JRCPTB
Joint Royal Colleges of Physicians Training Board

Guidance for trainees in Palliative Medicine

May 2014

This guidance has been produced by the SAC to guide trainees on:

- Changes to Workplace Based Assessments requirements
- Completing speciality specific questions in GMC survey

Palliative Medicine SAC guidance on changes to requirements for Workplace Based Assessments and completing speciality specific questions in GMC survey

This document follows the guidance circulated in March 2013, which was valid until the end of July 2013 and covers the following:

1. Changes to the DOPS requirement in the Palliative Medicine 2010 (amendments 2013) curriculum
2. Guidance for new DOPS
3. Introduction of the multiple consultant report (MCR) for training year August 2013-August 2014
4. Guidance for trainees in completing speciality specific questions in the annual GMC survey

1. DOPS (see appendix 1)

1.1 Trainees following the Palliative Medicine 2010 curriculum

There are ten mandatory DOPS in the 2010 curriculum as follows:

1. TENS application
2. Paracentesis
3. Pleural aspiration
4. Male urethral catheterisation
5. Female urethral catheterisation
6. Syringe driver set up
7. Nebuliser set up
8. Passing a nasogastric tube
9. Death certificate and cremation form procedure
10. Management of spinal lines

Competency must be demonstrated once for each of the above apart from syringe driver and paracentesis where competency must have been demonstrated four times during training.

During each year of training a trainee must demonstrate competence in at least four DOPS. A trainee must be independently competent at performing each procedure by the end of his/her training.

There are formative and summative DOPS available on the eportfolio. Trainees can use as many formative forms as they wish during training. However to demonstrate competence in performing a procedure trainees are required to achieve a pass using a summative DOPS assessment form.

Three of the current DOPS are classed as potentially life threatening. These are:

- Paracentesis
- Pleural aspiration
- Management of spinal lines.

Trainees can undertake as many formative procedures of life threatening blocks as they wish. However summative sign off for potentially life threatening procedures needs to be undertaken on two occasions with two different assessors (one assessor per occasion). The summative sign off for syringe driver set up and paracentesis only needs to be done four times during training.

1.2 Trainees following the Palliative Medicine 2010 Curriculum (2013 amendments)

Amendments made to the 2010 curriculum in 2013 include changes to the requirement for DOPS. The revised DOPS list is as follows:

1. TENS application
2. Syringe driver set up
3. Management of spinal lines
4. Management of tracheostomy
5. Care of peripherally inserted central catheters and Hickman lines
6. Management of non-invasive ventilation
7. Passing the nasogastric tube
8. Paracentesis

Competency must be demonstrated once for each of the above apart from syringe driver and paracentesis where competency must have been demonstrated four times during training. There are formative and summative assessment forms available on eportfolio. Trainees can use as many formative forms as they wish during training. However to demonstrate competence in performing a procedure trainees are required to achieve a pass using a summative DOPs assessment form.

Two of the DOPS are classed as potentially life threatening. These are:

- Paracentesis
- Management of spinal lines

Life threatening procedures should be signed off as competent on two separate occasions with two different assessors, with one assessor on each occasion. The summative sign off syringe driver session and paracentesis should be demonstrated four times in four years of training.

It is recognised that trainees may need to seek new training opportunities to help them become competent in the new DOPS (see section 2 below).

The 2013 amendments to the curriculum will go live in **August 2014**. It was not possible to make the changes to the ePortfolio any earlier without creating a new version and all links trainees made to previous versions would be lost. This issue will be resolved for August 2014 and trainees moving to the most up to date version of the curriculum will have existing evidence transferred automatically. Therefore the new DOPs requirement will be mandated from August 2014 i.e. after the current ARCP cycle.

Trainees who have 12 months or less FTE time left in training on 1 August 2014 will require to complete either the complete list of required DOPS for the 2010 curriculum (see item 1.1) **or** the complete list of DOPS for the 2010

curriculum (2013 amendments) (see item 1.2) by their final ARCP. Trainees who have more than 12 months FTE time left in training on 1 August 2014 will require to move to the updated DOPS list in the 2010 curriculum (2013 amendments) and to show competency in the new list.

1.3 Trainees still following the 2007 curriculum

Trainees who are currently following the 2007 Palliative Medicine curriculum and whose CCT is on or before 31 December 2015 can remain on the 2007 curriculum and demonstrate the competencies that the 2007 curriculum requires. A trainee on the 2007 curriculum whose CCT date is 1 January 2016 or later must transfer to the most up to date version of the curriculum, which is the 2010 (amendments 2013 version). However because of the e-portfolio changeover issues mentioned above trainees in this position are advised to wait until after August 2014 to make this change. Further information on transferring to the current curriculum is available on the JRCPTB website here.

2. Guidance for new DOPS

The principles behind the introduction of the new DOPS are that trainees should be able to manage patients with a tracheostomy, central line or NIV in a specialist palliative care setting. The guidelines in each area will be different and the trainees should be assessed according to the local guidelines and governance in place in their area. There are no specific forms for these DOPS and the generic forms on eportfolio can be used.

2.1 Management of a tracheostomy

The rationale behind this is that a trainee would be able to look after a patient with a tracheostomy in situ in a specialist palliative care setting. Trainees should therefore be able to manage common complications e.g. secretions and a simple tracheostomy change.

2.2 Care of peripherally inserted central catheters and Hickman lines.

The trainee in palliative medicine should be able to manage patients with a PICC or Hickman line in situ in a specialist palliative care setting. Trainees should be able to maintain the patency of these lines and to use the lines appropriately as required and in accordance with local policies.

2.3 Management of non-invasive ventilation.

The palliative medicine trainee would be expected to manage a patient who required non invasive ventilation in a specialist palliative care setting. Trainees should be able to set up and check non-invasive ventilation on a patient who has already been established on NIV and work with local guidelines within the local governance framework covering these devices.

3. Multiple Consultant Report (MCR)

The JRCPTB introduced the multiple consultant report (MCR) in October 2013. The MCR is a mandatory requirement and is included in the revised ARCP decision aids for 2013/4. In Palliative Medicine a minimum of two MCRs should be completed per year (NB each MCR is completed by one consultant and the results are collated automatically into the MCR year summary sheet). The MCRs should be completed by consultants who have a role clinically supervising

the trainee, but who are not in the Educational Supervisor role for that trainee over that time period. They may be completed by an associate specialist in Palliative Medicine and by consultants in other specialties who have had a role clinically supervising that trainee over the relevant period (eg oncology consultant). The MCR informs the educational supervisor report for each trainee. The ARCP panels will be encouraged to feed back on the quality of educational supervisors report and the trainees will be encouraged to feedback on educational supervision. More information on the MCR is available on the JRCPTB website and there are ePortfolio user guides for trainees and supervisors.

4. Acute care assessment tool (ACAT)

The ACAT is not currently a WPBA mandated for Palliative Medicine trainees. However it may be used voluntarily by trainees to provide useful feedback and enhance learning. The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take or during a busy ward round. It is recommended that at least five cases have been managed during ward round or session. Any doctor who has been responsible for the supervision of the ward round/acute medical take can be the assessor for an ACAT. The domains covered in the assessment are:

- Clinical assessment: appropriate diagnosis of cases on the take, and consideration of alternative diagnoses.
- Medical record keeping: quality of recording of patient encounters on the take, including drug and fluid prescriptions.
- Investigations and referrals: quality of a trainee's choice of investigations, and referrals during a ward round.
- Management of critically ill patient: quality of treatment given to critically ill patients encountered on the take (assessment, investigations, urgent treatment administered, and involvement of appropriate colleagues).
- Time management: prioritisation of cases and issues within the ward round, ensuring the sickest patients are seen first and the patient's most pressing issues are dealt with initially.
- Recognition of the quality a colleague's initial clerking to inform how much further detail is needed. A full repeat clerking is not always needed by a more senior doctor.
- Management of take/team working: appropriate relationship with and involvement of other health professionals.
- Clinical leadership: appropriate delegation and supervision of junior staff.
- Handover: quality of the handover of care of patients from the ward round/on call shift to the relieving team. If patients have been transferred to a different area of care then this applies to the quality of the handover to the new team.

5. Guidance in completing specialty specific questions in GMC Survey

There has been concern that interpretation of the responses to one of the specialty specific questions in the GMC survey may have been compromised by potential misunderstanding of the question by trainees. Please see the following guidance for the stated question:

'In your last on call weekend, how many unplanned face to face patient assessments or admissions did you undertake?'

This includes: patients who you have not been asked to review over the weekend by the patient's regular doctors during their handover process; patients who you have to review again having seen them already; new admissions; new hospital referrals requiring face to face review and reviewing a patient who has already been seen by another doctor. It does not include speaking to relatives.

Any questions relating to any of the above guidance should in the first instance be directed to the relevant educational supervisor or training programme director.

Dr Alison Mitchell
Palliative Medicine SAC Vice Chair
May 2014

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Appendix 1: Summary of Changes to DOPS in Palliative Medicine

	List of Mandatory DOPS (no of times during training)	Type of Assessment form to be used on E-Portfolio	Routine or Potentially Life Threatening Procedure (R/ PLT)	Number of Assessors Required	Additional Comments
2010 Curriculum	TENS application (1)	Summative	R	1	
	Paracentesis (4)	Summative	PLT	2	There is no requirement to increase the number of DOPS to above four times during training. Will need two different assessors over course of training.
	Pleural aspiration (2)	Summative	PLT	2	There is no requirement to increase the number of DOPS to above four times during training. Will need two different assessors over course of training
	Male urethral catheterisation (1)	Summative	R	1	
	Female catheterisation (1)	Summative	R	1	
	Syringe driver set up (4)	Summative	R	1	
	Nebuliser set up (1)	Summative	R	1	
	Passing a nasogastric tube (1)	Summative	R	1	
	Death certification and cremation form procedure (1)	Summative	R	1	
	Management of spinal lines (2)	Summative	PLT	2	Two different assessors
2010 Curriculum (2013 amendments)	TENS application (1)	Summative	R	1	
	Paracentesis (4)	Summative	PLT	2	There is no requirement to increase the number of DOPS to above four times during training. Will need two different assessors over course of training.
	Syringe driver set up (4)	Summative	R	1	
	Passing a nasogastric tube (1)	Summative	R	1	
	Management of spinal lines (2)	Summative	PLT	2	Two different assessors
	Management of NIV (1)	Summative	R	1*	
	Assessment of tracheostomy(1)	Summative	R	1*	
	Care of PICC/Hickman lines (1)	Summative	R	1*	
* Awaiting guidance regarding definition of 'life threatening' from JRCPTB – while awaiting guidance treat this new DOPS as 'non-life threatening'.					
2007 Curriculum[1]	TENS application (1)	Summative	R	1	
	Paracentesis (4)	Summative	PLT	2	There is no requirement to increase the number of DOPS to above four times during training. Will need two different assessors over course of training.
	Pleural aspiration (2)	Summative	PLT	2	
	Urethral catheterisation male/female(1)	Summative	R	1	
	Syringe driver set up(4)	Summative	R	1	
	Nebuliser set up (1)	Summative	R	1	
	Passing a nasogastric tube (1)	Summative	R	1	
	Controlled drugs storage	Summative	R	1	
	Death certification and cremation form procedure (1)	Summative	R	1	
	Use of NCPC Minimum Dataset(1)	Summative	R	1	
2003 Curriculum	There are no mandatory DOPS in the 2003 curriculum although trainees are strongly encouraged to complete those detailed in the 2010 curriculum				