The Role and Responsibilities of the ADVANCED SCRUB PRACTITIONER
Position Statement

Role clarification - assessing the risks of the dual role

SETTING THE SCENE

Many registered perioperative practitioners will have witnessed changes in their roles in recent times as the modernisation of patient services and service provision has occurred. Some of these changes have arisen as a means of reducing waiting times for surgery and the expanding day surgery provision. In addition the European Working Time Regulations, as well as a result of healthcare policy changes in the four countries of the UK, have also contributed to this situation. Some of these healthcare policy changes have been published in policy documents including:

- Creating a Patient-led NHS (March 2005)
- National Workforce Planning Framework (August 2005)
- Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century (May 2005)

Organisations in all four countries have recognised the many talents that staff within the perioperative multi-disciplinary team bring to patient care. This recognition has prompted skill mix reviews and the introduction of new ways of working so that patients receive the most effective and timely care. The Advanced Scrub Practitioner (ASP) is not a new role, as it is a well-established role in many perioperative environments. The Perioperative Care Collaborative (PCC) recognises that practitioners working in this role, as well as those involved in the management of practitioners in this role, may require clarification of the expectations and implications of the role, in particular the legal and ethical implications of undertaking the dual role.

The PCC therefore recognises that perioperative practitioners have undertaken the ASP role when surgical assistance has not been available from medical staff. The aim of this revised position statement is to ensure that practitioners undertaking such roles are informed of the associated risks of this aspect of their professional practice. At present, the ‘Bolam Test’, established in the case of Bolam v Friern Hospital Management Committee [1957] All ER 118 and the Case of Wilsher v Essex AHA [1988] All ER 871, would be the standard of care to which the practitioner would be measured against, in the event that their role is questioned in a court of law. The first case has established how the expected standard of care would be defined and against which a practitioner would be measured in the event that they were involved in a case that went to court. The Wilsher case established how the clinical responsibility of the practitioners concerned would be determined and again, practitioners may find that they would be measured against such findings.

DEFINITION:
ADVANCED SCRUB PRACTITIONER

In January 2003, the Perioperative Care Collaborative reviewed the role of the non-medical perioperative practitioner working as first assistant to the surgeon and re-defined the role, job description and title of the first assistant to that of ADVANCED SCRUB PRACTITIONER. This title reflects the Framework outlined within A Career Framework for Health and acknowledges that practitioners undertaking advanced roles such as the ASP role are ‘expert practitioners’.

The ASP role can be defined as the role undertaken by a registered perioperative practitioner providing competent and skilled assistance under the direct supervision of the operating surgeon while not performing any form of surgical intervention. Examples of practices that may be considered as part of the ASP role are highlighted in Table 1. Other activities such as direct electro diathermy to body tissues, applying haemostats or ligacips to vessels, applying cast bandages, suturing skin or any other tissue layers are the remit of a surgical care practitioner* and are outwith the remit of this position statement. It is important to note, that as with all other roles, the ASP works within a local clinical governance framework, albeit primarily within the intraoperative phase.

The PCC recommends that the ASP undertaking this role should have demonstrable comprehensive skills, competencies and underpinning knowledge beyond the standard level expected of a newly qualified theatre practitioner. Therefore registered practitioners are expected to produce evidence of lifelong learning within the perioperative field before undertaking a validated programme of study for this role.

The PCC recommends that the role of an ASP must be undertaken by a competent practitioner who has received recognised training in this role, which may be through an externally validated course or an in-house programme. The PCC acknowledges that access to validated training in this role may be limited, but recommends that employing organisations ensure that access to such training is

* Surgical care practitioner is currently a working title at the time of printing this statement.
facilitated for practitioners undertaking the ASP role. This will ensure that patient safety is not compromised by a level of practice below that of a medical practitioner and will ensure that registered practitioners can demonstrate their competence in accordance with the requirements of their professional registration, future employment with other organisations or during the course of any internal or external investigations. In addition, any member of staff who undertake the role of the ASP should ensure that their professional indemnity insurance will provide cover for undertaking this role at all times.

The PCC further recommends that the registered practitioner must NOT assume that a surgeon is automatically legally liable for their actions when functioning as an advanced scrub practitioner. The law states that whoever provides the care is responsible for the care given. Perioperative practitioners must maintain accountability for their actions in accordance with their relevant ‘Professional Codes of Conduct’. They must always act to identify and minimise any risk to patients and maintain their duty of care to the patient. Therefore they must retain the right to refuse to undertake the role of the advanced scrub practitioner if they believe they are not competent to take on this role.

THE DUAL ROLE

The PCC recommends that a registered practitioner undertaking the role of the ASP must be an additional member of the surgical team, with a clearly defined role. The practitioner acting as scrubbed assistant must manage the intra-operative care required by the patient and must not assume the additional duties of the advanced scrub practitioner. In the event that an employer considers that a dual role is required, then this decision should be endorsed by a policy that fully supports this practice and also be based on a risk assessment of each situation in order to ensure patient safety.

ADVANCED SCRUB PRACTITIONERS SPECIFICATION

The specification/duties of the advanced scrub practitioner may include but are not limited to:

- enhancing the communication link between theatre, patient and ward, including pre-operative assessment and post-operative care evaluation
- assisting with patients’ positioning, including tissue viability assessment
- skin preparation prior to surgery
- draping
- skin and tissue retraction
- handling of tissue and manipulation of organs for exposure or access
- handling instruments
- male/female catheterisation
- cutting of sutures and ties
- assisting with haemostasis in order to secure and maintain a clear operating field
- use of suction
- indirect application of electrocautery under supervision
- camera holding for minimal invasive access surgery
- use and maintenance of specialised surgical equipment relevant to area of working
- assistance with wound closure
- application of dressing
- transfer of patient to post anaesthetic care unit

The Perioperative Care Collaborative recommends that all advanced scrub practitioner interventions be documented within the patient’s notes or integrated care plan.
STRATEGIC PLANNING

The PCC recommends that the remit of the registered practitioner undertaking the role of the advanced scrub practitioner should be planned for strategically by employing organisations.

Registered practitioners must not undertake the role of advanced scrub practitioner until the relevant organisation has a policy in place to support this clinical practice and the individual concerned has this extended role specified within their job description and contract of employment. If the employing organisation accepts that the dual role is necessary, this must be clearly identified in a local departmental policy as detailed above. This policy should identify the skills, knowledge and competencies required to undertake the role and the category of surgery and situations for which the employing organisation determines the dual role as being acceptable. If this structure is not in place as part of an effective clinical governance framework then practitioners must not undertake either the advanced scrub practitioner or dual role.

These guidelines are crucial in establishing the vicarious liability of the employer if the employer is to be responsible for any acts or omissions of the employee undertaking the ASP role, within the sphere of their employment.

Finally, to maintain public trust and confidence, the PCC recommends as good practice, that patients are informed where practitioners other than those traditionally involved in delivering the care are being utilised.

**Bibliography**

- Bolam v Friern Hospital Management Committee [1957] All ER 118
- Department of Health 2005 Creating a Patient-led NHS Delivering the NHS Improvement Plan Department of Health in England London DH
- Health Professions Council 2003 Standards of conduct, performance and ethics London HPC
- Independent Healthcare Advisory Services 2005 Employers Guidance and Recommendations for the Utilisation of the Non Medical Practitioner working as the Advanced Scrub Practitioner (formerly First Assistant) within the Independent Sector London IHAS
- National Practitioner Programme 2006 Optimising the contribution of non-medical healthcare practitioners within the multi-professional team, A good practice checklist London DH
- Scottish Executive Health Department December 2005 National Workforce Planning Framework Edinburgh NHS
- Wilshere v Essex AHA [1988] All ER 871

THE PERIOPERATIVE CARE COLLABORATIVE

The PCC was formed in October 2002 with a clear aim to explore perioperative issues and reach a consensus view on how they should be addressed.

**Membership of the Collaborative is as follows:**

- Association for Perioperative Practice
- Association of Operating Department Practitioners
- British Anaesthetic and Recovery Nurses Association
- British Association of Day Surgery
- Independent Health Care Advisory Services
- PROPRIUS: Forum for Perioperative Education
- Royal College of Nursing Perioperative and Surgical Nursing Forum
- Royal College of Surgeons of England

The Perioperative Care Collaborative has formulated the above guidance for all practitioners working in the perioperative environment.