Quality in theatre care: a critical analysis

It is difficult to apply a universal definition to ‘quality’ and what constitutes ‘quality’ in nursing practice. This article examines quality care in operating theatres by reflecting on two critical incidents. The incidents are then analysed to elicit quality issues arising from them.

A review of some of the nursing literature on ‘quality’ reveals the lack of a universally applicable definition and a variety of ideas about what constitutes quality in nursing practice (Attree 1993). Reflection on and analysis of critical incidents is an accepted form of ‘collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles’ (Flanagan 1954). The technique has been used in research into quality issues (Norman et al 1992).

CRITICAL INCIDENT ONE
A consultant surgeon arranged for a patient to undergo a minor procedure (muscle biopsy) under local anaesthetic before the start of the following day’s theatre list. Details about the patient and the intended procedure were put onto the list and the muscle biopsy was scheduled to take place at 8.30am. It was anticipated that it would take about 20 minutes to complete.

The patient was sent for at 8.20am, arrived in theatre, was checked in and his details entered into the operation register. He was then helped onto the operating table and a nurse remained with him. There were no medical staff in the operating department at that time.

After about ten minutes the nurse accompanying the patient asked a colleague to find out where the surgeon was. It transpired that he was not yet in the hospital. Telephone messages were left with his secretary and with ward staff in case he visited other patients.

After about 15 minutes an attempt was made to contact the senior registrar. A ward nurse answered his bleep because he was seeing patients and a message was given to the ward nurse regarding the patient in theatre. The consultant surgeon finally arrived at 9.10am, by which time the patient had been on the operating table for 40 minutes.

The consultant surgeon was met by the theatre clinical manager and an argument ensued. Raised voices could be heard by the nurse and the patient in the theatre. It appeared that the surgeon had forgotten about the muscle biopsy that he had arranged and had not told any of his other staff about it.

The clinical manager insisted that the patient be returned to the ward so that the rest of the planned list could start and was supported in this by the consultant anaesthetist. The patient remained on the operating table while this argument took place. Eventually, the consultant surgeon apologised to the patient who was then sent back to the ward. The surgeon admitted to the patient that he had forgotten about the arrangements made the day before.

The patient had not eaten, had been brought to theatre and lain on the operating table for 50 minutes, only to return to the ward and be told the muscle biopsy would take place the next morning.

ANALYSIS
Many important issues arise from this incident. It is an example of poor quality care from both nurses and doctors. The patient was treated as an object to be fitted into a system run for the convenience of the hospital. Accepting that quality is related to excellence, value and worth (Attree 1993), none of these were attained in this incident.

Koch (1992) observed that quality in health care is driven by ‘market forces, coercion and professionalism’, all of which are apparent in this incident.

Market forces Market forces bring pressure on theatre and medical staff to perform more operations, meet targets and keep waiting lists down. Here was a consultant surgeon who willingly agreed to undertake what should have been a short procedure, without troubling an anaesthetist or other members of his team. He is to be commended for his good intentions and his lapse of memory is forgivable on the grounds that it is a failing we all share. In terms of market forces, this man was trying to do his bit to help.

Coercion The theatre manager acted in a coercive way in making the rest of the list a priority without apparent concern for the patient already...
lying on the table. This coercive behaviour was supported by the consultant anaesthetist who also disregarded a patient who did not require his specific attention.

Coercion may also have been the force behind sending for the patient without checking that the surgeon was at least in the hospital - a common practice which in most cases does not cause problems and does save time. For this patient, however, those 50 minutes were not saved. He was put through an uncomfortable and frightening ordeal which was now going to be repeated the next day.

**Professionalism** Professionalism is interpreted here as the behaviour expected of members of a profession. Patients put their faith and trust in professionals and satisfying these expectations should be an integral part of care (Bond and Thomas 1992). It is unlikely that this patient's expectations were satisfied, although it must be noted that no complaint arose from the incident.

The professionals involved do not come out of this well. The hierarchical nature of hospital organisation, so often typified in operating theatres, may have an effect on the quality of care. This was apparent to Johansson et al (1994) who observed that 'relationships with colleagues and leadership qualities seem to play a vital part'. The relationships and leadership qualities apparent in this incident are those of confrontation and manipulation.

The theatre manager had her own agenda and did not allow the surgeon to alter it. In terms of nursing leadership this was an organisational matter and she was exercising her organisational power (Williams 1995). As an example of nursing leadership this puts power before patients. She was supported by the consultant anaesthetist who had his own position to consider. He was, in hierarchical terms, the surgeon's peer and was exercising his power by manipulating the situation to the disadvantage of the surgeon. The confrontation and argument, heard by most of the department and probably by the patient, has to be judged as unprofessional behaviour.

A further aspect of the organisational influence on this incident is the fact that the patient had been fasted before coming to theatre. As the procedure was scheduled to take place under local anaesthetic, and there was not an anaesthetist in the hospital when the patient was brought to theatre, this raises the question of why the patient had not been allowed to eat.

It would seem to be another outdated ritual, like putting tape over rings, which patients are subjected to just because they are coming to theatre (Walsh and Ford 1989). Nurses, if they wish to assume the mantle of professionalism, must practice research-based care as an integral part of delivering quality care (Fitzpatrick et al 1992).

**CRITICAL INCIDENT TWO** At the end of an early shift, two theatre nurses were about to go off duty when they were approached by the theatre manager and asked to stay to help with another case, said to be an emergency. The late shift staff had taken over the remaining list cases which were over-running. The hospital in which this incident took place had two operating theatres, only one was staffed 'out of hours'.

The details given about the emergency case were that this was a patient who had been in hospital for four days and needed to have a biopsy in order to make a definitive diagnosis of a brain lesion noted on her CT scan. The patient's condition was not critical and her life was not in immediate danger. The consultant wanted to have a definitive diagnosis because the patient's only relative, a daughter, was coming from the US to see her mother. The nurses and an operating department assistant (ODA) stayed on duty and assisted with the procedure.

Operating theatre staff are used to dealing with emergency cases at all hours of the day and night. Usually, such cases are a matter of extreme urgency or life threatening. However, this was not so in this case and yet the response of theatre staff was to accept the request and respond positively to it.

**ANALYSIS** This is an example of good quality care, not just for the patient, but also for her daughter. It is highly unlikely that the patient or her daughter would know about the arrangements for the surgery. Sidel (1976) recognised there are many stakeholders in the quality equation, including the patient, family, surgeon, nurses and the wider public who finance the service. All have the right to demand good quality care.

Given the intangible nature of 'quality' (Parsons 1995), the factors which make this an example of good quality care come from the attitudes and behaviour of the people involved (Watkins 1994). Information is a vital component of quality (Moss 1994, Munro 1992) and the information required by the surgeon, the patient and her daughter was obtained.

Unlike the previous incident, there was no coercion or power play involved. The staff agreed to stay on duty because they were satisfied with the reasons given for the procedure needing to be carried out. In terms of working conditions, this could have been seen by the staff as an abuse of the emergency service, a common enough occurrence in theatres according to Williams (1996). However, conditions were such that they were happy to do what was asked.

Bergman's (1994) observations, that quality of patient care is directly related to the quality of work life experienced by staff, would seem to be borne out by this incident. This philosophical perspective extends the dimension of quality from the circumstances of the
occurrence to the quality of life of the patient and her daughter. Both objective and subjective domains of any nursing situation need to be considered in relation to quality of life (Benner 1985).

CONCLUSION

These two incidents illustrate the everyday frustrations of operating theatre nurses. Working closely with medical staff, organisational rigidity and role expectations can fuel conflicts. It can sometimes be difficult to see any value attached to theatre nurses’ work other than to facilitate the work of surgeons and anaesthetists by managing the organisation of lists and supporting surgery with technical skills and knowledge.

Combined with the current reluctance to allocate student nurses to operating theatres (Brackley and Bowles 1996), the future could be perceived as bleak. Theatre nurses need to realise this and that they can do something about it (Wicker 1996).

Quality nursing care in operating theatres can be achieved by making it the focus of every activity (Brown 1995). There are many pressures: to complete lists regardless of time; not to cancel patients; to undertake more operations. These pressures are not going to go away (Collins 1994). Quality should be built into every encounter and action to make it personalised for each patient (Pontin and Webb 1996).

Operating theatres can too readily become surgical production lines where quantity dominates and quality is an optional extra. Major manufacturers are abandoning rigid managerial hierarchies in order to get closer to the consumer and deliver what the consumer wants (Mitchell 1994). Surgery should not be separated from the context of peri-operative care, but should be, as Brown (1995) suggested, part of the holistic process in which ‘the operating department nurse can move towards personalising the operative procedure, which ought to lead to more attention being given to the principle of respect for persons’.

REFERENCES


Flanagan’s critical incident technique to elicit indicators of high and low quality nursing care from patients and their nurses. Journal of Advanced Nursing. 17, 785-794.


