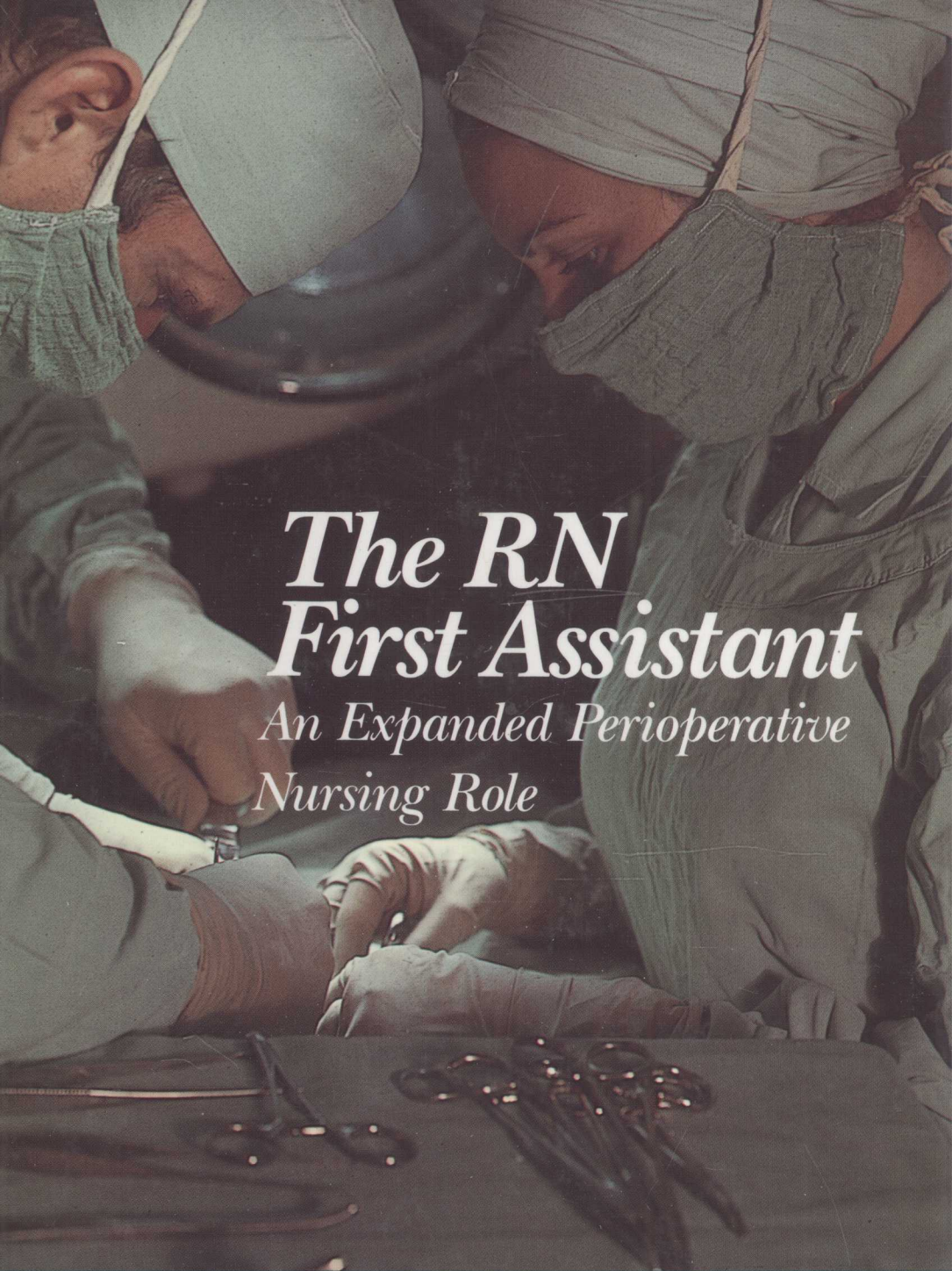

The RN First Assistant

An Expanded Perioperative Nursing Role

Jane C. Rothrock

J. B. Lippincott Company

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This book is dedicated to
my partner in life,
Joseph Trimble Rothrock III

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Foreword

The sophisticated and controlled environment of today's operating room is vastly different from the settings known to Morton and Lister. The almost unbelievable and miraculous interventions that are performed attest to the benefits of ongoing research and super space-age technology. Progress is stimulated by a constant flow of new pharmaceutical agents and anesthetics, exquisite and safer instruments, flexible fiberscopes, sophisticated microscopes, and finer sutures, all penetrating more deeply into the hidden recesses of the human body. In surgery each step is monitored by sensitive electrodes on a display screen that reveals the effects and progress of an operation.

With these advances have come increasing demands on operating-room personnel. Their primary desire is to have the most efficient collaborating team possible to achieve optimum results for their patients as they undergo anesthesia, surgical intervention, and recovery. In keeping with this goal is the recent progression of the well-prepared perioperative nurse into the legitimate position of first

assistant to the surgeon (registered nurse, first assistant—RNFA). Historically, this role has been developing for decades; thus it follows logically in the evolutionary process.

In the operating room, the essential members of a surgical patient-care team stand out in sharper relief than health care teams in other health-illness situations. The basic components of this group, in addition to the patient, are the surgeon, the anesthesiologist, and the nurse. All are highly trained in the essentials of *total* patient care, which requires the following attributes:

- Knowledge of the anatomic and physiologic functions of the human body
- Sensitivity to the effects of pharmaceutical agents
- Skill in interpreting visual and monitored changes in the anesthetized and recovering patient
- Alertness and preparedness for intervention in an emergency
- Awareness of the humanistic, ethical, and medicolegal implications of every patient procedure

Mutual respect, shared knowledge, trust, and dedication are the hallmarks of an efficient team. In addition, members must possess good health, expanded knowledge of their respective roles, alertness, coolness under stress, flawless aseptic technique, and a sense of humor.

Nursing literature includes many references to nurse-physician collaboration. Surveys and studies describe successes in specific arenas where serious attempts have been made to collaborate. Naturally these are affected by the pressures of cost, dedication of the principal participants, and shortages or oversupply in one or the other of the professions. Most, if not all, reports indicate improved patient care. Without a doubt, this will be the effect when a specially prepared professional nurse is a member of the operating team as first assistant to the surgeon.

The RNFA brings an added dimension to the surgical team that is otherwise unavailable. With a nursing background, the RNFA has already proven herself/himself to be an effective perioperative nurse with added expertise in the intraoperative phase. In addition to the special technical skills required to be a first assistant, the RNFA possesses acute patient sensitivity and a concept of wholeness in pa-

tient care, familiarity with all operating room equipment and its immediate accessibility, and the skills and knowledge called for in the event of instantaneous need.

This physician-nurse team blends effectively because their independent skills and knowledge are now permitted to be expressed and respected for their combined worth. Their value in facilitating operative procedures in the traditional operating room has been well proved. It is particularly timely for such a team to be available now, when their special skills are being broadened to move out into outpatient same-day surgery clinics and surgicenters.

The position of an RNFA on the surgical team will provide a model for the many other areas in which close collaboration between the professions of medicine and nursing could enrich professional experience while compounding the benefits to the patient.

Lillian S. Brunner, RN, MSN, ScD, FAAN

Preface

This book is based on a philosophy of perioperative nursing that reflects the critical nature of and the vital contribution made to the patient's care by the perioperative team. Perioperative nursing, more than any other clinical practice area, represents a care team that works coherently and clearly for a common patient goal. That nursing team may consist of a scrub nurse, a circulating nurse, and an RN first assistant. Each team member contributes a piece of the nursing expertise that eventuates in a safe and optimal patient outcome.

The view of the RN first assistant in an expanded perioperative role is critical to the philosophy that has guided the preparation of this book, which is about the knowledge and skill posited as requisite to that role. Presumably, the reader will be a perioperative nurse with a certain experiential base who is interested in role expansion, not role acquisition. For that reason, descriptions of practices basic to the function of perioperative nursing have been omitted. Instead, what has emerged is an attempt to elaborate and explore the critical elements of first assisting. The acronym RNFA has been used in this book deliberately. If this is to be a nursing role, it is seen as inappropriate to label the RN first assistant as anything other than an RN.

There have been references in the literature to RN surgical assistants, to nonphysician assistants, and to other nomenclature that does not accurately reflect that the person providing care is a nurse acting as first assistant in the absence of a qualified physician. That the first assistant is a nurse is a triumph we should emphasize and underline with both our nursing and physician colleagues.

This book's purpose is to enable perioperative nurses to prepare for role expansion. The discussion of the historical role of perioperative nurses in patient care activities lends support and credence to role assumption. In reviewing role origin, affirmation of nursing's positive contributions to patient care over the years emerges. It becomes evident that we are talking about a role neither new nor isolated and fragmented in its execution. Acting as assistant to the surgeon in direct patient care activities has long been a part of perioperative nursing. If part of that role execution is seen as technical, it is only because the physiological alterations that occur during surgery are themselves highly technical. Throughout the historical evolution of advances in surgery and asepsis, the nurse has been beside the patient; in that respect, the nurse has also been affected by and has been responsive to new technology.

Many questions have been posed regarding the legal status and aspects of the RN as first assistant. In the absence of legal precedence and case law, the nursing boards and nurse practice acts are essential to delineation of responsibility and safe practice that falls within the realm of nursing. Chapter 2 deals with the relationship of state boards, nurse practice acts, and legal aspects of first assisting. Perioperative nurses have begun interacting with their nursing boards in a relevant and meaningful way. This kind of mutual dialogue will be even more essential as the boundaries of the role are explored in terms of their congruency with the practice of nursing.

Practicing as an RN first assistant requires documentation of competency. The perioperative nurse will often be involved in application for practice privileges in this expanded role. The process of institutional credentialing, as described in Chapter 3, is meant to serve as a guide for nurses who apply for practice privileges and for hospitals that face the task of setting up a credentialing process. As perioperative nurses move into this new role, the need to be sophisticated in the application process and in the documentation of expertise becomes essential to professional practice.

The number of chapters about the knowledge and skill needed for expanded role function attests to the broad nature of the cognitive and psychomotor basis of the RN-first-assistant role. The microbiologic principles that guide aseptic practice are the foundation for nursing actions that prevent infection. Identification of barriers to microbial penetration of the surgical wound is essential in preparation of the wound site by chemical antisepsis and draping. Handling tissue gently, providing adequate wound exposure, recognizing tissue reactivity to suture material and its appropriate use, identifying the mechanisms of wound healing and classifying patient risk for wound complications, using surgical instruments appropriately, and helping to achieve a dry wound are all elements of safe patient care. They attest to the intellectual and manual dexterity required of the perioperative nurse acting as RN first assistant during surgical intervention.

Wholism is a widely respected value in nursing and one that should be preserved. From a health care perspective, nursing is the one profession that has held onto this value. In the chapter on positioning, a cogent and deliberate stand is taken on wholism as a theoretical base for the activities undertaken by the RN first assistant. I believe that wholistic care must be included in a book that pertains to an expanded perioperative role. The concept of wholism is clearly applied to the patient care activity of surgical positioning in a nursing-process framework that solidifies and models the prevention aspects of perioperative nursing. We have always been interested in patient care as our foremost concern, despite the fact that some of our colleagues have seen us as more skill oriented and less patient oriented. The theoretical basis for role function articulates our patient care focus in an indisputable way.

This book concludes with a discussion of collaborative practice as the model for perioperative nursing in the first-assistant role. The unique and close relationship of nurse-physician teams in the perioperative arena has long been recognized. This relationship is built on mutuality and respect. Because perioperative nurses have always been patient allies, they are often physician colleagues. The true nature of this collaborative role, with its interdependence between nurse and physician, is the hallmark of our practice and the essence of our professionalism.

Many elements of the RN-first-assistant role are not explicitly

expressed but are implicitly inherent in this book. I offer them to you, the reader, in praise and recognition of your interest. As a perioperative nurse who wishes to study and explore the role dimension of first assistant, you are a model of the things nursing wishes for the best of its practitioners. You are a critical thinker who strives to fill in learning gaps and find new ways of doing things. You are a problem solver who is involved in experimentation and research every day in your work setting. From your clinical practice as a perioperative nurse you have generated statements of hypotheses and teased your imagination to find a better way of doing things. You are a skilled observer, with a highly assisted eye. Professional judgment underlies your role as a decision maker. You are creative, a divergent thinker who constantly moves from concept exploration to concept utilization. You are a learner of skills, and this skill learning is a culmination of all the knowledge that precedes competent skill acquisition. You have learned to transfer your knowledge of nursing to the perioperative setting, where you are concerned with professional performance and the transfer of theory into practice. I recognize and commend your diversity, not your sameness, and I am proud to be one of you.

Jane C. Rothrock

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