2018

Competence, Curriculum and Governance Framework for Physician Associates at ELHT



Oct 2020

# Contents

[Glossary 3](#_bookmark0)

[Executive Summary 6](#_bookmark1)

[Introduction 7](#_bookmark2)

[Background 7](#_bookmark3)

[Physician Associates as part of the Medical Workforce 7](#_bookmark4)

[The Role of the Physician Associate 8](#_bookmark5)

[Employing a Physician Associate 9](#_bookmark6)

[Pre-employment considerations 9](#_bookmark7)

[Salary 9](#_bookmark8)

[Employing an experienced PA in a new specialty or a US PA 10](#_bookmark9)

[Governance structures for Physician Associates 10](#_bookmark10)

[The FPA 10](#_bookmark11)

[United Kingdom and Ireland Universities Board for Physician Associate Education](#_bookmark12) [(UKIUBPAE) 11](#_bookmark12)

[PAMVR 11](#_bookmark13)

[Regulation 12](#_bookmark14)

[Core Competencies and Procedural Skills 12](#_bookmark15)

[Core procedural skills 13](#_bookmark16)

[Training pathway for extended skills 13](#_bookmark17)

[Proposed Induction Process 14](#_bookmark18)

[Review Meetings and Appraisals 15](#_bookmark19)

[Assessments 15](#_bookmark20)

[Current limitations of the PA role 16](#_bookmark21)

[Ionising radiation 16](#_bookmark22)

[Prescribing 16](#_bookmark23)

[Supervision, Support and Continuing Professional Development (CDP) 16](#_bookmark24)

[Supervision 16](#_bookmark25)

[Appraisal 16](#_bookmark26)

[CPD 17](#_bookmark27)

[Recertification 17](#_bookmark28)

[Career development 18](#_bookmark29)

[References and useful resources 18](#_bookmark30)

[Appendix 1: Student PA Training Programme 19](#_bookmark31)

[Competence on qualification 19](#_bookmark32)

[The assessment of competence 19](#_bookmark33)

[Criteria for entry to the programme 20](#_bookmark34)

[Major entry groups 20](#_bookmark35)

[Other entry routes 21](#_bookmark36)

[The structure of the PA programme 21](#_bookmark37)

[Overall length of the programme 21](#_bookmark38)

[The educational aims of PA programmes 21](#_bookmark39)

[Clinical experience in the programme 22](#_bookmark40)

[Core theoretical knowledge 23](#_bookmark41)

[Learning partnerships 24](#_bookmark42)

[Accountability and supervision 25](#_bookmark43)

[Principles of learning and teaching 25](#_bookmark44)

[Roles of assessment 26](#_bookmark45)

[Criteria for assessment and standard setting 27](#_bookmark46)

[Progression 27](#_bookmark47)

[National assessment and initial certification 28](#_bookmark48)

[Appendix 2: Core Competencies and Procedural Skills 29](#_bookmark49)

[Specification of core competences 29](#_bookmark50)

[Specification of core procedural skills 32](#_bookmark51)

[Appendix 3: Transitioning from Qualification through 12 months post qualification 34](#_bookmark52)

[Appendix 4: Assessment Forms 36](#_bookmark53)

[Appendix 6: Feedback Forms 45](#_bookmark54)

[Colleague multi source feedback (MSF) extended questionnaire 45](#_bookmark55)

[Patient feedback questionnaire 46](#_bookmark56)

[Appendix 7: FAQs: PAs in secondary care 47](#_bookmark57)

[What level of doctor is a PA equivalent to? 47](#_bookmark58)

[How do trainees feel about PAs entering the medical workforce? 47](#_bookmark59)

[How do trusts fund posts for PAs? 47](#_bookmark60)

# Summary

1. A Physician Associate (PA) is defined as someone who is a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical team under defined levels of supervision, with a role designed to supplement the medical workforce.
2. Following completion of initial training, all students undertake a 12 month internship programme designed to consolidate their core knowledge and skills and demonstrate competence in action. It also provides an opportunity for students to undertake additional learning of relevance to the field in which they are practicing.
3. Although Physician Associates will acquire more specialist knowledge of relevance to their field, they are all required to maintain the same basic level of general competence across the whole scope of PA practice that is tested by the National Assessment.
4. To ensure that they do so, they are required to undertake a recertification exam similar to that taken at qualification every 6 years in order to remain on the register. CPD (PAs are required to demonstrate that they have met the minimum for CPD through each two- yearly cycle) is therefore likely to have a dual focus on maintenance / updating of core knowledge and development of new and more specialised skills and knowledge. At present, there is a PA managed voluntary register (PAMVR) held by the professional body (UKAPA) and overseen by an independent commission.
5. Physician Associates do not currently have prescribing rights nor can they request ionising radiation. PAs are unable to obtain consent from patients for operative procedures which require anaesthesia.
6. The format that this training and supervision takes will vary according to the procedure; however, it is highly recommended that a Directly Observed Procedural Skills (DOPS) assessment is used to record the supervised elements, and documented in a personal development record (these are available from the FPA website).
7. The Trust must ensure suitable governance around the practice of each extended skill. The need for the PA to learn and to provide these skills should form part of a discussion between the supervising consultant(s) and the PA(s). The education directorate has published a proposal form and a log book to be completed by the supervisors and the PA for such procedures and skills.

**Scope**

The framework applies to:

* All PAs working within the Trust regardless of specialty
* All supervisors of PAs
* PA line managers
* The PA Supervisor
* Those working alongside PAs within the multi-disciplinary team

This framework should be read by:

* All of the above
* HR functions
* Training and Development functions

# Background

To enrol on a PA programme, students must already hold an undergraduate degree, usually in a biomedical or health/ life science field, and have some prior health or social care experience.

Most programmes offer a Postgraduate Diploma in PA studies, with some offering a Master’s qualification.

PAs trained in the UK have undertaken postgraduate medical training in PA studies. These studies are spread over a period of at least 90 weeks (approximately 3,200 hours, divided into 1,600 hours of theory and 1,600 hours of clinical practice). This is an intensive 2-year course based on the Competence, Curriculum and Governance Framework for Physician Associate, consisting of theoretical learning in medical sciences, pharmacology and clinical reasoning, as well as clinical placement experience in a wide variety of settings, including:

* acute and emergency medicine
* community medicine
* surgery
* obstetrics and gynaecology
* paediatrics
* mental health.

All students must pass their university programme prior to sitting the PA national examination, which is required for entry into professional practice, and must be taken by every PA in the country, regardless of which programme they have passed. The exam sets the standards for PAs across the country and is designed, developed and administered by the Faculty of Physician Associates (FPA). It consists of 200 single best answer questions (MCQ style) and a 14-station objective, structured clinical examination (OSCE). Once a PA has passed both their university exams and the PA national examination, they are qualified and fit to practise as a PA. Detailed information about the Student PA training programme can be found at <https://www.fparcp.co.uk/employers/guidance>

# Physician Associates as part of the Medical Workforce

With the continuing increase in the overall size of the population and in particular the rise in the numbers of elderly people, the demand on services of the NHS will continue to increase.

Meanwhile, the European Working Time Directive has reduced the numbers of doctor hours available to provide medical care. As a consequence, many Trusts have been forced to take on locum doctors at great cost and offering limited continuity of care.

Not all medical care has to be undertaken by doctors. Over the last decade, the scope of practice of many health care practitioners in the National Health Service has expanded to include roles and tasks that were previously the reserve of the medical profession. Whilst all the evidence would suggest that this has generally been achieved without reduction in the efficacy with which those tasks have been carried out, there is a limit to which this approach can be taken without seriously diminishing the resource available for nursing, physiotherapy and other specialties.

In a situation in which the demand on all the established health professions will be increasing, the development of the PA offers a potential means of meeting the increased requirement for medical care without further reducing the resource available for the fulfilment of the vital roles of the other health professions.

# The Role of the Physician Associate

#### A PA is new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.

As a result of their training a PA can:

* formulate and document a detailed differential diagnosis having taken a history and completed a physical examination
* work with patients and, where appropriate, carers to agree a comprehensive management plan in light of the individual characteristics, background and circumstances of the patient
* maintain and deliver clinical management in collaboration with the patient and on behalf of the supervising physician whilst the patient travels through a complete episode of care
* perform diagnostic and therapeutic procedures and prescribe medications (subject to the necessary legislation)
* request and interpret diagnostic studies and undertake patient education, counselling and health promotion.

The Physician Associate role provides a new way of working that will complement roles already developed in primary and secondary care and strengthen the multi-professional team. A Physician Associate will always work under the supervision of a designated senior doctor (consultant, ST3+ or general practitioner). Their detailed scope of practice in a given setting is circumscribed by that of the supervising doctor. Although there may be circumstances when the supervising doctor is not physically present, they will always be readily available for consultation. Like all other regulated healthcare professionals the PA is responsible for their own practice though the supervising doctor always maintains the ultimate responsibility for the patient.

In addition, typical roles carried out by PAs in the secondary care setting include:

* attending ward rounds with junior doctors and consultants
* working in acute assessment (in the emergency department or on call)
* providing in- or out-of-hours ward cover
* working in outpatient clinics – seeing patients under supervision
* assisting first or second in theatre
* taking part in audit/quality improvement work.

The PA will always act within a predetermined level of supervision and within agreed guidelines. It is expected that over time the supervisory relationship with a named doctor will mature and whilst the doctor will remain in overall control of the clinical management of patients, the need for directive supervision of the Physician Associate will diminish.

Qualified PAs may develop specialist expertise that reflects the specialty of their supervising doctor. This will be gained through experiential learning and CPD. However, they are expected to maintain their broad clinical knowledge base through regular testing of generalist knowledge and demonstrated maintenance of generalist clinical skills.

# Employing a Physician Associate

It is imperative for employers to ensure that the role and remit of a PA are what is needed by your team, so that you do not employ a PA where an alternative healthcare professional would be better suited (e.g. an advanced clinical practitioner, doctor, or other healthcare professional).

The job plan for a PA working in secondary care will depend on the reason for their employment. Typical reasons for employing a PA in secondary care include:

* ensuring a level of continuity and added value at ward level
* the need for a permanent staff member (while most medical staff rotate)
* enhancing clinic services
* increased regular theatre support.

There must be a clear job plan to allow both employer and PA to understand what is expected of them. The job plan should indicate hours of work, opportunities for development and required duties. Newly qualified PAs or those moving from one specialty to another will need more close supervision, and so the job plan will need to allow for regular reviews with their supervisor.

The PA will be employed as a member of the clinical team in secondary care and will have a clinical supervisory relationship with a named doctor, who will provide clinical guidance when appropriate. The PA will always act within a predetermined level of supervision and within agreed guidelines

The benefits of employing PAs are realised over a period of time, as the relationship between the PA and their clinical supervisor develops. Therefore, it is important to ensure that the job being advertised allows for variation in daily work and for opportunities to develop. The employer should provide the PA with opportunities for study leave to attend training courses, to help them maintain their requirement for CPD and recertification (see Supervision, support and continuing professional development section (p16)).

### Pre-employment considerations

#### Qualifications and professional registration

To be appointed to a post, a PA must have successfully passed the final examinations of a recognised PA course in the UK or USA, and have successfully sat the UK PA national examination. Evidence of this must be provided and checked at interview. They must also be registered on the Physician Associate Managed Voluntary Register (PAMVR), which should be checked prior to appointment, and reviewed each year at appraisal. US-trained PAs are required to have, and maintain, their certification by the National Commission on Certification of Physician Associates (NCCPA) in order to work in the UK.

#### Indemnity arrangements

In secondary care, the current practice of PAs is covered by the Department of Health 2012 Clinical Negligence Scheme for Trusts (CNST). Qualified PAs are strongly recommended to have their own personal professional negligence insurance, which can be arranged through Medical and Dental Defence Union of Scotland (MDDUS).

### Salary

This is dependent on the skills and experience of the PA. In secondary care, the PA post has been evaluated under the Agenda for Change at band 7. Agenda for Change contracts are based on 37.5 working hours per week and job plans should be based on this. Additional payment would be required for working out of hours or at weekends. Recently graduated PAs are employed at band 6, but give more support and supervision in the first year of practice. On completion of their first year, these PAs then move up to band 7. Another suggested option is to employ recently qualified PAs for a few months at band 5 with support in place to have them “practice ready” within that time frame. There is an expectation that such PAs would continue to a band 6 post within the trust and then follow the schedule above.

All Agenda for Change staff undergo a period of six months’ probation. The designated line manager must ensure a review prior to completion of the probation period. If the PA has failed to achieve the required levels which are satisfactory to undertake the PA role then that would be a reason to call a probationary hearing to potentially dismiss the person for failing their probationary period, following usual Trust protocol. Alternatively, the probationary period may be extended if there are extenuating circumstances.

#### Interviewing

An interview should seek to understand the current level of practice of the PA, as well as their background and experience. It should also seek to understand the personal development plan of the PA. If possible, it is useful to include a qualified PA in employment on the interview panel.

### Employing an experienced PA in a new specialty or a US PA

Entering a new specialty as a PA initially necessitates more supervision and guidance from the supervising doctor. PAs who may have been practising for several years in varying areas of medicine or surgery will undoubtedly have picked up a breadth of skills and knowledge.

However, there will be new skills and procedures to be learned and knowledge to be gained, therefore it may be appropriate to follow a review timetable, similar to a PA in their first year of qualification. However, an employer should once again assess their knowledge and skills – this steep learning curve may be much shorter in duration than for a newly qualified PA.

If you have an experienced US PA, they too will need time to bed into the system and get used to the way the NHS works, systems and processes, culture and differences in language, medications and guidelines for treatment.

# Governance structures for Physician Associates

There are several organisations that facilitate the functioning and growth of the PA role in the UK.

### The Faculty of Physician Associates

The FPA is focused on campaigning for progress and change in the profession (including regulation), as well as offering advice to the government and taking part in national debates on medical, clinical and public health issues. The essential work-streams of the FPA are around:

* education and training
* examinations (both national and recertification)
* professional conduct (including the PAMVR).

The FPA will continue to manage the PAMVR until the profession achieves statutory regulation. Employers and users of healthcare services, including patients and relatives, can check whether a PA is on the PAMVR by contacting the FPA or by accessing the register on the FPA website.

**The Physician Associate Managed Voluntary Register**

PAMVR is a register of fully qualified physician associates who have been declared fit to practise in the UK. The PAMVR is held by the FPA and it allows supervisors and employers to check whether a physician associate is qualified and safe to work.

By managing the PAMVR, the FPA:

* ensures patient safety
* sets standards for postgraduate education and development
* advances statutory regulation for physician associates.

The physician associate profession is not yet subject to statutory regulation, so the PAMVR is a vital development in ensuring patient safety.

The register has a code of conduct and a scope of practice for PAs, and standards for education, CPD and recertification for the profession. The PAMVR also has a fitness to practise mechanism, whereby concerns raised about a PA may be investigated and acted upon. PAs who are on the

PAMVR may add the letters ‘PA-R’ as a postnominal to demonstrate that they are currently on the register and have signed up to maintaining high standards of practice.

**United Kingdom and Ireland Universities Board for Physician Associate Education (UKIUBPAE)**

The UKIUBPAE evolved out of the Higher Education Steering Group, which followed the successful certificate level pilot programmes. Members of this group are drawn from all the PA education programmes in the UK. The remit of the board is to:

* develop the education of PAs in the UK
* advance and support academic governance
* continually improve education standards.

**Regulation**

The aim of the FPA is to support the educational and professional development of PAs, and thereby enhance patient safety, as well as providing resources from the RCP. The FPA is a national body, with standards that apply across the UK.

In the UK, the FPA and RCP are consistently campaigning for statutory regulation for PAs, both publicly and behind the scenes. The Government and the Department of Health are considering regulation in order to provide a legally accountable framework for patient safety, set standards for the profession, protect the PA title, and ensure fitness to practise. While such standards are already in place for PAs in the UK, overseen by the FPA, they cannot be legally enforced without statutory regulation.

While work towards statutory regulation is underway, the decision regarding an eventual registering body for PAs will be made by the government. All UK-based PAs are therefore strongly encouraged to join the PAMVR, as it will form the initial list of PAs to enter a statutory register when established.

The RCP and the FPA, HEE and the higher education institutes involved in training PAs continue to work towards regulation of the profession and the establishment of a statutory register. Once this is in place, the title ‘physician associate’ will become protected, and only those on the statutory register will legally be allowed to practise as a PA.

# Induction Process

Following appointment it is proposed that the PA will go through the following induction process:

1. Trust Mandatory Induction
2. Directorate Induction
3. Specialty Induction

It is also recommended that they undertake a two day ward based clinical induction which will supplement that provided on the specialty induction, this will ensure a familiarity with the day to day workings of their base ward. In addition, the PA should undertake all appropriate mandatory training.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Day** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| AM | Trust Induction | Trust Induction | Divisional Induction | Ward based clinical induction | Ward based clinical induction |
| PM | Trust Induction | Trust Induction | Specialty induction | Ward based clinical induction | Ward based clinical induction |

They will also be required to do Intermediate Life Support (ILS) training at the earliest opportunity, if they have not already done so.

In addition, the PA will meet with their designated clinical supervisor who will need to discuss the following areas with them:

1. Scope of clinical work ( this has to be seen within the context of the supervising consultant’s clinical practice)
2. Mandatory teaching
3. Appraisal process and review meetings (see table 2; page 14)
4. Supervised Learning Events – DOPS, CbDs and Mini-CEX (see table 2; page 14)
5. Datix reporting

# Supervision

PAs are dependent practitioners and will always work under the supervision of a designated doctor. Their detailed scope of practice in a given setting is circumscribed by that of the supervising doctor. Although there may be circumstances when the supervising doctor is not physically present, they will always be readily available for consultation. The supervision requirements will vary from individual to individual and is dependent on a number of factors including, but not limited to, their past health care experience and years of experience as a PA. A new graduate, or those moving from primary to secondary care, will require more intensive supervision compared to an experienced PA.

Like all other regulated healthcare professionals, the PA is responsible for their own practice, although the supervising doctor always maintains the ultimate responsibility for the patient. It is the division’s responsibility to provide a supervisor for each PA employed.

The PA will be employed as a member of the clinical team in secondary care and will have a clinical supervisory relationship with a named doctor, who will provide clinical guidance when appropriate. The PA will always act within a predetermined level of supervision and within agreed guidelines.

Qualified PAs may develop specialist expertise that reflects the specialty of their supervising doctor. This will be gained through experiential learning and CPD. However, a PA is expected to maintain their broad clinical knowledge base through regular testing of generalist knowledge and demonstrated maintenance of generalist clinical skills.

**Accountability of Supervising Consultant**

PAs are able to practice in the UK as a result of a clause within the British General Medical Council's Guidance on Good Medical Practice. (British General Medical Council's guidance on Good Medical Practice 2013

[www.gmc-uk.org/guidance/good\_medical\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp))

“*Delegation involves asking a colleague† to provide care or treatment on your behalf. When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised.*  *When you delegate care you are still responsible for the overall management of the patient*.”

Although individual PAs are accountable for their work practice within the boundaries of supervision and defined scope of practice, their supervising consultants are accountable for their overall work and must accept responsibility for any duties undertaken by a PA in training or a qualified PA. On this basis doctors must determine the scope of duties and responsibilities of the PA on the basis of known competence within the relevant area of practice and demonstrated competence for practical procedures (see section 3.12 Gaining Extended Skills).

# Review Meetings, Assessments and Appraisals

The supervisor should meet with the PA in their first week as part of the induction process, and assess their skills and knowledge around hospital medicine. This assessment can then be used to design a structured programme of specific educational goals that will be reviewed on a 3–6- monthly basis, and appraised at the yearly review. The onus is on the PA to make arrangements with their clinical supervisors to schedule their review meetings.

Table 2 gives the numbers and timings of assessments in the first year

### Assessments

Physician Associates are required to undertake a number of supervised learning events: Case Based Discussions(CbD)/Mini-Clinical Examinations (Mini-CEX) and Direct Observation of Procedural Skills (DOPS). Table 2provides a timeline for the completion of these assessments in the preceptorship year. The assessment forms be found at: <https://www.fparcp.co.uk/your-career/resources>

**Table 2:Timeline for meetings and assessments during preceptorship year**

|  |  |  |  |
| --- | --- | --- | --- |
| **Timing** | **Number of CBD/Mini- CEX/DOPS** | **Date** | **Signed as Complete** |
| Commencement Meeting | N/A |  |  |
| 3 months | 3x CBD, 3x Mini-CEX, 3x DOPS |  |  |
| 6 months | A further 3x CBD, 3x Mini-CEX, 3x DOPS |  |  |
| 1 year | An overall total of 8x CBD, 8x Mini-CEX, 6x DOPS |  |  |

PAs should also have access to experiential learning in the clinical areas in which they are working, and should maintain a portfolio of cases and case discussions with clinicians, reviewed with their clinical supervisor. It is recommended that they undertake reflective practice and record this in a clinical diary/portfolio.

**Table 3. Recommendations for review meetings following the preceptorship year**

|  |  |
| --- | --- |
| **Year 2** | |
| 6 monthly review | 3 x CBD, 3 x MiniCEX |
| Yearly appraisal | 6 x CBD, 6 x MiniCEX |
| **Year 3** | |
| 6 monthly review | 1 x CBD, 1 x MiniCEX |
| Yearly appraisal | 2 x CBD, 2 x MiniCEX |
| **Year 4 onwards** | |
| Yearly appraisal | 2 x CBD, 2 x MiniCEX[SV24] |

PAs should also have access to experiential learning in the clinical areas in which they are working, and should maintain a portfolio of cases and case discussions with clinicians, reviewed with their clinical supervisor. It is recommended that they undertake reflective practice and record this in a clinical diary/portfolio.

**Appraisal**

The Trust requires that all PAs undertake a formal appraisal each year. The appraisal is in addition to the regular review meetings held with their clinical supervisor. The appraisal will be conducted by the Clinical Supervisor. Each PA will be expected to have prepared for the appraisal by completing the appropriate paperwork which reviews the years training and development, clinical and non-clinical activities. It will also be a formal review of miniCexs, CBDs, DOPs and MSF/360 documentation.

The Trust expects each PA to develop a portfolio of evidence throughout the year. The RCP CPD diary can be used as appropriate and a printout of this generated for the appraisal.

Evidence to be collected prior to appraisal includes:

* Current job plan
* Review meeting documentation copies (filed in the PA’s portfolio)
* Certificates of completion of Mandatory and Statutory training
* Personal development plan (review of previous and for the next year)
* MSF/360 – recommended 6 monthly in year one, annual in year two, then 3 yearly thereafter, unless appraisal suggests more frequently.
* Work Place Based Assessments and DOPS

Suggested additional documentation for portfolio:

* Evidence of experience in audit, research and teaching
* Patient and/or staff feedback results. Feedback can be obtained from a variety of Trust resources including Patient Opinion and Your Care Matters providing the PA is named
* Lessons learnt from involvement in a complaint
* At least two reflective pieces of writing

The appraisal provides an opportunity to review development and objectives over the year and set new achievable goals and identify areas for further development. The PA is matched to Trust core values and their overall performance is discussed.

It is the responsibility of the Lead PA and PA Supervisor to ensure adequate support is provided to clinical supervisors and PAs so their development goals can be achieved. The form found at <https://www.fparcp.co.uk/your-career/resources> ( Personal and professional development toolkit for the Physician Associate) should be used and uploaded to the learning hub. There are a number of forms available on the FPA website for PAs and employers to use to supplement the employer’s appraisal documentation including TAB can also be found at <https://www.fparcp.co.uk/your-career/resources>

PAs are required to complete the Knowledge, Skills Framework model of appraisal.

The purpose of the appraisal is to:

* Support the PA in their personal development
* Review the PDP objectives
* Identify any areas for performance development
* Ensure all contractual elements of practice are up to date including:
* mandatory and statutory training is up to date
* status of registration on the PAMVR

# Core Competencies and Procedural Skills

There are a range of core competencies expected of PAs at the point of qualification .These include broad professional competencies, competencies in terms of history taking, physical examination and diagnosis and competence in procedural skills.

A newly qualified PA should be provided with a supportive learning environment, in which they can consolidate and expand their skills and competencies in their chosen field. An overview of what is expected of the PA after a year in post can be found at <https://www.fparcp.co.uk/employers/guidance> (First year post qualification guidance for physician associates and physician associate employers). While a newly qualified PA should be able to deliver service, they will still require training and supervision, as would any new member of staff in a first job.

Initially, a PA will require some structured learning and planned supervision, although with time this should become less necessary, as their skills and knowledge grow and your confidence and trust in the PA and their ability to make good clinical decisions increase.

PAs can perform a variety of functions in secondary care. All PAs have a core set of skills that they will perform on a regular basis as part of their role within the trust, regardless of the specialty in which they work. Core skills include being able to:

* take medical histories
* conduct comprehensive physical examinations
* request and interpret certain investigations
* diagnose and treat illness and injuries
* counsel, or offer preventative healthcare.

The supervising clinician (consultant, specialty doctor or ST3+ – see Supervision (p16) for more information) must ensure that the PA is assigned to a patient who does not exceed their competence or confidence. However, PAs should not be restricted to one category of acuity, and should be encouraged to see a variety of acute and chronic diseases, including resuscitation patients and those with acute deterioration (providing both supervisor and PA are confident and competent to do so).

Ward rounds will be a key activity for most PAs working in secondary care. A PA is able to perform most tasks that a junior doctor would perform on a ward round and can lead the clinical review without direct supervision, providing a qualified and registered doctor is also working in the clinical area, and the supervising doctor is happy for them to do so. This is to ensure that there is not a delay in investigations and prescription of medications, given the current limitations on practice of PAs (see Current limitations of the PA role (pg8)).

PAs may confirm death but may not sign a death a certificate. Guidance for the confirmation of death by a PA can be found in Appendix XXXX

### Core procedural skills

PAs have trained in several core procedural skills (see below), and have been assessed as competent to perform these at qualification. Some of these include:

* venepuncture and blood culture sampling
* cannulation (PAs are expected to use pre-filled and sealed saline flushes when inserting cannulae)
* arterial gas sampling
* catheterisation (male and female)
* peak flow examination
* urine dip stick.

### Training pathway for extended skills

### The Trust expects PAs to acquire these extended skills in a manner that upholds a high standard of care, and to safeguard the patient, practitioner and the Trust.

As part of mutual agreement between a PA and their clinical supervisor, PAs may be trained in a range of extended skills over a period of time. Information on extended skills being undertaken by UK PAs is collected annually by the FPA in its annual census.

These extended skills include:

* ascitic drain insertion or tap
* backslab application
* lumbar puncture
* fracture reduction
* surgical first assisting
* joint aspiration/injection
* nerve blocks
* pleural tap
* incision and drainage of abscesses.

It is recommended that the clinical supervisor works in close collaboration with the newly appointed PA to identify how their career might develop – this activity should take place initially over the first 12/24 months following their starting in the post.

To be trained in extended skills, the PA should receive training from a qualified and competent practitioner in that skill, and then undergo a period of supervised practice. Both the initial training and supervised practice should be documented (see appendix XYZ) and form part of the PA’s work-based yearly appraisal. Competence to continue practising the extended skills should also be reviewed during this appraisal. The format that this training and supervision takes will vary according to the procedure but should include theoretical as well as practical aspects.

The decision to train PAs in a particular skill should be made in consultation with the PA, supervisor and CD of the directorate (or Divisional Director if the skill is to be used in more than one directorate). It should also be discussed at an appropriate governance board. A training package needs to exist or be designed for each skill: this should include both practical and theoretical aspects. The Education Directorate provides a generic pro forma for training in extended skills for PAs which includes a proposal, DOPS forms and a log book.( See appendix Z)

DOPS may be assessed as:

1. Unable to perform procedure
2. Competent to perform procedure under direct supervision
3. Competent to perform procedure with minimal supervision
4. Competent to perform unsupervised and able to deal with possible complications

**Levels of Competency and Supervision Required**

**Table 1** lists the current extended skills practiced by PAs within the UK. Once the number of required DOPS at level 3 is achieved then the PA should be deemed level 4 competent.

If formal training to recognise and manage complications of the procedure has been undertaken, and also the supervising Consultant deems the PA competent to perform extended skills with remote supervision (i.e. the Consultant is not in the room but is aware of the time and location that the procedure is taking place and is available via bleep or telephone) then the PA may be allowed to perform extended scope procedures under remote supervision. PAs can however, deliver local anaesthetic in order to perform extended procedures if it has been prescribed by a prescriber. PAs have been trained to deliver subcutaneous injections and been signed off to do so prior to qualification.

|  |  |
| --- | --- |
| **Procedure** | **Number of level 3 DOPS required** |
| Ascitic drain insertion | 5 |
| Ascitic tap | 5 |
| Arterial Lines | 5 |
| Backslab application | 5 |
| Casting/Splinting | 5 |
| Central Line insertion | 5 |
| Chest drain | 5 |
| Fascia-iliaca blocks with ongoing infusions (#NOF) | 5 |
| FAST scanning | Log book |
| Fetal Heart tones | 5 |
| Fracture/Dislocation reduction | 5 |
| High vaginal swab | 5 |
| Incision and drainage of abscesses | 5 |
| Joint aspiration | 5 |
| Lumbar puncture (diagnostic/therapeutic) | 5 |
| Nerve Blocks | 5 |
| Newborn examinations | 5 |
| NG placement | 3 |
| OGD |  |
| Pelvic Examination | 3 |
| PICC line insertion | 5 |
| Pleural tap (diagnostic/therapeutic) | 5 |
| Pulmonary Lung Function Tests | 3 |
| Psychiatric Assessment |  |
| Relocation of joints | 5 |
| Ring blocks | 5 |
| Skin lesion removal |  |
| Surgical First Assisting |  |
| Suturing | 5 |
| Point of Care Ultrasound | Log book/course |

**Table 1. Examples of extended skills** – **based on current procedures carried out by UK PAs**

Extended skills and the competencies of the Physician Associates performing them will be reviewed at yearly appraisals and documented in their portfolio.

The Trust requires that any additional extended skills not included in the table above be raised with the Head of Advanced Practice Development and Lead PA for consideration. They will be discussed at the Advancing Practice Group (or whatever we are going to call it)

Physician Associates carrying out extended skills are strongly recommended to take out personal professional negligence insurance.

Existing policies may need to be amended to include PAs.

PAs are able to obtain verbal consent for the extended skills listed above, providing that the verbal consent is documented in the medical notes. ***Please note that PAs are unable to obtain consent from patients for operative procedures which require anaesthesia.***

Any capability issues will be managed in line with the Trusts Capability Policy.

# Current limitations of the PA role

#### Due to the lack of statutory regulation, PAs cannot currently prescribe medications or request ionising radiation.

### Ionising radiation

PAs are able to request specific ultrasound examinations providing that the request is justified and directly sanctioned by a supervising clinician who takes overall responsibility for reviewing and acting upon the results of that investigation. The rationale for the request must be clear to the performing and reporting clinician.

As PAs lack statutory regulation they are unable to make requests for ionising radiation (ie. x-rays and CT scans).

The use of ionising radiation has been subject to specific legislation since 1988 which clearly specifies that only registered healthcare professionals are able to order ionising radiation. Even though many PAs have undertaken Ionising Radiation (Medical Exposure) Regulations (IRMER) training they are still unable to make these requests. However, PAs are encouraged to take IRMER training as part of their professional development in anticipation of regulation/registration.

PAs are not able to request Magnetic Resonance Imaging (MRI) due to resource constraints and MRI requests requiring sanction by the responsible Consultant.

### Prescribing

PAs in the UK are currently not able to prescribe medication. This is similar to the situation in the early days of PAs working in the USA.

Close work with supervising physicians, and arrangements developed individually, allow for flexible ways of working and the continuation and expansion of quality patient care.

At ELHT PAs may transcribe medications to the discharge letter to be checked and counter signed by a prescriber. See page AAA

### Preceptorship Year

### The first year after qualification is the preceptorship year, during which the supervision requirements are likely to be highest. The PAs participate in a 12 month Preceptorship programme which involves monthly contact with the clinical education team.

They should have regular meetings with the designated supervisor, as described above and an annual appraisal. During meetings an educational plan should be maintained and agreement made. Frequency of review meetings will depend on the experience of the PA and whether any areas are identified where the PA requires additional support.

### Table 2 provides a timeline for the completion of these assessments in the preceptorship year. The assessments should be recorded in an appropriate portfolio which will be reviewed at appraisal. These will need to be complete in order to progress to band seven following preceptorship. The assessment forms can be found at: <https://www.fparcp.co.uk/your-career/resources>

### Each PA should undertake a DOPS in each of the following skills during their preceptorship year:

### Venepuncture

### IV cannulation

### Arterial puncture in an adult

### Blood culture from peripheral sites

### S/C injection

### I/M injection

### Perform an ECG

### Interpret an ECG

### Perform peak flow

### Interpret Peak flow

### Urethral catheterisation male

### Urethral catheterisation female

### Airway care including simple adjuncts

**Progression from preceptorship**

In order to progress to band 7 at the end of the preceptorship year, the PA will attend a “Year End Assessment” panel where they are expected to demonstrate their progress to the standards set out by the FPA. See Appendix XXX

### Continuing Professional Development

All PAs are expected to maintain their CPD with a minimum of 50 hours annually, as required by the FPA. It is expected that a PA will establish a formal educational needs plan with their supervisor, which will be reviewed on a regular basis. PAs are required to keep an up-to-date CPD diary, which is available as part of the membership of the FPA. It is a mandatory requirement of the MVR to use the RCP/FPA CPD diary and this will be reviewed during scheduled meetings with the clinical supervisor. The CPD activities should meet the needs of the PA’s individual PDP.

CPD Type 1 example activities:

* Standardised courses – e.g. Advanced Life Support (ALS), Immediate Life Support (ILS), ALERT,
* FPARCP conferences
* Courses approved by other organisations eg. Royal College of General Practitioners (RCGP), Royal College of Physicians (RCP), Society for Acute Medicine (SAM)
* Conferences and CPD events approved by FPARCP for Type 1 CPD Credit

CPD Type 2 example activities:

* Teaching students
* Reading journal articles and writing a reflective log
* Undertaking clinical audits
* Reflective case studies
* Lobbying activities on behalf of the PA profession
* Mandatory and Statutory Training

Regional teaching takes place once per month as advertised. PAs should be given time to attend 50% of these.

Opportunities for specialty teaching should be encouraged.

**Study Leave**

PAs have an allowance of 10 days per year in order to attend courses. PAs wishing to take part in additional activities to aid their profession such as examinations and question writing may be granted professional leave at the discretion of their immediate supervisor, providing their portfolio has been maintained and that service provision is not disrupted. Study leave forms must be used in all cases (regardless of where funding originates) and can be found on the Learning Hub.

There is currently no budget specifically for study leave for PAs and applications will be considered on the same grounds all other Agenda for Change employees, alternatively divisional funding may be sought.

Learning needs that are necessary for the safe working of the trust should be documented in the annual learning needs analysis.

**Dedicated Curriculum Mapped Teaching Programme**

The Lead PA is responsible for organising a rolling PA educational programme delivered by different members of the multi-disciplinary team and mapped to the PA curriculum. Clinical Supervisors must be aware that PAs are expected to attend these sessions

Once per month an afternoon of teaching is held within the trust for PAs they are also invited to Advancing Practice Events which occur monthly in the evening.

### Recertification

Although PAs will acquire some specialist knowledge relevant to their field of practice, they are expected to maintain the same level of general competence across the whole scope of PA practice, as tested by the PA national examination and recertification examination.

In line with the Competence, Curriculum and Governance Framework for Physician Associate – and as stipulated by the PAMVR – a PA must recertify every 6 years in order to remain on the register.

PAs are given three attempts to sit and pass the recertification examination, with the first opportunity at the beginning of their fifth year since qualification. If any PA fails the recertification exam on three occasions within the 2-year period, they will be removed from the PAMVR and their employer notified of this change. They will then have to retake the qualifying exam.

**Acute Admissions Experience**

In order to maintain competencies in assessment and clerking unselected acutely presenting illnesses, (except if employed in the Emergency Department where core activities are acute admissions).

As a minimum the PA must take part in unscheduled care activities for one session a week (of at least three hours) during which PAs must have the opportunity to present to the on call Registrar or Consultant. During this session, PAs will have the opportunity to see a variety of cases including resuscitation patients and acutely deteriorating patients providing they are adequately supported. The level of acuity of the patient seen will be determined by the experience of the PA and the consent of the on call Consultant or Registrar. For acutely unwell or unstable patients it is advised that the Consultant or Registrar checks the suitability of patients to be seen by the PA prior to the PA attending the patient

This is in addition to skills in chronic disease management.

### Career development

Most PA careers develop laterally rather than vertically. After 5–7 years, some will be classed as senior PAs; however, career progression for a PA is more closely aligned with the advancement of their knowledge and skills in practice, rather than with time.

Over time, a PA may start to see more increasingly complex patients and take on more responsibility. In secondary care, this may mean seeing patients in clinic or performing advanced procedures. PAs may also be offered management roles, for example in leading audit or service development. Many PAs are involved in activities related to PA education, for example secondment to university PA programmes, or activities related to advancing the PA profession, for example working on sub-committees at the FPA.

**Day to day working for PAs at ELHT**

**Ordering Investigations**

The PAs within the Trust are able to use electronic ordering to request most common and standard blood tests and specialist blood tests under instruction by a senior doctor.

**Transcribing Medication**

There is no current national guidance around PA transcribing but the

“Close work and supervising physicians and arrangements developed individually allow for flexible ways of working and continuation and expansion of quality of care” and “In the hospital setting, PAs are able to write drug charts which require countersignature from a doctor.

PAs are able to transcribe from an earlier inpatient drug chart on a new drug chart or discharge letter. All transcribing must be countersigned by a qualified and registered doctor before the medicine can be administered. PAs must ensure that the doctor is happy to do so and the PA must have presented any essential clinical details to the doctor in advance of the request. If PAs are requesting administration of a medication or advising of a change of management (for example verbally to a nurse), the PA must make it clear that the instruction has come from a named doctor.

When a PA is seeing an acute admission, the PA will be responsible for ensuring that time critical medications/treatments are not delayed as a result of the patient seeing a PA. Initiation of new medication or changes to prescriptions should be made and written by a qualified and registered prescriber.

PAs are unable to transcribe cytotoxic medications or controlled medications.

**Discharge Medication and Discharge Letters**

PAs are able to transcribe medicines from the drug chart onto electronic discharge summaries, providing it is clear that they are the author and that the supervising clinician is satisfied that it meets Trust standards. Discharge medications must be signed for by a qualified and registered doctor and submitted to pharmacy by a registered prescriber. New medicines which are not on the current drug chart must be added by a registered prescriber. PAs must ensure that the countersigning doctor is happy to do so and that all clinical detail has been entered correctly. PAs must not make changes or additions to the discharge medications, nor add items not prescribed on the drug chart.

**Confirmation of Death**

PAs at ELHT are able to confirm a patient’s death and complete the preliminary electronic Mortality Review but are unable to complete the Medical Certificate of Cause of Death or make referrals to HM Coroner. As with all procedures, this should have been observed and signed off with feedback prior to doing this unsupervised. It should also be included in their portfolio as a DOPS.See appx XYZ

**Referrals**

PAs are able to make both written and verbal referrals to other specialties and healthcare facilities. This would be under the direction of the supervising clinician.

**End of Life Care and Do Not Attempt Resuscitation (DNAR) Decisions**

PAs, if asked to do so by the Registrar or Consultant they are working with and provided they are confident to do so, may be involved in discussions with patients and relatives around end of life care and resuscitation but are not authorised to make decisions regarding resuscitation. They can complete a DNAR order providing it is to be immediately countersigned by the responsible senior clinician (Consultant or Registrar). The overall responsibility for the content of the form and ensuring communication of that order remains with the countersigning senior clinician. The PA is responsible for clearly documenting the discussion in the clinical notes.

**Uniform**

At ELHT qualified physician associates are required to wear a uniform while performing clinical duties. This consists of a grey scrub top and navy trousers. This should be provided by the directorate employing the PA. PAs should follow the Trust Uniform/Dress Code Policy

(ELHT/HR77)

**Head PA**

The trust employs one PA as head PA. Their responsibility is to represent the group at appropriate meetings and to feed back to them. They also act as a lead for the group and have responsibilities to arrange local teaching.

**LIFT 2**

The trust is taking part in a pilot named LIFT 2. These PAs are employed job share with a foundation doctor and work across primary and secondary care. Their contract is for two years and they follow the foundation programme.

**Fitness to Practice**

Fitness to practice issues should be raised with the PA’s supervisor and, the Lead who will, in turn, report concerns to the PAMVR. The PAMVR ensures that no PA is placed on the register or remains on the register without demonstrating fitness to practice.

PAs also work to a code of conduct which brings together all sources, e.g. Competence and Curriculum Framework, General Medical Councils’ Good Medical Practice Guide. (see Appendix XUseful Resources)

**Trainee Physician Associates**

The Trust currently supervises PA student placements from University of Central Lancashire PG Diploma course students. The students are learning in various specialties. The range of specialties is expected to increase. Whilst on placement, PA students will be supervised by a named Consultant within each specialty and where possible paired with a working PA to provide mentorship and support, even if that PA does not work within the specialty of the placement. Students will have specific and differing learning objectives. The supervising consultants will be provided with student placement handbooks by the universities prior to the student arriving which should provide all the necessary details. Concerns about the progress of students should be raised with the Department of Undergraduate Education in the first instance who will liaise with the University. Whilst on placement, PA students should work under the scope of practice set out within this policy and within the scope of practice set out by the training university. Student PAs are not permitted to perform any of the extended skills listed in 3.12.

**Student Indemnity**

Indemnity for the work of the PA student is provided by standard NHS Indemnity. We would expect them to be in contact with patients either as an observer only or in a directly supervised role with the supervising doctor retaining responsibility for any patient contact and treatment. PA students are able to see patients without a doctor being present at the time, however. We would not expect students to make independent decisions about the diagnosis or management of patients or to provide specific clinical advice to patients (unless in the presence of the supervising doctor).

Supervising doctors or nurses working alongside student PAs have ethical and legal duties of care to their patients and retain professional responsibility for their patients when they are supervising the involvement of a student. If a patient were to be harmed as a result of a PA student’s involvement in their care, it is most likely that any claim brought would name the supervising doctor.

# 

# Appendix 1:Useful resources

# The documents:

# Who are physician Associates

# Code of conduct for Physician associates

# First year post qualification documentation

# Employers guide to PA

# Competency and curriculum framework

# Matrix of core clinical conditions

# Can be found at <https://www.fparcp.co.uk/employers/guidance>

# The document:

# Personal and professional development toolkit for the physician associate

# Includes CBD, minicex, DOPS and appraisal forms

# Can be found at <https://www.fparcp.co.uk/your-career/resources>

# BMA guidance on Physician Associates:

# <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/physician-associates-in-the-uk>

**Appendix 2**

**End of Year Assessment for Physician Associates in their Preceptorship Year**

In their preceptorship year Physician Associates are allocated a supervisor and Dr C Clark has overall responsibility for educational issues. They are employed at band 6 with the expectation that they will after an appraisal or assessment move to band 7 at the end of that year.

All PAs at ELHT are members of the Faculty of Physician Associates and clear guidance is given by the faculty for employers in the document found at <http://www.fparcp.co.uk/employers/guidance>.

During their preceptorship year the PAs should have regular documented meetings with their supervisor. There are recommended numbers of CBD and minicex. They should have a 360 TAB by 6 months and by 12 months.

Year-end assessment

A meeting should take place between the PA and a panel consisting of (ideally) 2 members. The members should have knowledge of the PA curriculum and experience of working with the PAs. PA supervisors would be ideally suited to this.

Items for discussion

1. Completion of all work place based assessments as per FPA guidance

2. Completion of 360 TAB by 6 months and by 12 months

3. Documented DOPS to include at minimum (this was communicated to the PAs at commencement of contract)

a. Venepuncture

b. IV cannulation

c. Arterial puncture in an adult

d. Blood culture from peripheral sites

e. S/C injection

f. I/M injection

g. Perform an ECG

h. Interpret an ECG

i. Perform peak flow

j. Interpret Peak flow

k. Urethral catheterisation male

l. Urethral catheterisation female

m. Airway care including simple adjuncts (completion of ILS or AIMS)

4. Evidence of CPD with reflection. The FPA recommends 50 CPD points and specifies 25 external. ELHT is seeking ways to provide as much education as possible internally and this is an artificial divide.

5. Evidence achievement of the skills specified in the FPA document by WPBA or reflection

The panel should decide on an outcome. This may be:

1. Internship complete: the PA has provided all evidence required and it is of an appropriate standard
2. Some evidence still required; The PA has provided the majority of evidence but is waiting for completion of assessment forms or has a small number of areas still to complete. In this case a date should be set within 6 weeks for that evidence to be submitted and arrangements made to review.
3. Internship incomplete: The PA has not provided evidence that they have completed or are close to completion of the internship requirements. In this case a date should be set for review within 3 months. There is an expectation that this will be completed by the agreed date, failure to do so may lead to a review of competence for the role

**Appendix 3**

**Checklist for PA End of Year Review**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of PA |  | Date |  |
| Signature |  | | |

**Panel**

|  |  |  |
| --- | --- | --- |
| Name | Signature | GMC number |
|  |  |  |
|  |  |  |
|  |  |  |

1. Completion of all work place based assessments as per FPA guidance

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Achieved | Not achieved | Comments |
| At 3 months | 3 minicex 3 CBD |  |  |  |
| At 6 months | Further 3 minicex and 3 CBD |  |  |  |
| At 12 months | Minimum of 8 Minicex and 8 CBD |  |  |  |

1. Completion of 360 TAB by 6 months and by 12 months

|  |  |  |  |
| --- | --- | --- | --- |
|  | Achieved | Not achieved | Comments |
| 360 at 6 months |  |  |  |
| 360 at 12 months |  |  |  |

1. Documented DOPS to include at minimum (this was communicated to the PAs at commencement of contract)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Achieved | Not achieved | Comments |
| Venepuncture |  |  |  |
| IV cannulation |  |  |  |
| Arterial puncture in an adult |  |  |  |
| Blood culture from peripheral sites |  |  |  |
| S/C injection |  |  |  |
| I/M injection |  |  |  |
| Perform an ECG |  |  |  |
| Interpret an ECG |  |  |  |
| Perform peak flow |  |  |  |
| Interpret Peak flow |  |  |  |
| Urethral catheterisation male |  |  |  |
| Urethral catheterisation female |  |  |  |
| Airway care including simple adjuncts (completion of ILS or AIMS) |  |  |  |

1. Evidence of CPD with reflection. The FPA recommends 50 CPD points and specifies 25 external. ELHT is seeking ways to provide as much education as possible internally and recognises this is an artificial divide.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Achieved | Not Achieved | Comments |
| CPD |  |  |  |

1. Evidence achievement of the skills specified in the FPA document by WPBA or reflection

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | On Completion of  ‘Internship’ | Achieved | Not Achieved | Comments |
| History and  consultation | Able to carry out a thorough  focused history, and be able to  identify appropriate comorbidities, predisposing/risk  factors in order to interpret  most likely differential and  reasons. |  |  |  |
| Examination  general | Supervising doctor has  confidence in PA findings and  in the PA using their clinical  findings to justify the  differential diagnosis. |  |  |  |
| Interpreting  evidence and  investigation | Confidently articulate findings  and investigation results. |  |  |  |
| Clinical  judgment and  risk  management | Identify main diagnosis and  justify reasoning.  Aware of best venue to nurse  patient e.g. ITU versus  medical ward. |  |  |  |
| Therapeutics  and prescribing | Start to justify choice of  medication. Able to  understand the impact of comorbidities and other  medications, poly-pharmacy)  on agent choice and  prognosis.  Confident in explaining to  patients their clinical  management plan and able to  modify plan according to age  and comorbidity. Developing  consultation skills to enable  shared patient practitioner  decision making. |  |  |  |
| Professionalism | Have completed a 360 TAB at  6 and 12 months and  beginning to deal with ‘difficult  patients’.  Be part of training for other  ‘internship’ PAs and/or  teaching PA and other  healthcare students. |  |  |  |

1. Reflections

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Achieved | Not achieved | Comments |
| Reflections | Minimum of two reflections |  |  |  |

**Outcome**

|  |  |  |
| --- | --- | --- |
|  |  | Review date (if required) |
| 1. Internship evidence complete |  |  |
| 1. Some evidence still required. | Remaining evidence to be submitted within 6 weeks |  |
| 1. Internship incomplete | Review planned at later date  (within 3 months) |  |

**Appendix 4**

**GUIDELINES FOR PHYSICIAN ASSOCIATES CONFIRMING DEATH**

A qualified physician associate is able to confirm death, but cannot complete a death certificate.

The recommendations in the document “A code of practice for the diagnosis and confirmation of death” published by the Academy of Royal Colleges should be adhered to at all times. <http://aomrc.org.uk/wp-content/uploads/2016/04/Code_Practice_Confirmation_Diagnosis_Death_1008-4.pdf>

As with any new procedure it is recommended that the PA first observe prior to undertaking the task under direct supervision in the first instance. Formal feedback should be sought and the procedure not be performed independently until the PA and their supervisor feel they have the competency to do so.

Procedure

1. The death may be expected and a DNAR in place or may be following a cardiac arrest call. In either case the procedure is the same. The death may be expected and a DNAR in place or may be following a cardiac arrest call. In either case the procedure is the same.
2. Note the exact time of death as far as possible.
3. Physical examination – pen torch, stethoscope, and gauze swabs are required. A brief inspection of the body (minimum 5 minutes) should be carried to ensure there are no suspicious signs. Within this period the practitioner must confirm:-

* Cessation of cardiorespiratory effort by listening to the chest, with a stethoscope, for 1 minute, checking both right and left lung fields
* Absence of either carotid or femoral pulse, by palpation for 1 minute
* Cessation of heart sounds by listening to heart apex region of the chest, with a stethoscope, for 1 minute. (This may alternatively be confirmed by asystole on a continuous heart rate ECG)
* Absence of pupil reaction to light, by using a pen torch. Pupils should be fixed, dilated, and with no reaction to light. Both eyes should be checked.
* Cessation of motor response. By pressure using finger or thumb to supra-orbital groove (the bony ridge at the top of the eye). No Motor response should be observed.
* Absence of corneal reflexes by corneal stimulation. Gentle touch with gauze to the cornea over the iris. There should be no response (e.g. blinking).

1. Confirm that death has occurred. Inform family / carers if present.
2. Where this has been used prior to death; complete the Verification of Death Section on the ‘Care After Death’ pages of the Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life. If this document has not been used make a clear annotation in the generic document for the care setting. In either case this annotation MUST include:-
   * date and time of death
   * identify any persons present at the death
   * person who discovered the death had occurred
   * time of verification
   * all the clinical signs of death (as above)
   * signature, clear name in print, and designation of the verifying practitioner.
3. The care should then follow that designated in the Policy for Care After Death and Support of the Bereaved. (i.e. offering opportunity for tissue donation, offering mementos such as locks of hair / handprints, preparing the body for transfer to the mortuary etc.).

**Appendix 4: Developing advanced skills**

**Appendix 4a: Advanced practice development proposal**

**Advanced Practice Development Proposal**

|  |  |
| --- | --- |
| Name of proposer |  |
| Job title |  |
| Email |  |
| Contact number/ extension |  |
| Division |  |
| Directorate |  |

**Details of proposal**

|  |  |
| --- | --- |
| What procedure/ skill is being taught? |  |
| Which staff group(s) will be taught |  |
| What is the need? |  |
| How often is it envisaged that the skill will be used? |  |
| Are there any local or national guidelines? (please provide copy or link). If not, please provide the standards that are being taught/ teaching package |  |
| How will the theory (consent, indications, contraindications, complications etc.) be taught? |  |
| Who will be doing the teaching? |  |

**Assessment**

|  |  |
| --- | --- |
| How will the practical skill be assessed? |  |
| What is the minimum number of successful observed procedures required? The actual number may vary depending on the needs of the individual |  |
| How will the understanding of the theory be assessed? |  |

Please send a copy of this form to Dr Chris Clark, Head of Advanced Practice Development [Christine.clark3@elht.nhs.uk](mailto:Christine.clark3@elht.nhs.uk)

**Appendix 4b: Advanced practice training log front sheet**

**Advanced Practice Training Log- front sheet**

|  |  |
| --- | --- |
| Name of practitioner |  |
| Job title |  |
| Supervisor |  |
| Procedure/ skill |  |
| How have you acquired the necessary knowledge of the theory required to perform this procedure/ skill safely? |  |
| What is the *minimum* number of observed practices required? The actual number may vary depending on the individual |  |

**Appendix 4c: Advancing Practice Training Log Sheet**

**Please use a separate sheet for each supervised practice**

|  |  |
| --- | --- |
| Name |  |
| Job title |  |
| Title of procedure |  |
| Date |  |
| Setting (ward/clinic etc) |  |
| Brief record of procedure | |
|  | |

**Feedback**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Good | Satisfactory | Needs further development |
| Preparation |  |  |  |
| Consent |  |  |  |
| Technique |  |  |  |
| Understanding of indications, contraindications, complications etc. |  |  |  |
| Comments from supervising professional | | | |
|  | | | |
| DOPS may be assessed as:1. Unable to perform procedure  2. Competent to perform procedure under direct supervision  3. Competent to perform procedure with minimal supervision  4. Competent to perform unsupervised and able to deal with possible complications | | | |
| DOPS assessment (1-4) | |  | |
| Agreed action | | | |
|  | | | |
| Reflection | | | |
|  | | | |

**Details of supervising professional:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **GMC/NMC number** |  |
| **Job Title** |  | | |
| **Email** |  | | |
| **Signature** |  | | |
| **Date** |  | | |

**Appendix 4d: Sign off**

I confirm that I am satisfied that the practitioner named has acquired both the practical skills and the theoretical knowledge to perform this skill independently:

|  |  |
| --- | --- |
| Name of Supervisor |  |
| Signature |  |
| Date |  |

I confirm that I have self-assessed myself as competent in the theory and practice of the named skill/ procedure and I have provided a reflection:

|  |  |
| --- | --- |
| Name of Practitioner |  |
| Signature |  |
| Date |  |

This log should be retained in your portfolio with a supporting reflection.