The case for advanced practice nurses in ED

By Geoff Wilson

Australia is a land of contrasts: this is particularly true of health care, and especially true of emergency care.

However, contrasts in the terminology and variety of roles of advanced practice nurses appear to have led to some confusion about the extent and potential benefit of their contribution to emergency services.

A nationally consistent approach to emerging nursing roles in Australian emergency departments would not only enable the consistent and continual development of advanced practice roles for emergency department (ED) nurses, but could also improve efficiency and thus patient welfare.

Advanced practice nurses at all levels must, however, be vigilant in ensuring that the public and other health professionals understand the nature and extent of their advanced practice as this will lead to greater acceptance of extended nursing practice.

It is also important that in creating roles for advanced practitioners, there is evidence the initiatives will benefit patients, and improve care.

The benefits of advanced practice roles such as nurse practitioner and clinical nurse specialist can be demonstrated by the following case study, which shows how the role of an ED nurse might be naturally extended, and how nurse-initiated management can contribute to reducing contemporary emergency department challenges such as extended waiting times.

The ED scenario

Imagine you are an experienced ED nurse on triage duty on a busy Saturday night in a large base hospital. There are 15 people in the waiting room all of whom are category four or five. Both the non-acute areas and the resuscitation area are full.

An adolescent boy approaches the triage desk, in the company of his father. He has a lightly blood-stained bandage wrapped around his forearm and appears pale and apprehensive.

His father tells you that his 17-year-old son was assisting with a home renovation project when a hand saw slipped, lacerating his son's forearm.

Why is it not possible for the triage nurse to make a clinical judgement, and to refer the patient direct to a dressing cubicle, where the next available nurse could conduct the treatment?

Your assessment reveals the following: radial pulse of 80, blood pressure 110/60mmHg, respirations of 12, SPO_2 of 98%.

Examination of the wound reveals a 5cm laceration on the inner aspect of the forearm. Haemostasis has been obtained, and the patient has full movement of his wrist and fingers, and no loss of sensation, with palpable distal pulses.

You place a clean dressing over the wound, and categorise the patient as a four, and explain that there will be at least a two hour wait, before he will see a medical officer. Three hours later the patient is called into an examination cubicle, where the nurse repeats your preliminary triage observations, which are essentially unchanged.

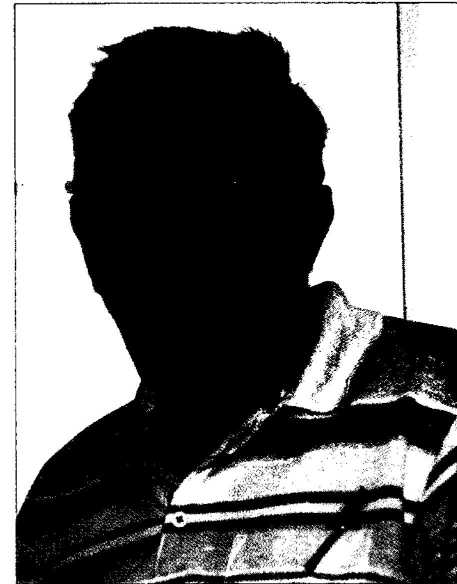
It is a further 25 minutes before this patient is seen by a junior medical officer, who confers with the ED consultant regarding the need for suturing. The consultant examines the wound, suggests cleaning, application of butterfly closures, and a dressing, plus tetanus prophylaxis.

A better way?

Consider for a moment the above sequence of events, and the duplication of services involving several health professionals.

Was there anything in this scenario which could not have been dealt with by a single health professional? Why was it not possible for the triage nurse to make a clinical judgement, and to refer the patient direct to a dressing cubicle, where the next available nurse could conduct the treatment?

ED nurses who have significant experience and education are very capable of making decisions in regard to wound management. Patients



presenting with minor ailments, or even serious illnesses, can often be assessed and referred to a more appropriate health professional.

Many patients with minor conditions may even be better served by nurses who are able to provide holistic care, including preventative advice, saving the system money in terms of recurrence.

Research supports the role

If the case study is not compelling enough, there is considerable research evidence to support the role.

A 1996 literature review of nurse practitioners in emergency departments found clinical decisions made by nurses compared favourably with medical practitioners in terms of safety and efficiency.[1] Patient satisfaction levels were high, with patients commenting about the more relaxed consultation style of ED nurses.

A reduction in waiting times, more appropriate use of medical and nursing staff time, better utilisation of nursing skills, improvement in the quality of

care and patient satisfaction all demonstrate the value of the role.

Another study found 97% of 332 patients with minor injuries who were managed by nurse practitioners were judged to have been appropriately managed when retrospectively reviewed by medical consultants.[2]

Research from Monash University on nurse-initiated x-rays demonstrates reductions in waiting times in emergency rooms.[3]

A Sydney study found triage nurses who ordered x-rays ordered appropriately and with a high degree of accuracy. This nurse-initiated management decreased waiting and processing times, decreased waiting room aggression, and had a positive impact on patient satisfaction.[4]

The administration of timely and effective analgesia is another area where nurse-initiated management by advanced practice nurses can have a positive impact on outcomes and patient satisfaction. Untreated severe pain can significantly increase patient fear and anxiety and lead to aggressive behaviour.

Existing models of care

A 2002 NSW study of nurse-initiated intravenous morphine found waiting times for analgesia were reduced from 52 minutes to 18 minutes when nurses were able to take the initiative for its adminstration.[5]

American nurse Deb Seguin developed an advanced triage protocol in 2004 to manage early pain. Under the protocol, nurses can order specific tests and radiographs before a medical evaluation.[6]

In her hospital (Michigan, USA), this frequently means the diagnostic results are on the chart before the physician sees the patient, significantly reducing the patient's length of stay in the ED.

Patients commented they did not feel ignored because 'something was being done', and Seguin reported the biggest champions of this change were the ED physicians.

The biggest challenge came from the supervising committee on the level of practice and education of ED nurses.

This same study found non-emergency attending physicians were very unclear about emerging nursing practice and the autonomy it entails.

This demonstrates how important it is to educate our fellow health professionals and the public about what a nurse does, and the level of education necessary to practice in ED in general, let alone as a clinical nurse specialist or nurse practitioner.

In spite of some misgivings, the documented improvement in a range of patient outcomes, as well as the educational and experiential benefits for junior medical officers working collaboratively with experienced nurses, demonstrates the importance of continuing to strive for a more flexible approach to tasks, in an environment in which the workload is constantly expanding.

After all, emergency nurses have historically had a primary role in the education of resident medical officers, and were major innovators of improved policies and procedures, developing for example, the emergency resuscitation trolley, or 'crash cart'.

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The way forward

While the nomenclature surrounding the role of the advanced practice nurse will continue to be debated, what seems certain is that since advanced practice nursing has a significant role in relation to improved patient outcomes, there can be little argument that emergency care deserves nurses who are specialists, with advanced skills and knowledge.

Nurses need to be vigilant in ensuring other health professionals and the community understand the nomenclature surrounding their roles, as the roles of nurse practitioners and clinical nurse specialists are becoming increasingly difficult to define.

We must also keep the needs of our patients at the centre of our endeavour to upgrade the profession. If we do this, it is certain that we can provide a much more efficient emergency system.

Many of our current ED clinical nurse specialists are capable of more responsibility. We need to overcome the bureaucracy preventing the development of more efficient services, by striving to use our advanced knowledge and skills to assess, treat and make clinical decisions independently and collaboratively where appropriate.

If we are prevented from using our 'real' or 'potential skills', then the health care system will be the poorer, and people's needs will remain unmet.

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