Objectives

1. Historical aspects of perioperative nursing
2. Define key focus areas and paradigm shifts
3. Influences within the perioperative arena
4. Discuss opportunities and challenges
We’ve come a long way

• The Perioperative Registered Nurse must have an understanding and appreciation of the history of surgery and the development of Operating Room Nursing. It is the foundation on which current practice is built upon, and the guide by which future practice will be defined.
Beginnings

• Necessity drove innovation and rationale
  – Mid 1800s- Usually not a separate operating room theater, but procedure performed in the patients room or on a counter in the hospital pharmacy

• Advancements through science and technology
  – 1893 World’s Columbian Expedition in Chicago showed the latest hospital technology, autoclaves, rubber gloves, and immaculate operating rooms
Origins in the OR

• 1873 Nurses brought into the surgical theater
  – Nursing advances.....into the Operating Room with the original motive to control the behavior of the medical students

• 1874 “notes of surgical nursing” with techniques for preparation by Dr. C.H. Barnes
  – Before the operating room became a specialty, surgical nurses assisted with preparation, based on individual surgeons preferences
Further progression

• 1889 Caroline Hampton wore gloves and was one of the first operating room head nurses
  – By the turn of the century, several hospitals in Detroit, Chicago, Boston and Brooklyn had head nurses of the operating room

• 1897 care of instruments in RN hands, better than any house MD
  – Usually never able to handle the instruments, nurses were utilized to deliver the anesthetic (spray) or to marine the sponges and dressings.

• 1898 graduate RN in charge, prepare sutures, life and death of surgeons case
  – Recommended all nursing students receive 2 months training in the OR and considered the operating room head nurse position as vital
1901 specialty of operating room was established in “duties of the operating room nurse” published in the 6th issue of the American Journal of Nursing

1902 1st OR Nursing Text-A Nurse’s Guide for the Operating Room (Dr. N. Senn)

1903 Formal OR experience required for RN licensure

1903 First state board exam

1905 OR Nursing Interventions listed prevention of infection, promotion of comfort, physical safety, patient monitoring, resuscitation, and psychological support
Emphasis was on the technical aspect of nursing rather than patient assessment and safety.

Although technology was rudimentary, there remains the basic steps.

"The duties of an operating-room nurse, especially if they include the care of the sterilizing room, are very numerous. They require a knowledge of the principles of asepsis, careful attention to details, and much forethought in the preparation of supplies."

The Duties of an Operating-Room Nurse,

Martha Luce, Boston
Gloves were washing, dried, and tested for holes, then powdered and re-sterilized
Sutures were prepared and sterilized
Instruments were boiled after cases
Sponges were washed and re-sterilized
Aseptic technique and the surgical conscience
“A surgery nurse must have many good qualities; but first of all, she must be most conscientious of sterile technique used, for the supervising nurse or surgeon is usually not present to watch the setting up of a case. Speed and efficiency are of no avail if a surgical wound breaks down due to an infection received in the operating room. The nurse must be enthusiastic about surgery or else is not able to continue in this type of nursing for long, as it is physically as well as mentally tiring....”

(M. Crawford – 1945)
Role of the Perioperative Registered Nurse and the ‘surgical conscience’

“The OR nurse...has a very responsible position. Every set-up a doctor uses is prepared by a nurse. Remember this obligation. Only you can answer the question, *Did I use good surgical technique while preparing and executing this procedure? Everyone connected in the procedure is sure you did. Have you betrayed these people and yourself?*

J. Willingham (*Logic of Operating Room Nursing, 1962*)
Key Focus Areas

- Patient advocacy
- Code of Ethics
- Influences in perioperative arena
- Safety
- Collaboration via professional relationships
- Relevance of professional organizations
## What has been happening globally?

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Paradigm Shift

• Surgery in acute care ORs to Ambulatory Surgery Centers
• Quality, efficiency, and safety during the rise of non-hospital settings for surgical services, through process changes/implementation such as lean, six sigma concepts
• Anecdotal sensibilities to evidentiary findings (EBP)
• Inventories of supplies and implants to consignment agreements and loaner trays
• Migration of invasive procedures out of the OR to Interventional Radiology, Cardiac Cath Labs, and physician offices
Growth of ASCs

- Shift from inpatient to outpatient to ambulatory surgery and the growth of new ambulatory procedures has been driven by changes in technology, patient preference, cost control efforts, regulatory policies and competition.

- Ambulatory procedures have come to dominate the total number of procedures performed in a facility.

- Patients have been quick to recognize the accessibility and convenience of outpatient health care. Ambulatory surgery centers in general were built to provide a setting for specific procedures, control costs and quality, and streamline delivery of care. Ambulatory surgery center growth followed not only technological advances, but also financial incentives.
Supply and Demand

- To meet market demand, some hospitals have relocated some proportions of their ambulatory surgery cases to a separate location on the hospital campus.
- Rates and charges for ASC services that are not provided at the hospital, are negotiated with individual payers, and payments are generally less than in the regulated settings.
Early studies indicated that switching from inpatient to outpatient surgery could save money.

Mid 1980s, surgical procedures such as cataract removal, tonsillectomies and adenoidectomies (T&A), hernia repairs, hemorrhoidectomies, and laparoscopies could be done on an outpatient basis at less cost and with greater patient satisfaction.

Deterrents to freestanding outpatient facilities, included substantial capital investment and startup expenses. Many hospitals were able to set up integrated outpatient surgical programs in existing facilities.
Surgical Care Infrastructure

- Facilities need to identify a variety of opportunities to improve patient flow, efficiency, and customer satisfaction within the department.
- Automated OR dashboard reports use data from existing systems to track performance.
- Frontline managers utilizing these reports can provide explanation of performance and engage stakeholders in future initiatives.
Metrics include:

- **OR utilization rate**
  - Acute vs. ambulatory, capacity/growth/resource allocation

- **Percentage of procedures with on-time starts**
  - Delay of future cases, overuse of labor

- **Number and percentage of canceled procedures**
  - Efficiencies impacting following procedures

- **Length of stay in the pre-and post-op areas**
  - Impact of anesthesia type (i.e., blocks)

- **Percentage of procedures accurately scheduled**
  - Utilization of room and labor
Time is Money

• Timing procedures is not as critical for inpatient surgery as it is in the outpatient setting.

• Case turnover and efficient use of inpatient operating rooms are not as good as in outpatient settings.

• Because of differences between the inpatient and outpatient surgery scheduling at one hospital, 5.1 arthroscopy cases could be done in the outpatient surgical facility each day while only 3.3 cases were done in the main operating room.

• The loss of 1.8 cases per day in the inpatient facility led to the introduction of specific start times for surgery in the main operating room.
Surgery is a Business

- Nurses have a responsibility to become active participants in shaping healthcare and managing resources. Nurses need to identify consumer care needs, the potential for harm, the complexity of the task, and the desired outcome when evaluating resource allocations. To accomplish this goal, nurses need to understand the financial and operational priorities behind healthcare business decisions.
Declining reimbursement and financial incentives connected to quality and patient satisfaction outcomes are making finance a language requirement for every future nurse manager. If nurse leaders want to continue to have a seat at the strategic table and remain influential advocates in future healthcare decisions, they must become fluent in the language of finance.
In today’s fast-paced OR setting, everyone is concerned about efficiencies. Appropriate resource utilization is essential to the success of the OR suite transformation. While resources are tangible and intangible, tangible are the easiest to measure and track.

Lean is gaining acceptance in hospitals across the US, but often Lean raises the guard of staff members who may feel threatened by the idea of doing more with less. The resistance is usually due to setting the wrong expectations of performance with little emphasis on the cultural aspect of lean.
Trends and Challenges

- Researching improvements to current practice while at the same time effectively laying the foundation for the future that the art of asking the right question emerges.
- “We have always done it that way” is being replaced with “where is the research to prove that position?”
How to overcome challenges

Education
Know practice guidelines
Knowledgeable about current issues
Join professional organizations for standards
Seek support from supervisors/administration
Be guided by ethical principles through care and compassion, knowing autonomy is the key
What Organizations Can Provide

• Structural ability
  – Shared governance models
  – Code of conduct
  – Support tools that make it easy to speak up
    • Surgical pauses
    • SBAR handoffs
    • Checklists
    • Debrief
Institute of Medicine Reports

- 1999 IOM Report - *To Err is Human. Building a Safer Healthcare System*

- 2001 IOM Report - *Crossing the Quality Chasm*

- 2001 IOM Report - *Envisioning the National Health Care Quality Report*

- 2010 IOM Report - *Future of Nursing. Leading Change Advancing Health*
IOM Recommendations

- Setting Performance Standards & Expectations
  - Focus on Patient Safety
  - Licensing Bodies and Professional Societies
  - Governmental Activities
- Implementing Safety Systems in Healthcare Organizations
  - Specific Programs
    - Improve Medication Delivery
  - Professional organization
    - Collaboration
World Health Organization (WHO)

- “SAFE SURGERY SAVES LIVES”
- June 25, 2008 – Formal launch, Wash D.C.
- Worldwide global project launch
- WHO Surgery Safety Checklist with 2015 initiative
- A tool for surgical teams to ensure that patients undergo the correct operation at the correct body site with safe anesthesia
- Dr. Atul Gawande (Project Leader)
The Association of periOperative Registered Nurse’s (AORN) mission is to promote safety and optimal outcomes for patients undergoing operative and other invasive procedures by providing practice support and professional development opportunities to perioperative nurses. AORN will collaborate with professional regulatory organizations, industry leaders, and other healthcare partners who support the mission.

The Association of periOperative Registered Nurses (AORN) is the leader in advocating for excellence in perioperative practice and healthcare.
AORN: Statement on the Perioperative Role
Scope of Practice

“The reason for the existence of perioperative nursing practice is the care of persons undergoing operative and other invasive procedures..... it begins with the prospect of an operative or other invasive procedure and is completed by evaluating the extent to which the recipient’s needs have been met”.
Perioperative nurses must be able to identify / validate the role of the registered professional nurse in the OR. Practitioners must delegate effectively and appropriately. Research must be conducted to identify nursing interventions, not just technical aspects, that positively affect patient outcomes and validate the need for professional registered nurses in the periOperative setting.
Changes in practice and architecture

• Procedure types
  – Surgical interventions will dramatically decrease and increase will be limited to obstetrics, trauma, and elective plastic, and organ/joint replacements.

• Imaging
  – Except for trauma, unanticipated surgeries will virtually disappear because of the accurate predictive modeling and full-body diagnostic and reference imaging.
  – Digital 3-dimensional virtual exploratory procedures will be fully integrated with noninvasive interventional technologies.
Changes in practice and architecture

• Robotics
  – Surgeries will increasingly be robot-assisted because of economic forces to reduce costs and the pressure to reduce the number of medication and procedural errors.

• OR design
  – Sterile environments, hybrid ORs, and supportive work environments impacting patient and employee safety
Our Opportunity

The passion for the perioperative nursing profession relies on those which can articulate and demonstrate the expertise and knowledge utilized during the performance of the nursing role.
Thank you!