Guidance for using Direct Observation of Procedural Skills in Surgery (Surgical DOPS)

Summary and overview

Direct Observation of Procedural Skills in Surgery (Surgical DOPS) is one of a number of assessments used in the clinical setting to help the teaching and assessment of a clinical skill in the workplace. In common with the other Workplace-Based Assessments (WBAs), its primary purpose is to provide structured teaching and feedback in a particular area of clinical practice. Surgical DOPS is applicable to short, diagnostic and interventional procedures, or part procedures, that comprise relatively few steps. It will be found most useful during the early years of surgical training. The counterpart of surgical DOPS for use with more substantial, operative procedures is the Procedure Based Assessment (PBA).

The assessment involves an assessor observing the trainee performing a practical procedure within the workplace. The assessor's evaluation is recorded on a structured form which is used by the assessor to provide the trainee with structured feedback.

Surgical DOPS can be used routinely every time a trainee performs, under supervision, one of the technical procedures listed in the surgical syllabus. The aim should be to make the exercise part of routine surgical training practice.

Each Surgical DOPS assessment forms contributes to the trainee's portfolio and helps inform the report of the Assigned Educational Supervisor (AES) at the completion of each placement.

Acknowledgement: The DOPS method is a surgical version of an assessment tool originally developed and evaluated by the UK Royal Colleges of Physicians and used in the Foundation Programme.

Surgical DOPS in the context of workplace-based assessment

A number of WBAs have been designed and made available for use during surgical training. Taken as a whole, there should be a WBA that will suit every training situation. For example: DOPS for short procedures or part procedures; CEX for directly observed clinical consultations; CBD for probing the clinical reasoning abilities of the trainee and so on. It is important that their purposes and *modus operandi* are understood. They should not be used in a mechanistic way. First and foremost, they should stimulate the assessor to observe all the aspects of the practice of the trainee and in so doing to gain adequate insights into the specific training needs of each trainee. Therefore, these WBAs are assessments *for* learning.

Towards the end of each placement the AES will use his/her knowledge of the trainee, the views of fellow consultant trainers and the training portfolio (of which the accumulated WBAs are a part) to form a judgement as to the overall progress achieved by the trainee. The annual review panel will use the evidence in the training portfolio, particularly the AES report to inform their decisions.

Who should assess Surgical DOPS?

The trainee should be evaluated on several different occasions by different assessors. Clinical Supervisors and other consultants, senior trainees and other healthcare professionals should be encouraged to assess as this improves reliability. The AES should be one of the assessors during each placement.

Assessors should know how to use the Surgical DOPS and be expert in the clinical problem/task. Assessors need not have prior knowledge of the trainee and in some instances it may be important that they do not. In general, however, assessments of this kind will be carried out by the trainers since they provide useful insights on the training that is required.

When and how often should Surgical DOPS be carried out?

Given the great variation in the rate of progress between individuals, absolute numbers of individual assessments are not prescribed. In clinical practice a number of observed activities, even if completed to a satisfactory level, are insufficient if not underpinned by adequate experience.

As a guide, a minimum of 40 WBAs (not including those done in a simulated setting) should be conducted throughout each year of Core Surgical Training of which there should be a minimum of 10 Surgical DOPS (or PBAs). The overall number should be agreed between the trainee and the AES in each placement and should be based on individual trainee need.

During piloting, it was found that surgical DOPS could be used almost routinely during any training session, without significant disruption of work schedules. Surgical DOPS can be used to assess the competence of a trainee to perform a procedure, and to provide feedback when learning a new procedure, Demonstration of progression should normally precede achievement of competence.

Ideally, trainees and assessors should use the assessment instruments during every training exercise i.e. at every possible opportunity. The great benefit of WBAs such as the Surgical DOPS is that by obliging the trainer to review the performance of the trainee across the full range of components involved in a procedure, a comprehensive picture of the trainee's strengths and weaknesses can be obtained and kept under review during the whole placement.

The GMC has not accepted the proposal for minimum specified experience in terms of numbers and it will be a matter of judgement for assigned educational supervisors and annual review panels to determine whether the experience element is sufficient when signing off their reports.

Using the Surgical DOPS

The trainee's Learning Agreement should indicate which Surgical DOPS are required. Ideally, there should be evidence of competence in at least three different procedures within each year.

Patient safety and well-being remain paramount throughout. The assessor supervising the procedure should ensure that the patient is informed, has provided consent for the exercise and suffers no increased risk or discomfort. The supervisor retains responsibility for patient care throughout and will intervene as the situation requires.

The assessment may be initiated by the trainee or the trainer, but since there will usually be a number of trainers/assessors involved during each placement, it remains the responsibility of the trainee to take a proactive approach and to ensure that sufficient exercises are completed. The encounter should be representative of the trainee's workload.

The assessor should observe the trainee undertaking the procedure and doing what they would normally do in that situation. Most procedures should take no longer than 15-20 minutes.

Completing the form

The online form must be completed. For convenience, a printed version of the assessment form can be used during the session after which the trainee must transpose the assessment in his/her electronic learning portfolio. The assessor must validate the assessment online in order for the assessment to be considered completed. If used, a copy of the paper form should be kept by both parties as a means of recalling the note of the discussion.

- **Feedback**

Feedback should take about 5-10 minutes. It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive. The assessor should summarise the feedback given together with agreed actions.

It must be emphasised that the most important purpose of the assessment exercise is to provide the trainee with formative feedback (i.e. information that forms and develops the trainee's practice), offering a significant impact on learning.

Ratings are used only for the purpose of identifying strengths and weaknesses and providing accurate feedback on that performance. Assessors should expand on the reasons for any ratings of *Development required* and make practical suggestions for any remedial steps if it is felt that the rate of progress is insufficient.

In this connection, it should be borne in mind that the AES has the facility to make substantial changes to the clinical timetable and sessional exposure that a trainee has during a placement, if it is deemed in the best interests of the trainee. It is expected that the clinical supervisors in any one placement work as a team and if an assessor, trainer or trainee feels that any such change might be indicated, then this should be brought to the notice of the AES at the earliest opportunity.

It is essential that trainees reflect on feedback and take a proactive approach to improving their practice.

- **Name of the procedure**

The trainee or assessor should complete the name of the procedure

- **Number of times procedure performed by trainee**

The assessor should ask the trainee for his/her estimation/logbook.

- **Difficulty of procedure**

The assessor should rate the difficulty of the procedure according to the stage of the trainee.

Definition of *Easier than usual:* uneventful procedure without any of the commonly encountered problems or variations.

Definition of *More difficult than usual:* unexpected problems, unrelated to the expertise of the trainee

- **Using the scale**

Each item should be rated, N *(not observed or not appropriate)*, D *(development required)*, or S *(satisfactory standard for completion of early years / core surgical training (initial stage), with no help or prompts required).*

- **Item 6 (performs the technical aspects in line with the guidance notes)**

One overall score is given for the technical aspects of the procedure (not for each of the technical steps). The Trainee/Trainer Guidance Points should to be used to inform the rating given for item 6.

- **Global summary**

If the trainee was observed by the assessor to have completed the entire procedure, a global statement should be chosen from the four levels shown.

The statements relate to the extent of supervision the trainee was seen to require in that procedure on that occasion. In order to achieve a global level 4b for an entire procedure, most (but not necessarily all) competencies should have been rated as satisfactory. Achieving a level 4b on one occasion does not confirm that the trainee is competent to perform that procedure unsupervised. This judgement will require repeated assessments by more than one assessor.

Each assessment is not a pass or fail event, nor does it award a ‘licence’ to practise without assistance or direct supervision: that remains the prerogative of the supervisor, who has responsibility for patient care. The decision to permit a trainee to perform a procedure without supervision will depend on evidence from a number of Surgical DOPS assessments of a sufficient standard (level 4b). The number required to inform that decision will depend upon many factors, including the complexity of the procedure and the experience of the trainee. The evidence provided by the trainee’s logbook complements the process.

- **Assessor details**

The assessor should complete all his/her details indicated which may be used as a means of validation.

The standards to be applied to Surgical DOPS assessments

The assessment should be judged against the standard expected at completion of early years/core surgical training (initial stage), defined in the syllabus.

Trainees should record all assessments in the electronic portfolio including those they regard as unsatisfactory. At the start of a stage it would be normal for trainees to have some assessments which are less than satisfactory because their performance is not yet at the standard for the completion of that stage. In cases when assessments are less than satisfactory, trainees should repeat assessments as often as required to show progress.

One of the purposes of the assessment is to demonstrate to trainees and their AES that they are maintaining progress during the placement and that they are on course to reach the standard required by the syllabus and their learning agreements for successful completion of the stage.

The completion standards are as follows:

1. **Describes indications, anatomy, procedure and complications to assessor:**
   Clearly explains to the assessor the indication for the procedure, the relevant anatomy and essential steps of the procedure.

2. **Obtains consent, after explaining procedure and possible complications to patient:**
   Conveys information that is complete, relevant, clear and jargon-free; is sensitive to patient's concerns, respects confidentiality, actively listens, answers questions correctly and checks patient's understanding before obtaining consent; establishes trust.

3. **Prepares for procedure according to an agreed protocol:**
   Demonstrates clear pre-operative plan, identifies any special equipment required, makes all relevant safety checks, briefs other staff appropriately.

4. **Administers effective analgesia or safe sedation (if no anaesthetist):**
   Selects appropriate local anaesthetic agent (or sedative) and checks with nursing staff; injects appropriate volume using the correct needle and technique.

5. **Demonstrates good asepsis and safe use of instruments and sharps:**
   Supervises and follows high standards of aseptic operative technique; handles instruments and sharps safely.

6. **Performs the technical aspects in line with the guidance notes:**
   Follows the protocol for the procedure, demonstrates good technique; uses instruments appropriately, handles tissue gently, controls bleeding appropriately, sutures skin neatly and atraumatically. See Trainee/Trainer Guidance Points for the procedure.

7. **Deals with any unexpected event or seeks help when appropriate:**
   Anticipates and responds calmly and appropriately, communicates clearly and consistently with patients and staff, uses assistants to best advantage, has awareness of own limitations.

8. **Completes required documentation (written or dictated):**
   Makes clear and legible notes which enables effective care by other practitioners.

9. **Communicates clearly with patient & staff throughout the procedure:**
   Makes a post-operative assessment; conveys relevant information orally and in writing; retains responsibility for the patient's ongoing care.

10. **Demonstrates professional behaviour throughout the procedure:**
    Demonstrates respect, and understanding of the patient's needs for comfort, respect, and confidentiality; demonstrates an ethical approach, and awareness of any relevant legal frameworks.

KEY POINTS

Summary of the method

- Formative method designed to provide adequate insights into the specific training needs of the trainee
- Observed short, diagnostic and interventional procedures during routine surgical practice
- Covers patient safety, preparation, operative technique, communication and documentation
- Available for most index procedures in core training
- As training progresses and operative procedures become more relevant, Surgical DOPS are superseded by Procedure-based Assessment (PBA) for the index procedures for each specialty

Minimum number of assessments per year

- Six in each year of early years/core surgical training (initial stage) in at least three different procedures. Three placements of four months equates to at least two assessments per placement. Two placements of six months equates to at least two assessments per placement. It is recommended that, surgical DOPS are used as frequently as possible.
- The number of Surgical DOPS in higher specialty training will depend on the specialty and stage of training.

Who should assess Surgical DOPS?

- The current Assigned Educational Supervisor must be one of the assessors
- Consultant clinical supervisors, specialty registrars, staff grades and other health care professionals who are expert in the clinical problem/task and who have been trained in objective assessment and giving feedback.
- Assessors do not need to have prior knowledge of the trainee.

Time needed

- Observation will be as long as the procedure itself plus about 15-20 minutes to complete the form
- 5-10 minutes for debriefing and feedback

Appropriate assessment settings

- A&E
- Theatre
- Out-patients
- Ward