Cut sutures? Too long or too short!

Opening a three hour orthopaedic surgery seminar to a 1st year student nurses cohort, I posed this question: ‘What will nursing be like in the next 40 years? I expect your medication rounds will be undertaken by a robot? Guided by you! I never expected to be stood in front of you, about to describe my advanced role as a member of a surgical team – I am just a nurse!’

Over last 23 years I have had the privilege, of supporting Surgical Care Practitioners (SCPs) become established members of perioperative surgical teams.

The role of the Surgical First Assistant (SFA) however has not been a straightforward development. The publication of the 2018 Perioperative Care Collaborative: Position Statement (PCC 2018) is intended to set the academic standard for future clinical practice, whilst recognising how the role has responded to meet challenging demands of surgical care delivery (RCS 2014). It considers an emerging graduate RN/RODP perioperative workforce, their continuing professional development and collaborative recognition in a surgical environment.

However some overarching principles remain, as in wound healing by primary intention:

- Two opposed surfaces of a clean, incised wound (no significant degree of tissue loss) are held together. Healing takes place from the internal layers outwards.

Not every SFA will be required to obtain extended skills that include suturing, only if deemed a requirement by supervising surgeons. Clinical practice demands that SFAs work within a framework of robust clinical governance at both a local and national level. They require role specific contracts and accompanying job descriptions to ensure the provision of vicarious liability by employers. Equally important is the supervisory framework, not only for trainees but also for those in established practice; ensuring that practitioners maintain high standards of care.

Local demand supported by a suitable risk assessment should be the drivers for the development of practice. It is not enough to seek role progression simply to meet one's own needs. Those of patients and the surgical care team within which one works require active consideration. Where there are regular requests for surgical intervention, beyond that of the areas defined in the Perioperative Care Collaborative SFA position statement, consideration should be given to the need to recruit an SCP.

Pressures on scrub practitioner to act as ‘a pair of retracting hands’, in a range of more complex procedures beyond original remit, should be recognised and staff protected from ‘bullish’ assertive surgeons by observant engaged managers. Dual role assistance is not an open season for procedural escalation to fit surgical expediency! Never events occur when migration towards, and violations of, safe practice occur, even to exceptional perioperative surgical teams!

Thanks to the Perioperative Care Collaborative and AfPP colleagues for your insight, vision and collegiate participation essential for safe surgical patient outcomes. However a word of warning!

‘After decades of attempts to program robots to perform complex tasks like flying helicopters or surgical suturing, the new approach is based on observing and recording the motions of human experts as they perform these feats - our robots are signing up for online learning.’

Ken Goldberg 2010

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