

# Competencies for Nurse Practitioners in Emergency Care

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# Contents

	<i>Page</i>
ENA NP Validation Work Team.....	iii
Consensus Panel.....	iv
Acknowledgments.....	v
Project Overview .....	1
Introduction.....	3
Competencies .....	6
Glossary.....	10
References.....	12

# Project Overview

Nurse practitioners have been practicing in emergency care for nearly five decades. Until now, competencies were not established to verify nurse practitioner ability to perform in the emergency setting. The National Organization of Nurse Practitioner Faculties (NONPF) established entry-level core competencies for all nurse practitioners (NONPF, 1995, 2000, 2002, 2006). The Emergency Nurses Association (ENA) recognizes these core competencies as the foundation for all nurse practitioner practice. In 2006, the ENA established a Nurse Practitioner Validation Work Team to explore and delineate the behaviors, knowledge, and skills necessary for a nurse practitioner to competently practice in emergency care.

The ENA Nurse Practitioner Validation Work Team consulted valid and reliable evidence-based sources in developing an initial list of clinical and professional competencies and skills for nurse practitioners in emergency care. A Delphi study was designed to verify and gain consensus on the competencies. From September 2007 to May 2008, the Delphi study was conducted with a national sample of credentialed nurse practitioners in emergency care (1<sup>st</sup> Round: n=128, 2<sup>nd</sup> Round: n=73, 3<sup>rd</sup> Round: n=52), representing a broad sample of emergency care settings such as emergency departments and fast tracks in rural, urban, and community hospitals, free-standing clinics, the prehospital setting, and the prison system.

The Delphi study entailed three rounds of surveys. Each survey was completed online and included a list of competency and skill statements. Respondents were asked to rate the importance and frequency of performance for each competency and skill as well as list competencies or skills they felt were not addressed in the survey. Each round was conducted in an effort to reach group

consensus. At the completion of each round, the results were compiled by a statistician and reviewed and evaluated by the ENA Nurse Practitioner Validation Work Team.

In October 2008, a Consensus Panel Meeting was conducted to validate the findings from the Delphi study and gain consensus from a multidisciplinary group of stakeholders. The stakeholders included nurse practitioner organizations as well as organizations representing providers of emergency care beyond the nurse practitioner, such as emergency nurses and emergency physicians. Stakeholders from educational, credentialing, certification, and regulatory organizations also participated as part of the Consensus Panel.

The outcome of the Consensus Panel Meeting yielded a list of entry-level competencies and skills as well as a list of advanced competency and skills for nurse practitioners practicing in emergency care. The final list of entry-level competencies and skills were approved by the ENA Board of Directors and sent to stakeholder organizations, including those who participated in the Consensus Panel Meeting, for final approval and endorsement.



# Introduction

This document describes entry-level competencies for nurse practitioners practicing in emergency care, regardless of setting (e.g., urgent care, fast track, emergency department). These entry-level competencies are the essential knowledge, behaviors, and skills that nurse practitioners should be able to demonstrate upon application for practice in emergency care. These competencies are intended to supplement the core competencies for all nurse practitioners (NONPF, 2006), as well as population-focused nurse practitioner competencies.

The care provided by nurse practitioners practicing in emergency care requires a vast body of knowledge relating to acute and chronic illness and injury as well as simple and complex skills. Advanced and additional knowledge and skills not included in these entry-level competencies may be required of a nurse practitioner with more experience and autonomy in his or her practice.

These competencies emphasize the unique aspects of practice for the nurse practitioner in emergency care and the needs of the patients served— individuals, families, and populations across the lifespan. Nurse practitioners in emergency care practice in a variety of primary, acute, and tertiary settings, including emergency departments in urban, suburban, and rural hospitals; trauma centers; ambulatory and medical mobile clinics; urgent and emergent care centers; air and ground transport services; prisons; and schools.

## WHY SHOULD AN ORGANIZATION DEVELOP COMPETENCIES?

Competencies delineate the unique aspects of a particular area of practice and provide a model for entry into that practice. Competencies for advanced practice registered nurses support their practice. Competencies are used in academic settings as a foundation for curricula.

Additionally, demonstrating competency in a particular area prepares an advanced practice nurse for employment in that specialty practice.

Entry-level competencies vary from state-to-state based on each particular state's rules and regulations, the practice environment, and particular employer arrangements. Enhanced skills and knowledge gained over time may alter competencies— both for the individual and for credentialing purposes.

Although competencies provide a model for entry-level practice, competencies in and of themselves do not stipulate a scope of practice. The scope of practice for an advanced practice registered nurse within a particular state is regulated by their state board of nursing (NCSBN, 2005). Competencies are reviewed, re-evaluated, and revised periodically as the science of advanced practice nursing evolves and changes. New evidence brings new competencies that are then added to the list of current competencies.

Presently, competency can be achieved through various pathways including a combination of successful academic course completion (e.g., emergency care concentration), continuing education course completion (e.g., advanced ECG interpretation), and on-the-job instruction (e.g., minor procedures, suturing). In the near future, advanced practice nurses will be afforded additional credentialing opportunities through which they can demonstrate their competency in a specialty area. These certification mechanisms include, but are not limited to, examination, portfolio review, and peer review.

The competencies in this document are intended to support the nurse practitioner pursuing employment in emergency care. In addition, these competencies along with the core competencies for all nurse practitioners, the population-focused nurse practitioner competencies, and the advanced practice nursing core curricula are intended to guide the preparation of nurse practitioners who plan to specialize in emergency care. This document represents the current understanding of the basic competencies for nurse practitioners practicing in emergency care. The competencies provide a model for professional nurse practitioners upon entry into emergency care practice, but do

not prescribe a scope of practice. As the practice of nurse practitioners in emergency care evolves, the requirements for competency will change. These competencies will be reviewed and updated periodically to reflect scientific advances and evidence-based practice changes in nurse practitioner practice in emergency care.

# Competencies

The following competencies include knowledge, behaviors, and skills an entry-level nurse practitioner should have in order to practice in emergency care. These competencies are intended to supplement the core competencies for all nurse practitioners as well as population-focused nurse practitioner competencies, while providing a model for entry-level practice in emergency care. Nurse practitioner practice may differ from that described in these entry-level competencies due to variations in state regulation, practice setting, employment arrangement, and as a result of increasing knowledge and experience.

## I. Management of Patient Health/Illness Status

1. Triage patients' health needs/problems.
2. Completes EMTALA-specified medical screening examination.
3. Responds to the rapidly changing physiological status of emergency care patients.
4. Uses current evidence-based knowledge and skills in emergency care for the assessment, treatment, and disposition of acute and chronically ill and injured (e.g., physiologic, psychological, socio-economic, cultural) emergency patients.
5. Specifically assesses and initiates appropriate interventions for violence, neglect, and abuse (e.g., physical, psychological, sexual, substance).
6. Specifically assesses and initiates appropriate interventions and disposition for suicide risk.
7. Assesses patient and family for levels of comfort (e.g., pain, palliative care, end of life, bad news) and initiates appropriate interventions.
8. Recognizes, collects, and preserves evidence as indicated (e.g., forensic evidence).
9. Orders and interprets diagnostic tests.
10. Orders pharmacologic and non-pharmacologic therapies.
11. Orders and interprets electrocardiograms.
12. Orders and interprets radiographs.
13. Assesses response to therapeutic interventions.
14. Documents assessment, treatment, and disposition.

## II. Professional Role

15. Functions as a direct provider of emergency care services.
16. Directs and clinically supervises the work of nurses and other health care providers.
17. Participates in internal and external emergencies, disasters, and pandemics.
18. Maintains awareness of known causes of mass casualty incidents and the treatment modalities required for emergency care.
19. Acts in accordance with legal and ethical professional responsibilities (e.g., patient management, documentation, advance directives).

## III. Airway, Breathing, Circulation, and Disability Procedures

20. Assesses and manages a patient in cardiopulmonary arrest (e.g., neonatal resuscitation, leads code team, rapid response team).
21. Assesses and manages airway (e.g., endotracheal intubation, ventilated patients).
22. Assesses and obtains advanced circulatory access (e.g., intraosseous).
23. Assesses and manages patients with disability (e.g., neurologic).
24. Assesses and manages procedural sedation patients.

## IV. Skin and Wound Care Procedures

25. Performs ultraviolet examination of skin and secretions (e.g., Woods Lamp).
26. Treats skin lesions (e.g., foot callus, skin tag, plantar lesion, decubitus care).
27. Injects local anesthetics.
28. Performs nail trephination.
29. Removes toe nail(s) (e.g., partial or complete removal for ingrown toe nail).
30. Performs a nail bed closure.
31. Performs closures (such as a single layer, multiple, staple, adhesive).
32. Revises a wound for closure.
33. Debrides minor burns (e.g., nonadhering blister).
34. Incises, drains, irrigates, and packs wounds.

## V. Head, Eye, Ear, Nose, and Throat Procedures

35. Dilates eye(s).
36. Performs fluorescein staining.
37. Performs tonometry to assess intraocular pressure.
38. Performs Slit lamp examination.
39. Performs cerumen impaction curettage.
40. Controls epistaxis.

## VI. Chest and Abdomen

41. Performs a needle thoracostomy for life threatening conditions in emergency situations (e.g., tension pneumothorax).
42. Replaces a gastrostomy tube.

## VII. Neck, Back, and Spine Procedures

43. Clinically assesses and manages cervical spine.
44. Performs lumbar puncture.

## VIII. Gynecologic, Genitourinary, and Rectal Procedures

45. Incises and drains a Bartholin's cyst.
46. Assists with imminent childbirth and post-delivery maternal care.
47. Removes fecal impactions.
48. Incises thrombosed hemorrhoids.
49. Performs sexual assault examination.

## IX. Extremity Procedures

50. Performs digital nerve block.
51. Reduces fractures of small bones (e.g., fingers, toes).
52. Reduces fractures of large bones with vascular compromise (e.g., traction splint).
53. Reduces dislocations of large and small bones.
54. Applies immobilization devices (e.g., splint, traction).

- 55. Bivalves/removes casts.
- 56. Performs arthrocentesis (e.g., knee, elbow).
- 57. Measures compartment pressure.

#### X. Other

- 58. Performs radio communication with prehospital units.
- 59. Interprets patient diagnostics (e.g., vital signs, 12-lead ECGs) as communicated by prehospital personnel.
- 60. Removes foreign bodies (e.g., from orifices and soft tissue).

# Glossary

**CERTIFICATION:** The voluntary process through which an organization grants recognition to an individual, organization, service, or product that meets certain established criteria. Certification mechanisms include, but are not limited to, examination, portfolio review, and peer review.

**COMFORT/PAIN MANAGEMENT:** Collaboration with patient, family, and nursing staff to provide appropriate interventions to address the patient's stated pain level (e.g., pharmacologic measures, positioning).

**DELIVERING BAD NEWS:** Communicating sensitive information to the patient and family in a supportive and professional manner.

**DISABILITY:** Neurologic component (e.g., pupils, level of consciousness) of the primary assessment (airway, breathing, circulation, disability).

**DISPOSITION:** The location or status of a patient upon completion of the emergency department visit (e.g., sent home, referred, admitted, transferred, died, left without treatment, left without being seen).

**EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (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 (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

**EXTERNAL DISASTER:** An incident that occurs outside the hospital that may impact the hospital's ability to provide care (e.g., hurricane, flood).

**INTERNAL DISASTER:** An incident that occurs within the confines of the hospital that may impact the hospital's ability to provide care (e.g., fire in the hospital, ethylene glycol spill).

**LIFESPAN:** From birth to death.

**MANAGES A PATIENT IN CARDIOPULMONARY ARREST:** Manages a coding patient (e.g., leads code team, manages airway, orders appropriate medications).

**RURAL SETTING:** An area typically in the countryside isolated by distance or other physical attributes; A geographic area in which inhabitants may have limited access to resources (e.g., health care facilities, health care technology, physicians).



**TRIAGE:** The process by which patients are evaluated and classified according to the type and urgency of their condition, for the purpose of determining treatment priorities.

**URBAN SETTING:** An area in a city or town marked by a density in buildings, structures, and population; A health care facility in an urban area may include high patient census, trauma center designation, and a teaching program for resident physicians.

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