attached.

You have been contacted by a midwife who works in a regional hospital connected with your hospital that provides maternity services. She has been attending a training session at your hospital.

The midwife is asking for advice about a patient with a history of Anorexia Nervosa now in remission who has been referred by her GP for delivery at her local hospital. She does not have much specific information about the patient and would like some general information and advice, including management strategies that may be employed to support a person who has a history of Anorexia Nervosa in the late antenatal period and early postnatal period.

Your tasks are to:

- Describe the major risks and management strategies associated with Anorexia Nervosa in the late antenatal period to the midwife.
- Describe the major risks and management strategies associated with Anorexia Nervosa in the early postnatal period to the midwife.

**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 are available for candidate use.
- Do a final rehearsal with your simulated health professional.

### 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 is no cue / time for any scripted prompt.
- DO NOT redirect or prompt the candidate unless scripted – the simulated health professional 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.

There is no opening statement and there are no prompts.

The role player opens with the following statement:

***'Thank you so much for making time to see me, I'm hoping to get some advice about a pregnant woman who has been referred to me.'***

#### 3.2 Background information for examiners

The aims of this station are to examine the ability of the candidates to provide advice about the risks and management of Anorexia Nervosa through the peripartum period. The midwife is concerned about a patient who has a history of Anorexia Nervosa who is due to deliver her second child at a regional hospital where the midwife works. The candidates are to engage with a midwife and demonstrate effective collegial engagement.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.
- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the post-natal period.
- Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

A surpassing candidate may present a systematic and comprehensive approach that identifies biological, psychological and social risks, and synthesises this to describe dynamic, static and environmental risk factors. The management of these risks would be presented in a way that identifies all important bio-psycho-social strategies structured into immediate, short and medium term plans.

According to the DSM-5 criteria, to be diagnosed as having Anorexia Nervosa a person must display:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

#### **Subtypes:**

Restricting type

Binge-eating / purging type

According to the ICD-10 criteria, for a definite diagnosis of Anorexia Nervosa, all the following are required:

- Body weight is maintained at least 15% below that expected (either lost or never achieved), or Body Mass Index (BMI) is 17.5 or less. Pre-pubertal patients may show failure to make the expected weight gain during the period of growth.
- The weight loss is self-induced by avoidance of 'fattening foods' and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and / or diuretics.
- There is body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.
- There is endocrine disorder, manifesting in women as loss of periods (amenorrhoea) and in men as a loss of sexual interest and potency.

The following is a summary from the *“Pregnancy and eating disorders: a professional’s guide to assessment and referral” nedc.com 2015*. [Acknowledgments to the National eating disorders collaboration who approved use of this information for examination purposes.]

Eating disorders occur in a significant number of pregnant and post-natal women, and the outcomes can be dangerous for both mother and baby. An eating disorder can develop as a result of a pregnancy (and subsequent changes in body shape and weight during pregnancy) or it can develop / exist prior to the pregnancy, with the pregnancy further complicating eating disorder symptoms and impacting health. These symptoms and body dissatisfaction can remain once the baby is born. A mother’s expectations of her post-natal body and of the time it ‘should take’ to return to her pre-pregnancy size and shape may be unrealistic. When it comes to pregnancy and childbirth, there is no ‘normal’ in terms of expectations to ‘return to’ or ‘become’ a particular size or shape before, during or after the pregnancy and early motherhood period. The health and nutrition of the mother and her baby is paramount and women should be encouraged to embrace any changes to their body as natural and healthy. Women who place emphasis on avoiding weight gain or a changing body shape during pregnancy and / or focus on intensive exercise in the early months following childbirth place themselves and their babies at additional health risks.

These risks include:

- antenatal and postnatal depression and anxiety
- impaired foetal development and antenatal complications
- premature births
- lower birth weights and birth defects
- hyperemesis (excessive vomiting)
- gestational diabetes
- unplanned caesareans
- increased risk of miscarriages
- breast milk supply complications due to nutritional deficiencies in the mother
- increased risks of nutritional deficiency for the baby when transitioning from breast or bottle feeding to introducing solids.

### **Recognising signs and symptoms**

In expectant mothers, eating disorder signs and symptoms can manifest as normal symptoms of the pregnancy (e.g. tiredness) or they can be disguised by other expected ailments associated with pregnancy (e.g. signs of vomiting may be mistaken for morning sickness rather than self-induced purging). Health professionals assessing a pregnant or postnatal woman should be aware of signs and symptoms in the context of eating disorders where they could be seen as not in the usual range associated with pregnancy or postnatal periods or are particularly severe. In general, common eating disorder presentations can be psychological, physical and behavioural:

#### **Psychological**

- Concern, distress or preoccupation with weight gain, even when weight is within the expected range.
- Dissatisfaction with body shape, even despite your discussions with them about expecting normal body shape changes with stages of pregnancy.
- Negative or unusual attitudes towards food and / or eating (see below).
- Negative attitudes towards the unborn baby.
- Depression, anxiety about pregnancy and anxiety about caring for their baby.

#### **Physical & Medical**

- Severe weight loss or low weight in relation to stage of pregnancy.
- Severe weight gain or excessive weight in relation to stage of pregnancy.
- Fainting, dizziness, headaches.
- Shortness of breath, fatigue.
- History of menstrual disturbances.
- Previous infertility or related problems.
- Gastrointestinal problems.
- Low bone density.

## Behavioural

- Indications of food intake restriction.
- Signs of repeated, self-induced vomiting.
- Restriction of certain foods not advised by a clinician.
- Avoidance of meals or changes in eating behaviour (e.g. refusing to eat with others).
- Evidence of substance / medication abuse in order to maintain body weight.
- Insomnia or disturbed sleeping patterns.
- Self-harming or suicidal behaviour (in which case emergency treatment will be vital).
- Excessive or distorted exercise patterns or signs of distress when exercising is not possible.

## Signs and complications

- Little or no weight loss (in the case of binge-eating disorder for example) or weight gain (in the case of anorexia nervosa for example) over the course of the pregnancy, despite a growing foetus.
- Problems with foetal growth and development.
- Gestational diabetes.
- Respiratory problems.
- Miscarriage.
- Premature labour / preterm.
- Complications during labour.
- Unplanned caesarean.
- Low birth weight.
- Stillbirth or foetal death.
- Postnatal depression.
- Measurable health indicators.

## Postnatal and early childhood specific signs include:

- A history of eating disorders prior to pregnancy or during pregnancy.
- Postnatal depression.
- Rapid, otherwise unexplained postnatal weight loss or weight gain.
- Negative feelings towards the baby or to becoming a mother.
- Anxiety about baby's appearance, e.g. overly referring to the baby as 'chubby'.
- A strong focus on pre-baby shape and / or returning to body shape-inspired exercise soon after childbirth.
- Compulsive / obsessive breast-feeding (can be associated with a desire to lose weight quickly).
- Difficulty maintaining or loss of milk supply.
- Signs associated with purge activities such as signs of excessive vomiting (bad breath, eroding teeth), laxative abuse, calluses on knuckles (from forced purging).
- Irregular weight gain in the infant.
- Signs of under or over feeding in the infant.
- Signs of malnutrition or under-nutrition in the mother and infant.
- Measurable health indicators.

## Physical assessment

- General physical state (well vs. unwell).
- Vital signs including temperature, lying and standing blood pressure and pulse.
- Alertness vs. somnolence / sleepiness.
- Height and weight history, and weight / height proportion – preconception, during pregnancy and postnatal.
- Menstruation pattern / history.
- Hydration (tongue, lips, sunken eyes, skin).
- Signs of vomiting (ketones on breath, bad breath, eroded teeth).
- Fundal measurements according to individual's expected progression of foetal growth (in pregnancy).

- Deep irregular sighing; breathing seen in ketoacidosis.
- Peripheral circulation (limbs, extremities) and cold peripheries.
- Physical changes, such as swelling in cheeks, jaw, ankles; calluses on knuckles; abdomen scaphoid.
- Electrolyte disturbances (thirst, dizziness, fluid retention, swelling, weakness / lethargy, muscle twitches).
- Alkaline urinary pH.

### **Management during pregnancy**

If an eating disorder is detected in a woman who is already pregnant, a high-risk management approach will need to be adopted throughout the perinatal period. You should:

- Refer to an eating disorder specialist and / or mental health professional or mental health team.
- Discuss notifying additional antenatal services of the eating disorder with the patient.
- Work with the patient's additional medical team, such as an obstetrician regarding risks and encourage the patient to undertake regular monitoring of foetus and development.
- Educate on the importance of good nutrition and foetal development.
- With patient's permission where possible, engage family members or carer to provide support and help.
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk.

### **Management after birth**

Clinicians involved in postpartum care should aim to:

- Assess parenting skills and the mother's relationship with infant in general.
- Provide advice and guidance to improve coping strategies if the mother is stressed or struggling.
- Increase self-esteem and confidence in mothers / parents.
- Provide breastfeeding support.
- Be aware of possible relapse if a prior eating disorder was present.
- Assess whether attitudes towards food and / or eating have changed.
- Assess whether the mother's attitude or feelings about her own body weight and shape have changed.
- Look for signs of postnatal depression or anxiety.
- Monitor infant growth, development and weight gain.
- Be aware of any negative emotions towards the infant.
- Be aware of anxious or avoidant attachment patterns.

If you suspect the mother may be at risk of developing an eating disorder or if you feel she may already be engaging in disordered eating, you can:

- Refer to an eating disorder specialist and / or mental health professional.
- Provide nutritional advice and emphasise the importance of nutrition for growing babies.
- Notify the assigned paediatrician, obstetrician, nurse or anyone else involved in the child's care.
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk.
- Communicate the issue to another family member or carer who can provide additional support and help (e.g. husband, parent, sister, friend).

### **Management and ongoing care**

- Create a management plan and provide ongoing reviews of eating disorder issues.
- Regularly review the health and condition of both mother and baby.
- Communicate regularly with other specialists and clinicians who may be involved in treating the patient for the eating disorder or providing care for the pregnancy (e.g. obstetricians, midwives, psychologists, early childhood nurses).
- Become familiar with the specific risks and / or complications associated with the particular health problem or eating disorder e.g. social isolation, family support, risks commonly associated with generalised postnatal depression.

Update other treating clinicians with relevant information and details throughout the course of the pregnancy so that they are informed when the time comes to deliver the baby or provide other forms of treatment.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

**Below the Standard** – the candidate demonstrates significant defects in several of the domains listed above.

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

Your name is Mary Jenkins, and you have been practising as a midwife at the Armadale health services for the last three years. You are in Perth for a hospital training day, and have asked to speak to one of the psychiatrists for some advice about a referral you have received from a GP, Dr Robbins, who works in a small rural town.

You are concerned about how to manage a patient, Tiffany Banks, who has a history of Anorexia Nervosa and is due to deliver her second child at the regional hospital where you work. You have arranged to speak to a psychiatrist in Perth today while you are here doing some training.

You would like advice about the management strategies that may be used to support a person with a history of Anorexia Nervosa in the late antenatal and early postnatal period. As you have never looked after a woman with Anorexia Nervosa you are hoping that the psychiatrist will describe the risks that Tiffany may face in the later stages of her pregnancy, and then after the birth. You are then expecting to hear how to manage these risks.

#### What you know about the patient

The referral you have received is for a 26-year-old patient, Tiffany Banks, whom the GP has been managing for a long time. She is pregnant with her second child. The patient has had Anorexia Nervosa since late adolescence which settled, and has caused her limited problems (in remission) since her early 20's. She is currently still in remission and the pregnancy has been uncomplicated so far.

Tiffany is due to deliver in the next 6-8 weeks, and the GP has referred her to your midwifery group for delivery at the hospital where you work in order to connect her into the local maternity services to ensure close observation. He has requested an extended stay at the maternity ward due to her history of Anorexia Nervosa. She has refused an offer of a referral to the tertiary maternity hospital in Perth as she does not want to be too far away from her family. The GP has discussed the patient with the obstetric medical staff who have accepted the referral.

There is no psychiatric service to provide advice and support to the maternity services where you work, and there is only limited psychiatric support from the local mental health team and currently your hospital is relying on locum psychiatrists. When you contacted the local psychiatric services, they suggested you contact the consultation-liaison psychiatrist in Perth to get specialist advice.

The GP did not elaborate on the details of Tiffany's mental health history, and you have limited information about her at the moment. While you are in Perth you want to get general advice about the risks that may be associated with Anorexia Nervosa during the late stages of pregnancy, and in the early period after delivery (postnatal) as you have no experience as midwife of managing a woman with Anorexia Nervosa before.

The GP had explained that Tiffany has a 5-year-old daughter, Amy, and a supportive husband, Bob. They live remotely running the local shop.

You have been working as a midwife for 5 years but have limited experience with patients that have psychiatric histories. You intend to ring the GP after your conversation with the psychiatrist to get more detailed information from him.

#### About your work area

Armadale Health Service provides a range of services including emergency services, a midwifery group practice, some general medical and surgical services, and general inpatient and community mental health. Community midwives provide shared antenatal care with local GPs where possible, including visiting and outreach services to expectant women throughout the area. Women can plan their birth to enhance the safety and wellbeing of their babies. Mental health in the community is provided in a 'shared-care' approach between GPs, mental health services and nurse practitioners.

#### 4.2 How to play the role:

You are casually but professionally attired as you have just attended an education session for work. You are a young and keen midwife who presents herself in a professional manner. You are interested to learn as much as you can to assist you to provide the best care that you can to Tiffany.

You are anxious (and a bit embarrassed) about managing a woman with Anorexia as you have no experience. You are a bit anxious about the situation but cooperative and accepting of any advice given. You will be able to use the information provided by the candidate to get further information from the GP.

#### 4.3 Opening statement:

***'Thank you so much for making time to see me, I'm hoping to get some advice about a pregnant woman who has been referred to me.'***

#### 4.4 What to expect from the candidate:

The candidate is expected to enquire about the patient and what you know about the patient. Your concerns are about a patient who has Anorexia Nervosa who is due to deliver in your hospital, you do not know much about the condition, and would like advice about the risks in pregnancy and in the weeks after delivery (postpartum period), and how these may be managed.

The candidates are to engage with the midwife and demonstrate effective collegial engagement.

The candidate should do most of the talking, and should recognise that your knowledge of psychiatry is limited; so should not use a high level of technical terminology.

#### 4.5 Responses you MUST make:

***'I only have limited information and would like general advice at this stage.'***

***'What are the critical things for me to watch out for before and after the birth.'***

***'Why would that happen?' (when the candidate explains the possible risks).'***

#### 4.6 Responses you MIGHT make:

Anticipated Question: If the candidate uses highly technical language.

Scripted Response: ***'Sorry, would you mind explaining that again?'***

Anticipated Question: If the candidate does not provide practical details for management.

Scripted Response: ***'So what do I have to do / look out for?'***

Anticipated Question: What psychiatric services are available in your hospital?

Scripted Response: ***'We only have access to the limited adult mental health services.'***

Anticipated Question: If asked about your knowledge of psychiatry.

Scripted Response: ***'I am really sorry but I don't know too much about psychiatry.'***

Anticipated question: What resources do you have available.

Scripted response: ***'We have access to a multidisciplinary team for obstetric care.'***

Anticipated question: Do you have access to a paediatrician?

Scripted response: ***'Yes, we have someone who visits once a week.'***

#### 4.7 Medication and dosage that you need to remember:

Nil

**STATION 6 – MARKING DOMAINS**

**The main assessment aims are:**

- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the late antenatal period.
- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the early post-natal period.

**Level of Observed Competence:**

**1.0 MEDICAL EXPERT**

**1.12 Did the candidate communicate the likely antenatal findings to the midwife sensitively, appropriately and accurately? (Proportionate value - 20%)**

**Surpasses the Standard (scores 5) if:**

communicates risks in a sophisticated manner that considers risk across biological, psychological and social domains using a structured approach that considers immediate, short, medium and long term risks; monitors physical and psychological status; interprets findings in a resource effective and ethical manner demonstrated by enquiring about available resources.

**Achieves the Standard by:**

recommending thorough assessment of physical status that takes into account the symptoms of Anorexia Nervosa, and assessment of current mental state and recent psychiatric history; correctly communicating risks with appropriate detail; outlining monitoring strategies to identify risks; reflecting on any limitations and value of examination / investigations.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.

**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. Must identify increased risk of relapse of Anorexia Nervosa and how symptoms may be masked by pregnancy.

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

does not synthesise risk factors in a cohesive manner, incorrectly recommends even routine / standard range of monitoring for risks.

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

**1.13 Did the candidate formulate and describe a relevant initial management plan for the antenatal period? (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; acknowledges the risk of relapse and the plan clearly considers possible masking of symptoms and how this can be addressed through assessment and monitoring.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence based care; recommending plans for risk management including of relapse; considering inpatient / community treatment environment; recommending specific treatments that include biological, psychological and social interventions; engaging safely and skilfully appropriate treatment resources; identifying potential barriers; recognising the importance to a multidisciplinary approach as far as possible; recognising the need for consultation and referral.

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

- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.

**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 will impact adversely on patient care; plan lacks structure or is inaccurate; plan does not tailored to patient's immediate needs or circumstances; fail to acknowledge the increased risk of relapse AND fail to identify the need for increased monitoring.

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

**1.12 Did the candidate communicate the likely postpartum risks to the midwife sensitively, appropriately and accurately? (Proportionate value - 20%)**

**Surpasses the Standard (scores 5) if:**

communicates risks in a sophisticated manner; considers risk across biological, psychological and social domains using a structured approach that considers immediate, short, medium and long term risks; monitors physical and psychological status of both mother and baby; interprets findings in a resource effective and ethical manner demonstrated by enquiring about available resources.

**Achieves the Standard by:**

recommending thorough assessment in postpartum period that takes into account the risks of Anorexia Nervosa relapse; explaining how symptoms of Anorexia Nervosa may impact on mother and baby; assessing mental state and recent psychiatric history; correctly communicating risks with appropriate detail; outlining monitoring strategies to identify risks; reflecting on any limitations and value of examination / investigations.

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

- a. Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the postnatal period.

**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:**

does not synthesise risk factors in a cohesive manner, incorrectly recommends even routine / standard range of monitoring for risks.

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

**1.16 Did the candidate formulate an appropriate longer term management plan, including preventative treatment and referral to other specialists? (Proportionate value - 30%)**

**Surpasses the Standard (scores 5) if:**

overall plan is sophisticated, tailored yet comprehensive; recognises the limitations of their role in effective treatment; recognises the important role of the father and other supports in the postpartum period.

**Achieves the Standard by:**

demonstrating ability to prioritise and implement evidence based care including need for acute and ongoing monitoring of the physical status of both mother and baby; acknowledging the increased risk of relapse psychiatric status; giving priority to continuity of care and inclusion of long-term outcomes; demonstrating awareness of possible complications of illness and available interventions / monitoring; acknowledging appropriately realistic possibility of treatment failure due to available resources; elaborating discharge arrangements.

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

- a. Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

**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 will adversely affect outcomes; failure to acknowledge an increased risk of relapse of symptoms of Anorexia Nervosa in the mother in the postnatal period, and that these symptoms may impact on both mother and baby; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT - Long-term, Preventative	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

## GLOBAL PROFICIENCY RATING

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

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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