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Productivity Commission
PO Box 80
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Dear Commissioners Woods, Owen and Fitzgerald

RE: Perioperative Nurse Surgeon's Assistant, and the increasing demand for their services in rural and regional areas of Australia.

Following written correspondence with the Minister for Health and Ageing, the Hon Tony Abbott MP, concerning Perioperative Nurse Surgeon's Assistants practicing in rural/regional areas of Australia, his office prompted me to make this submission.

The Perioperative Nurse Surgeon's Assistant (PNSA) is an expanded practice role that enables the perioperative registered nurse, through education, and in collaboration with, and at the direction of the surgeon, to provide a continuum of care and optimal outcome for patients undergoing surgical procedures. The nursing role of PNSA encompasses preoperative patient assessment and education, infra-operative assisting and patient care, progressing to immediate postoperative care, patient and family education and discharge planning.

I am a practicing PNSA in a large regional coastal centre of NSW. I was initially encouraged by the local surgeons to complete the expanded perioperative course, which is conducted by the Southern Cross University, in response to their increasing difficulty in procuring the services of local General Practitioners, as first assistants for operative procedures, due to the critical and chronic shortage of GPs in the local area. G Ps on average work 48 hours per week, are unable to afford the time away from their practice.

As a PNSA, as you well may appreciate, under these circumstances, I am of immense value to local and visiting surgeons in the regional area where I practice.

However, the major problem that exists for me, as a PNSA, is reimbursement. I am a viable alternative to a GP first assistant as I provide professional assistance during operative procedures, while allowing the GPs to attend his/her practice. I am also a cost effective alternative to the GP assistant, who charge 20% of the surgeon's fee, where as I charge in the vicinity of 10% for my services, which unfortunately at present, is an out of pocket expense for the patient, which strikes me as unfair. I am self-employed in this position as are several other PNSAs in Australia. We are aware that we would, therefore, be able to seek reimbursement from Government resources if we were able to access some form of provider number. If a provider number can't be considered at the present time, another method of reimbursement for the PNSA should be facilitated, either through the surgeon or the private hospital.

I will enclose a copy of the results of a questionnaire (regarding the role of the PNSA), distributed to surgeons at the 2004 Provincial Surgeons of Australia Conference, which demonstrates a strong support for the PNSA.

Because of the present climate of budgetary constraints in the delivery of health care, the Government undoubtedly, would be searching for avenues for cost effective patient care, while maintaining a high standard, and I believe the PNSA would be one such avenue.

Commissioners, I ask that the Productivity Commission recommend the implementation of the PNSA position as a cost effective alternate to patient care during operative procedures. This move would have the propensity to ease the pressure placed on GPs in rural and regional locations, to act as first assistants when they are already suffering critical GP shortages.

I wish to thank the Productivity Commission for allowing me to discuss the PNSA and the services they provide.

Yours sincerely

Moya T Anderson RN, PNSA.

Please find enclosed supporting documents.

1. Australian College of Operating Room Nurses, 2004, NR5 Perioperative Nurse Surgeon's Assistant (PNSA)

2. Brennan, Bernadette. PNSA Program Coordinator, 2005, The Role of the Perioperative Nurse Surgeon’s Assistant. (by permission 21st July 2005)

3. Associate Professor William Ross Conjoint Assoc. UNSW 2004, Perioperative Nurse Surgeons Assistant Survey – Provincial Surgeons of Australia Meeting Coffs Harbour 2004 (by permission 26th July 2005).

4. Copy of correspondence from the Australian Government Department Health and Aging. 28th June 2005.

Perioperative Nurse Surgeon's Assistant (PNSA)

This standard is relevant to clinical practice because it assists in providing acknowledgement by ACORN that the PNSA role is relevant to professional perioperative nursing practice.[2]

The appropriate person to act in the role of first assistant is a qualified medical practitioner. ACORN is aware of changes in the delivery of health care, coupled with developing roles in perioperative nursing. ACORN recognises that perioperative nurses are now undertaking an extended nursing role which encompasses the preoperative, intraoperative and postoperative phases of care, and that is an expansion of nursing practice. During the intraoperative phase the PNSA may be required to perform the function of assistant to the surgeon.[4] The patient's surgical outcome is influenced by the standard of assistance provided to the surgeon by the perioperative nurse surgeon's assistant.

The PNSA refers to the role undertaken by a suitably qualified perioperative registered nurse who undertakes functions that will provide extended perioperative nursing care (which includes assistance to the surgeon) to ensure optimal patient outcomes. The PNSA has acquired the knowledge, skills and attitudes necessary to competently provide extended perioperative nursing care.

Perioperative nurses required to perform the role of surgeon's assistant must at all times collaborate with the surgeon in all phases of patient care.

The perioperative nurse surgeon assistant's practice includes:

Pre-operative care

Assessment and planning of perioperative nursing care.[2]

Intra-operative care

Interventions which may include but not limited to:

- assisting with positioning
- skin preparation
- draping
- skin retraction
- diathermy under direction
- deep retraction and tissue handling
- assisting with the provision of haemostasis
- insertion and cutting of sutures
- application of dressing
- transfer of patient to trolley and or bed
- participation in patient handover in the post anaesthetic care unit

Post-operative care

Critical evaluation and review of patient care.

Standard Statement I
Perioperative nurses *required* to *perform the role* ***of surgeon's*** assistant *shall* collaborate with the surgeon *during all* phases of the *patient's* care. ***However the PNSA is under the direct supervision of the surgeon during the surgical procedure.***

Standard Statement **2**

The perioperative nurse who *undertakes* ***the role of surgeon's assistant shall*** **be** ***an additional member of the surgical*** **team.**

Criteria

Perioperative nurses who undertake the role of surgeon's assistant do not concurrently function as an instrument nurse. Perioperative nurses are legally responsible for their practice as a surgeon's assistant, act interdependently with the surgeon, and cannot partake in the counting procedures required in the role of instrument nurse.

Standard Statement 3

Perioperative **nurses** *who undertake* the *role of* surgeon's assistant *shall* meet **the** ***appropriate educational requirements,*** **be** ***suitably experienced, and demonstrate competence in the role.***

Criteria

The perioperative nurse shall:

3.1 undertake an education program;
3.2 maintain competence by undertaking continuing education programs;
3.3 participate in clinical learning activities;
3.4 have a minimum of five (5) years perioperative experience. **Standard**

Statement 4

Perioperative nurses shall maintain accountability for **their actions** ***in the role of surgeon's*** **assistant.**

Criteria

The perioperative nurse shall:

4.1 retain the right to refuse to undertake this role if they believe they are not competent to fulfill all requirements;
4.2 undergo an annual evaluation of their performance.

Standard Statement 5

Each health care facility shall develop a written policy and position description for the *role* of the *perioperative nurse* surgeon's assistant

Approval Statement

This Standard was authorised by the ACORN Board on 14 February 2004. First

Compiled 1993

Revised 2004

References
1. Brennan B. The registered nurse first assistant: The "downunder" experience. *Seminars in Perioperative Nursing* 2001; 10(2): 108-4. [D)

2. Brennan B. The role of the registered nurse as first assistant to the surgeon. [Unpublished Paper]. 2003. [D)
3. Ilton S. Perioperative Nursing: the benefits of registered nurse first assistant. *Canadian Nurse* 2002; 98(6): 22-7. [D]

4. Brennan B. The challenge of tomorrow. In Nightingale K. editor. In Understanding Perioperative Nursing. London: Arnold; 1999. [T[
5. AORN official statement on RN first assistant. In Standards, Recommended Practices and Guidelines. Denver: Association of periOperative Registered Nurses; 2003. [O)

6. *AORN* recommended *educational* standards *for RN first* assistant *programs.* In Standards Recommended Practices and Guidelines. Denver: Association of periOperative Registered Nurses; 2003. [O)

7. 2003 Practice Resources - RN First Assistant. Denver: Association of periOperative Registered Nurses; 2003. [O) Bibliography

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Keane A. Critical care nurse practitioners: evolution of the advanced practice nursing role. American Journal of Critical Care 1994; 3(3): 232-7.

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RN First Assistant Policy Manual. Millard Fillmore Hospitals, 1996.

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ROLE OF THE REGISTERED NURSE AS FIRST ASSISTANT TO THE SURGEON INTRODUCTION

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 provision of nursing care to patients in the operating suite. 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 an on-going commitment to accountable nursing practice.

Perioperative nursing practice is in a phase of evolution. The shift of surgical care from inpatient to outpatient surgery is escalating rapidly. Perioperative nurses will broaden 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. Although some health professionals espouse specialisation in perioperative nursing, in reality it is widely believed that this move will fragment the role of the registered nurse in the operating suite. The role of the perioperative advanced nurse practitioner 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 roles in perioperative nursing.

Perioperative nursing practice has historically included the role of the registered nurse (RN) as assistant at surgery. The definition of an RN first assistant at surgery is that of collaboration with the surgeon in performing a safe operation with optimal outcomes for the patient.

There is a growing trend in Australia for perioperative nurses to undertake the role of first assistant. Currently this occurs without specific qualifications or professional education. This trend has in part been influenced by the shortage of doctors in rural areas which is being addressed at present by the federal government. 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 has required urgent consideration. *(Source - Australian Medical Workforce Advisory Committee)*

There have been predictions that the Commonwealth intends to cut medical school intakes which has caused on-going discussion between the government and medical schools. The reasons for the decline 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.

It is posited that this projected decline will accelerate the development of the advanced nurse practitioner role within the operating suite.

In the current climate of economic constraint, management teams in hospitals are seeking ways of saving money in high cost centres such as the operating suite. There is a concerted move by hospital administrations, to employ technicians in all roles in the operating suite and the ACORN Council and the ANF are extremely concerned about this situation. It is our agreed position that patient care must be undertaken by registered nurses -in one of the most critical areas of the patient's hospital experience i.e the operating suite. It has been jointly agreed that exploration of the development of the role of the. RN as First Assistant be undertaken and that the development of a suitable post registration course in Australia to educate the registered nurse as first assistant be considered as an adjunct to this.

In 1990, the Australian Confederation of Operating Room Nurses (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, is widespread. The Association was being asked for direction on the matter and considered that a policy statement from ACORN was needed which would be used widely and to good effect.

Questions which were raised within this issue were:

l. 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?

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.

Some professional nursing bodies had becoming increasingly concerned about their members practising in clinical settings without the relevant education/registration. In their opinion the legal and ethical considerations involved which needed to be addressed included perioperative nurses closing wounds in the absence of the surgeon. Subsequently these bodies have accepted the concept of this role, believing it to be within the scope of nursing practice, as the nurse undertaking this role is always the supervision of the surgeon, particularly in the intraoperative phase.

The consensus of opinion of the bodies which were contacted are outlined in the following paragraphs

DUTY OF CARE

The nursing profession is very aware of the legal duty of care which must be provided for patients. But hospitals also have a duty of care, defined by professional standards, government regulation and by the various State and Federal legislation. Collectively as a profession we must ensure that our responsibility to patients is met, by ensuring that they have an acceptable standard of care, and to our employers by upholding the policies of the facility. In acting in the role of first assistant this duty of care must be upheld. If any RN believes that this role cannot be practised safely, there is an obligation to state this fact.

INFORMED CONSENT

All registered nurses are aware of the importance of informed consent and of ensuring that the patient is made fully aware of, and consents to, treatment. When a patient enters a hospital or health care facility, he enters into a contract with the administrators of the institution. If the patient is a private patient, he enters into a contract with his medical practitioner also. The registered nurse is perceived to be acting in the capacity of "servant" or agent of the hospital. Outside of this situation, as an independent or advanced practitioner, for example, the nurse enters into a direct contractual relationship with the patient. This will be the case in the future when the RN works as an independent practitioner, for example, as a first assistant to the surgeon.

It is important to remember that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." *(Schloendorff v. Society of New York Hospital as cited in "Nursing and the Law" - Pat Staunton & Bob Whyburn)*

Legal opinions have indicated that just as a patient gives consent for a surgeon to operate or to treatment by a medical practitioner, consent should be obtained for an assistant to be utilised, be they a medical practitioner or a registered nurse. As this role develops in Australia, this issue will need further exploration.

NEGLIGENCE

In the question of negligence the nurse must act in a way that a "reasonable nurse" with the same level of training and skill would act. Failure to do so would constitute negligence, if the breach of the duty of care causes damage to the patient. Competence in the role of first assistant will be a requirement and must be demonstrated.

VICARIOUS LIABILITY

The advice received from the Royal Australian College of Surgeons in 1990 considered that the surgeon is vicariously liable for medical indemnity covering all assistants. However, the majority of opinions stated that the employer is vicariously liable for the action of its employee. The definition of employer is not easy to define. Is the employer the hospital or the surgeon, in this instance? Will hospitals in the future employ registered nurses as first assistants? Will surgeons employ their own nurses as first assistants? Will the hospital provide the first assistant from their perioperative nursing staff and charge the surgeon a fee? All these questions need clarification.

If an employee acts outside the scope of his or her employment and outside the authority of that employment, the employer will not be liable for damage arising out of the employee's actions. In recent years, there have been cases of litigation in Australia in which the registered nurse has been sued separately from the surgeon, as the legal opinion has been that these nurses are accountable for their own actions and practice

The following quote came from the Royal Australasian College of Surgeons document from the legal adviser they approached and appears to reflect the general opinion. "A nurse is required to exercise a level of care and skill consistent with her qualifications and any special skills and qualifications she professes to have. Thus a nurse who undertakes a role of first assistant, holds her or himself out as having the competence to perform that role and is required to exercise the care and skill which a person having that competence should exercise." This document also stated that the fact that the operating room nurse acting as the first assistant is under the direct supervision of the surgeon would relieve her or him from the responsibility in respect of any action or procedure undertaken by the proper direction of the surgeon. The solicitors considered that no liability could attach to a nurse who competently carried out such a direction. But they went on to make the point that the nurse **would** be required to exhibit the standard of care and skill consistent with that expected of an operating room nurse who undertook the role of first assistant.

Furthermore, the point was made that, "If however the first assistant RN was routinely rostered on the theatre list as a first assistant and the RN performs first assisting duties on a regular basis, the surgeon may be entitled to rely on the skills and expertise of the nurse, therefore the nurse and/or hospital may be held responsible for requiring the nurse to perform those duties."

It was generally considered that, "The RN who carried out the task of first assistant possesses the necessary knowledge and skills to enable her to do that task to an acceptably safe standard."

The primary responsibility to ensure that this is the case lies with the employer who presumably is aware that this task is routinely performed by registered nurses. It is also deemed necessary that the employer provides necessary guidelines. It is likely that the employer would look to a professional body for assistance.

It was generally agreed that the nurse undertaking this role:

- is an experienced perioperative nurse
- has completed an appropriate course
- has a demonstrated skill in performing the required duties

These reasons are why it has been so important to undertake research into the role of the RN as First Assistant as it has been developed in other countries particularly in the United States of America and the United Kingdom. This investigation has provided the necessary information to allow a development of the role in Australia.

It should be noted that in the United Kingdom, another role for RNs, that of Surgeon's Assistant has been developed which includes surgical intervention i.e. assisting the surgeon by carrying out some invasive procedures. In the U.S.A., many RNFAs are dissecting and taking veins in cardiac surgery. Surgeons in Australia have indicated their preference for this role to be undertaken by an educated and qualified registered nurse.

Legal advice from a leading medico-legal solicitor in Australia indicates that this role is within the scope of practice of a registered nurse working within hospital policy and a defined position description. The advice offered was that this role is part of the expansion of nursing roles.

PROFESSIONAL CONDUCT

Most professions have established "Standards of Practice" which provide a legal and professional framework for practice. They are defined in legislation through the state Nurses' Acts. Standards of Practice are also defmed by collegiate means through the statements of codes of conduct and practice of the professional nursing organisations e.g. Australian Nursing Federation or the Royal College of Nursing, Australia.

While the perioperative nurse works in collaboration with other health professionals to determine and meet patient needs, the nurse has primary responsibility and accountability for nursing care of patients undergoing surgical intervention.

The registered nurse as first assistant will provide an expansion of the perioperative nurse's role and will allow perioperative nurses to maintain that primary responsibility and accountability.

ACCOUNTABILITY

The Victorian Nursing Council released a document which was circulated with the renewal of registered nurses' practising certificates at the end of 1993. In this document a statement was made that ....."each nurse is accountable for his or her practice and in the exercise of this practice must act in such a manner as to enhance the general health and harmony of the community, justify public trust and confidence, and enhance the reputation of the profession and safeguard the interests of individual clients. Therefore, nurses must only carry out those clinical procedures for which they have been prepared. This preparation has to include theory and supervised practice until the nurse has been assessed as competent.

Maintenance of knowledge and skills in performing clinical procedures is essential and measures must be in place to ensure regular review of competence.

Nurses are at all times ***responsible*** for their own acts. They are expected to be aware of the limits of their abilities and to function within these limits. Nurses should be aware of the policies and procedures of their employing organisation. However, it should be noted that within a guideline or policy statement of an employer, any other organisation or professional group does not relieve them of responsibility for their own acts and may not provide immunity in case of negligence."

This statement was adopted by the Victorian Nursing Council (now the Nurses Board of Victoria and replaces any pre-existing policy statements. All registered nurses must be fully aware of this statement and ensure that they possess the knowledge and the ability to undertake any procedures for which there is a request. This is of particular importance when contemplating the role of first assistant. As technology continues to burgeon, particularly in the field of minimally invasive surgery, there will be an increasing expectation for registered nurses in the operating suite to act in this role. An important issue for consideration is an awareness of the medico-legal issues. Accountability and responsibility coupled with the right of refusal to undertake any procedures for which preparation is inadequate are significant components of the role of registered nurse as first assistant.

OTHER CONSIDERATIONS

Professional Indemnity

If this role is to be a defined role within the scope of perioperative nursing practice, the issue of professional indemnity must be explored. Members of the Australian Nursing Federation in Victoria have an indemnity cover as part of their membership subscription, but for nurses who are not members the need to explore this issue will be necessary if they are working as a private or independent practitioner. Nurses in other states need to investigate their State's policy. Hospital employed nurses would be covered by the hospital's professional indemnity policy, unless acting outside their scope of practice.

Reimbursement

If the registered nurse acts as first assistant and is employed by a hospital or other facility, will this role become classified as part of a Nurses Award? Will there be a classified payment by the hospital for this expanded role? Will surgeons employ RNs as first assistants, and will this be reimbursed by health funds, as is the current situation for medical practitioners?

The question of reimbursement must be explored, both with the Federal Government and the private health funds if this role is developed educationally and professionally. There has already been some preliminary discussion with some of the health funds in Victoria with a positive response from the funds. ACORN has discussed this question with relevant people in government positions in Canberra and is working on this issue at present. It is hoped that in the near future there will be reimbursement available for registered nurses who work as a Perioperative Nurse Surgeon's Assistant both from Medicare and the private health funds. The Nurse Practitioner Projects in several states are providing the impetus for this question to be addressed expeditiously.

Collaborative Practice

Collaborative practice is being developed strongly in the U.S.A. at present. Many hospitals are introducing collaborative practice models which flow on from the introduction of shared governance. But in the operating room the concept of collaborative practice has been part of the operating team approach for many years. Perioperative education provides the knowledge and expertise necessary to undertake such a role. The expanded role of the RN AS first assistant is perceived as a further development in collaboration. The RN First Assistant is first and foremost a perioperative nurse and, in the future development of the role, will not only be responsible for assisting the surgeon intraoperatively, but also for preoperative assessment and postoperative evaluation of the patient. It is **crucial** that a registered nurse fulfils the perioperative role because first assisting **in and of itself** is not nursing but a medically supervised supportive service. This

distinction has serious ramifications for collaborative relationships. Collaborative practice can be achieved only among groups with accountability, responsibility and authority for their own profession and practice. It is complementary - not a subordinate type of relationship.

As a perioperative nurse, the RN as first assistant operates within the framework of nursing, although being supervised by the surgeon during the act of assisting. Registered nurses and doctors each offer areas of expertise making them interdependent in providing a total plan of care. This is a most significant development in health care. Neither medicine nor nursing **alone** can totally meet a patient's needs. Teamwork can only be achieved when doctors and nurses each decide that working together in the interest of the patient will bring them to their fullest professional potential.

HISTORY OF THE ROLE OF THE REGISTERED NURSES AS FIRST ASSISTANT

In order to understand the role of the registered nurse as first assistant, it is necessary to consider the history behind this role.

The origin of this role is evidenced throughout history and has its beginnings in war. Wars have always been a part of our civilisation. Wounds inflicted during times of war created the opportunity and need for the nurse to act as surgical assistant.

Florence Nightingale and her staff of 125 nurses provided services to soldiers wounded in the Crimean War from 1854 to 1856. Nightingale stressed the importance of the nurse's role in managing and supervising patient units and the operating room. Her care and vigilance, her identification of the role of cleanliness in infection control and her insistence on environmental sanitation formed the cornerstone of the principles of managing a hospital. These principles are also critical elements in nursing intervention in the operating room.

The role of nurse as first assistant was initially conceived during her tenure in the Crimea. At the surgeon's side, the nurse prepared wounds for surgery and assisted during the surgical procedures. Meticulous care of the surgical site and prevention of infection was of paramount importance. The expanded perioperative role as we know it today had its beginnings in that hospital in Turkey, designed to care for 1700 patients, but in reality housing 4000 injured soldiers.

During the American Civil War, conditions in hospitals were not improved. An American, Dorothea Dix, with 10,000 nurses provided care to the wounded soldiers. She followed in Nightingale's footsteps and the nurse again assumed the role of first assistant in surgery. Amputation was, of course, the predominant surgical procedure with haemorrhage and infection as dreaded complications. Infection and bleeding were of such magnitude that nurses were constantly tying off bleeders and cauterising blood vessels with heat.

The Spanish-American War, in 1898, had one major land battle which resulted in 968 casualties and 5438 deaths from disease due to poor sanitation and yellow fever. An allgraduate nursing staff replaced the previously used medical corpsmen. The role of the RN as first assistant expanded and after the war the Army and Navy Nurse Corps were founded. This helped stabilise the role of the nurse as first assistant and led to advanced specialisation in operating room nursing.

World War I saw 8,587 American nurses care for 184,000 wounded and sick soldiers on the European front. This war also produced enormous numbers of amputations for which the nurse acted as first assistant. Dead and devitalised tissue had to be removed and the practice was that one nurse administered the chloroform or ether while another nurse, functioning as first assistant, cleaned the wound and began debridement. The nurse also assumed primary responsibility for burns dressings and pinch grafting.

In World War 2, increasing numbers of nurses worked as first assistant in both civilian and military facilities. By 1944, casualties numbered as high as 1750 per day. By June of 1945, 29% of all graduate nurses were on duty with the armed forces. Personnel shortages combined with high casualty rates necessitated that nurses continued to act in this role. Nurses opened and closed wounds and the surgeon performed the internal operating. Tying and clamping of bleeders was routine. Nursing experience in abdominal and chest surgery increased with nurses sometimes performing both tracheostomies and insertion of chest tubes. Nurses were never more in demand than at this time. The role of the RNFA expanded to meet the patient-care need and was undertaken with great efficiency.

The Korean War from 1950 1953 saw a further expansion of the first assistant role in the M.A.S.H. units. Triage became a nursing responsibility at this time and remains so today. Nurses assessed injuries, prioritised casualties, provided initial emergency intervention and administered emergency medical services

Student nurses from 1873 until 1945 provided up to 80% of the nursing services in hospitals and consequently staffed the operating rooms. Student nurses undertook all roles, even administering the anaesthetic. Over the years it was recognised that the role of first assistant was a vital one and only the graduate nurse was allowed to act in this role by the 1960s.

Earlier in this century a large proportion of surgery was undertaken in the home. It has been demonstrated that wound morbidity and mortality were lower for patients having surgery at home than in hospital.

Education in operating room nursing grew rapidly but unfortunately in the U.S.A as here in Australia, perioperative nursing experience was deleted from the basic nursing courses.

There has been much research into this role in America studying the scope of the role and third-party reimbursement. In 1979 the Association of Operating Room Nurses (AORN) House of Delegates approved the following statement, "...in the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant."

In 1980 AORN developed guidelines for the registered nurse who functioned as the first assistant Emphasis was placed on the necessity for the assigned duties to fall within the scope of the various State Nurse Practice Acts.

By 1983 the RN was permitted to act as first assistant in 17 States. At that time, Washington State was the only one to clearly state that the RN could act as first assistant and still function within the scope of the Nurse Practice Act. The majority of States considered this to be a delegated medical function or a function regulated by hospital policy. 12 States said that the function was not clearly identified within the scope of the Act. Many other States continued to study the question.

In 1983 AORN appointed a task force to study and clarify the role and qualifications of the RNFA.

In 1989, at the AORN Congress in Anaheim, the House of Delegates approved a motion for the Board of Directors to charge a committee to develop a generic curriculum for the Registered Nurse as First Assistant (RNFA). The curriculum was developed and there are now 15 courses for the RNFA in America. This role is highly developed with each of the states having their own legislation regarding the legality of nurses acting in this role and the reimbursement offered for this work. Some states are covered under a third party reimbursement, other states are not. At the present time, more than 42 states have legislation permitting registered nurses to undertake the role of first assistant to the surgeon.

CURRENT PRACTICE IN THE U.S.A.

Definition

The definition of a RNFA, as outlined in the official position statement, is a nursing professional who renders direct patient care as part of the perioperative role by functioning as first assistant to the surgeon. The RNFA practices an expanded role of perioperative nursing and has acquired knowledge, skills, and the judgment necessary to assist the surgeon to perform a safe operation with optimal results for the patient. This is achieved through organised instruction and supervised practice. The decision by an RN to practice as a first assistant is made voluntarily with an understanding of the professional accountability the role entails. The RNFA does not concurrently as instrument nurse.

Scope of Practice

The scope of practice of the nurse performing as first assistant is part of perioperative nursing. The intra-operative practice is interdependent with the operating surgeon. While independent nursing skills and judgment are essential to this practice, all intra - operative activities must be directly supervised by the surgeon. All perioperative nurses are responsible for preoperative assessment and postoperative evaluation but the diversity of the role occurs primarily during the intraoperative phase.

Qualifications of the RNFA

Qualifications for the RNFA should include but not be limited to:

- demonstrated proficiency in perioperative nursing practice as an instrument and circulating nurse.
- knowledge and skill in applying principles of asepsis and infection control
- knowledge of surgical anatomy, physiology and operative technique related to the specific operative procedure in which the RN assists.
- ability to perform cardio-pulmonary resuscitation

- ability to perform effectively in stressful and emergency situations
- ability to recognise safety hazards and initiate appropriate preventative and corrective action
- ability to perform effectively as a member of the operative team
- meeting requirements of statutes, regulations and institutional policies relevant to the RNFA.

Preparation for the RNFA

The perioperative nurse who wished to undertake this role must develop a set of cognitive, psychomotor and affective behaviours which can be acquired in a variety of ways. It is commenced with the educational program undertaken by the RN which provides the basic knowledge on which is built further preparation for the role of First Assistant. Diversified experience as an instrument nurse and circulating nurse, structured education programs with didactic and supervised clinical learning activities or independent study with these components are required.

Establishment of Clinical Privileges for the RNFA

A credentialling process must be established by the institution in which the RN will practice. The process of granting practice privileges should include mechanisms for:

- Assessing individual qualifications for practice
- Assessing continuing proficiency
- Evaluating performance annually
- Assessing compliance with relevant institutional and departmental policies
- Defining lines of accountability
- Retrieving documentation of participation as FA.

Educational requirements

Following the recommendation by AORN that educational programs for RNFAs be developed, many educational institutions now provide courses. AORN developed a Core Curriculum which is used as a basis for these programs. The objectives for the Core Curriculum are:

- Describe factors influencing scope of practice for the RNFA
- Utilise the nursing process as a foundation for practice
- Apply principles of asepsis and infection control
- Review surgical anatomy and physiology

- Review surgical technique related to first assisting
- Recognise surgical hazards and initiate appropriate action
- Validate intraoperative nursing behaviours
- Develop effectiveness in communication skills

These objectives are the framework for the subject matter of the courses and it is suggested that modules of study are undertaken which reflect these objectives.

The current situation in Australia

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 which was entitled "The Perioperative Nurse Practitioner Surgeon's Assistant" - B 1. 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 RNFA as part of the advanced nurse practitioner role in the operating suite is essential if perioperative nurses in Australia are to make an informed decision to develop and undertake this role. Issues for investigation include:

- training and education requirements
- professional issues
- legal and ethical issues
- managerial issues

The scope of the role needs careful consideration to identify its parameters, in order to furnish ACORN and the A.N.F. with the required data. Accordingly, the Australian Confederation of Operating Room Nurses awarded a Fellowship to one of its members to undertake a comprehensive study tour overseas. This exploratory study was intended to provide background data to assist in defining the role of the advanced nurse practitioner and its evolution in Australia. Relevant penoperative nursing education would then be developed utilising the most appropriate tenets for the Australian nursing profession.

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

- 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

The development of a course to educate registered nurses as first assistants in Australia is timely and exciting to contemplate. The first course, a Graduate Certificate as the first part of a Masters in Health Science has already commenced as a distance education course through Southern Cross University. This Graduate Certificate consists of four (4) units:-

Unit 1 - The Role of the Perioperative Nurse Surgeon's Assistant
Unit 2 - Preoperative Assessment and Planning
Unit 3 - Intraoperative Assisting and Nursing Care
Unit 4 - Postoperative Nursing Care and Professional Issues

These units consist 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 will be 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.

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-seven (27) 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. Two graduates are 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 units provide four credits towards the Masters degree. Southern Cross University has recently indicated that the requirement to complete the Masters degree is 12 units of study. Following completion of the Graduate Certificate i.e. 4 units, the student can be granted 4 units by recognition of prior learning (RPL) and/or previous perioperative post-basic qualifications and may undertake a further 4 elective units of study and achieve a Masters.

It is proposed that a research project will be undertaken in the near future. The outcome of this research project will be used to:

- Attract more hospitals to fund nursing staff
- Encourage more perioperative nurses to undertake education to support the ad-hoc role
- Provide evidence for application for Nurse Practitioner status in NSW and other states
- Provide outcomes for RACS to influence more surgeons to act as mentors
- Provide evidence to support reimbursement

It is intended to survey students, nurse and surgeon mentors using a mixed methodology - a survey tool and interviews. The result of this project will be widely available for public examination.

When ACORN was considering as title for the role it was felt that "Registered Nurse First Assistant" or RNFA did not truly reflect the parameters of the role. Therefore it was decided that "Perioperative Nurse Practitioner Surgeon's Assistant" was more descriptive of all that the role entails. However, the legislation in all states which are undertaking nurse practitioner projects has resulted in a current embargo on the use of the term "practitioner" unless accredited. Therefore, currently the title of the role will be "Perioperative Nurse Surgeon's Assistant" or PNSA. Registered nurses who have successfully completed the course will be able to apply for accreditation as a Nurse Practitioner, in the relevant states.

In Victoria, the Minister for Health, after funding a pilot study to develop the Nurse Practitioner role in this state, launched an initial report. Further funding has been made available for additional pilot studies and there are some innovative projects underway at the present time. The Victorian initiative has gone further than New South Wales in that there is no restriction on where nurse practitioners can practise - that is, it is not restricted to rural and remote areas. South Australia and Western Australia have also developed the nurse practitioner role.

The Head of the School of Nursing and Health Care Practices at Southern Cross University has discussed the Southern Cross/ACORN course with the New South Wales Nurses Board and the PNSA course will be submitted for accreditation shortly. It is expected that the content of this course will fulfil the educative requirement for application for nurse practitioner status in the states which have introduced or are introducing this role.

The Australian College of Operating Room Nurses Ltd (formerly the Australian Confederation of Operating Room Nurses Ltd) and the Australian Nursing Federation have 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 have been seeking 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. Neither ACORN nor the ANF want a second level health worker taking on this role. At one of the 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. The RACS were impressed with the survey results and the excellent response rate. The President at that time indicated that the RACS would be prepared to support the intraoperative component of the role but at that juncture, not the pre or post operative components. ACORN has since continued to have discussions with the RACS.

When ACORN decided to enter into an industry partnership with Southern Cross University to develop the first program by distance education, the current President wrote to the RACS President to seek the nomination of a surgeon to be the RACS representative in the development of the curriculum. At that time, RACS indicated that they felt unable to continue supporting the development of the role and the course. Subsequently, the RACS President met with the President of ACORN and the PNSA Project Manager for ACORN, and asked for an outline of the course for further consideration by the Federal Executive. 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 human being undergoing a surgical procedure.

CONCLUSION

Continuing work needs to be undertaken on the following issues:

- Reimbursement/remuneration/provider numbers with Medicare/private health funds
- The possibility of attaining individual nurse practitioner status as the Nurse Practitioner projects develop in the various states
- Competency standards for the PNSA role

- Credentialling
- The development of further courses in other universities and colleges

The course was reviewed at Southern Cross University in 2001 by a committee comprising of representatives from ACORN and the University, the writer, the RACS representative and one of the first graduates. A review will occur every third year followed by an update, in line with University requirements. A minor update of the course is to commence shortly.

In 2003, ACORN decided to terminate their industry partnership with Southern Cross University. The University will continue to offer the course unilaterally and have had discussion with the Royal College of Nursing Australia (RCNA) regarding the feasibility of RCNA becoming the credentialling body for the Perioperative Nurse Surgeon's Assistants.

BERNADETTE BRENNAN OAM RN, RNFA, DIP APP SC, FRCNA Southern Cross University PNSA Program Coordinator May, 2005.

Perioperative Nurse Surgeons Assistant Survey - Provincial Surgeons of Australia Meeting Coffs Harbour 2004 - Initial results

Aim: to determine surgeons' views on the potential role of the in their private practices.

The current shortage of general practitioners in rural and regional Australia is affecting the availability of surgical assistants in private hospitals. The employment of the PNSA is one solution. Doctors who assist are reimbursed by health funds, DVA, Medicare and the patient if there is a gap. Nurse assistants cannot access health funds or government funding.

48 (69%) of approximately 70 surveys were returned

	Question	YES	NO	?
I	Have you had problems in obtaining a first assistant or do you expect to in the near future? (18 did not work in a private hospital)	18(60%)	12(40%)	
2	Were you aware ofthe PNSA role?	20,(42%)	27(56%)	1
3	Would you use the PNSA as a first assistant?	40(83%)	5(10%)	3
4	Who should pay for the PNSA? The private hospital The patient The surgeon The health funds, DVA and Medicare - some ticked more than one box	 9(19%) 5 1 36(75%)		
5	Do you have any objection to the PNSA being issued with a provider number?	9(19%)	37(77%)	2
6	Should the PSA, GSA and the RACS lobby the government for PNSA provider numbers?	36 (75%)	9 (19%)	4

Thank you for your help. Bill Ross, Coffs Harbour (billrossincoffs@bigpond.com)

Department of Health and Ageing
Australian Government

Ms Moya T Anderson
25 Avondale Road
LOWER BUCCA NSW 2450

Dear Ms Anderson,

Thank you for your letter of 22 May 2005 to the Minister for Health and Ageing, the Hon Tony Abbott MP, concerning Perioperative Nurse Surgeon's Assistants gaining access to Medicare pay-merits for patients. The Minister has asked me to reply on his behalf.

The proposal put forward in your letter represents a new way of recognising and remunerating work being done by nurses, and the Minister is always prepared to consider innovative approaches to delivering services, particularly in rural and regional areas.

You may also be aware that the Productivity Commission is currently undertaking a study of the health workforce, on behalf of the Council of Australian Governments. The Health Workforce study is taking a broad, whole-of-government perspective including health and education considerations and is covering the full range of health professionals. It is examining issues affecting both the demand for. and supply of, health professionals over the next ten years.

In preparing its report, the Productivity Commission will draw heavily on input from interested parties. You may therefore wish to make a submission based on the demand for your services as a Perioperative Nurse Surgeon's Assistant. Further information can be obtained from the Commission's website at www_pc.gov.au/study/healthworkforce-'index.html or by phoning 1800 020 083.

The Department is also aware that in some overseas countries the issue of providing support to surgeons has been addressed by establishing a type of health professional called "physician's assistant". although their role is more aligned to performing medical or paramedical procedures, rather than those associated with traditional nursing.

The question of direct access to Medicare with provider numbers for nurses is not a straightforward matter. It would create a precedent for other professional groups seeking access to Medicare, and it may have workforce implications which need to be fully investigated. While the Department is not considering moving in this direction at the present time, it intends to look further at the suggested approach you have put forward as part of its broader consideration of health workforce issues.

Thank you for drawing this matter to the Minister's attention.

Yours sincerely,

Jen Browning
A/g Assistant Secretary
Health Workforce Branch
June 2005

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