[Insert DHB]Nurse Specialist Gastroenterology/ Nurse Endoscopy Pre-requisites, Training requirements and Credentialing Programme

August 2015

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Acknowledgments

This document has been prepared for the development – training and education - of the Nurse Specialist Gastroenterology/ Nurse Endoscopy role at the [Insert DHB] and expanded practice registered nurse role.

It is acknowledged that the training programme is collaboration between Endoscopists and the Clinical Director of [Insert Department], Senior Nursing staff, academic staff of the School of Nursing at the University of Auckland and the national Nurse Endoscopy Advisory Group (NEAG) with Health Workforce New Zealand. This document will build on and extend the current Auckland DHB Nurse Specialist – Colorectal role training programme to meet agreed national standards.

The United Kingdom Joint Advisory Group (JAG) on gastrointestinal endoscopy has given permission for the use of direct observation of practice (DOPs) and direct observation of polypectomy (DOPyS) formative and summative assessment forms in the New Zealand Nurse Specialist Gastroenterology/ Nurse Endoscopy Credentialing Programme. These components should not be adapted or used outside this programme without express permission from the JAG.

Introduction

This training and credentialing programme sets out the knowledge, procedural skills and competencies necessary for an expanded practice registered nurse to achieve in order for that nurse to be considered competent and to be credentialed to perform defined endoscopic procedures. It is the intention of the programme to detail the specific procedures the nurse is competent to perform.

The Nursing Council of New Zealand (NCNZ) expanded practice guidelines stipulate that nurses will be assessed as part of a Professional Development and Recognition Programme (PDRP) and as part of an employer's credentialing programme or as part of the Council's re-certification process (NCNZ 2010, p.8). [Insert DHB] will endorse expanded practice through its Nursing Council approved PDRP assessment process and through the DHB Nursing Credentialing Committee. Once the registered nurse has completed the training and education components of the programme the evidence of knowledge and procedural skill achievement/competence will be submitted by the nurse through the PDRP for assessment and the documentation required by the DHB Nursing Credentialing Committee submitted to the committee as set out in the guideline. Prior to the registered nurse performing unsupervised procedures completion of assessment of achievement of the registered nurse and expanded practice competencies must be achieved and recorded and approval granted by the DHB/ employer Nursing Credentialing Committee.

At the present time the [Insert DHB] Nurse Specialist – Gastroenterology/ Nurse Endoscopy training and credentialing programme will focus on diagnostic procedures of the gastrointestinal tract including gastroscopy, flexible sigmoidoscopy and colonoscopy [delete as required].

In the future it is anticipated that further endoscopic knowledge, procedural skill and competencies may be added to this programme as the need to extend further the endoscopic procedures registered nurses within an expanded practice role undertake becomes necessary.

Background

'Better sooner, more convenient health care' (Ministry of Health, 2011) is one key driver for the extension of registered nurse practice by developing the Nurse Specialist – Gastroenterology/ Nurse Endoscopy role. The increasing and aging population, the cancer control strategy and insufficient endoscopists when combined have resulted in the need for a safe and innovative response to deliver timely interventions to our population. Although endoscopic procedures are not new, to date in New Zealand they have only been performed unsupervised by specialty credentialed doctors and trainees who have met the standards set by the conjoint committee for recognition of training in gastrointestinal endoscopy (NZCC gastro). In other jurisdictions such as the United Kingdom, Canada, the Netherlands and Hong Kong nurses have been trained to undertake endoscopic procedures for over 10 years. In 2001 nurse endoscopists were employed at 40% - 50% of district general and University teaching hospitals in the United Kingdom (Pathmakanthan et al., 2001).

The role of Nurse Specialist – gastroenterology already exists in New Zealand on the senior nurse level. Nurses undertake clinics for inflammatory bowel disease, hepatitis, faecal incontinence and constipation, dyspepsia, gastrostomy care, colorectal cancer screening and surveillance. The expanded practice of Nurse Endoscopy is an added component within the context of existing practice. Patients referred to the Nurse Specialist – Gastroenterology/ Nurse Endoscopy Clinic receive a 'full package' of care that begins with thorough assessment, treatment plan, interventions, diagnostic and/or therapeutic procedures, follow-up, communication with the initial referrer and the Gastroenterology Specialist. The target patient population is adults requiring gastrointestinal flexible endoscopic procedures. This training and credentialing programme will extend performance of gastrointestinal flexible endoscopic procedures (gastroscopy, flexible sigmoidoscopy and colonoscopy) to registered nurses specifically selected for this training. The training will

use a standards based approach that ensures knowledge and procedural skills are assessed at the same level of performance and competence as other disciplines undertaking these procedures. Doing this will ensure patients, and [Insert DHB], can expect the registered nurse credentialed to perform this activity will do so with same level of assessment, procedural, diagnostic, communication skill and knowledge as medical staff.

Expanded Scope of Practice

Nursing practice in New Zealand is regulated by the Nursing Council of New Zealand under the Health Practitioners Competence Assurance Act 2003 (the Act). The Council's role is to ensure nurses are safe and competent to practise. One of the ways the Council does this is by setting scopes of practice for nursing. In 2010 the Nursing Council of New Zealand (NCNZ) promulgated its Guideline: Expanded practice for Registered Nurses. This document sets out the context within which expanded practice may develop specifically the relationship between the nurse, employer, regulator and professional organisation. The Nurse Specialist Gastroenterology/ Nurse Endoscopy Credentialing Programme framework adheres to the NCNZ expanded practice Guideline. (See flow diagram of expanded practice pathway appendix 1.)

The expanded practice guideline states that 'the employer is responsible for ensuring the appropriate skill mix of staff so that additional activities completed by the RN do not compromise the standard of care provided to health consumers'(p. 14). For this reason a trainee nurse endoscopist should be supernumerary and not undertake normal nursing duties while training. This should be made clear in role descriptions.
[Insert DHB] is responsible for ensuring the nurse is supported and are appropriately assessed as competent to undertake nurse endoscopy. In New Zealand there are currently no nurses credentialed to perform or assess performance of endoscopy therefore assessment of competence will be undertaken by an endoscopist who is trained to train.
When the nurse trainee is considered by the training supervisor to be ready for the summative Direct Observation of Practice (DOPS) qualified assessors (Senior Medical Officers with relevant qualifications) are selected to undertake the assessments.

Credentialing of nurses performing endoscopy will be through the [Insert DHB] PDRP for assessment and the documentation required by the DHB/ employer Nursing Credentialing Committee is submitted as set out in the [Insert DHB] Guideline (Example Nursing Credentialing Committee terms of reference and policy are included in appendix 2 and 3 respectively). Documentation in addition to the senior nurse PDRP will include:

- Proof of successful completion of the academic program
- Summative DOPs and positive assessor declaration
- Expanded scope of practice competencies (NCNZ 2010):
    - Demonstrates initial and ongoing knowledge and skills for specific expanded practice role/activities through postgraduate education, clinical training and competence assessment.
    - Participates in the evaluation of the outcomes of expanded practice, e.g. case review, clinical audit, multidisciplinary peer review.
    - Integrates and evaluates knowledge and resources from different disciplines and health-care teams to effectively meet the health care needs of individuals and groups.

Upon successful completion of all assessments and [Insert DHB] Nursing Credentialing Committee endorsement, practice extension is recorded in the [Insert DHB] Human Resource Information System.

The expanded practice guideline expects employers 'to pilot the expanded scope of practice for a specific time and evaluate before full introduction.' (p. 14). Piloting and evaluation of the Nurse Specialist – Gastroenterology/ Nurse Endoscopy will be undertaken throughout the first cohort of the New Zealand nurse endoscopy training programme. At the completion of each year of practice following credentialing the Nurse Specialist will submit an outcomes report to the DHB/ employer Nursing Credentialing Committee.
The expanded practice guideline states that 'employers should have processes in place for monitoring the outcomes of expanded practice and for staff to document and report client-related concerns' (pg. 14). [Insert DHB] has a reportable event system where staff document adverse outcomes these are monitored by the nurse leaders as are patient complaints.

Training Programme Components

This training and education programme focuses on expanding the practice of selected Registered Nurses to perform gastrointestinal endoscopy for adult patients requiring diagnostic gastrointestinal endoscopy (gastroscopy, flexible sigmoidoscopy or colonoscopy) who are referred to the Nurse Specialist – Gastroenterology/ Nurse Endoscopy following referral to a gastroenterology/ colorectal specialist who has reviewed the referral and referred the patient on to the Nurse Specialist – Gastroenterology/ Nurse Endoscopy.

Prerequisites

It is essential Registered Nurses selected for this training programme have as a minimum completed a Postgraduate Diploma. The postgraduate diploma should include:

- Advanced assessment and diagnostic reasoning.
- Advanced biological science/ an advanced practice paper that includes biological science (gastro-intestinal system focus).
- Pharmacology leading to nurse prescribing.
- Evidence based practice is recommended.

In addition to academic prerequisites the nurse should have professional experience:

- Minimum of 5 years clinical experience post registration.
- 3 years in Gastroenterology/Endoscopy or related areas such as colo-rectal surgery.
- Advanced cardiac life support skills are a prerequisite for Nurse Endoscopy training.

Postgraduate Education

The curriculum and assessment of the academic work required for postgraduate study is set and assessed by the University of Auckland. It is expected the nurse will demonstrate application of knowledge gained through postgraduate study in practice and in the work-based training programme. The program consists of two core papers:

- Gastrointestinal disease management
- Knowledge and skills for Gastrointestinal Endoscopy including:
    - Introduction to endoscopy (simulation learning)
    - Procedural sedation (simulation learning) *to be confirmed*.

The Registered Nurse may complete optional papers to achieve a Master's degree however this is not required. The Registered Nurse shall not be credentialed to perform independent procedures until the core academic component is successfully completed. The academic qualifications recognize the increase of knowledge for clinical practice.

Procedural Sedation

Adequate patient tolerance is essential for completion of a safe endoscopic examination and compliance with subsequent follow-up. As a result endoscopists have developed skills in administering a variety of sedative and analgesic agents to facilitate procedures and enhance patient comfort. The trainee Nurse Endoscopist will always be under the direct supervision of a qualified endoscopist who will be responsible for prescribing procedural sedation. Nursing Council New Zealand has submitted an application for designated prescribing rights for registered nurses practicing in specialty teams. It is not known how long the granting of prescribing rights will take. If procedural sedation is part of practice the nurse performing endoscopy will work within a

collaborative, multidisciplinary team and manage and monitor patients with these conditions in outpatient clinics. They will be able to seek advice or refer patients with complicated, complex or uncertain health conditions which are beyond their experience and education to a medical or nurse practitioner within the team (NCNZ, 2014).

Details on procedural sedation training for nurses performing endoscopy will be updated as they become available.

Nurse Prescribing

The registered nurse authorised by Nursing Council New Zealand as a designated prescriber will have:

1. A minimum of three years' experience in the area of prescribing practice

2. Completed a postgraduate diploma in registered nurse prescribing for long-term and common conditions (e.g. asthma, diabetes, hypertension)

3. Completed a **prescribing practicum** with a designated authorised prescriber (a medical or nurse practitioner) as part of the postgraduate diploma

4. A limited list of medicines from which they can prescribe within their competence and area of practice

5. A condition included in their scope of practice to complete a further 12 months of supervised prescribing practice when they are authorised by the Council to prescribe, and

6. Ongoing competence requirements for prescribing.

Details of prescribing for nurses performing endoscopy will be updated in the Gastroenterology/ Nurse Endoscopy credentialing pathway as they become available.

Work-based Training Principles

The principles of this training and credentialing programme are drawn from the NZSG Endoscopy Training Guidelines. These guidelines are based on current literature and provide tools to gather evidence of skill and competency.

The programme principles include:

1. Training in gastrointestinal endoscopy should occur in appropriately equipped facilities.
2. Exposure to gastrointestinal endoscopy procedures should be available to all trainees.
3. Training implies a career plan is in place that will lead to an advanced practice nurse role that incorporates endoscopic procedures.
4. Cognitive and interpretive skills are as important as technical skills and a clear understanding of the purpose of gastrointestinal endoscopy in patient care is expected. This includes attendance at radiological and histological teaching sessions and relevant operations.

5. Understanding of the principles and practice of cleaning and disinfection of instruments in accordance with current guidelines of cleaning and disinfection.

6. The nurse must complete the specified minimum number of procedures under supervision before the supervisor may consider assessing competence.

7. A satisfactory report from the supervisor is required at the completion of the training programme. The supervisor should attest that the nurse is competent to:

    a. perform gastrointestinal endoscopy and specific procedures safely and expeditiously, is able to competently explain indications for and findings of the investigative procedure, safely carry out diagnostic procedures and record and report these appropriately in the patient record.

    b. Understand risk factors, manage complications and recognise personal and procedural limits

8. An expectation the nurse will maintain continuing education in the field of gastro-intestinal endoscopic practice, regularly audit their own practice and have their practice audited by other qualified endoscopists.

It is explicitly acknowledged that training alone does not attest to assessment of competence. The literature is inconclusive regarding the number of supervised procedures considered necessary to be completed before summative assessment of competence is conducted. Sedlack's (2010) research to validate the Mayo Colonoscopy Skills Assessment Tool (MCSAT), used to assess gastroenterology fellows, concludes assessing in a continuous manner throughout the training results in data that can establish average learning curves and competency thresholds based on performance scores rather than simply basing assessment on numbers of procedures performed. Therefore it is recommended that for this programme formative assessments during the training are undertaken regularly to gauge progress towards competence and to identify learning needs rather than relying on completion of a particular number of procedures as being the measure of competence. Williams, Russell, Durai *et al* (2009) in their randomised trial found no significant difference in outcomes for patients between nurse and doctor performed endoscopic procedures, which included gastroscopy flexible sigmoidoscopy and colonoscopy and conclude that diagnostic endoscopy can be safely and effectively performed by nurses.

The work-based training programme is drawn from the New Zealand Society of Gastroenterology Guidelines for Endoscopy Training (NZSG), the United Kingdom Joint Advisory Group on Gastro-Intestinal Endoscopy (JAG) – a collaboration between the royal colleges that insists all endoscopists (doctors and nurses) are trained to the same high standard - (Norton, Grieve & Vance. 2009), the Mayo Clinic, Mayo Colonoscopy Skills Assessment Tool (Sedlack, 2010) and the NZ Nurses Endoscopy Advisory Group (NEAG). While the NZSG guidelines are specifically aimed at doctors training, the JAG programme is not discipline specific. Using these guidelines provides assurance that the same standard of performance and knowledge is required and assessed whether the endoscopist is a doctor, a nurse or other health professional competent in performing endoscopy. In the New Zealand Nurse Endoscopist Credentialing Programme it is envisaged that the Nurse Endoscopist will ultimately take on expanded roles leaving the medical staff free to perform the more complex endoscopic procedures requiring a high degree of technical and diagnostic skills (Shum, N.F. et al., 2010, Ministry of Health, 2011). This training programme is designed in a modular fashion with independent assessment of competence in each domain: gastroscopy, flexible sigmoidoscopy or colonoscopy. It is envisaged that training would be sequential but this is not mandatory and can be undertaken as a single unit. In the first instance however in [Insert DHB], the Nurse Specialist – Gastroenterology/ Nurse Endoscopy will train to perform [Insert procedure].

National Endoscopy Training Governance

It is anticipated that all endoscopy trainees (medical, surgical, nursing or others) will be trained under a single conjoint curriculum and assessment process under the newly formed Endoscopy Governance Group New Zealand (EGGNZ). The Nurse Endoscopy programme will be updated when details on the governance structure and processes are available. The national endoscopy credentialing process will become part of the submission to the registered nurse expanded practice and credentialing committee under the NCNZ expanded scope of practice pathway.

Work-based Training Component

Work-based training comprises the greatest component of this training, education and credentialing programme. A qualified supervisor must be named to both support skill and knowledge development and to assess competence and achievement during and at the completion of the training programme. The work-based programme includes practical aspects of gastrointestinal endoscopy and recognition of normal and common pathology of the gastrointestinal tract. As discussed by Duthie et al. (1998) during the practical training at [Insert DHB] the nurse must keep a prospective record of procedural success and number of procedures observed, attempted or performed, participate in regular one to one review of cases with the clinical supervisor, present cases to medical and other nursing staff at patient review sessions and where relevant participate in one-one teaching with the supervisor.

During the training period all procedures performed will be under the direct supervision of the supervisor. According to the NZCC for Recognition of Training in Gastrointestinal Endoscopy recent literature on training in endoscopy has documented two important features:

- Trainees require more procedures that previously recommended to achieve competence.
- More emphasis should be placed on assessing competence by documenting procedural success rates rather than the number of procedures performed.

With this in mind the number of supervised procedures represents a minimum and some trainees may require more than the stated number to reach an acceptable level of competence. Formative DOPs assessment should be carried out on at least one case for each supervised session during the training programme.

The registered nurse trainee will record sequentially and prospectively in their log book each procedure attempted whether successful or not together with details of the indications, time taken, complications occurring and success.

Eligibility criteria

Eligibility criteria are shown in the tables below. The previous three months of data on the e-portfolio will be used to calculate the eligibility criteria.

Provisional criteria	**Requirement**	**Notes**
Caecal intubation rate	>90%	
Formative DOPS scores	>90% “3”s and “4”s	A minimum of 10 DOPS required
Formative DOPyS scores*	>90% “3”s and “4”s	Last 4 DOPyS scores, or last 3 months, whichever is greater

Unassisted physically	>90%	I.e. the trainer does not take the scope for >90% of procedures
Formative Lower GI DOPS (colon)	>10	
Formative Lower GI DOPS (colon) 3s and 4s	>90%	
Formative DOPyS (lvl 1)	>4	
Formative DOPyS (lvl 1) 3s and 4s Overall score	>90%	
Recommended lifetime procedure Count	200	
Basic skills lower GI course	Attended	

Training should include instruction in:

1. The indications and contraindications for the endoscopic procedure
2. Obtaining informed consent
3. Communicating endoscopic findings and their implications to patients, relatives and carers
4. Providing a high standard of written reports and communications with other colleagues
5. Communicating bad news, including discussing complications of the endoscopic procedure
6. The skills of the endoscopic procedure
7. The causes, prevention, recognition, management and avoidance of endoscopy-related complications.

Some of which may also be covered in the academic component assessment points of the overall training.

Details of Work based Training and Assessment

The content and Direct Observation of Procedural Skills (DOPS) assessment of performance is drawn from JAG material. This provides a strong and evidenced based set of criteria and standards against which to conduct both formative and summative measurement of competence.

Endoscopic Safety

Subject Matter	Knowledge	Skills	Attitudes
Equipment	Describe the structure and function of the endoscope, the light source, processor & accessories e.g. biopsy tool	Able to clean and disinfect equipment in accordance with GENCA guidelines (Gastroenterological	Demonstrates willingness to undertake endoscope cleaning as necessary and uses equipment

		Nurses College of Australia) and use equipment in accordance with the manufacturers recommendations	appropriately
Informed Consent	Recalls the medico-legal issues concerning informed consent and the provision of information. Is familiar with Code of Rights	Demonstrates ability to obtain informed consent from a patient in accordance with organisational Consent Policy and accesses interpreters appropriately	Demonstrates willingness to obtain consent for endoscopic procedures in an appropriate manner. Respects the patients privacy and dignity
Patient monitoring	Describes necessary patient monitoring throughout the procedure	Performs gastrointestinal endoscopy safely and effectively. Uses safe and appropriate monitoring before and after the procedure	Exhibits a willingness to participate in safe gastrointestinal endoscopy practice

Gastroscopy

Subject Matter	Knowledge	Skills	Attitudes
Diagnostic Gastroscopy	Define the indications, target patient group, contraindications, complications and their management. Outline patient preparation and documentation	Performs procedure to the second part of the duodenum in at least 90% of cases. Where indicated takes biopsies and undertakes other necessary actions as required.	Demonstrates willingness to undertake gastroscopy in such a way as to minimise risk and discomfort to patients and obtain help when needed.

Flexible Sigmoidoscopy

Subject Matter	Knowledge	Skills	Attitudes
Investigative descending colon and rectal flexible sigmoidoscopy	Define the indications, target patient group, contraindications, complications and their management. Outline patient preparation and documentation	Performs procedure to reach the point where the descending colon becomes the left colic flexure in at least 90% of cases. Where indicated takes biopsies and undertakes other necessary actions as	Demonstrates willingness to undertake flexible sigmoidoscopy in such a way as to minimise risk and discomfort to patients and obtain help when needed.

		required.	

Colonoscopy

Subject Matter	Knowledge	Skills	Attitudes
Investigative colonoscopy	Define the indications, target patient group, contraindications, complications and their management. Outline patient preparation and documentation	Performs procedure to reach the caecum and preferably into the ileum in at least 90% of cases. Where indicated takes biopsies and undertakes other necessary actions as required	Demonstrates willingness to undertake colonoscopy in such a way as to minimise risk and discomfort to patients and obtain help when needed.

DOPS Assessment

Introduction

The generic JAG framework for the DOPS assessment of Colonoscopy/ flexible sigmoidoscopy has been thoroughly trialled, and shown to be reliable and valid (Barton 2008). Whilst there are ongoing efforts to evaluate the Upper GI DOPS in a similar fashion, there is no reason to suppose that the value of the DOPS will be significantly different – the DOPS forms are substantially the same, and the process is identical.
Relevant components have been adapted for use in the Nurse Specialist – Gastroenterology/ Nurse Endoscopy credentialing programme. Permission for the use of DOPs and DOPyS has been granted by the Joint Advisory Group on GI Endoscopy (JAG) UK and should not be adapted or used outside this programme without express permission from the JAG.

Formative DOPS Assessment Form

Nurse Specialist / Gastroenterology– Diagnostic Gastroscopy

Trainee Name :

Supervisor Name :

Assessment Date :

Scale and Criteria Key
(full criteria described in Grade Descriptors)

4. Highly skilled performance

3. Competent and safe throughout procedure, no uncorrected errors

2. Some standards not yet met, aspects to be improved, some errors uncorrected

1. Accepted standards not yet met, frequent errors uncorrected

n/a Not applicable

Criteria	Score	Comments
Assessment, consent, communication		
■ Informed consent obtained, patient understanding checked:		
• Satisfactory procedural information		
• Risks and complications		
• Checks for co-morbidities		
• Sedation		
• Opportunities for questions		
■ Demonstrates respect for patients views and dignity during the procedure		
■ Communicates clearly with the patient, including what to expect post procedure, what to do and explains who follows up		
Safety and sedation		
■ Safe and secure IV access		
■ Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and peri-procedural patient monitoring		
■ Clear effective communication with nursing staff, including dosages and vital signs		
Endoscopic skills during insertion and procedure		
■ Checks endoscope function before intubation		
■ Intubates oesophagus under direct vision		
■ Maintains luminal view		
■ Demonstrates awareness of the patient's consciousness and comfort during the procedure and takes appropriate action		
■ Uses distension, suction and lens washing appropriately		
■ Passes the scope into the second part of the duodenum		
■ Uses retroflexion to visualise fundus and cardia		
■ Completes procedure in a reasonable time		
Diagnostic and therapeutic ability		
■ Adequate mucosal visualisation		
■ Recognises and notes position of gastro-oesophageal junction, and is appropriately oriented within the stomach and duodenum		
■ Accurate identification and management of pathology		
■ Uses diathermy and therapeutic techniques appropriately and safely		
■ High quality images recorded		
■ Recognises and manages complications appropriately		

Case Difficulty – Please circle below

Extremely Easy	Fairly Easy	Average	Fairly Difficult	Very Challenging
1	2	3	4	5

Learning Objectives for future cases:

_____

_____

_____

Formative DOPS Assessment Form – Diagnostic Gastroscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

Summative DOPS Assessment Form

Nurse Specialist / Gastroenterology– Diagnostic Gastroscopy

Trainee Name :

Supervisor Name :

Assessment Date :

Scale and Criteria Key
(full criteria described in Grade Descriptors)

4. Highly skilled performance

3. Competent and safe throughout procedure, no uncorrected errors

2. Some standards not yet met, aspects to be improved, some errors uncorrected

1. Accepted standards not yet met, frequent errors uncorrected

n/a Not applicable

Criteria	Score	Comments
Assessment, consent, communication		
■ Informed consent obtained, patient understanding checked: • Satisfactory procedural information • Risks and complications • Checks for co-morbidities • Sedation • Opportunities for questions		
■ Demonstrates respect for patients views and dignity during the procedure		
■ Communicates clearly with the patient, including what to expect post procedure, what to do and explains who follows up		
Safety and sedation		
■ Safe and secure IV access		
■ Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and peri-procedural patient monitoring		
■ Clear effective communication with nursing staff, including dosages and vital signs		
Endoscopic skills during insertion and procedure		
■ Checks endoscope function before intubation		
■ Intubates oesophagus under direct vision		
■ Maintains luminal view		
■ Demonstrates awareness of the patient's consciousness and comfort during the procedure and takes appropriate action		
■ Uses distension, suction and lens washing appropriately		
■ Passes the scope into the second part of the duodenum		
■ Uses retroflexion to visualise fundus and cardia		
■ Completes procedure in a reasonable time		
Diagnostic and therapeutic ability		
■ Adequate mucosal visualisation		
■ Recognises and notes position of gastro-oesophageal junction, and is appropriately oriented within the stomach and duodenum		
■ Accurate identification and management of pathology		
■ Uses diathermy and therapeutic techniques appropriately and safely		
■ High quality images recorded		
■ Recognises and manages complications appropriately		

Case Difficulty – Please circle below

Extremely Easy	Fairly Easy	Average	Fairly Difficult	Very Challenging
1	2	3	4	5

Summative DOPS Assessor Declaration

Diagnostic Gastroscopy

This declaration is to be completed by the assessor to support the DOPS Criteria form

DOPS STANDARDS

Major domains

☐ I declare that the candidate received a Grade 3 or Grade 4 on all 20 major domains

☐ I declare that there are **no** Grade 1 or Grade 2 scores in any of the 20 major domains.

Confidential – Expert Global Evaluation

Please give your expert global assessment **independent** of the above grading. In other words do you personally judge that the candidate is ready to become an independent endoscopist in the area of –colonoscopy/ flexible sigmoidoscopy (delete as appropriate)?

Please check one of the two boxes below:

☐ The nurse **should** be credentialed to undertake Gastroscopy

☐ The nurse **should not** yet be credentialed for Gastroscopy

Assessor sign off

I certify that _____ APC No._____

☐ Meets the DOPS criteria outlined on page one

☐ Meets the minimum DOPs standards above

Name:…… Signature:……..

Assessor requirements

Gastroscopy, Flexible Sigmoidoscopy and Colonoscopy

When a nurse trainee is considered by the trainer to be ready to sit the Summative DOPS assessments, those assessments (four observed case judgments) can be carried out in any combination of ways that fulfil the following criteria:

1. Minimum of two assessors
2. Minimum of two cases
3. Minimum of four DOPS (observations and judgments)
4. Within a month
5. No assessor is the current primary endoscopic trainer

All Summative DOPS must meet the criteria, if one does not, then the DOPS process (four observed case judgements) must start again. So this could result in the four Summative DOPS being completed as below (or a variation of the below):

- as a 2 x 2 process simultaneously = 2 assessors over 2 case
- as a 2 x 2 process sequentially = 2 assessors over 4 cases
- as a 2 x 1 x 1 process = 3 assessors over 4 cases
- as a 1 x 1 x1 x 1 process = 4 assessors over 4 cases

Summative DOPS Assessment Form – Diagnostic Gastroscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPS Grade Descriptors – Diagnostic Gastroscopy

Descriptors for each grade in all four domains are given below to improve consistency of grading. The key descriptor level is Grade 3. Grade 4 assumes achievement of all components at Grade 3 level and some achievement above this.

The descriptors set expectations for the performance in each domain, but should be used as a guide – endoscopists do not have to meet all criteria in each descriptor to achieve a grade in that domain.

ASSESSMENT, CONSENT AND COMMUNICATION
Grade 4
Complete and full explanation in clear terms including proportionate risks and consequences with no omissions of significance, and not unnecessarily raising concerns. No jargon. Encourages questions by verbal and non-verbal skills and is thoroughly respectful of individual's views, concerns, and perceptions. Good rapport with patient. Seeks to ensure procedure is carried out with as much dignity and privacy as possible. Clear and appropriate communication throughout procedure and afterwards a thorough explanation of results and management plan. Full endoscopy report, using objective description, agreed grading systems where possible, including all relevant details and sites of pathology.
Grade 3
Good clear explanation with few significant omissions, covering key aspects of the procedure and complications with some quantification of risk. Little jargon, and gives sufficient opportunity for questions. Responds to individual's perspective. Aware of and acts to maintain individual's dignity. Appropriate communication during procedure including warning patient of probable discomfort. Satisfactory discussion of results and management plan with adequate detail. Satisfactory endoscopy report, using largely objective description, agreed grading systems where possible, including most relevant details and sites of pathology.
Grade 2
Explains procedure but with several omissions, some of significance. Vague discussion of risks, or raises occasional unnecessary concerns. Some jargon and limited opportunity for questions or sub-optimal responses. Incomplete acknowledgement of individual's views and perceptions. Occasional communication during the procedure. Just adequate explanation with some aspects unclear, inaccurate or lacking in detail. Endoscopy report has less objective description, or lacks use of agreed grading systems. Omits some relevant details, or is somewhat inaccurate.
Grade 1
Incomplete explanation with several significant omissions and inadequate discussion, lacking explanation of risks or raising significant fears. Uses a lot of jargon or technical language; minimal or no opportunity for questions. Fails to acknowledge or respect individual's views or concerns. Minimal or no communication during procedure. Explanation of results and management is unclear, inaccurate or lacking in detail without opportunity for discussion. Endoscopy report has little objective description, lacks use of agreed grading systems, a number of relevant omissions or inaccuracies.
SAFETY AND SEDATION
Grade 4
Safe and secure IV access with doses of analgesia and sedation according to patient's age and physiological state, clearly checked and confirmed with nursing staff. Patient as comfortable throughout as possible. Oxygenation and vital signs monitored continually as appropriate, remaining satisfactory throughout or rapid and appropriate action taken if sub-optimal. Clear, relevant and proactive communication with endoscopy staff.
Grade 3
Secure IV access with a standard cannula and appropriate dose of analgesia and sedation within current guidelines, checked and confirmed with nursing staff. Patient reasonably comfortable throughout, some tolerable discomfort may be present. Oxygenation and vital signs regularly monitored and satisfactory throughout, or appropriate action taken. Clear communication with endoscopy staff.
Grade 2
IV access acceptable with just satisfactory analgesia and sedation, incompletely confirmed or checked with nursing staff, patient too sedated or too aware and in discomfort. Oxygenation and vital signs monitored but less frequently than appropriate or parameters occasionally unsatisfactory with action taken only after prompting or delay. Intermittent or sub optimal communication with endoscopy staff.
Grade 1
Insecure or absent IV access or butterfly used; inadequate or inaccurate check of analgesia and sedation. Patient significantly under- or over-sedated or needing use of a reversal agent because of inappropriate dosage. Patient in discomfort much of the time, or significant periods of severe discomfort. Oxygenation and vital signs rarely or inadequately monitored and mostly ignored even if unsatisfactory. Minimal or significantly flawed communication with endoscopy staff.
ENDOSCOPIC SKILLS DURING INSERTION AND WITHDRAWAL
Grade 4
Excellent luminal views throughout the vast majority of the examination, with judicious use of key manoeuvres. Skilled scope steering and well-judged use of distension, suction and lens clearing. Quick to use different technical strategies or manoeuvres when appropriate. Immediately aware of patient discomfort with rapid response. Smooth rapid and effective scope manipulation using angulation control knobs and torque.
Grade 3
Check scope functions. Intubates oesophagus readily, and largely under direct vision. Clear luminal view most of the time. Adequate

use of the angulation control knobs with smooth scope control (into D2 & J-manoeuvre). Aids examination using distension, suction and lens washing. Aware of any discomfort to patient and responds with appropriate actions. Timely completion of procedure, not too quickly or too slowly for the circumstances.
Grade 2
Omits scope check. Luminal views lost a little more than desirable or pushes blindly. Small areas of mucosa not visualised. Could manipulate scope more effectively or smoothly. Some under or over distension or lack of lens washing. Use of other manoeuvres occasionally late or inappropriately. Aware of and responsive to patient but may be slow to do so. Procedure slightly too fast or too slow.
Grade 1
Omits to check scope. Luminal views frequently lost for long periods, or large areas inadequately examined. Poor or jerky scope control. Under- or over-distension of stomach, or fails to attempt lens clearing. Inappropriate or no use of key manoeuvres. Barely aware of patient's status, or very tardy / inappropriate / no response to discomfort. Completes examination too quickly or takes far too long.
DIAGNOSTIC AND THERAPEUTIC ABILITY
Grade 4
Rapid recognition of all major anatomical landmarks present and rapidly identifies abnormal anatomy. Fluid pools fully suctioned. Thorough assessment and accurate identification of pathology present. Skilled and competent management of diathermy and therapeutic techniques. Rapid recognition and safe and comprehensive management of complications.
Grade 3
Recognises all major anatomical landmarks and identifies abnormal anatomy. Fluid pools suctioned. Assesses and identifies pathology present. Competent management of diathermy and therapeutic techniques. Recognises and manages complications safely.
Grade 2
Recognises most major anatomical landmarks, and recognises variation from the normal. Mucosal views a little impaired by fluids. Most pathology identified with occasional missed or mis-identified lesions. Just acceptable use of diathermy and therapeutic tools with some sub-optimal use. Delayed or incomplete recognition of complications or sub-optimal management.
Grade 1
Recognises some anatomical landmarks. May fail to recognise incomplete examination. Misses significant pathology, or inappropriate management. Unsafe use of diathermy and therapeutic techniques. Fails to recognise or significantly mis-manages complications.

DOPS Grade descriptors – Diagnostic Gastroscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

[Insert DHB] Nurse Specialist Gastroenterology/ Endoscopy - Gastroscopy Log Book

Trainee: …….. **Supervisor:**…….

No.	Date	Patient Age	Gender M/F	Sedation S, T, A[1]	Completed successfully Unassisted Y/N	Unassisted Therapeutic Procedure [2]	Complications (specify)	Supervisors signature
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								

1. **Sedation** – Administered by: **S**- Supervisor **T** – NE trainee **A** – Anaesthetist

2. **Therapeutic Procedure** A-Adrenaline APC-Argon Plasma Coagulation B-Banding D-Dilatation P-Peg
C-Coagulation L-Polypectomy Sc Sclerotherapy R- removal Foreign Body O-Other-specify

[Insert DHB] – Nurse Specialist Gastroenterology/ Endoscopy Gastroscopy Summary Sheet

Trainee:…….. **Supervisor:**…….

Completion Date	Total Attempted (TA)	Total Completed Unassisted (TC)	% Success TC/TE x 100	Complications	No of Therapeutic
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				
	25				

TOTALS

	Total Attempted	Total Completed (minimum = 200)	TC/TA x 100 =	Complications	Therapeutic (Minimum =30)

Formative DOPS Assessment Form

Nurse Specialist / Gastroenterology– Colonoscopy and Flexible Sigmoidoscopy

Trainee Name :

Supervisor Name :

Assessment Date :

Scale and Criteria Key
(full criteria described in Grade Descriptors)

4. Highly skilled performance

3. Competent and safe throughout procedure, no uncorrected errors

2. Some standards not yet met, aspects to be improved, some errors uncorrected

1. Accepted standards not yet met, frequent errors uncorrected

n/a Not applicable ■ Major criteria ❍ Minor criteria

Criteria	Score	Comments
Assessment, consent, communication		
■ Informed consent obtained patient understanding checked: • Satisfactory procedural information • Risks and complications • Checks for co-morbidities • Sedation • Opportunities for questions		
■ Demonstrates respect for patients views and dignity during the procedure		
■ Communicates clearly with the patient, including what to expect post procedure, what to do and explains who follows up		
Safety and sedation		
■ Safe and secure IV access		
■ Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and peri-procedural patient monitoring		
■ Clear effective communication with nursing staff, including dosages and vital signs		
Endoscopic skills during insertion and procedure		
❍ Checks endoscope function before intubation		
❍ Performs PR		
■ Maintains luminal view and inserts in luminal direction		
■ Demonstrates awareness of the patient's consciousness and pain during the procedure and takes appropriate action		
❍ Uses torque steering and control knobs		
❍ Uses distension, suction and lens washing appropriately		
■ Recognises and logically resolves loop formation		
❍ Uses position change and abdominal pressure to aid luminal views		
❍ Completes procedure in reasonable time		
Diagnostic and biopsy ability		
■ Adequate mucosal visualisation		
■ Recognises caecal/desc. Colon landmarks or incomplete examination		
■ Accurate identification of pathology		
■ Uses diathermy and therapeutic techniques appropriately and safely		
■ Recognises and manages complications appropriately		

Case Difficulty – Please circle below

Extremely Easy	Fairly Easy	Average	Fairly Difficult	Very Challenging
1	2	3	4	5

Learning Objectives for future cases:

_____

_____

_____

Formative DOPS Assessment Form – Diagnostic Colonoscopy and Flexible Sigmoidoscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

Summative DOPS Assessment Form

Nurse Specialist / Gastroenterology– Colonoscopy and Flexible Sigmoidoscopy

Trainee Name :

Supervisor Name :

Assessment Date :

Scale and Criteria Key
(full criteria described in Grade Descriptors)

4. Highly skilled performance

3. Competent and safe throughout procedure, no uncorrected errors

2. Some standards not yet met, aspects to be improved, some errors uncorrected

1. Accepted standards not yet met, frequent errors uncorrected

n/a Not applicable ■ Major criteria ❍ Minor criteria

Criteria	Score	Comments
Assessment, consent, communication		
■ Informed consent obtained patient understanding checked: • Satisfactory procedural information • Risks and complications • Checks for co-morbidities • Sedation • Opportunities for questions		
■ Demonstrates respect for patients views and dignity during the procedure		
■ Communicates clearly with the patient, including what to expect post procedure, what to do and explains who follows up		
Safety and sedation		
■ Safe and secure IV access		
■ Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and peri-procedural patient monitoring		
■ Clear effective communication with nursing staff, including dosages and vital signs		
Endoscopic skills during insertion and procedure		
❍ Checks endoscope function before intubation		
❍ Performs PR		
■ Maintains luminal view and inserts in luminal direction		
■ Demonstrates awareness of the patient's consciousness and pain during the procedure and takes appropriate action		
❍ Uses torque steering and control knobs		
❍ Uses distension, suction and lens washing appropriately		
■ Recognises and logically resolves loop formation		
❍ Uses position change and abdominal pressure to aid luminal views		
❍ Completes procedure in reasonable time		
Diagnostic and biopsy ability		
■ Adequate mucosal visualisation		
■ Recognises caecal/desc. colon landmarks or incomplete examination		
■ Accurate identification of pathology		
■ Uses diathermy and therapeutic techniques appropriately and safely		
■ Recognises and manages complications appropriately		

Case Difficulty – Please circle below

Extremely Easy	Fairly Easy	Average	Fairly Difficult	Very Challenging
1	2	3	4	5

Learning Objectives for future cases:

_____

_____

_____

Summative DOPS Assessment Form – Diagnostic Colonoscopy and Flexible Sigmoidoscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

Summative DOPS Assessor Declaration

This declaration is to be completed by the assessor to support the DOPS Criteria form (page one).

DOPS STANDARDS

Major domains

☐ I declare that the candidate received a Grade 3 or Grade 4 on all 14 major domains

☐ I declare that there are **no** Grade 1 or Grade 2 scores in any of the 14 major domains

Minor domains

☐ I declare that the candidate received **no more than** six Grade 2 scores across all four DOPS Criteria forms in any of the six minor domains

☐ I declare that there are **no** Grade 1 scores in any of the six minor domains.

Confidential – Expert Global Evaluation

Please give your expert global assessment **independent** of the above grading. In other words do you personally judge that the candidate is ready to become an independent endoscopist in the area of –colonoscopy/ flexible sigmoidoscopy (delete as appropriate)?

Please check one of the two boxes below:

☐ The nurse **should** be credentialed to undertake colonoscopy/ flexible sigmoidoscopy (delete as appropriate) and meets the DOPS major and minor criteria.

☐ The nurse **should not** yet be credentialed for colonoscopy/ flexible sigmoidoscopy (delete as appropriate).

Assessor sign off

I certify that _____ APC No._____

☐ Meets the DOPS criteria outlined on page one

☐ Meets the minimum DOPs standards above

Name:…… Signature:……..

Assessor requirements

Gastroscopy, Flexible Sigmoidoscopy and Colonoscopy

When a nurse trainee is considered by the trainer to be ready to sit the Summative DOPS assessments, those assessments (four observed case judgments) can be carried out in any combination of ways that fulfil the following criteria:

1. Minimum of two assessors
2. Minimum of two cases
3. Minimum of four DOPS (observations and judgments)
4. Within a month
5. No assessor is the current primary endoscopic trainer

All Summative DOPS must meet the criteria, if one does not, then the DOPS process (four observed case judgements) must start again. So this could result in the four Summative DOPS being completed as below (or a variation of the below):

- as a 2 x 2 process simultaneously = 2 assessors over 2 case
- as a 2 x 2 process sequentially = 2 assessors over 4 cases
- as a 2 x 1 x 1 process = 3 assessors over 4 cases
- as a 1 x 1 x1 x 1 process = 4 assessors over 4 cases

Summative DOPS Assessment Form – Diagnostic Colonoscopy and Flexible Sigmoidoscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPS Grade Descriptors – Certification in Colonoscopy and Flexible sigmoidoscopy

Descriptors for each grade in all four domains are given below to improve consistency of grading. The key descriptor level is Grade 3. Grade 4 assumes achievement of all components at Grade 3 level and some achievement above this.

The descriptors set expectations for the performance in each domain, but should be used as a guide, colonoscopists do not have to meet all criteria in each descriptor to achieve a grade in that domain.

ASSESSMENT, CONSENT AND COMMUNICATION
Grade 4
Complete and full explanation in clear terms including proportionate risks and consequences with no omissions of significance, and not unnecessarily raising concerns. No jargon. Encourages questions by verbal and non-verbal skills and is thoroughly respectful of individual's views, concerns, and perceptions. Good rapport with patient. Seeks to ensure procedure is carried out with as much dignity and privacy as possible. Clear and appropriate communication throughout procedure and afterwards a thorough explanation of results and management plan.
Grade 3
Good clear explanation with few significant omissions, covering key aspects of the procedure and complications with some quantification of risk. Little jargon, and gives sufficient opportunity for questions. Responds to individual's perspective. Aware of and acts to maintain individual's dignity. Appropriate communication during procedure including warning patient of probable discomfort. Satisfactory discussion of results and management plan with adequate detail.
Grade 2
Explains procedure but with several omissions, some of significance. Little or no quantification of risk, or raises occasional unnecessary concerns. Some jargon and limited opportunity for questions or sub-optimal responses. Incomplete acknowledgement of individual's views and perceptions. A few lapses of dignity only partially or tardily remedied. Occasional communication during the procedure and intermittent warnings of impending discomfort. Barely adequate explanation with some aspects unclear, inaccurate or lacking in detail.
Grade 1
Incomplete explanation with several significant omissions and inadequate discussion, lacking quantification of risks or raising significant fears. Uses a lot of jargon or technical language; minimal or no opportunity for questions. Fails to acknowledge or respect individual's views or concerns. Procedure lacks dignity and there is minimal or no communication during it. Explanation of results and management is unclear, inaccurate or lacking in detail without opportunity for discussion.
SAFETY AND SEDATION
Grade 4
Safe and secure IV access with doses of analgesia and sedation according to patient's age and physiological state, clearly checked and confirmed with nursing staff. Patient very comfortable throughout. Oxygenation and vital signs monitored continually as appropriate, remaining satisfactory throughout or rapid and appropriate action taken if sub-optimal. Clear, relevant and proactive communication with endoscopy staff.
Grade 3
Secure IV access with a standard cannula and appropriate dose of analgesia and sedation within current guidelines, checked and confirmed with nursing staff. Patient reasonably comfortable throughout, some tolerable discomfort may be present. Oxygenation and vital signs regularly monitored and satisfactory throughout, or appropriate action taken. Clear communication with endoscopy staff.
Grade 2
IV access acceptable with just satisfactory analgesia and sedation incompletely confirmed or checked with nursing staff, patient too sedated or too aware and in discomfort. Oxygenation and vital signs monitored but less frequently than appropriate or parameters occasionally unsatisfactory with action taken only after prompting or delay. Intermittent or sub optimal communication with endoscopy staff.
Grade 1
Insecure or absent IV access or butterfly used; inadequate or inaccurate check of analgesia and sedation. Patient significantly under- or over-sedated or needing use of a reversal agent because of inappropriate dosage. Patient in discomfort much of the time, or significant periods of severe discomfort. Oxygenation and vital signs rarely or inadequately monitored and mostly ignored even if unsatisfactory. Minimal or significantly flawed communication with endoscopy staff.
Endoscopic Skill during Insertion and Withdrawal
Grade 4
Checks scope functions, performs PR. Excellent luminal views throughout the vast majority of the examination, with judicious use of "slide-by". Skilled torque steering and well-judged use of distension, suction and lens clearing. Rapid recognition and resolution of loops. Quick to use position change or other manoeuvres when appropriate. Immediately aware of patient discomfort with rapid response. Smooth scope manipulation using angulation control knobs and torque steering.
Grade 3
Check scope functions, performs PR. Clear luminal view most of the time or uses slide-by appropriately. Appropriate use of the angulation control knobs. Uses torque steering adequately. Aids progress using distension, suction and lens washing. Recognises most loops quickly and attempts logical resolution. Good use of position changes to negotiate difficulties. Aware of any discomfort to patient and responds with appropriate actions. Timely completion of procedure, not too quickly or too slowly for the circumstances.
Grade 2
Omits scope check or PR. Luminal views lost a little more than desirable or uses slide-by a little too long or frequently. Could torque steer usefully more often or more effectively. Some under or over distension or lack of lens washing. Recognises most loops with reasonable attempts at resolution. Use of position change or other manoeuvres occasionally late or inappropriately. Aware of and responsive to patient but may be slow to do so. Procedure slightly too fast or too slow.

Grade 1
Omits to check scope or rectal examination. Luminal views frequently lost for long periods and pushes on regardless. Little or no use of torque steering. Under- or over-distension of bowel, or fails to attempt lens clearing. Recognises loops late or not at all and little or no structured attempt to resolve them. Inappropriate or no use of position change or other manoeuvres. Barely aware of patient's status, or very tardy / inappropriate / no response to discomfort. Completes examination too quickly or takes far too long.
Diagnostic and Therapeutic Ability
Grade 4
Excellent mucosal views throughout the majority of the procedure. Recognition of all caecal landmarks present or rapidly identifies incomplete examination. Faecal pools fully suctioned. Retroflexes in rectum. Thorough assessment and accurate identification of pathology present. Skilled and competent management of diathermy and therapeutic techniques. Rapid recognition and appropriate management of complications.
Grade 3
Adequate mucosal visualisation with only occasional loss or sub-optimal views unless outside control of endoscopist (e.g. stool, severe diverticular disease). Faecal pools adequately suctioned. Attempts to retroflex in rectum. Correctly identifies caecal landmarks or incomplete examination. Accurately identifies pathology and manages appropriately according to current guidelines. Correct and safe use of diathermy and therapeutic techniques. Rapid recognition of complications with safe management.
Grade 2
Mucosal views intermittently lost for more than desirable periods. Recognises most caecal landmarks present or eventually identifies an incomplete examination. Most pathology identified with occasional missed or mis-identified lesions. Just acceptable use of diathermy and therapeutic tools with some sub optimal use. Delayed or incomplete recognition of complications or suboptimal management.
Grade 1
Frequent or prolonged loss of mucosal views. Incorrect identification of caecal landmarks, or fails to recognise incomplete examination. Misses significant pathology, or inappropriate management that may endanger patient or contravenes guidelines. Unsafe use of diathermy and therapeutic techniques. Fails to recognise or significantly mis-manages complications to the detriment of the patient.

DOPS Grade descriptors – Diagnostic Colonoscopy and Flexible Sigmoidoscopy. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

[Insert DHB] Nurse Specialist Gastroenterology/ Endoscopy - Colonoscopy Log Book

Trainee: …….. **Supervisor:**……

No.	Date	Patient Age	Gender M/F	Sedation S, T, A[1]	Intact Colon Yes/No	Scope passed to Ileum, Caecum, Incomplete	Completed[2] unassisted Yes/No	Reasons for Non Completion	Insertion Time (min)	Total time anus to anus (min)	Snare Biopsy/ Tattoo[3] S,A,F	Complications (specify)	Supervisors signature
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21													
22													
23													
24													
25													

1. **Sedation** – Administered by: S- Supervisor T – NE trainee A – Anaesthetist

2. **Unassisted** – NE trainee performs all procedures without hands on assistance from Supervisor **Assisted** – NE trainee attempts procedure but part of procedure is performed by supervisor

3. **Snare Biopsy or Tattoo** - S = successful unassisted A = assisted F = failed

[Insert DHB] – Nurse Specialist Gastroenterology/ Endoscopy Colonoscopy Summary Sheet

Trainee:…….. **Supervisor:**…….

Completion Date	Total Attempted Intact Colons (TA)	Total completed Unassisted (TC)	% Success TC/TE x 100	Mean time (min)	Complications	No with snare Polypectomy
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
	25					
TOTALS						
	Total Attempted	Total Completed (minimum = 100)	TC/TA x 100 =	Time	Complications	Snare Polypectomies (Minimum =30)

DOPyS Polypectomy Assessment Form

Date ……/……/……Assessor…….. Colonoscopist: …….. Case ID: …….. Polyp Number……..

Polyp site: C / AC / HF / TC / SF / DC / SC / R

Scale: **4 - Highly skilled performance**
3 - Competent & safe throughout procedure, no uncorrected errors
2 - Some standards not yet met, aspects to be improved, some errors uncorrected
1 - Accepted standards not yet met, frequent errors uncorrected
N/A - Not applicable/Not assessable

The underlined parameters can only be assessed during 'live' polypectomy

Generic	Score	Comments
Optimising view of / access to the polyp:		
1. Attempts to achieve optimal polyp position		
2. Optimises view by aspiration/insufflation/wash.		
3. Determines full extent of lesion (+/- use of adjunctive techniques e.g. bubble breaker, NBI, dye spray etc.) if appropriate		
4. Uses appropriate polypectomy technique (e.g. taking into account site in colon)		
5. Adjusts/stabilises scope position		
6. Checks all polypectomy equipment (forceps, snare, clips, loops) available		
7. Checks (or asks assistant to) snare closure prior to introduction into the scope		
8. Clear instructions to and utilisation of endoscopy staff		
9. Checks diathermy settings are appropriate		
10. Photo-documents pre and post polypectomy		
Stalked polyps: Generic, then		
11. Applies prophylactic haemostatic measures if deemed appropriate		
12. Selects appropriate snare size		
13. Directs snare accurately over polyp head		
14. Correctly selects en-bloc or piecemeal removal depending on size		
15. Advances snare sheath towards stalk as snare closed		
16. Places snare at appropriate position on the stalk		
17. Mobilises polyp to ensure appropriate amount of tissue is trapped within snare		
18. Applies appropriate degree of diathermy		
Small sessile lesions / Endoscopic mucosal resection: Generic, then		
19. Adequate sub mucosal injection using appropriate injection technique, maintaining views		
20. Only proceeds if the lesion lifts adequately		
21. Selects appropriate snare size		
22. Directs snare accurately over the lesion		
23. Correctly selects en-bloc or piecemeal removal depending on size		
24. Appropriate positioning of snare over lesion as snare closed		
25. Ensures appropriate amount of tissue is trapped within snare		
26. Tents lesion gently away from the mucosa		
27. Uses cold snare technique or applies appropriate diathermy, as applicable		
28. Ensures adequate haemostasis prior to further resection		
Post polypectomy		
29. Examines remnant stalk/polyp base		
30. Identifies and appropriately treats residual polyp		
31. Identifies bleeding and performs adequate endoscopic haemostasis if appropriate		
32. Retrieves, or attempts retrieval of polyp		
33. Checks for retrieval of polyp		
34. Places tattoo competently, where appropriate		

Polyp Size	**……mm**			
Overall Competency at Polypectomy:	**4**	**3**	**2**	**1**

DOPyS: Polypectomy Assessment Form. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPyS Grade Descriptors – Certification in Polypectomy

Descriptors for each grade in all four domains are given below to improve consistency of grading. The key descriptor level is Grade 3. Grade 4 assumes achievement of all components at Grade 3 level and some achievement above this.

The descriptors set expectations for the performance in each domain, but should be used as a guide – endoscopists do not have to meet all criteria in each descriptor to achieve a grade in that domain.

DOPyS Grade Descriptors - Generic	
Grade 4	**Highly Skilled Performance**
1. Ensures good (5-11 o'clock axis) polyp position with no errors. Attempts made at position correction throughout the procedure. 2. Maintains clear polyp views throughout the procedure. 3. Determines the full extent of the lesion, using adjunctive measures where appropriate. 4. Uses most appropriate polypectomy technique safely with no errors. 5. Maintains stable scope position throughout the polypectomy. This may involve asking an assistant to hold the scope in position to provide a stable platform for polypectomy. 6. Checks all polypectomy equipment is available and functioning with correct settings prior to the procedure. 7. Checks snare prior to introduction into the scope and ensures that snare is marked appropriately on the snare handle. 8. Maintains effective communication with the staff and addresses patient's concerns. 9. Checks diathermy settings are appropriate and ensures diathermy equipment is available and working. Ensures pad is attached to patient, foot pedal is accessible, no contraindication to diathermy. 10. Accurately photo documents pre and post polypectomy if appropriate.	
Grade 3	**Competent and safe throughout procedure, no uncorrected errors**
1. Maintains 5-11 o'clock axis during procedure with attempts at position correction. 2. Attempts to obtain clear polyp views through aspiration, insufflation and lens wash. 3. Determines the full extent of the lesion, may not use adjunctive measures. 4. Uses appropriate polypectomy technique safely based on size, site and morphology. 5. Adjusts and stabilises scope position prior to polypectomy 6. Checks polypectomy equipment is available and functioning. 7. Checks snare prior to introduction into the scope and ensures handle is marked. 8. Maintains effective communication either with the staff or patient. 9. Checks diathermy settings are appropriate. Ensures diathermy equipment is available and working, pad is attached to patient, foot pedal. 10. Photo documents pre and post polypectomy if appropriate.	
Grade 2	**Some standards not yet met, aspects to be improved, some errors uncorrected**
1. Does not maintain 5-11 o'clock axis. Few attempts at position correction. 2. Clear polyp views not maintained. 3. Does not determine the full extent of the polyp or fails to recognise features suggestive of malignancy. 4. Chooses inappropriate polypectomy technique. 5. Scope not stabilised adequately. Little or no attempts made at use of adjunctive techniques. 6. Does not check essential polypectomy equipment is available and functioning prior to the procedure. 7. Does not check snare function and marking prior to introduction into the scope. 8. Fails to give clear instructions to endoscopy staff or ignores patient concerns. 9. Does not check diathermy settings. 10. Does not photo documents pre and post polypectomy where appropriate.	
Grade 1	**Accepted standards not yet met, frequent errors uncorrected**
1. Does not maintain polyp in optimal position at any time during the procedure. 2. Poor polyp views throughout the procedure with no attempts at correction. 3. No attempt to determine or visualise full extent of the polyp. Attempts polypectomy on lesions which are unlikely to be endoscopically resectable. 4. Inappropriate polypectomy technique. Uses inappropriate diathermy settings. Uses diathermy or hot biopsy techniques unsafely or inappropriately. 5. Unstable scope position throughout procedure with no attempts made at correction. 6. Does not check for any polypectomy equipment. 7. Does not check snare function and marking prior to introduction into the scope. 8. Does not communicate with endoscopy staff or patient throughout the procedure. 9. Makes no attempt to check, or uses incorrect diathermy settings. 10. Does not photo document where appropriate.	

DOPyS: Polypectomy Grade descriptors. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPyS Grade Descriptors – Stalked Polyps	
Grade 4	**Highly Skilled Performance**
11. Applies prophylactic haemostasis measures (e.g. endo-loop, clips) where appropriate with excellent technique. 12. Always selects snare size appropriate to the polyp. 13. Always steers the snare over the polyp head accurately. 14. Correctly selects en-block or piecemeal removal. 15. Advances snare sheath slowly towards stalk as snare is closed gradually. 16. Excellent position on stalk with snare, midway between polyp head and stalk base. 17. Always mobilises the polyp to tent stalk away from mucosa and contra-lateral wall. 18. Applies appropriate degrees of diathermy with no evidence of contra-lateral burns or cutting through too quickly causing bleeding.	
Grade 3	**Competent and safe throughout procedure, no uncorrected errors**
11. Applies prophylactic haemostasis measures (e.g. endo-loop, clips if deemed appropriate) with good technique 12. Selects appropriate snare size. 13. Steers the snare over the polyp head with reasonable accuracy. 14. Correctly selects en-block or piecemeal removal. 15. Advances snare sheath in a controlled fashion towards stalk as snare is closed. 16. Appropriate position on stalk with snare. 17. Mobilises the polyp e.g. to tent stalk away from mucosa and contra-lateral wall if necessary. 18. Applies appropriate degrees of diathermy. Does not cause contra-lateral burns or cut through too quickly causing bleeding.	
Grade 2	**Some standards not yet met, aspects to be improved, some errors uncorrected**
11. Attempts to use prophylactic measures where appropriate) but with poor technique and uncorrected errors. 12. Snare size may be inappropriate for polyp size. 13. Multiple attempts at snare positioning over the polyp head. 14. Incorrectly selects en-block or piecemeal removal. 15. Closes snare too rapidly or in an uncontrolled fashion. 16. Poor snare position on polyp stalk. 17. Does not attempt to mobilise the polyp prior to diathermy where deemed necessary. Does not check for additional trapped tissue. 18. Inappropriate diathermy technique risking either bleeding or burns.	
Grade 1	**Accepted standards not yet met, frequent errors uncorrected**
11. Makes no attempt to use prophylactic measures where required. 12. Inappropriately small or large snare size used. 13. Multiple unsuccessful attempts at snare positioning over polyp head. 14. Incorrectly selects en-block or piecemeal removal. 15. Closes snare too rapidly, cutting/ shearing through the polyp stalk. 16. Poor snare position on polyp stalk either too close to the polyp head or too close to the base. 17. Makes no attempt to mobilise the polyp prior to diathermy where necessary. Does not check for additional trapped tissue. 18. Uses inappropriate diathermy technique causing either bleeding or burns.	

DOPyS: Polypectomy Grade descriptors. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPyS Grade Descriptors – Small sessile lesions/ Endoscopic mucosal resection	
Grade 4	**Highly Skilled Performance**
19. Accurately injects the submucosa, maintaining excellent views of the lesion 20. Always checks for lifting and only proceeds if the lesion lifts adequately. 21. Always selects snare size appropriate to the polyp 22. Steers appropriately sized snare accurately over the lesion head with no errors. 23. Correctly selects en-bloc or piecemeal removal depending on size of lesion. Removes piecemeal in as few pieces as possible. 24. Accurately positions snare over lesion as snare closed gradually. 25. Always ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa and mobilising the snare. 27. Applies appropriate diathermy with no complications. 28. Always ensures adequate haemostasis prior to further resection.	
Grade 3	**Competent and safe throughout procedure, no uncorrected errors**
19. Injects the submucosa, maintaining adequate views of the lesion. 20. Only proceeds if the lesion lifts adequately. 21. Selects appropriate snare size. 22. Steers appropriately sized snare accurately over the lesion head with minimal difficulty. 23. Correctly selects en-bloc or piecemeal removal depending on size of lesion. 24. Advances snare sheath in a controlled fashion towards stalk as snare is closed. 25. Ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa. 27. Applies appropriate diathermy with no complications. 28. Ensures adequate haemostasis prior to further resection.	
Grade 2	**Some standards not yet met, aspects to be improved, some errors uncorrected**
19. Attempts submucosal injection but inadequate views of the lesion obtained. 20. May proceed despite parts of the lesion not lifting and inadequate attempts at further lifting. 21. Snare size may be inappropriate for polyp size. 22. Clumsy steering of snare over the lesion head. 23. Incorrectly selects en-bloc or piecemeal removal, or piecemeal removal in excessive pieces. 24. Closes snare too rapidly or in an uncontrolled fashion. 25. Does not ensure that additional tissue is not trapped within snare. Inadequate attempt to tent the lesion away from the mucosa. 27. Inappropriate diathermy technique risking either bleeding or burns. 28. Does not necessarily ensure adequate haemostasis prior to further resection.	
Grade 1	**Accepted standards not yet met, frequent errors uncorrected**
19. Does not attempt submucosal injection. Optimal views of the lesion not obtained. 20. Does not check for lifting prior to attempting polypectomy. 21. Inappropriately small or large snare size used. 22. Clumsy steering of snare causing mucosal injury. 23. Incorrectly selects en-bloc or piecemeal removal. 24. Closes snare too rapidly, cutting/shearing through the polyp tissue. 25. Does not check for additional tissue trapped within snare prior to applying diathermy. No attempt to tent the lesion away from the mucosa. 27. Applies inappropriate diathermy with bleeding or burns. 28. Does not ensure adequate haemostasis prior to further resection.	

DOPyS: Polypectomy Grade descriptors. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

DOPyS Grade Descriptors – Small sessile lesions/ Endoscopic mucosal resection	
Grade 4	**Highly Skilled Performance**
26. Accurately injects the submucosa, maintaining excellent views of the lesion 27. Always checks for lifting and only proceeds if the lesion lifts adequately. 28. Always selects snare size appropriate to the polyp 29. Steers appropriately sized snare accurately over the lesion head with no errors. 30. Correctly selects en-bloc or piecemeal removal depending on size of lesion. Removes piecemeal in as few pieces as possible. 31. Accurately positions snare over lesion as snare closed gradually. 32. Always ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa and mobilising the snare. 29. Applies appropriate diathermy with no complications. 30. Always ensures adequate haemostasis prior to further resection.	
Grade 3	**Competent and safe throughout procedure, no uncorrected errors**
26. Injects the submucosa, maintaining adequate views of the lesion. 27. Only proceeds if the lesion lifts adequately. 28. Selects appropriate snare size. 29. Steers appropriately sized snare accurately over the lesion head with minimal difficulty. 30. Correctly selects en-bloc or piecemeal removal depending on size of lesion. 31. Advances snare sheath in a controlled fashion towards stalk as snare is closed. 32. Ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa. 29. Applies appropriate diathermy with no complications. 30. Ensures adequate haemostasis prior to further resection.	
Grade 2	**Some standards not yet met, aspects to be improved, some errors uncorrected**
26. Attempts submucosal injection but inadequate views of the lesion obtained. 27. May proceed despite parts of the lesion not lifting and inadequate attempts at further lifting. 28. Snare size may be inappropriate for polyp size. 29. Clumsy steering of snare over the lesion head. 30. Incorrectly selects en-bloc or piecemeal removal, or piecemeal removal in excessive pieces. 31. Closes snare too rapidly or in an uncontrolled fashion. 32. Does not ensure that additional tissue is not trapped within snare. Inadequate attempt to tent the lesion away from the mucosa. 29. Inappropriate diathermy technique risking either bleeding or burns. 30. Does not necessarily ensure adequate haemostasis prior to further resection.	
Grade 1	**Accepted standards not yet met, frequent errors uncorrected**
26. Does not attempt submucosal injection. Optimal views of the lesion not obtained. 27. Does not check for lifting prior to attempting polypectomy. 28. Inappropriately small or large snare size used. 29. Clumsy steering of snare causing mucosal injury. 30. Incorrectly selects en-bloc or piecemeal removal. 31. Closes snare too rapidly, cutting/shearing through the polyp tissue. 32. Does not check for additional tissue trapped within snare prior to applying diathermy. No attempt to tent the lesion away from the mucosa. 29. Applies inappropriate diathermy with bleeding or burns. 30. Does not ensure adequate haemostasis prior to further resection.	

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DOPyS Grade Descriptors – Post Polypectomy	
Grade 4	**Highly Skilled Performance**
29. Always examines remnant stalk/polyp base thoroughly to check for bleeding and any residual polyp tissue. 30. Identifies and resects any residual tissue accurately. 31. Identifies bleeding and performs adequate endoscopic haemostasis promptly. 32. Retrieves polyp using method appropriate to polyp/s size. 33. Checks for retrieval of entire polyp tissue and confirms retrieval with endoscopy staff. 34. Uses tattooing in the appropriate setting. Raises a bleb at appropriate site prior to switching to appropriate ink. Places appropriate number of tattoos.	
Grade 3	**Competent and safe throughout procedure, no uncorrected errors**
29. Examines remnant stalk/polyp base to check for bleeding and any residual polyp tissue. 30. Identifies and resects any residual tissue. 31. Identifies bleeding and performs adequate endoscopic haemostasis with satisfactory immediate results. 32. Retrieves, or attempts retrieval of polyp. May not use method appropriate to polyp/s size. 33. Attempts to check for retrieval of polyp. 34. Attempts to check for retrieval of polyp.	
Grade 2	**Some standards not yet met, aspects to be improved, some errors uncorrected**
29. Makes inadequate attempt to examine remnant stalk/polyp base. 30. Does not adequately identify or treat visible residual polyp tissue. 31. Does not determine the full extent of the polyp. Inadequately identifies or treats bleeding. 32. Chooses inappropriate polypectomy technique. 33. Does not check for retrieval of polyp**.** 34. May not use tattooing in the appropriate setting. Does not raise a bleb prior to switching to appropriate dye. May not place tattoos at appropriate site. Inappropriate depth of ink, risking peritoneal staining.	
Grade 1	**Accepted standards not yet met, frequent errors uncorrected**
29. Makes no attempt to examine remnant stalk/polyp base. 30. Leaves residual polyp tissue behind. 31. Does not identify or treat bleeding. 32. No attempts made at polyp retrieval. 33. Does not check for retrieval of polyp with endoscopy staff. 34. Does not use tattooing in the appropriate setting. Place tattoos at inappropriate site. Inappropriate depth of ink, risking peritoneal staining.	

DOPyS: Polypectomy Grade descriptors. Adapted from the Joint Advisory Group on GI Endoscopy (JAG) DOPS assessment forms, UK for the use in New Zealand Nurse Endoscopy Credentialing Programme

Continuing Competence

The expanded practice guideline requires a process of ongoing education to maintain competence for the expanded scope of practice (Pg. 12). Nursing Council of New Zealand has a minimum requirement of 60 hours professional development over three years however at senior nurse level with expanded practice this may not be sufficient. Continuing postgraduate education requirements should be acknowledged in the job description. Education may be through:

- Case presentation to medical and nursing colleagues
- Attendance or presentation at scientific meetings and conference (local, national or international)
- Attendance and participation in Multi- disciplinary meetings (MDM)
- Attendance at radiology and histo-pathology meetings
- Participation in research activities
- Annual learning needs analysis to plan education

Outcomes of expanded practice activities must be monitored and evaluated (NCNZ, 2010). Ongoing participation in processes that enable demonstration of continued competence including:

- Review of procedural data to ensure achievement meets expected performance standards (i.e. clinical audit).
- Mentorship to endoscopic trainees

In addition annual (or at least three yearly) assessment of continuing competence through the [INSERT DHB] PDRP portfolio assessment process including evidence pertaining to the three expanded practice competencies:

- Demonstrates initial and ongoing knowledge and skills for specific expanded practice role/activities through postgraduate education, clinical training and competence assessment.
- Participates in the evaluation of the outcomes of expanded practice, e.g. case review, clinical audit, multidisciplinary peer review.
- Integrates and evaluates knowledge and resources from different disciplines and health-care teams to effectively meet the health care needs of individuals and groups.

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Appendix 1

Registered Nurse Expanded Practice Role Development and Continuing Competence Pathway