Crossing boundaries and moving in the right direction

Professional boundaries are there for a reason so crossing over is significant in either direction. For over a decade the professional bodies, Royal College of Surgeons (RCS), Association of Anaesthetists of Great Britain and Ireland (AAGBI), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), Association for Perioperative Practice (AfPP), College of Operating Department Practitioners (CODP) and the Perioperative Care Collaborative (PCC) have been contributing to the debate involved in the redesign of advanced practitioners in the perioperative environment.

Dealing with professional staffing shortages and anticipating future challenges requires an innovative approach to provide solutions. We in the operating theatres have been providing solutions for decades, specifically with the introduction of advanced practitioners: Surgical First Assistants (SFAs), Surgical Care Practitioners (SCPs), Assistant Theatre Practitioners (ATPs) and others.

Experience in practice and numerous studies demonstrate that these models of advanced practitioner work very well delivering high quality care and achieving good outcomes for patients. However workforce challenges and the introduction of new roles in the operating theatre has not been a straightforward process, or one that has been achieved overnight. Indeed, we are still challenged with aspects of non adherence and compliance to care delivery in this setting.

The advanced roles of SFA and SCP are well-established in practice in terms of required competency, responsibility and professionalism, from an organisational and individual perspective. The competencies which practitioners are required to achieve are well-defined and agreed between the professions.

Why then do we have the recurrent issue where nurses and ODPs are in a situation at the operating table where they are expected to ‘cross the line’ from that of the scrub role into the domain of the advanced practitioner, most commonly to the SFA role? This dual role is not acceptable outside of very minor surgical procedures and only then when specific criteria are applied as defined by the PCC and AfPP.

It is clear that many organisations, and indeed many healthcare professionals, are prepared to float this in practice and go to the operating table on a daily basis in the full knowledge that a surgical first assistant will be required, and without attempting to resolve this in advance.

One of the questions that is raised most frequently, and again became a much debated topic at the AfPP Residential in York last month, sounds something like this: What can I do if the surgeon needs help during a procedure with holding the retractor, the camera etc... not to help would put the patient at risk... wouldn’t it?... it’s like an emergency situation?... normally we can manage, just sometimes... he needs help.

Let me be clear that what we are talking about here is not an emergency. It is a foreseeable situation which if we walk into it time after time we become part of the problem and not the solution.

I agree it is very difficult not to provide assistance to a surgeon during a procedure when the need arises but my question to you is: how did you as a professional in your own right not know that this would be likely? On any level of even the most basic risk assessment, in the majority of the situations discussed, it will be clear that assistance is a requirement.

Forseeability is a considered aspect of clinical negligence cases which the legal professionals use to determine the proximate causes of an event and identify responsibility.

In a situation such as we are discussing here what are the answers to the following:

(a) What is your perception in relation to the tasks that you are undertaking or going to undertake?
(b) Do you know in advance what the outcome is likely to be, what is the expected and optimal outcome?
(c) What are the risks and benefits?
(d) What could reasonably be anticipated as a consequence in terms of damage or injury to a patient in this situation?
(e) In what way could your acts or omissions contribute to this?
(f) Are you trained and competent to undertake this role?

So, in relation to the initial questions raised, this is a situation that is foreseeable and therefore should not occur. No it is not like an emergency situation, it is planned or accepted as it is and therefore foreseeable, and No the stated claim that normally the surgeon can manage is not sufficient mitigation for the absence of appropriate assistance at the outset.

In conclusion, if you are working within the scrub role that is your responsibility in its entirety and you have very specific requirements to be delivered within that role which are crucial to the management of a safe and optimal outcome for the patient. Extending this role and crossing the line into an advanced professional area is not acceptable practice for several reasons. The main ones being that if you undertake the ‘dual role’ in these interventions you are at risk of compromising the roles of the scrub practitioner placing patients at risk of foreseeable harm. This is generally further compounded when undertaken by practitioners who have received no training or competency assessment. Indeed, I expect that those trained in the role of SFA or SCP would never participate in this practice. I would add a caution here that if you do cross boundaries and something untoward takes place or you are being observed during audit, you can be fairly sure that whatever indemnity insurance scheme you belong to will not accept liability or support this practice.

We must stop making excuses for unacceptable professional practice and take the responsibility that we as healthcare professionals are expected to take as part of our duty of care and in compliance with the mandated professional regulations determined by the NMC and HCPC.

Aside from all of this why can’t we just do it for ethical reasons and because it’s the right thing to do!

Mona Guckian Fisher
President AfPP
president@afpp.org.uk

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