Teamwork: how does this relate to the operating room practitioner?

by Sue Corbett

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Teamwork in the operating room is vital. We must view a picture of the evolving role of operating room practitioners and our educational needs. By raising our profile, we can encourage teamwork amongst multidisciplinary groups and secure the future of operating room practitioners in this complex matrix of patient care. With support we can create professional teams that will meet the values and expectations of trusts as well as government targets on a day to day basis.

The operating room practitioner – teamwork essential

We work in times of ever changing expectations to meet the needs of the patients, delivering high quality care for all: ‘We will empower frontline staff to lead change that improves quality of care for patients’ (Darzi 2008 p7).

This would be achievable if we had the manpower on the frontline but with the decreasing number of both nursing and medical staff joining the operating room environment I question the reality of this goal. This surgical environment struggles to recruit operating room practitioners (ORPs) and we see junior medical staff less frequently in the operating room (OR) due to other demands on their time in wards and other departments.

Dobson (DH 1998 p2) believed that all patients are entitled to high quality care, and that over a 10 year period NHS staff with expertise and innovation in clinical practice would modernise the health service in England. Ten years on we should ask ourselves what has changed, besides the extra workload we endeavour to cope with due to increases in life expectancy, brought upon us through research and modern techniques that have been developed within our clinical practice.

Workload has increased to meet trust targets with little or no extra resources seen on the shop floor to cushion this extra impact and productivity explosion, and now implementation of the World Health Organisation Safe Surgery Checklist (WHO 2009) and the Productive Operating Theatre Program (NHS 2009) which are due to be rolled out this year. Although both were designed to assist with improving efficiency and patient safety only time will tell on what effect this will have if recruitment issues continue to be a problem in operating rooms. I must ask the question - will this add even more strain on the depleted teams?

Staines (2009) asks the question - is this speciality ready for these challenges? Nurses will be central to the program’s success. ORPs must be proactive as a professional group, through effective education programs and by joining together with other multidisciplinary groups. This could be one solution in enhancing our patients’ experience during their pathway of care.

Within this article I hope to highlight:

- Who are ORPs and how diverse is the team?
- What are our educational needs and what sort of learning environment should we be offering both to existing and potential new staff?
- What support is required to strive for an educational pathway, aid recruitment, and unite the ORPs and medical staff?

Who are ORPs?

Operating room practitioners are a highly professional group, working behind the doors of an environment that is unfamiliar to the public. It is also new to some nursing colleagues who have never before been exposed to the three main areas of patient care: the anaesthetic room, operating room and recovery. Our patients meet us only briefly while entering and exiting the department during their pathway of care and very few patients remember us or would recognise us again. Through effective alliance with other multidisciplinary teams we can raise the profile of operating department teams by promoting ourselves to the public and perhaps increase recruitment opportunities into theatre suite.

Mardell (1998) stated that newly appointed nurses should visit the operating theatre as part of their hospital induction program, and greater public awareness through publicity and open days would help the public to become more aware of our existence. Within an operating department lies a unique multidisciplinary team who work closely together to ensure that patients receive quality care. This team is built up of surgeons, anaesthetists, nurses, operating department practitioners, healthcare support workers, radiographers, porters, pharmacists and clerical teams. The goal of these teams is to work effectively to ensure patients’ safety during their anaesthetised state and to trap human errors. Although we cannot avoid adverse events, we can strive for an effective surgical outcome as our goal. Edwards (2008 p170) stated that: ‘Every member of the surgical team has a clear role to play in the promotion of safe surgery’, Gilmour (2009) reinforces the need within NHS trusts to use the WHO safer surgery checklist (WHO 2009). Launched in 2008, this surgery checklist was designed to

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Teams are co-operative groups where members acknowledge other members’ contributions (Bond 1998). This is widely articulated where all disciplines in a specialist operating room communicate, support and acknowledge each other’s accomplishments. However, Bond (1998 p22) states ‘the medical profession places great value on its clinical freedom to direct and decide on patient care’. She implies that ORPs have little or no influence on direct care. This is not solely true in all operating rooms since, according to Corbett (2007a), ‘people respond in amazing ways when given some control over what they do. The more ownership they feel, the more interest they will have, and the harder they will try and do a good job’.

In an ideal world we should be striving for interactive teams, with a shared vision to deliver quality care. By building up interactive teams who share a distinct concept of patient care and where professional groups reflect through collaborated finding, this is possible. Undre et al (2006) inform us that professionals within the OR would welcome a change from the current structure of the team. We should be striving for coherent teams who excel in all aspects of their roles and who aim to improve the patient experience through the OR.

Williams (1998), who reviewed Bond (1998), suggested that the operating theatre work is one of the best examples of team work in the NHS environment. But will this be so if we do not remove the banner of hierarchy and ritual ways? I believe that well informed, motivated and confident ORPs are a clear asset to their surgeon. Their knowledge and timely support can positively influence the outcome of the operative procedure. Successful team building begins with the general concept that educating teams together is the best way for achieving the quality care we strive for. We need to understand what the surgeon or anaesthetist is aiming for, why, and how the goal is met. Teamwork is highly valued in OR nursing due to the orchestrated smooth actions and co-operation of a variety of professionals (Cromwell 2000).

Educational needs

Education is appreciated worldwide amongst my peers, which I have discovered through networking from being a member of an international organisation. We should promote an ongoing education package which could be utilised in order to accomplish the common international goal to achieve global high standards and objectives.

ORPs and medical personnel need jointly to develop an education curriculum aimed at their specialist area of surgery that can be changed when evidence based practice dictates and surgical options change. This would address the issues that we all have in the OR today, which include lack of time allocated for education, staff shortages and, to some degree, funds. In fact, anything that would have a significant impact and saving on the teams’ resources like time, personnel commitments and costs, has to be seen as a bonus. Corbett (2007b p27) agreed: ‘Having the resources to further enhance skills and competencies is key to achieving positive patient outcomes’. An ORP daily goal should be to improve the treatment of patients though research, development, clinical investigation and education. Trust in each other’s professionalism permits the team members to triumph over educational boundaries and allows flexibility within the team to accomplish excellence in care.

Creating a better professional supportive environment for the surgical procedure will improve the service our patients receive. A team who is more informed, understands the surgical steps and is familiar with the equipment improves the outcome for the patient. Speciality and individual team development needs can be achieved through education, by expanding knowledge and supporting joint skills.

Life-long learning is also an investment, allowing staff to keep pace with the changing world of medical advances, new technologies and approaches. Due to public awareness through media resources and their increased expectations of the care we deliver, we must perform with regard to quality. Mitchell (2008) observes that humans are prone to making mistakes, and through research with theatre nurses is trying to help theatre team members from different clinical backgrounds to work together more effectively to manage error and maintain patient safety.

All patients have common care needs worldwide during their preoperative, intra-operative and postoperative journey. To facilitate these needs, we have an obligation to ensure that organizational issues relating to our practice are delivered efficiently and that the educational needs of the team are identified and addressed. Corbett (2007b p27) highlights ‘It is imperative that all hospitals and healthcare facilities offering surgical services ensure that their ORPs have been adequately trained to protect their patients’. Increased liability and negligence cases may be the catalyst to identify and facilitate these educational needs.

This can be difficult to deliver in some busy units due to time, funding and expert input. With effective communication and dedicated teams, this is well within the boundaries if they are offered an education program.

In today’s busy operating environment with reduced time and lack of any structured specialist educational package, our rare new team members have short orientation programs - the basics are taught, and then they are thrown to the wolves, so to speak. Whatever happened to the theatre course that gave the long standing ORP the platform on which to build their expertise?
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Continued

Saxon et al (2000) highlight that learning the art of intra-operative nursing is a long process that usually goes beyond the orientation period, and new team members may lack the skills required to work in a team environment. Teamwork is enjoyable because it can lead to active communication between multidisciplinary groups and will improve job satisfaction. We should all be striving for this on a daily basis, to reduce stress and the pressures we face within our working environment.

The learning environment

Measuring competency levels of expertise within the team can be a tool to monitor and evaluate team members to ensure consistency and patient safety. If we develop an educational curriculum dedicated to specialist areas, that is transportable and built up of modular courses and delivered via different vehicles, we can set gold standards that will produce an environment that is safe and free from injury to our patients.

The author believes a curriculum could:
- have strategies that build skills through productive collaboration from other experienced teachers and peers. Practitioners could aim to complete the curriculum within their own time frame.
- All the above can be met, by tapping into knowledge and skills of other members of the multidisciplinary teams within the OR, and networking with our peers both at home and internationally.
- We should have a mutual understanding between operating room disciplines to undertake the task of taking care of patients undergoing surgery. All educational needs can be met with support from management, while recognising our constraints due to workload. The understanding of ‘reaching government targets’ and ‘generating income’ and ‘fulfilling the patient’s need’ is not going to go away, but without time and funding set aside to educate the team members, we will become robots by just fulfilling the task set, with little or no job satisfaction.
- Within a good team every member of that team will know what they require for their individual educational pathway and no one member stands in isolation in a united team.
- It must be said though that not all hospitals and surgery centres worldwide are equivalent. This can depend on the demands of treatment required, the size of the centre and the structure and values set. The educational package must be flexible to meet the demands and needs as ‘one size does not fit all’. On reflection, perhaps short online e-learning modules and short day courses may be the answer, allowing the individual to keep abreast of new technologies and practices within each specialist area.

Benefits to working in the operating room

As a long standing member of an operating room team, this could have stemmed from the enjoyment of a theatre placement during training. Other reasons are job availability and a liking for the technical aspects; the influence of television (Mardell 1998) and ‘fly on the wall documentaries’ may also play a part.

Alongside a positive perception of who we are in the operating room also comes a negative view of working in this environment. The ORP has been tagged with the label trolley dolly, trained monkey, and robot within the worlds of both medicine and nursing. Generally in the past this stemmed from a lack of knowledge outside the department of what our role consisted of.

Our role today is to support the surgeon in multiple facets of the operation process. In many cases a positive working relationship between a surgeon and individuals within his or her ORP team results in a strong bond of trust, respect and even friendship. This promotes a culture of value and respect.

Unlike surgeons, ORPs tend not to specialize. Depending on an institution’s size and diversity of specialist care, ORPs may work for different operating firms in different areas in a single day; reinforcing the need to educate.

Recruitment to the OR is essential for the development of future teams and to protect patients during their unconscious state. Resources need to be increased to train more ORPs, and student nurses must have exposure to the OR during training. We need to plan ahead and replace the long standing nurses who will retire within the next 10 years. If no formal action is taken soon to address the operating room establishment and replenish staff numbers, trust and government targets will not be met, but more importantly, there will be an increased risk of injury and liability and negligence cases will arise.

Conclusion

No organisation can remain stagnant. Challenges are imposed to meet the patients' expectations within this modern society. There is a need to create an environment of expertise within ORP teams and to establish systems that will help future teams to flourish, and remove any
The operating room has to consist of teams that pull together; no one can work in isolation.
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