## Direct Observation of Procedural Skills [DOPS] Airway

***Please complete this form in BLOCK CAPITALS and*** *BLACK* ***ink***

|  |  |
| --- | --- |
| ACCP’s Surname |  |
| ACCP’s Forename(s) |  |
| NMC number or equivalent  |  | **NUMBER MUST BE COMPLETED** |
| Procedure |  |
| Code Number |  |

|  |  |
| --- | --- |
| Observed by |  |
| GMC Number |  | **GMC NUMBER MUST BE COMPLETED** |
| Date |  |  |
| Signature of observing doctor |  |

**Assessment:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Practice was satisfactory** | Tick one | Assessor’s signature |
|  | **Practice was unsatisfactory**  | Tick one | Assessor’s signature |
| Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given. |
| **Was oxygenation maintained:****Was the airway secured:****Example of good practice were:****Areas of practice requiring improvement were:****Further learning and experience should focus on:** |

## Clinical Evaluation Exercise [CEX] Advanced Airway

***Please complete this form in BLOCK CAPITALS and BLACK ink***

|  |  |
| --- | --- |
| ACCP’s Surname |  |
| ACCP’s Forename(s) |  |
| NMC number or equivalent  |  | **NUMBER MUST BE COMPLETED** |

|  |  |
| --- | --- |
| Observed by |  |
| GMC/NMC Number |  | **GMC/NMC NUMBER MUST BE COMPLETED** |
| Date |  | Profession/grade |
| Signature of observing clinician |  |

**Assessment:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Practice was satisfactory** | Tick one | Assessor’s signature |
|  | **Practice was unsatisfactory**  | Tick one | Assessor’s signature |
| Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given. |
| **Example of good practice were:****Areas of practice requiring improvement were:****Further learning and experience should focus on:** |

If you have rated the performance unsatisfactory, you **MUST** indicate which elements were unsatisfactory

## Case Based Discussion [CBD] Airway

***Please complete this form in BLOCK CAPITALS and BLACK ink***

|  |  |
| --- | --- |
| ACCP’s Surname |  |
| ACCP’s Forename(s) |  |
| NMC or equivalent number |  | **NUMBER MUST BE COMPLETED** |

|  |  |
| --- | --- |
| Code Number or Description of Case |  |
| Observed by |  |
| GMC Number |  | **GMC NUMBER MUST BE COMPLETED** |
| Date |  |  |
| Signature of supervising doctor |  |

**Clinical Setting:**

ICU [ ]  HDU [ ]  ED [ ]  Ward [ ]  Transfer [ ]  Other [ ]

**Assessment:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Practice was satisfactory** | Tick one | Assessor’s signature |
|  | **Practice was unsatisfactory**  | Tick one | Assessor’s signature |
| Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given. |
| **Examples of good practice were:****Areas of practice requiring improvement were:****Further learning and experience should focus on:** |

|  |
| --- |
| **Special focus of discussion:** |

## Module completion sign off proforma

**This application form is for use by Advanced Critical Care Practitioners (ACCPs) with FICM membership who are employed in the role of ACCP and:**

(a) Have satisfactorily completed Advanced Critical Care Practitioner training to equivalence of the FICM ACCP National Curriculum 2015

(b) Have successfully completed all aspects of the FICM Optional Skills Framework for Advanced Airway Management for ACCPs.

**The application form must be submitted electronically.** Please complete in full using the electronic version of the document. Do not alter the format. **Submit the form to** **contact@ficm.ac.uk**the submission will be acknowledged by return email. Hard copies will **not** be accepted.

**Please read the guidelines in this form carefully** and note the supporting documentation required for your application to be considered. Where supporting documents are needed from a referee, please ensure that these are scanned versions of signed letters.

# Part 1: Personal Details

1.1 Title 1.2 Last name 1.3 First name(s)

1.4 Full address (you must include postcode) 1.5 Telephone number (Home)

1.6. Telephone number (Work)

 1.7 Telephone number (Mobile)

1.8 Gender 1.9 Date of birth (DD/MM/YYYY) 1.10 Email address

1.11 NMC / HCPC Registration Number 1.12 Expiry date

Name of applicant Signature of applicant\*

Date declaration signed (DD/MM/YYYY)

*\*Signature: Please either include an electronic signature or print this page out, sign it in hard copy and scan it for submission electronically.*

##

## Part 2: Training Supervisor Certificate

**This certificate must be completed and signed by the Training Supervisor of the applicant who supervised their period of training. This certificate is to confirm the applicant’s training status.**

 I (Training Supervisor)

 of (work address)

 verify that (name of applicant)

**Has successfully completed the knowledge, skills and competencies for the OSF for Advanced Airway management for ACCPs. I realise it is a probity issue for me to sign this certificate without having understood the standard identified in those competencies and/or for signing the certificate of an applicant who does not reach the standard. Please ensure each competency below is ticked; failure to do so will result in the form being returned.**

|  |
| --- |
|  |
| Advanced Airway Skills Part One: Theatre-based training  | [ ]  |
| Advanced Airway Skills Part Two: Critical Care-based training | [ ]  |

**Please provide details of Training Supervisor in case further information is required:**

Email address (es):

Telephone number(s):

Signature\*:

*\* Please either include an electronic signature or print this page out, sign it in hard copy and scan it for submission electronically.*

## Part 3: Clinical Supervisor Certificate

**This certificate must be completed and signed by a second Consultant Supervisor who has been involved in delivering the module to confirm the applicant has completed all relevant parts of the module.**

 I (Consultant Supervisor)

 of (work address)

 verify that (name of applicant)

**Has successfully completed the knowledge, skills and competencies for the OSF for Advanced Airway management for ACCPs. I realise it is a probity issue for me to sign this certificate without having understood the standard identified in those competencies and/or for signing the certificate of an applicant who does not reach the standard. Please ensure each competency below is ticked; failure to do so will result in the form being returned.**

|  |
| --- |
|  |
| Advanced Airway Skills Part One: Theatre-based training  | [ ]  |
| Advanced Airway Skills Part Two: Critical Care-based training | [ ]  |

**Details of Clinical Supervisor in case further information is required:**

Email address (es):

Telephone number(s):

Signature\*:

*\*Please either include an electronic signature or print this page out, sign it in hard copy and scan it for submission electronically.*

## Part 3: ACCP Programme Director/Lead Certificate

**This certificate must be completed and signed by the ACCP Programme Director / Lead in the applicant’s current trust. This may be the same person as the Training Supervisor.**

 I (ACCP Lead)

 of (name of Region)

 at (work address)

support the application for ACCP Membership of

 (name of applicant)

Signature\* Date (DD/MM/YYYY)

*\* Please either include an electronic signature or print this page out, sign it in hard copy and scan it for submission electronically.*

## Reflective Account Proforma (Optional)

## Reflective Account Form

Completing a reflective account of advanced airway management can be used as part of your revalidation cycle demonstrating that you are meeting the needs of the NMC Revalidation Process, HCPC Continuing Professional Development (CPD) Guide and Good Medical Practice.

|  |  |
| --- | --- |
| Discussion topic |  |
| Key lessons learnt |  |

|  |  |
| --- | --- |
| Name of reviewer |  |
| NMC/HCPC/GMC number |  |
| Signature |  |

Module Completion Sign Off via “Prior Learning” Route Proforma

**Advanced Airway Management for Advanced Critical Care Practitioners Module Completion for those who have pre-existing Advanced Airway Practice**

FICM acknowledge that many ACCPs have undertaken Advanced Airway practice as a core part of their role for many years. These ACCPs may wish/be eligible to complete the FICM ACCP Advanced Airway Optional Skills Framework Module (OSFs) 2021 via a “Prior Learning” route. This route will only be open to those ACCPs who have undertaken regular Advanced Airway practice prior to January 2022. It is recommended that training undertaken after this date uses the FICM Advanced Airway OSF

In order to complete the Advanced Airway Module via the “Prior Learning” route the ACCP will have to demonstrate:

* Maintenance of a logbook of all advanced airway interventions undertaken including details regarding any complications.
* Regular planned theatre sessions, at least every 6 months.
* Review of advanced airway skills must be undertaken as part of annual appraisal including review of any related adverse incidents and ongoing experience and maintenance of competency.
* They have undertaken an annual simulation session to practice emergency airway drills, or evidence of actual situations in practice.
* They regularly attend relevant courses, update days and educational opportunities relating to Advanced Airway Management.
* They have relevant airway experience recorded in a logbook, including simulation exercises. A logbook should include details of number of elective theatre lists undertaken, numbers of procedures performed, sim sessions and workshops attended.

Prior to sign off for Advanced Airway Module via the “Prior Learning” route, the ACCP should meet with their Clinical Supervisor and review their previous training in relation to the OSF document Advanced Airway Management for Advanced Critical Care Practitioners.

**This form is for use by Advanced Critical Care Practitioners (ACCPs) with FICM membership who are employed in the role of ACCP and:**

1. Have satisfactorily completed Advanced Critical Care Practitioner training to equivalence of the FICM ACCP National Curriculum 2015
2. Have previously completed Advanced Airway training to an equivalence of all aspects of the FICM Optional Skills Framework for Advanced Airway Management for ACCPs prior to October 2021
3. Continue to undertake all aspects of governance relating to Advanced Airway Practice to the standard outlined in the document *Supplementary Document: Advanced Airway Management for Advanced Critical Care Practitioners Module Completion for those who have pre-existing Advanced Airway Practice.*

**The form must be submitted electronically.** Please complete in full using the electronic version of the document. Do not alter the format. **Submit the form to** **contact@ficm.ac.uk**the submission will be acknowledged by return email. Hard copies will **not** be accepted. **Please read the guidelines in this form carefully** and note the supporting documentation required for your form to be accepted. Where supporting documents are needed from a referee, please ensure that these are scanned versions of signed letters.

Part 1: Personal Details

 1.1 Title 1.2 Last name 1.3 First name(s)

 1.4 Full address (you must include postcode) 1.5 Telephone number (Home)

1.6 Telephone number (Work)

 1.7 Telephone number (Mobile)

 1.8 Gender 1.9 Date of birth (DD/MM/YYYY) 1.10 Email address

 1.11 NMC / HCPC Registration Number 1.12 Expiry date

 Name of applicant Signature of applicant\*

*\*Please either include an electronic signature or print this page out, sign it in hard copy and scan it for submission electronically.*

 Date declaration signed (DD/MM/YYYY)

Part 2: Training Supervisor Certificate

**This certificate must be completed and signed by the Training Supervisor of the applicant who supervised their period of training. This certificate is to confirm the applicant’s training status.**

 I (Training Supervisor)

of (work address)

verify that (name of applicant)

**Has previously successfully completed the knowledge, skills and competencies equivalent to the OSF for Advanced Airway management for ACCPs. I acknowledge it is a probity issue for me to sign this certificate without having understood the standard identified in those competencies and/or for signing the certificate of an applicant who does not reach the standard. Please ensure each competency below is ticked; failure to do so will result in the form being returned.**

|  |
| --- |
|  |
| Historical training equivalent to Advanced Airway skills Part One: Theatre-based training  | [ ]  |
| Historical training equivalent to Advanced Airway skills Part Two: Critical Care-based training | [ ]  |
| Maintenance of a logbook of all advanced airway interventions undertaken including details regarding any complications  | [ ]  |
| Attends regular planned theatre sessions, at least every 6 months | [ ]  |
| Has had a review of advanced airway skills undertaken as part of annual appraisal including review of any related adverse incidents and ongoing experience and maintenance of competency  | [ ]  |
| Has undertaken an annual simulation session to practice emergency airway drills, or evidence of actual situations in practice  | [ ]  |
| Regularly attends relevant courses, update days and educational opportunities relating to Advanced Airway Management | [ ]  |
| Has relevant airway experience recorded in a logbook, including simulation exercises. A logbook should include details of number of elective theatre lists undertaken, numbers of procedures performed, sim sessions and workshops attended.  | [ ]  |

**Please provide details of Training Supervisor in case further information is required:**

Email address (es):

Telephone number(s):

Signature\* Date (DD/MM/YYYY)

*\* Please either include electronic signatures or print the appropriate pages out, sign them in hard copy and scan it for submission electronically.*

Part 3: Clinical Supervisor Certificate

**This certificate must be completed and signed by a second Consultant Supervisor who has been involved in delivering the module to confirm the applicant has completed all relevant parts of the module.**

 I (Consultant Supervisor)

of (work address)

verify that (name of applicant)

**Has successfully completed the knowledge, skills and competencies for the OSF for Advanced Airway management for ACCPs. I acknowledge it is a probity issue for me to sign this certificate without having understood the standard identified in those competencies and/or for signing the certificate of an applicant who does not reach the standard. Please ensure each competency below is ticked; failure to do so will result in the form being returned.**

|  |
| --- |
|  |
| Historical training equivalent to Advanced Airway skills Part One: Theatre-based training  | [ ]  |
| Historical training equivalent to Advanced Airway skills Part Two: Critical Care-based training | [ ]  |
| Maintenance of a logbook of all advanced airway interventions undertaken including details regarding any complications  | [ ]  |
| Attends regular planned theatre sessions, at least every 6 months  | [ ]  |
| Has had a review of advanced airway skills undertaken as part of annual appraisal including review of any related adverse incidents and ongoing experience and maintenance of competency  | [ ]  |
| Has undertaken an annual simulation session to practice emergency airway drills, or evidence of actual situations in practice  | [ ]  |
| Regularly attends relevant courses, update days and educational opportunities relating to Advanced Airway Management | [ ]  |
| Has relevant airway experience recorded in a logbook, including simulation exercises. A logbook should include details of number of elective theatre lists undertaken, numbers of procedures performed, sim sessions and workshops attended.  | [ ]  |

**Details of Clinical Supervisor in case further information is required:**

Email address (es):

Telephone number(s):

Signature\* Date (DD/MM/YYYY)

*\* Please either include electronic signatures or print the appropriate pages out, sign them in hard copy and scan it for submission electronically.*

Part 4: ACCP Programme Director/Lead Certificate

**This certificate must be completed and signed by the ACCP Programme Director / Lead in the applicant’s current trust/health board. This may be the same person as the Training Supervisor.**

 I (ACCP Lead)

 of (name of Region)

 at (work address)

Confirm the completion of the Advanced Airways OSF by

 (name of applicant)

 Signature\* Date (DD/MM/YYYY)

*\* Please either include electronic signatures or print the appropriate pages out, sign them in hard copy and scan it for submission electronically.*