Perioperative Nurse Competencies

The Thai Perioperative Nurses Association
2014

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A perioperative nurse is a professional nurse who looks after the patients undergoing surgery in the operating room: they are in attendance during preoperative, intra-operative, and postoperative phases. The nursing process is assessed by nursing diagnosis, planning, implementation and evaluation of a nurse's performance. Holistic care includes physical, psychological care, social care as well as spiritual care. The use of knowledge and practice is necessary to be able to perform the tasks. Therefore, the perioperative nurse should be well prepared in order to be competent.

Competency is the ability to perform some task (Cambridge International Dictionary,1995)JCAHO (Joint Commission on Accreditation of Healthcare Organization as referred to by Gruendeman and Fernsebnee (1993) a competency of a nurse is the ability to perform a task based on his/her knowledge, skills, attitude and behavior towards the goal. The knowledge, skills and ability to perform tasks as the role of a perioperative nurse is defined by AORN (Association of peri Operative Registered Nurses)

There are 2 types of competency:

1. Core Competency is demonstrated by good behavior which requires that everyone behaves according to the culture of their organization.
2. Functional Competency is the specific role of each nursing position in order to successfully perform a task as planned.

Therefore, the competency of a perioperative nurse is the ability to employ knowledge and skills in providing nursing care as his/her roles require, including the other characteristics of their specific role.

The committee of the TPNA (The Thais Perioperative Nurses Association) has carefully considered and agreed that Core Competency should be implemented and accepted by all medical institutes and professional nursing organizations. The competency requirements proposed by the TPNA committee, only relate to the responsible roles with regard to the needs of patients, and took some parts from the AORN framework and adapted it to the general nursing process, as well as the holistic care for patients.

There are four categories for Perioperative Nursing Competency:

1. Competency related to patient safety.
2. Competency related to patient's physiological response.
3. Competency related to patient's behavioral response.
4. Competency of the health- care syste

The Competency Related to Patient Safety.

1. Competency related to tissue trauma prevention from chemical substances:

1.1 Assess the medical history of the patient's allergies i.e. medication, adhesive plaster, latex and chemical substances. Document, and inform the team work.

1.2 Avoid using latex rubber on the patient who indicates a risk of latex allergy, such as rubber gloves, drains, or catheter, etc. Prepare non-latex supplies in advance, and organize with the team. Evaluate any possible symptoms and signs of a latex allergy.

1.3 Tissue- trauma prevention from chemical solutions:

1.3.1 Choose correct solution for skin condition, surgical site, procedure.

1.3.2 Follow the criteria of using any solution.

1.3.3 Record the type of solution, instructions, surgical site in the operative notes during surgery.

1.3.4 When using ESU (Electro Surgical Unit) or laser, an flammable solution needs to be dried out first.

1.4 Assess the patient's condition; If there is any sign of tissue trauma from chemical substances by observing an abnormality on the skin surface, or any allergies in other body systems. If there is any sign of tissue trauma from chemical substances, convey the information to the person in charge and follow up the results.

2.Competency related to tissue trauma prevention from cauterization.

2.1 Prepare the ESU well, and is ready to be used.

2.2 Assess the skin condition, and the risk of using cauterization on a patient who has a pacemaker, an implant or jewelry and record this in the nurse's notes.

2.3 If the patient has a pacemaker on, notify the physician and consult the cardiologist to adjust the mode of the pacemaker, or use the bipolar mode: a magnetic plate should be placed on the patient' chest at the location of the pacemaker in order to protect its function.

2.4 Choose the proper dispersive electrode and apply it to the suitable area. Be alert while using it.

2.5 Assess any symptoms and signs of tissue trauma as the result of cauterization post operation. Check alteration of skin condition where the dispersive electrode was applied such as redness, swelling, or burn.

2.6 Document any abnormality of skin condition where the dispersive electrode was used and notify the surgeon. Provide first- aid treatment if necessary and follow up for further nursing care.

3. Competency related to tissue trauma prevention from radiation.

3.1 Assess the medical history of pregnancy, an allergy of contrast media, radiation therapy and diagnosis, as well as the skin condition prior to surgery.

3.2 Risk prevention from radioactive source

3.2.1 Install the protection equipment properly.

3.2.2 Limit any radiation such as fluoroscopy: this should be shut off if not in use.

3.2.3 Employ proper shields to protect important organs, i.e. thyroids, testes, ovaries and fetus.

3.3 Assess the change of skin or tissue conditions, following the work instructions of the workplace.

Notice: For the medical staff:

3.3.1 Carefully discard and discharge for analysis the tissue which was contaminated by radiation per the work instructions.

3.3.2 Utilize the proper shields to protect important organs such as thyroids, testes, and ovaries, by using thyroid shield ,lead apron, lead glasses.

3.3.3 A pregnant woman should not be working in the radiation therapy area.

3.3.4 Utilize the film badge in order to record the quantity of radiation: it should not exceed the standard.

4. Competency related to tissue trauma prevention from patient transferring.

4.1 Assess and indicate the limited mobility of patient.

4.2 Use the proper equipment and appropriate technique when transferring a patient.

4.3 Assess and observe any symptoms and signs of tissue trauma when transferring. Employ an anatomical alignment for proper position.

4.4 Document and refer the information to the team if trauma occurs.

5. Competency related to tissue trauma prevention from patient positioning.

5.1 Assess the risk of positioning a patient in any type of surgery, according to age group; physical condition of limited mobility; overweight; patient with prosthesis or with pacemaker; with drains, premedication and the lab results.

5.2 Provide the proper equipment to assist positioning according to the patient’s condition and the type of surgery.

5.3 Provide the proper equipment to assist positioning according to the patient’s condition. Be careful of any attached device such as oxygen cannula; IV line; urine catheter, or chest drain, etc.

5.4 Positioning the patient with a view to the purposed schedule e.g. in the dorsal position, the arms should always be placed at less than a 90 degree

angle to the body with palms facing up to diminish pressure on the brachial and ulnar nerves.

5.5 Apply an adequate amount of oxygen in the tissue, as this should sustain the respiratory and circulatory functions as well as mobility.

5.6 After positioning, assess any symptoms and signs of inadequate oxygen supply in tissue, or any trauma from positioning by checking the skin color, the distal pulse and vital signs.

5.7 Details of positioning and assessment results should be recorded in the intra- operative record.

6. Competency related to tissue trauma prevention from laser beam.

6.1 Check the function and smoke evacuator of laser device before starting the case.

6.2 Provide the instruments and other equipment that are unglazed.

6.3 Provide laser shield or glasses on the type of laser to protect the patient and users.

6.4 Protect the nearby tissue or organs by covering the eyes and skin with a wet cloth.

6.5 Be alert to the possibility of combustibility from contact with oxygen especially when using laser for the respiratory tract.

6.6 Use the standby mode when pausing to use the laser device, in order to prevent it starting unintentionally.

6.7 Assess any signs of tissue trauma or eye vision.

6.8 Request the patient to observe their tissue trauma or eye vision caused by laser.

6.9 Document the use of laser and fill in the intra- operative notes.

7.Competency related to risk prevention from applying a tourniquet.

7.1 Assess the skin condition to decide where to apply a tourniquet.

7.2 Prepare the tourniquet set to use at surgical site and carefully check the instructions, including the cuff sizes.

7.3 Set the pressure appropriately and the length of using time as indicated, in order to protect from deficiency of blood supply to the distal organs.

7.4 Check the signs of tissue integration ,and tissue trauma after the tourniquet has been applied and the cuff is removed such as bruises, skin shrinking, groove, necrosis, the movement of fingers or toes and peripheral nerves.

7.5 Record where the tourniquet was applied, the pressure, the duration time and the skin condition, in the patient’s records.

8.Competency related to environmental hazards and use of equipments.

8.1 Reconfirm the right patient, correct diagnosis, correct surgical site, N.P.O, premedication, consent form. In the case of a child patient, or an unconscious patient, reconfirm agreement with the next of kin or relatives.

8.2 Prepare the operating room and area well e.g. the temperature and humidity, etc.

8.3 Check the sterile condition of medical supplies, instruments and devices as indicated of packages, boxes, or containers.

8.4 Assess the risk of tissue trauma from heat, coming from instruments, the solution for casting, hyperthermia or the heat from lights.

8.5 Be aware of patient's body temperature, and maintain the normal condition of the skin.

8.6 Observe the skin condition periodically during and after using forced air manner.

8.7 Test the temperature of a solution before using for cleansing or for intravenous therapy.(purposes)

8.8 Be careful of hot or cold instruments being used on internal organs.

8.9 Electrical equipment should be inspected for damage periodically and before each use. Keep them in dry and clean areas; they should be insulated and visible. The warning signal should work properly.

8.10 Assess the risk of tissue trauma as a result of any device such as clippers, or invasive device. Check for an allergy to adhesive plaster before applying it, dry the skin area first.

9. Competency related to the prevention from other risks

9.1.Competency related to risk prevention of medication.

9.1.1 Check for any allergies to food or other allergic substances by interviewing the patient and medical record, and inform the team if any.

9 1.2 Administer all medication per the doctor's instruction to the right person, right time, right drug, right dose and right method.

9.1.3 Assess the response to the drugs by observing the side effects of the drugs after being administered.

9.2 Competency related to preparing for lab analysis.

9.2.1 Understand the method of collection per the instructions.

9.2.2 Prepare the containers for the types of samples as planned, label the name of specimen, patient's name, age, Hospital Numbers (H.N), ward name , and the date.

9.2.3 Check that the documents and the samples to be analyzed are the same.

9.2.4 Record all details on the patient's intra- operative notes.

9.2.5 Be responsible for sending to the lab on time.

9.3 Competency related to operation error.
(Wrong patient, wrong side, wrong site, wrong organ, wrong procedure)

9.3.1 Sign in by reviewing the schedule, then check whether the patient is correct, the surgical site (mark site), as well as whether the surgery is invasive. Reconfirm these details with the patient or relative, X-ray film, the medical record, consent form. Prepare the surgical supplies, the correct side of prosthesis being used for the case and record the details such as the name of manufacturer (the distributer), lot number, type of prosthesis, size, the certification of the product issued by the Government office. Be prepared for the implant identification which includes the patient's full name, age, date of birth, H.N., Ward, The doctor's notes and the type of surgery (procedure).

9.3.2 Take time (Time out) prior to incision in order to announce the name, last name, date of birth, H.N. ward, surgical site, surgical side, procedure, type of invasive surgery from the medical record.

9.3.3 Sign off by reconfirming the procedure with the team , the use of sponges, used implant, specimen and the amount of blood loss during surgery.

9.3.4 Inform the surgeon and the product's company or related person if there is a malfunction of defect supplies or prosthesis.

9.4 Competency related to inadvertent retention of items. (sponged, instruments)

9.4.1 Instrument, sponge and needle counts should be made 3 times, i.e before the operation, before internal wound closure and before skin closure as well as when scrub persons interchange.

9.4.2 Instrument, sponge, and needle counts should be performed by 3 persons i.e a scrub person and 2 circulating persons, one of which should be a registered nurse. Count out loud and be able to see each item,

9.4.3. Do not move any instruments, sponges or needle out of the operating room suite before the case complete. Packages containing an incorrect number of sponges at the first count must be removed immediately from the operating room area. (field)

9.4.4 Do not cut any of the sponges into pieces, nor use the sponges for any other reason.

9.4.5.Check the function of all instruments and sharp objects, in order to make sure that during surgery. they are not defect or left inside of the patient's wound. If there is any missing part, notify the surgeon and look for it by taking X-rays and follow the work instructions of the work- place policy.

9.4.6 Notify the results of instrument, sponge, needle counts to the surgeon prior to internal wound closure and external wound closure. If the surgeon left any of packing inside the wound, a scrub person must report this to the team before closure of wound.

9.4.7 In the event that instrument, sponge, needle counts are in doubt, notify the surgeon immediately and proceed according to the policy of the work-place immediately and carry out as the policy of the work place.

9.4.8 Document the type of instrument, device, sponge or packing which has been left inside of the wound.

9.4.9 Record the results of counting and sign the name on the operative notes.

The competency related to patient's physiological response

1. Competency related to infection prevention.

1.1 Nursing intervention with aseptic technique

1.1.1 Monitor and maintain the sterile area. (field).

1.1.2 Apply the utilization of aseptic technique.

1.1.3 Prepare the operating suit according to the standard of cleanliness.

1.1.4 Utilize the standard precaution in order to protect from the transmission of the microorganism.

1.1.5 Care for drains (device), invasive devices such as a tracheostomy tube, endotracheal tube, intravenous line, urine catheter, and drainage tube.

1.1.6 Supervise other members in the team to keep strictly follow the aseptic technique.

1.2 Assessment of the risk of infection.

1.2.1 Assess the risk factors of infection such as the pathological factor, nutritional status, the receiving of some medications, etc.

1.2.2 Identify the source of pre- operation infection such as viral , protozoa, bacteria or fungi infections from internal or external sources.

1.2.3 Isolate the patient who has a risk of nasocromial infection.

1.3 Sort the types of surgery according to the standard of the Center of Disease Control and Prevention.

1.4 Skin preparation for surgery.

1.4.1 Assess the patient' conditions.

1.4.2 Assess the skin condition prior to surgery, the site of incision and scar of previous surgery.

1.4.3 Choose the appropriate disinfecting solution and correct skin preparation for the wound site.

1.4.4 Cleanse the surgical site and surrounding area by sterile supply.

1.4.5 Apply the disinfecting solution on the surgical site after cleansing.

1.5 Prevention of contamination.

1.5.1 Use proper operating- room attire and follow the regulations of the divided areas.

1. Wear only clean operating room attire.
2. Attire includes a hat or hood which covers the entire hair and face mask.
3. Do not wear any jewelry such as ear rings ,rings, or necklaces.
4. Finger nails must be clean and trimmed :no painting.
5. Shoe covers should be worn by all persons entering the restricted areas of the surgical suits. Boots should be worn in order to protect from contaminated cases.
6. Proper adherence to aseptic technique in hand scrubbing, gowning and gloving. Refer to Alexander's Care of the Patient in Surgery
7. Be aware of infection prevention such as the utilization of Spaulding classification isolation precaution.

1.5.2 Avoid contamination by carefully following all the regulations of the operating room traffic, staff, and instruments.

1. Do not bring an outside trolley into the O.R suite.
2. Seperate the clean stuff from contaminated stuff and waste materials. Do not allow any contaminated stuff to go through the semi- sterile area.
3. The traffic in the operating room must be divided strictly and clearly, especially the entrance of sterile stuff and the exit of contaminated stuff.

1.5.3 Promote and maintain the cleanliness of the O.R area as well as personal hygiene of the team.

1. Ensure that any person who has an open wound, or an infected wound is kept away from the sterile field.
2. Maintain good personal hygiene per the expectation of the workplace.

1.6 Plan to reduce the time for surgery such as prepare the schedule in advance, organize the time of waiting, prepare all instruments and equipments properly in order to complete the tasks.

1.7 Reconfirm the status of prophylaxis to prevent an infection, nothing per oral, an enema and personal hygiene of the patient

1.8 Instruct and motivate the patient to do breathing exercise.

1.8.1 Before surgery (Pre-operation)

1. Request the patient to stop smoking.

2.Suggest the separation of a person with respiratory infection.

3.Instruct the use of Spirometer

4.Evaluate the result of instructions and allow the patient's behavior.

1.8.2 After surgery (Post operation)

1.Motivate the patient to cough effectively as well as take a deep breath activating the diaphragm.

2.Self practice in the use of a Spirometer 10-12 times per hour.

3.Evaluate the efficiency and efficacy of the patient's performance.

1.9 Wound care.

1.9.1 Proper wound dressing depending on the type of procedure.

1.9.2 Contaminated wound should be attended to.

1.9.3 Observe the exudation from a surgical wound: assess the symptoms and signs of infected wound.

2. Competency Related to Tissue Perfusion Care.

2.1 Assess the risk of inadequate blood supply from malnutrition, a medical problem (chronic disease), skin condition, and the limited range of motion.

2.2 Assess blood circulation during and after surgery, as follows:

2.2.1 Assess the skin condition per the work instruction of the work place.

2.2.2 Monitor patient when positioning , avoid pressure causing necrosis.

2.2.3 Employ the accessories to assist in positioning a patient in order to prevent pressure necrosis.

2.2.4 Monitor any change of neurological signs, mental condition, level of consciousness, response, speech, motion, signs of abnormalities.

2.2.5 Monitor any change of vital signs, skin color, inadequate blood supply to capillaries.

2.2.6 Monitor any change of skin condition, cut, abrasion, edema, blister.

2.2.7 Report to the team any abnormalities.

2.2.8 Record in the operative notes.

3. Competency Related to Caring Body Temperature.

3.1 Assess the risk of hypothermia.

3.1.1 A patient with body temperature of 36 degrees Celsius or less.

3.1.2 The duration of undergoing surgery and under anesthesia.

3.1.3 Neonates or infants who have less fatty tissue will lose body heat more easily than adults.

3.1.4 A burnt patient will lose the body heat more easily.

3.1.5 Check the intravenous fluid temperature.

3.1.6 Check the environment temperature.

3.1.7 Monitor the chance of blood loss.

3.2 Proper administration of intravenous fluid: monitor the patient ‘s body temperature at all times while using hyperthermia equipment, and stop using it when the body temperature returns to normal.

3.2.1 Take patient’s temperature periodically.

3.2.2 Assess a shivering symptom.

3.2.3 Monitor against blood loss.

3.3.4 Report and continue close observation.

4. Competency Related to Caring Fluid, of Electrolytes, Acid and Base Balances

4.1 Assess the factors of the risk of blood, fluid, electrolytes imbalance such as coagulated blood, dehydration, previous trauma, some diseases.

4.2 Monitor any pathophysiological changes which are:

4.2.1 Assess the level of consciousness and neurological signs.

4.2.2 Assess the blood loss from sponges, suction, drainage of wound or the chest.

4.2.3 Assess the vital signs.

4.2.4 Follow up the results of lab analysis, such as Hematocrit (Hct), Blood Urea Nitrogen (BUN),Protein, Sodium, Potassium, as well as acid or alkaline disturbance.

4.2.5 Monitor for Acidosis or Alkalosis.

4.2.6 Monitor for respiratory disorder and heart problem.

4.2.7 Monitor for hypoxia.

4.3 Employ proper hemostasis.

4.4 Administer intravenous therapy per the treatment plan.

4.5 Administer medication per the treatment plan, to reduce acidosis or alkalosis.

4.6 Manage the electrolytes imbalance as ordered.

4.7 Evaluate the result of fluid and electrolytes administration.

5. Competency Related to Caring Cardio-vascular System.

5.1 Assess the heart condition before surgery.

5.1.1 Assess the respiration.

5.1.2 Assess the awareness and the level of consciousness.

5.1.3 Assess the heart condition by using the signs of blood pressure, heart rate, and rhythm, Oxygen saturation, CVP, MAP, PAP,PCWP,EEG etc.

5.1.4 Assess color, coldness or dryness of skin on arms and legs.

5.1.5 Report any abnormalities to the team.

5.1.6 Identify and report a patient with a cardiac pacemaker.

5.2 Monitor the heart condition during and after surgery, compare to the pre- operation condition.

6. Competency Related to Pain Management.

6.1 Assess pain.

6.1.1 Review the treatment plan and indication of painkillers to administer.

6.1.2 Allow the patients to assess their pain by using a pain score or facial grimace scale.

6.1.3 Interview the patient of pain management according to his/her knowledge and experience.

6.1.4 Observe the patient's pain level from activities or expression.

6.1.5 Evaluate the response to pain management.

6.2 Pain management per the instructions.

6.2.1 Assess the pain type, the indication of drug administration, and the patient's condition.

6.2.2 Review the pain management.

6.2.3 Provide comfort position to reduce pain.

6.2.4 Administer painkiller per treatment plan.

6.3 Alternative method to control pain.

6.3.1 Review the pain type and indication of receiving painkillers.

6.3.2 Interview the patient about the effectiveness of pain relief.

6.3.3 Review pain relief without using painkillers such as cold/hot compress, music therapy.

6.3.4 Instruct the method of pain relief.

6.3.5 Educate the relative (family) of pain management.

6.3.6 Evaluate the patient's response.

6.4 Evaluate the response to pain- relief treatment.

6.4.1 Document pain levels.

6.4.2 Observe pain levels by actions, facial and vocal (verbal) expressions.

6.4.3 Assess the nature of pain or painlessness after pain management effectively.

6.4.4 Use the pain scores or scales in pain management effectively.
6.4.5 Assess the change of pain levels.

The Competency Related to Patient's Behavioral Response

1.Competency related to educating patient and relative.

1.1 Assess the patient's capability of communication.

1.1.1 Assess the factors that affect communication.

1.Age and patient development.
2.Understanding of language/speech.
3.Ability of hearing.
4.Ability of seeing.
5.The assistive device for respiration such as an endotracheal tube.

1.1.2 Provide the environment to facilitate better communication.

1. Calm surrounding, suitable light.
2. Private area.

1.2 Assess the patient's readiness to learn.

1.2.1 Assess levels of knowledge, communication, and perception.
1.2.2 Assess the mechanism of dealing with any problems.

1.3 Assess the level of a patient's medical knowledge.

1.3.1 Assess their language skills and understanding.
1.3.2 Assess any obstacle to communication.
1.3.3 Assess their basic knowledge of surgery.

1.4 Giving instruction and knowledge as requested by patient and relative.

1.4.1 Assess the readiness of patient and relative to improve their knowledge.
1.4.2 Inform and motivate the patient and relative to be part of the learning process, and allow them to ask and give opinions.
1.4.3 Instruct them how or what to do before, during, and after surgery.
1.4.4 Assess their understanding and capability of self-practice.

1.5 Assess the psycho- social condition.

1.5.1 Assess their mind related to age, self-development, disease, and procedures.
1.5.2 Assess the factors that affect communication.

1.5.3 Assess the level of a patient's knowledge.
1.5.4 Assess their mechanism of dealing with any problems.
1.5.5 Assess their basic knowledge of surgery.
1.5.6 Assess patient's social supporting sources.

1.6 Patient's mental-health care.
1.6.1 Assess any symptoms and signs of anxiety.
1.6.2 Inform the patient of the date of surgery as well as the place, surrounding areas, and include the daily nursing care routine.
1.6.3 Introduce the team who will look after the patients and make sure they will receive intimate care.
1.6.4 Inform and answer the questions openly.
1.6.5 Assess the difference in social status and culture of different patients.
1.6.6 Inform the patient of the purpose of nursing care every time.
1.6.7 Cooperate with the physician by giving more information of treatment to patient as requested.
1.6.8 Motivate the patient to be part of the nursing care plan, and in making decision.
1.6.9 Assess the response to mental care.

1.7 Giving instructions the steps of self-practice in the operating room.
1.7.1 Instruct about self- care before surgery and in the waiting area of operating room.
1.7.2 Review the time of arrival at the operating room and waiting area.
1.7.3 Review the instructions before surgery such as N.P.O, skin preparation ,enema, clean body and clean clothing.
1.7.4 Review basic knowledge of self- care after surgery including the attached devices on patient.
1.7.5 Explain the changes after surgery and how to adapt oneself to promote comfort.
1.7.6 Assess the patient's awareness and understanding of this instruction.

1.8 Education for nutrition.
1.8.1 Patient nutrition assessment, eating behavior, nutrition knowledge.
1.8.2 Suggest food for specific diseases and the type of surgery.
1.8.3 Evaluate the results of patient's understanding to these suggestions.

1.9 Education for drugs administration.

1.9.1 Assess for allergy of drugs or any substance.

1.9.2 Assess his/her drugs knowledge.

1.9.3 Instruct on the use of drugs.

1.9.4 Inform the patient of drugs interaction and any possible harmful side- effects which need to be noticed.

1.9.5 Evaluate the patient's understanding of the above instructions.

1.10 Education for pain management.

1.10.1 Describe the pain types resulting from surgery.

1.10.2 Suggest to use pain self-assessment by using the tools of numerical- pain scale or facial- grimace scale.

1.10.3 Advise on how to relieve pain by other methods instead of taking analgesics.

1.10.4 Instruct the patient on pain relief by taking analgesics, dosage, drugs interactions, instructions and side-effects of the drugs.

1.11 Education for wound care.

1.11.1 Assess the patient's and relative's basic knowledge of wound care.

1.11.2 Explain the factors that affect wound healing or wound infection.

1.11.3 Instruct on the wound- care method, choosing appropriate dressing supply to his/her life style and economic status.

1.11.4 Evaluate the patient's understanding related to wound care.

2. Competency related to ethics and patient's rights.

2.1 Check the surgical consent form.

2.1.1 If consent by patient is required.

1.Generate a better relationship with patient by using appropriate communication.

2.Assess patient's knowledge of surgery.

3.Inform patient as needed and explain the steps of surgical treatment including answers to all queries.

4.Cooperate with physician(surgeon) in answering some queries regarding the risk of surgery, or any complication after surgery that may occur.

5.Complete the documentation.

2.1.2 In the case of urgent surgery.

1.Generate a better relationship with patient, by utilizing appropriate communication.

2.Consult a relative or legal parents and request the permission of both parties as witnesses, then record it.

3.Reconfirm the procedure with surgeon.

2.1.3 In the case of refusal of consent

1.Generate a better relationship with patient by use appropriate communication.

2.Assess patient's knowledge and understanding of their surgery as well as their social status.

3.Reconfirm the steps of surgical procedure.

4. Cooperate with physician in answering some queries regarding the risk of surgery, an alternative treatment, and the effects from surgery.

5.Arrange for the patient and a legal relative to sign the consent form with both parties as witnesses.

6.Answer the patient's or relative's questions.

7.Complete the documentation.

2.1.4 In the case of disable patient.

1.Generate better relationship with patient, use appropriate communication. Consider the level of knowledge, assess psycho- social status and his understanding.

2. Reconfirm the steps of surgical procedure.

3. Arrange the patient and a legal relative to sign the consent form with both parties as witnesses.

4.Confirm their consent and allow his/her relative to ask questions.

5.In the event there is no relative, follow the hospital's policies.

2.2 Care for patient's values and needs.

2.2.1 Assess his/her knowledge, ability to understand something.

2.2.2 Provide enough time to give adequate information. Do not rush; put your patient at ease.

2.2.3 Assess the factors that influence his/her believe and values.

2.2.4 Information to be given to your patient must take into account his belief, philosophy ,culture, and his values that influence to his health and behavior.

2.2.5 Encourage the family members to be part of a care plan, for both before and after surgery, and allow them to give an opinion.

2.2.6 Nursing care must be considerate of his/her culture.

2.3 Discharge planning by patient and relatives

2.3.1Motivate the willing relatives who are able to look after the patient

2.3.2 Assess and review the capability of patient and relatives to do this.

2.3.3 Assess the relative for physical , psychological conditions and supporting source.

2.3.4 Make sure the relatives understand the patient's condition and let them to be part of discharge planning.

2.3.5 Inform the patient and relative of the possibility of desirable outcome to surgery.

2.3.6 Assess the expectation of relatives and level of the patient's needs.

2.3.7 Evaluate the patient's discharge plan.

2.4 Giving information and instructions for patient's needs.

2.4.1 Review the document of patient's intention on the medical record.

1.Assess patient's understanding and his psycho-social status.

2.Review the patient's needs.

3.Look after him as needed.

2.4.2 In the event that there is no document of intent please do as follows:

1.Assess his knowledge and psycho-social status.

2.Assess the needs and his intention for health condition.

3.Inform, and answer questions as requested.

4.Record on medical chart per hospital's work instruction.

5.Assess his/her knowledge as the patient's intention.

2.5 Nursing care in accordance with the standard of the Nursing Profession.

2.5.1 Utilize the nursing process for nursing care.

1.Review patient's information from assessment of both physical and psychological conditions as well as his/her values and culture status.

2.Set the nursing diagnosis.

3.Set the goal, indication and result of nursing care.

4.Set nursing intervention: allow patient and relatives to be part of this.

5.Use the nursing- care plan as planned, and assign a responsible staff member to the task.

6.Evaluate the results of nursing care.

2.6 Maintain the patient's privacy.

2.6.1 Operating room traffic control by

1.Limit an access to the area of nursing care and the numbers of staff in the OR. suites.

2. Record staff members name who are part of the team.

2.6.2 Keep the patient's medical record safely in an appropriate area.

2.6.3 Respect the patient's dignity and privacy.

1.Do not expose the patient physically.

2.Treat the patient by considering his culture, belief and honor.

3.Provide comfort and keep warm.

4.Care for dead body respectfully.

2.6.4 Keep the patient's confidentiality by

1.Limiting access of patient's information, to concerned persons only.

2.Consult with or refer the information to concerned persons only.

3.Get permission from patient under all circumstances.

4.Limit the number of nursing personnel in the area: allow concerned persons only.

2.7 Treat the patient according to the nursing etiquette (manners) and legal standard.

2.7.1 Provide nursing care to accepted nursing standard, regardless of the patient's social and economic status, education, culture, religion, age and gender.

2.7.2 Provide nursing care with respect to the patient and their human rights according to the nature of illness.

1.Treat the patient by considering his culture, belief and dignity.

2.Provide a private environment.

3.Always give good nursing care to every patient.

4. Evaluate the patient's response.

2.7.3 Act as patient's representative, to protect him/her from malpractice and illegal action.

1. Provide nursing care as a competent OR professional nurse.

2. Provide nursing care, fulfilling the role of OR nurse.

3.Assign all tasks to experienced staff members

2.8 Treat all patients equally without prejudice, and appropriately in every situation.

2.8.1 Treat all patients equally in the treatment area whether they are inpatients or outpatients.

2.8.2 Respect a patient's privilege, dignity and legal's rights by:-

1.Checking the consent form.

2.Letting the patient and relatives be part of treatment decisions.

3.Maintaining privacy during nursing care.

4.Explaining and getting permission prior to any nursing care,

2.9 Agree with the importance of human rights, lifestyle, culture, race of patient.

2.9.1Assess the factors of a patient's culture and spiritual, background and belief.

2.9.2 Gather all assessed data to be included in the nursing- care plan.

2.9.3 Maintain effective communication with the team to ensure appropriate nursing care.

The Competency Related to Health- Care System.

1. To be member of the nursing profession.

1.1 Obtain a certificate of perioperative nurse.

1.2 Obtain Nursing License.

1.3 Continue his/her education consistently.

1.4 Be able to utilize critical thinking to interpret complex data.

1.5 Take a significant part in studies and research.

2. To perform the task according to the policies and standards of the organization.

2.1 Perform to safety standard policies of workplace and per work instructions.

2.2 Understand his/her role and rights.

2.3 Maintain the good condition of OR. environment at all times.

2.4 Follow the hospital's policies and work instruction with regards to fire protection.

3. To support and comply with the organization's goals.

3.1 Follow the organization's regulations.

3.2Maintain good communication skill and work toward resolution of conflict.

3.3 Always be aware of good manners and the law.

3.4 Know the organization and levels of management.

3.5 Participate in professional development and understand terminology.

3.6 Understand and follow the organization's policies.

3.7 Be Responsible in the utilization of the organization's budget.

3.8 Be Able to work as a team member.

Assessment of Perioperative Nurse Competency

Assessment of perioperative nurse competency is composed of 2 parts. The first part is assessment of perioperative nurse's role, these are competency of patient safety, physical nursing care (intervention), behavioral nursing care and health- system nursing care as well as perioperative Nurse competency of surgical procedures of which there
are 16 types. The other skills are included in the utilization of equipment and supplies.
This 'assessment' was adapted from Nursing Interventions of Benner, in order to be harmonious to standard work performance in the operating room.

The committee of the Thai Perioperative Nurse Association who has provided these documents hope that these ' assessments' will be applicable to your workplace as a tool in assessing to your nursing staff members.

Criteria of Perioperative Nurse Competency

Levels	Behavioral indications
1.Experience 0-2 years	**Level 1 New member(Novice**) Able to perform nursing intervention during pre, intra and post surgical phases per work instructions/ standard for each simple procedure .Unable to work alone, must be under supervision and orientation. Lack of confidence and slow working. Mistakes might happen unless closely monitored.
2.Experience 2-4 years	**Level 2 Beginner**. Able to perform nursing intervention during pre, intra and post surgical phases per work instructions/standard for each simple procedure correctly but inconsistently .Sometimes some mistakes may occur if working alone.
3.Experience 4-6 years	**Level 3 Competency(Competent)** Able to perform nursing intervention during pre, intra and post surgical phases per work instructions/standard for each simple procedure correctly, properly and consistently and be able to learn from their previous mistakes to improve performance.
4.Experience 6-10 years	**Level 4 Proficiency(Proficient)** Met level 3 and perform skillfully under crisis situations, prevent and/or solve problems correctly and in time. Recognized by other staff nurses and served as preceptor. Utilize research and development information to improve performance in the workplace with the multidisciplinary.
5.Experience more than 10 years.	**Level 5 Expert** Met level 4. Develop innovative strategy to enhance the O.R tasks. Publicize his/her research findings to be used in other institutes with acceptance.

How to use the Form of Assessment of Perioperative Nurses' Competency.

This form is a behavioral guide for nurses and mentors to self assess their performance in the operating room.

1.Objective:

1.1 To assess the perioperative nurses competency.
1.2 To practice self-competency.
1.3 To demonstrate your competency to your supervisors.
1.4 To provide information for assignments.

2.Definitions:

E = Expectation
S = Self- assessment
P = Preceptor assessment
G = Gap(the different levels of competency)
Above expectation +
Below expectation – Needs to improve
N/A = Not Applicable

3.How to assess.

3.1 Self-assessment

3.1.1 Allow the (assessor) performer to understand clearly about the level of behavior.

3.1.2 The performer is able to compare the 4 levels of competency from work instructions for each unit such as doctor preference cards, operation procedures
for any type of surgery, hand washing, lab collection for analysis, etc.

3.1.3 Assessor must level their own competency into S box, going from level 1to 5 for each behavioral indicator.

3.1.4 In the case of ' no assignment' or 'no performance' to be assessed, put N/A in that box.

3.1.5 All perioperative nurses must complete the 4 levels of competency.

3.1 6 Competency for each procedure will be assessed as assigned only.

3.1.7 Competency for utilization of equipments & supplies will be assessed as assigned only.

3.2 Preceptor assessment

3.2.1 Complete the expected competency into E box as required to assess.

3.2.2 Provide the assessment form to assessor to complete self-assessment first.

3.2.3 Assess per instructions.

3.2.4 Use the scores in P box minus scores in E box then complete the results in G box which is the score to be considered to improve his/her performance. The scores can be either plus or minus.

After assessment, submit to immediate superior or Head Nurse to consider his/her plan for self-development as well.

References

Jiraprapa Akarabovorn .Build people, build jobs. Bangkok. K.Polpim.1996.
AORN.Standards Recommended Practices and Guidelines. Denver. AORN Inc.1999.
AORN.Standards Recommended Practices and Guidelines. Denver AORN Inc.2006.
Benner.Patricia Benner's Model of Novice to Expert describes five stages of nurse development.www.cpep-net.ca/system/files/PatriciaBenner.pdf. (Online) 2001.
FASTAFF.Rwgistered professional nurses job description perioperative care.www.fastaff.com/pdfs/skills_checklists/operative_combination.pdft. (Online) 2005.
Gruendemann.B.J. and Fernsebner.B. Comprehensive perioperative nursing. Boston.Jones and Bartlett.1995.
Robin Chard. Perioperative Competencies. Position Descriptions and Evaluation Tools. Denver: AORN, Inc.2010.