

SAC Recommendations and Guidance on the introduction of DOPS (Directly Observed Procedural Skills) in Training for Renal Medicine Version 2: 7/12/2006

1. Time-line

The JCHMT has indicated that it expects DOPS to be introduced from the autumn of 2005. From October 2005 Training programs should commence introduction of DOPS to all trainees who have not yet had their Penultimate Year Assessment. From April 2006 review of DOPS will be a compulsory part of the RITA.

2. Procedures covered

- a.* Renal Biopsy (Essential)
- b.* Non-tunnelled acute Dialysis Catheters/Line (Essential)
- c.* Tunnelled permanent of semi-permanent Dialysis Lines (Non-essential)
- d.* Non-surgical insertion of PD catheters (Non-essential)

3. Minimal requirements

The JCHMT have stipulated minimal requirements for the DOPS in the assessment of these skills. **Over a 4-year training cycle six DOPS must be undertaken by a minimum of three assessors, each assessor on two occasions.**¹ It is left to each speciality to formulate a framework that takes into account its own specific requirements, which should address the differing nature of the skills, training opportunities, service delivery etc. Where possible trainees should aim to achieve training in the essential procedures prior to their PYA. **For trainees already partway through training it would be appropriate for a *pro rata* reduction in the number of necessary assessments according to their level of experience and prior training opportunities.**

4. Supervision & Teaching versus Assessment

There needs to be clarity for both trainers and trainees in the processes of supervision and training versus the DOPS. Whilst a DOPS session will provide both supervision and an opportunity for training it is not a substitute. The level of immediate supervision and training will be determined by the experience of the trainee and the clinical governance issues associated with this. A junior trainee will need close supervision for each procedure, a more advanced trainee being able to undertake procedures solo without having completed the full cycle of DOPS assessment at the discretion of his/her supervising consultant.

¹ Minutes of the JCHMT committee meeting, 14th April, 2005 (Annex)

5. *Who should assess?*

DOPS assessments may be undertaken by anyone who has themselves been trained in the procedure and who has maintained this skill as defined at their last appraisal. This might include specialists who are not primarily nephrologists (e.g. Radiologists² in the case of renal biopsy or Intensive Care Physicians in the case of acute dialysis line placement). It is *proposed* that senior trainees, who have completed their cycle of training satisfactorily, can also fulfil this role. In *all* cases, however, assessors should have gained training in DOPS assessment, which might be cascaded within departments.

6. *Documentation*

The documentation developed and validated by JCHMT will be used. In the case of renal biopsies an additional supplementary form was used and thus validated in the JCHMT study. For the other procedures it is proposed that the generic form is used for the time being. After DOPS has been introduced the SAC will seek feedback from regional training committees, the Renal Association training committee and individuals to establish whether there is a need for additional supplementary forms.

The DOPS forms, including the guidelines for their completion and the annual RITA summary forms can be found on the website: www.jcmt.org/assessment .

7. *Proposed schedule of assessments*

In proposing a schedule of assessments, flexibility needs to be built in to account for the individual differences in the trainee's learning curves, service requirements and the variable availability of learning opportunities during a typical trainee's rotation. It is worth noting that during the DOPS assessment that marking should be undertaken in the context of the stage of training and level of experience. This will inevitably be procedure specific, and not just determined by the year of training. Training in the insertion of acute dialysis lines, for example, is likely to be concentrated very early in the experience of a trainee whose first job is in a renal unit, such that it is reasonable to expect them to be fully trained quite early on. Renal Biopsy training is likely to require more time. The following is proposed:

- a. For each procedure, the minimum of 6 DOPS, assessed by three different assessors, each on two occasions is required, (fulfilling the JCHMTs requirements). These are minimum requirements, however, and additional DOPS are to be encouraged provided sufficient learning opportunities have been available for trainees to gain experience and address issues raised in previous DOPS.
- b. Provided the minimum number of assessments resulted in satisfactory scores (i.e. commensurate with stage of training), then the trainee is considered trained. Additional DOPS would be required if any aspects were marked as unsatisfactory.

² It is recognised that radiologists, for example, would only be able to carry out a limited assessment e.g. interpreting diagnostic information may be hard to assess, whereas their assessment of the procedural technique might be of considerable value

- c. There is no limit on which year or years of training (provided before PYA for essential procedures) that these assessments are undertaken; this should be dictated by the training opportunities. For example a new trainee working in a busy renal unit may achieve full training in the insertion of acute dialysis lines within a few months, whereas another trainees may have no opportunity to undertake biopsies until years 2 or 3.
- d. Having completed training in a procedure satisfactorily there should be an additional annual 'revalidation' DOPS undertaken, provided the opportunity exists. This is especially important on return to clinical training after a period out of programme.
- e. In the case of renal biopsies, at least two of the DOPS should be undertaken with transplant kidneys.
- f. In the case of non-tunnelled line insertion, it is appropriate that 2 of the 6 minimum number of DOPS is in the context of an acutely ill patient i.e. emergency dialysis. At least 2 of these line should be femoral.
- g. Non-tunnelled line insertion may be seen as the first part of a tunnelled line procedure. The two components could be scored separately and then count at DOPS for both procedures. (See form developed by David Eadington, Hull).

8. *Practical Issues*

- a. **Time requirements.** The JCHMT Study indicated that DOPS assessment added 25% of the time of the procedure, so if the minimum number of assessments are performed the additional time per trainee per year is not excessive – in the region of an hour, *assuming* that the procedure was being supervised as well. Perhaps the greater challenge is capturing the procedure itself for assessment, which in the case of acute dialysis lines may often be out of hours or when assessors are in clinic. Training centres will have to develop process in order to enable this to happen and clinical directors would need to ensure that this requirement is reflected in the development of current and future job plans.
- b. **Training the assessors.** There is a need for those involved in the assessment of practical skills to gain training in the use of DOPS. JCHMT has circulated a DVD to clinical directors and a number of Royal College training days have been set up. Heads of Regional Training Committees need to consider cascade training.
- c. **Timing of Introduction.** Whilst it is intended that DOPS assessments will become part of the RITA as from next April, 2006, it is recognised that trainees will be at very different stages of their own training and the opportunity for having had DOPS assessments will have varied between now and then. Trainees will not be penalised for not having achieved full DOPS assessments by then; they will be expected to have undertaken DOPS appropriate to their learning opportunities, however, and inevitably they have a responsibility to ensure that the sessions take place. For trainees partway through their training the number of compulsory DOPS can be reduced accordingly, provided they are satisfactory, (see point 3 above).