# Peer review of practice (anaesthetics) observation form

### Participant Details:

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| Name of active anaesthetist (Observed): | ACRRM Number: | Email: |
| Name of peer reviewer (Observer): | Position: | Email: |

### Observation Details:

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| --- | --- |
| Date: | Location: |
| Duration in hours: | Type of theatre list: |

Observation and Feedback Focus Points (suggested by the candidate, in accordance with pre-observation reflection and identification of learning needs)

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| **Category of practice** | **Observations** | **Outcome of discussion** | **Action Plan** |
| **PATIENT MANAGEMENT (Medical expert)** | | | |
| Preoperative assessment |  |  |  |
| Additional investigations/interventions |  |  |  |
| Selection of anaesthetic technique |  |  |  |
| Case preparation |  |  |  |
| Use of monitoring devices |  |  |  |
| Clinical and situational awareness |  |  |  |
| Response to change in patient status |  |  |  |
| Postoperative management plan |  |  |  |
| Ethical care of the patient |  |  |  |
| **COMMUNICATION (Communicator)** | | | |
| Management of consent process |  |  |  |
| Relationship with patients and their families/carers |  |  |  |
| Negotiating patient concerns, values and wishes |  |  |  |
| Communication with anaesthetic assistant |  |  |  |
| Communication with theatre team |  |  |  |
| **TEAMWORK/COLLABORATION (Collaborator)** | | | |
| Plan of care agreed with surgeon |  |  |  |
| Communication of anaesthetic management plan to all team members |  |  |  |
| Negotiation with other staff to optimise patient care, as required |  |  |  |
| Cooperation with team and requesting assistance from others |  |  |  |
| Clear delegation of tasks |  |  |  |
| Responsiveness to questions or suggestions |  |  |  |
| **LIST MANAGEMENT (Leader and Manager)** | | | |
| Case allocation and prioritisation |  |  |  |
| Operating list organisation and efficiency |  |  |  |
| Management of theatre resources and cost/utility implications |  |  |  |
| Vigilance |  |  |  |
| Handover of patient care |  |  |  |
| **PATIENT SAFETY (Health advocate and professional)** | | | |
| Adherence to agreed standards and guidelines, including participation in WHO Surgical Safety Checklist |  |  |  |
| Risk minimisation (practices to reduce patient harm) |  |  |  |

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| **REFLECTION AND DISCUSSION SUMMARY (see below for discuss prompts)** |
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| Action Plan (smart goals-specific, measurable, achievable, realistic, timely) |
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Name (Observed) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Observed) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When complete please use the Report an activity function in your CPD portfolio to add this to your CPD record or email to [pdp@acrrm.org.au](mailto:pdp@acrrm.org.au)

### DISCUSSION PROMPTS

* I noticed that you <insert anaesthetic technique here>. What were your reasons for using this approach?
* How do you find <insert device/equipment here>?
* The team <insert statement re communication/collaboration>. <Insert statement re elaborating on how this changes when working with different teams>.
* I noticed you <insert risk minimisation strategies here> and this prevented <insert specifics>. Have you had a similar case where the outcome was not as favourable?
* With the last patient I could see that <insert specifics>. How would you have managed <insert alternate scenario>?
* Can you tell me about a time when <insert specifics e.g. where a device failed, or a patient deteriorated, or you encountered a difficult airway or access?
* What did you do well?
* What would you change if you were to re-run that consultation?
* What could you do differently next time to improve/prevent …...?
* Things I saw that contribute to your effectiveness regarding …. included ….
* Perhaps if you did less/more of.…it could improve your effectiveness regarding ….
* Have you ever tried …...?
* Can I offer you something from my experience about ….?
* I was wondering what you were considering when you ….