1

The nature of emergency nursing

Ruth Endacott

Recent policy documents have highlighted the central role of the nurse in the provision of emergency care; this text aims to furnish emergency nurses with a sound underpinning for their diverse role. The wider context for this role is explored in this chapter by defining emergency nursing and articulating the values underpinning its provision. Legal and ethical aspects of practice are explored, together with concepts of teamwork.

DEFINING EMERGENCY NURSING

Emergency care is often ill defined, for example, through the use of terms such as “casualty” or through the grouping of services or courses as “critical care”. This has led to misplaced professional and public perceptions of the role of those working in Emergency Departments (Scholes et al 2000). A recent definition of emergency nursing is provided in Figure 1.1.

This definition highlights the following features of contemporary emergency nursing and the wider delivery of health care:

- the patient at the centre,
- the nurse responding to the patient’s presentation of their illness,
- the independent and inter-dependent nature of the nursing role,
- the breadth and depth of knowledge and skills required by the emergency nurse.

These principles underpin the approach taken within this text, highlighting areas of knowledge and skill with which the emergency nurse needs to be familiar and practised in order to fulfil the role. The textbook uses groups of patients as the focus for chapter content.

The provision of immediate nursing care to people who have defined their problem[s] as an emergency or where nursing intervention may prevent an emergency arising.

The emergency nurse:

1. accepts without prior warning any person requiring health care with undifferentiated and undiagnosed problems originating from social, psychological, physical, spiritual or cultural factors;
2. leads, initiates and co-ordinates patient care.

Components of the role include:

- rapid patient assessment and assimilation of information often beyond the presenting problem;
- allocation of priorities for care;
- intervention based on the assessment;
- on-going evaluation;
- discharge or referral to other sources of care undertaken independently by the nurse within guidelines.

(RCN 1994a; Endacott et al 1999)

Figure 1.1 Definition of emergency nursing

allowing the reader to explore, for example, specific issues relating to the emergency care of older people.

VALUES UNDERPINNING EMERGENCY NURSING

The way in which emergency care services are designed and delivered reflects underlying values at both local and national level. A review of publications, policy and educational documents suggested that emergency nursing reflects the following key values (Endacott et al 1999) about

- nursing,
- the environment,
Emergency nursing care

- the individual,
- health.

Nursing
Emergency nursing embraces art, science, ethics and use of self. It is more than the response to a set of patient observations, or a series of actions determined by a protocol (for example, Advanced Life Support). In responding to a situation presented by the patient as an emergency, the nurse uses a range of technical, intuitive and personal knowledge in deciding how to best manage the patient.

Environment
Emergency nursing is undertaken in a range of settings and influenced by a wide-ranging socio-political context. The emergency nurse has to be aware of, for example, changes in the provision of primary care, with the development of primary care trusts. Similarly, emergency nursing is defined as the interface between primary and secondary care (Royal College of Nursing, RCN 1994a; Crouch et al 1997), requiring liaison with a range of in-hospital and community services in order to ensure the patient is discharged or transferred to the right environment.

The individual
Emergency nursing emphasizes the individuality of both the patient and the staff; review of journal content emphasizes the value placed on patient’s accounts of their experiences in informing nursing practice. Emergency nurses also tailor their patient assessment and management according to the patient’s position on a range of continua, for example, their stage of development; age; pre-existing health problems.

Health
Emergency nursing embraces the following beliefs about health:

1. the need to restore health, and return the patient to homeostasis, where possible and facilitate coping for chronic health problems;
2. the need to respond to, and accept, the patient’s perception of an emergency;
3. the importance of recognising and responding to local population needs.

The manner in which emergency nursing addresses these four aspects is drawn through in the individual chapters of this text. The overall approach is structured around the different patient groups and the Components of Life nursing model described in Chapter 2.

The Changing Policy Context of Emergency Care

In the UK, the location of emergency care has changed in focus over the years, with the rapid expansion of nurse-led services such as minor injuries units (Audit Commission 1996) and NHS Direct. This policy shift is also reflected in a more flexible approach to workforce planning, with the suggestion of developing an Emergency Care Practitioner, able to work in the hospital or community setting (JRCALC 1999). This practitioner may come from a range of professional backgrounds, for example, nursing or paramedical training. This emphasizes the need for inter-professional working and inter-professional education, but also provides a driver for the articulation of the unique nursing contribution to emergency care.

There have also been changes in the nursing role in recent years, for example the development of nurse practitioner roles and nurse-led triage. Central to both of these roles is the nurse’s key role in patient assessment.

This was emphasized in Sbaib’s (1997) ethnographic research exploring how nurses “become” emergency nurses. However, Sbaib also highlighted the problems arising from the nurses need to safely assess patients but also meet government targets for Patient’s Charter. This work also highlighted how the initial patient assessment has the potential to affect the work of the entire department. The central importance of patient assessment in the emergency nurse role is highlighted in this textbook, with coloured textboxes emphasizing key aspects of assessment related to individual patient groups or conditions.

The diversity of patients entering the Emergency Department has been recognized in the past two decades, with a more structured approach to the management of specific patients, for example, the management of children and elderly patients in the Emergency Department; the development of protocols for trauma management; the management of patients presenting with mental health problems. Gender and cultural diversity have also been given greater prominence in
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health care, protecting the public, the potential for conflict between these areas can be seen where an incident is viewed by an employer as a breach of contract but not seen by the NMC as unprofessional conduct. In this scenario, a nurse could be sacked by his employer but not removed from the professional register.

Accountability has been usefully defined as follows:

_The ability to demonstrate the necessary competency, skill and knowledge to take charge of a case, knowing the limits of one’s ability to carry out that charge and having the confidence gained from experience and up-to-date knowledge to decide what has to be done and to do it_ (Kitson 1993).

This emphasizes the need for nurses to also have the authority and autonomy to make decisions about the management of the patient (for example, requesting radiographs). Nurse-led services such as minor injuries units are often in the forefront of these debates.

FORMULA FOR ESTABLISHING NEGLIGENCE

In discussing the legal context of emergency care, it is helpful to focus on the nurse’s accountability to ensure that care given is not negligent. In addressing this issue, a court of law would ask the following three questions:

1. Was a duty of care owed by the defendant (trust) to the plaintiff (patient/relative)?
2. Was the standard of care broken?
3. Did the breach in the standard of care cause the plaintiff harm?

The acceptable standard of care is determined by both national and local policies (see Figure 1.2).

In the UK, the extent to which individual trusts meet the acceptable standard of care is reflected in the level of indemnity they are awarded against claims of negligence. This is administered by the NHS litigation authority through the Clinical Negligence Scheme for Trusts (CNST) and is usually embraced within the Trust’s Clinical Governance strategy.

The move towards a culture of “no blame” should mean that any errors or adverse incidents are more likely to be reported. Moreover, Lord Woolf proposed that doctors, and other health care professionals, should be obliged, as part of their ethical code, to report

LEGAL DIMENSIONS OF CARE

The legal context, in which emergency nurses work, is defined and debated in detail elsewhere. However, it is crucial for the nurse to understand the central tenet of accountability for his/her actions, and the indirect accountability for actions delegated to others by the nurse.

Four main arenas of accountability in law are of particular relevance to nurses:

- The Public = Criminal liability
- The Patient = Civil liability
- The Profession = Professional liability
- The Employer = Employment liability.

Whilst all areas of law are seeking to protect the common goal of individual rights and, specifically for

approaches to patient assessment and management. The nursing role is central in all these policy developments and has informed the structure of this text.

Shifts in policy thinking are also seen in health department campaigns to encourage patients to seek help from professionals other than emergency care practitioners, for example, pharmacists. This reflects concerns with the heavy workload of Emergency Departments and pre-hospital emergency services. It has also been highlighted through initiatives such as the trolley-waits surveys conducted by the RCN (1994b; 1996), and consumer bodies such as the Community Health Councils. From another angle, there have been numerous studies exploring the “appropriateness” of attendance at Emergency Departments (Jeffery 1979; Sbaïh 1993; Walsh 1995) and the reactions of nurses and other professionals to those whose “emergencies” are perceived as non-urgent (Lewis and Bradbury 1982; Byrne and Heyman 1997).

There has also been a move to a culture where the “work” of emergency care is perceived as patient needs that have to be met. Who meets those needs and where they are met is increasingly left to local health services to determine. For example, in some health authorities, all minor injuries will be managed outside of Emergency Departments, whereas in other settings this remains part of the Emergency Department role. This policy shift is reflected in this text, with the emphasis on the care required by the patient (emergency care) rather than the location (the Emergency Department).
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Figure 1.2 National and local standards underpinning emergency care

to the patient any act or omission in their care that may have caused injury, and that doctors (and other health care professionals) who fail to comply should be subject to disciplinary action (Lord Woolf 2000).

The overall means of achieving an “open” culture could be summarized as

- identifying not who went wrong but what went wrong,
- talking through the incident rather than instigating an investigation,
- treating the incident as a training point rather than a disciplinary matter,
- learning lessons and changing systems as appropriate.

Figure 1.3 Five key ethical principles (after Beauchamp and Childress 1989)

- Respect for the individual
  The need to ensure confidentiality and privacy.
- Respect for the autonomy of the individual
  The need to ensure appropriate consent is given by the patient or relative.
- Beneficence/non-malefance
  The need to ensure that decisions regarding treatment for the individual patient are designed to be of benefit to the patient, not merely to avoid harm.
- Honesty
  That individual patients and families are given honest information regarding progress and prognosis. This ethical principle also relates to Lord Woolf’s assertion that health care professionals admit their mistakes to the patient (see above).
- Justice
  Equity of access rather than postcode services.

Of these issues, the matter of informed consent is one which troubles many health care professionals. Following an audit of informed consent in one NHS Trust, Campbell and Gladstone (2000) used the following principles to educate clinicians:

1. description of the procedure should be in words which the patient can understand, with no abbreviations,
2. the person signing the consent form should be a competent clinician – one who could potentially undertake the procedure,
3. clinicians should use any opportunity to record discussions about informed consent in the case notes,
4. clinicians can add relevant risk information to the consent form.

There is no legal requirement for the patients’ signature on the consent form to be witnessed. However, it is essential that patients and their families are given sufficient explanation of the procedures for which they are consenting. In some departments where this activity is likely to be undertaken by a diverse number of staff, it may be helpful to define, for each procedure, what constitutes “explanation of the procedure”. An overview of the law on consent has been published by the Department of Health (DH 2001) and is reproduced in Figure 1.4.
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<tr>
<th>When do health professionals need consent from patients?</th>
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<tr>
<td>1. Before you examine, treat or care for competent adult patients you must obtain their consent.</td>
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<td>2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.</td>
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<td>3. Patients may be competent to make some health care decisions, even if they are not competent to make others.</td>
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<td>4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.</td>
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<th>Can children consent for themselves?</th>
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<td>5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 or 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.</td>
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<th>Who is the right person to seek consent?</th>
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<td>6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specifically trained to seek consent for that procedure.</td>
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<th>What information should be provided?</th>
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<td>7. Patients need sufficient information before they can decide whether to give their consent: for example, information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.</td>
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<th>Is the patient’s consent voluntary?</th>
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<td>8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.</td>
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<th>Does it matter how the patient gives consent?</th>
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<td>9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove that the consent is valid – the point of the form is to record the patient’s decision, and also increasingly, the discussions that have taken place. Your trust or organization may have a policy setting out when you need to obtain written consent.</td>
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<th>Refusal of treatment</th>
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<td>10. Competent adult patients are entitled to refuse treatment, even where it would clearly benefit their health. The only exception to this rule is when the treatment is for a mental disorder and the patient is detained under the 1983 Mental Health Act. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.</td>
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<th>Adults who are not competent to give consent</th>
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<td>11. No one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. “Best interests” go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences.</td>
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<td>12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an “advance refusal”), and those circumstances arise, you must abide by that refusal.</td>
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Figure 1.4 Twelve key points on consent: the law in England (DH 2001)
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| Article 1 | The Convention |
| Article 2 | Right to Life |
| Article 3 | Prohibition of Torture |
| Article 4 | Prohibition of Slavery and Forced Labour |
| Article 5 | Right to Liberty and Security |
| Article 6 | Right to a Fair Trial |
| Article 7 | No Punishment without Law |
| Article 8 | Right to Respect for Private and Family Life |
| Article 9 | Freedom of Thought |
| Article 10 | Freedom of Expression |
| Article 11 | Freedom of Assembly and Association |
| Article 12 | Right to Marry and Found a Family |
| Article 14 | Prohibition of Discrimination |
| Article 16 | Restrictions on Political Activity of Aliens |
| Article 17 | Prohibition of Abuse of Rights |
| Article 18 | Limitations on Use of Restrictions on Rights |

Figure 1.5 Articles of the Human Rights Act (1998)

These ethical issues are explored further in individual chapters relating to the management of different patient groups.

The importance of these considerations in everyday relationships is highlighted through the publication of the Human Rights Act (1998), derived from the European Convention on Human Rights. The act contains 18 articles, identified in Figure 1.5. A helpful analysis of the implications of the act for practitioners in the NHS has been provided by the NHS Litigation Authority (NHSLA 2000) and is reproduced in Figure 1.6. Wilkinson and Caulfield (2000) provide a more detailed outline of the act as it applies to nursing practice. The full text of the act can be found at www.homeoffice.gov.uk/hract

This flowchart provides a useful framework for decisions regarding new and existing policies and procedures for emergency nursing in your setting. You need to be able to demonstrate that you have considered the convention rights and taken appropriate action to ensure that practice is compatible with the act.

One area of practice that has received much publicity in recent years, and is highlighted in several articles of the act, is the issue of racism. Following the McPherson report on institutionalized racism within the Metropolitan police the RCN discussed this issue at its congress. The question was raised regarding racism within the health care services and the RCN.

Since that debate the RCN has promoted diversity awareness through a number of key activities. Staff and activists have had specific training and RCN offices hold a range of events celebrating diversity and supporting a number of network groups. A diversity resource guide has been developed which supports activists in assessing employers’ policies and progress in managing diversity and equality.

The RCN has also pioneered an innovative Connect Project, which examines strategies for cultural diversity networks, communication and learning. The project builds alliances with city councils, health authorities, trusts and community organizations.

**TEAM CONCEPTS**

Emergency nursing is not practised in isolation; the success of interventions is likely to be dependent on the contributions of many practitioners, from the Paramedic and Fire and Rescue Personnel in the pre-hospital setting to the consultant anaesthetist and radiographer. In order to work effectively in a team, key features are required. These are presented in Figure 1.7 (p. 8).

Teamwork can be promoted and “practised” through the use of simulation where poor teamwork and communication have been demonstrated, practising team roles using simulation has been demonstrated to improve teamwork (Santora et al 1996). However, teamwork is also a key to the success of “everyday” situations. The diverse nature of emergency nursing, with patients from across the entire age range, disease range and cultural range, emphasizes the need for the nursing team to develop complementary roles, as the goal of being competent in all those dimensions of care is largely unattainable for the individual nurse. Hence there is a need to recognize, value and develop the individual contributions of team members. This process starts with the preceptorship of new staff and builds through mentoring, clinical supervision and appraisal processes.

The key to effective emergency nursing care is the development of a team of nurses, with appropriate knowledge and skills, who work with other professionals to respond to emergency situations. The
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Figure 1.6 The Human Rights Act 1998 – Checklist for the NHS (reproduced with permission, NHSLA Review issue 19-2000)
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Figure 1.7 Key elements of teamwork

remaining chapters in this text provide a foundation for that process.

References

London: HMSO.

RCN (1994a) Accident and emergency: challenging the boundaries. London: RCN.
Care of the emergency patient – frameworks for nursing assessment and management

Gary Jones

This chapter provides the reader with an insight into various models and frameworks used within emergency care and focuses specifically on the Components of Life framework. Throughout the chapter the use of the Components of Life framework is linked with clinical conditions that commonly present to the emergency care setting showing how a structured approach to nursing care can be achieved. More details regarding individual “conditions” can be found in the subsequent chapters.

INTRODUCTION

While most patients require emergency care for physical problems (conditions) many others will require care stemming from a psychological or social source. In addition the emergency nurse provides care to relatives and friends of the patient. Spiritual and cultural factors are also important when caring for an individual.

Provision of good emergency nursing care results from the nurse working in a structured and logical way. The very nature of emergency nursing requires the use of a model or framework that underpins the assessment, planning, intervention and evaluation process.

Emergency nursing frameworks are seen in such tools as the SOAPE format (Blythin 1988), triage (Mackway-Jones 1996) and trauma care (TNCC 2000).

These frameworks do not encompass major theorist philosophies but rather provide a structure on which to build the patient assessment, intervention and evaluation. No one tool is used in isolation, each one compliments the other.

THE TRIAGE FRAMEWORKS

Triage (allocation of a priority for care) has been used in the emergency care setting for many years. Until the mid-1990s there was no agreed national standards or priority categories and many Emergency Departments developed in-house systems often based on previous work (Blythin 1988; Jones 1988). In 1996 the Royal College of Nursing Emergency Department Association with the British Association for Emergency Department Medicine agreed a UK national triage scale based on a five-point framework. This framework places the patient into one of five priority categories (Crouch and Marrow 1996; Marrow 1998). The Manchester Triage System (Mackway-Jones 1996) (Figure 2.1) has been adopted by a large number of emergency care settings and this methodology is now the most commonly used. The Manchester system links comfortably with the agreed national triage scale and uses flow charts based on presenting conditions in adults and children such as chest pain, headache and abdominal pain. The tool also uses discriminators such as pain, which automatically places the patient into a specific priority category.
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Immediate resuscitation (red)
- Patients in need of immediate treatment for the preservation of life
- No delay
- Patient usually met by a team on arrival

Very urgent (orange)
- Seriously ill or injured patients whose lives are not in immediate danger
- Should be seen within 10 min of arrival

Urgent (yellow)
- Patients with serious problems, but apparently in a stable condition
- Should be seen within 60 min of arrival

Standard (green)
- Standard Emergency Department cases without immediate danger or distress
- Aim to see within 120 min

Non-urgent (blue)
- Patients whose conditions are not true accidents or emergencies
- Should not have to wait for more than 240 min

Figure 2.1 Manchester Triage System

While triage is about setting priorities for care, in its day to day use it encompasses a number of goals including:

Goals of triage (Jones 1990)
- Early patient assessment
- Priority rating
- Assignment to correct area of care and infection control
- Control of patient flow
- Initiation of diagnostic measures
- Initiation of emergency care
- Patient education.

TRAUMA CARE FRAMEWORKS

In trauma care a simple framework based on the alphabet has been used very successfully over the last 10–15 years. The most recent update of the framework (TNCC 2000) uses an A–I mnemonic (Figure 2.2). It is not intended to encompass the whole person but simply provides the essential structure to the primary and secondary survey. This is explored in greater detail in Chapter 7.

NURSING CARE MODELS AND FRAMEWORKS

Throughout the last 20 years nursing has seen the development of theories and nursing models. A nursing model is based on a philosophy (belief and values) about humans being the recipients of nursing and includes achievable goals and the knowledge and skills on which nursing practice is based. Names such as Henderson, Roper, Orem, Rogers and Roy are just some that reflect the number of nursing theories and models available. The majority of models were developed from the theorist conceiving an idea, expounding and developing it into a model, then putting it into practice. While some of these models were (and still are) implemented in wards and departments many other models and frameworks have been developed from analysing practice and developing a usable tool from what actually exists.

A practice-based approach to the development of nursing models was given credibility by Wright (1986) and has been used by many since. Jones (1990) used this approach to develop the Components of Life model. This model was developed from practice within an Emergency Department and was introduced into emergency nursing in 1986 after an extensive piece of work at the authors own Emergency Department in England. The model in various formats is now used in a number of Emergency Departments throughout the UK. It has also been referenced in work from Australia, and the USA. The model has been validated by a number of emergency nurses and lecturers within emergency care. Through independent work it has been shown that the model provides a definition of the four metaparadigms as described by Fawcett (1989).

The original Components of Life model was based on seven components that are all reflected within emergency nursing practice. A new Components of Life framework retains the components in a slightly