The First Assistant Role: Fact or Fiction?

Adrian Jones : RN - SCP
AfPP Vice President
In whom do you put your trust?

ON THE 7TH MAY

I WILL BE VOTING FOR THE PARTY I TRUST
Aims

• Review development of surgical assistance in the United Kingdom

• Introduce development of PCC 2012 Surgical First Assistant role

• Contemplate future education & practice
“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.
“England Expects That every man will do his duty”
Duty

Duty - "due" meaning "that which is owing"; a term that conveys a sense of moral commitment or obligation to someone or something.

Expectation

In the case of uncertainty, expectation is what is considered the most likely to happen. An expectation, which is a belief that is centred on the future, may or may not be realistic.
Professional Expectations
“See one, Do one, Teach one!”

Learning → Assessment → Performance

Medical Model

Shah et al
RCS Bulletin
2001
“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
NHS revolution: nurses to train as surgeons

BY JEREMY LAURANCE
Health Editor

MINISTERS ARE planning a revolution in the NHS under which nurses will be trained to perform surgery to help reduce hospital waiting lists.

John Reid, the Secretary of State for Health, is desperate to increase the surgical workforce to meet a government pledge that no one will wait longer than 18 weeks for treatment from GP referral by 2008.

Doctors accused ministers yesterday of misleading the public and “sacrificing patient safety” by drafting in nurses in the rush to get waiting lists down. Figures published last week show that despite a 35 per cent fall in hospital waiting lists in the past six years, there were still 857,200 people waiting for operations at the end of October, with 69,000 waiting more than six months.

Under the Government’s plans, a wide range of operations, including hernia repair, vasectomies and arthroscopies (internal examination of joints), will be performed by surgical care practitioners — nurses, physiotherapists and operating department assistants — after two years of training. Between 4,000 and 5,000 will be appointed over the next decade depending on demand. They can qualify with five GCSEs, the minimum required to become a nurse, and will provide support to consultant surgeons as well as operating alone.

A consultation document to be published in the next month proposes the move to save £400 million a year. Dr David Nagl, consultant surgeon at St James’s University Hospital in Leeds, questioned the need for nurses to perform vasectomies and other surgical procedures.

Nurses could perform a range of surgical procedures, such as vasectomies

by the Royal College of Surgeons in 2007, are already causing alarm about falling standards. They will see consultants appointed after six years of postgraduate training, half the current minimum of 12. Junior doctors are also working fewer hours, following a European Union directive, further reducing the availability of surgical manpower and time for training.

Hugh Phillips, president of the college, said the consultants of the future would have to be trained more intensively to ensure standards were maintained. “I am very concerned because I don’t see any move from the Government to fund [the training] in an appropriate way.”

From 2010, there would be one junior surgeon in training for every five consultants, Mr Phillips, an orthopaedic surgeon, said. Consultants cannot operate without assistance from junior surgeons. “Who is going to support the other four consultants? It is in my view perfectly reasonable to skill other people in the team to do the work,” he said. He dismissed as “scaremongering” the suggestion that the practitioners might carry out these procedures, alone and unsupervised.

Jill Biggin, chair of the National Association of Assistants in Surgical Practice, said the plans to train nurses were aimed at filling a gap in the clinical service caused by the shortage of junior doctors. There are 400 practitioners working in the NHS carrying out procedures such as stripping veins from the leg for coronary bypass surgery, but they have had no formal training.

The move comes as a new NHS pay offer to doctors is being negotiated, worth £2.7 billion over five years, but does not include a mention of training nurses to perform surgery.
Peysner’s concerns

- Role of Helper
- Second Opinion
- Trainee
- Deputy
- Observer
- Witness

John Peysner – 1996
M.D.U Journal
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
Too Hot To Handle?
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

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.

The College recognised this by contributing to the development of training curricula for these practitioners with the Department of Health in 2006.

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The Extended Surgical Team
• The College believes that the wide range of titles in use for practitioners who assist surgery, is a patient safety issue because it can cause confusion for patients and clinical staff.

• The public must be fully informed about the background and meaning of the various job titles currently in use within the surgical healthcare setting.
A Surgical Care Practitioner

A non-medical practitioner working in clinical practice as a member of the extended surgical team, who performs surgical intervention, pre-operative and post-operative care under the direction and supervision of a consultant surgeon.
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.**
LOCAL
Orthopaedic S.A Education Core Plan
• The work of surgical assistants must be properly supervised, monitored and appraised, and must involve surgeons from the relevant departments.

• Extending practice beyond the defined clinical remit poses risks to patient safety.

• Consultant surgeons must have sufficient time to supervise surgeons-in-training as well as the surgical assistants who are clinically accountable to them.

• The College believes strongly that surgical assistants should not operate independently (unsupervised) under any circumstance.

• Trusts must ensure that all members of the surgical team are aware of their role and clinical remit, the training this requires, and their regulatory accountability.
The Perioperative Care Collaborative

Position Statement

The Role and Responsibilities of the
ADVANCED SCRUB PRACTITIONER
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
OPERATOR INTERFACE = HAND GRIP

TISSUE INTERFACE

OPERATOR

INSTRUMENT

TISSUE
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
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.
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.
Have we got the bottle to

—

Just Say No!
Role - Key recommendations:

- 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.

- SFAs should give consideration to the necessity of indemnity cover. This is essential for those working in private practice.
- The role of the SFA should be supported by an organisational policy.

- The SFA’s name must be recorded within the patient’s documentation.

- SFA should be requested in advance by the surgical team and rostered as an additional member of the perioperative team.
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.
Excluded Practice

• 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.
Surgical First Assistant – Duties

- Cutting of superficial/deep sutures and ligatures under direct supervision of the operating surgeon
- Skin, nerve and deep tissue retraction –
- Retractors should not be placed by the SFA but by the operating surgeon
- Handling of tissue and manipulation of organs for exposure or access
• Assisting with haemostasis in order to secure and maintain a clear operating field including indirect application of surgical diathermy by the surgeon

• Use of suction as guided by the operating surgeon

• Camera manipulation for minimal invasive access surgery

• Assistance with wound closure.
Delegation

...must be sure:

• That the person to whom you delegate care or treatment is competent to carry out the procedure or provide therapy involved

• Pass on enough information about the patient and the treatment needed

• Still be responsible for the overall management of the patient.

Good Medical Practice - 2001
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 training packages.
A CLEAR
SENSE OF
DIRECTION
There must be an equivalent standard of assessment for both Surgical Trainees and Non-Med Assistant’s who will perform similar activities.
The first three students to graduate in ODP celebrate at Rochester Cathedral

(from left: Ilona Gray, Debbie Cay, Chelsea Woodward)
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.
MIRROR

SIGNAL

MANOEUVRING

IN-ACTION

ON-ACTION

RE-ACTION
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

2001/3

2006
The Curriculum Framework
For the Surgical Care Practitioner

Curriculum Developed

Voluntary List 2012
Registration ?

NURSING & MIDWIFERY COUNCIL
hpc health professions council
Each runner must hand off the baton to the next runner within a certain zone.............
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”. 
Future C.P.D

- Maintenance – necessitated by a climate of rapid social, economic and political change

- Survival – necessitated by a need to remain competent and effectiveness

- Mobility – to enhance mobility in the labour market.

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”
OPERATOR INTERFACE = HAND GRIP

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TISSUE
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.
Filling the Void!

Defining the Future?