Productivity Commission

Health Workforce Study

SUBMISSION

INTRODUCTION

This submission will in particular address that part of the terms of reference which refer to " …. the distribution of the health workforce and its consequential efficiency and effectiveness, including workforce structure, skills mix and responsibilities, including evolving health workforce roles and redesign, and the flexibility, capacity, efficiency and effectiveness of the health workforce to address current and emerging health needs, including indigenous health." The information contained in this submission addresses the perceived needs of patients from a nursing perspective and the proposed improvement to address these needs, while acknowledging the multi-faceted and collaborative approach of all the professional groups involved in providing direct patient care.

Perioperative nursing practice has been in a phase of evolution for some years. The shift of surgical care from inpatient to outpatient surgery is escalating rapidly. Perioperative nurses are broadening their responsibility to encompass preoperative assessment, preparation and education, intraoperative nursing practice including assisting the surgeon and postoperative recovery, evaluation of the surgical experience and discharge planning. A perioperative advanced practice role which incorporates that of the registered nurse as first assistant to the surgeon has the potential and the ability to provide cost-effective nursing care and the versatility to undertake all the current roles in perioperative nursing.

The Australian College of Operating Room Nurses Ltd (ACORN) (formerly the Australian Confederation of Operating Room Nurses) and the Australian Nursing Federation (ANF) had discussions some years ago regarding the planning of the provision of nursing care to patients in the operating suite in the future. The health care needs of patients have become more complex as technology and science advance and change. The resultant treatment options have also increased in complexity. This has necessitated that the provision of nursing care be undertaken by professionals who can demonstrate a substantial education in nursing and related sciences with a continuing commitment to accountable nursing practice.

It must be noted here that ACORN and the ANF are adamant that direct patient care in the perioperative environment must be undertaken by registered nurses. There is an escalating trend for management to introduce other categories of health care workers into the perioperative environment in a misguided effort to address the perioperative nursing shortage. These workers are perceived to be a cheaper alternative but in reality more staff need to be employed because of the inflexibility posed by the inability for these workers to fill all roles within the perioperative environment. It must be acknowledged here that other categories of health care workers provide valuable technical assistance in the perioperative environment and are members of the perioperative team. However, they must not ever be involved in direct patient care, as to do so has serious medico-legal ramifications .

BACKGROUND INFORMATION ON THE DEVELOPMENT OF THE FIRST ASSISTANT ROLE IN PERIOPERATIVE NURSING

There is a growing trend in Australia for perioperative nurses to undertake the role of first assistant. This trend has in part been influenced by the shortage of doctors in rural areas, which is being addressed at present by reviews such as the Perioperative Workforce in Australia Project. Information presented in the Medical Workforce Data Review Committee's Annual Report which highlighted a downward trend in the number of doctors graduating from 1996 to the year 2000 was perceived by ACORN to require urgent consideration. In 1996 information was provided to ACORN in discussions with medical and government colleagues that the Commonwealth intended to cut medical school intakes. The reasons for this were given as:-

- a slower than expected population growth
- a larger than predicted input from New Zealand
- the effect of gender and lifestyle changes i.e. more females and part-time doctors.

In 2003, the Australian Government initiated action to overcome the shortage, but according to the *Australian Medical Workforce Advisory Committee Annual Report 2003*, “across regions, the number of medical practitioners had decreased as the population numbers lessened. The number of medical practitioners per 100,000 population was 307 in ‘capital cities’ and 94 in ‘other rural areas’ and the average hours of work were 45 hours in ‘capital cities’ and 49 hour in ‘remote areas’ (AMWAC, 2003). The average hours of work indicate that the workload of both metropolitan and rural medical practitioners limits their abilities in two areas:

1. The throughput of patients in specialist surgical practices
2. The provision of the first assistant role during surgery.

In 1990, ACORN was approached with a problem which had been placed before the Operating Room Nurses Association of Western Australia (ORNA). Because Western Australia is such a large state with a large rural area, the practice of registered nurses acting as first assistants, particularly in private hospitals, was widespread. ACORN was being asked for direction on the matter and considered that a policy statement from ACORN was needed.

Questions which were raised within this issue were:-

1. Does ACORN agree that nurses should act as surgeons' first assistants if requested?

2. If ACORN does agree what criteria should be set regarding the role?

3. Should the limitations of the role be set in regard to suturing, dissecting etc?

4. Does the patient have the right to know beforehand that a nurse will be acting as first assistant?

5. Do nurses have the right to refuse to fulfil the role of first surgical assistant?

6. What are ACORN's comments on the current recommended staffing establishments which allow for three registered nurses per operating room namely:-
    - Instrument nurse
    - Circulating nurse
    - Anaesthetic nurse

   Is there meant to be flexibility in the nurse staffing establishment to allow for nurses to act as first surgical assistants?

7. If O.R. nurses are to act as first assistants, should there be a requirement for specific education and experience prior to undertaking the role?

8. In the private sector, should there be a payment made to the hospital by the surgeon, if a nurse acts as first assistant?

9. Should the first assistant be able to complete the surgery if the surgeon becomes ill during the procedure?

10. What level of assistance should be given by the instrument nurse to the surgeon if there is no surgical assistant present? For example, is it possible to concentrate on the full duties of the instrument nurse in regard to the surgical count if expected to act as the first assistant as well?

The ACORN Council obtained legal advice from various avenues of expertise i.e.

- The Royal Australasian College of Surgeons
- The Medical Defence Union
- Patricia Staunton (at the time the General Secretary of the NSW Nurses Association and a Solicitor)
- Mary Venning (Wallmans Solicitors and Consultants, Adelaide, SA)
- Darlene Steele (Legal Consultant, Health Department of WA)

Following the receipt of the advice from these professional bodies, ACORN produced a policy statement on the registered nurse as first assistant, defining the role and writing nine (9) guidelines to assist registered nurses in this undertaking.

The Australian Confederation of Operating Room Nurses (ACORN) Council, following the development of the policy statement in 1991, developed an outcome standard for the Registered Nurse as First Assistant in 1995. As part of a continuing review of the ACORN *Standards, Guidelines and Policy Statements,* in May, 1998, a revised standard was published. This standard has subsequently been revised in 2000, 2002 and 2004. In this standard, one of the criteria required that a suitable education course be developed for the education of registered nurses as first assistants.

The provision of information from other countries who have researched and implemented the first assistant role, however titled, as part of an advanced practice role in the perioperative was considered essential, if an informed decision in Australia was to be made to develop and undertake this role. Issues for investigation included:-

- training and education requirements

- professional issues
- legal and ethical issues
- managerial issues

The scope of the role needed careful consideration to identify its parameters, in order to furnish the required data. In 1996, ACORN awarded me a Fellowship to undertake a comprehensive study tour overseas. This exploratory study was intended to provide background data to assist in defining advanced practice and its evolution in Australia.

The perceived benefits resultant from the development of such a role included:

- Improvement in the quality of patient care
- Improved communication between care groups
- An increase in the continuity of patient care
- Improvement in the standards of surgical teamwork
- Provision of highly educated health professionals

After careful consideration by the ACORN Council, it was decided that an advanced practice role would be developed, with the title of Perioperative Nurse Surgeon's Assistant (PNSA).

INVOLVEMENT OF THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

During the period of role development, ACORN and the ANF worked for some years to obtain the support and collaboration of the Royal Australasian College of Surgeons (RACS) in their research into this role. ACORN and the ANF, during many meetings with the RACS, sought the College's commitment to the premise that the registered nurse is the best person to work in this role if a medically qualified assistant is not available. As has been already stated, neither ACORN nor the ANF want a second level health worker undertaking this role. During discussion with the RACS, a commitment was made by both bodies to survey their members regarding a range of issues including the use of registered nurses as first assistants. Accordingly, ACORN circulated a questionnaire which elicited some interesting and relevant facts and figures (see Appendix 1).
NB A further survey is to be undertaken in the near future in conjunction with a rural surgeon and his PNSA.

The RACS were impressed with the survey results and the excellent response rate. Following this, the RACS President informed ACORN that the Executive Council had decided to support the development of the course and he appointed a surgeon to work with ACORN to provide surgical input to the course, advice as required and to provide liaison between ACORN and the RACS. Since that time, there has been continued support from RACS and communication between the two bodies has assisted greatly in the development of the role. It is believed that this interaction will ensure true collaboration between medical and nursing professionals in their combined care of the patient in surgery and the resultant optimal outcomes which are the right of every patient undergoing a surgical procedure.

THE PNSA COURSE

The development of a course to educate registered nurses as first assistants in Australia commenced in 1997 as a distance education course through Southern Cross University in Lismore, New South Wales. Currently there are fifteen (15) students enrolled in the course,

spread across the 4 units. The first eight (8) students graduated in May 2001. Twenty–nine (29) more have since completed the course, five of these are from New Zealand. There are a further 3 students from New Zealand undertaking the course. One graduate was employed full-time by a private hospital as a PNSA initially; she is now employed full time by a professor of orthopaedics as his PNSA, working in the role and is undertaking some exciting research projects. Another graduate is employed by several surgeons as their first assistant in several hospitals. Another is working in a rural hospital as a PNSA part-time with two (2) surgeons, is undertaking research for the surgeons and perioperative clinical education for the regional Base Hospital. Four other graduates have been employed by surgeons to work with them in their surgical practices. One hospital has a funded position for a PNSA.

The course is a Graduate Certificate and provides four credits towards a Master of Health Science. It consists of four theoretical external study units of 150 hours each. The units must be completed consecutively and each involves written and clinical assessments. Each unit is assigned a sixteen week study period in which all written assessments must be completed for award credit. Clinical assessment involves the demonstration of competence in surgical assisting skills and perioperative nursing practice relevant to the course content and is undertaken by a surgeon and nurse mentor. The units are provided by flexible entry mode which ensures that the student can choose a time to enrol that will suit them, their family and their workplace.

DESCRIPTION OF THE PNSA ROLE

DEFINITION:

The PNSA is a perioperative nurse with additional education and skills, functioning in an expanded role. The PNSA to the surgeon during a surgical procedure carries out functions intended to assist the surgeon in performing a safe surgical procedure with optimal results for the patient. The PNSA practises perioperative nursing and has acquired the knowledge, skills and judgement necessary to assist the surgeon through organised instruction and supervised practice. The PNSA functions interdependently with the surgeon during the intraoperative phase of practice. The PNSA does not concurrently function as an instrument nurse.

PRINCIPAL RESPONSIBILITIES:

To uphold the patient's right to safety and well -being during surgery.

To have responsibility for preoperative assessment and postoperative evaluation with a primary emphasis on the intraoperative phase.

KEY DUTIES:

Preoperatively assesses the patient

Assists with preparation and administration of pharmaceutical agents perioperatively, as directed by the surgeon.

Assists with patient positioning, skin preparation and draping.

Provides haemostasis by clamping blood vessels, coagulating bleeding points, ligating vessels and by other means, as directed and supervised by the surgeon.

Provides wound exposure through appropriate use of instruments, retraction, suction and sponging techniques.

Handles tissue as directed by the surgeon; sutures fascia, subcutaneous tissue and skin.

Applies surgical dressings, assists with the application of casts or immobilising devices.

Writes perioperative orders according to agreed protocols (must be countersigned by the surgeon)

Assists with transferring the patient from the operating room to the post-anaesthetic care unit and participates in the hand-over.

Performs perioperative patient evaluation, teaching and discharge instructions.

Practises within the limitations of preparation and experience.

Maintains continuing education relative to practice.

Recognises hazards and initiates appropriate corrective action.

Performs postoperative assessment of patient and undertakes postoperative care as required.

Participates in Continuous Quality Improvement monitoring as indicated.

SPECIFIC DUTIES:

The PNSA will:

Assist with the patient positioning, skin preparation and draping of the patient, or perform these actions independently, if so directed by the surgeon.

Provide retraction by:

Closely observing the operative field at all times.
Demonstrating stamina for sustained retraction.
Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.

Provide haemostasis by:

Applying the electrosurgical point to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.

Sponging and utilisation pressure, as necessary.
Utilising suctioning techniques.
Applying clamps on superficial vessels and the tying or coagulation by electrosurgery, as directed by the surgeon.
Placing suture ligatures in the muscle, subcutaneous and skin layer.
Placing haemoclips on bleeders, as directed by the surgeon.

Perform knot tying by:

Having knowledge of the basic techniques of knot tying to include: two-handed tie; one handed tie; instrument tie.
Tying knots firmly to avoid slipping.
Avoiding undue friction to prevent fraying of suture.
Utilising the technique of "walking" the knot down the tissue with the tip of the index finger and laying the strands flat.
Preventing tissue necrosis by approximating tissue rather than pulling tightly

Perform dissection as directed by the surgeon by:

Having knowledge of the anatomy and demonstrating the ability to use the appropriate instrumentation.
Dissecting all layers to but not including the peritoneum, for abdominal surgery.
Dissecting (including harvesting when applicable) the saphenous vein or other vessel for cardiac and vascular surgery, as directed by the surgeon.

Provide closure of layers by:

Correctly approximating the layers, under the direction of the surgeon.
Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs continuous; skin sutures vs staples; subcuticular closure; horizontal mattress.
Correctly approximating skin edges when utilising skin staples or sutures.

Assist the surgeon at the completion of the procedure by:

Affixing and stabilising all drains.
Cleaning the wound and applying the dressing.
Assisting with applying casts; splints; bulky dressings.

NOTE: In cardiac surgery, if the surgeon wishes the PNSA student to learn the dissection (including harvesting when applicable) of the saphenous vein or other vessels, this will be decided on a one-on-one basis.

These last two will be practised by the PNSA in situations deemed appropriate by the surgeon and only after assessment of their ability to undertake this dissection.

The activities outlined are determined based on the experiences and education of the PNSA. The performance of other activities in the role of the PNSA is dependent on the ability of the PNSA to safely perform the activities under the direction of the surgeon in a competent manner.

SPECIFIC ATTRIBUTES:

- Advanced perioperative clinical skills.
- Advanced skills in developing, implementing and evaluating policies and standards in relation to patient care.
- Advanced communication and interpersonal skills.
- Demonstrated leadership, organisational and decision making abilities.
- Ability to undertake research projects.
- Demonstrated knowledge and skill in applying the principles of asepsis and infection control.
- Demonstrated knowledge of anatomy, physiology and relevant surgical operative procedures.
- Demonstrated ability to function effectively and harmoniously in a surgical team.

ADDITIONAL RESPONSIBILITIES

The following additional responsibilities are desirable to fulfil the scope of the role of the PNSA and apply also to a PNSA independently and/or surgeon - employed:

- Performs initial assessment of patients on admission or prior to evaluation by surgeon. This entails detailed history taking, examination and the ordering of routine tests.

- Provides preoperative counselling and education to patients scheduled for surgery and their families and commences discharge planning.

- Provides postoperative care by way of wound management, postoperative education, application and removal of dressings and plaster casts.

- Visits patients postoperatively to complete planning of discharge and to provide discharge instructions.

- Participates in the follow-up post-operative visit of the patient.

ASSESSMENT OF THE PNSA ROLE

The feedback obtained from students, surgeon and nurse mentors and patients has been extremely positive. It has been clearly demonstrated that this role is cost-effective and provides a high standard of direct patient care. The ramifications of having one person – the PNSA - to undertake the pre-operative planning and assessment, the intraoperative nursing care and first assisting and the post-operative care and discharge planning has the potential to provide considerable cost benefits to the government and to health care facilities. The benefit to the patient is that all this is provided directly within a nursing framework, therefore ensuring that delivery of safe, high quality patient outcomes in the perioperative environment is assured.

Although the PNSA role is an interdependent and collaborative one, it also has an independent component and therefore fits into the nurse practitioner category. Two of our graduates are pursuing this currently. The provision of a provider number will allow patients to obtain a rebate on the cost of an assistant for their surgical procedure. It is envisaged that PNSAs, following further education, will be able to prescribe medications, in collaboration with the surgeon and to a formulary, and make referrals as required.

SURGEON COMMENTS

Many surgeons have commented on the benefit of employing or working with a PNSA. These comments are offered as Appendix 2.

Anecdotal information obtained from surgeons and PNSAs indicates that in many health care facilities there is an identified shortage of junior doctors to undertake the assisting role in the perioperative environment. In one rural hospital in New South Wales the public hospital had no registrars. One surgeon had employed a perioperative nurse on a part-time basis to work with him as his first assistant for his surgical lists. Several other surgeons report similar situations.

RECOMMENDATIONS

- That the PNSA role be evaluated by the Productivity Commission as a strategic and flexible approach in future health workforce planning.

- That the scope of the PNSA role be studied by the appropriate bodies in planning projected future requirements, perioperative workforce supply and the best use of resources over the next ten years.

I would like to thank the Productivity Commission for the opportunity to provide input into this study. My positions as a member of the ACORN Council from 1989 – 1998, the Project Manager for ACORN in the development of the PNSA role from 1996 until 2001 and as the PNSA Course Co-ordinator for Southern Cross University provide me with the ability to be a valuable resource in forums such as this.

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APPENDIX 1

THE PERIOPERATIVE NURSE SURGEON'S ASSISTANT PROJECT

In recent years the Australian Confederation of Operating Room Nurses (ACORN) Council, (now the Australian College of Operating Room Nurses Ltd) has been researching developing roles in perioperative nursing. As part of this extensive work, the Council reached a decision to introduce the Registered Nurse First Assistant role into Australia. Discussions have taken place on several occasions with the President of the Royal Australasian College of Surgeons (RACS) to gain their collaboration and support in the introduction of this perioperative nursing role, particularly relevant in the rural and private sectors, following an identified need. This need was reinforced by information supplied in reports and projections compiled by the Australian Medical Workforce Advisory Committee (AMWAC) 1995 - 1996.

A meeting was held between Mr Colin McRae, President, Royal Australasian College of Surgeons (RACS), Mr Peter Carter, Chief Executive Officer, RACS, Carol Webster, President of the Australian Confederation of Operating Room Nurses (ACORN) and Bernadette Brennan, Senior ACORN Councillor, Victoria, on 29th August, 1997, in Melbourne. During the discussion, following some questions posed by Mr Mc Rae and Mr Carter, ACORN offered to provide RACS with more detailed information about the current situation. ACORN decided that the most effective way to obtain information was to circulate a survey to operating suites nationally. This document outlines the findings from that national survey, sent to four hundred and forty nine (449) operating suites, which according to the ACORN database, is the current recorded number of surgical suites within Australia.

TOTAL NUMBER OF HOSPITALS - 449

TOTAL NUMBER OF RESPONDENTS TO THE SURVEY - 274 (61% response rate)

TOTAL NUMBER OF PUBLIC HOSPITALS RESPONDED - 181

TOTAL NUMBER OF PRIVATE HOSPITALS RESPONDED - 93

It should be noted that this survey offered optional anonymity and was sent to operating suite managers. As a result, a large proportion of respondents opted not to include the name of their hospital in the survey.

NUMBER OF OPERATING ROOMS, MINOR PROCEDURE AND ENDOSCOPY ROOMS IN EACH FACILITY

	PUBLIC	PRIVATE
Number of Operating Rooms	1-20	1-13
Number of Minor Procedure Rooms	1-4	1-2
Number of Endoscopy Rooms	1-5	1-3

FREQUENCY OF PERFORMING THE ROLE OF FIRST ASSISTANT TO SURGEON

	ALWAYS		FREQUENTLY		OCCASIONALLY		RARELY	
	Public	Private	Public	Private	Public	Private	Public	Private
Specialist Surgeon	3.90%	0.00%	17.70%	18.30%	24.30%	32.20%	29.30%	26.90%
General Practitioner	6.60%	7.50%	20.40%	55.90%	23.20%	15.10%	29.80%	10.80%
Registrar	17.10%	0.00%	29.30%	20.40%	4.40%	31.20%	11.60%	18.30%
Intern	3.90%	0.00%	30.40%	2.20%	12.20%	8.60%	13.30%	19.40%
Registered Nurse	9.40%	2.20%	28.70%	41.90%	29.30%	39.80%	21.50%	16.10%
Other*	0.60%	2.20%	2.20%	8.60%	6.10%	2.20%	6.10%	2.20%

N.B. Results are presented as percent (%) of public or private hospitals responding to survey.

* Other:
Specialist Medical Surgical Assistants
Enrolled Nurses
Student Nurses
Dental Nurses
Medical Students
Company Representative
Medical Director or Assistant
Surgeons' Own Staff
RFDS Medical Officer
Optometrist

REQUIREMENT OF INSTRUMENT NURSE TO ACT AS FIRST ASSISTANT SIMULTANEOUSLY DURING MAJOR PROCEDURES IN THE OPERATING ROOM (% OF TOTAL RESPONDENTS)

AFFIRMATIVE	50%
NEGATIVE	46%
NO RESPONSE	4%

FREQUENCY OF PROCEDURES REQUIRING A FIRST ASSISTANT WHEN A QUALIFIED ASSISTANT IS NOT AVAILABLE

FREQUENT	20%
OCCASIONAL	62%
NEVER	11%
NO RESPONSE	7%

The comments in the responses included :

RNs used because health funds do not cover many procedures.
Rural hospital - no other qualified assistant available.
Out of hours - registrars/interns unavailable.
No other medical personnel available in the town.
Visiting surgeons/local GPs never provide assistants.

PROVISION OF PRE/POST OPERATIVE VISITS BY PERIOPERATIVE REGISTERED NURSES (% OF TOTAL RESPONDENTS)
a)

AFFIRMATIVE	50%
NEGATIVE	46%
NO RESPONSE	4%

FREQUENCY OF VISITS (% OF AFFIRMATIVE RESPONDENTS FROM 'a')
b)

NUMBER OF VISITS PER WEEK	PERCENTAGE
< 1	5.0%
1	13.9%
2	14.9%
3-5	49.9%
6-10	5.9%
as required	10.9%

EXISTENCE OF A PRE-OPERATIVE ASSESSMENT CLINIC (% OF TOTAL RESPONDENTS)
c)

AFFIRMATIVE	52%
NEGATIVE	39%
NO RESPONSE	9%

NOMINATION OF MOST APPROPRIATE PERSON TO FUNCTION AS FIRST ASSISTANT TO SURGEON

	% OF TOTAL NOMINATIONS*
SPECIALIST SURGEON	19%
GENERAL PRACTITIONER	15%
REGISTRAR	29%
INTERN	5%
REGISTERED NURSE	32%

*In many cases more than one person was nominated as being equally appropriate.

INTEREST EXPRESSED IN PERIOPERATIVE REGISTERED NURSES UNDERTAKING A FORMAL EDUCATION PROGRAM FOR REGISTERED NURSE AS FIRST ASSISTANTS (% OF TOTAL RESPONDENTS)

AFFIRMATIVE	80%
NEGATIVE	8%
NO RESPONSE	12%

Question seven (7) of the survey requested an indication of the number of times during the past two (2) years that the Operating Suite Manager had received a formal or informal request to provide a registered nurse as first assistant.

The number of times for the Formal Request ranged from 1 to 104 times.
The number of times for the Informal Request ranged from 2 to 7500 times.

Responses to the question included the following:

FORMAL REQUEST	INFORMAL REQUEST
Occasionally	Impossible to quantify
Never	Frequently
Many	Often
Not recorded	Many
Can't estimate	On demand
Too many	Not recorded
Regularly	Occasionally
Frequent	Can't estimate
Rare	Too many
Too many to count (x4)	Always
Often	Constant
Daily	1000 times a month
	Regularly
	Almost daily
	Inestimable
	Too many to count (x3)
	Numerous

EXAMPLES OF COMMENTS RECEIVED AS PART OF THE SURVEY

- "We are firmly committed to the concept of the RNFA as we believe the program priority is patient outcome focused. The pre and post surgery care in a facility, (with no on - staff medical officers,) provided by RNFA trained nurses would vastly improve outcomes."

- "We have provided 1st Assistant services for many years. The staff numbers were increased to cover this when RMO secondment from Royal North Shore was ceased in the 1980's. New staff are preceptored into instrument RN duties, then assistant to the surgeon as they become proficient. This system has worked very well for us - our staff has remained very stable with small turnover which has led to very experienced assistants providing a very proficient service. Quite frankly, both surgeons and nursing staff in our institution would be very disappointed to see this role taken away from the nurses. We would however welcome with open arms a formal trainee program to acknowledge the qualification and skill level required by these nurses. Not every good instrument RN makes a good assistant."

- "With the remote rural area, a degree of expertise for operating theatre is required due to the facilities needed for maintaining standards. With the G.P. doing surgery, a lack of knowledge in standards is seen and a competent operating theatre nurse needs to correct these deficiencies."

- "The introduction of the RNFA would be a real bonus to rural and remote perioperative nurses as most of us are already undertaking this role informally. Recognition of this extended role would please all rural and remote perioperative nurses!"

- "Our hospital is a 70 bed hospital which has between 20-40 cases per month. Two RNs are alternately on call 7 days per week. We usually perform the role of 1st assistant due to lack of medical staff available. I would like to see this role more recognised and defined for legal concerns."

- "This hospital is a small rural hospital where surgeons perform a wide range of surgical procedures - GPs are reluctant to act as 1st assistant as "can make more money in my rooms!" Experienced RN assistant then becomes very important. Also cost saving measure for the health service!!"

- "The benefits of nursing staff performing the role as we see them are:-

- Nursing Staff are very happy to perform the role of First Assistant as required (job satisfaction).
- Better aseptic technique than junior medical staff.
- Better competency than junior medical staff.
- Allows junior medical staff to perform other duties around the hospital."

- "Before nurse assistants became the norm within this unit all surgeons were questioned as to the requirements in this area and asked for any objections to this idea. Our program has worked very well and both the surgeons and the nursing staff have benefited. I can only encourage formalised education to be commenced in this area as I feel this is going to become a more frequent request in many units."

- "The questionnaire seems to imply that the use of an RN as a first assistant is a rare

event. The fact is that this hospital and, I believe, many other private hospitals would not function at all if they did not use nurses as assistants."

- "I hope a recognised course becomes available in the not too distant future. I see this as the next step up in theatre skills for the nurses who have had considerable experience and looking for something extra in theatre nursing - another challenge!!"

- "For basic general and other surgery, a nurse with good perioperative skills and a sound understanding of the operation makes the most effective assistant. Medical officers arrive late, leave early and are distracted by other obligations. Our experience is that GPs are not well prepared for the role of assistant and don't get enough regular experience to maintain skill. A good RN rostered on for the role is prepared and develops skill as she works regularly with a variety of surgeons."

- "Some doctors expect us to assist. Others ask, others prefer us to a GP. GPs never come on time, leave early and work could have easily been done by a nurse."

- "We have a system within our own hospital which trains senior scrub RNs to be able to assist in major procedures. They are then examined and with the VMO's support, apply to the nursing Peer Reviews Committee for formal accreditation. However, they can refuse to assist at any time if they do not feel comfortable with the operation/procedure."

- "We have about 6 RNs who love assisting, and would do it professionally if they were allowed to charge for the service. As there is a shortage of regular assistants, it would be very helpful to have RNs to assist, particularly in private hospitals."

- "Many developed countries currently operate under a system where the 1st Assistant is a trained RN. I have been trained and worked with this excellent system for many years. Given the correct training, I can only encourage the development of this in Australia as it can improve the care and service we provide to both our patients and surgeons."

- "I believe RNs are ideal first assistants to the surgeon because they do it from a patient care perspective and they are usually well experienced in OR procedures and particular surgeon's techniques."

- "There is an agreement by the surgical staff to support this concept - Professor of Surgery / Head of Surgery is involved along with colleagues in the provision of education and skills development for the role. Course to commence February '98 in conjunction with the University of Adelaide."

- "We feel as RNs in a country hospital that the role of 1st Assistant is the "cream" of the job and enjoy the role. Our skills are readily accepted by our surgeons."

- "This is an 89 bed outer metropolitan hospital (non teaching). We have 2 general surgeons, 3 gynaecologists and 2 obstetricians. We have one 1st year intern for surgical services. They come to us sometimes as their first term. In this hospital I believe the experienced RN is the best

person to be an assistant, rather than an extremely junior intern. The nurse can offer more practical assistance than the interns we have. We would welcome a formal education in this role."

- "If staffing levels permitted, 4 RNs would be allocated to lists where a 1st assistant is required - this would also enable pre and post op. visits. The hospital with case mix involvement, looks at costs per case - those surgeons who do not bring an assistant can be looked at favourably as the cost is less, however the nursing time is not calculated."

- "We are keen at CBH to further our interest in RN first assist programs and have the support of our Medical Superintendent. The Operating Suite Manager has had discussions with him regarding this and thus far the response has been positive from medical and nursing staff."

- "The perioperatively trained RN would make an ideal first assistant as he/she has appropriate knowledge and skills to ensure quality and safe patient care. They can anticipate care needed and be a valuable member of the surgical team."

- "The calibre and skill level of assistants varies considerably, be it RN/GP/Registrar or intern etc. The donning of surgical gown and gloves poses difficulty for some non-nursing assistants. Some surgeons routinely use non-nurse assistants. Others use them on an adhoc basis depending on their availability. This poses problems with staffing, however we do encourage surgeons to let us know if they intend bringing an assistant with them. On average RNs assist for 80.5% of cases requiring an assistant. Visiting Doctors (GPs, Registrars) assist for 19.5% of cases requiring an assistant."

ADDITIONAL INFORMATION FROM THE SURVEY

Question 7b requested examples of the reason (s) for the request for a Registered Nurse First Assistant. The following are some instances:-

No assistant available (x 59)
Outside registrar/intern hours
Insufficient medical officers available
Shortage of GPs (x 20)
Assistant fails to arrive
No rebate
Didn't bother
Surgeon forgot to organise an assistant
No registrar/intern at hospital (Public rural)
Regularly uses RN so that patient does no have to pay (patient uninsured)
Registrar/intern in A & E with emergencies
RNs expected to assist
Rarely requested, occasionally demanded, usually expected
Traditional expectation that assistants will be provided - staff allocated with this assumption (x 4)
VMO budget provides for RN to act as first assistant
A surgeon made a formal request for a regular assistant as RMOS and JMOs were not available but request was denied as nursing staff were not trained according to ACORN Standards. (Public hospital)

N.B. 1 respondent (O.R. manager) stated that one surgeon brings his wife to assist to obtain the Medicare assistants fee, but the staff RN does the actual assisting.

Question 7c asked about time of the day the request was received for a registered nurse to work as first assistant and requested comments, if wished. These are some examples:-

Routine expectation of many surgeons so no request made
Can occur at anytime, depending on type of surgery,
Request occur anytime, usually when scrubbing
Generally assumed that a nurse will do the job (x 3)
This was routine for emergencies prior to establishing an emergency unit with an on-call roster

Question 10c referred to the type of patients who received a pre-operative visit from the RNs in the operating suite. Here are some examples:-

All patients each day (x 19)
Major procedures (x 20)
Paediatric patients (x 13)
All Total Hip Replacement patients
Most patients (x 10)
Although not organised, ad hoc visits undertaken

Day patients (40%)
Major oncology
Random

Question 11 sought to ascertain the most appropriate person to function as first assistant to ensure quality patient care. These are some answers:-

GPs as they are available
Registrars as they have much to learn
Nurses more focused on patient as individual
RN because keeps mind on the job, is not busy discussing other patients with anaesthetist
"Is it appropriate to use a GP when they often have no surgical training/unfamiliar with principles of asepsis. RNs who have completed perioperative education programs including anatomy and physiology, asepsis and surgical procedures."
All persons, but need adequate education first
Specialist surgeon best assistant as knowledge base can provide replacement following illness (x 4)
GPs/interns don't understand - experienced RNs provide good assistance (x 3)
GPs experienced
GPs leave early - RNs more familiar with procedure (x 2)
Registrars/RNs have appropriate knowledge and skills (x 6)
Continuity of practice (Registrar/Surgeon)(x 2)

NB These examples are only a few of the comments received but give a broad overview of the information received on the surveys.

APPENDIX 2

PERIOPERATIVE NURSE SURGEON'S ASSISTANT COURSE

MEDICAL COLLEAGUES' COMMENTS.

Since the course commenced in 1997, some of our medical colleagues, particularly the surgeon mentors of our students and the doctors who work with the student PNSAs as they progress through the course have commented on the role and its impact on patient care. The following are a sample of these comments.

Surgeon mentor:

"It has never been uncommon for surgeons to request the assisting skills of a perioperative nurse in a variety of circumstances; so it makes good sense for a surgeon mentor to be actively involved in the dedicated training of a perioperative nurse who has the interest and aptitude to undertake the first assistant role. In addition, the PNSA's involvement does not begin and end with the operative procedure, as is usually the case with a medico first assistant. It embraces much more, which I have found to be invaluable in my practice."

This surgeon continues:

"My participation as a surgeon mentor has also been educative for me. Concepts such as nursing diagnoses were unknown to me, and I have come to an awareness of their importance to the optimal care of my patients."

This surgeon believes that the superspecialisation of surgery, the socialisation and subsequent de-skilling of general practitioners (G.Ps.) and the increasing opportunities for postgraduate education within the nursing profession are likely to increase the demand for the PNSA role in health institutions and private practices. He concluded by saying ".....it is timely for the surgical and nursing professions and academic institutions to collaborate in the co-ordination of the necessary education, training and qualifications (of the PNSA role). I would like to congratulate Southern Cross University and ACORN for having taken the initiative (in developing this course and role)"

Another surgeon mentor wrote:

"My PNSA aids my practice in three main ways:

Firstly, she allows better utilisation of my time. Whilst she is continuing patient education and 'doing the paperwork', I can see another patient and am free to do what I do best rather than be bound down by administrative procedure. She gives me the ability to perform operations in a District Hospital where there are no doctors able to be an assistant. This helps the public hospital waiting lists enormously.

Secondly, she helps me achieve better outcomes in general for my patients. I find that patients that have been better educated and have more knowledge about their procedures have more realistic expectations. My PNSA's knowledge of surgical procedure, outcomes and anatomy and physiology allows her to reiterate clearly all my information and instructions to the patient. Undoubtedly this aids their recovery. Her care postoperatively also allows for earlier discharge of patients. This also achieves better outcomes.

Thirdly, she gives me greater confidence in my consultations with patients. This is important in various ways, from chaperoning a nervous female patient who is having an invasive procedure to being an independent witness to consultations where patients may be confused or upset. My PNSA has benefited my practice and my patients in so many ways."

This surgeon has detailed figures on the extra number of surgical procedures he has been able to undertake because of ustilising a PNSA and the positive effect on the waiting lists in his area.

Some surgeons who work with PNSAs in the operating suite contributed the following:

"I have found the assistance of a PNSA to be invaluable. In rural areas there is a great shortage of doctors. As such, there are no GPs who are available to act as surgical assistants. This role has been undertaken by a PNSA at our District Hospital. I have found that this person has fulfilled the role with professionalism and great ability. Their ability to assist in an operation is no less than that of a doctor and this particular PNSA I have found to be far more useful as a surgical assistant than other doctors who have assisted me in the past, in other places. Any steps that can be taken to gain further recognition and credentialing for this role of a registered nurse would be invaluable for the provision of surgical services in rural areas.

Another surgeon who utilises the services of a student PNSA says:

"…..I have only the fullest praise for the concept (of the PNSA). I have always been impressed with their enthusiasm, dedication and professionalism….The standard of assistance (provided by the PNSA) is equivalent to the best of the surgical trainees that I have had to work with at the public hospitals. I can only emphasise my support for the concept of the PNSA in the provision of excellent and evolving medical care for patients."

"For the past three years I have now had two full time nurses as my surgical assistants. … I would now be very hard put to return to using a GP or career medical officer as a surgical assistant. I would grade the nurses on a par with an experienced medically trained assistant in both their ability to assist as well as their skill at general surgical tasks. I have discussed this issue with several of my colleagues who have also taken up fulltime use of perioperative nurses to fulfil the assistant's role. Most of them, again, have the same feeling as I do about skill, dedication and level of training."