The perioperative nurse practitioner: reality or myth? A Western and Eastern States' perspective

Associate Professor Rene Michael
School of Nursing and Midwifery, Curtin University of Technology, WA

Carolyn Williams
Barwon Health, Deakin University, VIC

This paper provides a snapshot of nurse practitioner (NP) issues and educational programmes from both a Western Australian and Victorian perspective. The NP scope of practice and challenges confronting perioperative nurses within these States are also discussed briefly using some comparative examples from other countries.

The nurse practitioner (NP) in Australia is a new and unique level of healthcare provider. The developing role has been driven in part by social forces, demographic considerations, cultural shifts and the development of new models of healthcare.

The core role of the NP is distinguished by autonomous practice working collaboratively in an advanced and extended clinical role. NP practice is dynamic in that it requires the application of high-level clinical knowledge and skills in stable, as well as unpredictable and complex, situations. The role is further characterised by professional efficacy and clinical leadership, and has a therapeutic potential enhanced by autonomy and legislated privileges. Across Australian States and Territories there are over 30 separate Acts related to the regulation of nursing practice, for example Nurses Acts, Medical Acts, Poisons Acts, Pharmacy Acts, Radiation and Safety Acts, Road Traffic Acts, Misuse of Drugs Acts and Mental Health Acts, just to name a few. These Acts enable the extension of NP practice to include limited prescribing, initiating diagnostic testing, referral to other healthcare providers, admitting and discharge rights, and writing medical certificates.

The scope of practice of the NP is determined by the context in which the NP is authorised to practice. Variations in the role, scope of practice, core competencies, and legal and educational standards are evident, with some States more or less developed on all parameters. However, these variations have impacted on role definition, development of educational standards, and implementation of the role by industry. An issue repeated at many levels relates to what appears to be role confusion about what the term NP really means for Australia. The term appears to be emerging as an umbrella term to include multiple forms of expanded roles or advanced practice, with most seeing the NP as the highest level of advanced nursing practice in Australia.

The career ladder (or lack of one) for clinical nurse consultants, coupled with no formal graduate education for the clinical nurse consultant, is influencing the emergence of multiple categories of NP with limited or circumscribed scopes of practice. An example of this can be seen in Table 1, which illustrates some of the NP designated areas/categories in Western Australia (WA).

In 2006 the National Competency Standards for the Nurse Practitioner were developed by the Australian Nursing and Midwifery Council (ANMC), with contributions from the Nursing Council of New Zealand. The competency standards, which have been endorsed by all the nurse regulatory authorities in Australia, are those by which performance is assessed to obtain and retain licence to practice as a NP in Australia. Once individuals are registered and practising, they may also need to retain professional indemnity insurance if they are not covered under vicarious liability such as in WA. Universities in Australia use the standards when developing nursing curricula and to assess student performance. Educationally, qualifications vary; some nurse registering authorities accept a graduate diploma and others expect the course completed by NPs to be at the Masters level.

In WA, Curtin University of Technology offers Graduate Diploma and Master programmes for prospective NPs and Edith Cowan University offers a cross-institutional Master programme with Flinders University, South Australia. There are more than 70 students enrolled in these programmes, 36 registered and endorsed with the Nurses Board of WA, 10 practising in designated areas, and a further five designations to occur within the next few months. The designated areas involve rural and remote, metropolitan and outer metropolitan areas.

In Victoria, four universities, Deakin, Melbourne, Monash and LaTrobe, offer NP streams within their Masters programmes. However, only Monash University and the University of Melbourne offer units relating to prescribing and administration of medications, and thus candidates studying at the other universities are also required to enrol in one of these options. To date, 10 NPs have been endorsed in Victoria in the areas of child and adolescent health, intensive care unit liaison, wound management, palliative care, and emergency.
nursing. Ten more endorsements are before the Nurses Board of Victoria and five regional business plans and clinical protocols are underway in the area of emergency nursing.

From the perioperative nurse perspective, we need to question whether the NP role 'fits or doesn't fit' and if it is achievable within our specialty. In so doing, it requires us to address the scope of practice and challenges confronting perioperative nurses to attain NP status. Perioperative nursing practice is expounded as a nurse prepared beyond generalist level who practices as a specialist with advanced expertise in this specialty of nursing.

However, becoming an expert by experience is not, on its own, deemed to be advanced nursing practice. Advanced practice differs from expert practice in its scope and sphere of influence, including its application of advanced nursing knowledge. It can be defined as having acquired the depth and breadth of knowledge and competencies for more autonomous scope of practice.

In examining extended practice, which is necessitated by the dynamic nature of NP practice, it is described as the ability to further improve patient outcomes and fill gaps in the health service delivery. Nursing and midwifery regulatory authorities describe expanded roles as an extension of advanced practice and different to specialist practice, with extended practice recognised as the NP. With this information in mind, we need to align it to our own specialty practice.

It is well known that perioperative nurses continue to adapt to changing technology, expanding treatment options and new models of care for surgical patients, in juxtaposition with the escalating shift of surgical care from inpatient to outpatient surgery. Although the traditional roles remain, perioperative nurses are broadening their responsibility to encompass pre-operative assessment and pre-admission preparation and education, intra-operative nursing practice including assisting the surgeon (perioperative nurse surgeon’s assistant [PNSA]), as well as post-operative recovery and discharge planning. The pre-admission perioperative nurse and PNSA are two such roles that could be explored to build further upon and expand the scope of practice.

However, in WA and Victoria, the perioperative NP role to date has not come to fruition. Within WA there has been one PNSA who enrolled into the NP Postgraduate Diploma programme. Unfortunately, due to lack of support, the individual withdrew from the course. There has also been some discussion regarding the feasibility of the NP role for perioperative nurses involved with vessel

Figure 1. Registered nurse scope of practice.
Table 1. NP designated areas in Western Australia.

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<td>Wound/stomal therapy/gastroenterology</td>
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harvesting during coronary artery bypass grafting. Additionally it has been recognised that, due to the shortage of anaesthetists in the rural areas, this is one area for which perioperative nurses could be considered.

In Victoria, perioperative nurses who have an expanded scope of practice in the area of anaesthesia were considered unsuitable for the NP role due to the fact they worked under the direction of anaesthetists (i.e. their practice was not autonomous). Similarly, nurses working in a perioperative pre-admission clinic who participated in the first round of NP demonstration models were deemed as not practising at a NP level and consequently did not seek endorsement.

It is seen within WA and Victoria, as is possibly the case in most other States, that perioperative nurses are pioneers attempting to forge a new role in territory that is no way prepared for them. Consequently, it is envisaged, similarly to the NP role generally within Australia, that there will challenges that range from confronting active hostility, explaining who we are to other perioperative colleagues, nurses, medical and allied health colleagues and a range of frustrations around legislative and infrastructure issues which may not have been addressed.

Aligned with these issues, the pathway to the development of the perioperative nurse NP may not necessarily be clearly differentiated. Roads may need to be taken which would not normally have been considered. An example of this is the recent endorsement of an ophthalmic NP in South Australia. Although to date the role does not have an intra-operative focus, it includes conducting pre- and post-operative assessments for patients undergoing cataract surgery. The NP conducts pre-operative ocular examination, assessment and biometry, provides education and obtains consent. The NP assesses patients on Day 1 post-operatively, prescribes antibiotics and corticosteroids according to surgeon preference, and sees the patient again 4 weeks later to determine the degree of visual acuity. A study into this role indicated that the waiting time for cataract surgery has been reduced by 9 months, thus improving access to care and enhancing care outcomes. Some criticism has been raised, with these findings being refuted by Hamish, McKee & Gole, who conclude that this investigation into the use of NP-led perioperative cataract clinics contains flaws and that the conclusions are premature.

Considering the criticism of the outcomes and the fact that the role does not cover all parameters of the perioperative nurse roles, such as the intra-operative phase, with further development it is an example of how the role of perioperative NPs may be initiated. Moreover, the questions should be asked, do we need to think outside the square in relation to the formation of the role of perioperative NPs?

Despite the fact that the perioperative NP role is in an embryonic stage in Australia, internationally they have been practising for some time in countries such as the United Kingdom, Canada and the United States. The scope of practice of NPs practising in perioperative areas includes expanding practice in the areas of pre- and post-operative clinics and in the intra-operative role.

In the bounds of the UK, evidence of the perioperative NP is seen with the expansion of the first assistant to the surgeon nurse role to NP level with further education and training to conduct minor surgery in a ‘see and do’ plastics clinic. The perioperative NP also consults and assesses patients as suitable for procedures to be performed under local anaesthetic. Consent is obtained, surgical procedure performed, request for histology is written, post-procedure education provided and a letter written to the patient’s general practitioner. The clinic has positive outcomes in reducing waiting lists and meeting patients’ needs. Another UK example includes the perioperative NP role moving beyond the walls of the operating suite to conduct pre-admission clinics. This expansion of the role resulted from pre-operative medical preparation of day surgery patients being inadequate due to a shortage of doctors. Outcomes were also positive as patients valued the detailed and personal care they received from the nurse. Overall, patients were better prepared for surgery that included their physical, psychological and social suitability.

Within the UK and Canada, in response to bowel cancer screening initiatives, perioperative nurses perform endoscopies with demonstrated improved patient outcomes. As a consequence, waiting lists have been reduced, diagnosis is comparable to medical outcomes and, in remoter, areas they are meeting primary healthcare needs.

Other instances of perioperative NPs are found in the USA, such as the ambulatory surgery unit (ASU) NP and the orthopaedic NP. The primary purpose of the ASU NP role is to conduct extensive pre-operative health assessments on patients who are scheduled for surgery and will be admitted through the ASU. The orthopaedic NP developed from an expanded registered nurse first assistant (RNAF) role to enable pre-operative and post-operative surgical clinics to be conducted for the elderly patients facing joint replacement. The focus is on screening for actual and potential problems, specifically cardiovascular, health education and promotion, and post-operatively restoration and maintenance of health. The RNAF maintains close collaboration with the surgical team and it can be inferred that the intra-operative experience of the RNAF would enhance patient assessment and education regarding the perioperative experience.

As is evident, NP practice melds specialist, advanced and extended practice beyond established contemporary scope that is distinguished by the autonomy to practise at the very edges of the expanding boundaries of nursing. Using a nursing framework, it is firmly grounded in the unique body of knowledge that is nursing and also draws from other disciplines practices. We believe it is achievable in perioperative nursing practice for those with the ingenuity and foresight to develop an area of expanded practice that meets the changing needs of perioperative patient care.

However, firstly we need proof of concept, that it is feasible. To ensure this, we need to consider how the three phases involved with
the NP role – the pre-operative phase, the procedural/treatment phase (intra-operative) and the postoperative phase – merge within the perioperative NP concept. In so doing, it will ultimately have implications for curriculum development, scope of practice, clinical protocols and collaboration with other health providers. As perioperative nurses we need to continue to debate and differentiate what the NP role means for us in Australia as well as determine which populations best stand to benefit from perioperative NP practices.

References
3. Nurses Practitioner Forum '06 (2006). Office of the Chief Nursing Officer, Department of Health, Western Australia

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