Formative DOPS: Percutaneous endoscopic gastrostomy (PEG)

Date of procedure			
Trainee name		**Membership no. (eg. GMC/NMC)**	
Trainer name		**Membership no. (eg. GMC/NMC)**	
Outline of case			
Difficulty of case	**Easy**	**Moderate**	**Complicated**
Please tick appropriate box			

Level of supervision Complete DOPS form by ticking box to indicate the appropriate level of supervision required for each item below. Constructive feedback is key to this tool assisting in skill development.	**Maximal supervision** Supervisor undertakes the majority of the tasks/decisions & delivers constant verbal prompts	**Significant supervision** Trainee undertakes tasks requiring frequent supervisor input and verbal prompts	**Minimal supervision** Trainee undertakes tasks requiring occasional supervisor input and verbal prompts	**Competent for independent practice** no supervision required	**Not applicable**
Pre-procedure					
Blood results					
Confirm indication					
Abdominal scars					
Safe to proceed					
Consent					
Iv access & sedation					
Antibiotics given					
Monitoring					
Comments					
During insertion - endoscopist					
Supine intubation					
Diagnostic OGD					
Pathology					
Insufflation					
Site identification					
Snare handling					
Withdrawal of scope & wire					
Attachment of PEG					
Comments					
During insertion – PEG inserter					
Trolley set up					
Aseptic technique					
Check equipment					

For further information, please contact the JAG Office askjets@rcp.ac.uk 020 3075 1222 www.thejag.org.uk

Level of supervision	Maximal supervision	Significant supervision	Minimal supervision	Competent for independent practice	Not applicable
During insertion – PEG inserter					
Position check					
Check no air aspiration					
Needle in stomach					
Scalpel incision					
Needle into stomach					
Advance wire					
Pull wire / string to advance PEG					
Fixation of PEG					
Tract length					
Comments					
Post Procedure					
Antibiotics given					
Report					
Disposal of sharps					
Patient communication					
Team communication					
Manages complications					
Comments					
ENTS (endoscopic non-technical skills)					
Communication and teamwork					
Situation awareness					
Leadership					
Judgement and decision making					
Comments					

Learning Objectives for the next case The objectives should be added to the trainee's personal development plan (PDP) once DOPS is completed	
1.	
2.	
3.	

Overall Degree of Supervision required	**Maximal Supervision** Supervisor undertakes the majority of the tasks/decisions & delivers constant verbal prompts	**Significant Supervision** Trainee undertakes tasks requiring frequent supervisor input and verbal prompts	**Minimal Supervision** Trainee undertakes tasks requiring occasional supervisor input and verbal prompts	**Competent for independent practice** no supervision required
Please tick appropriate box				

For further information, please contact the JAG Office askjets@rcp.ac.uk 020 3075 1222 www.thejag.org.uk

DOPS form descriptors

Pre Procedure	
Blood results	Blood tests are checked pre-procedure to ensure no risk of bleeding – coagulation screen and full blood count
Confirm indication	The indication for the PEG is reviewed and confirmed as appropriate
Check abdominal wall scars	The abdominal wall is examined for any scars that may make insertion difficult
Clinical assessment of safety to proceed	The patient is assessed to be well.
Consent	The procedure should be postponed if any signs of chest sepsis or acute illness until such illness is treated
Antibiotics given	The consent form is reviewed and completed.
Iv access & sedation	In the case of a patient with capacity, the consent is taken from the patient.
Monitoring	In those patients without capacity, consent form completed using the Mental Capacity Act Best Interests principles.
DURING PROCEDURE – ENDOSCOPIST	
Supine intubation	• The endoscopist demonstrates the ability to safely intubate the oesophagus with the patient in the supine position.
Diagnostic ogd	• The endoscopist performs a full diagnostic OGD to D2.
Pathology	• If pathology is encountered this is dealt with appropriately. • If this raises doubt about the appropriateness of PEG insertion the procedure should be abandoned and rescheduled after further discussion with patient (eg. upper GI cancer).
Insufflation	• The endoscopist must ensure maximum air insufflation to hold the stomach in place and ensure easy access for PEG insertion.
Site identification	• The PEG inserter uses finger indentation to identify a site for insertion. • The endoscopist manoeuvres the tip of the endoscope to allow transillumination and visualisation of digital indentation to verify a safe site for PEG insertion. • The procedure should not proceed if this is not achieved and an alternate means of gastrostomy used (eg. radiologically inserted gastrostomy).
Snare handling	• The endoscopist communicates clearly with the assistant so that the snare can catch and gain secure hold of the wire / string.
Withdrawal of scope, wire / string	• The endoscopist removes the scope with secured wire / string and ensures this is safely held in position by an assistant
Attachment of peg	• The PEG is attached to the wire and lubricated to allow easy passage through the upper gastrointestinal tract. • The PEG is guided into the upper gastrointestinal tract as the wire is pulled.
DURING PROCEDURE – PEG INSERTER	
Trolley set up	• The PEG inserter ensures that the trolley is equipped with all kit needed to insert the PEG. • Gloves, local anaesthetic, syringes, PEG kit, swabs, sterile drapes.
Aseptic technique	• The PEG inserter ensures aseptic technique is used at all times.
Check equipment	• The PEG inserter checks that the PEG kit equipment is in working order before commencing.

Position check	• The PEG inserter uses digital indentation to reconfirm the site for insertion. • In the event of this not being possible further sites must be explored and confirmed with trans-illumination (over the sterile stomach wall).
Check no air aspiration	• Local anaesthetic is infiltrated under the skin and through the tract leading to the stomach. • Gentle traction of the syringe plunger must be used during insertion of needle to ensure that no hollow viscus (other than the stomach) has been punctured. If air is aspirated when the needle is not visible in the stomach then the site must be changed as hollow viscus perforation (eg. transverse colon) is likely.
Needle in stomach	• The needle is seen to enter the stomach by the endoscopist. • The needle can be left in place as a marker or removed depending on preference.
Scalpel incision	• An adequate incision is made in the skin with a scalpel that will allow easy passage of the PEG.
Needle into stomach	• The PEG inserter advances the introducer needle into the stomach again with an attached syringe with gentle traction of the plunger to ensure no hollow viscus punctured. • The introducer needle must be seen to enter the stomach.
Advance wire	• The PEG inserter withdraws the trocar and inserts the wire. • This is seen to enter the stomach and is snared by the endoscopist. Where necessary the PEG inserter alters the angle of the introducer needle to allow the wire to be caught by the snare more easily.
Pull wire to advance peg	• Once the endoscopist has attached the PEG, the PEG inserter pulls firmly and smoothly to advance the PEG into position. • One hand is used to maintain abdominal wall pressure against which the PEG can be pulled through. • The introducer needle should remain in place as long as possible to reduce the time the wire pulls against the skin – this will reduce the chance of a cheese wire cut.
Fixation of peg	• The PEG inserter puts all the attachment parts over the PEG in the correct order.
Tract length	• The PEG inserter secures the PEG and notes the tract length.
Post procedure	
Report	A report is completed that: 1. Documents position of PEG and tract length 2. Includes the NPSA sticker or instructions to the ward 3. Provides feeding and aftercare instructions
Disposal of sharps	• All sharps are disposed of safely.
Patient communication	• The patient is informed of the outcome of the procedure, including if the PEG insertion was abandoned and why.
Team communication	• Any specific instructions are communicated to those responsible for ongoing care of the patient, either through the written report or orally.
Manages complications	• Any complications are identified and managed with continued monitoring of patient post procedure.
ENTS (endoscopic non-technical skills)	
Communication and teamwork	• Maintains clear communication with assisting staff • Gives and receives knowledge and information in a clear and timely fashion • Ensures that both the team and the endoscopist are working together, using the same core information and understand the 'big picture' of the case • Ensures that the patient is at the centre of the procedure, emphasising safety and comfort • Clear communication of results and management plan with patient and/or

For further information, please contact the JAG Office askjets@rcp.ac.uk 020 3075 1222 www.thejag.org.uk

	carers
Situation awareness	• Ensure procedure is carried out with full respect for privacy and dignity • Maintains continuous evaluation of the patient's condition • Ensures lack of distractions and maintains concentration, particularly during difficult situations • Intra-procedural changes to scope set-up monitored and rechecked
Leadership	• Provides emotional and cognitive support to team members by tailoring leadership and teaching style appropriately • Supports safety and quality by adhering to current protocols and codes of clinical practice • Adopts a calm and controlled demeanour when under pressure, utilising all resources to maintain control of the situation and taking responsibility for patient outcome
Judgement and decision making	• Considers options and possible courses of action to solve an issue or problem, including assessment of risk and benefit • Communicates decisions and actions to team members prior to implementation • Reviews outcomes of procedure or options for dealing with problems • Reflects on issues and institutes changes to improve practice