

**COLLEGE OF ANAESTHESIOLOGISTS OF IRELAND**  
 Professional Competence Scheme (PCS)

# Guidance on Verification of Practice Review and Work-Based Learning Activities

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## EXECUTIVE SUMMARY

This document provides authoritative guidance for Fellows and trainees of the College of Anaesthesiologists of Ireland on the verification, documentation, and evidencing of Practice Review and Work-Based Learning activities within the Professional Competence Scheme (PCS). It reflects the requirements of the Medical Council Maintenance of Professional Competence (MPC) Framework and sets out the standards expected of doctors, verifiers, and governance leads. Minimum annual requirements are: Practice Review — 10 hours; Work-Based Learning — 15 hours.

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## 1. Purpose and Scope

This document provides guidance to Fellows and trainees participating in the College Professional Competence Scheme (PCS) regarding the verification of Practice Review and Work-Based Learning activities under the Medical Council Maintenance of Professional Competence (MPC) Framework.

The guidance covers: eligible activities; acceptable evidence; verification requirements; reflection requirements; Medical Council domain mapping; and Annual Verification Process (AVP) expectations. It should be read alongside the PCS Clinical Audit Standards Guidance (v2.0) for detailed requirements relating to clinical audit submissions.

### Regulatory Basis

Participation in the PCS is a statutory requirement under the Medical Practitioners Act 2007. Doctors who fail to meet PCS requirements, or who submit inaccurate or unsupported activity records, may be referred to the Medical Council. This guidance is intended to support compliance, not to create additional bureaucratic burden — its purpose is to ensure that PCS records accurately reflect genuine professional development activity.

## 2. Principles

All activities submitted under Practice Review and Work-Based Learning should satisfy the following principles. These principles reflect the requirements of the Medical Council MPC Framework and the College's commitment to patient safety and professional excellence.

#	Principle	What This Means in Practice
1	<b>Relevance</b>	The activity must be relevant to the doctor's current scope of anaesthetic practice. Activities unrelated to the doctor's clinical role will not ordinarily be accepted.
2	<b>Patient Safety</b>	The activity must support patient safety and quality improvement, either directly or through professional development that enhances the quality of care delivered.
3	<b>Learning and Reflection</b>	The activity must demonstrate genuine learning. For Practice Review activities, a reflective summary is required. For selected Work-Based Learning activities, reflection is strongly recommended.
4	<b>Documentation</b>	The activity must be documented in the doctor's PCS portfolio at the time of the activity, or as soon as reasonably practicable thereafter. Retrospective backdating is not acceptable.
5	<b>Verifiability</b>	The activity must be verifiable by an acceptable senior clinician or governance lead. Activities that cannot be independently confirmed will not ordinarily be accepted.
6	<b>Domain Alignment</b>	The activity must align with one or more Medical Council Domains of Good Professional Practice (Section 3). Doctors should identify the relevant domain(s) at the time of recording the activity.
7	<b>Contribution to Competence</b>	The activity must contribute to the maintenance and development of the doctor's professional competence, consistent with their specialty and scope of practice.

### 3. Medical Council Domains of Good Professional Practice

All PCS activities must be mapped to one or more of the eight Medical Council Domains of Good Professional Practice. Doctors should identify the relevant domain(s) when recording each activity in their PCS portfolio. The domain mapping is used during the Annual Verification Process to confirm that activities span an appropriate breadth of professional practice.

Domain	Description and Typical PCS Activities
<b>Patient Safety and Quality of Patient Care</b>	Activities that directly improve or review the safety and quality of clinical care — including audit, QI projects, incident reviews, and M&M meetings.
<b>Relating to Patients</b>	Activities involving patient feedback, patient communication, and advocacy — including patient satisfaction surveys and open disclosure training.
<b>Communication and Interpersonal Skills</b>	Activities that develop communication skills — including multidisciplinary meetings, teaching, simulation debriefing, and MSF with communication focus.
<b>Collaboration and Teamwork</b>	Activities involving team-based working — including MDT participation, committee work, clinical governance, and team-based QI projects.
<b>Management (including Self-Management)</b>	Activities relating to service management, personal organisation, and leadership — including appraisal, committee work, and service improvement projects.
<b>Scholarship</b>	Activities relating to knowledge generation, dissemination, and education — including research, publication, teaching, journal clubs, grand rounds, and audit.
<b>Professionalism</b>	Activities relating to professional conduct, ethics, and standards — including appraisal, MSF, supervision, and professional development activities.
<b>Clinical Skills</b>	Activities that directly develop or maintain clinical competence — including simulation, grand rounds, M&M review, and clinical audit of outcomes.

#### Domain Coverage

While there is no requirement to cover all eight domains in a single PCS cycle, the College expects that, over time, a doctor's activity profile demonstrates breadth across the domains. An AVP assessor may note an unusually narrow domain profile as a basis for discussion.

### 4. Practice Review Activities

Practice Review activities involve structured review of clinical practice against recognised standards, with the aim of identifying learning opportunities and driving quality improvement. The minimum annual requirement is 10 hours.

#### Minimum Requirement

10 hours of Practice Review per PCS year. At least one activity should involve a structured review against an external standard (e.g. a clinical audit or national guideline review). Simply accumulating passive attendance hours does not fulfil the intent of Practice Review.

#### 4.1 Clinical Audit

Examples of acceptable activity:

- Local or departmental clinical audit with governance oversight
- National audit programme participation (e.g. NAP projects, CPOC PQIP)

- Outcome audit against departmental or national benchmarks
- Benchmarking exercise against published standards or guidelines

**Acceptable evidence:**

- Formal audit report covering standards, methodology, results, and action plan
- Presentation evidence (programme or signed departmental confirmation)
- Completed PCS Clinical Audit Submission and Verification Form (v2.0)
- Re-audit data where available

**Medical Council domains:**

*Patient Safety and Quality of Care • Scholarship • Clinical Skills*

**Guidance Note**

Audit is subject to the additional specific requirements set out in the PCS Clinical Audit Standards Guidance (v2.0). Doctors must complete the separate PCS Clinical Audit Submission and Verification Form for all audit submissions. Simple attendance at audit meetings without active participation does not qualify as Practice Review.

## 4.2 Quality Improvement Projects

**Examples of acceptable activity:**

- PDSA (Plan-Do-Study-Act) cycle projects
- Lean or Six Sigma methodology projects
- Service improvement initiatives with measurable outcomes
- Departmental or hospital-wide QI programmes

**Acceptable evidence:**

- Formal project report with aim, methodology, outcome measures, and improvement evidence
- Presentation evidence
- QI documentation (PDSA worksheets, run charts, process maps)
- Outcome data demonstrating improvement

**Medical Council domains:**

*Patient Safety • Management • Scholarship*

**Guidance Note**

QI projects must include a measurement strategy and demonstrable outcome. Projects without measurable outcomes or improvement evidence will not ordinarily be accepted. Refer to Section 8.3 of the PCS Audit Standards Guidance for accepted QI methodologies.

## 4.3 Critical Incident and Significant Event Review

**Examples of acceptable activity:**

- Structured critical incident review using a recognised methodology (e.g. London Protocol, RCA)
- Serious event analysis with documented learning
- SEAMS (Significant Event Audit and Management System) submissions

**Acceptable evidence:**

- Attendance record or participation confirmation
- Structured review report with learning points and action plan
- Reflection documenting personal learning

**Medical Council domains:**

*Patient Safety • Professionalism*

**Guidance Note**

Participation must be active and documented. Attendance at an incident review without contribution or reflection does not qualify. The review must include a documented action plan arising from the analysis.

#### 4.4 Mortality and Morbidity Review

##### Examples of acceptable activity:

- Departmental M&M meeting participation (presenter or active contributor)
- Hospital mortality review committee participation
- National programme mortality review (e.g. NCEPOD equivalent)

##### Acceptable evidence:

- Meeting agenda with doctor's participation noted
- Attendance record
- Presentation slides (where doctor presented)
- Brief reflection on learning arising

##### Medical Council domains:

*Patient Safety • Clinical Skills • Collaboration and Teamwork*

##### Guidance Note

Passive attendance at M&M meetings may qualify for Work-Based Learning (Section 5) but does not ordinarily qualify as Practice Review. For Practice Review credit, the doctor should demonstrate active participation — for example, by presenting a case, leading discussion, or contributing to the action plan.

#### 4.5 Multisource Feedback (MSF)

##### Examples of acceptable activity:

- Formal MSF process using a validated instrument
- 360-degree feedback integrated within appraisal
- Peer or colleague assessment with structured developmental output

##### Acceptable evidence:

- Completed and validated MSF report
- Personal development plan arising from MSF findings
- Reflection on feedback received

##### Medical Council domains:

*Professionalism • Communication and Interpersonal Skills • Collaboration and Teamwork*

##### Guidance Note

MSF must use a validated, standardised instrument. Informal peer feedback, without a structured report, does not qualify. MSF is only accepted under Practice Review where it generates a documented personal development response.

#### 4.6 Appraisal

##### Examples of acceptable activity:

- Formal annual appraisal with a designated appraiser
- Structured appraisal incorporating review of practice and development planning
- Fellowship or College appraisal process

##### Acceptable evidence:

- Signed appraisal documentation
- Personal development plan with specific objectives
- Reflection on progress against previous development goals

**Medical Council domains:***Professionalism • Management (including Self-Management)***Guidance Note**

Appraisal must be a formal structured process, not an informal supervisory conversation. The documentation must include a personal development plan with specific, time-bound objectives.

**4.7 Patient Feedback****Examples of acceptable activity:**

- Standardised patient satisfaction survey (validated instrument)
- Patient-reported outcome measure (PROM) analysis
- Complaint and compliment thematic review with documented improvement response

**Acceptable evidence:**

- Survey summary report with response rates and data
- Reflection on findings
- Documented improvement plan arising from feedback

**Medical Council domains:***Relating to Patients • Communication and Interpersonal Skills***Guidance Note**

Patient feedback activities must use a validated, standardised instrument. Ad hoc or anecdotal feedback, without systematic collection and analysis, does not qualify. The doctor must demonstrate a reflective response and, where findings warrant, an improvement action.

**5. Work-Based Learning Activities**

Work-Based Learning activities promote learning at or through work. They are reflective in nature and should contribute to the maintenance and development of professional competence. The minimum annual requirement is 15 hours.

**Minimum Requirement**

15 hours of Work-Based Learning per PCS year. Activities should span a range of types across the year. A doctor whose entire WBL record consists of a single activity type may be asked to provide additional evidence of breadth of engagement during AVP.

**5.1 Multi-Disciplinary Team (MDT) Meetings****Examples of acceptable activity:**

- Peri-operative MDT meetings
- Pain management MDT
- ICU MDT
- Cancer MDT or other clinical MDT relevant to anaesthesia scope

**Acceptable evidence:**

- Attendance record (signed or electronic)
- Meeting agenda confirming clinical content
- Brief reflective note (recommended)

**Medical Council domains:**

*Collaboration and Teamwork • Communication and Interpersonal Skills***Guidance Note**

Regular MDT attendance may be claimed annually as a grouped activity, provided an attendance log is maintained. The total hours claimed should reflect actual attendance, not a nominal allocation.

**5.2 Grand Rounds and Clinical Presentations****Examples of acceptable activity:**

- Departmental or hospital grand rounds (attendance or presentation)
- Regional or national clinical presentations
- College scientific meetings

**Acceptable evidence:**

- Attendance record or meeting programme
- Presentation slides (where doctor presented)
- Reflection on clinical learning arising

**Medical Council domains:**

*Scholarship • Clinical Skills*

**5.3 Journal Clubs****Examples of acceptable activity:**

- Departmental journal club (attendance or presentation)
- Regional or national journal club
- Evidence-based practice review groups

**Acceptable evidence:**

- Attendance record
- Presentation materials (where applicable)
- Reflection on how evidence reviewed will influence practice

**Medical Council domains:**

*Scholarship*

**Guidance Note**

Where a doctor presents at a journal club, this may attract additional hours compared to attendance only. The key requirement is that the activity involves engagement with the evidence base and reflection on its application to practice.

**5.4 Teaching and Training****Examples of acceptable activity:**

- Undergraduate medical teaching (lecture, bedside teaching, tutorial)
- Postgraduate anaesthesia teaching (registrar teaching, SHO teaching)
- Faculty development activities
- Simulation teaching and scenario delivery
- OSCE or structured clinical teaching

**Acceptable evidence:**

- Teaching programme or schedule
- Teaching materials (lecture slides, handouts)
- Attendance record of participants

**Medical Council domains:**

*Scholarship • Communication and Interpersonal Skills***Guidance Note**

Hours claimed should reflect time actively engaged in teaching, including preparation where appropriate (typically 1:1 ratio for novel material). Repeat delivery of identical material should be claimed at the delivery-only rate.

**5.5 Mentoring and Supervision****Examples of acceptable activity:**

- Formal mentoring of a junior colleague or trainee
- Structured clinical supervision of trainees
- Research supervision
- Fellowship or higher training supervision

**Acceptable evidence:**

- Mentoring log or supervision record
- Meeting records with dates and duration
- Supervisee confirmation (where applicable)

**Medical Council domains:**

*Professionalism • Scholarship*

**5.6 Assessment Activities****Examples of acceptable activity:**

- College written or clinical examination (examiner role)
- Workplace-based assessment (DOPS, Mini-CEX, CBD)
- OSCE examiner or standardised patient trainer
- Examination development or item-writing activities

**Acceptable evidence:**

- Examiner appointment letter or timetable
- Examination programme
- Assessment record

**Medical Council domains:**

*Scholarship • Professionalism*

**5.7 Research Activities****Examples of acceptable activity:**

- Peer-reviewed publications (first or co-author)
- Oral or poster presentations at scientific meetings
- Active participation in funded research projects
- Peer review of manuscripts or grants
- Research supervision of students or trainees

**Acceptable evidence:**

- Publication (with author listing)
- Abstract with acceptance confirmation
- Presentation evidence (programme or abstract book)
- Peer review confirmation (anonymised where required)

**Medical Council domains:**

*Scholarship*

**Guidance Note**

Hours claimed for research should reflect genuine time commitment. Publication of a single paper may attract 5–20 hours depending on the extent of the doctor's contribution. Authorship credit should be consistent with ICMJE authorship criteria.

**5.8 Committee and Governance Participation****Examples of acceptable activity:**

- College committees and subcommittees
- National Clinical Programme working groups
- Guideline development or review groups
- MPC/PCS committees
- Hospital clinical governance committees
- Medical Board or equivalent

**Acceptable evidence:**

- Meeting minutes with attendance noted
- Appointment or invitation letter
- Committee work output (guideline, report, policy)

**Medical Council domains:**

*Management (including Self-Management) • Professionalism*

**5.9 Simulation Activities****Examples of acceptable activity:**

- Simulation faculty (scenario delivery or debriefing)
- Simulation scenario design and development
- Crisis resource management training facilitation
- High-fidelity simulation training participation

**Acceptable evidence:**

- Faculty roster or programme
- Simulation scenario documentation
- Attendance record

**Medical Council domains:**

*Clinical Skills • Scholarship • Patient Safety and Quality of Care*

**5.10 Clinical Governance Activities****Examples of acceptable activity:**

- Hospital clinical governance meetings
- Risk management meetings
- Open Disclosure training
- Patient safety culture surveys
- Adverse event reporting and review processes

**Acceptable evidence:**

- Attendance record
- Certificate of completion (for formal training)
- Meeting minutes (where applicable)

**Medical Council domains:**

*Patient Safety and Quality of Care • Professionalism*

## 6. Reflection Requirements

Reflection is a core component of continuing professional development and is required for all Practice Review activities. It is strongly recommended for Work-Based Learning activities, particularly those involving learning from significant clinical events.

### Academic Basis for Reflection

Gibbs' Reflective Cycle (1988) and Schön's concepts of reflection-in-action and reflection-on-action provide the theoretical foundation for reflective practice in medical education. The Medical Council of Ireland requires that PCS records demonstrate not merely that activities occurred, but that they generated learning. A reflective statement is the primary means by which this learning is evidenced.

### 6.1 Required Elements

A compliant reflective summary must address all four of the following questions:

#	Reflective Question	Guidance on Answering
1	<b>What was the activity?</b>	Describe the activity briefly: what it was, when it occurred, your specific role, and the clinical or professional context.
2	<b>What did I learn?</b>	Identify specific learning points — not generalities. Reference the evidence, standards, or feedback that generated the learning. Be concrete: 'I learned that our department's fasting compliance was 62%, below the AAGBI standard of 100%.'
3	<b>How will this influence my practice?</b>	Describe specific changes you intend to make — or have already made — to your clinical practice, communication, teamwork, or professional behaviour as a result of this activity.
4	<b>What is the anticipated impact on patients or the service?</b>	Articulate the patient safety, quality, educational, or service benefit that you expect the changes described above to deliver.

### 6.2 Length and Format

A reflection of approximately 150–300 words is recommended. Longer is not necessarily better: a focused, specific reflection of 150 words that identifies concrete learning is of greater value than a generic account of 500 words. Reflections may be written in the first person. They do not need to follow a prescribed template, but must address all four questions above.

### What Not to Write

Avoid vague, unverifiable statements such as: 'I enjoyed the conference and learned a lot.' A compliant reflection identifies what specifically was learned, from what evidence or experience, and how it will change practice. AVP assessors are trained to distinguish substantive reflection from pro forma completion.

## 7. Evidence Requirements

Acceptable evidence is documentation that an independent assessor could use to confirm that the claimed activity occurred, that the doctor participated in the manner described, and that the activity meets the requirements of the relevant category.

Evidence Type	Activities Where Typically Applicable	Notes on Acceptability
<b>Attendance records</b>	MDT meetings, grand rounds, journal clubs, governance meetings	<i>Must show date, meeting title, and doctor's name. Electronic records acceptable.</i>
<b>Certificates</b>	Formal training events, CPD courses, simulation programmes	<i>Must show issuing body, doctor's name, date, and hours.</i>
<b>Audit / QI reports</b>	Clinical audit, QI projects	<i>See PCS Audit Standards Guidance v2.0 for detailed requirements.</i>
<b>Meeting minutes</b>	Committee work, governance meetings, M&M meetings	<i>Doctor's name or contribution should be identifiable in the minutes.</i>
<b>Publications</b>	Research, guideline authorship	<i>Full citation required; author listing must include the submitting doctor.</i>
<b>Abstracts</b>	Conference presentations, research activities	<i>Must include acceptance confirmation from the meeting organiser.</i>
<b>Teaching programmes / schedules</b>	Teaching and training, simulation	<i>Should confirm the doctor's teaching role, topic, date, and audience.</i>
<b>Appointment / invitation letters</b>	Assessment activities, committee work, research supervision	<i>Issued by the relevant body on official letterhead.</i>
<b>Supervisor confirmation</b>	Mentoring, research supervision	<i>Written confirmation by the supervisor on institutional letterhead.</i>
<b>Reflective summaries</b>	All Practice Review activities	<i>Must address all four reflective questions; 150–300 words recommended.</i>
<b>MSF reports</b>	Multisource feedback	<i>Must be generated by a validated instrument; raw questionnaires alone are not acceptable.</i>
<b>Presentation slides</b>	Grand rounds, journal clubs, audit presentations	<i>Must include date and venue on title slide, or accompanied by meeting programme.</i>

## 8. Verification Requirements

All Practice Review and Work-Based Learning activities are subject to potential verification during the Annual Verification Process (AVP). Doctors should ensure that activities are recorded contemporaneously and that supporting evidence is retained.

### 8.1 Acceptable Verifiers

The verifier must be a senior clinician or governance lead with direct knowledge of the activity claimed. The following are acceptable verifiers:

- Clinical Director
- Head of Department
- Training Programme Director
- College Committee Chair
- Research Supervisor

- MDT Chair
- Quality Improvement Lead
- National Clinical Programme Lead
- Hospital Manager (for governance activities)
- Other appropriate senior responsible person with direct knowledge of the activity

#### Verification Standard

Verification should normally be completed on official Hospital, University, or Organisation letterhead. Forms should be signed and, where available, stamped by the organisation. Electronic signatures are acceptable where the verifier's identity and institutional affiliation can be independently confirmed.

## 8.2 What Verifiers Confirm

By signing a verification form, the verifier confirms that:

- The doctor participated in the activity as described.
- The activity is relevant to the doctor's scope of anaesthetic practice.
- The hours claimed are a reasonable reflection of the time committed.
- The supporting evidence submitted is authentic and accurately represents the activity.

## 9. Annual Verification Process (AVP)

A proportion of PCS participants are selected annually for the Annual Verification Process. Selection may be random or risk-based. Doctors selected for AVP must provide documentary evidence demonstrating compliance with PCS requirements.

### 9.1 AVP Evidence Requirements

Doctors selected for AVP must provide evidence demonstrating:

- Active participation in each claimed activity (not merely registration or enrolment).
- Relevance of each activity to their current scope of practice.
- Completion of the required reflection for Practice Review activities.
- Alignment of claimed activities with the Medical Council MPC Framework requirements.
- Achievement of the minimum annual hours for Practice Review (10 hours) and Work-Based Learning (15 hours).

### 9.2 AVP Outcomes

Following assessment of submitted evidence, the AVP assessor may determine one of the following outcomes:

Outcome	Description
<b>Satisfactory</b>	All evidence meets the required standard. No further action required. Doctor's PCS record is confirmed.
<b>Further Evidence Required</b>	Evidence is incomplete or insufficient for one or more activities. Doctor is invited to provide additional supporting documentation within a specified timeframe.
<b>Activity Not Accepted</b>	One or more activities are found not to meet the requirements. The doctor's claimed hours are adjusted accordingly. The doctor may be required to undertake additional activity to meet the minimum requirements.

Outcome	Description
<b>Referral for Further Review</b>	Where evidence is materially inaccurate, insufficient to verify claimed activities, or raises concerns about professional conduct, the matter may be referred to the College PCS Committee for further review.

## 10. Conclusion and Practical Guidance

The PCS is designed to support doctors in maintaining and demonstrating professional competence throughout their careers. The requirements set out in this document are intended to be achievable within normal patterns of professional practice — they reflect what competent, engaged anaesthesiologists routinely do, properly documented.

Doctors are encouraged to record activities at the time they occur, rather than attempting to reconstruct their portfolio at the end of the PCS year. A contemporaneous portfolio is both easier to maintain and more likely to satisfy AVP requirements.

### Practical Tips

1. Record activities in your PCS portfolio within two weeks of the activity occurring.
2. Keep a folder (physical or digital) with supporting evidence for each activity.
3. Complete your reflection at the time of recording, while the learning is fresh.
4. Map each activity to its Medical Council domain as you record it.
5. If in doubt about whether an activity qualifies, contact the College PCS office before the activity — not after.

## Appendix — Glossary of Key Terms

Term	Definition
<b>Annual Verification Process (AVP)</b>	The process by which the College selects a proportion of PCS participants each year and reviews the evidence underpinning their PCS records.
<b>Medical Council Domain</b>	One of the eight domains of Good Professional Practice defined by the Medical Council of Ireland, against which all PCS activities must be mapped.
<b>MPC Framework</b>	The Medical Council's Maintenance of Professional Competence Framework, which sets the overarching requirements for continuing professional development in Ireland.
<b>Multisource Feedback (MSF)</b>	A validated, structured process in which feedback on a doctor's professional performance is collected from a range of colleagues, including peers, trainees, and other healthcare professionals.
<b>PCS (Professional Competence Scheme)</b>	The statutory scheme, administered by the College of Anaesthesiologists of Ireland, through which doctors demonstrate ongoing professional competence.
<b>Practice Review</b>	The PCS component comprising structured review of clinical practice against recognised standards, with a minimum requirement of 10 hours per year.
<b>Reflection</b>	A structured, evidence-based account of learning arising from a professional activity, addressing what occurred, what was learned, how practice will change, and what patient or service benefit is anticipated.
<b>Verifier</b>	A senior clinician or governance lead who independently confirms the authenticity and relevance of a claimed PCS activity.
<b>Work-Based Learning</b>	The PCS component comprising learning activities conducted at or through work, with a minimum requirement of 15 hours per year.