Governance Statement regarding patient safety issues in relation to practical procedures carried out by physicians in training

1. In order to guarantee patient safety, no trainee should be required to undertake a practical procedure that they do not feel competent to carry out. They must have previously been trained in that procedure and have documented evidence of both the training and appropriate competency assessment (normally in the form of a work placed based assessment – Direct Observation of Procedural Skills – DOPS).

2. Successful completion of Internal Medicine Year 2 (IMY2) with an ARCP Outcome 1 confirms that trainees have demonstrated competence to perform the following procedures independently without supervision

- Direct current (DC) cardioversion
- Aspiration of pleural fluid or air (in line with BTS guidelines)
- Insertion of nasogastric tube
- Tapping of ascitic fluid
- Lumbar puncture

3. Additionally, successful completion of IMY2 confirms that trainees as a minimum have been trained to be competent in a skills lab environment to perform

- Insertion of an intercostal (chest) drain to drain fluid (effusion) or air (pneumothorax)
- Central venous cannulation
- Access to circulation via intraosseous or femoral route
- External cardiac pacing
- Abdominal paracentesis (therapeutic drain)

4. It follows that an organisation employing training-grade doctors at IMY3 level or above should not assume that they are independently competent to perform the procedures listed in item 3 above. It is also possible that a trainee may have previously gained competence in a practical procedure but then may have become deskilled as a result of time away from the acute medical environment. Training grade alone therefore should not be regarded in itself as an indicator of procedural competence

5. Hospitals admitting acute medical patients, or where medical teams are called to provide care for acutely unwell inpatients, must ensure that they have explicit arrangements for all necessary practical procedures to be performed when required (particularly out of hours). Careful review of a trainee's competency at the time of their placement in an acute medical role is vital. If competence cannot be confirmed before any out-of-hours shift, the medical trainee and others in the medical team must be familiar with that escalation plan. Involvement of other specialties may be required. Anaesthetists may help with circulation access and lumbar puncture, chest teams may help with pleural procedures and emergency department clinicians may also provide valuable assistance/supervision. This is a Clinical Governance issue of service provision rather than training and is therefore the responsibility of the Medical Director.

6. These important patient safety issues will need close monitoring by Trusts, health boards,

Deaneries, the JRCPTB and other regulatory and training bodies.

7. If a life-saving procedure is urgently required (eg relief of a tension pneumothorax) the medical registrar will – as any other doctor faced with such a situation - have to make a rapid risk/benefit assessment of the necessity of undertaking a procedure that they are not formally “signed-off” as competent to perform unsupervised. In the circumstance of a patient who is likely to die if a procedure is not performed in the next few minutes their judgment of risk/benefit will be different from that in a patient who requires a procedure, but where the need for this is less urgent.

January 2020