Chapter 1

The Caring Perioperative Practitioner

Julie Quick

Introduction

Care, defined as the process of protecting someone and providing what that person needs [1], is a fundamental principle at the centre of operating department practice, which subsequently links to every chapter of this book. Care is not a single event and therefore the definition of the word can be more complex, as care is provided in several different settings including the pre-, intra-, and postoperative phases of the patient's journey. The care provided depends upon several factors including the needs of the patient, the setting where care is provided, and who provides the care.

The principle of care should not be considered in isolation. As one of the '6Cs' (see Table 1.1), care should form one of the foundational values inherent in all healthcare professionals [2]. To provide care without compassion or commitment simply becomes a task, and without competence it may be unsafe. Poor communication skills or the lack of courage to speak up could put patients at risk. Consequently, the provision of high-quality care delivered by compassionate and competent practitioners and aligned to all the 6Cs forms part of the UK's National Health Service (NHS) Constitution that puts the patient first and ensures the care they receive is safe and effective [3].

Perioperative Care

There are several prefixes associated with the word 'care' and this is often confusing, particularly when some terms appear to be associated with different disciplines. Nursing care is a term usually associated with the care nurses provide due to the historical role of nurses as the main caregivers in hospitals or community settings. With the emergence of the operating department practitioner (ODP), perioperative care can be defined as the care provided by any practitioner working within the operating theatre. However, care does not always have to be delivered by registered practitioners. Theatre support workers (TSWs), other theatre team members such as students, apprentices, nursing associates, and other caregivers such as family members may also provide certain aspects of care within the patient's journey. Those who

Table 1.1 The 6Cs [2]

Care	Compassion
Courage	Commitment
Competence	Communication

provide care often have an instinct to care but healthcare practitioners learn additional skills required to care for patients through experience, training, and education [4]. In this chapter, care is explored in relation to that provided by perioperative practitioners whether they are ODPs, nurses, or non-registered members of the team. Supervised students within the disciplines of operating department practice and nursing may also find this chapter useful to identify the fundamental principles of perioperative care.

Theories of Care

A theory is a set of ideas and concepts that attempt to explain or predict something, often formulated by people who are experts in their field. Several theories have been put forward to explain concepts of care in health and the social sciences. The majority of these emerged in the mid-twentieth century, derived by nurses to develop an evidence base to move away from the myths and ritualistic practice often seen in nursing at the time [5]. To examine each theory in depth is beyond the remit of this chapter and so overviews of some of the more well-known frameworks and their models are provided within Table 1.2.

Models of Care

While theories of care examine the wider concepts of care delivery, models of care are deeper, multi-layered concepts, which provide a detailed view of how care is delivered [7]. At their broadest sense, models of care refer to where care is delivered, as seen in the new care models programme for the NHS [8]. This programme aims to improve care and coordinate services. Within this model, surgery and, consequently, perioperative care, are often provided in a purpose-built operating theatre although patients requiring minor procedures such as excision of a skin lesion may be offered the option to have their surgery performed in a primary care setting such as general practice.

At a clinical level, models of care identify who will provide the care. Historically, care was often based upon the disease the patient presented with rather than their individual needs. Even today, treatment still follows this medical model of care, using disease-specific evidence-based clinical guidelines [9]. In the nineteenth century, Florence Nightingale identified that nursing care should be assessed on an individual basis and all care provided should be holistic in nature [10]. Holism can be defined as the recognition that all aspects of an individual – the physical, social, psychological, and spiritual needs – are attended to with equal importance [10]. Therefore, perioperative practitioners need to consider the patients' physical, psychological, and emotional needs (while respecting their social and cultural beliefs), rather than just the surgery or procedure that the patient is undergoing.

As identified earlier, care is not a one-off episode but a process whereby patient needs are identified, planned, and managed [11]. This process is often called the 'nursing process' since the concept of a methodological approach was established by nurse theorists in the 1950s. This has since been developed to reflect the complexity of care requiring critical thinking and decision-making skills and to acknowledge the inclusion of practitioners from other disciplines in caring for the perioperative patient. Within the perioperative environment, care is delivered in three, often separate, phases: the pre-operative, intraoperative, and postoperative phase. Patients' needs will differ in each stage, with each one often determining care required in the next. Aspects of care will also vary depending upon whether the surgery is elective, urgent, or an emergency. Any episode of perioperative care should be assessed, systematically diagnosed, planned,

Table 1.2 Nursing models (adapted from [6])

Model	Main concept	Aspects of care assessed	Framework through which care is assessed
Peplau's interpersonal model	Emphasised the nurse–client relationship as the foundation of practice	Orientation Identification Exploitation Resolution	Observation Description Formulation Interpretation Validation Intervention
Orem's self-care model	Encourages independence	Model looks to identify the needs that patients have or acquire	History taking Planning care Intervention Evaluation
Roy's adaptation model	Person is constantly adapting to surroundings	Physiological Self-concept Role function Interdependence	Assessment Nursing diagnosis Goal setting Intervention Evaluation
Roper, Logan and Tierney's activities of daily living model	Looks to assess how well a person performs each of the 12 activities of daily living	Breathing Eating and drinking Eliminating Mobilisation Sleep/rest Washing/dressing Temperature control Hygiene Maintain safe environment Communication Death and dying Working/playing	Assessment Planning Implementation Evaluation

implemented, rechecked, and evaluated. This is called the ASPIRE process of care and is an adaptation of Yura and Walsh's assessment, planning, implementation, and evaluation (APIE) process [5]. Using this process allows perioperative practitioners to identify and document patient care needs, justify why that episode of care was carried out and provide an evaluation of that care [5]. This process is carried out using the framework of a nursing model such as those detailed in Table 1.2 and forms the basis for a care plan [12].

Due to the critical nature of surgery, care planning in the operating theatre may appear buried in the urgency of the practitioner's work or even appear to be non-existent [13]. The perioperative practitioner has a short timeframe to establish a rapport with the patient and must assess their care needs quickly. Within the operating theatre, practitioners become

experienced in prompt care planning to ensure that the care delivered is not only safe and effective but also efficient and responsive.

Assessment

The assessment of the surgical patient can take place in several different settings, such as the preoperative assessment clinic a few weeks before the planned operation, on the day of surgery, or in the anaesthetic room. Assessment involves collating information about the patient by talking to them or a family member, reviewing medical records, performing baseline observations, and liaising with the ward and medical staff. This first stage of the nursing process allows the identification of an individual patient's needs by using a problem-solving approach to allow the assessment of existing or potential problems a patient may have.

Assessment in the perioperative setting is often carried out in the form of risk assessments to ensure patient safety and prevent complications [13]. The use of the National Patient Safety Agency (NPSA) *Five Steps to Safer Surgery* documentation incorporating the World Health Organization (WHO) Surgical Safety Checklist [14] also allows for the assessment and identification of potential problems that can be communicated to the whole team. Using these tools, the perioperative practitioner can ascertain the care that will be required during anaesthesia, surgery, and postoperative recovery. For example, on handover from the ward nurse, the anaesthetic practitioner (ODP or nurse) is informed that the patient is worried about the surgery and so she introduces herself to the patient with the aim of forming a therapeutic relationship and takes the time to explain her own role in the procedure in a calm and gentle way. Developing this type of interpersonal relationship where the perioperative practitioner demonstrates empathy and a genuine interest allows the opportunity to help the patient navigate their care [15]. When baseline observations are taken in the anaesthetic room, they confirm patient anxiety – his heart rate and systolic blood pressure are above normal limits. The anaesthetic practitioner identifies that anxiety may also be a potential problem during the surgery due to the planned spinal anaesthetic, as the patient will be awake for the procedure.

Systematic Diagnosis

Once all pertinent information is gathered in the assessment stage, this is documented in the patient's care plan, allowing them to consider this information and diagnose the care that is required for the patient. The anaesthetic practitioner in the above example detects that the patient's anxiety levels may well worsen due to the nature of the surgery and anaesthetic. She records this on the care plan and considers how she and the team can plan care to help reduce the patient's anxiety. Having carefully looked through the patient's notes she identifies that the patient has chronic obstructive pulmonary disease and reasons that the patient is not being sedated due to the increased risk of respiratory complications. She shares this information with the anaesthetist who confirms this is the case.

Planning

When the assessment and diagnosis stages have been completed, the perioperative practitioner plans the exact aspects of care required and communicates this to the patient and appropriate members of the team. The anaesthetic practitioner in the example above

suggests to the patient that he may like to listen to some music during the procedure to reduce the amount of noise the patient hears when the surgery is underway. She also suggests to the team that background noise is kept to a minimum in theatre to avoid causing additional patient anxiety.

Implementation

After planning the care required for each patient, the next stage is to implement the planned care. Who delivers that care will depend upon what aspect of care needs to be implemented and the role and responsibility of the specific practitioner. All members of the team should be trained to nationally recognised standards, which means that only practitioners who have undergone a university-accredited training programme can perform the role of the anaesthetic practitioner [16]. Following additional training, some practitioners may go on to provide aspects of enhanced or advanced care within the perioperative setting, practicing as surgical first assistants, surgical care practitioners, or anaesthetic associates (see Chapter 39).

In some instances, a team approach may be required, such as when positioning the patient for surgery. After the patient is positioned on the operating table, the anaesthetic practitioner asks the circulating TSW to access some headphones and an electronic tablet, ready for when the surgery commences. The TSW asks the patient what music he would like to listen to and then helps the patient select his choice for the duration of the procedure. During the surgery, the patient asks if everything is fine and the scrub practitioner and surgeon relate that all is progressing well. The patient is reassured, further alleviating his anxiety.

Recheck and Evaluation

In these final two stages of the care process, the care that is being delivered is initially rechecked. Using the same example, during the procedure the TSW checks that the patient is still listening to the music and is comfortable. The anaesthetic practitioner rechecks the patient's heart rate and blood pressure to ensure that they are stable, indicating that his anxiety has reduced. When the surgery has finished, the surgical team reassures the patient that the surgery went well. The Sign Out stage of the WHO Surgical Safety Checklist is utilised in this stage of the care process to ensure all key information is collated and handed on to other team members now taking over the patient's care. In this example, it is handed over to the recovery practitioner, who is made aware that the patient was anxious preoperatively but his fears have been alleviated with reassurance and the use of music therapy. In the post-anaesthetic care unit, the recovery practitioner introduces himself to the patient and evaluates the patient's anxiety level by checking with the patient. He reports that he feels much better and the practitioner notes that his baseline observations are within the normal physiological range. At this point in the patient's journey, the practitioner also performs an initial postoperative assessment to identify any new or potential problems; and so the perioperative care process commences again until the patient meets the discharge criteria to return to the ward.

Recording Care

Within the perioperative setting, several different documents are used to record individual aspects of care at different times in the patient's perioperative journey by different members

of the team. This includes but is not limited to the surgical checklist, consent form, theatre care plan, theatre register, operation notes, and discharge checklist. In some departments, these documents are collated together to form one document, which specifies and records key aspects of care. Often used for patients undergoing surgery, this model is often known as an integrated care pathway (ICP) and allows the assessment of individual patient's needs and identification of the care that has been planned, implemented, and evaluated through each step of their journey [7]. Documentation of care is a legal and professional requirement [17–19]. If any aspect of care is not recorded, then it may be deemed not to have been performed and, subsequently, care plans and ICPs may be used as evidence when investigating a complaint regarding care or if required during a court case. It is therefore essential that documentation is completed to provide an accurate, legible, and contemporaneous record of the assessment, management, and evaluation of the patient's needs [20].

Scope of Practice

The scope of practice describes the limits of a registered practitioner's knowledge, skills, and experience. As identified in the implementation stage, the care provided in the operating theatre will depend upon both patient need and the boundaries of a perioperative practitioner's knowledge, skills, and prior experience. Working within their professional scope of practice ensures that, while responding to the needs of patients, practitioners only carry out aspects of care that they are trained and experienced to undertake [17, 18]. The role and responsibilities of a perioperative practitioner will vary depending upon what is outlined in an individual's job description, contract of employment, and organisational policy. Providing patient care that falls within their role remit, training, and scope of practice ensures the care provided is safe and of a high standard, and protects practitioners against litigation.

Monitoring Care

The monitoring of care is essential to protect those receiving it. For any health and social care organisation the provision of care is regulated by four independent bodies in each of the countries of the United Kingdom. The Care Quality Commission, Care Inspectorate, Healthcare Inspectorate Wales, and the Regulation and Quality Improvement Authority are responsible for ensuring care meets national standards in England, Scotland, Wales, and Northern Ireland, respectively. Each independent regulator inspects, monitors, and rates healthcare services, publishing findings to facilitate patient choice. When care is judged to fall below the expected standard, the regulator takes action to help the organisation improve services to ensure that care provided is patient centred, dignified, and safe [21]. Furthermore, health organisations monitor care through a framework known as clinical governance that includes audit and research [7].

The provision of care is also monitored by professional regulatory bodies such as the Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC), who set the standards for education and practice ensuring that each registered practitioner provides care that is safe and effective, safeguarding high standards of care [17, 18]. Non-registered practitioners such as the TSW are not regulated by a professional body. However, like registered practitioners they are responsible through a duty of care to their employer and the patient for the care they deliver [19]. Perioperative practitioners also have a professional obligation to monitor the care they provide through reflecting on their

practice [22, 23]. Reflection is an integral part of professional development that can help practitioners gain a deeper understanding of themselves and the care they provide [24].

Summary

This chapter has defined the principles of perioperative care delivered by registered and non-registered practitioners within the operating department. Perioperative care is a systematic, cyclic, and dynamic process whereby the current and potential needs of each patient are assessed, managed, and evaluated on an individual basis at each stage within their perioperative journey. Ensuring that perioperative care is safe and effective is monitored by healthcare organisations, regulatory bodies, and independent regulators across the UK. Adhering to their scope of practice ensures that the care a practitioner provides within the operating theatre is safe and delivered to a high standard.

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Chapter 2

Evidence-Based Operating Department Practice

Paul Rawling

Introduction

Safe and effective healthcare underpinned by a sound evidence base is considered the gold standard of quality and compassionate patient care. For example, before any new practice, surgical technique, drug, or technology are used in the operating department it is essential that their implementation is based on high-quality evidence that has been critically appraised [1]. Evidence-based practice (EBP) is commonly assumed to be reducible to empirical research. Despite its value, it should also be integrated along with clinical experience and expertise to enhance clinical performance and ensure effective clinical decision making [2, 3]. The roots of EBP can be found in the desire to move away from unsystematic and ritualistic practices [4, 5] and towards an approach to patient care that is systematic and supported by a sound evidence base. EBP can easily just become a buzzword and so it is vital that perioperative practitioners clearly understand what it is, what it demands, and what can hinder its implementation.

What Is Evidence-Based Practice?

In 1996, David Sackett et al. [6], defined EBP as the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. This provided a broad definition of what EBP was that included the best available evidence at the specific point in time, and acknowledging that this could change over time, in conjunction with clinical expertise and experience, and the inclusion of patient preferences and values.

EBP can be summarised as having three core elements [7, 8]:

- the integration of the best available evidence from accepted robust and reliable research;
- professional expertise; and
- patient choice and values.

In perioperative care the three core elements of EBP are readily seen, although practitioners are often required to presume that patient preferences have been discussed prior to their arrival in the operating department. It is never ideal practice to start considering changes to care or consent following the patient's arrival.

Why Is Evidence-Based Practice Important?

EBP is important because it is the primary means of ensuring that patient care is effective, safe, and improving. All practitioners from the most junior to the most senior should be willing and able to question current practice because this is the primary means by which the standards of care will continue to develop and improve [9]. One way that EBP can be utilised

is to promote standardisation of practice that leads to a reduction in the variance of care [10]. An example would be the National Safety Standards for Invasive Procedures (NatSSIPS), which are standards all practitioners are tasked with meeting to reduce the incidence of never events and other serious incidents. A further example would be the use of the World Health Organization (WHO) Surgical Safety Checklist. These strategies do not just appear from the ether, they are based on evidence and are developed to improve patient outcomes and ensure patients are kept safe. EBP is essential to continue improving the quality of patient care and to ensure it is safe.

Where Can Evidence Be Found?

It is important to understand where evidence can be found, what it looks like, and how valuable it may be. In real terms there is a clear hierarchy of evidence, which places different forms of information and knowledge into a broad list from high- to low-quality evidence. The higher up the hierarchy something is, the more likely it is that the methodology and study design will have reduced the likelihood of bias affecting the findings of the study. Systematic reviews provide a comprehensive and careful summary of all the available empirical evidence in response to a clear research question. They use explicit and transparent methods to reduce bias and provide replicable findings that can then be used to assess the effectiveness of the intervention and inform recommendations and changes to practice. It is rare that a single research study provides enough evidence to justify a change in practice. Therefore, a good systematic review can provide a sound basis for clinical decision making because there is a lower risk of being misled, which can happen when only considering the findings from one study. A basic evidence hierarchy [11] is set out below:

There are numerous sources of evidence that can be readily accessed. Importantly, evidence should always be critically appraised to ensure that it is not accepted at face

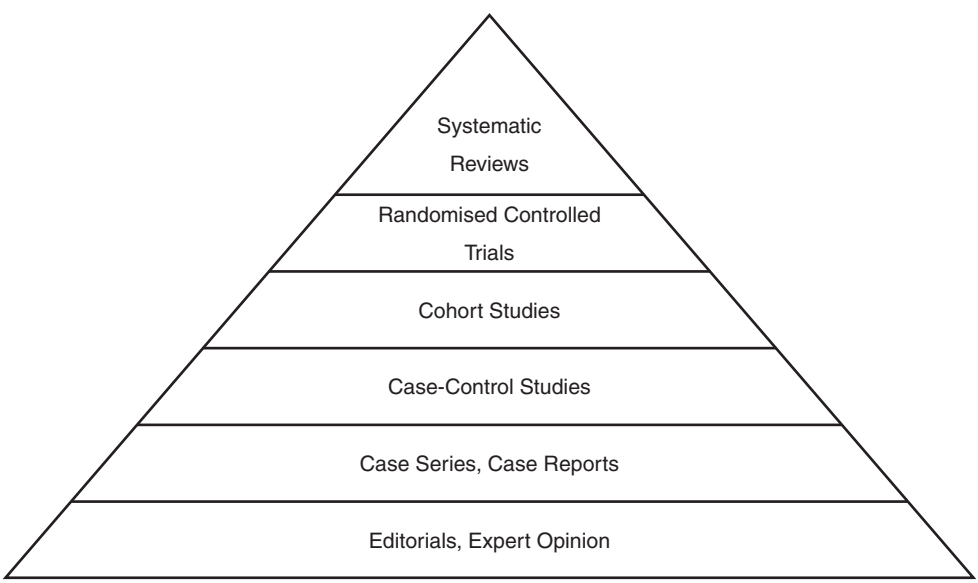

Figure 2.1 Basic hierarchy of evidence