Becoming a advanced scrub practitioner

I qualified as an Operating Department practitioner in September 2005, since qualifying I have worked hard to consolidate my training and look for ways in which to develop my career. Six months ago my theatre manager approached me and asked if I would be interested in undertaking a course at university to become an Advanced Scrub Practitioner. Before I accepted the offer I had to read up on what the role was and what it entailed. I found that the role of the Advanced Scrub Practitioner is what was previously known as the First Assistant. The Peri-Operative Care Collaborative (2007) refer to an Advanced Scrub Practitioner as being a registered peri-operative practitioner providing competent and skilled assistance under the direct supervision of the operating surgeon while not performing any form of surgical intervention. However in order to undertake these roles they must have specific training and qualifications in order to undertake certain skills that a Scrub Practitioner would not be able to undertake. In 1993 the National Association of Theatre Nurses (NATN) lists the skills required by the First Assistant, these are: patient positioning, skin preparation, draping, holding retractors in place, handling tissues and organs, use of suction, haemostasis using swabs and indirect diathermisation, cutting sutures and ligatures, more recently skills that have been added include catheterisation of both male and female patients and camera holding for laparoscopic operations.

Theatre practitioners began the role of First Assistant during the second world war when there was a shortage of surgeons, however this became a more formal arrangement in 1989 when according to Higgins (1997) the government decided that the number of hours being worked by junior doctors was not acceptable, so they looked at ways in which to reduce these

hours, this included passing down tasks to Nursing staff that had previously been thought of as a doctors role. For example assisting with surgery.

Carrying out this new role would have an impact on the Nursing Staff, they will have an increased duty of care for the patient and also a greater amount of accountability and responsibility. Hind states that there are four areas that should be considered when undertaking this increased role. These being Professional, Legal, Contractual and Self,

Professionally the Nursing and Midwifery Council (2008) states that Nurses must provide a high standard of practice and care at all times and they must recognise and work within the limits of their competence they must also keep their knowledge and skills up to date throughout their working life. Whilst the Health Professions Council (2008) states the an Operating Department Practitioner's scope of practice is the area or areas of their profession in which they have the knowledge, skills and experience to practice safely and effectively, in a way that meets our standards and does not pose any danger to the public or to the practitioner.

Legally, theatre practitioners are accountable to the public for their acts or omissions via criminal law and to the patient via civil law. Therefore if a practitioner does not feel they are competent to perform a specific role they have a duty under civil law not to undertake the task (Bernthal 1999), this is also set out in the standards of conduct both by the NMC and the HPC as mentioned above.

Contractually, employers have the right to say what their staff will do and how they will do it. This can sometimes put the practitioner under pressure

to do specific tasks that they may not have the skills or competence to do. The staff member has a responsibility to the patient to not perform tasks they are not competent in, but on the other hand they also have a responsibility to their employer under the terms of their contract of employment. To combat this employers have an obligation to provide sufficient training to enable their staff to perform the tasks expected of them (Bernthal 1999).

Self, Bernthal (1999) discusses practitioners have a legal and moral duty towards the patient. Part of this duty is to ensure that they keep themselves educated and up to date in current best practices. This was also mentioned earlier by the NMC in their code when they stated Nurses must keep their knowledge and skills up to date throughout their working life (NMC 2008).

For this assignment I will attempt to reflect on my role as an Advanced Scrub Practitioner and how I have developed into the role personally and professionally, the reflective model I will use for this will be Borton, What, So What, What Now (Borton 1970) . Throughout the assignment care will be taken to adhere to the Standards of Conduct, Performance and Ethics (Health Professions Council 2008) to ensure that a professionalism and confidentiality is maintained at all times, I will do this by ensuring where I refer to a colleague or patient confidentiality will be maintained by the use of pseudonyms.

Before carrying out the role of the Advanced Scrub Practitioner I had to ensure that the department had carried out a sufficient risk assessment for

the role. The Health and Safety Executive (2010) defines a Risk Assessment as:

“ A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm.”

(Health & Safety Executive 2010)

For the role of Advanced Scrub Practitioner the risk assessment looked at items such as how much harm could I do to the patient performing my newly acquired skills and what measures were in place to minimise the risk or likelihood of them occurring. It also looked at what harm can come to me whilst carrying out the new role, one specific area that had increased with the new role was risk of needle stick injury and splashes of bodily fluids into the eye. The reasons for the increase was you are now a lot closer to the patient therefore a higher chance of splashes in the eye, the control measure for this was to ensure eye protection is worn at all times when scrubbed at the table. The increase in risk for needle stick injury was due to the fact you are now assisting with the operation therefore your hands and fingers are in the direct field of operation, the control measure for this was to ensure you wear double gloves, ideally they should be reveal gloves which means if you puncture your top gloves you get a visible warning by a change of colour in your glove. As we have already had members of staff complete the Advanced Scrub Practitioner course the risk assessment was in place and was appropriate for the task. The risk assessment should be reviewed

annually or sooner if an incident occurs which may affect the risk assessment (Health & Safety Executive 2010)

Throughout the Advance Scrub Practitioner course I have tried to work across a variety of specialities, however the one that sticks in my mind the most was when I working within the Vascular Theatre. I was assisting the Consultant Vascular Surgeon with a Carotid Endartrectomy, this operation is carried out when the Carotid Artery, which is the main blood vessel that supplies the brain with oxygenated blood becomes occluded or stenoses due to atheroma, and therefore reducing the volume of oxygenated blood going to the brain (Kingsnorth & Majid 2006). The majority of patients who undergo this operation present with similar symptoms, which can include the patient suffering either a transient ischaemic attack (TIA) which will cause them to visit their Doctor, the condition is then picked up or at least investigated by their GP or the other way it presents itself is the patient will suffer from short spells of temporary blindness or what is referred to as the curtain effect, this is when the patient will feel as if a curtain has come down over their eyes it will lift again after a few moments, because these symptoms are not as well known as the TIA the patients do not go to their Doctor therefore it takes longer for these patients to be diagnosed. Almost certainly all patients that suffer from this condition are smokers or have been smokers, which is the biggest cause of this condition. If they are left untreated they are at risk of having a major stroke within the next couple of months (Ellis et al 2006).

Prior to the Operation I went to the ward to carry out a pre op visit with the patient. The patient (Mr Black) was a fit and well gentleman who has always been active, he lives with his wife and has two children with six

grandchildren, he lives in a small village with lots of his friends close by, before he retired he and his wife used to own a golf club so he was very busy with running the business, however as with most of the patients who suffer from this condition Mr Black used to smoke forty cigarettes a day, he quit smoking two years ago, he says he did it for his family. Mr Black was diagnosed with having a blocked Carotid Artery in December after suffering from a stroke in November where he collapsed and lost consciousness for ten minutes as a result of the stroke he had left sided weakness for one week and suffered from slurred speech for two days. In view of this Mr Black was treated as a high risk case and was operated on as soon as possible. Mr Black had already undergone a pre-operative assessment with a Doctor who will have taken a history from Mr Black, then examined him and listened to his heart and lungs and more than often send off blood investigations (Ellis et al 2003) and consent him for his operation. When I visit the ward as an Advanced Scrub Practitioner, I go there to introduce myself to the patient and explain my role within the team, I check that all the paperwork is in place such as pre-op checklist, consent forms and blood results. I also check as to whether the patient should have thromboprophylatic treatment ie TED stockings.

By checking all this it helps to cut down on delays within the Theatre Department. Just before I leave I ask the patient if they have any questions. Most of the time they do not have questions however there have been a couple of occasions when the patient has asked me to clarify something they did not understand when the Consultant spoke to them. I find that the patient finds it easier to ask me questions as I am not a Doctor and therefore

they do not feel under pressure that you have to dash off to see the next patient. There has been one occasion when a patient asked a difficult question around breast cancer, I was no comfortable to answer her question as I did not want to give her incorrect information on such a sensitive topic. I said to the patient I am not really the right person to answer that question but I will get the consultant to come and discuss it with you if you like. The consultant explained the situation and put the patient at ease, the patient thanked me as she said she would never have asked the consultant as he is a very busy man. With me spending ten minutes with my patient pre-op it can help in so many ways, however what I tend to do now with the big cases is I go along with the consultant so they are close by should the patient have any questions.

Mr Black was anaesthetised and brought into theatre for the surgeon and myself to position. According to Servant & Purkiss (2002) for this procedure the patient is in the supine position with their head in a head ring, the head end of the table is slightly flexed down to created a 10 degree extension of the head, caution should be used when doing this to ensure you do not hyperextend the neck as this will cause nerve damage to the patient and also distort the anatomy of the patient thus making it unnecessarily difficult for the surgeon. Then we apply a small amount of reverse trendelenburg to the table, this is to lower the pressure on the vessels within the neck. Pressure areas are then checked and a bair hugger applied to maintain normothermia.

I then scrubbed, donned my gloves and my gown checked the patient allergies and prepped and draped the patient ensuring a sufficient surgical

field was exposed for the surgeon. Before prepping it is important that we check the patient is not allergic to the prep for obvious reasons, however one thing I did not know until I was on my Advanced Scrub Practitioner course was that you should not use iodine based products on pregnant women or women who are breast feeding. This topic was raised during an infection control lecture at the university when one of my fellow students mentioned it. I had never heard of this before so I read up around this and found it to be true. Since then I have discussed this with my senior colleagues at work who too had not heard of it. I contacted our medicines information service within our pharmacy department who completed a literature search and also contacted the suppliers to find out exactly what were the risks, severity and likelihood related to its use. Since then we have had formal feed back from pharmacy advising us against the use of iodine based products in pregnancy and breast feeding ladies as it is linked to cause thyroid problems with the baby (Adams Health Care 2003). This made me realise the importance of networking and discussing your practice with colleagues, I also realised if it had not of been for my Advanced Scrub Practitioner course I would not of been aware of this, therefore it would not of been researched by pharmacy and we would be putting our patients at potential risk of problems with the baby. We now have to use a chlorhexadine based product as an alternative for our pregnant or breast feeding patient, it has also been added to the risk assessment that is carried out on staff members when they inform us they are pregnant.

Now that we had prepped and draped we could start the procedure, Mr Green the Consultant Vascular Surgeon begins to make the incision, as he is

doing this he is providing traction to one side of the skin, it is my job to provide equal and opposite traction on the other side. Providing traction to both sides of the incision site help to prevent oozing from the skin edges (Kirk 2002), it is important that the traction is equal otherwise you would distort the anatomy of the patient. Mr Green then begins to dissect down using blunt dissection, sharp dissection and diathermy, diathermy was introduced into the operating theatre in the early 20th century, it was introduced to achieve haemostasis and to cut through tissue (Meeker & Rothrick, 1999). Cutting and coagulation is achieved by the use of electricity, the electricity passes through the diathermy machine where it is converted into a high frequency alternating current, which then produces heat. This heat is used to control the bleeding by coagulating the blood vessels or to cut through the tissues it self. As an Advanced Scrub Practitioner I am able to apply indirect diathermy, indirect diathermy is when the surgeon has located a bleeding vessel they hold it with a set of forceps, I then have to apply the diathermy to the forceps which will carry the current down to the tissues to coagulate them. The first time I performed this skill I was a little bit weary as if you do not touch the forceps correctly you can create a spark when you press the foot switch to activate the machine, this could potentially be an ignition source for a fire, therefore extra care should be taken when performing this skill.

During the dissection phase I have to try to maintain a bloodless field, I try to achieve this by using the suction to remove the bulk of the blood and then use swabs to absorb the remaining parts. You have to time this right so as you are not hindering the surgeon by getting in his way but you have to do it

often enough that he can still see what he is trying to dissect. To assist with the exposure we used 2 self retainers, which are instruments that are designed to hold the wound open for you to allow access for the surgeon. We then identified where we needed to perform the endartrectomy, it was in the Left common Carotid Artery just above the bifurcation, according to Garden et al (2002) this is one of the most common site for endartrectomy. Mr Green then got 3 vascular clamps ready, these were to clamp above and below the atheroma and the bifurcation too. He then got an internal shunt and filled it with heparinised saline, the internal shunt will maintain cerebral blood flow whilst the blockage is removed (Garden et al 2002). At this point in the operation I was feeling very nervous, we were about to clamp Mr Black's blood supply off to his brain, I had to make sure I was ready with the suction as when Mr Green cuts into the artery and inserts the shunt there will be a lot of arterial blood filling the surgical field.

Mr Green clamped the artery and inserted the shunt without a problem, we then had to remove the plaque from the walls of the artery, this again was a tense moment for me as I had to keep the suction on to suck up any small pieces that came away, I also had to squirt heparinised saline into the operative site to stop it from drying out. After we had removed the plaque Mr Green began to close the artery using a single continuous spiral suture, I had to follow him keeping the tension on the suture otherwise it would have created holes for the blood to seep through. Mr Green then removed the shunt and finished closing the artery, he then asked me to cut the suture, again I felt very nervous I had to cut a suture that was holding an artery closed if I slipped I could of either nicked the artery or cut the suture too low

and it may have come undone. I steadied my hand and cut the suture “ perfect” said Mr Green, I breathed a sigh of relief we had gotten through the difficult portion of the procedure all we had to do now was insert a drain and close the wound.

When the operation had finished Mr Black was transferred to his bed and woken up from his anaesthetic, before leaving the theatre Mr Green checks that Mr Black has movement in all his limbs and can follow basic commands such as squeeze his hands. This is to assess if there are any signs of neurological deficit which could have been caused by the prolonged clamping of the artery or a small fragment of plaque travelling up into the brain.

The patient is then taken to recovery for approximately 30 minutes where he will have his level consciousness, heart rate and rhythm, blood pressure, respirations and temperature recorded (Association of Anaesthetists of Great Britain and Ireland 2002). Upon discharge from recovery Mr Black will spend the night on the High Dependency Unit, this is for close monitoring purposes, I visited Mr Black on HDU the next morning he was sat up in the chair looking very cheerful, he was later discharged to the ward.

Looking back on this case and how complex it was compared to the cases I had started off doing made me realise that I had actually started to develop into an Advanced Scrub Practitioner. I had improved over time with assisting with haemostasis and using indirect diathermy, also using a fine suction when dissecting the artery. Even though I had started to evolve into my new role I still had the respect for the dangers associate to the task I was carrying

out, for example when I was nervous cutting the sutures on the artery I took my time and concentrated on what I was doing, I did not just think I've cut sutures before its not a problem. I found that I could understand the theory side of the course, but it did not really click into place until I physically was carrying out the role, they say practice makes perfect, I found this to be true.

Reeves and Parker (2003) agrees that this method of learning and education is a good way of gaining in sight into a skill, and go on to discuss about how teachers should plan learning to enhance memorabiltiy. Reeves and Parker (2003) also describe how in order to get a student to retain information you need to get the information into their long term memory, this can be done by appealing to their senses touch, taste, smell, hearing and sight. They then go on to discuss ways of making the information stick, one of the methods used is repetition.

However Rogers (1983) disagrees and states that practiced based learning is the most effective way of learning a new skill. He would deem that the best way of learning would be through programmed learning and literature along with self initiated significant learning. Rogers also goes on to say it is not the aids, books or method of presentation that creates the best for learning but it is the attitude and personal relationship between the teacher and the learner which creates the best situation for learning. Personally I do not agree with the first part from Rogers in that, the best learning takes place via the text books, through research it has shown that this may be an older style of teaching hence why there is a 20 year difference between Rogers and Reeves & Parker.

The Advanced Scrub Practitioner course as a whole has not only taught me to become an Advanced Scrub Practitioner but it has taught me how to become a better practitioner on the whole. I have learnt so many new things that are not just relevant to the advanced role but also relevant to my current role as Anaesthetic and Surgical Team Leader. I can apply parts of the course to all aspects of my work, which I can pass on to my colleagues and to the students.