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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	Maximal	Significant	Minimal	Competent	Not
	supervision	supervision	supervision	for	applicable
Complete DOPS form by	Supervisor	Trainee	Trainee	independent	approable
ticking box to indicate the	undertakes the	undertakes tasks	undertakes tasks	-	
appropriate level of	majority of the	requiring	requiring	practice	
supervision required for each	tasks/decisions &	frequent	occasional	no supervision	
item below. Constructive	delivers constant	supervisor input	supervisor input	required	
feedback is key to this tool	verbal prompts	and verbal	and verbal		
assisting in skill development.		prompts	prompts		
	T	Pre-proced	ure	1	
Blood results					
Confirm indication					
Abdominal scars					
Safe to proceed					
Consent					
Iv access & sedation					
Antibiotics given					
Monitoring					
Comments					
	Duri	ing insertion - e	ndoscopist		
Supine intubation			•		
Diagnostic OGD					
Pathology					
Insufflation					
Site identification					
Snare handling					
Withdrawal of scope &					
wire					
Attachment of PEG					
Comments					
	Duri	ng insertion – P	EG inserter	1	T
Trolley set up					
		1	1	1	1
Aseptic technique					

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		·		•		(PEG
Level of supervision	on	Maximal supervision	Significant supervision	Minimal supervision	Compete for independ practice	applicable
		Du	ring insertion – P	EG inserter		
Position check						
Check no air aspir	ration					
Needle in stomac	h					
Scalpel incision						
Needle into stom	ach					
Advance wire						
Pull wire / string advance PEG	to					
Fixation of PEG						
Tract length						
Comments		I		I	1	I
			Post Proced	ure		
Antibiotics given						
Report						
Disposal of sharps	s					
Patient communie	cation					
Team communica	tion					
Manages complic	ations					
Comments						
		ENTS (endoscopic non-1	technical skills)		
Communication a	nd					
teamwork						
Situation awarene	ess					
Leadership						
Judgement and de	ecision					
making Comments				1		
The el	hiectives of		ng Objectives for he trainee's personal de			completed
1.	ojectives SI		ne trainée s personal de	PDI (PDI	J ONCE DOF 3 IS	completed
2.						
3.						
Overall	Maxin	nal	Significant	Minimal		Competent for
Degree of	Superv	-	Supervision	Supervisi	on	independent
Supervision	Supervis	or undertakes	Trainee undertakes ta	sks Trainee unde	rtakes tasks	practice
required	tasks/de	ority of the cisions & delivers verbal prompts	requiring frequent supervisor input and verbal prompts	requiring occ supervisor in verbal promp	put and	no supervision required
Please tick appropriate box						

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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	The indication for the PEG is reviewed and confirmed as appropriate
indication	
Check	The abdominal wall is examined for any scars that may make insertion difficult
abdominal wall	
scars	
Clinical	The patient is assessed to be well.
assessment of	
safety to	
proceed	
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 &	In the case of a patient with capacity, the consent is taken from the patient.
sedation	
Monitoring	In those patients without capacity, consent form completed using the Mental
	Capacity Act Best Interests principles.
	DURING PROCEDURE – ENDOSCOPIST
Supine	The endoscopist demonstrates the ability to safely intubate the oesophagus
intubation	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	• The PEG inserter uses finger indentation to identify a site for insertion.
identification	 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	• The endoscopist removes the scope with secured wire / string and ensures this
scope, wire /	is safely held in position by an assistant
string	
Attachment of	• The PEG is attached to the wire and lubricated to allow easy passage through
peg	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	 The PEG inserter ensures aseptic technique is used at all times.
technique	
Check	• The PEG inserter checks that the PEG kit equipment is in working order before
equipment	commencing.

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Position check	• The PEG inserter uses digital indentation to reconfirm the site for insertion.
r oshion check	 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	 Local anaesthetic is infiltrated under the skin and through the tract leading to
aspiration	the stomach.
aspiration	 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	 The needle is seen to enter the stomach by the endoscopist.
stomach	 The needle can be left in place as a marker or removed depending on
Stornach	preference.
Scalpel incision	 An adequate incision is made in the skin with a scalpel that will allow easy
Scalper incision	passage of the PEG.
Needle into	 The PEG inserter advances the introducer needle into the stomach again with an
stomach	attached syringe with gentle traction of the plunger to ensure no hollow viscus
Stomach	punctured.
	 The introducer needle must be seen to enter the stomach.
Advance wire	 The PEG inserter withdraws the trocar and inserts the wire.
Advance 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	 Once the endoscopist has attached the PEG, the PEG inserter pulls firmly and
advance peg	smoothly to advance the PEG into position.
uuvunee peg	 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	All sharps are disposed of safely.
sharps	· · · · · · · · · · · · · · · · · · ·
Patient	• The patient is informed of the outcome of the procedure, including if the PEG
communication	insertion was abandoned and why.
Team	Any specific instructions are communicated to those responsible for ongoing
communication	care of the patient, either through the written report or orally.
Manages	Any complications are identified and managed with continued monitoring of
complications	patient post procedure.
	ENTS (endoscopic non-technical skills)
Communication	Maintains clear communication with assisting staff
and teamwork	• 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

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	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

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