

Perioperative nurse practitioners (NP) – the first two perioperative NPs are authorised in NSW



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Abstract

This paper explores the development and subsequent authorisation of the first two perioperative nurse practitioners in NSW. It locates their experiences within the wider debate concerning the evolution of advanced nursing practice and roles, both in Australia and globally. However, the focus is on the role of nurse practitioners (NPs).

The need for a collaborative, systematic and evidence-based process to develop perioperative NPs (like others), the lack of clarity about the terminology associated with advanced perioperative nursing practice, and the role confusion evident in the literature, was mirrored in the experiences of the two Sydney-based perioperative NPs. Their still-evolving role, associated activities and future directions are described here in detail. The external factors which contributed to NP role development are also addressed.

What is known about the topic

Advanced nursing roles, including those in perioperative settings, have been evident for many decades outside Australia. The development of NPs, particularly in Australia and New Zealand, is much more recent.

What this article contributes

It describes the development, role and activities of the first authorised perioperative NPs in NSW. It locates NP role development within a model of emergency surgery clinical redesign.

Introduction

Globally, over the past several decades, nursing practice has become more specialised in response to the increasing and changing needs of the consumers of health care; the relentless evolution of medical technologies and as a result of external environmental factors^{1,2}. Nursing specialisation can be more narrowly defined and associated with extended and/or advanced nursing practice³, and with the development of specialist competencies such as those developed by the Australian College of Operating Room Nurses (ACORN). Occurring in tandem with nursing specialisation has been the development of advanced practice roles^{1,2}. Like the unsuccessful calls by the International Council of Nurses (ICN) in the 1980s for nursing specialisation to occur in a coherent and orderly fashion⁴, so too, the evolution of advanced practice roles has been ad hoc and confusing. The literature is replete with a myriad of names, roles and functions associated with advanced practice nurses^{1,2,5,6}. However, it is beyond the remit of this paper to examine these; rather the focus is on one advanced role, that of the nurse practitioner (NP) which is, arguably, the most significant of these variously titled advanced roles⁵; and the development of the NP role within perioperative settings. Following an examination of advanced perioperative roles globally,

an overview of the evolution of NPs in Australia will be presented. Finally, the role and the journey travelled by the first two authorised perioperative NPs in NSW will be explored.

Overview of advanced perioperative nursing practice and roles

Advanced perioperative nursing practice has no authoritative, universally acknowledged definition and it encompasses a range of activities and roles. These have evolved in an ad hoc fashion and are often context-bound. Viewed on a continuum, they may be based on a narrow skill set practised solely with the operating room (OR), such as the perioperative nurse surgeon's assistant (PNSA), which some authors deem a role associated with extended technical skills and not one that appears to constitute advanced nursing practice^{7,8} (e.g. see Tanner, 2001, 2003). At the other end of this spectrum are advanced practice perioperative nurses, whose role and scope of practice extend well beyond the OR, traversing other departments and wards, and which encompass a broad range of skills/activities such as diagnosing patient conditions, ordering tests and referring patients to other health care workers^{9,10}. Additionally, in the United Kingdom (UK) some (called surgical care practitioners) also perform surgery¹¹. Many have teaching and research responsibilities.

Advanced perioperative roles are variously, and often contextually, described and/or titled; for example, in North America the registered nurse first assistant (RNFA) has equivalence with the PNSA, as does the perioperative specialist practitioner (PSP) in the UK. Advanced practice perioperative NPs may be formally recognised with a second level of licensure¹² such as occurs in North America and Australia but this is not universal. Some RNFAs/PNSAs have undertaken further training and have a combined RNFA/Acute Care NP role¹². Finally, the range of educational preparation for advanced perioperative practice varies from a few weeks to several years, depending on the location, role and activities performed.

NPs in Australia

In the 1990s, initially in NSW, and in other states and territories later, the NP role was developed to fill gaps in health care provision^{5,6,13}. NPs (like other advanced practice roles), were implemented in the United States of America and Canada in the 1960s^{1,14} and in other parts of the world such as the UK in the 1980s^{1,15}, ahead of Australia and New Zealand¹⁶. The evolution of the NP role 'down under' was associated with different priorities, and recommendations for accreditation and education of NPs have been more comprehensive in Australia than is evident elsewhere^{1,5}. Additionally, the centrality of expert clinical nursing judgement and the collaborative nature of the NP model within the Australian setting further distinguish the role^{5,17}. Australia has national NP practice competency standards, legislative protection of the title and a national definition¹⁸. The Australian NP is a:

...registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise¹⁸.

The surgical advanced practice nurse in NSW – background

The role of the surgical advanced practice nurse (APN) appears to be a new and innovative one. It evolved in response to an unmet need associated with patients requiring surgical care who were admitted to the emergency department (ED) of a principal referral hospital in NSW. Historically, patients admitted to Nepean Hospital were triaged and assessed by an ED physician who then (as appropriate) referred them to the 'on-call' surgical registrar. However, the latter were often scrubbed in the OR assisting with or undertaking surgery, or they were busy assessing their in-patients and unavailable to see ED patients for lengthy periods of time. This 'on-call' model of emergency surgical patient management resulted in surgeons not reviewing the patients in ED until after they had finished their elective lists and/or sessions in their consulting rooms and/or out-patient clinics. The problems identified with this approach to care were:

- 1) Delayed patient assessment.
- 2) Delayed operative management and subsequently, large volumes of surgery performed in the evening and out-of-hours.

- 3) Lengthy delays for patients waiting to see specialists, that is, ED was failing to meet NSW Department of Health (DoH) key performance indicators (KPI) for patient access and there was 'bed block' in ED.
- 4) Prolonged hospitalisation¹⁹.

Because of the above issues, access to appropriate care and services was suboptimal; and there was inefficient use of hospital resources such as emergency surgical lists, ward beds and staff for patients with acute surgical presentations. The APN role was instigated to address these specific needs and, in particular, to reduce the lengthy waiting time experienced by surgical patients in the ED at Nepean Hospital. It was achieved in due course by employing and training two perioperative nurses, whose role was to assess patients who were awaiting surgical review. The APNs were then to contact the appropriate speciality surgical registrar and ensure these patients were seen by the latter in a timely manner; the APNs also arranged patient admission or discharge as appropriate. The plan worked, the access breach rate dropped and Nepean Hospital met, indeed exceeded, this DoH KPI. This may have been the sum total of the surgical APN role; however, other forces were at work.

Clinical service redesign

The approach to emergency surgery management described above was also practised at many other hospitals – and it was equally problematic for them, too. Although it is tempting to believe that emergency surgery is unpredictable and cannot be planned for, this is not the case²⁰. It can be quantified, based on data such as individual hospital emergency surgery case load, range and volume of specialities offered, existence of an ED, surgical consultant availability, and hospital location and designation²¹.

Following on from a redesign of elective surgery services several years ago²², NSW DoH redesigned the management of emergency surgery, subsequently developing and publishing the *Emergency Surgery Guidelines* in 2009²¹. This document outlines a number of models of emergency surgery management, and the model selected by any hospital would be determined by the particular features of that hospital. One of these models, the *Acute Surgery Unit (ASU)* was the model of care implemented at Nepean Hospital to improve services to general surgical patients; it is patient-focused, and addresses issues such as infrequent consultant surgeon review of patients, unsupervised registrar activity and prolonged patient stays. This model suits hospitals such as Nepean, which are principal referral hospitals with a large emergency surgery case load and high case complexity²¹. It is also the model used at several other hospitals in NSW²⁰. The other factor that was influential to continuing role evolution was the abilities and experiences of the surgical APNs. These perioperative nurses were functioning at a very high level and possessed a skill set that was highly advantageous to the ASU team. Consequently, they were deployed to work solely in the ASU, which catered for general surgical patients. (Note: other surgical specialities remained on the old on-call model of care.)

The Nepean Hospital ASU

The Nepean Hospital ASU is an independent unit that admits patients through the ED for the assessment and management of all acute general surgical patients. A modified form of the first ASU, which had been established at the Prince of Wales Hospital, Randwick, was initiated at Nepean Hospital. The latter has a

dedicated team, including a consultant surgeon on-site for 12 hours and then on-call for 12 hours, surgical registrars, NPs and junior medical officers. In keeping with the precepts of this model, there are dedicated emergency operating sessions, for which ASU competes with other specialities, surgeon control of case priority, agreed clinical guidelines for common emergency surgical admissions, and formalised handover processes.

Once identified as a patient with a surgical issue by the ED physician, a consultation is requested, a member of the ASU team reviews the patient, and the appropriate treatment is commenced. If surgery is required, it is prioritised, booked in on the emergency list, and undertaken as determined by the consultant. The patient, once accepted by ASU, is transferred to an appropriate surgical bed in the hospital.

The entire ASU team meet at 7 am every morning in the ED to assess and review all patients admitted overnight, and/or to see any new referrals, so that their management plan can be formulated and implemented. All patients under the ASU team are then reviewed, by way of a paper round, anticipated problems addressed and plans made for the day. Finally, the team then reviews all of the admitted ASU in-patients.

This system has proven beneficial to both patients and perioperative staff. These benefits include:

- 1) More rapid patient assessment in both ED and the wards.
- 2) Daily consultant surgeon review of patients.
- 3) Reduced waiting times for specialist team review in ED.
- 4) Improved 'on call' services for trauma patients.
- 5) Improved in-hospital medical cover of surgical patients.
- 6) Improved registrar supervision and enhanced training opportunities.
- 7) Reduced length of patient stay.
- 8) More emergency surgery completed in standard operating hours.
- 9) Improved work conditions for consultant surgeons.

From APN to surgical nurse practitioner in the ASU

Additionally, this new model of care has brought benefit to the two surgical APNs, because joining the ASU team became a conduit for their further development – from APN to authorised NP. Responding to health service reform is a frequent driver of new or innovative roles²³ and this was the case here.

However, for the first two authorised (now titled) surgical nurse practitioners (SNPs) this has been a roller coaster ride from the beginning, in 2006, when they stepped into the APN role. In addition to moving into a traditional medical domain and learning a whole new series of skills (while keeping their nursing identity intact) they have also made the transition from the instrument/circulating role to functioning in the ED and on the wards, thus working in entirely different environments. This transition was made easier because of a long career working with the surgical consultants in the OR, intimate knowledge of the functioning of Nepean Hospital and their excellent communication skills.

Initially, the APN role was a static and fixed position with one aim: to get all the emergency surgical patients in ED reviewed as soon as possible. This included all general surgical, vascular, thoracic, orthopaedic, neurosurgical, plastic, facio-maxillary and urological patients who presented there. While a certain level of competence in patient assessment of all these specialities was developed, there was no specific focus or opportunity to develop in-depth skills (that is, each APN became a 'Jill of all trades') and consequently there was some dissatisfaction in the role. With the formation of the ASU and the embedding of the APN within this model of care, the incumbents were presented with a sharper focus, improved job satisfaction and an opportunity to develop into the NP role.

Consequently, they were employed in transitional SNP roles. Positive experiences that encouraged them to continue in pursuit of this new role were feedback from patients, their surgeon mentor(s), and the support and encouragement of the majority of their medical and nursing colleagues. Additionally, the attraction of fulfilling the advanced clinical role of NP enabled them to stay at the patients' bedside, which was more appealing than moving up the management ladder. The opportunity to work both independently and collaboratively within the multidisciplinary ASU team was also attractive.

As authorised SNPs, their proposed scope of practice includes physical assessment, formulation of provisional and differential diagnoses, ordering and interpretation of diagnostic tests, and referral of patients within their defined parameters. These activities enable effective SNP collaboration with the medical members of the ASU team, as they discuss and instigate treatment plans for surgical patients on an equal footing. This enhanced clinical component of their current role is gratifying; however, it is only one aspect of their role in the ASU. During the admission process or on team ward rounds, certain patients may need further physical or emotional support, and the SNPs provide this. Working within a nursing framework, the SNPs continually assess patients' progress and their ability to tolerate rapid throughput and expected timely discharge from hospital. In addition, the SNPs ensure the timely coordination of a myriad of services for ASU patients, enabling a speedier recovery. Any potential problems are identified sooner, and appropriate planning or referral to other services arranged. This ability to identify and address issues before patients are discharged has resulted in improved patient satisfaction and a lower readmission rate, compared to other surgical models. Additionally, as the consultant surgeon changes daily within the ASU, the SNP becomes one of the patients' 'constant caregivers' during their admission to hospital, improving continuity of care.

However, there were some negative experiences encountered along the way. A minority of nursing and medical colleagues displayed behaviours associated with horizontal violence, which was difficult for the SNPs to address at times. This may have originated from confusion about the SNP role or misinterpretation/lack of understanding related to their scope of practice and/or capabilities. Such behaviours are often prompted by initiatives like this new role²⁴.

Notwithstanding these challenges, the first two SNPs completed a Masters of Nursing (NP) program, and subsequently demonstrated that they met the rigorous NP requirements of the Nurses and Midwives Board, NSW; they were formally authorised in September, 2009. The acceptance of this role was highlighted when attainment of NP status was equally acknowledged and celebrated by their

nursing colleagues, all of the ASU medical team and their health service managers.

The future

The SNP role has seen an expansion of responsibilities beyond their initial APN role and they now participate equally in the decision-making and problem-solving for the ASU patients, thus facilitating their rapid transit through the surgical services of their health care facility, to discharge home. However, the next hurdle for them to cross is obtaining formal approval for their scope of practice, drug formulary and clinical protocols through the various local and area authorising bodies.

The experience of these SNPs has shown that there is certainly a need for this role within other areas of the surgical arena and it also resonates with the reformed model of health care discussed. Advanced clinical competence and skills are essential when caring for patients with specialised needs, and developing these requires a supportive environment and a multidisciplinary HC team prepared to embrace the role and individuals in them.

Education regarding SNP roles is imperative, in order to avoid confusion and misinterpretation surrounding the role and scope of practice. Promotion of this role is ongoing via dissemination of information about the value of the SNP with other health services locally, nationally and internationally, as well as through discussions with visiting surgical teams from other facilities, and presentations to DoH personnel, and medical and nursing professional enclaves. This paper should further that promotion, and promulgate the advantages to perioperative patient care associated with the SNP role – and encourage other perioperative nurses to pursue this advanced role, too.

Conclusion

This paper has described the introduction of an APN role and its evolution to a more formalised one, that of a NP within a perioperative setting. It did so against a backdrop of advanced nursing practice and, in particular, advanced perioperative roles, globally. It also situated the development of the role within the context of emergency surgical services redesign within NSW. The experiences of the first two perioperative nurses who have broken through the NP 'glass ceiling' are highlighted and their achievements acknowledged, as 'path finders' and clinical leaders.

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References

- Duffield C, Gardner G, Chang A & Catling-Paull C (2009). Advanced nursing practice: A global perspective. *Collegian*, Vol.16, pp.55–62.
- Sheer B & Wong F (2008). The development of advanced nursing practice globally. *Journal of Nursing Scholarship*, Vol.40, No.3, pp.204–211.
- Australian Nursing Federation (ANF) (1997). *Competency standards for the advanced nurse*. Melbourne: Australian Nursing Federation.
- International Council of Nurses (ICN) (1987). *Specialization in nursing: A discussion paper*. Geneva: ICN.
- Gardner A & Gardner G (2005). A trial of nurse practitioner scope of practice. *Journal of Advanced Nursing*, Vol.49, No. 2, pp.135–145.
- Reveley S (2001). Clinical nurse specialists, nurse practitioners and levels of practice: What does it all mean? In: S Reveley, M Walsh & A Crumbie (Eds). *Nurse Practitioners: Developing the role in hospital settings* (pp. 28–37). Oxford: Butterworth Heinemann.
- Tanner J (2001). First assistant activities. *British Journal of Perioperative Nursing*, Vol.11, No.4, pp.172–178.
- Tanner J (2003). Advanced practitioners within the operating theatre. *British Journal of Perioperative Nursing*, Vol.13, No.12, pp.514–518.
- Radford M, Abbassi A, Williamson A & Johnston P. (2003). Redefining perioperative advanced practice the nurse specialist in anaesthesia and emergency surgery. Part 1. *British Journal of Perioperative Nursing*, Vol.13, No.11, pp.468–471.
- Davis J (2006). Setting up the role of emergency surgical nurse practitioner. *Journal of Perioperative Practice*, Vol.16, No.3, pp.144–147.
- Gooding L (2004). Nurse begins training for routine hernia operations. *Nursing Standard*, Vol.18, No.19, p.7.
- Wadas T (2008). Expanding the scope of acute care nurse practitioners with a registered nurse first assist specialty. *AACN Advanced Critical Care*, Vol.19, No.3, pp.261–263.
- Carrier J, Gardner G, Dunn S & Gardner A (2007). The core role of the nurse practitioner: practice, professionalism and clinical leadership. *Journal of Clinical Nursing*, Vol.16, pp.1818–1825.
- Savrin C (2009). Growth and development of the nurse practitioner role around the globe. *Journal of Pediatric Health Care*, Vol.23, pp.310–314.
- Lloyd Jones M. (2005). Role development and effective practice in specialist and advanced practice roles in acute hospital settings: Systematic review and meta-analysis. *Journal of Advanced Nursing*, Vol.49, No.2, pp.191–209.
- Furlong E & Smith R (2005). Advanced nursing practice: Policy, education and role development. *Journal of Clinical Nursing*, Vol.14, pp.1059–1066.
- Reid M (2001). Nurse practitioners in NSW – the facts. *The Lamp*, December/January, 24–25.
- ANMC (2006). National competency standards for the nurse practitioner. Available at: http://www.anmc.org.au/userfiles/file/competency_standards/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf Accessed: November 2008.
- NSW Department of Health. Emergency Surgery Guidelines. Available at: http://www.health.nsw.gov.au/policies/gl/2009/pdf/GL2009_009.pdf
- Willis J, Meredith G, Cansdell D, MacLellan D, Cregan P & Deane S (2010). Emergency surgery redesign-what does it mean for OR nurses? *ACORN Journal*, Vol.23, No.1, pp.10–12.
- NSW Department of Health (2009). Emergency surgery guidelines. Available at: www.health.nsw.gov.au/policies/gl/2009/pdf/GL2009_009.pdf Accessed: April 2010.
- MacLellan D, Cregan P, McCaughan B, O'Connell T & McGrath K (2008). Applying clinical redesign methods to planned arrivals in New South Wales hospitals. *Medical Journal of Australia*, Vol.188, Suppl., pp. 23–26.
- Gardner G, Chang A & Duffield C (2007). Making nursing work: breaking through the role confusion of advanced practice nursing. *Journal of Advanced Nursing*, Vol.57, No.4, pp.382–391.
- Gilmour D & Hamlin L (2003). Bullying and harassment in perioperative settings. *British Journal of Perioperative Nursing*, Vol.13, No.2, pp.79–85.