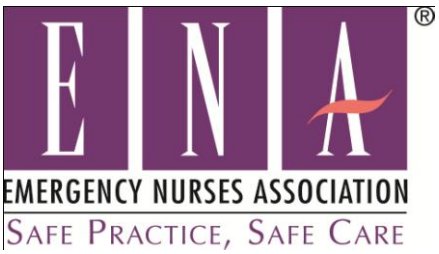
Competencies for Clinical Nurse Specialists in Emergency Care



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Recommended Citation

Emergency Nurses Association. (2011). *Competencies for clinical nurse specialists in emergency care*. Des Plaines, IL: Author.

Contents

Introduction

The Institute of Medicine[1] recommends that all nurses practice to the fullest extent of their education and training and that State scopes of practice for advanced practice registered nurses (APRN) support this expanded practice. The role of the APRN in emergency care continues to evolve, and APRNs are assuming more responsibility in providing health care. For the continued advancement of the role, the natural evolution, promoted by professional and societal forces, is to clarify and define the scope of practice and specialty competencies for APRNs in emergency care.

This document defines the specialty competencies for the clinical nurse specialist (CNS) practicing in emergency care. Clinical nurse specialists are one of four APRN roles.[2] In recent years, there has been diminishing recognition of the CNS role as an advanced practice role. In addition, misunderstanding of the practice of clinical nurse specialists at local, state and national levels exists. To address these issues, it is critical that clinical nurse specialists identify their scope of practice[3] and standards of practice and delineate competencies for practice.

While the National Association of Clinical Nurse Specialists (NACNS) has developed core competencies for all clinical nurse specialists,[4] specialty organizations are expected to establish competencies in their specialty area. Therefore, the Emergency Nurses Association (ENA), as the professional organization for emergency nurses, delineated the specialty competencies for clinical nurse specialists in emergency care.

The competencies in this document emphasize the needs of health care professionals and patients served including individuals, families and populations across the lifespan. The care provided by clinical nurse specialists in emergency care requires a vast body of knowledge relating to acute and chronic illness and injury, focusing on complex conditions and vulnerable patient populations. Clinical nurse specialists in emergency care practice as part of an interdisciplinary team, as appropriate, in a variety of settings, including emergency departments in urban, suburban, and rural hospitals; trauma centers; pre-hospital settings; and urgent and emergent care centers.

The competencies for clinical nurse specialists in emergency care can serve to guide policies and decisions related to the practice, education and potential certification of clinical nurse specialists in emergency care. The competencies also help to differentiate the CNS role from other APRN roles in emergency care. (see Appendix A. *Competencies for Clinical Nurse Specialists in Emergency Care*)

Background and Core Tenets

According to the National Council of State Boards of Nursing *Consensus Model for APRN Regulation*, an APRN is a licensed independent practitioner who is expected to practice within standards established or recognized by a licensing body.[2] The *Consensus Model* identifies four APRN roles: nurse anesthetist, nurse midwife, clinical nurse specialist and nurse practitioner.[2] APRNs are educationally prepared to provide care to patients across the health continuum, although the emphasis and implementation varies by role. APRNs share many competencies, but the focus of practice is different for each role. A defining factor for all APRN roles is that a significant component of the education and practice must focus on the direct care of individuals.[2] APRN practice builds on the competencies of registered nurses by demonstrating the core tenets of a greater depth and breadth of knowledge, a greater synthesis of data,

increased complexity of skills and interventions and greater role autonomy. The specialty competencies for the CNS in emergency care build upon these core tenets of APRN practice. A clinician who wishes to excel as a CNS must incorporate these core tenets into his or her practice.

Clinical nurse specialists focus on the provision of advanced practice nursing care to patients in all health care settings and across all specialties. In addition to being an expert direct care clinician ranging from primary provider to consultant, clinical nurse specialists are experts in the synthesis, integration, transformation and translation of best practices to facilitate bridging the gap between research and practice. Competent CNS practice ensures quality and safe patient care both directly and indirectly.

The educational preparation of APRNs in emergency care requires graduate education at the Master's, post-Master's, or doctoral levels. The educational program should adhere to the educational curriculum standards set forth by the American Association of Colleges of Nursing[5-6] and other agencies responsible for advanced practice educational programs, such as, but not limited to, the National Association of Clinical Nurse Specialists.

In addition to graduate course completion, APRNs wishing to specialize in emergency care must obtain educational preparation related to emergency care and may do so through various pathways including: 1) successful academic course completion specific to emergency care; 2) continuing education course completion; and/or 3) on-the-job instruction in emergency care.

The role of the CNS in emergency care varies widely. The role is influenced by the needs of an ever changing emergency care environment. The CNS in emergency care must be flexible to meet the needs of the patient, family, staff and institution. The setting may range from inside the walls of the hospital to the community at large. The CNS in emergency care anticipates as well as responds to rapidly changing situations that may require different skills on a daily basis. The role of the CNS in emergency care is one that is required to be as adaptable as the environment in which they practice.

In response to a resolution passed by the ENA General Assembly in 2006, ENA convened the Clinical Nurse Specialists in Emergency Care Work Team to develop competencies for the CNS practicing in emergency care. The Work Team initiated its charges in 2009, which included conducting a literature review and contacting other national organizations to identify potential competencies. Facilitated by staff of the ENA Institute for Emergency Nursing Research, the work team designed a research study to identify, refine and validate the essential competencies for clinical nurse specialists in emergency care. (see Appendix B. *ENA Clinical Nurse Specialists in Emergency Care Work Team Members*)

Theoretical Framework

The competencies for clinical nurse specialists in emergency care outlined in this document build upon the NACNS core competencies.[4] The only competencies included here are unique to and differentiate the essential knowledge, behaviors and skills of clinical nurse specialists in emergency care. Additionally, the CNS in emergency care possesses the competencies of registered nurses in emergency care and practice within the scope of their State Practice Act. These competencies help shape the current and future practice and education of clinical nurse specialists in emergency care.

The practice of APRNs in emergency care is grounded in the core values and scope of practice for the generalist nurse. APRNs adhere to the American Nurses Association's *Nursing's Social Policy Statement*,[7]

Nursing: Scope and Standards of Practice[8] and the *Code of Ethics* for nurses.[9] APRNs in emergency care also possess the core knowledge and skills of emergency nurses as described in the *Emergency Nursing Core Curriculum*[10] and *Emergency Nursing Procedures*.[11]

The ENA Clinical Nurse Specialists in Emergency Care Work Team refers to the *Consensus Model for APRN Regulation* for regulatory guidance as it relates to licensure, accreditation, certification and education (LACE).[2] Licensure is the granting of authority to practice. Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs. Certification is the formal recognition of the knowledge, skills and experience demonstrated by the achievement of standards identified by the profession. Education is the formal preparation of APRNs in graduate degree-granting or postgraduate certificate programs. Furthermore, the *Consensus Model* recommends specialty education and practice to build upon the educational foundation that focuses on the role and population focus appropriate for that specialty.[2]

ENA acknowledges the core competencies established by NACNS as the foundation for all clinical nurse specialist practice.[4] The NACNS core competencies, developed in 2010, include the following domains: direct care, consultation, systems leadership, collaboration, coaching, research and ethical decision-making/moral agency/advocacy. Within these domains, the competencies for the CNS in emergency care are specified to meet the needs of a unique population. The competencies in this document define the role of the CNS in emergency care as it relates to expertise in emergency care, evidence-based practice, and education of the staff, health care consumers and family with a goal of improving health care outcomes in the emergency care setting as well as in the community.

The ENA Clinical Nurse Specialists in Emergency Care Work Team found that the Lewandowski and Adamle[12] framework was the most appropriate to guide the development of the competencies. Lewandowski and Adamle define three substantive areas related to the role of the CNS: 1) managing the care of the complex and or vulnerable patient, 2) educating and supporting interdisciplinary staff, and 3) facilitating innovation and change within health care systems.[12] Utilizing this framework does not only allow clinical nurse specialists in emergency care to conceptualize their practice but it provides a foundation for defining the competencies, which can be shared with organizations, administrators, consumers and other health care professionals.

Process

The process to develop the competencies involved an extensive literature review followed by development of an initial list of competencies. The competencies were reviewed by an expert panel and presented to a group of representatives from stakeholder organizations. As a final stage in the development of the competencies, they were validated with a national sample of clinical nurse specialists practicing in emergency care.

Literature Review

In early 2009, the ENA Clinical Nurse Specialists in Emergency Care Work Team conducted a literature review to explore issues affecting the practice and competencies of emergency clinical nurse specialists. A primary focus of the literature review involved identification of existing competencies relevant to CNS practice in emergency care. Based on the literature review, the work team developed an initial list of 43 competencies.

Expert Panel Review

The initial list of competencies was reviewed by a 31-member expert panel through two rounds of review (September – November 2009). Members of the expert panel were identified by the ENA Clinical Nurse Specialists in Emergency Care Work Team as having expertise in emergency CNS practice (e.g., through some level of scholarship). Expert panel members were all active clinical nurse specialists working in emergency care (e.g., emergency department, emergency/urgent care clinic, pre-hospital EMS, military). (see Appendix C. *Expert Panel Members*)

The purpose of the expert panel review was to obtain feedback on the competencies. In Round I, expert panel members were asked to rate the importance of each competency for CNS practice in emergency care. In addition, they rated the clarity of each statement and provided their overall impression of the list of competencies. In Round II, panel members were asked to rate their level of agreement with whether each competency could be considered a core competency.

After each round of the expert panel review, the work team evaluated the results and revised and refined the list of competencies based on the feedback received. At the completion of the expert panel review there were 33 competencies in the list, which was then shared with a group of organizational stakeholders.

Stakeholders Meeting

In April 2010, ENA hosted a stakeholders meeting to discuss and gain consensus on the competencies for clinical nurse specialists in emergency care. Stakeholders included organizations that addressed regulatory, educational, certification and practice issues relative to clinical nurse specialists in emergency care. During the meeting, an overview of the history and practice of clinical nurse specialists in emergency care, as well as a summary of the ENA project to define the competencies, was provided. An interactive discussion took place among representatives regarding each competency and its relationship to national issues affecting CNS practice in emergency care (e.g., education, practice, regulation). (See Appendix D. *Organizations Represented at Stakeholders Meeting*)

Following the stakeholders meeting, the competencies were revised by the ENA Clinical Nurse Specialists in Emergency Care Work Team as appropriate, incorporating feedback from the stakeholders. The resulting list of 28 competencies was then validated with a national sample of clinical nurse specialists practicing in emergency care.

Validation Study

From May 2010 through July 2010, a cross-sectional, descriptive study using a one-time online questionnaire was conducted to validate the competencies. Specific aims of the Validation Study were to: a) describe the characteristics of clinical nurse specialists practicing in emergency care and b) examine the extent to which the competencies reflected actual practice relative to perceived importance and frequency of performance by study participants.

Validation Study participants were clinical nurse specialists who currently practiced in emergency care in the U.S., including all types of clinical nurse specialists (e.g., critical care CNS, adult CNS, pediatric CNS) and

all types of settings where emergency care is delivered (e.g., emergency departments, urgent care clinics, air and ground transport services). Individuals functioning as a CNS who did not have the title "clinical nurse specialist" were considered to be eligible for the study provided that they were prepared as a CNS at the graduate level and currently practicing in emergency care. A total of 119 participants met the eligibility criteria for the study and were included in the final analysis.

In the questionnaire, participants were asked to rate each of the 28 competencies on the following scales:

1. How important is this competency in your practice as a CNS in emergency care? (6-point scale with 1 = Not At All Important and 6 = Very Important)
2. How often do you perform this competency in your practice as a CNS in emergency care? (6-point scale with 1 = Never and 6 = Always)

Participants also were asked their overall impression of the list of competencies and given an opportunity to comment on the list. Demographic questions and questions regarding current role and practice characteristics also were included.

Decision Rules

A competency statement was included in the final list if: 1) 80% or more of Validation Study participants rated the competency as highly important (i.e., rated importance at 4 or more on the 6-point scale) and/or 2) 50% or more of Validation Study participants rated the competency as frequently performed (i.e., rated frequency at 4 or more on the 6-point scale). For statements that had 60%-80% of participants rating as highly important and less than 50% of participants rating as frequently performed, the ENA Clinical Nurse Specialists in Emergency Care Work Team deliberated to make a decision regarding whether the statement should be included in the final list.

Competencies

Of the 28 competencies rated in the Validation Study, 23 received ratings that met the criteria for inclusion in the final list. The remaining five competencies had importance ratings that fell below the 80% cut off and frequency ratings that fell below the 50% cut off; however, all five had greater than 60% of participants rating them as highly important. The Work Team discussed the five competencies during their October 2010 face-to-face meeting, and after taking into consideration the qualitative feedback received from expert panel members and validation study participants, determined that two of the five would be included in the final list of competencies. (See Appendix A. *Competencies for Clinical Nurse Specialists in Emergency Care* and Appendix E. *Glossary of Terms*)

Conclusion

The CNS in emergency care is an advanced practice registered nurse that provides care to the most complex or vulnerable patients. In addition, the CNS educates and supports interdisciplinary staff and facilitates change and innovation within health care systems. These cornerstones of CNS practice are founded upon the core tenets of APRN practice that include providing direct care of individuals, having greater role autonomy, and demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, and increased complexity of skills and interventions. The specialty competencies for the CNS in emergency care will provide clarity for practice and education to decrease the confusion that has affected the role for decades.

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Appendix A.

Competencies for Clinical Nurse Specialists in Emergency Care

Direct Care

Direct interaction with patients, families and groups of patients to promote health or well-being and improve quality of life. Characterized by a holistic perspective in the advanced nursing management of health, illness and disease states.

Competency Statement	Substantive Areas of CNS Practice[1]
1. Triages and responds to the rapidly changing physiological and psychological status of complex emergency care patients.	*Manage the care of complex and vulnerable populations*
2. Performs advanced life-saving interventions.	
3. Prioritizes differential diagnoses and implements a plan of care appropriate for emergency patients and families.	
4. Applies current evidence-based knowledge and skills for assessing, diagnosing, planning care for and determining disposition of emergency patients and families.	
5. Utilizes skillful, culturally sensitive and crucial communication during crisis or conflicts.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff*
6. Facilitates care coordination and transitions for critical, complex or vulnerable patients as well as their families.	*Manage the care of complex and vulnerable populations* *Facilitate change and innovation within health care systems*

Consultation

Patient, staff or system-focused interaction between professionals in which the consultant is recognized as having specialized expertise and assists consultee with problem solving.

Competency Statement	Substantive Areas of CNS Practice
7. Provides clinical consultation to nurses, physicians and other interdisciplinary colleagues regarding emergency patient care, systems, processes, specialty technology and equipment.	*Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*
8. Provides and translates evidence-based recommendations for complex patients including boarded patients and those with critical illness/injury or atypical presentations.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*

[1] Lewandowski, W., & Adamle, K. (2009). Substantive areas of clinical nurse specialist practice: A comprehensive review of the literature. *Clinical Nurse Specialist, 23*, 73-90.

Systems Leadership

The ability to manage change and empower others to influence clinical practice and political processes both within and across systems.

Competency Statement	Substantive Areas of CNS Practice
9. Collaborates with facility personnel to maintain EMTALA compliance.	*Educate and support interdisciplinary staff*
10. Assesses, anticipates and mitigates risks inherent in the delivery of emergency care through interdisciplinary collaboration.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff*
11. Develops, implements, disseminates and evaluates evidence-based practice guidelines for emergency patients with complex, high-risk or chronic conditions in emergency care.	*Facilitate change and innovation within health care systems*
12. Engages staff and the organization to incorporate performance improvement, quality and safety initiatives into practice.	*Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*
13. Interprets and evaluates current regulations to develop or implement clinical practice guidelines and policies for situations of violence, neglect or abuse.	
14. Analyzes the effects of community systems, resources and factors, such as regional trauma systems and EMS/prehospital protocols, and identifies opportunities for improvement to promote optimal emergency care.	
15. Participates in disaster management activities for the facility, external agencies and the community.	*Manage the care of complex and vulnerable populations* *Facilitate change and innovation within health care systems*

Collaboration

Working jointly with others to optimize clinical outcomes. The CNS collaborates at an advanced level by committing to authentic engagement and constructive patient, family, system and population-focused problem-solving.

Competency Statement	Substantive Areas of CNS Practice
16. Collaborates with interdisciplinary teams to facilitate clinical initiatives and expedite emergency patient care.	*Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*
17. Collaborates with community agencies to facilitate appropriate and safe care coordination and transitions for complex or vulnerable patients.	*Manage the care of complex and vulnerable populations* *Facilitate change and innovation within health care systems*

Coaching

Skillful guidance and teaching to advance the care of patients, families, groups of patients and the profession of nursing.

Competency Statement	Substantive Areas of CNS Practice
18. Serves as mentor, role model and expert resource for prehospital personnel, interdisciplinary colleagues and students.	*Educate and support interdisciplinary staff*
19. Develops, implements and evaluates educational programs related to emergency care (e.g., triage, trauma, psychiatric emergencies, disaster response).	*Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*
20. Coaches, mentors and acts as a role model for staff through emergency clinical scenarios or during rapidly changing situations.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff*
21. Facilitates the recognition, prevention, referral and treatment of stress responses among emergency care providers as it relates to critical incidents, compassion fatigue, vicarious trauma, acute stress disorder or post-traumatic stress disorder (PTSD).	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*

Research

The work of thorough and systematic inquiry. Includes the search for, interpretation and use of evidence in clinical practice and quality improvement, as well as active participation in the conduct of research.

Competency Statement	Substantive Areas of CNS Practice
22. Participates in interdisciplinary research and incorporates knowledge of unique emergency research requirements and guidelines.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*

Ethical Decision-Making, Moral Agency and Advocacy Identifying, articulating and taking action on ethical concerns at the patient, family, health care provider, system, community and public policy levels.	
Competency Statement	**Substantive Areas of CNS Practice**
23. Models respectful and professional care to staff and advocates for the needs of vulnerable and marginalized emergency patients.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff* *Facilitate change and innovation within health care systems*
24. Leads efforts to foster a family-centered care environment, including advocating for family presence during and after invasive procedures and resuscitation.	
25. Initiates discussions and participates in decision-making related to ethical concerns, many of which are time-sensitive.	*Manage the care of complex and vulnerable populations* *Educate and support interdisciplinary staff*

Appendix B.

ENA Clinical Nurse Specialists in Emergency Care Work Team Members

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Appendix C.

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Appendix D.

Organizations Represented at Stakeholders Meeting

American Academy of Nurse Practitioners
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American Association of Colleges of Nursing
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American Association of Critical Care Nurses
Marian Altman, MS, RN, ANP, CCRN

American College of Emergency Physicians
Ronald A. Hellstern, MD, FACEP

American College of Nurse Practitioners
Tom Shields, ARNP

American Nurses Association
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Commission on Collegiate Nursing Education
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National Association of Clinical Nurse Specialists
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National Council of State Boards of Nursing
Nancy Chornick, PhD, RN, CAE

National League for Nursing
Lynn Engelmann, EdD, MSN, RN, ANEF

In addition to the above stakeholders and members of the ENA Clinical Nurse Specialists in Emergency Care Work Team, the following representatives from ENA were present at the stakeholders meeting:

AnnMarie Papa, MSN, RN, CEN, NE-BC, FAEN, *2011 ENA President*
David A. Westman, MBA, CAE, CPA, *ENA Executive Director*
Jill S. Walsh, DNP, RN, *ENA Chief Nursing Officer*

Appendix E.

Glossary of Terms

Acute stress disorder: The development of characteristic anxiety, dissociative and other symptoms that occurs within one month after exposure to an extreme traumatic stressor. As a response to the traumatic event, the individual develops dissociative symptoms. Individuals with acute stress disorder may have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities, and frequently feel guilty about pursuing usual life tasks.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, D.C: Author.

Boarded patients: Admitted patients in the emergency department for whom the time interval between decision to admit and physical departure from the emergency department treatment area exceeds 120 minutes.

Welch, S., Augustine, J., Camargo, C. A., & Reese, C. (2006). Emergency department performance measures and benchmarking summit. *Academic Emergency Medicine, 13*, 1074-1080.

Care coordination: The deliberate organization of patient care activities among two or more participants (including the patient and/or the family) to facilitate the appropriate delivery of health care services. Organizing care involves marshalling personnel and other resources to carry out all required patient care activities, which is often managed by the exchange of information among participants responsible for different aspects of the care.

NTOCC Measures Work Group. (2008). *Transitions of care measures*. Retrieved from http://www.ntocc.org/portals/0/TransitionsOfCare_Measures.pdf

Complex emergency care patients: Patients who present for emergency care with two or more chronic conditions where each condition may influence the care of the other condition(s) through limitations of life expectancy, interactions between drug therapies and/or direct contraindications to therapy for one condition by other conditions themselves. Complex patients may also have challenges posed by demographic characteristics such as lack of insurance or poverty, which may affect complexity in clinical practice.

Agency for Healthcare Research and Quality. (2007). *Optimizing prevention and healthcare management for the complex patient: Technical assistance call*. Retrieved from http://www.ahrq.gov/fund/trans101507.htm

Community: The patients, families, colleagues, hospital systems and external agencies with which the clinical nurse specialist interacts.

Compassion fatigue: A phenomenon experienced by those who care for the traumatized. Compassion fatigue occurs as a result of secondary exposure to a traumatic event experienced by another. The traumatic event or situation may be as obvious as a threat to life or violence toward another.

Newsome, R. (2010). Compassion fatigue: Nothing left to give. *Journal of Nursing Management, 41*, 42-45.

Critical incident: Any event outside the usual realm of human experience that is markedly distressing. Such incidents usually involve the perceived threat to one's physical integrity or the physical integrity of someone else.

Critical Incident Stress Management International (2010). *What is a critical incident?* Retrieved from http://www.criticalincidentstress.com/critical_incidents

Crucial communication/conversations: Discussions that occur between two people where stakes are high, opinions vary and emotions run strong.

Patterson, K., Grenny, J., McMillan, R., & Switxler, A. (2002). *Crucial conversations: Tools for talking when stakes are high*. McGraw Hill: New York.

Culturally sensitive: The caregiver considers culture during planning and delivery of care. Culture is a system of beliefs, values, rules and customs that is shared by a group, and is used to interpret experiences and direct patterns of behavior. Culture plays a large role in shaping each individual's health-related values, beliefs and behaviors and clearly impacts clinical care.

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2010). Cross-cultural care and communication. *UpToDate, April 29, 2010*. Retrieved from http://www.uptodate.com/patients/content/topic.do?topicKey=~tii50IRVeYyqVE5

Disaster management: A multifaceted and continuously evolving discipline that requires a change in the paradigm of utilizing the greatest number of resources for the greatest good of each individual patient to the allocation of limited resources for the greatest good of the greatest number of casualties.

Emergency Nurses Association. (2007). *Trauma nursing core course provider manual* (6th ed.). Des Plaines, IL: Author.

EMTALA: In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (1986).

Evidence-based practice: A problem-solving approach to clinical care that incorporates the conscientious use of current best evidence from well-designed studies, a clinician's expertise and patient values and preferences.

Melnyk, B., M., & Fineout-Overholt, E. (2005). *Evidence-based practice in nursing & healthcare: A guide to best practice*. Philadelphia: Lippincott Williams & Wilkins.

Expert resource: As defined within the clinical nurse specialist role, one who synthesizes, integrates, transforms and translates best practices into clinical expertise.

National Association of Clinical Nurse Specialists. (2007). *A vision of the future for clinical nurse specialists*. Retrieved from http://www.nacns.org/LinkClick.aspx?fileticket=7AX5Ga5RbTg%3D&tabid=117

Family- centered care: The understanding that the family is the child's primary source of strength and support and that the child's and family's perspectives and information are important in clinical decision making. Family-centered practitioners are keenly aware that health care experiences can enhance parents' confidence in their roles and, over time, increase the competence of children and young adults to take responsibility for their own health care, particularly in anticipation of the transition to adult service systems.

American Academy of Pediatrics Committee on Hospital Care. (2007). Policy statement: Family-centered care and pediatrician's role. Retrieved from http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/3/691

Family presence: The presence of family in the patient care area, in a location that affords visual or physical contact with the patient, during invasive procedures or resuscitation events.

Eckle, N. (2007). Presenting the option for family presence (3rd ed.). Des Plaines, IL: Emergency Nurses Association.

Marginalized patients: People who are vulnerable to health risks resulting from discrimination, environmental dangers, unmet subsistence needs, severe illness, trauma or restricted access to health care.

Hall, J. M. (1999). Marginalization revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science, 22,* 88-102.

Mentor: One who offers knowledge, insight, perspective or wisdom that is helpful to another person in a relationship that goes beyond doing one's duty or fulfilling one's obligations.

Shea, G. F. (1999). *Making the most of being mentored*. Boston, Massachusetts: Thomson Learning NETg.

Post-traumatic stress disorder: Psychiatric disorder that can occur in people who have experienced or witnessed life-threatening events such as natural disasters, serious accidents, terrorist incidents, war, or other violent personal assaults.

American Psychiatric Association. (2010). Posttraumatic stress disorder. Retrieved from http://www.healthyminds.org/Main-Topic/Posttraumtic-Stress-Disorder.aspx

Regional trauma systems: An organized, inclusive approach to facilitating and coordinating a multidisciplinary system response to severely injured patients in intrastate-designated trauma areas (regions). A trauma system encompasses a continuum of care provision and is inclusive of injury prevention and control, public health, EMS field intervention, ED care, surgical interventions, intensive and general surgical in-hospital care and rehabilitative services, along with the social services and the support groups that assist injured people and their significant others with their return to society at the most productive level possible.

American College of Surgeons. (2008.). *Glossary of terms, acronyms, and abbreviations*. Retrieved from https://www.socialtext.net/acs-demo-wiki/index.cgi?glossary_of_terms_acronyms_and_abbreviations

Transitions of care: The movement of patients between health care locations, providers or different levels of care within the same location as their conditions and care needs change. Transitions of care are a set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.

NTOCC Measures Work Group. (2008). *Transitions of care measures*. Retrieved from http://www.ntocc.org/portals/0/TransitionsOfCare_Measures.pdf

Vicarious trauma: A process of change that happens because you care about other people who have been hurt and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical and spiritual well-being.

Headington Institute. (n.d.). *Understanding and addressing vicarious trauma*. Retrieved from http://www.headington-institute.org/Default.aspx?tabid=2648

Vulnerable patients: Persons who have or potentially have risk, susceptibility, poor resource availability, poor health status and health perceptions that predispose the person to poor health outcomes.

Dorsen, C. (2010). Vulnerability in homeless adolescents: concept analysis. *Journal of Advanced Nursing, 66,* 2819-2827.