



DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS)

Please complete the questions using a cross Please use black ink and CAPITAL LETTERS

Doctor's Name: _____

PMDC Number: _____

Clinical setting:		A&E <input type="checkbox"/>	OPD <input type="checkbox"/>	In-patient <input type="checkbox"/>	Acute Admission <input type="checkbox"/>	Other		
Procedure number		<input type="checkbox"/> <input type="checkbox"/>						
Assessors position:		Consultant <input type="checkbox"/>	SpSR <input type="checkbox"/>	SpR <input type="checkbox"/>	Specialty doctor <input type="checkbox"/>	Nurse <input type="checkbox"/>	Other <input type="checkbox"/>	
Number of previous DOPS observed by assessor with any trainee		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5-9 <input type="checkbox"/>	>9 <input type="checkbox"/>
Number of times procedure performed by trainee:		0 <input type="checkbox"/>	1-4 <input type="checkbox"/>	5-9 <input type="checkbox"/>	>10 <input type="checkbox"/>	Difficulty of procedure:		
					Low <input type="checkbox"/>	Average <input type="checkbox"/>	High <input type="checkbox"/>	
Please grade the following areas	Well below expectations	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above expectations	U/C*	
	1	2	3	4	5	6		
1 Demonstrate understanding of indications, relevant anatomy, technique of procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 Obtains informed consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 Demonstrates appropriate preparation pre-procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 Appropriate analgesia or preparation pre-procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5 Technical ability safe sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6 Aseptic technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7 Seeks help where appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8 Post procedure management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9 Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10 Consideration of Patient/professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11 Overall ability to perform procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* U/C Please mark this if you have not observed the behaviour and therefore feel unable to comment.								
Please use this space to record areas of strength or any suggested development								
Anything especially good?				Suggestions for development:				
Have you had training in the use of this assessment tool? <input type="checkbox"/> Face to face <input type="checkbox"/> Have read guidelines <input type="checkbox"/> Web/ CD-Rom								
						Time taken for observation: (in minutes) <input type="checkbox"/> <input type="checkbox"/>		
						Time taken for feedback <input type="checkbox"/> <input type="checkbox"/>		
Assessors signature:		Date (mm/yy)						
<input type="text"/>		<input type="text"/>						
Assessor's Name: _____		<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>						

*if appropriate

Please note failure of return of all completed forms to your administrator is a probity issue

Acknowledgement: Adapted with permission of the American Board of internal Medicine

SpSR - Specialty Senior Registrar
SpR - Specialty Registrar