Nurses have a duty to the public, their profession, and themselves to maintain and demonstrate competence throughout their career. 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. 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). 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, 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, 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.

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.
ENA’s Movement Toward Competencies

The ENA document *Emergency Nursing: Scope and Standards of Practice* 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 meets the call to action provided by the IOM reports, particularly from the *Future of Nursing: Leading Change, Advancing Health*.

ED nurses may use the ENA document *Emergency Nursing: Scope and Standards of Practice* 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. 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). 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.

ENA created the *Emergency Nursing: Scope and Standards of Practice* document 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.

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

**Definitions of Competence**

ANA’s position statement on professional role competence 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.” Subsequently, ENA 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 Ethics12 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 nurses 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. ANA10 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.

ADULT LEARNING THEORY

Knowles16 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.

| 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? |
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. 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

![FIGURE 2](https://example.com/figure2.png)

ED triage competency validation record.

### 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** = VALIDATION METHOD
- [ ] Other (Brief Description)

<table>
<thead>
<tr>
<th>Performance Criteria:</th>
<th>M</th>
<th>VM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard of Practice: Triage</strong></td>
<td></td>
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<tr>
<td>- 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.</td>
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<tr>
<td><strong>Competencies:</strong></td>
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<td><strong>Preparation</strong></td>
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<td>- Utilizes a valid and reliable triage system to designate triage acuity (i.e., Emergency Severity Index: Version 4 (ESI)).</td>
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<td>- Distinguishes criteria for triage acuity levels per current ESI.</td>
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<td>- Identifies abnormal vital signs for adult &amp; pediatric populations.</td>
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<td>- Determined to be a role model and excellent performer.</td>
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<tr>
<td><strong>Interview process</strong></td>
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<tr>
<td>- Obtains pertinent subjective and objective data while providing physical, emotional, and psychosocial support to the health care consumer, family and others as appropriate.</td>
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<tr>
<td>- Assesses educational needs of healthcare consumer &amp; families entering the emergency care system.</td>
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<tr>
<td>- Determines factors (e.g., age, developmental level, culture, language, anxiety) that may influence the interviewing process.</td>
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<tr>
<td>- Respects the emergency patient’s privacy.</td>
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<tr>
<td>- Demonstrates empathetic understanding when caring for emergency patients &amp; their families.</td>
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<tr>
<td>- Uses a combination of open &amp; closed-ended questions during the interview process.</td>
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<tr>
<td>- Elicits appropriate medical history questions related to the chief complaint.</td>
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<tr>
<td>- Elicits objective &amp; subjective data related to the patient’s chief complaint, associated symptoms, clinical assessment &amp; significant medical history.</td>
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<tr>
<td><strong>Interventions</strong></td>
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<tr>
<td>- Implements appropriate interventions according to established organization policies/protocols, as warranted by the health care consumer’s status.</td>
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</tbody>
</table>
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 choose.
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
• Triage Introduction
• Triage Documentation
• ESI
• EMTALA - Legal Regulatory
• Abdomen
• Cardiac
• Trauma
• Cardiac/Chest
• Psychiatric
• Fast Track
• Musculoskeletal
• Special Circumstances – Red Flags
• Pediatrics

Skills
• ** 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, Shing, 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.

<table>
<thead>
<tr>
<th>Rate</th>
<th>ORIENTEE ASSIGNMENT</th>
<th>MET</th>
<th>NOT MET</th>
<th>PRECEPTOR ASSIGNMENT</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Review with preceptor basic knowledge and definition of triage.</td>
<td>Review and discuss</td>
<td></td>
<td>Review and discuss</td>
</tr>
<tr>
<td></td>
<td>Review with preceptor ESI level</td>
<td>Review and discuss</td>
<td>Distinguish and delineate ESI examples for the orientee for different levels.</td>
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<td></td>
<td>Review triage policy &amp; procedure.</td>
<td>Review policies</td>
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<td>Phone message</td>
<td>Review policies</td>
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<td>Review policies</td>
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<td></td>
<td>Direct Admits</td>
<td>Review policies</td>
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<td>Review policies</td>
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<td></td>
<td>Active Labor</td>
<td>Review policies</td>
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<td>Review policies</td>
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<td></td>
<td>Other Testing</td>
<td>Review policies</td>
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<td>Review policies</td>
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<td></td>
<td>Private MD patients</td>
<td>Review policies</td>
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<td>Review policies</td>
</tr>
</tbody>
</table>

**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

Lower Extremities
- Toes
- Foot Ankle
- Tibia/Fibula

Splint, sling, ice, & dressing application and documentation
Review policies & discuss
Identify ways to assess 5 P’s for distal circulation

FIGURE 3
(continued)
ing, and a skill validation checklist. In recent years, clinical simulation has been a popular method for nurses to assess competence. The use of professional portfolios is a means of displaying nurses’ lifelong learning and continued competence. Certification is another means of measuring and displaying nursing competence.

Application to Practice

Evidence about the reliability and validity of competency assessment tools is not strong. 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. 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. 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* standards. All 10 of the *Emergency Nursing: Scope and Standards of Practice* competencies
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 = VALIDATION METHOD

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 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.
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.\cite{30}

Standards 1, 4, 5 and 6 from Emergency Nursing: Scope and Standards of Practice\cite{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
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. 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. 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 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*. 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.

**Acknowledgments**

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**REFERENCES**


Submissions to this column are encouraged and may be sent to Nancy McGowan, RN, PhD
Mcgowan@uthscsa.edu