The surgical first assistant: are you compliant?

by J Quick and S Hall

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It is over a century now since the importance of the knowledge and skills of the surgeon’s assistant were first considered (Brickner 1907). More recently both the Royal College of Surgeons of England (RCSE 1999, 2011) and the Perioperative Care Collaborative (PCC 2007) have reviewed the role of the non-medically qualified surgical assistant. In 2012, the PCC published their review of the surgical first assistant (SFA) role in response to a call by the RCSE for greater clarity in relation to the plethora of titles afforded to non-medical surgical assistants (RCSE 2011).

Introduction

Since the publication of the Surgical first assistant: position statement (PCC 2012) it has become evident from observation, face to face discussion as well as issues raised via the AfPP Advancing Surgical Roles specialist interest group forum that there remain variations in compliance by individual practitioners, healthcare organisations, managers and academic institutions with regard to the role of the SFA. This article will re-affirm the position statement issued by the PCC and thus clarify the obligations of all healthcare personnel in relation to the role of the SFA.

Professional and legal obligation

The surgical assistant is required to cross the boundary that separates the nurse or operating department practitioner from medical practitioners. Extension of any role brings new responsibilities. Practitioners who perform surgical assistance remain under the governance of their own professional regulatory authority (HMSO 2007) but are obliged to provide care at the same level as that expected of the medical staff they replace (Dimond 1994, 2011). Cases which have brought healthcare into disrepute have had a significant impact on practitioners who work in extended and expanded roles. The most significant of these were considered in the Bristol Inquiry (DH 2001), the Shipman Inquiry (DH 2006), the ‘Foster’ report (DH 2006) and the Francis report (2013). The recommendations of the Bristol Inquiry are particularly relevant to the work of surgical assistants because they endorse the establishment of robust mechanisms for competence assurance for all healthcare professionals.

Competence and scope of practice

The General Medical Council (GMC 2013) stipulates that when a medical practitioner delegates elements of patient care to a colleague they ‘must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.’

Regulating authorities (the Nursing and Midwifery Council and the Health Care Professions Council) require healthcare professionals to participate in appropriate learning and practice activities in order to develop and maintain specialist skills (NMC 2008, HCPC 2012). This is particularly important in extended roles, where there is the expectation that practitioners will have appropriate academic education to support their work, in addition to their use of specialist, practical skills (DH 2006).

When asked to provide surgical assistance, practitioners working in advancing surgical roles must recognise and work within the limits of their competence and performance (NMC 2008, HCPC 2012). Practitioners who are asked to provide surgical assistance without achieving competence are thus contravening their professional code of conduct.

Three levels of assistance

The PCC position statement identifies three distinct levels of non-medical surgical assistance which may be provided by: a scrub practitioner in minor surgery, a surgical first assistant (SFA) or a surgical care practitioner (SCP). The latter role has become established in a number of surgical specialties and is endorsed by a national governance framework (RCSE 2014). The provision of surgical assistance by other practitioners is less clear and will therefore be clarified here.

The surgical first assistant (SFA)

The PCC (2012) defines the SFA as a qualified practitioner: ‘who provides continuous, competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention.’

Working primarily in the intra-operative phase, the SFA should undertake their role and responsibilities separate from those of other team members assigned to carry out scrub duties. Following competency training, the responsibilities of an SFA are limited to:

- enhancing communication between theatre, patient and ward
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- involvement in the team completion of the WHO surgical safety checklist for all surgical interventions as part of the ‘Five steps to safer surgery’
- male urethral catheterisation
- assistance with patient positioning, including tissue viability assessment
- skin preparation prior to surgery and draping as required
- use and maintenance of specialised surgical equipment relevant to area of work
- the handling of tissues and manipulation of organs for exposure or access under direct observation of the operating surgeon
- superficial and deep tissue retraction (NB: retractors should not be placed by the SFA but by the operating surgeon)
- assistance with haemostasis in order to secure and maintain a clear operating field, including indirect application of surgical diathermy as directed by the operating surgeon (NB: activities such as application of direct electro surgical diathermy to body tissue, applying haemostats or ligacips to vessels, cast bandaging, suturing skin or any other tissue layers are the remit of the surgeon, supervised surgical trainee or surgical care practitioner and not the remit of the SFA)
- use of suction guided by the operating surgeon
- camera and instrument manipulation under the direction of the surgeon during minimal access surgery (NB: camera insertion and application of instruments should be performed by the operating surgeon)
- the cutting of deep sutures and ligatures under direct supervision of the operating surgeon
- assistance with wound closure – cutting of sutures and ligatures under direct supervision of the operating surgeon
- application of dressings as required
- assistance with the transfer of patients to the postoperative anaesthetic care unit.

The SFA remains a member of the theatre team, whose dedicated assistance is requested by the surgeon at least 24 hours in advance (Figure 1). The PCC (2012) is clear that the SFA should not perform anything that might be considered surgical intervention. Therefore, suturing and local infiltration of wounds, for example, are no longer a recognised aspect of the SFA role. The authors suggest that the practitioner who had acquired validated competency training in additional skills, such as skin suturing, prior to the PCC position statement, may continue to use them but only if these skills are documented within their job description. If practitioners are repeatedly asked to perform interventional skills outside the remit of the SFA role, it is probable that a re-evaluation of service needs is required as employment of a SCP may be more beneficial to the surgical team. In this case, the career pathway for SCPs offered by the (2014) Royal College of Surgeons of England should be followed, with the associated academic framework.

The scrub practitioner

The PCC (2012) distinguishes the role of the SFA from that of the scrub practitioner. It suggests that a scrub practitioner may ‘dual role’ only when an employer considers that the dual role is required. A governance framework of risk assessment and local protocol must be in place to support this decision. In this instance, a scrub practitioner may provide surgical assistance on an ‘as required’ basis in minor surgery only. The responsibilities of this ‘dual role’ are limited to:

- assisting with wound closure – cutting of sutures and ligatures under direct supervision of the operating surgeon
- application of dressings as required
- assistance with the transfer of patients to the postoperative anaesthetic care unit.
- use of suction guided by the operating surgeon
- camera and instrument manipulation under the direction of the surgeon during minimal access surgery (NB: camera insertion and application of instruments should be performed by the operating surgeon)
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- assistance with patient positioning, including tissue viability assessment
- skin preparation prior to surgery and draping as required
- the use and maintenance of specialised surgical equipment relevant to area of work
- superficial skin and tissue retraction
- assistance with superficial wound closure, including the cutting of superficial sutures
- application of dressings as required
- assistance with the transfer of patients to the postoperative anaesthetic care unit.

Providing assistance at this level must be undertaken by an experienced practitioner, who feels competent to assist within the boundaries of the framework outlined above and who demonstrates experience of the surgical specialty, it should never compromise the responsibilities associated with the scrub role, for instance when carrying out a swab count.

Implications in practice
The PCC (2012) recommends that the SFA works within a local clinical governance framework. This includes the involvement of senior clinicians and managers, and risk assessment. This ensures that:
- any cost implications are clearly identified early
- each discipline within the interprofessional team are aware of the accountability, responsibility and possibility of litigation against those undertaking SFA training
- appropriate responsibilities are clarified and agreed with:
  - the trainee SFA
  - the departmental manager
  - senior members of the surgical teams
  - the employer’s clinical governance team
- the boundaries of the SFA role are clarified in the form of written guidance and clinical protocols.

Training
The PCC statement (2012) makes it clear that practitioners who undertake the SFA role are required to have followed a nationally recognised programme of study and to have attained proficiency in all areas in order to attain the knowledge and skills required for the safe, effective performance of the SFA role. Any registered practitioner who does not achieve and maintain their competence endangers patients and renders themselves liable to disciplinary action at both local and national level.

There are currently two training routes. The first is through the completion of an in-house training package supported by the SFA competency toolkit (APP 2013a). The second is via a university accredited programme, including the College of Operating Department Practitioners’ BSc in operating department practice – although consolidation of practice will be required for newly qualified ODPs. Higher education institutions that offer accredited modules for SFAs must ensure that the programme offered is up to date and follows the recommendations of the PCC. This includes incorporating the specified responsibilities and title of the SFA into the programme.

Once qualified as a SFA, practitioners need to ensure that they maintain competence in the skills and responsibilities of the role. This should form the basis of a role specific annual appraisal and continuing skills assessment, using the competencies outlined in the APP SFA competency toolkit (2013a).

Documentation
Best practice dictates that patients are informed that an SFA forms part of the surgical team that will be caring for them (APP 2013a). This may be through local publication of patient information leaflets, or through discussion with patients prior to the day of surgery. Pre and postoperative visits may therefore be part of the SFA role. The date and time, plus any significant care which was instigated as a result of this visit must be documented. This includes recording the relevant activities that were performed while performing duties as the SFA (for example, tissue retraction and use of suction). A record of the performance category (i.e. primary, second or other assistant) should also be recorded in the patient’s notes and theatre register. In addition, an up-to-date register of practitioners acting as surgical first assistant should be kept in each department (APP 2013a).

Professional and employer liability
Vicarious liability is provided by the majority of employers on behalf of their employees however, it only applies if the conditions outlined in the practitioner’s job description are met. A review of the individual practitioner’s job description will be required to reflect the role and responsibilities of the SFA. In addition, (s)he must act within the policies and protocols of the department in which they are working, and should be aware of current national guidelines relating to advancing surgical roles.

Policies may need to be put in place or amended to reflect the role and responsibilities of the SFA. For example, if only medical staff have historically undertaken male catheterisation then local policy revision will be required to reflect that this can now be performed by an SFA. The implementation of a ‘just say no’ policy can support perioperative practitioners who recognise that providing surgical assistance is outside their professional scope of practice.

It is the practitioner’s responsibility to ensure that they have sufficient professional indemnity cover; a number of associations, including AfPP, offer liability insurance. This is in line with new professional legislation and is particularly important for SFAs working independently in the private sector and/or in the absence of vicarious liability (HCPC 2013, NMC 2013).

Duty of care
Practitioners who undertake extended roles have a professional obligation to ensure that they adhere to the professional code of conduct of their governing body and the voluntary code of conduct for non-medically qualified surgical assistants (APP 2013b). Failure to do this may result in actions for misconduct or negligence. Each healthcare professional should be aware of the elements upon which an action for negligence stands (Dimond 2011). In order for a claim to be successful the three statements listed below must be proved:
- The professional (being sued) owed the claimant a duty of care.
- The professional breached that duty of care.
- The breach of the duty of care caused the claimant loss (Herring 2012).
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Failure to comply with the recommendations made by the PCC could, if a claim for negligence were to be made, leave the employee liable. The use of a best practice checklist (Table 1) can help individual practitioners, managers, surgeons and academics ensure that compliance with the PCC standard is achieved.

Conclusion

Many perioperative practitioners may have already undertaken some aspects of the duties of a surgical first assistant without the relevant education, training and risk assessment. This raises questions about the standing of their employer’s vicarious liability and professional indemnity cover. It also raises professional issues with regulating bodies, as their registration may be placed at risk if adherence to their scope of practice or duty of care was questioned. By undertaking a suitable, validated, training programme based on proof of competence, which is supported by a local clinical governance framework, both the SFA and their employer can be satisfied that the criteria necessary to avoid legal and professional conflict are met.

Since the merger of National Association of Assistants in Surgical Practice (NAASP) with the Association for Perioperative Practice, AfPP is now leading in setting the standards for non-medical surgical assistants. Contact the Advancing Surgical Roles specialist interest group via the AfPP website for more information.

Can you demonstrate that there is/are:
- a service requirement for the SFA role?
- managerial, medical and nursing/allied professional agreement and support?
- approval from the clinical governance committee?
- a completed risk assessment?
- access to a validated SFA training programme that reflects the recommendations of the PCC?
- clear responsibilities detailed in the job description, supported by local policy?
- a role specific appraisal framework?
- stringent documentation and record keeping?
- sufficient liability insurance for each individual practitioner?
- awareness of the professional and legal obligations?
- evidence that patients are informed of the SFA role?

Table 1 Surgical first assistant best practice checklist

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<th>Details</th>
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<td>5. Health and Care Professions Council 2008 Standards of performance,</td>
<td>conduct and ethics London, HCPC</td>
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<td>6. Health and Care Professions Council 2012 Your guide to our standards</td>
<td>for continuing professional development London, HCPC</td>
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References

Association for Perioperative Practice 2013a Surgical first assistant competency toolkit Harrogate, AfPP

Association for Perioperative Practice 2013b Voluntary code of conduct for registered practitioners Harrogate, AfPP


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