JRCPTB

Joint Royal Colleges of Physicians Training Board

# Palliative Medicine ARCP Decision Aid – AMENDED APRIL 2020 FOR COVID19 PANDEMIC

The guidance below documents the targets to be achieved for a satisfactory ARCP outcome at the end of each training year. The April 2020 amendments reflect the need to revise the ARCP requirements for trainees for 2020 ARCPs only, with the minimum requirements for supervised learning events and DOPS shown in brackets. This decision aid should be used in conjunction with the JRCPTB ARCP guidance available on the webpage www.jrcptb.org.uk/covid-19.

| Assessment/ supporting evidence | | ARCP year 3 (End of ST3) | ARCP year 4 (End of ST4) | ARCP year 5 (End of ST5 = PYA) | ARCP year 6 (End of ST6 = CCT) |
|---|---|---|---|---|---|
| **Expected competence** | | ES to confirm trainee has gained experience in the initial assessment and management of patients presenting with common palliative care problems and common palliative care emergencies<br><br>Evidence of engagement in 3-4 of 1-7 of the top 10 topics for mini-CEX*#<br>Evidence of engagement in 4 of 1-11 top topics for CbD*# | ES to confirm trainee is competent in the assessment and management of patients presenting with any of the common palliative care problems and common palliative care emergencies<br><br>Evidence of engagement in all of 1-7 of the top 10 topics for mini-CEX*#<br>Evidence of engagement in 8 of 1-11 top topics for CbD*# | ES to confirm trainee is autonomously competent in the assessment and management of patients presenting with all common palliative care problems/emergencies<br><br>Evidence of engagement with at least 8 of the top 10 topics for mini-CEX*#<br>Evidence of engagement in 12 of top 20 topics for CbD*# | ES to confirm trainee is autonomously competent in the assessment and management of patients presenting with all palliative care problems/emergencies<br><br>Evidence of engagement with 100% of the top 10 topics for mini-CEX*#<br>Evidence of engagement in 16 of top 20 topics for CbD*# |
| **SCE** | | | | Attempted SCE | Passed SCE to obtain CCT |
| **SLEs** | **mini-CEX*#** | 6 (3) | 6 (3) | 4 (2) | 2 (1) |
| | **CbD*#** | 4 (2) | 4 (2) | 4 (2) | 4 (2) |

| Assessment/ supporting evidence | | ARCP year 3 (End of ST3) | ARCP year 4 (End of ST4) | ARCP year 5 (End of ST5 = PYA) | ARCP year 6 (End of ST6 = CCT) |
|---|---|---|---|---|---|
| **(2020 ARCPs)** | **ACAT** | Optional – can be used to receive feedback and improve learning on acute medical take or ward round. It is recommended that at least five cases have been managed during ward round or session | | | |
| **Supervised learning events (SLEs)** should be performed proportionately throughout each training year by a number of different assessors across the breadth of the curriculum with structured feedback and action plans to aid the trainee's personal development | | | | | |
| **MSF#** | | 1 satisfactory | 1 satisfactory | 1 satisfactory | 1 satisfactory |
| **DOPS*#** | | Minimum 2 (1) | Minimum 2 (1) | Minimum 2 (1) | Minimum 2 (1) |
| **BLS#** | | Must have valid BLS | Must have valid BLS | Must have valid BLS | Must have valid BLS |
| **Audit Assessment (AA)** | | Evidence of participation in an audit | Evidence of completion of an audit with major involvement in design, implementation, analysis and presentation of results and recommendations<br><br>1 audit assessment | Evidence of participation in supervision of a second audit with major involvement in supervising a clinician in the design, implementation, analysis and presentation of results and recommendations | Evidence of satisfactory completion of portfolio/record of audit involvement,<br><br>1 audit assessment |
| **Teaching Observation (TO)** | | Evidence of participation in teaching of medical students, junior doctors and other AHPs<br><br>1 teaching observation | Evidence of participation in teaching of medical students, junior doctors and other AHPs<br><br>1 teaching observation | Evidence of participation in teaching with results of students' evaluation of teaching. Evidence of understanding of the principles of adult education<br><br>1 teaching observation | Portfolio evidence of ongoing evaluated participation in teaching. Evidence of implementation of the principles of adult education<br><br>1 teaching observation |
| **Research** | | Evidence of critical thinking around relevant clinical questions | Evidence of satisfactory preparation for a project | Evidence of developing research awareness and competence. Evidence might | Satisfactory academic portfolio / record with evidence of research |

| Assessment/ supporting evidence | ARCP year 3 (End of ST3) | ARCP year 4 (End of ST4) | ARCP year 5 (End of ST5 = PYA) | ARCP year 6 (End of ST6 = CCT) |
|---|---|---|---|---|
| | | based on sound research principles | include participation in research studies, critical reviews, presentation at relevant research meetings or participation in (assessed) courses | awareness and competence. Evidence might include a completed research study / guideline / protocol with presentations/publication. Research project educational supervisor report satisfactorily completed |
| **Management** | Evidence of participation in and awareness of some aspect of management – e.g. responsibility for organising on call rotas, organise and manage own workload effectively and flexibly, supervision of junior medical staff | Evidence of participation in and awareness of some aspect of management – examples might include preparing rotas; delegating; organising and leading teams. Organising teaching sessions or journal clubs<br><br>Evidence of leading MDT meetings. | Evidence of awareness of managerial structures and functions within the NHS. Such evidence might include attendance at relevant courses, participation in relevant local management meetings with defined responsibilities.<br><br>Evidence of leading MDT, involvement in induction of junior doctors | Evidence of understanding of managerial structures e.g. by reflective portfolio entries around relevant NHS and voluntary sector management activities.<br><br>Evidence of contribution to senior management meetings, recruitment process, handling of critical incidents |
| **Record of Reflective Practice (RRP) #** | 2 (1) satisfactorily completed RRPs | 2 (1) satisfactorily completed RRPs | 2 (1) satisfactorily completed RRPs | 2 (1) satisfactorily completed RRPs |

| Assessment/ supporting evidence | ARCP year 3 (End of ST3) | ARCP year 4 (End of ST4) | ARCP year 5 (End of ST5 = PYA) | ARCP year 6 (End of ST6 = CCT) |
|---|---|---|---|---|
| **Educational supervisor's report** | Satisfactory – to include summary of MCR and any actions resulting | Satisfactory – to include summary of MCR and any actions resulting | Satisfactory – to include summary of MCR and any actions resulting | Satisfactory – to include summary of MCR and any actions resulting |
| **Multiple Consultant Report** | 2 | 2 | 2 | 2 |
| **Events giving concern**<br>The following events occurring at any time may trigger review of trainee's progress and possible remedial training: issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; issues arising from supervisor report; issues of patient safety | | | | |

***** # ***See supplementary guidance below***

**Supplementary guidance on WPBAs for Palliative Medicine**

In the context of the COVID19 pandemic, it is recognised that there will be an impact on training and on workplace-based assessments. Trainees may therefore not be able to demonstrate the range of assessments through SLEs as required in the ARCP decision aid. The Educational Supervisor Report (ESR) should explicitly identify any gaps and particularly for ST5 and ST6 trainees, reference evidence of sampling of assessments across the range of the curriculum and competence achievement, based on clinical supervision and observation; trainee reflection; MCRs, MSFs and the SCE. ARCP panels should not penalise a high performing trainee where some of the top curriculum topics have not all been assessed in SLEs where there is adequate evidence of attainment elsewhere in the eportfolio, including the ESR.

**Top 10 topics for mini-CEX** [with references to curriculum topics]:

1. Communication with patients and families [3.1, 3.2, 3.3, 3.4]
2. Clinical evaluation/examination for symptom management [2.2, 2.3, 2.4, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13]
3. Clinical evaluation of concurrent clinical problems [2.5]
4. Clinical evaluation of emergencies [2.14]

5. Managing family conflict in relation to unrealistic goals [2.20]
6. Assessing the dying patient [2.22]
7. Clinical evaluation and ongoing care of the dying patient [2.22]
8. Prescribing in organ failure [2.18]
9. Evaluation of psychological response of patient & relatives and to illness [4.1, 4.2, 4.3]
10. Evaluating spiritual and religious needs [6.2]

**Top 20 topics for CbD** [with references to curriculum topics]:

1. Communication with colleagues and between services [1.3, 1.4]
2. Recognition, assessment and management of critical change in patient pathway [2.4]
3. Shared care in different settings [2.4]
4. Management of concurrent clinical problems [2.5]
5. Management of symptoms/clinical problems (including intractable symptoms) [2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13]
6. Symptoms as sensory, psychological and social experience for patients and impact on carers [2.6]
7. Therapeutic options & appropriate choice of treatment/non-treatment [2.6]
8. Opioid use (including opioid switching) [2.7]
9. Other interventions in pain management [2.7]
10. Management of emergencies [2.14]
11. Pharmacology/therapeutics [2.17, 2.18]
12. Psychosocial care [2.22, 4.1]
13. Psychological responses of patients and carers to life-threatening illness and loss [4.2]
14. Self-awareness and insight [5.1]
15. Grief and bereavement [4.5]
16. Patient and family finances [4.6]
17. Culture, ethnicity, religion, spirituality [6.1, 6.2]
18. Ethics [7.1, 7.2]

19. Doctor/patient relationship [7.2, 8.1, 8.2, 8.3]
20. Teamwork & leadership [9.1, 12.2, 12.6]

**DOPS requirements**

Amendments made to the 2010 curriculum in 2015 include changes to the requirement for DOPS (please see appendix 1 for a summary of DOPS requirements for each curriculum). 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.

In the context of the COVID-19 pandemic, it is recognised that some ST6 trainees may struggle to complete outstanding DOPS, particularly those relating to tracheostomy and NIV. In part, this is because respiratory and ICU clinicians are busy managing the new cohort of patients and in part as it is not appropriate to expose trainees to the risk of aerosol generating procedures for the purposes of undertaking an assessment. In these situations, if trainees can demonstrate competence in this area through training in skills labs or simulation, or from indirect feedback from clinical and educational supervisors, clearly documented in the ESR, these will be accepted.

- **Management of spinal lines:** The management of spinal lines DOPS allows a trainee to be assessed on any one of a range of different systems in order to facilitate the acquisition of this practical experience. The assessor's role is to ensure that whatever system is in use locally, the trainee has a solid understanding both of the indications and background for use of intrathecal/epidural drug delivery systems in the immediate clinical setting. Assessors should also take the opportunity of the Spinal Line DOPS to explore the use of intrathecal/epidural drug delivery systems in palliative medicine overall. This is particularly relevant if the only opportunity for the trainee to achieve these DOPs is in a non-palliative care setting. Examples of relevant opportunities include, but are not limited to:
    - Fully implanted ITDD systems- implanted pump refill, implanted pump bolus injection, implanted pump CSF sampling, implanted pump programme change
    - External epidural/Intrathecal drug delivery systems- external pump refill, external pump line change, external pump filter change, external pump bolus injection, external pump programme change , external pump CSF sampling

- **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.

- **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.

- **Management of non-invasive ventilation (NIV):** 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.

DOPS are separated into two categories of ***routine*** and ***potentially life-threatening*** procedures, with a clear differentiation of formative and summative sign off. Formative DOPS for routine and potentially life threatening procedures should be undertaken before doing a summative DOPS and can be undertake as many times as the trainee and their supervisor feel is necessary.

The following procedures are categorised as *routine* and require summative sign off on **one occasion with one assessor to confirm clinical independence.** The relevant syllabus section is given in brackets for reference:

- **TENS application** [2.7]
- **Management of spinal lines** [2.7]*
- **Passing the nasogastric tube**[2.8]
- **Management of tracheostomy**[2.9]
- **Management of non-invasive ventilation**[2.9]
- **Syringe driver set up** [2.13]
- **Care of peripherally inserted central catheters and Hickman lines** [2.13]

*CMT procedural competency must be maintained

The following procedure is potentially life threatening and therefore requires DOPS summative sign off on **two occasions with two different assessors (one assessor per occasion):**

- **Paracentesis** [2.8]

**Other requirements**
**BLS**: can be online. If not achievable for 2020 ARCP, ensure evidence of valid BLS in previous years
**MSF**: will accept MSFs with fewer than minimum number of assessors in 2020

**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 (R) or Potentially Life Threatening (PLT) Procedure | Number of Assessors Required | Additional Comments |
|---|---|---|---|---|---|
| **2010 Curriculum with 2013 amendments** | TENS application (1) | Summative | R | 1 | |
| | Paracentesis (2) | Summative | PLT | 2 | Two different assessors. For a ST6 trainee that is not able to complete a 2nd DOPS with a different assessor, the ES should comment in the ESR whether there is sufficient evidence across training to demonstrate competence in procedure |
| | Syringe driver set up (1) | Summative | R | 1 | |
| | Passing a nasogastric tube (1) | Summative | R | 1 | |
| | Management of spinal lines (1) | Summative | R | 1 | For ST6 trainee, assessment in a skills lab or simulation setting is acceptable. If this is not possible, the ESR should outline the experience gained by the trainee across duration of training to demonstrate that the trainee has achieved sufficient competence in this area |
| | Management of NIV (1) | Summative | R | 1 | For ST6 trainee, assessment in a skills lab or simulation setting is acceptable. If this is not possible, the ESR should outline the experience gained by the trainee across duration of training to demonstrate that the trainee has achieved sufficient competence in this area |

| | | | | | |
|---|---|---|---|---|---|
| | Assessment of tracheostomy(1) | Summative | R | 1 | For ST6 trainee, assessment in a skills lab or simulation setting is acceptable. The ESR should outline the experience gained by the trainee across duration of training to demonstrate that the trainee has achieved sufficient competence in this area |
| | Care of PICC/Hickman lines (1) | Summative | R | 1 | |
| | | | | | |