MASTERY SKILLS PATHWAY

Diagnostic Ascitic Aspiration

August 2019

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01 MASTERY SKILLS PATHWAY OVERVIEW

The NHS Lothian Mastery Skills Pathway has been developed to enhance the technical and non-technical skills of clinicians undertaking complex clinical procedures.
MASTERY SKILLS PATHWAY OVERVIEW

A NEW DEVELOPMENT
Welcome to this NHS Lothian Mastery Skills Pathway Reading Pack. We hope you find this pack a valuable learning resource to complement your simulated practice sessions.

The Mastery Skills Pathway is an educational, quality assurance and patient safety initiative to promote high-quality training and safe, effective patient care for high-risk procedural skills.

Your Pre-Learning (Videos and Reading pack), Deliberate Practise and Simulation-Based Assessment sessions will optimally prepare you for real-life procedural performance, under direct supervision.

Below is some additional information about Mastery methodology.

METHODS

GAINING COMPETENCY
We recognise that the traditional model of “see one, do one, teach one” is no longer acceptable. Our new approach allows development of fundamental skills, in a completely safe manner before real-life practice.

In addition, this novel approach allows refreshment of old skills, minimising the effects of potentially harmful skill decay.

The path to procedural competency for clinicians is supported by the following:

A trained faculty.

Knowledge packs containing a combination of written and video educational resources for each procedural skill, with a consistent emphasis on patient safety.

Self-Directed Deliberate Practice where you can spend as much time as you like familiarising yourself with the technical aspects of the procedure.

A supervised simulated checklist-based assessment session where you will receive feedback on your performance from your tutor.

Real-life practice under direct supervision until you are independently competent.
PROCEDURAL PHASES

Complex procedural skills can be daunting prospects initially. It is not uncommon for novices to become overwhelmed when performing such procedures, resulting in avoidable error or harm. It can be helpful to fragment the task into discrete, manageable parts, ensuring one is complete before moving onto the next.

Our “Mastery Procedural Phases” is one method of approaching any complex skill. Six Procedural Phases have evolved to help break down skills into more manageable components. These can be more broadly grouped into domains of Pre-procedure, Procedure and Post-procedure (as shown across). This will be discussed more in the videos and simulation skills sessions.

Phase 1
Preparation and Positioning
Consider whether a procedure is indicated, that no contraindications exist and that informed consent has been given. An appropriately trained assistant should be available to assist you with preparing equipment and in positioning the patient correctly to make the procedure as easy as possible.

Phase 2
A Three-point Procedural Pause
The procedural pause is an opportunity for all those involved in the procedure, including the patient, to acknowledge that they are content and happy to proceed.
1. Ensure that the patient is comfortable and that they are happy to proceed.
2. Your assistant should have the opportunity now to voice any concerns, identify any problems or anything else that needs addressed
3. The clinician should ensure that the equipment is all present, checked and laid out in the order of use.
Once this is completed, and a verbal rehearsal performed, the insertion can begin.

Phase 3
Asepsis and Local Anaesthetic infiltration
Asepsis should be strictly observed to prevent potentially life-endangering infections. Local anaesthetic should be used, for most procedures, to minimise any discomfort experienced by the patient.

Phase 4
Insertion
This phase will be covered in a later section of this pack and during the video demonstration.

Phase 5
Anchor & dress
All indwelling devices must be secured & dressed to minimise risk of movement, failure and contamination.
Each procedure has specific requirements.

Phase 6
Completion
You should communicate with the patient and the team looking after them, particularly with regard to symptoms to report and observations required.

Pre-procedure
1. Preparation & Positioning
2. Procedural Pause
3. Asepsis & Anaesthesia
4. Insertion
5. Anchoring & Dressing
6. Completion
Each skill covered in the NHS Lothian Mastery Skills Pathway has been assigned learning outcomes for you to achieve.
LEARNING OUTCOMES

After reading and viewing the content contained within this pack the trainee should gain the following:

1. An understanding of the indications for performing the procedure and its use in clinical practice.
2. An understanding of risk assessment, patient safety concerns and contraindications to the procedure.
3. An understanding of the potential complications of the procedure and the basic principles of their management.
4. An understanding of the practicalities of performing the procedure in a safe and structured fashion.
5. An awareness of your own personal limitations and when to obtain help from a senior clinician.
Diagnostic ascitic aspiration (also known as an ascitic tap) is a frequently performed procedure, used to obtain a sample of fluid from the peritoneal cavity.

It is a key investigation in the assessment of new ascites and should be performed urgently (within 6 hours) in all unwell patients with cirrhosis and ascites to exclude infection.

This is a procedural competency requirement for several postgraduate curricula.

**Indications**

1. To determine the aetiology of new-onset ascites

2. To exclude spontaneous bacterial peritonitis in any cirrhotic patient with ascites and a clinical deterioration

**Risk Assessment: Ascitic aspiration**

**Potential Contraindications:**

1. Anticoagulation

2. Patient factors increasing technical difficulty
Risk Assessment: Ascitic aspiration (cont.)

Anticoagulation:

- A prolonged prothrombin time (PT) is a common finding in cirrhotic patients as a result of impaired synthetic liver function and reduced production of clotting factors. However, as these patients also have reduced production of anticoagulant factors, a prolonged PT does not equate to an increased bleeding risk. There is therefore no need to correct a prolonged PT prior to an ascitic tap.

- Similarly, low platelets are common in cirrhosis and ascitic taps can safely be performed in patients with platelets >20. If the platelet count is less than 50 you should seek senior advice about the risks and benefits of a platelet transfusion.

- In contrast, anticoagulation with warfarin or direct-acting oral anticoagulants (DOACs) does increase bleeding risk and these should be withheld or reversed if possible. An ascitic tap should be avoided in patients with disseminated intravascular coagulation.

Patient Factors:

- A confused/agitated patient increases the technical challenge and should prompt consideration of whether a more experienced practitioner is available to perform the procedure.

- Other physical patient factors can increase the technical challenge of performing an ascitic tap. These include obesity, significant organomegaly, and previous abdominal surgery with the risk of adhesions. Again, seek an experienced practitioner.

- Pregnancy, abdominal skin infection at the proposed puncture sites, and severe bowel distension are usually contraindications to an ascitic tap.
04 PATIENT SAFETY CONSIDERATIONS

With all skills, time should be taken to consider patient safety and how any potential risk factors can be mitigated.
SAFETY

SPECIFIC CONSIDERATIONS
When performing procedures, the goal is to safely obtain diagnostic information, or therapeutically intervene, having removed or minimised any potential risk factors. If there is any concern that significant risk of harm may compromise patient safety, delay the procedure and seek senior advice.

Specific safety considerations are listed below:

<table>
<thead>
<tr>
<th>MANDATORY COMPONENT</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS TO FULL RESUSCITATION EQUIPMENT</td>
<td>• Location of resuscitation trolley should be known</td>
</tr>
<tr>
<td></td>
<td>• Ensure access to airway and suction equipment</td>
</tr>
<tr>
<td></td>
<td>• Consider establishing IV access pre-procedure</td>
</tr>
<tr>
<td>COMPETENT PRACTITIONER</td>
<td>• Supervisor for training</td>
</tr>
<tr>
<td>APPROPRIATE ASSISTANT</td>
<td>• Must be present throughout the procedure</td>
</tr>
<tr>
<td></td>
<td>• Competent to contribute to equipment checking and ensure patient comfort etc.</td>
</tr>
</tbody>
</table>

QUESTIONS TO CONSIDER

ALWAYS CONSIDER THE FOLLOWING
• Does it need to be done?
• Does it need to be done now?
• Am I competent to do this?
• Is supervision/assistance available?
• Am I familiar with the equipment?
• Does the patient have capacity to consent to the procedure?

PATIENT EDUCATION

ALWAYS TALK WITH THE PATIENT
Communicating and informing the patient of exactly what the procedure involves can reduce anxiety and facilitate better positioning for the procedure.
The patient should be made aware why they are having the procedure, the benefits, the potential risks/complications and the alternatives to the procedure.
Once this has been done, informed consent should be sought and documented. There is a consent form available in NHS Leeds which can be used for written consent for lumbar puncture.
If the patient does not have capacity to give informed consent, and the procedure is deemed clinically necessary, ensure an Adult with Incapacity form is completed.
Always establish whether the patient has any known allergies prior to the procedure - they may have an allergic reaction to local anaesthetic or antiseptic skin preparation.

IN SUMMARY
Tell the patient:
- Why there is a need for the procedure
- How the procedure will be performed
- What the potential risks/complications are
- What the alternatives are
Gain consent.
Always offer the patient the opportunity to ask questions.
There are several complications associated with this procedure. Some of these, although rare, can be extremely serious. It is your responsibility to explain these risks so that the patient may make an informed decision about their care.
## Complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal wall haematoma (&lt;1%)</td>
<td>Local pressure, reassurance, simple analgesia</td>
</tr>
<tr>
<td>Haemoperitoneum (&lt;0.1%)</td>
<td>Monitor for circulatory compromise/ haemoglobin drop.</td>
</tr>
<tr>
<td></td>
<td>Volume replacement, correct coagulopathy, seek senior support.</td>
</tr>
<tr>
<td></td>
<td>May require cross-sectional imaging e.g. CT angiogram</td>
</tr>
<tr>
<td>Viscus (bowel or bladder) perforation (&lt;0.1%)</td>
<td>Seek senior support and surgical review. Likely to require cross-sectional imaging.</td>
</tr>
</tbody>
</table>
06 ANATOMY & PHYSIOLOGY

A sound understanding of the relevant anatomy and physiology will allow you to improve your practice, predict and prevent problems.
Ascites is the accumulation of excess fluid within the peritoneal cavity. This usually becomes clinically detectable when there is more than 1L of fluid although >20L can ultimately collect within the peritoneal cavity.

Abdominal distension should be investigated by percussion for flank dullness, and assessment for “shifting dullness” by rolling the patient onto their side.

Upon suspicion of first presentation with ascites, the person should undergo abdominal imaging, in the form of Ultrasound or CT, to confirm presence of ascites before interventional procedures.

Surface Anatomy

There are 3 preferred safe sites for performing an ascitic tap, as illustrated below. These sites are selected as those least likely to result in injury to either major blood vessels (especially the inferior epigastric arteries) or internal organs.

![Figure 1: potential paracentesis sites marked with 'X' along with representation of the normal course of the inferior epigastric arteries (Adapted from Thomsen et al, 2006)](image)

1. Left and right lower quadrants: 3cm above and 3cm medial to the anterior superior iliac spine (ASIS) represents a site where the abdominal wall is usually thin and the fluid pool is often deep.
   
The left side is generally preferred to the right as it avoids the caecal pole and any potential hepatosplenomegaly (as both organs enlarge towards the RIF).
2. Midline: 3cm below the umbilicus represents a site with a low risk of bleeding as the linea alba is generally avascular.
Pathophysiology

Cirrhosis is the most common cause of ascites and accounts for approximately 80% of cases. The onset of ascites is a major landmark in the natural history of cirrhosis and is associated with a worsening in prognosis.

In cirrhotic ascites, there is also a risk of bacterial translocation across the gut barrier resulting in spontaneous bacterial peritonitis (SBP). This may present in a non-specific manner, and some patients may not have either fever or abdominal pain. SBP is often associated with an acute kidney injury and carries a relatively high mortality. For these reasons, it is crucial to assess for SBP in a cirrhotic patient with ascites and any clinical deterioration. The British Society of Gastroenterology cirrhosis care bundle recommends that an ascitic tap is performed within 6 hours of admission in all patients with cirrhosis and ascites.

Ascitic Fluid Analysis

The appearance of ascitic fluid can provide useful clues. Ascites is usually clear and straw-coloured. It may become turbid in the presence of infection, or blood-stained in malignancy (or following a previous paracentesis). Chylous ascites appears milky and suggests impaired lymphatic drainage.

The analysis of ascitic fluid plays an essential role in determining the underlying aetiology of new onset ascites.

<table>
<thead>
<tr>
<th>Routine tests</th>
<th>Rarer tests (in specific situations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin</td>
<td>Amylase (if suspected pancreatic cause)</td>
</tr>
<tr>
<td>Protein</td>
<td>Cytology (if clinical suspicion of malignancy)</td>
</tr>
<tr>
<td>White cell count</td>
<td>AFB smear / culture (if suspicion of TB)</td>
</tr>
<tr>
<td>C&amp;S (blood culture bottles)</td>
<td>Triglyceride (if chylous)</td>
</tr>
<tr>
<td></td>
<td>Bilirubin (if suspected bile leak eg post-surgical)</td>
</tr>
</tbody>
</table>
As with pleural effusions, one of the primary aims is to distinguish transudate from exudate. This distinction is best made by using the serum ascites-albumin gradient (SAAG) which is calculated as a simple subtraction:

\[ \text{SAAG} = \text{serum albumin} - \text{ascitic albumin} \]

A value of ≥11g/L is consistent with ascites secondary to portal hypertension (see table below).

<table>
<thead>
<tr>
<th>Serum ascites-albumin gradient &gt;11 g/l</th>
<th>Serum ascites-albumin gradient &lt; 11 g/l</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis</td>
<td>Malignancy</td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>Pancreatitis</td>
</tr>
<tr>
<td>(Nephrotic syndrome)</td>
<td>(Nephrotic syndrome)</td>
</tr>
</tbody>
</table>

Low protein (total protein <15g/L) ascites is a risk factor for SBP and should prompt consideration of long-term antibiotics as primary prophylaxis against infection.

Ascitic white cell count and fluid culture are key investigations in patients with cirrhosis. A polymorphonuclear leucocyte count >250/mL indicates the presence of bacterial infection. Inoculating some ascitic fluid into blood culture bottles at the bedside improves the yield of an organism from 40-50% to 70-80%.

Other relevant biochemical tests may include amylase (>1000U/L suggests pancreatic ascites) and bilirubin (>6mg/dL might suggest a post-operative bile leak). A sample should be sent for cytology in cases where peritoneal malignancy is suspected. However, as the diagnostic yield is relatively low, larger volumes of fluid may be required.
EQUIPMENT & RESOURCES

Taking time to ensure you have the equipment and resources you require will ultimately make your task easier, allowing you to consider eventualities and how you will deal with them.
CHECKLIST

Equipment + Resources

- Competent supervisor
- Skilled assistant
- Clean trolley, waste disposal and sharps bin
- Sterile gloves and apron
- Betadine or chlorhexidine antiseptic solution
- Sterile dressing pack including gauze, liquid container and drape
- 20ml syringe
- Green (21G) needle
- Universal containers and blood culture bottles
- Adhesive dressing
08 INSERTION PROCEDURE

Phase 1 - Preparation & Positioning
Phase 2 - Procedural Pause
Phase 3 - Asepsis & Anaesthesia
Phase 4 - Insertion
Phase 5 - Anchoring & Dressing
Phase 6 - Completion
PREPARATION, ASSISTANCE & POSITIONING

Exclude contraindications

- Check whether known allergies
- Examine patient – note organomegaly, scars of previous surgery
- Review platelet count and any recent imaging
- Check for anticoagulant medications

Preparation

- Ensure patient has emptied bladder
- Lie patient supine, head elevated 20-30 degrees
- Identify and mark planned site for tap (e.g. with blunt needle cap)
  (3cm above and 3cm medial to Left ASIS)

Arrange equipment (non-touch technique)

- Open sterile pack onto procedural trolley
- Open procedural equipment onto pack
- Ensure trolley on correct side for clinician

**Local anaesthetic is optional (most practitioners do not use it for a diagnostic tap)**
PROCEDURAL PAUSE

VISUALISE THE PROCEDURE IN THE CORRECT ORDER

PERFORM A VERBAL REHEARSAL WITH YOUR ASSISTANT, INCLUDING A PLAN FOR YOUR POSITIONS RELATIVE TO EACH OTHER WHILE COLLECTING ANY SAMPLES

PERFORM A 3 POINT CHECK; PATIENT, ASSISTANT AND YOURSELF

PROVIDE EVERYONE PRESENT THE OPPORTUNITY TO SPEAK UP PRIOR TO COMMENCING

PERFORM A FINAL EQUIPMENT CHECK

ASEPSIS & ANAESTHESIA

Aseptic Conditions

Wearing apron, wash hands and put on sterile gloves

Apply antiseptic skin preparation to patient

Drape the area

Allow skin to dry

Local anaesthetic is optional for a diagnostic ascitic aspiration
Attach a 21G (green) needle to the 20mL syringe

At the appropriate site, advance the needle slowly whilst gently aspirating the syringe until there is free aspiration of fluid (indicating entry into the peritoneal cavity)

Aspirate approximately 20ml fluid for samples (greater volume if needed for pathology)

Remove the needle and put the sample safely aside on the sterile surface

If gas is aspirated, this indicates passage of the needle into bowel.
The procedure must be stopped and urgent senior advice obtained.
ANCHORING & DRESSING

No specific anchoring is required for diagnostic aspiration

Apply a simple adhesive dressing to the entry site, following removal of the needle

COMPLETION & DOCUMENTATION

Inoculate fluid into blood culture bottles and universal containers

Dispose of waste and sharps appropriately

Label and send samples to:
  - Microbiology for cell count and culture
  - Biochemistry for albumin and protein
  - Pathology if malignancy suspected

Paired serum should be sent for albumin

Document the procedure, including any immediate complications and results
  - Ideally use an electronic menu to prompt high standard documentation
09 APPENDICES

Mastery Assessment Procedural Checklist

References
# Mastery Assessment Procedural Checklist

## Diagnostic Ascitic Aspiration

<table>
<thead>
<tr>
<th>Skill Phase + Component</th>
<th>Start Yes</th>
<th>Start No</th>
<th>End Yes</th>
<th>End No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 – Preparation + Positioning</strong></td>
<td></td>
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<tr>
<td><strong>Identifies correct patient and lists contra-indications</strong></td>
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<tr>
<td><strong>List core consent topics</strong></td>
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</tr>
<tr>
<td><strong>Lists essential equipment + ensures trained assistant present</strong></td>
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<tr>
<td>Describes optimal position (supine + arm raised)</td>
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<td></td>
</tr>
<tr>
<td>Optimises ergonomics (bed height / spread of equipment)</td>
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<tr>
<td><strong>Identifies and marks insertion site (3cm + 3cm from ASIS)</strong></td>
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<tr>
<td><strong>Phase 2 – Procedural Pause</strong></td>
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<tr>
<td><strong>Performs final equipment check</strong></td>
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<tr>
<td>Performs 3-point check: Patient, Assistant and Clinician</td>
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<tr>
<td><strong>Phase 3 – Asepsis + Anaesthesia</strong></td>
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<tr>
<td><strong>Puts on Apron + Sterile Gloves</strong></td>
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<tr>
<td><strong>Applies antiseptic skin wash + allows to dry (non-touch)</strong></td>
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<tr>
<td><strong>Drapes the patient (non-touch +/- tape by assistant)</strong></td>
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<tr>
<td>Discusses option of local anaesthetic</td>
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<tr>
<td><strong>Phase 4 – Insertion</strong></td>
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<tr>
<td><strong>Safely inserts needle (double-handed, pincer grip)</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Aspirates as needle advances</td>
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<tr>
<td>Obtains ascitic fluid (at least 20ml)</td>
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<tr>
<td><strong>Phase 5 – Anchoring + Dressing</strong></td>
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<tr>
<td>Describes application of simple adhesive dressing</td>
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<tr>
<td><strong>Phase 6 – Completion + Global Points</strong></td>
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<tr>
<td>Describes processing of fluid samples + documentation of procedure</td>
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<tr>
<td><strong>Maintains control of needle throughout</strong></td>
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<tr>
<td><strong>Demonstrates safe sharps management throughout</strong></td>
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<tr>
<td><strong>Maintains asepsis throughout</strong></td>
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<tr>
<td>Demonstrates effective communication with assistant throughout</td>
<td></td>
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</tr>
<tr>
<td><strong>Total Score (out of 21)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>/21 /21</td>
</tr>
</tbody>
</table>

## Summative Assessment

<table>
<thead>
<tr>
<th><strong>ALL CRITICAL SAFETY ITEMS PASSED?</strong></th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final score ≥ 17?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Would you be content for this learner to proceed to directly supervised clinical practice?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ask the learner; would they be content to proceed to directly supervised clinical practice?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **YES** to all items: Proceed to Directly Supervised Clinical Practice
- **NO** to any item: Return for another session

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REFERENCES


