- Surgical Assistance -

Hands up if you think expectations of the perioperative team are to high?

Adrian Jones : RN - SCP
AfPP Vice President

Aims

- Interactive session exploring challenges facing perioperative teams
- Opportunity for delegates to express their own opinion & concerns
- Discuss current options available to meet expectations
- Explore future collaborative opportunities!
To the best of your knowledge, you have no history or evidence of:

1. Hepatitis infection, jaundice, HIV infection….
6. High Risk Activity for HIV / Hepatitis infection Inclusive of IV Drug Abuse / Tattoos / Body piercing / Acupuncture
7. Diabetes
12. Have you ever paid anyone for sexual favours
Patients First!
Pain, Disability, Distress, Social Impact.

Waiting lists, Resources, Time, Litigation.

Consensus

2013 Proceedings of the International Consensus Meeting on Periprosthetic Joint Infection
Chairmen: Javad Parvizi MD, FRCS - Thorsten Gehrke MD

Every stone turned in search of evidence for these questions:
• 3,500 related publications evaluated, Cumulative wisdom of 400 delegates from 52 countries, over 160 societies has been amassed to reach consensus about practices that lack higher level of evidence

Question 5: What strategies should be implemented regarding OR traffic?
Consensus: We recommend that OR traffic should be kept to a minimum.
Delegate Vote: Agree: 100%, Disagree: 0%, Abstain: 0%
(Unanimous Consensus)
In the last month, have you had concerns about the number of members in surgical team?
“See one, Do one, Teach one!”

Learning ➔ Performance

Medical Model

Assessment

Shah et al
RCS Bulletin
2001

CONTROVERSIAL TOPICS IN SURGERY

• Times have changed.
• The ‘apprenticeship system’ has gone.
• Junior doctors are now less able to provide clinical support for service activity and, when they are available, demand their training opportunities be maximised.

Mr D L Mc Whinnie –
Consultant General and Vascular Surgeon –
Milton Keynes General Hospital & Last President of NAASP

In the last week, have you had concerns about the number of members of your team?

“As I get older, I find it hard to tell where the nurse ends and the doctor begins”

“Nurses have been dabbling illicitly with the instruments for years, usually to rescue cack-handed junior doctors”

Phil Hammond M.D.
24th September 1996
Perioperative Team:

• The recommendations include as a minimum and after risk assessment of patients’ needs and the skills and competencies required of the perioperative team:

• **ONE SCRUB PRACTITIONER**

• **ONE CIRCULATING STAFF MEMBER**

• **ONE ANAESTHETIC ASSISTANT PRACTITIONER**

• **ONE RECOVERY PRACTITIONER**

*Staffing for Patients in the Perioperative Setting - AfPP 2014*
Should assisting be seen as part of a perioperative practitioners role?

Surgical Assistants
College Position Statement

The College recognises that a significant contribution to health services has been achieved through the development of the roles of practitioners who undertake duties that have traditionally been carried out by medical staff.

The College supports these roles within the surgical team which have become critical to the delivery of surgical services in some specialties.

© RCS (Eng) 2011
The College therefore expects:

- Greater clarity in the roles and related competency requirements for healthcare professionals who assist surgery.
- Surgical assistance to be carried out by surgeons-in-training wherever possible.
- If this cannot be a doctor we expect the role to be filled by a trained nurse or registered allied health professional.
- That full training for those who assist surgery is essential & that quality assured competencies and accreditation must be mandatory.
Does your department have a policy for surgical assisting roles?

The Perioperative Care Collaborative

Position Statement

SURGICAL FIRST ASSISTANT
(formerly the 'Advanced Scrub Practitioner')

In 2011 The Royal College of Surgeons of England (RCSEng 2011) called for greater clarity in relation to the wide range of titles currently in use by practitioners assisting in surgery stating that confusion as to their meaning could potentially be a safety risk for patients and clinical staff. In recognition of this, the Perioperative Care Collaborative (PCC) has reviewed the title, roles and responsibilities of the Advanced Scrub Practitioner (ASP).

CURRENT POSITION
The PCC recommends that any perioperative practitioner who participates in the role of the Surgical First Assistant (SFA) must have demonstrable skills and an underpinning knowledge beyond the standard level of knowledge expected of a qualified perioperative practitioner. The SFA role can be defined as the role undertaken by a
Scrub Practitioner

Scrub Practitioner who may provide assistance on an ‘as required’ and risk-assessed basis particularly during minor procedures, such as carpal tunnel release, within the context of and without compromise to the scrub role.
Free Hand – Dual Role

- In the event that an employer considers that a dual role is required - (e.g. in minor surgery).

Then this decision should be endorsed:

- **By a policy that fully supports this practice and should also be based on a risk assessment of each situation in order to ensure patient safety.**
Accountability

Is assisting an extended role that requires competency education?

Have we got the bottle to –

Just Say No!
A.S.P - Confusion

• Place within extended surgical team.
• Advanced status of role (Theatre team & AfC)
• Frustration with qualification!
• Extending role risk taking! – Surg Interventions
Surgical First Assistant

The role:

• Undertaken by a registered practitioner who provides continuous competent and dedicated assistance

• under the direct supervision of the operating surgeon throughout the procedure

• whilst not performing any form of surgical intervention.

Clinical focus supporting policy into practice

© Perioperative Care Collaborative October 2012

Role - Key recommendations:

- The role of the SFA should be supported by an organisational governance policy.

- Completed a programme of study that has been benchmarked against nationally recognised competencies required for the role.

- The role of the SFA must be included in the job description/specification of the individual undertaking the role.
DUAL ROLE

• A practitioner undertaking the role of the SFA must be an additional member of the surgical team.

• The practitioner acting as Scrub Practitioner must manage the intra-operative care required by the patient and must not assume the additional duties such as that of the SFA.

Supervision

Do your surgeons understand surgical assisting roles boundaries?
Excluded Practice: Surgical Intervention

- Activities such as direct electro surgical diathermy to body tissues, applying haemostats or ligaclips to vessels, applying cast bandages, suturing skin or any other tissue layers are the remit of a Surgical Care Practitioner (SCP).

- It is important to note, that as with all other roles, the SFA works within a local clinical governance framework, albeit primarily within the intraoperative phase.
The Surgical First Assistant Competency Toolkit

Provides a reference tool for both managers and practitioners to assist the process of strategic planning for, and implementation of, the Surgical First Assistant (SFA) role in operating theatre departments throughout the United Kingdom.

Guides operating department managers and surgical supervisors to develop a co-ordinated and nationally recognised in-house training programme for individual trainee SFAs.

- Ensures that registered perioperative practitioners demonstrate achievement of the national standards required of practitioners working in the SFA role.

- Defines the range of knowledge, skills and standards of practice for the SFA.

- Can be used alongside academic modules and awards, and other in-house training packages.
Surgical Care Practitioner

A registered non-medical practitioner who has completed a Royal College of Surgeons accredited programme (or other previously recognized course), working in clinical practice as a member of the extended surgical team, who performs surgical intervention, pre-operative care and post-operative care under the direction and supervision of a Consultant surgeon.

RCS (Eng) President Norman Williams in his Jan 2013 newsletter – Bulletin RCS (Eng) says:

- Without many of these individuals we would not be able to provide a first-class service. It is therefore incumbent on us to ensure that such individuals are supported and made to feel part of the ‘family’: My personal view is that it is imperative we embrace these groups; as such action will strengthen all parties”.
“Houston we have a problem!”

would you Adam and Eve it
The SFA’s knowledge and skills are integral to the new pre-registration curriculum document for the BSc in Operating Department Practice, College of Operating Department Practitioners April 2011.

Therefore, those practitioners who have qualified under this programme of study are able to act as an SFA on qualification, supported by the employing authority.

- Curriculum Document:
- Bachelor of Science (Hons) in Operating Department Practice – England, Northern Ireland and Wales;
- Bachelor of Science in Operating Department Practice – Scotland,

Unilateral decision?

- We also looked at the added value on taking on extra skills (advanced scrub which currently is seen as a post reg activity) that would contribute to the team and address areas arising in medical training.

- Therefore we felt in light of changes that were due to happen in nursing it would be reasonable from an equity standpoint as well as the evidence on graduate nursing (health profession) offering better patient outcomes.
A CLEAR SENSE OF DIRECTION

The National Association of Assistants in Surgical Practice
Promoting high quality care through the development of skilled, competent healthcare professionals

Survive to Thrive
A possible way ahead?
Future Presence!

1994
Cardiac Surgeons Assistant
Guidelines for Heads of Departments

1999

2001/2003
NAASP
Curriculum Developed

1999

2006
The Curriculum Framework
For the Surgical Care Practitioner

Voluntary List 2012
Registration?

NURSING & MIDWIFERY COUNCIL
hpc health professions council

Guilty as Charged

Failed in your duty of care to patients by working outside the boundaries and training of your role as a first assistant by undertaking a technique (inserting and advancing a guide wire during an orthopaedic procedure in Theatres) that you have no authority to perform.
Point to Ponder - Legal Action

1997 Alabama Supreme Court Case
Health Care Trust  v  Cantrell

$ 818,000  Compensatory damages against hospital theatre technician.

Suit brought on behalf of child for Sciatic Nerve damage during Hip surgery

Oct 1998 - Intraoperative use of Unlicensed Assistive Personnel
Ellen Murphy  Prof - University of Wisconsin AORN

“England
Expects
That every
man will do
his duty”
5 When you do not provide your patients’ care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.

• Good Medical Practice - 2013

The Perioperative Practitioner: Advancing Surgical Care – Who's supporting Who?
17th October 2015

This unique one-day conference will allow delegates to explore current and future challenges facing SCPs and SFAs along with discussion about the role that RCSEd can play in providing support.

“….to all my teammates. It is them I have to thank for putting me in this position!”

The Sunday Times - 26.7.15
Our vision and mission for the future

“Our vision is to lead perioperative excellence”

“Our Mission is to improve patient care through constantly developing the leading standards for perioperative practice and practitioners”

Filling the Void!

Defining the Future?