A Framework for Creating and Evaluating Competencies for Emergency Nurses

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Nurses have a duty to the public, their profession, and themselves to maintain and demonstrate competence throughout their career.[1] Increasing numbers of patients access health care through the emergency department, placing increased importance on ED nurses to maintain competencies. However, a consensus definition and methodology to maintain clinical competence remains elusive. Competency is an intangible construct that is not a specific skill or task to be completed but rather is a necessary characteristic required to act effectively in a nursing setting.[2] Individual nurses and health care agencies struggle to demonstrate and document competencies, often relying on skill checklists, return demonstrations, portfolios, and certifications. The purpose of this article is to discuss the development of competencies and provide examples of competencies for nurses to use in their quest to maintain and demonstrate clinical competence.

Institute of Medicine's Call for Competencies

Efforts in the United States to promote competency to ensure that citizens receive safe, high-quality health care are anchored by *Health Professions Education: A Bridge to Quality*, a report by the Institute of Medicine (IOM).[3] The authors of this IOM report successfully called health care professionals, regulatory agencies, and legislators to action to demonstrate quality health care. The emphasis on validating quality by decreasing medical errors, maintaining continuing education, providing patient-centered care through implementation of interdisciplinary teams, and instituting evidence-based practices is evident throughout the health care industry.

In 2009, the IOM released *Redesigning Continuing Education in the Health Professions*,[4] which illustrates current concerns related to continuing education. Proposed solutions include providing a system of "continued professional development" (ie, education and training after licensure), thereby promoting collaborative, learner-centered, effective, and valuable lifelong learning. Most recently the IOM published *Future of Nursing: Leading Change, Advancing Health*,[5] a blueprint to improve the nursing workforce. The report includes the following 4 key messages:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health care professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.[5]

The profession of nursing is called to change the system within which we practice. Nursing is encouraged to adapt and provide leadership to meet or exceed increased health care consumer demands. Additionally, nursing needs to transform professional educational processes to incorporate lifelong learning and demonstrate continuous clinical competence. As a profession, it is necessary to increase our legislative influence to lead regulatory reform while continuously providing our nursing colleagues with current research and evidence-based practices that lead to improved, safe health care.

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TABLE 1
American Nurses Association nursing specialty designation criteria

To be recognized as a specialty, the American Nurses Association requires that the following criteria be met.

A nursing specialty:

- Defines itself as nursing.
- Is clearly defined.
- Has a well-derived knowledge base particular to the practice of the nursing specialty.
- Is concerned with phenomena of the discipline of nursing.
- Subscribes to the overall purposes and functions of nursing.
- Can identify a need and demand for itself.
- Adheres to the overall licensure, certification, and education requirements of the profession.
- Defines competencies for the area of specialty nursing practice.
- Has existing mechanisms for supporting, reviewing, and disseminating research to support its knowledge base and evidence-based practice.
- Has defined educational criteria for specialty preparation or graduate degree.
- Has continuing education programs or other mechanisms for nurses in the specialty to maintain competence.
- Is practiced nationally or internationally.
- Includes a substantial number of registered nurses who devote most of their professional time to the specialty.
- Is organized and represented by a national or international specialty association or branch of a parent organization.

ENA's Movement Toward Competencies

The ENA document *Emergency Nursing: Scope and Standards of Practice*[6] provides a strong foundation for professional nurses to recognize and understand the current practice and professional standards for emergency nurses. This Scope and Standards document also meet the call to action provided by the IOM reports, particularly from the *Future of Nursing: Leading Change, Advancing Health*.[5]

ED nurses may use the ENA document *Emergency Nursing: Scope and Standards of Practice*[6] when developing competencies. This document provides direction for the application of the scope and standards related to emergency nursing competence, competency creation, competence assessment, and evaluation.

Standard of Care

The term "standard of care" is defined by the state(s) in which the registered nurse (RN) is licensed. Standard of care is used to determine the acceptable practices of a nurse that would be considered reasonable and prudent by other nurses within the applicable nursing specialty.[7] In the United States, individual states create and interpret laws that guide the scope of practice and standards of care for professional registered nurses (ie, nurse practice acts).[8] ENA embraces a broad view toward scope and standards of emergency nurses both at the domestic and international levels. It is essential that every emergency nurse know and practice within the licensee's state regulations and within their respective nurse practice act. ENA's *Emergency Nursing: Scope and Standards of Practice* document steers professional nurses to recognize and understand the current practice standards for emergency nursing.[6]

ENA created the *Emergency Nursing: Scope and Standards of Practice* document[6] to demonstrate the rigor and independence of emergency nursing as a specialty within the nursing profession. In 2011, the American Nurses Association (ANA) formally recognized emergency nursing as a specialty nursing practice. To be recognized as a specialty nursing practice, several criteria are required to demonstrate achievement of this goal (Table 1). The *Emergency Nursing: Scope and Standards of Practice* document is viewed as the definitive resource regarding the standards of care, standards of professional practice, and related competencies for emergency nursing.[6]

Because the competencies listed within the *Emergency Nursing: Scope and Standards of Practice* document[6] are not all inclusive, it is necessary for RNs to evaluate

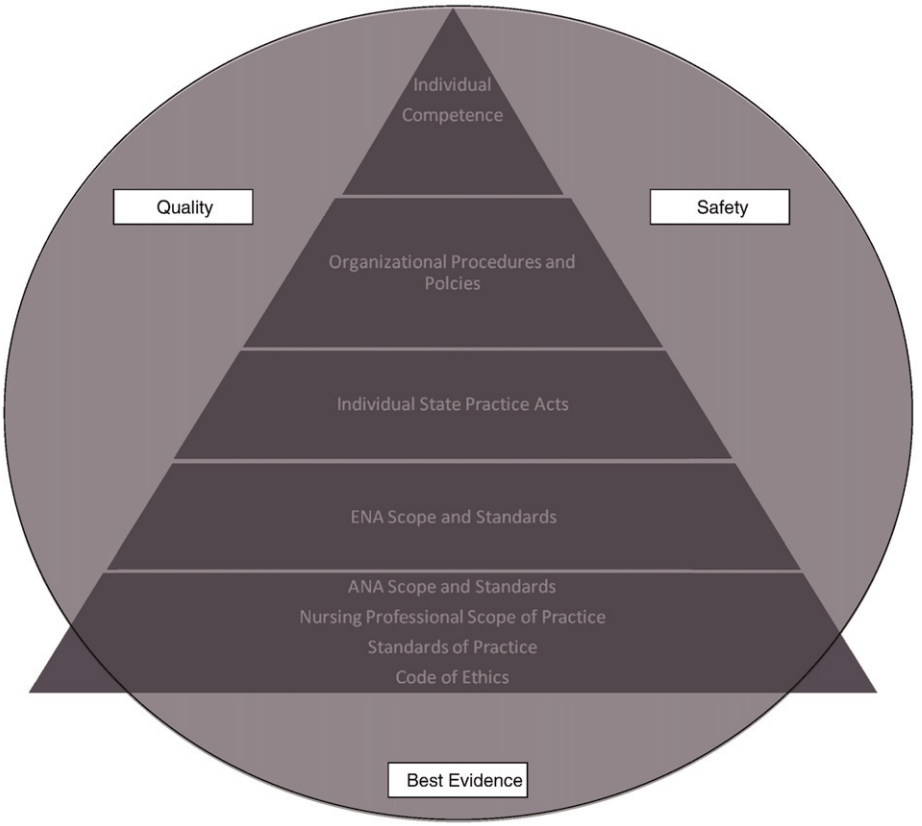

FIGURE 1
The foundation of competence for the emergency registered nurse. *ANA*, American Nurses Association.

their practice environment and implement competencies based on the standards and safety within the context of their emergency nursing practice. Additionally, the *Emergency Nursing: Scope and Standards of Practice* document is beneficial for the creation of job descriptions and institutional policies, procedures, and practices.[6] Emergency nurses should expect, and be provided with, clear expectations regarding their nursing practice based on these standards and job descriptions from their respective institutions.

Organizational Policies

Organizational policies are directions provided to employees that relate to nursing practice and employee behavior within that institution. Policies typically are used to interpret, describe, and inform health care providers about how to perform processes or procedures within the confines of law, best practice, and professional judgment. Noncompliance with organizational policies places the health care provider at risk for litigation, discipline, and/or termination by acting outside of the local standards of practice.[9]

Definitions of Competence

ANA's position statement on professional role competence[10] is a beacon for all nurses to shine a light on the term and function of competence in nursing practice. ANA defines competence as "an expected and measurable level of nursing performance that integrates knowledge, skills, abilities, and judgment, based on established scientific knowledge and expectations for nursing practice."[11] Subsequently, ENA[6] defines competence as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." Each of these definitions seeks to

advance professional practice and professional practice measurements. The major themes of these 2 definitions are woven into the *Emergency Nursing: Scope and Standards of Practice* document, which utilizes the term "competencies" to provide measurable and expected behaviors for emergency nursing practice in relation to each corresponding standard.[6]

Individual RNs are responsible and accountable for maintaining professional competence and practicing competently.[6,8,11] ENA's *Code of Ethics*[12] specifically states that the duty of the emergency nurse is to "maintain competence within, and accountability for, emergency nursing practice." ANA's *Code of Ethics* also discusses the nurse's duty to self, which includes maintaining professional competence.[13] ANA further solidifies the nursing profession's dedication to professional role competence in its social policy statement, which describes the contract between the nursing profession and society.[14] ANA's position statement *Professional Role Competence* describes the primary purpose for ensuring continued competence as the protection of the public while incorporating other major purposes, such as the advancement of the profession and ensuring the integrity of professional nursing.[10]

The fundamental pieces of emergency nursing practice and competence are illustrated in Figure 1. This model addresses the foundation and building blocks for competence of individual emergency nurses. Emergency nursing competence develops from the generalist perspective outlined in ANA's documents to that of specialty emergency nursing practice as outlined in ENA's documents. Competence occurs not in isolation but needs to be tailored to the current best evidence, quality initiatives and indicators, and safety. Individual states, as governed by their nurse practice acts and the unique emergency care settings in which nurse's work, require different ways of determining and measuring nursing competence and competency. The focus of the emergency nurse competence paradigm is the individual emergency nurse and his or her professional responsibility for maintaining practice competence.

Teaching and Learning

DOMAINS OF LEARNING: COGNITIVE, AFFECTIVE, AND PSYCHOMOTOR

The most familiar educational domains of learning were written by Bloom,[15] and competencies often are based on Bloom's taxonomy. Bloom's 3 domains of learning include cognitive (knowledge; mental skills), affective (attitude; values; emotions; judgment), and psychomotor (physical skills; coordination) behaviors.[15] Therefore it is important to determine which domains of practice or policy are being addressed for the education and measurement of competence to be appropriate. ANA[10] states:

> *Knowledge encompasses thinking, understanding of science and humanities, professional standards of practice, and insights gained from practical experiences, personal capabilities, and leadership performance. Skills include psychomotor, communication, interpersonal and diagnostic skills. Ability is the capacity to act effectively. It requires listening, integrity, knowledge of one's strengths and weaknesses, positive self-regard, emotional intelligence and openness to feedback. Judgment includes critical thinking, problem solving, ethical reasoning, and decision making.*

The domains of learning are woven into the fabric of the competency framework. These categorizations of learning provide a useful means of determining the strengths and opportunities for improvement of a nurse's practice. An example is provided in Table 2.

TABLE 2
Displaying the domains of learning

Example: Triaging a patient who reports chest pain
Cognitive
What pertinent data are collected during triage from a patient experiencing chest pain?
Is the patient pale and diaphoretic?
Does the patient have a medical history that would lead an emergency nurse to more or less be concerned about a myocardial infarction?
Psychomotor
Is the nurse adept at using the electronic documentation triage system?
Can the nurse place an identification bracelet on the patient?
Can the nurse perform an electrocardiogram?
Affective
Is the nurse open to listening to all patient complaints?
Does the nurse get overwhelmed easily?
Does the nurse treat the patient objectively and with respect?

ADULT LEARNING THEORY

Knowles[16] is the father of adult learning methods or "andragogy." Andragogy makes 4 distinct assumptions about adult learners:

1. Adults need to know why they are learning.
2. Adults are problem solvers.

The Registered Nurse will:

Learning Activities:

- Participate in orientation session that reviews procedures, policies, and documentation tools designed to support the ED RN in triaging patients.
- Demonstrate the performance criteria listed below:

KEY: M = MEETS PERFORMANCE

VM = VALIDATON METHOD

[OB] Observation [WT] Written test [RP] Role Play [CS] Case Study
[RR] Record Review [RD] Return Demonstration [DS] Discussion
[ ] Other (Brief Description) _____

	Performance Criteria:	**M**	**VM**
	Standard of Practice: Triage		
	• The emergency registered nurse triages each health care consumer utilizing age, developmentally appropriate, and culturally sensitive practices to prioritize and optimize health care consumer flow, expediting those health care consumers who require immediate care.		
	Competencies:		
	Preparation		
	• *Utilizes a valid and reliable triage system to designate triage acuity* (i.e., Emergency Severity Index: Version 4 (ESI))		
	• Distinguishes criteria for triage acuity levels per current ESI		
	• Identifies abnormal vital signs for adult & pediatric populations.		
	• Determined to be a role model and excellent performer		
	Interview process		
	• *Obtains pertinent subjective and objective data while providing physical, emotional, and psychosocial support to the health care consumer, family and others as appropriate.*		
	• Assesses educational needs of healthcare consumer & families entering the emergency care system.		
	• Determines factors (e.g., age, developmental level, culture, language, anxiety) that may influence the interviewing process.		
	• Respects the emergency patient's privacy.		
	• Demonstrates empathetic understanding when caring for emergency patients & their families.		
	• Uses a combination of open & closed-ended questions during the interview process.		
	• Elicits appropriate medical history questions related to the chief complaint.		
	• Elicits objective & subjective data related to the patient's chief complaint, associated symptoms, clinical assessment & significant medical history.		
	Interventions		
	• *Implements appropriate interventions according to established organization policies/protocols, as warranted by the health care consumer's status*		

FIGURE 2

ED triage competency validation record.

3. Adults learn through doing.
4. Adults will learn better if they can immediately use the material they learn.

Adult learning theory clarifies that adults learn better when they are given choices, when they are allowed to use self-directed learning as an option when available, and finally, when they can build on and share life experiences.[17] ENA addresses adult learning needs through the provision of diverse examples mixed with didactic and hands-on skills applicable to most environments. Further, emergency nursing practice requires manual skills, problem solving, understanding the "why" and not just the task, as well as the immediate

	• *Interprets data obtained incorporating the age-appropriate physical, developmental, and psychosocial needs of the health care consumer.*		
	• Performs a rapid systematic collection of data related to the healthcare consumer chief complaint.		
	• Identifies potential differential diagnoses related to the chief complaint.		
	• Determines acuity based on subjective & objective information (symptoms, statements, vitals, visual assessment) per current ESI.		
	• Identifies the healthcare consumer with identification & allergy bands as applicable.		
	• Places healthcare consumer in appropriate waiting area after triage for pending placement in the department.		
	• Communicates pertinent data to the appropriate member of the emergency care team regarding the healthcare consumer conditions.		
	• Informs the healthcare consumer (i.e., patient, family, significant others) as to patient placement.		
	• Initiates advanced treatment protocols as indicated (e.g., ice, immobilization, antipyretics).		
	• Correctly prioritizes the triage of multiple healthcare consumers.		
	• Communicates need for additional resources in triage, as needed.		
	• Implements ED overflow process as applicable.		
	• Continually monitors healthcare consumer in waiting area to determine changes in acuity.		
	Documentation		
	• *Documents relevant data and triage acuity for every health care consumer in a retrievable form.*		
	• *Communicates significant findings to team members.*		
	• Documents chief complaint in the healthcare consumer's own words.		
	• Documents pertinent healthcare consumer data into the electronic documentation system.		
	• Documents interventions on the healthcare consumer record.		
	• Documents reassessment of healthcare consumer in the waiting area, patient education, & acuity.		
	In a disaster, the emergency triage registered nurse:		
	• *Collaborates with appropriate disaster personnel and incident command for situational awareness, safety, and security measures.*		
	• *Identifies the nature of the disaster and resources required.*		
	• *Utilizes a rapid triage system to determine priority of emergency treatment, categories, and mode of transport*		
	• *Documents according to established organizational policies/protocols.*		
	• *Modifies the triage decision depending on the circumstances, as either by routine operations or disaster management.*		

Comments: _____

Preceptor: _____ Date: _____
Signature

Staff member: _____ Date: _____
Signature

Reference: Emergency Nurses Association & American Nurses Association. (2011). *Emergency Nursing: Scope and Standards of Practice*. Silver Springs, MD: Emergency Nurses Association.

* *Italicized* wording is directly quoted from the *EN: S&SP*.

FIGURE 2
(continued)

applicability to practice given the specialty's breadth, depth, and diverse nature.

METHODS OF ASSESSMENT

No single method of evaluation can be used to absolutely determine nurses' competence. Rather, varied assessment evaluations should be used to determine competence within the context of practice. Subjective and objective data should be obtained with use of tools that take into consideration the actual knowledge and practice context to be measured and the expected outcomes of the competence measurement tool. A selected list of classic tools for competency assessment include direct observation, chart review, demonstration, return demonstration, written test-

Triage Definition:

To sort out or chose.

It is the process by which patients are sorted and classified according to the type and urgency of their conditions.

Triage is not specifically a room but rather an action of sorting and stratification of patients and must be performed by an educated, experienced emergency nurse.

Reason

Triage assists in the delivery of timely and effective health care with your resources. Facilitates the flow or patients through the emergency care system and ensures timely evaluation according to the health care needs of the patients. Each patient who arrives at triage brings with them a unique presentation, communication skills, history, and social situation. The triage nurse must be adept at working through these issues in an effort to identify the priorities that exist and to assign an appropriate triage level.

The 3 formats for triage assessment include the rapid systematic collection of data related to the patient's chief complaint

Spot triage – quick look and complaint and then directly bedded prior to completion of full triage record.

Comprehensive triage is the most advanced type of triage performed using subjective and objective assessments

Disaster triage is used when a surge or mass influx of patients occurs and the triage nurse gives the care to the most (least-sick) patients first instead of spending a ton of resources on one sick patient.

Emergency Severity Index (ESI) is a tool for use in emergency department triage that provides rapid, reproducible and clinically relevant stratification of patients into five groups

Ratings are Level one (most urgent) to Level 5 (least urgent)

The ESI provides a method for categorizing ED patients by acuity, severity of symptoms, degree of risk for deterioration while waiting, and the need for additional resource

Level One: The highest risk patients, including patients who are intubated, apneic, pulseless or unresponsive, requiring immediate physician presence at the bedside (resuscitation)

Level Two: High-risk situations such as patient confusion, lethargy, disorientation, severe pain/distress (emergent)

Level Three: Patients who are urgent and require 2 or more resources and have normal vital signs (Urgent)

Level Four: Patients who require only one resource and have normal vital signs (Semi-Urgent)

Level Five: Non-urgent patients who require no resources (Non-Urgent)

Emergency Nurses Association Standard of Emergency Nursing Practice

STANDARD 1A. TRIAGE

The emergency registered nurse triages each health care consumer utilizing age, developmentally appropriate, and culturally sensitive practices to prioritize and optimize health care consumer flow, expediting those health care consumers who require immediate care.

Competencies

The emergency registered nurse:

- Obtains pertinent subjective and objective data while providing physical, emotional, and psychosocial support to the health care consumer, family, and others as appropriate.
- Interprets data obtained incorporating the age-appropriate physical, developmental, and psychosocial needs of the health care consumer.
- Utilizes a valid and reliable triage system to designate triage acuity.
- Implements appropriate interventions according to established organizational policies/protocols, as warranted by the health care consumer's status.
- Documents relevant data and triage acuity for every health care consumer in a retrievable form.
- Communicates significant findings to team members.

Knowledge	Skills
• Triage Introduction • Triage Documentation • ESI • EMTALA - Legal Regulatory • Abdomen • Cardiac • Trauma • Cardiac/Chest • Psychiatric • Fast Track • Musculoskeletal • Special Circumstances – Red Flags • Pediatrics	• ** See Emergency Department Skills Competency • Determining acute versus non-acute • Pain Scale (appropriate selection) • Interview Skills • CyraCom Phone for Translation • Subjective & Objective Assessment • Weight • Visual Acuity • Personal Safety/Panic Buttons • Nursing Interventions • Ice, Elevation, Sling, Splint, Security, • Instituting patient care protocols

FIGURE 3

Triage competency assessment. *FLACC*, Face, Legs, Activity, Cry, Consolability Scale; *NIPS*, Neonatal Infant Pain Scale; *CRIES*, Crying, Requires Oxygen, Increased Vital Signs, Expression, Sleepless Pain Assessment Tool; *LMP*, last menstrual period.

Emergency Department Triage Skills Competency
ENA Standard:
The emergency registered nurse triages each health care consumer utilizing age, developmentally appropriate, and culturally sensitive practices to prioritize and optimize health care consumer flow, expediting those health care consumers who require immediate care.

Rate	ORIENTEE ASSIGNMENT	MET	NOT MET	PRECEPTOR ASSIGNMENT
	Review with preceptor basic knowledge and definition of triage.			Review and discuss
	Review with preceptor ESI level			Review and discuss Distinguish and delineate ESI examples for the orientee for different levels.
	Review triage policy & procedure.			Review policies
	Phone message			Review policies
	Direct Admits Active Labor Other Testing			Review policies
	Private MD patients			Review policies
	ASSESSMENT			
	Chief Complaint Subjective Objective Assessments			Review policies Discuss interview skills
	Primary Survey *A=Airway* *B=Breathing* *C=Circulation* *D= Disability*			Review policies & discuss emergency procedures, code and panic buttons.
	Secondary Survey *O=Onset* *L=Location* *D=Duration* *C=Characteristics* *A=Aggravating factors* *R=Relieving factors* *T=Treatment*			Review policies & discuss based on systems review and differential diagnosis
	Vital Signs			Review policies & discuss the difference in age and disease specific vital signs
	Pain *P=Provoking Factors* *Q= Quality of Pain* *R= Region/Radiation* *S= Severity/Scale* *T= Time pain began*			Review policies & discuss based on systems review. Review available pain measurement strategies (e.g., Wong Baker, Visual analog, Oucher, FLACC, NIPS, CRIES)
	Allergies/Past Medical History/ Medications			Review policies & discuss Place bracelets
	Immunization/Tetanus Status			Review policies & discuss
	LMP			Review policies & discuss
	Weight			Review policies & discuss
	Objective Data/Observational Skills			Review policies & discuss
	Skills/Nursing Interventions			
	Upper Extremities *Fingers* *Hand* *Wrist* *Forearm*			Review policies
	Lower Extremities *Toes* *Foot Ankle* *Tibia/Fibula*			Review policies
	Splint, sling, ice, & dressing application and documentation			Review policies & discuss Identify ways to assess 5 P's for distal circulation

FIGURE 3
(continued)

	Communication			
	Tracking			Review procedure & roles
	Charge RN			Review procedure & roles
	MD's			Review procedure & roles
	Tech's/Triage Tech			Review procedure & roles
	Secretaries			Review procedure & roles
	Patient Liaison			Review procedure & roles
	Fast Track			Review procedure & roles
	Pediatric patients			Review procedure & roles
	Patients in waiting room			Review procedure & roles
	Legal Issues			
	ENAScope & Standards of Practice			Review policies & discuss
	COBRA			Review policies & discuss
	EMTALA			Review policies & discuss
	Leaving before seeing an MD or being registered			Review policies & discuss
	Leaving prior to triage			Review policies & discuss
	Patient Care Protocols			Review protocols & discuss

Name: _____ Date: _____

Preceptor: _____Rating Scale: _____Method of Validation: _____

Rating Scale
A = Performs skill independently and competently
B = Performs skill but requires supervision
C = Can Verbalize how to perform a skill but has had minimal opportunity to practice skill
D = Unable to perform
NA = Not Applicable

Methods of Validation
CS = Case Studies
DO = Direct Observation
GS = Group Discussion
P = Presentation
PR = Peer Review
PT = Post-Test
QI = Quality Improvement monitors
RD = Return Demonstration
SA = Self Assessment

FIGURE 3
(continued)

ing, and a skill validation checklist. In recent year, clinical simulation has been a popular method for nurses to assess competence.[18-21] The use of professional portfolios[22-24] is a means of displaying nurses' lifelong learning and continued competence. Certification is another means of measuring and displaying nursing competence.[25-27]

Application to Practice

Evidence about the reliability and validity of competency assessment tools is not strong.[28] However, it is necessary to use objective documentation as a means of recording a nurse's competencies at a single point in time. Moreover, regulatory, accreditation, and certifying bodies require written or electronic documentation of education and successful competency completion and evaluation.[29] Useful tools are available to demonstrate how emergency nurse competencies can be created and evaluated. The following are examples of actual competencies in different formats utilized by various emergency departments.

TRIAGE COMPETENCY

Emergency Nursing: Scope and Standards of Practice Standard 1A states that triage has 10 competencies corresponding to the standard that must be evaluated and achieved to ensure the criterion standard is met.[6] However, the stated competencies are not exhaustive and require augmentation to reflect the actual RN's performance expectations within the specific organization and standard of care. Figures 2 and 3 depict 2 triage competencies that address the practice expectations and *Emergency Nursing: Scope and Standards of Practice*[6] standards. All 10 of the *Emergency Nursing: Scope and Standards of Practice* competencies[6]

Performance Objective:
Given all the necessary equipment, the American Heart Association Pediatric Advanced Life Support (PALS) certified nurse will identify the need for and demonstrate the proper procedure for the proper use of the Broselow® Pediatric Emergency Tape.

VM = VALIDATON METHOD
[OB] Observation [RD] Return Demonstration [DS] Discussion

Therapeutic Effects:

The Broselow® Pediatric Emergency Tape is designed to be used as a quick reference to drug dosing and equipment sizing on pediatric patients	

Indications:

All pediatric medical and traumatic emergencies	

Contraindications:

Conscious pediatric patients that the use of such equipment might worsen their condition.	

Side Effects:

Inaccurate use will lead to errors in drug dosing and equipment sizing.	

Demonstration of the Procedure:

Determine the need for the Broselow® Pediatric Emergency Tape	
Place the patient in the supine position	
Remove the tape from its protective sleeve and unfold it	
Place the tape next to the patient, ensuring that the multicolored side is facing up	
Place the RED end of the tape even with the top of the patient's head	
Hold the tape, so that it remains even with the top of the patient's head and stretch the tape out to measure the length of the child	
Measure the length of the child to the heel of the foot. If the patient falls on the line, go to the next higher section	
Identify, and verbalize the appropriate "color block"	
Use the "color block" to identify the weight range of the patient	
Use the weight range to determine the appropriate sizes Resuscitation sheet that is to be used for the Code.	

Critical Criteria
_____Failure to use the tape when indicated
_____Failure to measure the patient appropriately
_____Failure to identify, mark and verbalize the appropriate "color block" weight zone
_____Failure to use the recommended size equipment
_____Failure to use the recommended drug dose

Name: _____ Skill: Broselow® Pediatric Emergency Tape
Date: _____
Evaluator Signature: _____ Date: _____
Evaluator Print: _____
Evaluator Signature: _____ Date: _____
Evaluator Print: _____

FIGURE 4
Broselow pediatric emergency tape competency.

are listed in both examples from Standard 1A: Triage, along with specific competencies required by the institution to meet its expectations of emergency nursing triage performance. These additional performance criteria adapt well given that *Emergency Nursing: Scope and Standards of Practice*[6] acknowledges that their competencies are "not exhaustive" and that some competencies are determined by the "context" of the emergency nurses' practice circumstances. Figures 2 and 3 display a list of criteria with the rating scale of "met" or "not met," along with an opportunity to record the validation method of the competency. The competencies differ in format and reflect differing organizational policies, and they also may differ in accordance with organizational policies and instructions to the nurse. Organizational specifics may include the type of triage stratification system used, the methods of communication, the interventions required for critically ill or rapidly deteriorating patients, available employer resources, and communication modalities. Either evaluation can be used because they both address the desired information and criteria to be evaluated and completed in the triage role.

Name:	Unit/Care Area:	Completion Date:
Instructor/Examiner:		Nurse Educator:

Instructions
1. RN will perform a self assessment.
2. Instructor or Examiner—if an experienced nurse rates his/herself as Independent, observe the skill and validate, otherwise review topic and then validate.

Self Evaluation	Validation Methods	
I – RN can perform independently	O – Observation	DS – Discussion
S – RN can perform with supervision	D – Demonstration	CS – Case study
NE – RN has had no previous experience with this knowledge/skill/ability	T – Test	RD – Return demonstration
	CR – Chart review	

GOAL: The RN will demonstrate the safe use of the Level 1® Hotline® Blood and Fluid Warmer

Self Evaluation	COMPETENCY VALIDATION Level 1® Hotline® Blood and Fluid Warmer	Performance Validation		
I/S/NE	**Knowledge**	Validation Method(s)	Meets Performance (√)	Date Completed
	Review applicable organizational policy and procedures			
	Identifies indications for using Level 1® Hotline® Blood and Fluid Warmer			
I/S/NE	**Skills**	Validation Method(s)	Meets Performance (√)	Date Completed
	Washes hands and uses personal protective equipment as needed			
	Gathers age appropriate equipment based on physicians orders			
	Check water level, plug warmer into outlet			
	Insert warmer tubing, turn on machine			
	Connect IV tubing to Hotline® tubing; prime tubing fully			
	Connect tubing to patient and infuse via IV pump or pressure bag as appropriate			
	Provides maintenance of the equipment when necessary			
	Documents all treatments on the restraint flow sheet			

References
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FIGURE 5
Hotline fluid warmer competency.

WEIGHT-BASED RESUSCITATION TAPE COMPETENCY

The development of the weight-based resuscitation system (eg, weight/color zone per Broselow pediatric emergency tape) competency stemmed from the need to address high-risk, low-volume, and time-sensitive tasks (Figure 4). Misidentification of the pediatric patient's weight zone could cause injury or death; thus the emergency nurse needs to rapidly intervene and emergently perform this skill. Therefore the use of "return demonstration" allows trained observers to evaluate nursing performance.[30]

Standards 1, 4, 5 and 6 from *Emergency Nursing: Scope and Standards of Practice*[6] are most strongly associated with the use of a weight-based resuscitation system competency. These standards include assessment, planning, implementation of care, and evaluation. Assessment is critical to identifying the acutely ill child in need of rapid intervention. Upon identifying the acutely ill child, the nurse is able to implement the standard of care and use the Broselow tape to provide competent care during a pediatric emergency. Evaluation relates to the postintervention implementation effectiveness and

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Competency Type	Objectives	Content	Talking Points
Level 1® Hotline® Blood and Fluid Warmer	Discuss indications for using Level 1® Hotline® Blood and Fluid Warmer	Indications • To prevent hypothermia when large quantities of fluid or blood products are administered • To provide core re-warming • To prevent coagulopathies in trauma patient related to un-warmed fluids	• Prevent hypothermia • Provide core re-warming • Prevent coagulopathies
	State the procedure to initiate the Level 1® Hotline® Blood and Fluid Warmer	Procedure to initiate • Check water level, plug warmer into outlet • Insert warmer tubing, turn on machine • Connect IV tubing to Hotline tubing; prime tubing fully • Connect tubing to patient and infuse via IV pump or pressure bag as appropriate	• Checking the water level ensures warming will occur and not damage the warming unit • When the tubing is inserted into the machine, you will notice fluid and bubbling around the outer core • Thoroughly prime tubing prior to connecting to patient
	Discuss maintenance of the equipment	Maintenance • Refill water chamber as needed. Fluid should be maintained between lines on the water chamber	• Check fluid levels when checking trauma room or before use • Maintain based on manufacturer recommendations and or per hospital policy
	Identify components of documentation	Documentation • Interventions and assessment as appropriate for patient • Intake and output • Start and stop times	• Intake and output is important specifically during a resuscitation episode • Start and stop times of IV fluids allows for safe patient care and accurate billing • Complications

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FIGURE 5
(continued)

professional peer review assessment of Broselow tape use in patient care.

FLUID WARMER COMPETENCY

When advanced technology devices are provided to emergency care providers, the devices should be used as recommended by the manufacturer and according to organizational policy. Competencies are created for these devices, particularly if the device directly affects the patient's care. Failure to adhere to these standards may result in patient harm and place the care provider at risk for litigation or discipline.[31] The manufacturer's recommendations for items with advanced technology, such as a fluid warmer, are the safest practice for using the device.

The Hotline fluid warmer competency (Figure 5) is an example of using the manufacturer's recommendations in nursing education. This competency provides an opportunity for the learner to complete a self-assessment and is congruent with recommendations from ANA.[10] The competency also provides a "facilitation guide" for the educator or instructor. This guide describes 4 key objectives using Bloom's taxonomy. The content column shares the vital information for meeting the stated objectives, and a third column, "talking points," provides useful thoughts, axioms, and points of information to share with the learner during instruction.

Conclusion

The Emergency Nursing: Scope and Standards of Practice document[6] is beneficial for the creation of job descriptions and institutional policies, procedures, and practices. Emergency nurses should expect, and be provided with, clear expectations regarding their nursing practice based on these standards and job descriptions from their respective institutions.

The dynamic specialty of emergency nursing is based on frameworks built from generalist to specialist knowl-

edge, including input from standards of practice within a nurse's state nursing practice act, health care organizations, and the nurses themselves. Emergency nurses are able to define and measure their practice with a new set of tools, the *Emergency Nursing: Scope and Standards of Practice*.[6] Emergency nurse competence should be measured using subjective and objective data, including direct observation, chart review, return demonstration skill validation, written testing, professional portfolios, and certification.

The 4 examples provided (ie, Figures 2 to 5) are different approaches to objectively assess and record an emergency nurse's competence. Competencies on nursing practice processes (eg, triage), patient assessment tools (eg, Broselow tape), and products (eg, the Hotline Fluid Warmer) are examples of learning needs that can be objectively evaluated with competencies. These competency assessments can be transferred and tailored to meet the needs of the readers, learners, educators, managers, or clinical specialists in many different emergency settings.

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