



ANZCA Course in Perioperative Medicine curriculum

December 2023 v1.1

Our innovative multidisciplinary collaboration

ANZCA	RNZCGP	RACS	RACGP
FPM	RACP	ACRRM	CICM



ANZCA
FPM

Contents

Introduction.....	3
Aim of the course	3
Graduate outcome statement.....	4
Prerequisites for enrolment.....	4
The aim of the ANZCA Course in Perioperative Medicine Curriculum	4
Principles of curriculum design	4
Recognition of prior learning and experience (RPLE)	6
Key features of the curriculum	6
Format of the curriculum	7
Abbreviations in the curriculum	8
Learning outcomes.....	8
Assessment within the ANZCA Course in Perioperative Medicine	9
eLearning modules.....	11
Logbook	11
Workshops	11
Planning, reviewing and recording	11
Unit of study 1 – Preoperative assessment.....	13
Unit of study 2 – Preoperative planning.....	16
Unit of study 3 – Optimisation	21
Unit of study 4 – Intraoperative impacts on patient outcomes	24
Unit of study 5 – Postoperative assessment and management.....	28
Unit of study 6 – Discharge planning and rehabilitation.....	32
Appendix 1 – Lists of medical conditions, circumstances and history	37

Introduction

The term “perioperative” refers to the time around surgery, for which there are three key phases: pre, intra, and postoperative. These phases have traditionally been used by medical professionals to differentiate and establish roles and responsibilities for patient care, however, this can result in medical specialists practicing in ‘silos’ with gaps in knowledge and care. The perioperative clinician has the knowledge and skills to effectively identify complex patient needs, that may or may not require intervention, before, during or after surgery, and can appropriately collaborate in a multidisciplinary team to coordinate and optimise patient care and surgical outcomes.

As part of the advancement of perioperative medicine education, ANZCA has formed a Chapter of Perioperative Medicine and a course in perioperative medicine. The design of the ANZCA Course in Perioperative Medicine aligns with the framework described in [A framework for perioperative care in Australia and New Zealand](#). The framework is an ANZCA initiative that was developed in collaboration with representatives of other specialist colleges and perioperative medicine special interest groups. The perioperative medicine course supports ANZCA’s vision for perioperative medicine, which is to advance care within a more seamless, coordinated, multidisciplinary and interdisciplinary model.

The perioperative medicine course consists of six units of study, each of which are 10 weeks in duration. Aspects of the program are self-guided, however, participants are required to attend a workshop and clinical immersion experience with each unit of study.

This document should be read in conjunction with:

- Regulation 45 – Education program leading to Graduate of the Chapter of Perioperative Medicine (regulation 45)
- ANZCA Course in Perioperative Medicine Handbook (the handbook)

Aim of the course

The aim of the course is to equip participants with the knowledge and practical skills to establish and deliver excellence in perioperative care that align with the principles outlined in the ANZCA Perioperative Care Framework.

By completing the perioperative medicine course, participants will be able to:

- Have an in-depth understanding of requirements for patient perioperative assessment and medical management.
- Identify and manage risks for patient optimisation.
- Reduce incidence of post-surgical complications.

And contribute to:

- Improving patient safety and quality of care.
- Patient support, advocacy, education and awareness.
- Record keeping and research.

- Staff collaboration and multidisciplinary decision making.

Graduate outcome statement

While remaining medical specialists in their practice area, graduates can use the post-nominals GChPOM. The post-nominals indicate that the clinician has undertaken further learning to be able to carry out excellence and leadership in perioperative care; that is, to work as part of a collaborative and multidisciplinary team to ensure patients are informed and medically optimised before, during and after surgery and throughout the recovery period.

The perioperative medicine course does not qualify as a specialist qualification; the perioperative clinician remains an expert in their speciality area and can coordinate the care of a patient with other medical and allied health professionals, therefore, minimising the gaps in specialist knowledge and contributing to personalised, comprehensive patient care.

Prerequisites for enrolment

To be eligible to register, medical practitioners wishing to undertake the perioperative medicine course must either:

- hold a fellowship with the: Australian College of Rural and Remote Medicine (ACRRM), Australian and New Zealand College of Anaesthetists (ANZCA), College of Intensive Care Medicine (CICM), Royal Australasian College of Physicians (RACP), Royal Australasian College of Surgeons (RACS), Royal Australian College of General Practitioners (RACGP), Royal New Zealand College of General Practitioners (RNZCGP), or
- if a trainee of one of the above colleges, have completed their fellowship examination (if there is one), and be within 12 months (one full time equivalent) of expected completion of their primary fellowship.

The aim of the ANZCA Course in Perioperative Medicine Curriculum

The ANZCA Course in Perioperative Medicine Curriculum (the curriculum) defines the course structure and design, including the required teaching and assessment activities. The curriculum aims to:

- Articulate the extent of knowledge, range of skills and professional behaviours necessary for safe, consistent and high-quality perioperative patient care.
- Detail the learning and assessment strategies.
- Specifies learning outcomes.

Principles of curriculum design

Learning is aligned to patient needs: Learning is directed toward meeting the healthcare needs of patients from when surgery is contemplated through to optimal outcome. Learning is relevant to current and anticipated demands of perioperative medicine practice, including development of

attributes across all the perioperative medicine roles in practice. There is a particular focus on shared decision making and providing culturally safe perioperative care.

Learning is focused on perioperative medicine as a component of the whole

perioperative care context: Learning focuses on key features of perioperative services within a multidisciplinary and interdisciplinary context, as distinct from isolated service delivery. This includes the ability to effectively communicate with, and refer to, other medical craft groups and allied health practitioners involved in perioperative medicine and perioperative care provision, as their expertise is required.

Learning is based on identified competencies: The foundation of this curriculum is the ANZCA curricula documents which were developed using evidence based, best practice methodology. Prerequisites and learning activities are identified to assist participants in achieving competencies articulated within the curriculum document. The assessment strategy and course are formulated specifically to determine whether participants have achieved the standard required in the curriculum.

Learning is experiential and occurs in a hybrid program: Learning occurs within the context of a hybrid program of eLearning modules, workshops, and a clinical immersion experience in perioperative units. Participants will engage in clinical activities at varying degrees of autonomy appropriate to the participants expertise and specialist craft group.

Learning is focused on achieving outcomes: Participants must spend a minimum amount of time in the clinical immersion setting as outlined in the handbook. Clear assessment targets ensure that only those participants who demonstrate competence in the breadth and depth of theoretical knowledge and clinical practice, as articulated by the curriculum, are awarded the graduate of the Chapter of Perioperative Medicine of ANZCA (GChPOM) to ensure high quality and safe, unsupervised perioperative medical care for patients.

Learning is guided and participant-driven: Participants engage in self-directed learning through eLearning modules, workshop content and clinical immersion experiences. Participants can view their progress on the learning management system (LMS) platform and must maintain a logbook where they can plan their clinical immersion experiences with their supervisor. This allows the participant and their supervisor to monitor and review progress toward competence and completion.

Learning is facilitated by feedback and reflection and confirmed by summative assessment: Participants initiate two micro-assessments in the clinical area during the 10-week unit of study. In addition, the eLearning assessments are designed to be both an online activity and also a reflective discussion with supervisors. This enables participants to incorporate multi-sourced learning, self-reflection and feedback into future practice.

Learning is flexible: Individuals learn at different rates. Although minimum durations of time are fixed for each unit of study, sequencing of learning is flexible within that time frame to account for the different learning opportunities available in different learning contexts.

Learning uses case-based scenarios: Assessment of learning is determined by assessments directly relevant to working in a perioperative unit, utilising clinical case scenarios and technology for delivery where required.

Learning is a continuum: Curriculum requirements acknowledge continuing professional development (CPD) initiatives that align with the Medical Board of Australia (MBA). Lifelong learning, beyond achievement of the ANZCA Course in Perioperative Medicine, is promoted to ensure that perioperative medicine leadership and practice remains current, competent and safe.

Recognition of prior learning and experience (RPLE)

No prior learning and/or experience will be recognised towards completion of the perioperative medicine course, with the exception of some credit for recent clinical training time.

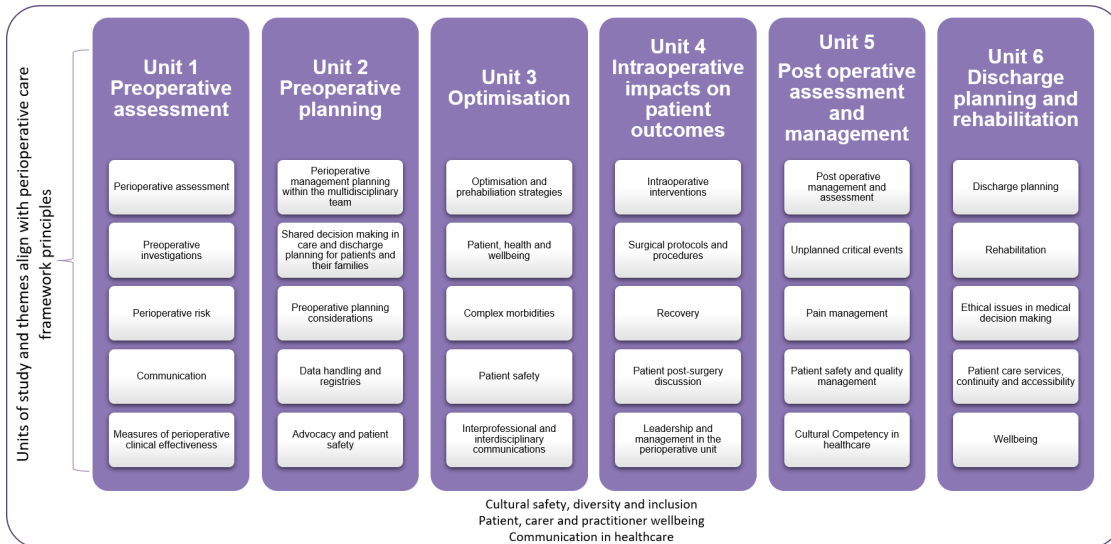
Participants undertaking the perioperative medicine course, who are working in a perioperative medicine (POM) related training role, may have time credited for the clinical immersion time, as outlined in the handbook.

Key features of the curriculum

The curriculum consists of:

- Perioperative medicine learning outcomes integrated with roles in practice.
- Themed units of study delivered programmatically (see Figure 1).

The achievement of learning outcomes (LOs) and completion of a program of assessments within the course are underpinned by development of the breadth of professional behaviours referred to within the roles in practice. As participants focus their attention on gaining learning outcomes within the units of study, they will be applying the knowledge and skills they have gained while working through the clinical immersion experiences.



Roles in practice

The CanMEDS framework, developed by the Royal College of Physicians and Surgeons of Canada, is the basis of the ANZCA roles in practice. These emphasise a comprehensive medicine practice, rather than a narrow, biomedical and medical expert one.

The perioperative medicine course roles in practice are medical expert, communicator, collaborator, leader and manager, health advocate, professional, and scholar. They are embedded across the curricular components, with all clinical and theoretical learning outcomes considered in terms of how they align with the roles in practice.

Format of the curriculum

Each unit of study is presented in the following format:

Code	Learning outcome	Competency area	Assessment
PA_ME 1.1.1	Demonstrates the ability to conduct a comprehensive medical history specifically relevant to the planned anaesthesia and surgery	S	C

1. Section header

The header at the top left of the page indicates to which unit of study the learning outcomes relate.

2. Learning outcome code

This indicates the code for the learning outcome, which is made up of the code for the unit of study, the role in practice and sequential numbering of the learning outcome. In the above example, this is unit of study one (1) – perioperative assessment (PA), medical expert (ME), and 1.1 as the first outcome under subsection 1.

3. Learning outcome

This describes the learning outcome to be achieved.

4. Competency area

Refers to knowledge, skills and behaviours aligned with a learning outcome

5. Assessment method

This indicates the primary assessment method(s) for the learning outcome and whether the outcome is to be achieved in the e-learning module, the clinical setting or both.

6. Role in practice title

Indicates the title of the role in practice aligned with the learning outcomes.

Abbreviations in the curriculum

Unit of study key	Competency domains key
Unit of study 1: Preoperative assessment (PA) Unit of study 2: Preoperative planning (PP) Unit of study 3: Optimisation (O) Unit of study 4: Intraoperative impacts on patient outcome (IIPA) Unit of study 5: Post operative assessment and management (POAM) Unit of study 6: Discharge planning and rehabilitation (DPR)	Knowledge (K) Skill (S) Behaviours (B)

Perioperative medicine course roles in practice key	Learning strategy key
Communicator (CM) Medical Expert (ME) Collaborator (CL) Leader and Manager (LM) Health advocate (HA) Scholar (SC) Professional (PF)	Clinical immersion (C) e-Learning module (eM) Workshop (W)

Learning outcomes

Learning outcomes describe what the participant will learn as the result of specified and supported study. Learning outcomes are defined in terms of knowledge, skills or behaviours and here completes the phrase: “By completing the unit of study, the participant will”

In each unit of study, learning outcomes have been grouped into knowledge, skills, or behaviours within the perioperative medicine course roles in practice. While these separate areas of competence are important, overall, the program aims to guide the development of competence in professional judgment, which is the unique combination of all three.

The meanings of verbs that begin a number of knowledge-related learning outcomes are as follows:

- Outline – give the main features or general principles.
- Define – give the precise meaning.
- Describe – give a detailed account of.
- Compare – examines the similarity or dissimilarity between two concepts.
- Analyse – examine component parts in detail.
- Explain – make plain, interpret, and account for.
- Discuss – present in detail for examination and consideration.
- Evaluate – make an appraisal of the worth of something, assess, consider and examine.

In relation to skill-related learning outcomes, the use of the words ‘demonstrate, identifies, performs, plans, participates, applies and assesses’ indicates that participants must be able to show how they would perform the skill, for example in a simulated scenario, not necessarily perform the skill with a patient involved.

Assessment method

An assessment strategy that supports the curriculum has been developed. Every learning outcome has been matched to a minimum of one assessment method. Learning outcomes and competencies for each unit of study are assessed using:

- Knowledge checks and reflections based on activities in the eLearning modules.
- Clinical based assessments (CBAs) conducted in the clinical setting or in simulation.

The following four CBA tools each have a different focus. They guide participants to competence in key clinical tasks and assist supervisors in monitoring participant performance and progress.

Assessment within the ANZCA Course in Perioperative Medicine

Clinical-based assessments

Clinical based assessments have a significant role in the assessment of many of the learning outcomes, specifically those that involve the application of knowledge in practice. The assessed outcomes are defined by the specific case, procedure, environment and issues encountered during an assessment. Supervisors are encouraged to ask relevant questions to explore the participant’s knowledge, and how they apply it in that clinical setting and patient circumstance.

The four clinical-based assessments are:

Observation of clinical skills (OCS)

The OCS is an assessment designed to assess and provide a structured feedback format for both knowledge and technical proficiency regarding a discrete clinical skill.

The OCS is assessed by the supervisor in the clinical immersion setting. Details on how the assessment will be marked are available on the LMS. Details on the assessment requirements are available in the handbook.

Micro clinical assessment (MCA)

The micro clinical assessment is designed to assess the clinical skills of a participant and assist them in attaining greater autonomy.

It provides the supervisor with a structured format for directly observing and assessing the performance of a participant during clinical immersion which will range from the preoperative assessment to the postoperative discharge and rehabilitation.

An assessment can be used to cover the entire encounter or to focus on certain aspects of a case, such as the preoperative assessment.

The MCA is assessed by the supervisor in the clinical immersion setting. Details on how the assessment will be marked are available on the LMS. Details on the assessment requirements are available in the handbook.

Case analysis activity simulation (CAAS)

This assessment tool examines the skills of reasoning, decision making, interpretation and application of evidence in relation to a fictional case (simulation) presented to the participant.

The CAAS activity discussion focuses on patient case records which the participant has completed independently.

It provides an opportunity for supervisors to assess and give guidance on relevant clinical knowledge, understanding, documentation and reasoning and encourages the participant to research the issues raised in the case.

The CAAS is assessed in two parts.

- Part one: Assessed on the LMS.
- Part two: Assessed by the supervisor in the clinical immersion setting.

Details on how the assessment will be marked are available on the LMS. Details on the assessment requirements are available in the handbook.

Patient consultation observation assessment simulation (PCOAS)

This assessment tool focuses on a patient consultation, which a participant has completed independently.

The PCOAS assesses and provides structured feedback about proficiency to communicate with the patient and conduct a structured, comprehensive, preoperative assessment of the patient.

In developing an appropriate plan, the participant must seek consent and consider the patient, facility, proposed surgery and other factors, including cultural safety. The participant can then reflect on how these influence planning and, where appropriate, the need for referral and/or transfer to an alternate centre for care.

The PCOAS is assessed by two clinicians who have not been involved in supervision of a participant. Details on how the assessment will be marked are available on the LMS. Details on the assessment requirements are available in the handbook.

eLearning modules

The eLearning modules for each unit of study are assessed using a series of knowledge checks. Each of the knowledge checks are considered individually formative and collectively summative upon completion of a unit of study.

The knowledge check activities provide the participant with a positive learning experience and the progressive development of knowledge and skills that are consolidated in the clinical environment. The learning is self-paced and provides opportunity to repeat a knowledge check where additional learning is required.

Although the eLearning modules are listed in sequence, the learning management system (LMS) enables the participant flexibility to complete the modules in any order within the 10-week duration of the unit of study.

Logbook

Participants are required to complete a logbook for each unit of study, outlining the number of hours spent within each clinical immersion setting, and the activities and observations conducted.

The logbook is not assessed, however, it is a requirement that participants complete and submit it as part of each unit of study.

The logbook must be submitted within two-calendar weeks of completing the unit of study.

Failure to complete the logbook will result in failure of the unit of study.

Workshops

Each unit of study requires compulsory attendance of a one-day workshop which is normally delivered on the weekend between week seven and week eight of the unit of study.

The program for each workshop intentionally focuses on case-based scenarios and reflects the unit of study content.

The venue for the workshops will be ANZCA House in Melbourne, Victoria. Face to face attendance is recommended, however, attendance via webinar can be arranged where required.

Planning, reviewing and recording

It is each participant's responsibility to ensure that planning occurs as part of their orientation to the clinical immersion setting.

There are two stages:

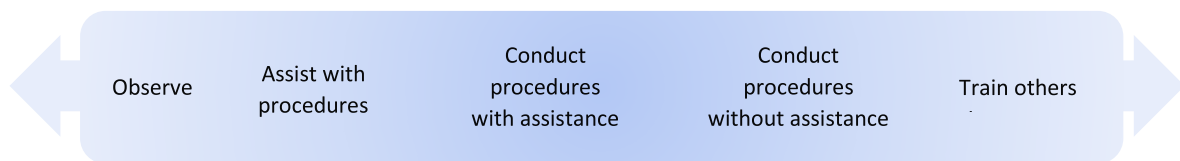
Clinical immersion plan: In consultation with their supervisor, participants must complete and submit their clinical immersion plan through the LMS within the first two calendar weeks of starting the unit of study.

During clinical immersion, participants will experience a variety of perioperative care settings, some of which will be familiar or current working environments and others that will be less familiar or outside their area of practice. Participants attend clinical immersion, usually, but not always, in a supernumerary capacity.

During clinical immersion orientation and planning of the 10-week experience, the supervisor and participant will discuss and agree the level of autonomy the participant will have in any given setting based on the participants individual past clinical experience.

The level of clinical autonomy does not indicate a level of achievement but instead indicates the extent of participation during the planned clinical experiences. It provides guidance for the participant and the perioperative practitioners of the range of activities the participant can do during clinical immersion experience, that is: observe, assist with procedures, conduct procedures with assistance, conduct procedures without assistance, and able to train others.

Clinical immersion is experienced through activities on the autonomy continuum:



Completion of clinical immersion review: This review is facilitated by the supervisor and conducted once all clinical immersion requirements are completed.

Time management is an essential component of study. This includes allocating appropriate time to acquire the knowledge, skills and behaviours associated with each unit of study and ensuring assessments are conducted in accordance with the assessment table.

Unit of study 1 – Preoperative assessment

The aim of the unit of study is to provide the participant with medical knowledge and clinical experience in the following aspects of perioperative care:

- Perioperative assessment.
- Preoperative investigations.
- Perioperative risk.
- Communication.
- Measures of perioperative clinical effectiveness.

Code	Action/activity	Competency area	Learning strategy
1.1 Medical expertise			
PA_ME 1.1.1	Demonstrate the ability to conduct a comprehensive medical history specifically relevant to the planned anaesthesia and surgery	S	C
PA_ME 1.1.2	Demonstrate the ability to perform a clinical examination	S	C
PA_ME 1.1.3	Discuss the importance of applying appropriate investigations and perioperative clinical risk stratification tools including the 'Choosing Wisely Framework' in the perioperative preassessment setting	K	eM, W
PA_ME 1.1.4	Demonstrate the use of a frailty scale to assess a patient's frailty status	S, K	C
PA_ME 1.1.5	Demonstrate the use of appropriate assessment tools to assess a patients' mental state	S, K	C, eM
PA_ME 1.1.6	Demonstrate the use of the ASA physical status classification grading to identify a patient's preoperative health status	S, K	C, eM
PA_ME 1.1.7	Discuss the evaluation of a patients' mental state and its potential impact upon surgical outcomes	K	eM
PA_ME 1.1.8	Assess severity and stability of co-morbid medical conditions and, together with the findings from functional capacity assessment, determine major domains of perioperative risk	S	C
PA_ME 1.1.9	Identify patients with factors predictive of chronic postsurgical pain and consider a pain management plan to mitigate the transition from acute to chronic pain	S, K	C, eM
PA_ME 1.1.10	Discuss the evaluation of a patient's functional capacity and its potential impact upon surgical	K	eM

Code	Action/activity	Competency area	Learning strategy
	outcomes		
PA_ME 1.1.11	Discuss the rationale for assessing patients' social environment and circumstances	K	eM, W
PA_ME 1.1.12	Discuss the importance of managing self-care with the patient to promote healthy lifestyle choices and self-directed wellbeing development	K, B	eM, W
PA_ME 1.1.13	Demonstrate the ability to appropriately order preoperative investigations based on the patient circumstances and the contemplated surgery	S	C
1.2 Communicator			
PA_CM 1.2.1	Demonstrate the ability to apply effective communication skills and strategies to inform the patient about their medical condition and proposed care and enable them to make informed decisions based on their values, beliefs, concerns, expectations and experiences	S, K	C, eM
PA_CM 1.2.2	Discuss the benefits and limitations of telemedicine in the perioperative period and describe situations in which in person consultations are preferred	K, S	eM, W, C
PA_CM 1.2.3	Demonstrate the ability to communicate with patients who have cognitive or sensory impairments	S, K	C, eM
PA_CM 1.2.4	Demonstrate the ability to accurately documents consultations and decisions to ensure safe transition between all phases of care	S	C
1.3 Collaborator			
PA_CL 1.3.1	Identify patients with undiagnosed or unstable medical conditions and refer as required	S	C
PA_CL 1.3.2	Identify patients with dementia or delirium and refer as required	S	C
PA_CL 1.3.3	Identify patients who have a substance abuse disorder and refer as required	S	C
PA_CL 1.3.4	Identify a patient's surgical and anaesthetic factors that may result in an increased risk of need for critical care, and collaborate with colleagues to organise post-operative care	S, K	C, eM
PA_CL 1.3.5	Identify when to utilise additional resources to communicate with first nation peoples	K, B	eM, W

Code	Action/activity	Competency area	Learning strategy
PA_CL 1.3.6	Identify when to utilise additional resources to communicate with patients who are ethnically, culturally and linguistically diverse	K, B	eM, W
1.4 Leader and manager			
PA_LM1.4.1	Describe how a standardised approach to perioperative care would benefit patients, using examples such as ERAS	K	eM
PA_LM 1.4.2	Describe measures that improve perioperative team performance, for example morbidity and mortality/clinical review meetings	K	eM
PA_LM 1.4.3	Identify the indicators to evaluate the capacity and quality of perioperative care services provided by a hospital	K	eM, W
1.5 Health advocate			
PA_HA 1.5.1	Describe the principles underpinning culturally safe and competent care in the preoperative context that may impact upon interactions between Aboriginal and Torres Strait Islander peoples and Māori and Pacific peoples and health services	K	eM, W
PA_HA 1.5.2	Demonstrate ability to advocate for and supports access to appropriate preoperative care for Aboriginal, Torres Strait Islander and Māori patients, who may face additional barriers	S, B, K	C, W, eM
PA_HA 1.5.3	Demonstrate ability to advocate for and supports access to appropriate preoperative care for patients with a disability who may face additional barriers	S, B	C, W
PA_HA 1.5.4	Demonstrate ability to advocate for and supports access to appropriate preoperative care for LGBTIQIA+ patients who may face additional barriers	S, B	C, W
PA_HA 1.5.5	Demonstrate ability to advocate for and supports access to appropriate preoperative care for patients who are refugees or are culturally or linguistically diverse	S, B	C, W
PA_HA 1.5.6	Identify in discussion with the patient, the risks and benefits of proceeding with surgery	S, B, K	C, W, eM
1.6 Scholar			
PA_SR 1.6.1	Describe various models of preoperative assessment in context of Australia and New Zealand	K	eM

Code	Action/activity	Competency area	Learning strategy
PA_SR 1.6.2	Describe a range of risk stratification models and how risk stratification may influence shared decision making when determining patient management and treatment options	K	eM
PA_SR 1.6.3	Explain the application of the ASA physical status classification system and the implications for perioperative care	K	eM
PA_SR 1.6.4	Explain the concept of frailty, its characteristics, prevalence and the impact of frailty upon surgical outcomes	K	eM
PA_SR 1.6.5	Discuss the financial and resource implications of perioperative investigations	K	eM
PA_SR 1.6.6	Discuss the application, utility and limitations of cognitive screening tools within the perioperative context	K	eM
1.7 Professionalism			
PA_PF 1.7.1	Demonstrate understanding of ethical practice during preoperative assessment	S, B, K	C, W, eM
PA_PF 1.7.2	Outline and applies to practice the standards of ethical and professional conduct required of a medical practitioner	S, B, K	C, W, eM
PA_PF 1.7.3	Outline and applies practice standards to perioperative medicine practice	S, B, K	C, eM

Unit of study 2 – Preoperative planning

The aim of the unit of study is to provide the participant with medical knowledge and clinical experience in the following aspects of perioperative care:

- Perioperative management planning within the multidisciplinary team.
- Shared decision making in care and discharge planning for patients and their families.
- Preoperative planning considerations.
- Data handling and registries.
- Advocacy and patient safety.

Code	Activity	Competency area	Learning strategy
2.1 Medical expertise			

Code	Activity	Competency area	Learning strategy
PP_ME 2.1.1	Discuss the general planning considerations to minimise common intraoperative adverse events and impact upon the perioperative period	K	eM
PP_ME 2.1.2	Discuss considerations for perioperative management of specific populations	K	eM, W
PP_ME 2.1.3	Describe the physiological responses of the body to surgery and factors which may trigger or modulate the stress response during the perioperative period	K	eM
PP_ME 2.1.4	Explain how patients requiring emergency surgery may differ from those presenting for elective surgery	K	eM
PP_ME 2.1.5	Discuss the potential physiological consequences of preoperative fasting	K	eM
PP_ME 2.1.6	Discuss the potential physiological consequences of bowel preparation before surgery	K	eM
PP_ME 2.1.7	Discuss the management of prescribed medication in the perioperative period including the contraindications and potential drug interactions of common medications (including indigenous and complementary medicines) in the perioperative period and refer to a pharmacist or other health professional as required	K	eM
PP_ME 2.1.8	Demonstrate ability to review all patient prescription and non-prescription medication, and refer to a pharmacist, or other relevant health professional, as required	S	C
PP_ME 2.1.9	Identify patients at risk of adverse events from common pharmacological anaesthetic agents and refers to an anaesthetist	S	C
PP_ME 2.1.10	Demonstrate ability to implement measures which reduce the likelihood of postoperative delirium	S	C
PP_ME 2.1.11	Explain the management options to minimise risks of thromboembolic disease in the perioperative period	K	eM
PP_ME 2.1.12	Discuss key aspects of patient blood management, including haemoglobin optimisation before surgery, minimisation of blood loss and management of postoperative anaemia	K	eM
PP_ME	Discuss the role of antimicrobial prophylaxis and	K	eM

Code	Activity	Competency area	Learning strategy
2.1.13	stewardship in the perioperative setting		
PP_ME 2.1.14	Compare the management of a patient with acute or pre-existing chronic pain in the perioperative period	K	eM
PP_ME 2.1.15	Discuss predictive and risk factors for the onset of postoperative nausea and vomiting, and the appropriate regime for prevention and treatment	K	eM
PP_ME 2.1.16	Outline the perioperative risk factors for the development of neurocognitive disorders (specifically, postoperative delirium) and the impact upon postoperative outcomes	K	eM
PP_ME 2.1.17	Demonstrate the ability to prepare a plan for a patient's postoperative rehabilitation, including potential functional gain to present in a multidisciplinary team planning meeting	S	C, W
PP_ME 2.1.18	Demonstrate the ability to formulate appropriate perioperative management plans in collaboration with patients, their families/significant other(s), and other health care professionals	S, K	C, W, eM
PP_ME 2.1.19	Demonstrate the ability to formulate perioperative management plans for patients who have predictive factors for chronic postsurgical pain in consultation with a specialist pain medicine physician, as required	S	C, W
PP_ME 2.1.20	Plan postoperative analgesia using multimodal techniques, in consultation with the patient	S	C
PP_ME 2.1.21	Demonstrate ability to amend perioperative plans in line with risk prediction throughout the perioperative period	S	C
PP_ME_2.1.2 2	Discuss the application of perioperative protocols that have been tailored according to individual patient risk (for example ERAS)	K	eM
2.2 Communicator			
PP_CM 2.2.1	Demonstrate respectful and effective communication, using recognised techniques, with all members of the health care team	S, B	C, W
PP_CM 2.2.2	Identify barriers to effective communication with colleagues and develops strategies to mitigate these	K, B	eM, W
PP_CM 2.2.3	Demonstrate ability to adjust communication delivery appropriately, with respect to a patient's healthcare	K, B, S	eM, W, C

Code	Activity	Competency area	Learning strategy
	literacy, and checks for comprehension and consent		
PP_CM 2.2.5	Explore patient care goals and expectations, in the context of risk and likely outcomes, to ensure appropriate shared decision-making regarding their care	K	eM , W
2.3 Collaborator			
PP_CL 2.3.1	Explain the contribution of primary and community services in developing shared plans of care in the perioperative period	K	eM
PP_CL 2.3.2	Collaborate with members of the multi-disciplinary team, as appropriate, in planning the selection of analgesic and surgical techniques	S, B	C
PP_CL 2.3.3	Describe management of barriers to perioperative shared decision making for different groups	K	eM, W
PP_CL 2.3.4	Explain the need to discuss alternative treatment options with the patient with respect to their defined goals and values	K	eM, W
2.4 Leader and manager			
PP_LM 2.4.1	Identify pathways to achieve an agreed management plan, that best supports the patient, in situations of interprofessional conflict	K, B	eM, W
PP_LM 2.4.2	Demonstrate the ability to recognise when poor professional behaviour may impact upon patient care and addresses and/or raises concerns with appropriate personnel	K, B	eM, W
PP_LM 2.4.3	Plan measures to evaluate standards of perioperative care provided by a hospital	S	C
PP_LM 2.4.4	Outline the principles of conducting and reporting mortality and morbidity/clinical review meetings, including the role of such meetings for institutional and broader system improvement	K	eM
PP_LM 2.4.5	Discuss hospital national safety and quality standards of care in relation to the delivery of perioperative medicine for patients	K	eM
PP_LM 2.4.6	Discuss the application of change management principles in the implementation of new perioperative medicine initiatives	K	eM

Code	Activity	Competency area	Learning strategy
2.5 Health advocate			
PP_HA 2.5.1	Discuss stages of a health behaviour model aimed at lifestyle modifications for a patient	K	eM
PP_HA 2.5.2	Apply motivational interviewing techniques to encourage a patient to become active participants in improving their own health	B	W
PP_HA_2.5.3	Demonstrate ability to advocate for individual patient contexts, displaying sensitivity and communicating without prejudice or judgement	B	W
PP_HA_2.5.4	Discuss the use of clinical registry data in relation to use of specific surgical procedures, devices, drugs or products to improve patient outcomes	K	eM
PP_HA_2.5.5	Apply knowledge of the disease incidence of Aboriginal and Torres Strait Islander and Māori and Pacific peoples towards perioperative planning	S	C, W
PP_HA_2.5.6	Discuss legislation in relation to 'persons responsible' and the use of enduring power of attorney and guardianship, relevant to their local jurisdiction	K	eM
PP_HA_2.5.7	Explain the roles of advanced care directives and resuscitation plans	K	eM
PP_HA_2.5.8	Identify when to discuss advanced care directives planning with a patient and their family	K	eM
PP_HA_2.5.9	Demonstrate ability to develop an advanced care plan which includes the predicted eventualities and institute limits of care which would apply to each	S	C
2.6 Scholar			
PP_SR 2.6.1	Describe evidence-based patient centred outcome measures which may be used by researchers during perioperative medicine clinical effectiveness trials	K	eM
PP_SR 2.6.2	Discuss evidence-based perioperative care protocols and enhanced recovery pathways	K	eM
2.7 Professional			
PP_PF 2.7.1	Describe legal and ethical considerations for determining a patient's capacity to make decisions, including use of formal assessments of cognitive capacity	K	eM

Code	Activity	Competency area	Learning strategy
PP_PF 2.7.2	Describe the legal and ethical principles of a valid informed consent conversation	K	eM, W
PP_PF 2.7.3	Discuss material risk with and the process for obtaining a valid, informed consent from a patient for medical treatment	K	eM, W
PP_PF 2.7.4	Discuss how a medical practitioner's own values and beliefs could potentially influence the care provided	K	eM, W

Unit of study 3 – Optimisation

By completing the unit of study, the participant will gain medical knowledge and clinical experience in the following aspects of perioperative care:

- Optimisation and prehabilitation strategies.
- Patient health and wellbeing.
- Complex morbidities.
- Patient safety.
- Interprofessional and interdisciplinary communications.

*COM – Cambridge Online Modules, University of Cambridge Winton Centre.

Code	Action/activity	Competency area	Learning strategy
3.1 Medical expertise			
OP_ME_3.1.1	Discuss a concept of wellness and how considering dimensions of wellness can positively contribute to optimisation planning for patients	K	eM, W
OP_ME_3.1.2	Discuss optimisation strategies for patients with common diseases of the various systems	K	eM, W, C
OP_ME_3.1.3	Discuss the benefit of the use of optimisation strategies perioperatively in accordance with a patient's circumstances	K	eM, W
OP_ME_3.1.4	List the components of multimodal prehabilitation and discusses the benefits of uni- versus multi-modal	K	eM, w
OP_ME_3.1.5	Outline techniques, including non-pharmacological interventions, to alleviate a patient's anxiety about surgery and identifies when a referral for psychological intervention should be considered	K	eM
OP_ME_3.1.6	Describe the optimisation of blood sugar control and refers to the endocrinologist as appropriate	K	eM
OP_ME_3.1.7	Discuss the importance of perioperative management of patients on anti-coagulant medication	K	eM

Code	Action/activity	Competency area	Learning strategy
OP_ME_3.1.8	Discuss indications for oral iron therapy, intravenous iron preparations, haematinics and erythropoiesis stimulating agents, and including iron provision for patients who refuse use of blood products	K	eM
OP_ME_3.1.9	Outline specific patient groups that would mostly benefit from a comprehensive prehabilitation program	K	eM
3.2 Communicator			
OP_CM_3.2.1	Communicate with and enlists cooperation of staff to optimise patient care and safety, considering factors such as urgency and procedural requirements	S	C
OP_CM_3.2.2	Contribute to multidisciplinary discussions in a meaningful way, including peri-procedural checklists	S	C
OP_CM_3.2.3	Explain to the patient the intervention options, following a comprehensive nutritional assessment, to optimise their functional capacity during and post-operative recovery	S	C
OP_CM_3.2.4	Discuss with the patient, where necessarily, the onset of sarcopaenia and the benefits of optimisation of nutrition and physical activity	S	C
OP_CM_3.2.5	Explain the improvement to surgical outcomes following a reduction in substance abuse. Such as smoking, vaping, alcohol and non-prescription drug use	S	C
OP_CM_3.2.6	Outline to the patient the resulting improvement to surgical outcomes following reduction in consumption of alcohol, smoking and non-prescription drug use and, options for interventions	S	C
OP_CM_3.2.7	Discuss the development and delivery of programmes to educate patients about what to expect during the perioperative period	K	eM, W
3.3 Collaborator			
OP_CL_3.3.1	Explain situations where a patient should be referred for co-morbidity review to optimise surgical outcomes	K	eM
OP_CL_3.3.2	Recognise when referral to other medical specialists and healthcare professionals, for patient care optimisation, is unwarranted	K	eM
OP_CL_3.3.3	Explain the situations where a patient, who would benefit from exercise therapy or prehabilitation, should be referred to a physiologist or physiotherapist	S	C

Code	Action/activity	Competency area	Learning strategy
OP_CL_3.3.4	Identify reasons for collaboration with an endocrinologist and/or diabetic educator, in a patient with poor glycaemic control and previously undiagnosed diabetes for optimisation prior to surgery	S	C
OP_CL_3.3.5	Identify reasons for collaboration with a haematologist, for a patient with iron deficiency or anaemia, which may impact surgical outcomes	S	C
OP_CL_3.3.6	Demonstrate collaborative working with other healthcare professionals, and the patient, to provide optimisation management options that aligned with a patient's values and goals	S	C
OP_CL_3.3.7	Plan perioperative medical management and optimisation with reference to a perioperative checklist	S	C
3.4 Leader and manager			
OP_LM_3.4.1	Discuss the perioperative unit protocols for postponing or cancelling elective surgery for patients requiring optimisation to minimise the risk of post-surgery complications	K	C
OP_LM_3.4.2	Compare the roles and responsibilities of healthcare professionals who contribute to prehabilitation services	K	eM
OP_LM_3.4.3	Discuss key aspects of effective interprofessional health care team coordination in the provision of prehabilitation services	K	eM
OP_LM_3.4.4	Discuss factors to consider in the preparation and leadership of multidisciplinary team optimisation meetings	K	Em, W
OP_LM_3.4.5	Discuss employer and employee legislative duty of care to ensure the health and safety of staff, patients and other visitors to the hospital	K	eM, W
OP_LM_3.4.6	Discuss how potential hazards, events or situations in the workplace could potentially affect staff wellbeing and the local protocols and policies in place to ensure staff wellbeing and their health and safety in the workplace	K	eM, W
3.5 Health advocate			
OP_HA_3.5.1	Explain strategies to assist the patient in taking responsibility for their own health and decisions, to achieve optimal surgical outcomes	K	eM
OP_HA_3.5.2	Explain the importance of critical decision making when intervening on behalf of a patient to ensure their	K	eM, W

Code	Action/activity	Competency area	Learning strategy
	concerns are recognised and addressed		
OP_HA_3.5.3	Describe strategies to assist colleagues who are experiencing difficulty in the workplace which has potential to negatively impact their physical or emotional wellbeing	K	eM
3.6 Scholar			
OP_SR_3.6.1	Describe evidence-based guidelines for exercise prescription for surgical patients, including any contraindications	K	eM
OP_SR_3.6.2	Discuss the evidence for the benefits associated with incorporating preoperative education programs, to optimise patient surgical outcomes	K	eM
OP_SR_3.6.3	Discuss evidence-based indicators for psychological support referral to improve patient surgical outcomes	K	eM
OP_SR_3.6.4	Outline the evidence for nutritional intervention, including the impact of factors such as malnutrition, unintentional weight loss and low albumin levels on surgical outcomes	K	eM
OP_SR_3.6.5	Explain how a public health approach to mental health may impact positively on the incidence and management of mental health	K	eM
OP_SR_3.6.6	Discuss evidence based practices for improving poor nutrition in patients with dental and intraoral conditions to improve surgical outcomes	K	eM
3.7 Professionalism			
OP_PF_3.7.1	Discuss the importance of perioperative standards of care in services which optimise surgical outcomes for patients	K	eM
OP_PF_3.7.2	Perform as an effective team member in interprofessional optimisation team settings, demonstrating respect for culture and diversity within the team	S	C

Unit of study 4 – Intraoperative impacts on patient outcomes

By completing the unit of study, the participant will gain medical knowledge and clinical experience in the following aspects of perioperative care:

- Intraoperative interventions.
- Surgical protocols and procedures.

- Recovery.
- Patient post-surgery discussion.
- Leadership and management in the perioperative unit.

Code	Action/activity	Competency area	Learning strategy
4.1 Medical expertise			
IP_ME_4.1.1	Describe the use of the WHO surgical safety checklist and its implications for patient safety throughout the intra operative period	K	eM
IP_ME_4.1.2	Demonstrate awareness of interdisciplinary functioning of the team within the operating theatre	S	C
IP_ME_4.1.3	Explain evidence-based practice for surgical positioning for different procedures	K	eM
IP_ME_4.1.4	Assess and employs measures for the prevention and relief of hypothermia	S	C
IP_ME_4.1.5	Identify risk factors for the development of malignant hyperthermia and immediate management protocols	S	C
IP_ME_4.1.6	Discuss the role of the anaesthetist in the intraoperative setting	K	eM
IP_ME_4.1.7	Identify the role of multidisciplinary medical team in the management of emergency surgery for an acutely ill patient	K	eM
IP_ME_4.1.8	Discuss protocols for patient blood loss and management	K	eM
IP_ME_4.1.9	Discuss the principles of surgical technique choices, including open versus laparoscopic surgery, and the impact on patient recovery	K	eM
IP_ME_4.1.10	Describe physiological changes associated with laparoscopy and associated haemodynamic consequences	K	eM
IP_ME_4.1.11	Discuss intraoperative physiological system dysfunction and management options	K	eM
IP_ME_4.1.12	Discuss the management of common problems and the deteriorating postoperative patient in recovery	K	eM
IP_ME_4.1.13	Apply of knowledge of intraoperative care to individualise post operative plans	S	C

Code	Action/activity	Competency area	Learning strategy
IP_ME_4.1.14	Apply of knowledge of patient positioning to reduce perioperative complications	S	C
IP_ME_4.1.15	Demonstrate correct procedure for effective face mask ventilation	S	C
IP_ME_4.1.16	Demonstrate safe suctioning of the oropharynx and trachea	S	C
IP_ME_4.1.17	Explain recognition of a potentially difficult airway and options to relieve airway obstruction and laryngospasm including the use of an oropharyngeal and nasal airway	K	eM
IP_ME_4.1.18	Discuss the indications for oxygen therapy and different delivery methods, for example CPAP, BIPAP, high flow oxygen	K	eM
IP_ME_4.1.19	Describe the incidence and management of acute pulmonary oedema	K	eM
IP_ME_4.1.20	Discuss protocols for managing patients at risk of pulmonary aspiration	K	eM
IP_ME_4.1.21	Demonstrate proficiency in advanced life support	S	C
IP_ME_4.1.22	Describe unintended consequences of surgery and indications for a higher level of care	K	eM
4.2 Communicator			
IP_CM_4.2.1	Discuss how effective communication directly pre and post operatively impacts upon the patient experiences and clinical outcomes	K	eM
IP_CM_4.2.2	Discuss communications with patients and/or their families when unexpected or difficult outcomes occur during the intraoperative period	K	eM
IP_CM_4.2.3	Discuss the importance of interdisciplinary communication in ensuring patient safety directly before and during surgery	K	eM
IP_CM_4.2.4	Explain the protocol for communicating the procedure, patient condition, complications and risks during handover from recovery to the ward or critical care unit	K	eM
IP_CM_4.2.4	Demonstrate the use of the ISBAR handover tool to aid the safe transfer of patient information in clinical handover	S	C
4.3 Collaborator			

Code	Action/activity	Competency area	Learning strategy
IP_CL_4.3.1	Identify how multidisciplinary collaboration in the preoperative period can contribute to a more informed and prepared surgical team, resulting in improved outcomes during and post-surgery	S	C, W
IP_CL_4.3.2	Demonstrate ability to collaborate as a member of the interdisciplinary operating theatre team to assist with the efficient functioning of the operating suite	S	C, W
IP_CL_4.3.3	Outline collaboration protocols between anaesthetist, surgeon, intensivist and physicians when a patient's condition requires admission to the critical care unit or high dependency unit post operatively	K	eM, W
4.4 Leader and manager			
IP_LM_4.4.1	Discuss the importance of interdisciplinary management and teamwork in ensuring patient safety during the intraoperative period	K	eM, W
IP_LM_4.4.2	Identify considerations for staffing in the operating theatre and recovery and the implications for an operating list which has a predominance of high-risk patients undergoing elective surgery	S	C, W
IP_LM_4.4.3	Describe operating department organisational considerations in the preparation and management of patients undergoing emergency surgery	K	eM, W
4.5 Health advocate			
IP_LM_4.5.1	Identify situations when the patient requires an advocate and/or support in the operating suite prior to commencement of surgery	B	C
IP_LM_4.5.2	Demonstrate respectful practice when dealing with the unconscious patient	B	C, W
IP_LM_4.5.3	Identify situations when the patient requires an advocate and/or support in the recovery room	B	C
IP_LM_4.5.4	Outline considerations for adhering to religious or cultural requirements during and post-surgery	K	eM
4.6 Scholar			
IP_SR_4.6.1	Outline evidence based considerations for determining intraoperative choice of fluids and their limits	K	eM
IP_SR_4.6.2	Demonstrate awareness of clinical decision making protocols for the preparation and management of common issues encountered in patients undergoing emergency surgery	S	C

Code	Action/activity	Competency area	Learning strategy
IP_SR_4.6.3	Outline strategies considered by the multidisciplinary perioperative medical team to identify patients at risk of failure to emerge from anaesthesia	K	eM
IP_SR_4.6.4	Demonstrate awareness of the criteria for discharge from the recovery room	S	C
IP_SR_4.6.5	Discuss evidence-based protocols for the intraoperative management of implanted devices	K	eM
4.7 Professionalism			
OP_PF_4.7.1	Demonstrate awareness of professional scope of practice in the operating suite	S	C
OP_PF_4.7.2	Demonstrate ability to contribute effectively to the interprofessional operating department team	S	C
OP_PF_4.7.2	Demonstrates understanding of and respect for individual professional roles	S	C

Unit of study 5 – Postoperative assessment and management

By completing the topic, the participant will gain medical knowledge and clinical experience in the following aspects of perioperative care:

- Postoperative assessment and management.
- Unplanned critical events.
- Pain management.
- Patient safety and quality management.
- Cultural competency in healthcare.

Code	Action/activity	Competency area	Learning strategy
5.1 Medical expertise			
PM_ME_5.1.1	Outline the role of non-pharmacological measures in the management of acute pain	K	eM
PM_ME_5.1.2	Discuss the management of acute pain for patients with an addiction, chronic pain and/or opioid tolerance	K	eM
PM_ME_5.1.3	Discuss the indications, contraindications, side effects, risks and monitoring requirements for patients receiving patient-controlled analgesia (PCA), continuous opioid infusion or intermittent administration of opioids for acute pain management	K	eM

Code	Action/activity	Competency area	Learning strategy
PM_ME_5.1.4	Discuss the management of postoperative oliguria and anuria	K	eM
PM_ME_5.1.5	Discuss the management of common postoperative fluid and electrolyte imbalance, including acid/base disturbance	K	eM
PM_ME_5.1.6	Discuss the risk factors and management of postoperative acute kidney injury	K	eM
PM_ME_5.1.7	Discuss the incidence and management of postoperative bleeding	K	eM
PM_ME_5.1.8	Discuss the incidence, diagnosis and management of blood-related postoperative disorders, including anaemia and jaundice	K	eM
PM_ME_5.1.9	Discuss the occurrence and management of postoperative neurological complications, such as neuropraxia, strokes and seizures	K	eM
PM_ME_5.1.10	Plan and provides postoperative care in accordance with relevant enhanced recovery pathways	S	C
PM_ME_5.1.11	Demonstrate the ability to formulate a comprehensive and safe postoperative patient management plan	S	C
PM_ME_5.1.12	Demonstrate the ability to identify patients requiring a falls risk assessment and refers appropriately	S	C
PM_ME_5.1.13	Assess the management of postoperative patients presenting with complex conditions	S	C
PM_ME_5.1.14	Discuss the reasons why futile medical treatments might be provided to patients and the potential consequences	K	eM
PM_ME_5.1.15	Identify when restorative or curative treatment may not be appropriate and refers accordingly	K	eM
PM_ME_5.1.16	Outline the management of conditions which may occur postoperatively	K	eM
PM_ME_5.1.17	Apply strategies for the management of postoperative nausea and vomiting	S	C
PM_ME_5.1.18	Identify delirium in confused surgical patients using appropriate tools	S	C
PM_ME_5.1.19	Describe the common presentation of postoperative delirium and distinguishes it from emergence delirium, dementia or depression	K	eM
PM_ME_5.1.20	Discuss management of patients with postoperative delirium using non-pharmacological and pharmacological strategies	K	eM

Code	Action/activity	Competency area	Learning strategy
PM_ME_5.1.21	Demonstrate the ability to consider factors which may inhibit early mobilisation	S	C
PM_ME_5.1.22	Discuss the assessment and management of post-operative fever	K	eM
PM_ME_5.1.23	Discuss underlying causes of common postoperative arrhythmias, diagnostic features and management (for example atrial fibrillation)	K	eM
PM_ME_5.1.24	Discuss the management of patients with post-surgical complications which may require urgent surgical input or return to theatre	K	eM
PM_ME_5.1.25	Discuss the management of postoperative hypertension and hypotension	K	eM
PM_ME_5.1.26	Discuss the risk factors, diagnosis and treatment of postoperative sepsis and septic shock	K	eM
PM_ME_5.1.27	Outline the common pathogens associated with different types of surgery and appropriate antibiotic therapy to manage surgical site infection	K	eM
PM_ME_5.1.28	Discuss home, hospital and community-based (assisted and non-assisted) exercise programs	K	eM
5.2 Communicator			
PM_CM_5.2.1	Demonstrate empathy and awareness of communication considerations when advising family and carers of patients, for whom further surgery is likely futile	S	C
PM_CM_5.2.2	Describe an evidenced based approach to the delivery of bad news and options which may include palliative care, end of life and organ donation with patients and their families	K	eM
PM_CM_5.2.3	Demonstrate proactive communication with other practitioners responsible for the care of the patient to keep them informed of a patient's progress and any changes to plans	S	C
5.3 Collaborator			
PM_CL_5.3.1	Identify patients who need more intensive monitoring on the ward in the postoperative period and collaborates with the MDT to plan management	S	C
PM_CL_5.3.2	Identify when patients fulfil medical emergency team (MET) criteria and activate protocols accordingly	S	C
PM_CL_5.3.3	Discuss the referral of patients requiring admission to intensive care, high dependency units, or similar monitored units	K	eM

Code	Action/activity	Competency area	Learning strategy
5.4 Leader and manager			
PM_LM_5.4.1	Describe how health system audit protocols may influence sepsis rates and management.	K	eM
PM_LM_5.4.2	Discuss the leadership and management structure for effective functioning of cardiac arrest protocols within the hospital to ensure patient safety	K	eM
PM_LM_5.4.3	Discuss the importance of perioperative medical practitioner self-reflection in the coordination of patient care across multidisciplinary teams	K	eM
PM_LM_5.4.4	Demonstrate the ability to use the diverse skills of all members of their multidisciplinary team and apply them for the provision of best patient care	S, B	C
PM_LM_5.4.5	Discuss the importance of developing a shared vision and purpose within the perioperative multidisciplinary team in the pursuit of optimising patient care	K	eM
5.5 Health advocate			
PM_HA_5.5.1	Identify patients requiring palliative care services from those needing end-of-life care, and refer appropriately	S	C
PM_HA_5.5.2	Demonstrate the ability to advocate for the timely introduction of palliative and end-of-life care	S	C
PM_HA_5.5.3	Discuss how indirect discrimination can impact patient care	K	eM
5.6 Scholar			
PM_SR_5.6.1	Discuss current evidence base protocols for the management of postoperative patients	K	eM
PM_SR_5.6.2	Explain evidence-based protocols for chest pain and dyspnoea diagnosis and management	K	eM
PM_SR_5.6.3	Describe evidence based protocols for the identification and management of deep vein thrombosis, pulmonary embolism and venous thromboembolism	K	eM
PM_SR_5.6.4	Demonstrate knowledge of current evidence based protocols when prescribing drugs in post operative acute pain management	K	eM
PM_SR_5.6.5	Discuss the current evidence based protocols for the effective assessment, diagnosis and management of wounds and indication for referral	K	eM

Code	Action/activity	Competency area	Learning strategy
5.7 Professionalism			
PM_PF_5.7.1	Discuss the importance of individual awareness of scope of practice and know when to seek advice of others	K,B	eM,W
PM_PF_5.7.2	Discuss situations when circumstances conflict with professional codes of conduct and the process for notification to statutory authorities to ensure patient safety	K	eM

Unit of study 6 – Discharge planning and rehabilitation

By completing the unit of study, the participant will gain medical knowledge and clinical experience in the following aspects of perioperative care:

- Discharge planning.
- Rehabilitation.
- Legal and ethical issues in medical decision making.
- Patient care services, continuity and accessibility.
- Patient wellbeing.

Code	Action/activity	Competency area	Learning strategy
6.1 Medical expertise			
DR_ME_6.1.1	Define the concept of rehabilitation and its contribution to full-functional patient recovery	K	eM, W
DR_ME_6.1.2	Discuss the contribution of rehabilitation in reducing post-surgical complication during the recovery period	K	eM
DR_ME_6.1.3	Identify patients who require more complex discharge management and plan accordingly	S	C
DR_ME_6.1.4	Describe the assessment and management of patients at risk of falls, including the use of validated tools	K	eM
DR_ME_6.1.5	Discuss and develops a plan for the role of analgesic tapering in the post-operative patient being discharged	K	eM
DR_ME_6.1.6	Identify a patient who may require a referral plan for a medication compliance issue	S	C
DR_ME_6.1.7	Identify rehabilitation goals for patients and organises referrals to appropriate health professionals	K	eM, W
DR_ME_6.1.8	Assess a patient's discharge needs, including changes in activities of daily living and functional capacity	S	C, W
DR_ME_6.1.9	Identify a patient, who requires subspecialty care and refers appropriately	S	C

Code	Action/activity	Competency area	Learning strategy
DR_ME_6.1.1 0	Identify when a patient would require in-patient postoperative rehabilitation and refers to the appropriate specialist	S	C
DR_ME_6.1.1 1	Identify patients who require additional care services at home and refers accordingly	S	C
DR_ME_6.1.1 2	Discuss factors that influence patient wellbeing and the resulting effects on rehabilitation outcomes.	K	eM, W
DR_ME_6.1.1 3	Explain options for improving a patient's mental wellbeing and outlook to reduce likelihood of complications and hospital readmissions.	K	eM
6.2 Communicator			
DR_CM_6.2.1	Demonstrate ability to apply appropriate communication style to manage inappropriate requests for continuing treatment or requests for withholding treatment	S	C
DR_CM_6.2.2	Explain the importance of including patients and families or carers and community health professionals, in discussions on discharge planning	K	eM
DR_CM_6.2.3	Discuss the requirement of additional time in order to explain and check for understanding of the discharge plan to patients and family or carers	S	C
DR_CM_6.2.4	Plan discharge summaries, and other relevant information, in a timely manner for facilities or healthcare providers, to maintain continuity of care	S	C
6.3 Collaborator			
DR_CL_6.3.1	Identify when a patient would require an assessment of home safety and/or activities of daily living, by occupational therapist or physiotherapist, and refers accordingly	K	eM, W
DR_CL_6.3.2	Identify when a patient would require assistance to regain physical functionality and/or improvements to balance, mobility and limb function, and refers to a physiotherapist and/or exercise physiologist, as required	S	C
DR_CL_6.3.3	Identify when a patient requires assessment and/or treatment of speech and swallowing difficulties and refers to a speech pathologist	S	C
DR_CL_6.3.4	Identify when a patient requires nutritional assessment and/or advice on specialised nutritional support, such as tube feeding or nutritional strategies to manage chronic condition/s and refers to a dietitian	S	C
DR_CL_6.3.5	Identify when a patient requires assessment for hearing or vision impairment and refers to an audiologist or optometrist	S	C

Code	Action/activity	Competency area	Learning strategy
DR_CL_6.3.6	Identify when a patient requires support to manage and overcome mental health issues, that may impact on their rehabilitation, and refers to a psychologist and/or psychiatrist	S	C
DR_CL_6.3.7	Identify when a patient's pain is increasing, and functional state is decreasing during rehabilitation and refers to a specialist pain medicine physician	S	C, W
DR_CL_6.3.8	Demonstrate ability to develop a plan for a patient who needs long- term financial government support.	S	C
6.4 Leader and manager			
DR_LM_6.4.1	Apply appropriate clinical handover protocols between different care settings and identifies opportunities to improve continuity and quality of care	S	C
DR_LM_6.4.2	Demonstrate the ability to contribute to facilitation of a case conference or multidisciplinary team meeting to communicate patient needs for transition from the hospital to the community	S	C
DR_LM_6.4.3	Outline the possible avenues for resolving disagreements which escalate, including second medical opinions, time-limited treatment trials, patient transfer and involvement of a clinical ethics committee or legal intervention	K	eM, W
6.5 Health advocate			
DR_HA_6.5.1	Discuss the current legislation in relation to voluntary assisted dying, specifically for the patient's local jurisdiction	K	eM, W
DR_HA_6.5.2	Outline circumstances and possible conditions that can be effectively managed by the hospital substitution models, such as 'hospital at home'; geriatric evaluation management (GEM) at home' and 'rehabilitation in the home'	K	eM, W
DR_HA_6.5.3	Discuss medication discrepancies and over-the-counter or complimentary medicines with patients and their family or carers	S	C
DR_HA_6.5.4	Discuss ethical frameworks that may be utilised to guide deliberations and justify for complex medical decision making	K	eM, W
DR_HA_6.5.5	Identify when to utilise ethical support services to assist with balancing viewpoints between patient, carer and clinician	S	C, W
DR_HA_6.5.6	Demonstrate the ability to advocate when disagreements arise withing the treating team or, between a patient, their family, carers and the treating team	S	C, W

Code	Action/activity	Competency area	Learning strategy
6.6 Scholar			
DR_SR_6.6.1	Discusses the importance of medication reconciliation to prevent potential harm to the patient	K	eM
DR_SR_6.6.2	Discuss protocols to determine patient suitability for, and adherence to, a rehabilitation program	K	eM, W
DR_SR_6.6.3	Discuss the key components of an effective discharge planning system, its effect on patient outcomes and strategies to reduce hospital re-admission rates	K	eM, W
6.7 Professionalism			
DR_PF_6.7.1	Demonstrate perioperative medicine role model attributes in practice	S	C, W
DR_PF_6.7.2	Demonstrate profession-society specific awareness	S	C
DR_PF_6.7.3	Demonstrate ability to appropriately allocate responsibility to colleagues	S	C
DR_PF_6.7.4	Demonstrate the ability to accept accountability for practice	S	C

Definitions

ANZCA: Australian and New Zealand College of Anaesthetists

RACP: Royal Australasian College of Physicians

RACS: Royal Australasian College of Surgeons

CICM: College of Intensive Care Medicine

ACRRM: Australian College of Rural and Remote Medicine

RNZCGP: Royal New Zealand College of General Practitioners

RACGP: Royal Australian College of General Practitioners

LMS: refers to ANZCA's learning management system

Unit of study lead: refers to a person who provides expertise and guidance on the delivery of the clinical immersion experience and workshops for a particular unit of study

Assigned supervisor: refers to the person who arranges and supervises the required observation or practice experiences that the participant receives in a clinical setting

Delegated supervisor: refers to a supervisor who accepts temporary responsibility for a participant when the assigned supervisor is unavailable

Participant: refers to medical professionals undertaking the perioperative medicine course

Primary college: refers to the college in which the participant is undertaking their primary fellowship. This will be ANZCA, RACP, RACS, CICM, ACRRM, RNZCGP, RACGP

Appendix 1 – Lists of medical conditions, circumstances and history

Social circumstances

- Caring ability of family and friends
- Social network
- Current government financial support and eligibility for additional care assistance
- Home arrangements (facilities and safety)
- Transport
- Accessibility to local resources

Mental states

- Cognition
- Mood, anxiety and fears
- Decision making capacity
- Postoperative delirium

Cognitive screening tools

- Mini-Mental State Examination (MMSE)
- Mini-Cog
- Montreal Cognitive Assessment (MoCA)
- Rowland Universal Dementia Assessment Scale (RUDAS)
- Kimberley Indigenous Cognitive Assessment (KICA)

A comprehensive medical history of

- Surgical diagnosis and the natural history of the disease
- Comorbid conditions and disease severity
- Nutritional status
- Use of drugs and/or alcohol
- Smoking history
- Current and past medication/s
- Drug allergy/s
- Information about previous anaesthetics and relevant family history

A clinical examination of

- Cardiovascular system
- Respiratory system
- Gastrointestinal system
- Central and peripheral nervous system
- Musculoskeletal system: patient positioning, neck stability/movement, suitability for regional blockade
- Airway assessment/dentition
- Skin integrity, wounds

Functional capacity

- Activities of daily living
- Gait and balance
- Activity/exercise status
- Use of visual, hearing, mobility aids, where relevant
- Other: anaemia, jaundice

Risk stratification tools

- American College of Surgeons (ACS)
- National Surgical Quality Improvement Program (NSQIP)
- Surgical Outcome Risk Tool (SORT)
- New Zealand's national risk prediction model for perioperative mortality in non-cardiac surgery

Perioperative management plans

- Findings from medical review, and functional and psychosocial assessment
- Measures to reduce perioperative risk
- Patient values, preferences and beliefs
- Any limitations in relation to the facility's resources
- Likely discharge pathways
- Recommendations/outcomes from multidisciplinary team

Medication for management in the perioperative period

- Cardiovascular medications
- Pulmonary agents
- Endocrine agents
- Gastrointestinal agents
- Neurologic agents
- Rheumatological agents
- Immunomodulators/disease modifiers
- Antiplatelet/anticoagulant
- Analgesics
- Antiretroviral agents
- Psychotropic agents
- Cancer therapies

Perioperative management considerations of the following populations:

- Adolescents
- Older people
- Obese / malnourished patients
- Frail patients
- Palliative patients
- Obstetric patients
- Cancer patients
- Psychiatric patients
- Transplant patients
- Patients with implanted devices
- Patients with chronic pain
- Indigenous patients
- Patients with an intellectual or physical disability
- Lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) patients

Common intraoperative adverse events include:

Cardiovascular disorders

- Respiratory disorders
- Endocrine and metabolic disorders
- Gastrointestinal and renal disorders
- Neurologic, muscular and neuromuscular disorders
- Haematologic and immunologic disorders
- Common genetic disorders
- Frailty

Cardiovascular disorders

- Coronary artery disease
- Valvular heart disease

- Cardiac conduction abnormalities
- Pacemaker/AICDs/mechanical assist devices
- Heart failure
- Cardiomyopathy
- Myocarditis and endocarditis
- Hypertension
- Cerebrovascular disease (embolic and haemorrhagic)
- Peripheral vascular disease and diseases of the aorta
- Renovascular disease
- Pulmonary hypertension
- Congenital heart disease
- Transplantation

Respiratory disorders

- Chronic obstructive pulmonary disease
- Asthma
- Hypersensitivity pneumonitis
- Respiratory tract infection
- Obstructive sleep apnoea
- Obesity-related respiratory conditions
- Bronchiectasis
- Cystic fibrosis
- Interstitial lung disease
- Lung cancer
- Lung transplantation

Endocrine and metabolic disorders

- Obesity
- Anorexia nervosa
- Diabetes
- Electrolyte and acid base disorders
- Steroid dependence
- Porphyria
- Thyroid disease
- Carcinoid syndrome and disease
- Calcium disorders
- Pheochromocytoma
- Adrenal diseases
- Inborn errors of metabolism

Gastrointestinal and renal disorders

- Acute kidney injury (AKI)
- Chronic kidney disease (CKD)
- End stage renal disease and dialysis
- Liver disease including hepatitis and cirrhosis
- Gallbladder disease
- Bowel disease including obstruction
- Pancreatitis
- Oesophageal/gastric obstruction & motility disorders
- Malignancy
- Transplantation

Neurologic, muscular and neuromuscular disorders

- Epilepsy and seizures

- Parkinson's disease and other extrapyramidal disorders
- Multiple sclerosis
- Cerebral palsy
- Myasthenia gravis and myasthenic syndrome
- Muscular dystrophies, myopathies and myotonias
- Spinal cord injury
- Transient ischaemic attacks and stroke
- Neurocognitive disorders
- Dementia – including subtypes for example Alzheimer's, Vascular, Mixed, Front-temporal
- Delirium
- Intellectual disability

Haematologic and immunologic disorders

- Anaemia
- Thrombocytopenia and thrombophilia
- Coagulopathy
- Thromboembolic disease
- Haematological malignancies
- Immunocompromised patient
- Anaphylaxis
- Inflammatory arthropathies
- Systemic lupus erythematosus
- Systemic sclerosis
- Vasculitis disorders
- Sarcoidosis and amyloidosis

Psychiatric disorders

- Eating disorders
- Acute intoxication
- Substance use disorder
- Depression
- Post-traumatic stress disorder
- Anxiety disorder
- Bipolar affective disorder
- Autism spectrum disorder
- Psychotic disorders (acute and chronic)

Infectious diseases

- Acute for example Sepsis
- Chronic for example HIV
- COVID-19

Change control register

Version	Author	Approved by	Approval date	Sections modified	Next review
1.0	Kristen Sinni	Council	July 2023	For use in the Pilot Program (4 September – 17 November 2023)	2023
1.1	K. Sinni	Council	December 2023	Throughout document: Name change – From Diploma of Perioperative Medicine to ANZCA Course in Perioperative Medicine Amended LO: PA_HA 1.5.6 Deleted LO: PP_CM 2.2.4	2024