Direct Observation of Procedural Skills Assessment Form

Trigeminal Microvascular Decompression

Trainee Name: _____

The trainee should initiate completion of this DOPS when they feel they have a reasonable chance of demonstrating safe and efficient independent practice. The Assessor must be the Surgical Supervisor or another Surgical Trainer recognised by the Board of Neurosurgery who has supervised the trainee undertaking the procedure on multiple occasions. Where the Assessor is not the Surgical Supervisor, the Surgical Supervisor must also sign the DOPS form to confirm they are confident with the assessment completed by the Assessor.

This DOPS form must submitted to the Board by the trainee within two weeks of the date the procedure was last observed by the Assessor as recorded on this DOPS form.

I confirm the trainee can perform all of the principal procedure independently in a consistently safe and effective manner based on my direct observations of the trainee performing the procedure on multiple occasions. This includes but is not limited to the trainee satisfactorily achieving the following:

- Pre-operative preparation (clinical assessment, investigations, consent, formal timeout etc)
- Site of incision
- Craniotomy, venous sinus exposure and management of mastoid air cells
- Appropriate atraumatic exposure of CPA, identification & protection of cranial nerves
- Management of venous bleeding
- Management of tight posterior fossa
- Microvascular decompression technique
- Appropriate closure technique
- Post-operative management

I consent to this Form being provided to all future training units in which the trainee is placed as part of the Surgical Education and Training Program.

_____ / _____ / _____

Date this procedure was last observed by the Assessor

_____ / _____ / _____

Date this DOPS Form was signed

Assessors' Name (write above)

Assessors' Signature (sign above)

If the Assessor was not the Surgical Supervisor, the Surgical Supervisor must also complete the following declaration.

As Surgical Supervisor, I verify that I have discussed the above assessment with the Assessor and am confident that it is an accurate assessment of the trainee's ability. I consent to this Form being provided to all future training units in which the trainee is placed as part of the Surgical Education and Training Program.

Surgical Supervisors' Name (write above)

Surgical Supervisors' Signature (sign above)