

# CHAPTER 1

## The Context of Perioperative Care

Kate Woodhead and Lesley Fudge

### What is Perioperative Practice?

The word 'perioperative' is a fairly recently devised term. The Association for Perioperative Practice (AfPP 2005) describes the perioperative environment as the area utilised immediately before, during and after the performance of a clinical intervention or clinically invasive procedure.

Previously, the care of the patient undergoing a surgical procedure was separated into distinct and separate areas of care. In the case of elective surgery the majority of patient journeys began with a visit to the GP, followed by a wait, hopefully appropriate to the urgency of their disease needs, for a referral to a specialist surgeon to come to fruition and then again, subject to urgency, another wait for an admission date to a hospital for surgery possibly after a series of investigations. Once admitted, the patient started on another journey in less familiar surroundings which, dependent on age, ethnicity and language, competence and understanding may have caused anxiety and fear which the healthcare professionals responsible for the care of the patient must make every effort to resolve as part of their service to the people who need their help and support.

It was then at this point that the perioperative care in anaesthesia, surgery and postanaesthetic recovery took place as suggested by the AfPP.

More recently, the patient has been considered holistically and the term 'perioperative' now much better describes the care of the patient from initial referral and diagnosis to full recovery, or as full as that recovery might be for their physical condition. That final outcome may inevitably be death and it is not necessary to deem that conclusion as a failure.

The word 'peri' derives from the Latin 'around', so perioperative means around the operation or intervention. Therefore perioperative care should start with good-quality information-giving and sharing with the patient from the first time they interact with a healthcare professional in the doctor's surgery or possibly in the emergency department of a hospital. Today's elective patients are likely to have investigated their own symptoms, often using unregulated internet sites and may arrive for their first healthcare consultation believing that they have already discovered their own diagnosis. The patient's first interaction and continuing care may be as part of the caseload of a surgical

nurse consultant or advanced surgical care practitioner, who may care for the patient throughout their surgical journey and should be considered as perioperative.

All patients should be treated as individuals and not as a diagnosis or surgical operation. Sometimes, in this busy pressurised world, there may a tendency to forget that the patient does not experience the surgical environment every day as do the specialised healthcare professionals. Even the least complex procedure in the perioperative environment may be a major event for the patient.

## Where Does it Take Place?

Historically, perioperative care was undertaken in an operating theatre or suite of theatres in an acute hospital, but more recently the settings for surgery have expanded after recognition that as long as the allocated area meets standards required for asepsis and infection management, conventional environments are not necessarily the only available option. These various settings can include doctors' surgeries and treatment centres for routine and more minor cases, keeping the acute or tertiary setting for the most complex and urgent surgeries. Patients can therefore access their surgical care closer to home and with less personal inconvenience and, it is hoped, with reduced waiting times. Healthcare is unfortunately enmeshed with the political system, but one of the better outcomes for patients over the last decade is that they usually have to wait less time than previously to see a specialist and receive appropriate treatment for non-urgent surgery.

In addition, in the current climate of global unrest, life-saving surgery is undertaken in conflict zones across the world and standards expected in more settled places may not be able to be fully met, the first priority being the saving of life. For example, surgery takes place in mobile operating rooms, in vehicles and ships, tents and other settings which will be completely alien to the practitioner who works in a standard hospital operating room. Working in the armed forces, for non-governmental organisations, charities and the like can broaden the practitioner's experience at the same time as engendering appreciation of their own high-quality operating suites within a recognised standard situation. Many advances in care and treatment have been innovated and initiated in times of conflict because of the needs of the patient with multiple trauma injuries.

Perioperative practice caregiving is delivered by a range of professionals who work collaboratively towards the best-quality outcome for the patient. There is a confusing range of these roles; names may differ across organisations and countries, but despite the differing titles their functions are similar. Boundaries have been crossed in recent times, with role expansion and development for many perioperative practitioners.

Many practitioner roles now have their own patient caseload and perform tasks within the surgical field that were previously only performed by medical staff. Through training and supervision, continuing assessment and quality outcome measurements, it has been shown that practitioners other than medical staff can perform many surgical procedures competently. The medical staff are then freed to perform more complex procedures. These less difficult cases are being performed competently and the stability or care delivery has been shown to have better outcomes for patients and the practitioners undertaking these advanced roles often become the instructors for junior medical staff, given their expertise and the stability of their role.

## The Patient's Perspective – Consent and Competence

At all times it must be remembered that the patient must be at the centre of individualised care and unless their capacity to make decisions is compromised, their autonomy to make decisions for themselves must be respected. From an ethical perspective, each

competent adult is an autonomous person and their own decisions about ‘self’ must be respected and followed.

Coercion to undergo treatment is unacceptable but difficult to avoid in a healthcare setting. With admission on the day of surgery becoming common practice, if consent has not been taken preadmission, then the patient has had insufficient time to ask further questions should they wish to gain the necessary information on which to base a decision. Decision-making on the morning of surgery or when the patient has already changed into a theatre gown is not appropriate or good practice.

As Martin Hind, senior lecturer in critical care, states ‘it may be difficult to prevent some degree of coercion in securing consent from a patient, but misrepresentation of the facts or overt manipulation of the patient should be avoided’ (Woodhead and Wicker 2005). What healthcare professionals must also always accept is that refusal to consent is as valid as agreement to consent to treatment, even if that decision is contrary to what they would advise.

Consent should be taken recognising the following conditions; these are not exclusive but examples of what may block fully informed consent being made by the patient:

- *Language*: Does the patient understand the person taking consent? Is the patient, deaf, blind, lacking understanding of the language being used or might they require support from a translator or signer? Does the consent taker, speak the patient’s language sufficiently well? In a multi-ethnic system real comprehension of information given and received can be difficult.
- *Understanding*: Has the healthcare professional used medical terminology that can be understood by the patient? Without understanding of what the treatment entails, including any likely complications, the patient is not sufficiently able to make a fully informed decision. With good planning, the patient can be given language- and age-specific information about their disease, treatment, outcomes and complications along with frequently asked questions. Written information along with a verbal interaction between the patient and a competent information-giver, while sounding like utopia, is best practice and should be a clinical aspiration.
- *Capacity*: Is the patient a child or do they suffer from learning difficulties or another impairment such as unconsciousness or brain injury? Consent for minors under the age of 16 in the UK is taken from parents, legal guardians and legal caregivers. In cases where there are difficulties best interest principles must be used or the intervention of the legal system to ensure that the patient is at all times at the centre of the process and outcomes.
- *Best interest principles*: These have to be taken into account in a range of situations where the patient does not have the capacity to make a decision for themselves. The UK Mental Capacity Act 2005 identifies a single test for assessing whether a person lacks capacity to take a particular decision at a particular time.

So, for example a patient may be admitted unconscious and unidentifiable to an emergency department. Following examination, only emergency surgery will give the person a chance to survive. In other circumstances, this person may be competent and able to make decisions for themselves but in this situation and at this time the patient cannot, therefore others must make that decision for them and consent to surgical intervention will be foregone and surgery performed. As in any clinical situation, contemporaneous documentation must be made and the rationale for the decision recorded and signed by more than one clinician.

As in so many healthcare situations, unless decisions, actions and possibly rational omissions are contemporaneously documented, if the care records become part of a

legal process at sometime in the future, the responsible carer will not be able to prove what they did or did not do for the patient.

The Nursing and Midwifery Council (2008) published principles of good record-keeping for nurses and midwives that is relevant for all healthcare professionals. They state that good record-keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information between members of the multi-professional healthcare team
- helping to identify risks, and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning
- helping to address complaints or legal processes.

## Evidence-Based Practice and Clinical Effectiveness

All care delivery should be based on evidence of its effectiveness by all healthcare professionals in the many multi-professional spheres. Where the evidence is derived from and how broad and deep the research has been behind the evidence should determine the practice delivered. Cochrane Reviews gather global information and create a matrix of the strength of the evidence based on the number of clinical papers that reach a similar outcome with comparable levels or breadth and depth and putting them into a scoring system to suggest efficacy ([www.cochrane.org/cochrane-reviews](http://www.cochrane.org/cochrane-reviews)).

Even with evidence, not all practitioners observe best practice principles. To cite a specific scientifically proven best practice perioperative principle – that shaving of body hair prior to surgery should be undertaken as close to the time of surgery as viable but not in the operating room – this is flouted on a daily basis across the world, while at the same time the antibiotics needed to protect the patient from postoperative infection possibly caused by bacteria introduced through shaving continue to outwit the scientists (Tanner *et al.* 2006).

Being fixed to the idea that all practice must be derived from clinical evidence and published science may, however, slow innovation in the clinical field and this, along with global and specific financial pressures in healthcare, carries a risk of a lack of progress. McKenna *et al.* (2000) make some valid points about considerations that should be taken into account in their paper on demolishing myths around evidence-based care and practice.

### Staffing and skill mix

Staffing levels in nursing have always been a bone of contention. Nurses frequently, especially when asked, say that they have insufficient numbers to provide the quality of care that they would like to provide. Staff numbers on wards and in operating theatres have never been mandated in the UK, although in Victoria, Australia, unions and governments have agreed minimum levels of staff patient ratios which hospitals have

to adhere to. In the UK we have an NHS Constitution which is enshrined in law, which states that patients have a right to be cared for by appropriately qualified and experienced staff in safe environments. The National Health Service Act 1999 ensures that the Board of any hospital is responsible for the quality of care delivered. In addition, regulatory bodies, such as the Nursing and Midwifery Council, stipulate nurses' responsibilities for safe staffing levels. In England, being able to demonstrate safe levels of staffing is one of the essential standards which all healthcare providers must meet to comply with the Care Quality Commission Regulations (Care Quality Commission 2010).

In operating theatres, recommendations from the AfPP make available online a formula for managers to use to ensure safe staffing levels (AfPP 2008). These include:

- one qualified anaesthetic assistant practitioner for each session involving an anaesthetic
- two qualified scrub practitioners as a basic requirement for each session, unless there is only once planned case on the operating list
- one trained circulating practitioner for each session
- one qualified post anaesthetic recovery practitioner for the immediate postoperative period. There may be occasions where two qualified staff are required if there is a quick throughput of patients requiring minor procedures, such as in a surgical day unit (AfPP 2011).

### **Skill mix**

The term 'skill mix' is often used to describe the mix of posts, grades or occupations in an organisation or for a specific care group (e.g. within a department such as an operating suite or in a speciality ward).

Skill mix needs to be examined on a regular basis, so that managers and practitioners account for changing patient demographics, the skills of the practitioners available and acuity in the patient population. It is difficult, therefore, to give specific guidance on an ideal skill mix for a given situation. Reviewing the evidence, Buchan and Dal Poz (2002) identified that increased use of less-qualified staff would not be effective in all situations. Evidence on the nurse/doctor overlap suggests that there is unrealised scope in many systems for extending the use of nursing staff. In addition, they cite that many of the studies regarding skill mix are poorly designed and are often biased towards the qualified/unqualified argument focused on cost containment (Buchan and Dal Poz 2002).

## **Training and education**

It is vital that, in order to provide the appropriate level of quality care, all staff have the necessary capability, skills, knowledge and competence to perform the role which they are employed to undertake. In order to reach, maintain and develop the appropriate level of skill and knowledge there needs to be a system in place that provides access to continuing professional development. This may include a level of mandatory education, on-the-job skills training and a continuing mechanism to ensure that competence is regularly assessed. Six main areas for consideration have been outlined by the AfPP (2011):

- educational support
- orientation and induction
- resources
- assessment

- professional development
- pre-registration learners.

## Accountability and responsibility

The duty of care which nurses and other registered professionals owe to their patients can be found iterated within Codes of Conduct. The Nursing and Midwifery Council Code states ‘As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions’ and ‘You must always act lawfully, whether those laws relate to your professional practice or personal life’ (Nursing and Midwifery Council 2008).

If a nurse or midwife is asked to deliver care they consider unsafe or harmful to a person in their care, they should carefully consider their actions and raise their concerns to the appropriate person. Nurses and midwives must act in the best interest of the person in their care at all times (Nursing and Midwifery Council 2008).

The Health Professions Council, which regulates operating department practitioners, Code of Proficiency states that registrant operating department practitioners must:

- be able to practise within the legal and ethical boundaries of their profession
- understand the need to act in the best interests of service users at all times
- understand the need to respect, and as far as possible uphold the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing (Health Professions Council 2008).

Accountability is integral to professional practice. Judgements have to be made in a wide variety of circumstances, bringing professional knowledge and skill to bear in order to make a decision based on evidence for best practice and the patient’s best interest. Professionals should always be able to justify the decisions that they have made.

## New roles

During the last 20 years many new roles have emerged to meet identified needs within the patient population as well as perceived needs for professionals to remain in clinical practice. The roles are many and varied. Roles change as professionals expand existing roles; many of the new roles fit within existing scope of professional practice, or they may be completely new and need specific developments and education. Whichever of the approaches an organisation decides is appropriate, a structured means of development is essential. The Career Framework sets out to standardise and describe roles at different levels of responsibility, supervision and knowledge and to illustrate career progression routes (Skills for Health 2006). Further detail has been identified into the Knowledge and Skills Framework, which is now the basis of job descriptions and competence assessment.

Nurses and others who develop their roles to include tasks or roles currently undertaken by other healthcare professionals must be aware of their legal boundaries. ‘The rule of law’ requires professionals to act within the law and ‘the rule of negligence’ requires the task or role to be delivered to the same standard as undertaken by another. Sufficient education and training are required to ensure the health professional is competent to perform the role to the required standard. In perioperative care, various roles are likely to be encountered. These include the following.

### **Surgical care practitioner**

The role of the surgical care practitioner (SCP) is as a non-medical practitioner, working as part of the extended surgical team, under the supervision of a consultant surgeon. The SCP must be previously registered as a healthcare professional with either the Nursing and Midwifery Council or the Health Professions Council.

SCPs perform a range of duties, including examination, clerking and requesting investigation. They can assist and perform delegated duties in theatres, manage patients postoperatively, adjust treatment plans, discharge and follow-up (Association of Cardiothoracic Surgical Assistants 2011).

### **Advanced scrub practitioner**

The Perioperative Care Collaborative provides the following definition of an advanced scrub practitioner (ASP). 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 (Perioperative Care Collaborative 2007).

### **Assistant theatre practitioner**

The assistant theatre practitioner (ATP) carries out all the tasks of a senior theatre support worker but is also trained and competent to perform the scrub role for a limited range of cases. In addition, some ATPs work within the post-anaesthetic care unit, taking delegated care from registered practitioners (NHS National Practitioner Programme 2006).

## **Advancing practice**

In recent years there has been a proliferation in the number of innovative advanced roles such as clinical nurse specialists, nurse practitioners and the broader role of consultant nurse. Role diversity is valuable if it improves health and well-being for patients and workers. The purpose of the consultant role is to improve practice and patient outcomes, strengthen leadership in the professions and help retain nurses by establishing a new clinical career opportunity. Some overlap occurs with specialist nursing posts in that half the consultant's time is spent in expert practice, but where the specialist works principally with patients in a clearly defined area of clinical practice, the consultant role is expected to be more strategic and broad based, to improve the practice of others and occupy a leadership position in nursing similar to that held by medical consultants (National Nursing Research Unit 2007). Examples of all the specialist roles can be found within perioperative care across the UK.

## **Professional development**

There are a variety of definitions of continuing professional development (CPD) across the professions but it is usually taken to mean learning activities that update existing skills. CPD requirements should be identified on the basis of the needs of individuals, within the context of the needs of the organisation and patients.

In the NHS, CPD is determined through appraisal with a personal development plan agreed between the individual professional and his or her manager with the commitment of the necessary time and resources. A key development in ensuring that health professionals maintain their competence is the move among the regulatory bodies to develop CPD strategies for the revalidation/recertification of their members (Department of Health England 2007).

In perioperative practice, CPD is required by the regulators to ensure that competence is maintained. For this purpose, resources and support should be made available within the work environment. Development needs are usually identified during the annual individual performance review and are recorded by the individual practitioner within his or her personal development plan. Registrants are also required to record continuing development in their portfolios, which may be requested by the regulator at regular re-registration to prove the practitioner's education and training on an ongoing basis.

## References

- AfPP (Association for Perioperative Practice) (2005) NATN definition of a perioperative environment. [www.afpp.org.uk/filegrab/periopdef.pdf?ref=54](http://www.afpp.org.uk/filegrab/periopdef.pdf?ref=54) (accessed March 2012).
- AfPP (2008) *Staffing for Patients in the Perioperative Setting*. Harrogate: AfPP.
- AfPP (2011) *Standards and Recommendations for Safe Perioperative Practice*, 3rd edn. Harrogate: AfPP.
- Association of Cardiothoracic Surgical Assistants (2011) Definition. <http://acsa-web.co.uk/about-surgical-care-practitioners/> (accessed 4 December 2011).
- Buchan J and Dal Poz M (2002) Skill mix in the healthcare workforce: reviewing the evidence. *Bulletin of the World Health Organization* 80(7): 575–580.
- Care Quality Commission (2010) *Guidance about Compliance: Essential standards of safety and quality*. London: CQC.
- Department of Health England (2007) [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Managingyourorganisation/Workforce/EducationTrainingandDevelopment/PostRegistration/DH\\_4052507](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Managingyourorganisation/Workforce/EducationTrainingandDevelopment/PostRegistration/DH_4052507) (accessed 4 December 2011).
- Health Professions Council (2008) *Standards of Proficiency for Operating Department Practitioners*. [http://www.hpc-uk.org/assets/documents/10000514Standards\\_of\\_Proficiency\\_ODP.pdf](http://www.hpc-uk.org/assets/documents/10000514Standards_of_Proficiency_ODP.pdf) (accessed March 2012).
- McKenna H, Cutcliffe J and McKenna P (2000) Evidence based practice: demolishing some myths. *Nursing Standard*: 14(16): 39–42.
- National Nursing Research Unit (2007) Advanced nursing roles: survival of the fittest? *Policy+ issue 6*. <http://www.kcl.ac.uk/content/1/c6/03/25/81/PolicyIssue6.pdf> (accessed March 2012).
- NHS National Practitioner Programme (2006) *Introducing Assistant Theatre Practitioners: A best practice guide*. Assistant Theatre Practitioner Project, NHS East of England.
- Nursing and Midwifery Council (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*. [www.nmc-uk.org/publications/standards](http://www.nmc-uk.org/publications/standards) (accessed March 2012).
- Perioperative Care Collaborative (2007) *The Roles and Responsibilities of the Advanced Scrub Practitioner*. <http://www.afpp.org.uk/careers/Standards-Guidance/position-statements> (accessed March 2012).
- Skills for Health (2006) *Key Elements of the Career Framework*. [http://www.skillsforhealth.org.uk/images/stories/Resource-Library/PDF/Career\\_framework\\_key\\_elements.pdf](http://www.skillsforhealth.org.uk/images/stories/Resource-Library/PDF/Career_framework_key_elements.pdf) (accessed March 2012).
- Tanner J, Woodings D and Moncaster K (2006) Preoperative hair removal to reduce surgical site infection. *Cochrane Database of Systematic Reviews* 3: CD004122.
- Woodhead K and Wicker P (2005) *A Textbook of Perioperative Care*. Oxford: Elsevier.

## Further Readings

- Association for Perioperative Practice (2011) *Standards and Recommendations for Safe Perioperative Practice*, 3rd edn. Harrogate: AfPP.
- Gordon S, Buchanan J and Bretherton T (2008) *Safety in Numbers: Nurse to patient ratios and the future of healthcare*. New York: Cornell University Press.
- Hood PA, Tarling M and Turner S (2011) *AfPP in your Pocket: Perioperative Practice*. Harrogate: AfPP
- Hughes S and Mardell A (2009) *Oxford Handbook of Perioperative Practice*. Oxford: Oxford University Press
- Professional Education in Practice (2009) *Advanced Surgical Care Practitioners*. [http://pepractice.co.uk/course\\_advanced\\_scrub\\_practitioner.html](http://pepractice.co.uk/course_advanced_scrub_practitioner.html) (accessed March 2012).
- Wicker P and O'Neill J (2010) *Caring for the Perioperative Patient*, 2nd edn. Wiley-Blackwell.
- Woodhead K and Wicker P (2005) *A Textbook of Perioperative Care*. Oxford: Elsevier.