AAENP
AMERICAN ACADEMY OF
EMERGENCY NURSE PRACTITIONERS

Practice Toolkit for Advanced Practice Registered Nurses in Emergency Care

Acknowledgements

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Toolkit Purpose & Intended Audience

The American Academy of Emergency Nurse Practitioners (AAENP) Practice Committee developed this toolkit to serve as a resource and guiding document for nurse practitioners in emergency care. The toolkit offers an overview of the advanced practice registered nurse (APRN) role, education, certification, licensure, and utilization of nurse practitioners in emergency care to their full potential. Additionally, the toolkit provides strategies to attract, develop and retain the best talent to optimally leverage the highly specialized skills of nurse practitioners in emergency care. The practice toolkit was designed as an evolving document and will be updated regularly to reflect innovations in emergency care.

Practice Toolkit intended audience:

- Nurse practitioners and clinical nurse specialists in emergency care
- Employers of nurse practitioners and clinical nurse specialists in emergency care
- Physicians and other members of the healthcare team
- Health systems, organizational leaders, strategic planners
- Policymakers (national, state, local, and entity)
- Human resources and hiring managers
- Chief Medical Officers, Chief Nursing Officers, Medical Directors, & Department Chairs
- Healthcare administrators
- State Boards of Nursing
- Educators (Academic and postgraduate)
- Payers and insurance bodies
- Medical staff offices and credentialing entities

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) practice within emergency care settings may include but are not limited to the following:

- Emergency departments (ranging from critical access facilities to tertiary emergency care centers)
- Urgent care clinics
- Free-standing emergency centers
- Pre-hospital care
- Mobile integrated services

Disclaimer: *The practice toolkit is intended to serve as a reference document while recognizing scope of practice is regulated by individual state licensure laws and Boards of Nursing. Please consult your State Boards of Nursing regarding the scope of practice that governs ENP practice in your state. This document does not supersede national, state or local regulatory guidelines.*

Section 1. Role of Advanced Practice Registered Nurses (APRNs) in Emergency Care

The American Academy of Emergency Nurse Practitioners (AAENP) defines emergency care as encompassing "the evaluation, management, and treatment of patients across the lifespan with unforeseen illness or injury of varying complexity. Emergency care is delivered by clinicians that are educated and trained to comprehensively address a wide variety of illnesses and injuries, ranging from resuscitation and stabilization of life-threatening health problems to management of minor injuries and illnesses" (AAENP, 2018) in collaboration with a multidisciplinary team. Within emergency care, advanced practice registered nurses (APRNs) include the Emergency Nurse Practitioner (ENP) and the Clinical Nurse Specialist (CNS) roles.

Role of the Emergency Nurse Practitioner (ENP)

Simply stated, emergency nurse practitioners (ENPs) are specialty care providers who provide and manage the care of patients across the lifespan in diverse emergency care settings. ENPs practice within the scope of the population-area of advanced practice education and national certification, inclusive of acuity levels from non-urgent to emergent conditions. Emergency Nurse Practitioner specialization builds upon NP entry-into-practice knowledge with a minimum of master's level preparation (AAENP, 2016). ENP competencies can be achieved through formalized ENP academic program, postgraduate emergency medicine fellowship, or on the job training with continuing education[3]. The ENP functions as part of the multidisciplinary health team in accordance with approved privileges to provide high-quality, cost-effective advanced nursing care to patients within their scope of practice. The ENP role has rapidly transformed over the last 40 years and continues to evolve today[3]. Currently, there are over 355,000 Nurse Practitioners licensed in the United States[4], with an estimated 25,000 NPs employed in a variety of emergency settings including but not limited to: emergency departments (critical access facilities to tertiary emergency care centers), urgent cares, free-standing emergency centers, pre-hospital care, mobile integrated services, observation medicine units and emergency medical response vehicles across the United States[5].

ENPs make evidence-based medical decisions, formulate differential diagnoses, monitor and re-evaluate patient conditions, interpret diagnostic tests, prescribe therapies (both pharmacological and non-pharmacological), evaluate patient outcomes, and develop disposition plans[6]. The ENP functions as part of the multidisciplinary health team in accordance with approved privileges to provide high-quality, cost-effective advanced nursing care to patients within their scope of practice. Whether working in a metropolitan emergency department, in urgent care, or in a rural setting, the ENP is a highly trained, cost-efficient practical staffing option. ENP utilization within emergency care settings has proven to reduce patient wait times and increase patient satisfaction, while providing quality appropriate patient care[7,8].

> **Scope & Standards of ENP Practice |** Scope and standards of ENP practice have been established by AAENP, and are based on specialty education, national licensure, and certification[2]. The ENP scope of practice must be considered in regard to the individual ENP's national regulatory licensure requirements, state board of nursing, and organizational credentialing and hospital bylaws and privileging body[2].

ENP Competencies | While prior iterations of clinical competencies have been published[3], the most recent set of ENP competencies was jointly developed and published in December of 2021 by the AANEP & ENA[6], integrating works from previously published versions from both organizations. In addition to broad competencies, essential skills and procedures that may be performed by ENPs were identified during a 2016 practice analysis[9]. Although this is not an exhaustive list, the procedures included support the delivery of high-quality emergency care.

Role of the Clinical Nurse Specialist (CNS)

Clinical nurse specialists (CNSs) are advanced practice nurses who are uniquely prepared to meet the increased demand for health care within a specialized area of nursing with bedside expertise and who work to improve nursing practice that safeguards the provision of quality care and outcomes[10]. The Emergency CNS provides both health promotion and maintenance through assessment, diagnosis, and management of acute and chronic patient problems that include pharmacologic and non-pharmacologic interventions[11]. The Emergency CNS role is uniquely suited to lead the implementation of evidence-based quality improvement actions that also reduce costs throughout the health care system. They also play an essential role in care coordination and transitions of care that result in reduced hospital length of stay, fewer hospital readmissions and hospital-acquired conditions.

The Emergency CNS works with specific patient populations across the lifespan in various emergency care settings. In contrast to NPs, the CNS often functions as an educator and consultant to the nursing staff and as experts on ensuring evidence-based practice and quality patient outcomes. The CNS is in an ideal position to coordinate, implement, and evaluate a plan to prevent costly readmissions and improve care.

Scope & Standards of CNS Practice | Clinical nurse specialists have a nationally recognized, state-specified scope of practice that cannot be replaced by the scope of practice of other APRNs or nurse leaders [11]. The Emergency CNS works with a specific patient population across the lifespan, in various emergency care settings. In contrast with nurse practitioners, clinical nurse specialists often function as educators and consultants o the nursing staff and as experts on ensuring evidence-based practice and quality patient outcomes. The CNS is in an ideal position to coordinate, implement, and evaluate a plan to prevent costly readmissions and improve care. They also have a significant impact in implementing practices to reduce patients' lengths of stay in various emergency care settings.

CNS Competencies | The CNS role has 4 components: expert clinician, educator, researcher and consultant. CNS competencies are integrated into a CNS Statement which is available from the National Association of Clinical Nurse Specialists[12]. A review of the CNS Core Competencies supports the centrality of the function of care coordination within the CNS role.

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Section 2. Educational Preparation & Certification of APRNs in Emergency Care

Education and certification of advanced practice nurses (including NP and CNS roles) within the United States is guided by the 2008 Consensus Model for APRN Licensure, Accreditation, Certification and Education (LACE)[1]. Both NP and CNS providers are educated at the graduate level (master's or doctorate) in nursing.

Educational Preparation of the ENP

All entry-level NPs (regardless of population or specialty) must meet NP core competencies[2] and population-focused competencies based on educational preparation. The core NP competencies should be evident upon graduation regardless of a graduate's population focus. The ENP competencies build upon the NP core competencies to identify the unique characteristics and care provided by the emergency nurse practitioner. Graduate-level academic programs preparing ENPs are now aligned to content nationally. Programs undergo a rigorous validation process by the AAENP to ensure that essential didactic and skills components are included in the program. A complete listing of academic ENP programs currently validated by AAENP can be found on AAENP's website.

Educational preparation of ENPs from validated programs ensures congruence with applicable competencies. The didactic and clinical education within ENP academic programs provides graduates with the knowledge required to manage patients "requiring advanced diagnostic reasoning, risk stratification, and medical decision-making that is distinct from other APRN practices… across the lifespan incorporating the trajectory of acuities in the context of the patient's developmental stage" (2021 ENP Competencies, pg. 7). Additionally, essential skills and procedures are included in educational preparation. These may include, but are not limited to:

- Airway Management (including intubation & ventilator management)
- Arterial line placement
- Arthrocentesis
- Central line (including intraosseous) placement
- Control of Epistaxis
- Foreign body removals
- Laceration repair
- Lumbar Puncture
- Needle decompression and chest tube thoracostomy
- Paracentesis
- Point of care Ultrasound
- Regional Nerve Blocks
- Thoracentesis
- Tooth stabilization
- Wound care

ENP Certification

Currently, the only mechanism for certification as an Emergency Nurse Practitioner is through the certification program of the American Academy of Nurse Practitioners Certification Board (AANPCB)[3]. This exam-based certification was launched in January 2017. Before that time, a portfolio process was utilized by the American Nurses Credentialing Center (ANCC) to award the credential of ENP-BC. The portfolio certification process was retired in 2017[3]. The ENP certification by examination is a competency-based, accredited examination available for certified Family Nurse Practitioner (FNP) candidates who complete specialized education in emergency care. The exam eligibility criteria are found in the AANPCB ENP Certification handbook. Additional information, including the current exam blueprint and reference lists, are available on the AANPCB website.

Educational Preparation of the CNS

Clinical Nurse Specialists are broadly educated to achieve three spheres of impact: direct clinical care, nursing/nursing practice, and organization/systems[4]. The roles may vary depending on area of specialization. CNSs provide an expansive range of services that may be patient specific, population centered, and system or community focused. The spectrum of care or consultation provided may be generalized, disease specific or problem focused[5].

CNS Certification

Current CNS practice is founded on evidence-based competencies with three options for population-specific certification available through ANCC (Adult/Gerontology, Neonatal, and Pediatric) necessary for licensure in states having adopted the APRN Consensus Model. CNSs may further obtain specialty certification in multiple areas (i.e., oncology, diabetes, cardiology and others). To date there is no emergency specialty certification available for CNSs. Information regarding population specific CNS certification is available on the ANCC website.

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Section 3. Characteristics of APRN Practice in Emergency Care

According to the Association of American Medical Colleges, there is a predicted shortage of 122,000 physicians in the United States by 2032[1]. The New England Journal of Medicine Career Center[2] further reports that this physician shortfall not only affects primary care physicians, but also those in emergency medicine and urgent care. These reports contrast a national emergency medicine workforce survey conducted by the American College of Emergency Physicians which predicts an oversupply of the emergency medicine workforce by 2030[3]. This surplus is attributed to estimates of future changes in the demand for emergency services, the number of physicians entering and leaving the workforce, and the increasing use of advanced practice providers.

Despite the anticipated surplus of emergency medicine providers, there is a nationwide maldistribution of the workforce with significant gaps within rural communities that will likely continue[3]. Data showing rural coverage gaps has also been reported by the Emergency Medical Residency Association who found that four out of five new emergency physicians choose to practice in urban areas where there is a strong distribution of physicians compared with rural communities where only 12% of emergency physicians are currently practicing[4]. With these gaps, there has been an estimated increase in the use of advanced practice providers in emergency care from 23% in 2010 to a 62% utilization in 2016[3], along with increased utilization within rural communities[5]. In response to the shifting emergency workforce, diverse APRN care delivery models within emergency care settings began to emerge, including the following:

- Higher numbers of NPs practicing in states with fewer practice restrictions/regulations[5]
- Expanded integration of NPs within emergency medical services systems[6]
- Varied practice models for clinical utilization of APRNs in emergency care exist[7,8], including provider roles in triage, fast track, academic/tertiary care, suburban/community emergency departments, rural emergency settings, urgent care, and solo practice in critical access facilities.

Practice Model Variations

- **Provider in triage role:** APRNs can be placed in triage areas to provide medical screenings exams in an attempt to decrease left without being seen (LWBS) rates, as well as to decrease the possibility of a critically ill patient not receiving timely interventions and orders.
- **Fast track provider role:** Utilization of an ENP in the fast track area allows timely and efficient evaluation, treatment, and disposition of ESI level 4 and 5 patients. This model often allows better patient flow of lower acuity patients, which improves patient satisfaction.
- **Main emergency department provider:** The ENP is educated to see complex and critically ill patients. By working collaboratively with emergency physicians, a safer patient ratio can be achieved. In addition, complex time-consuming procedures can be performed by the ENP while allowing the physician to continue evaluation and management of other patients.
- **Solo provider in critical access facility:** As allowed by state laws and regulations, ENPs may provide solo coverage in critical access facilities to improve access to healthcare in areas where essential services might otherwise be unavailable.
- **Urgent care provider:** The ENP is prepared to provide primary and urgent care within stand-alone urgent cares or those integrated within larger health facilities.

- **Telehealth:** The ENP may combine a multitude of models with a telehealth approach to care delivery. This emerging platform for healthcare delivery has grown exponentially during and following the COVID-19 pandemic.

Based upon state regulations (see below) in conjunction with group and/or facility policies, different levels of physician collaboration and/or supervision may be required[8,9].

- **Direct supervision** is when the physician is physically present with the nurse practitioner and the patient. The physician personally evaluates each patient when direct supervision is used.
- **Indirect supervision** is when the physician is available to be consulted on the patient care but does not personally see the patient. This may be achieved in multiple ways including the physician being physically present in the same emergency department, or with the nurse practitioner being in a separate site and they are available by phone or electronic device.

Combined, or tiered, approaches of supervision may also be utilized in some facilities. For example, during the first year following graduation or with a new group the nurse practitioner is supervised by the physician. At the one-year mark and with approval from the group/ and/or supervising physician, the NP is allowed to independently treat ESI level four and five. The level three patient must be discussed at some point during the patients stay in the emergency department, level two must be discussed with the physician within 30 minutes, and level one must be discussed with the supervising physician immediately.

Additionally, some states provide the NP with Full Practice Authority, meaning that the NP practices under the exclusive licensure authority of the state board of nursing[10]. This is the model recommended by the National Academy of Medicine (formerly called the Institute of Medicine) and the National Council of State Boards of Nursing.

Regardless of the models utilized, the nurse practitioner must work within and be knowledgeable to the limits in their practice. Nurse practitioners must possess awareness of their own limitations as well as practice regulations to know when to seek expert consultation regarding patient care. Open lines of communication between the nurse practitioner and the physician are essential for establishing trust between the providers, with the physician being able to trust they will be consulted when needed, while maintaining being approachable and willing to answer questions or assist with procedures as needed.

State Regulatory Variations | APRN practice varies by state, as well as by institution. It is incumbent on both the individual provider, employer and facility to ensure that State regulations regarding practice, regulatory agency, and continuing education requirements to maintain NP licensure are maintained. Provided by the American Association of Nurse Practitioners, an overview of each state's current regulations is available highlighting regulations, licensure requirements, and continuing education requirements among other information.

Salary Variations | Salaries of APRNs in emergency care vary widely, based on practice settings. In the United States (U.S.), the average salary for NPs in the emergency department is $119,304 as of June 28, 2022, but the range typically falls between $110,000 and $135, 000[11,12]. The average hourly rate for NPs in emergency care settings ranges from $70-$108/hour[12]. The average CNS salary in the U.S. is $112,578 vary depending on education, certifications, additional skills, the number of years in your profession[13].

Medical-Legal Considerations

Most emergency providers will at some time in their career be named in a medical professional liability claim[14]. Factors such as an increased volumes[15], stress of the unknown, high acuity patient presentations, and lack of historical patient information contribute to the increased liability for all emergency care providers. As part of the emergency care continuum, multiple points may give rise to a liability claim: arrival/transport, triage, waiting for an exam room, evaluation and management, diagnostic testing, specialty consultations, and disposition. Documentation and communication throughout the course of care are essential to reducing medicolegal claims.

The literature on medicolegal issues relating to APRNs in the Emergency Department is limited. Some literature addresses the liability associated with working with NPs and/or PAs in the ED, and there's no evidence that a physician working with an APRN increases medicolegal liability or judgments. However, the general medicolegal issues for physicians also apply to NP in the ED, including the risk of errors in medical decision-making, misdiagnoses, miscommunication with patients & family/staff/other providers, wrong-site/wrong-patient errors, and the other risks that accompany our unique clinical work environment.

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Section 4 | APRN Onboarding Considerations in Emergency Care

A strong orientation and on-boarding process is critical to success in an emergency department role[1,2]. In order to ensure the successful integration of new providers into an institution, standard onboarding guidelines should be established, which clearly outline the expectations and knowledge required to work in the department.

Onboarding & Transition to Practice

An APRN entering emergency medicine can greatly benefit from a structured on-boarding and mentoring process as an opportunity to enhance long-term success and reduce the time to reach full productivity in the new role[3]. The role transition from an experienced registered nurse to a novice advanced practice role is often challenging with feelings of anxiety and insecurity[1], even if prior nursing was within the emergency setting. The role transition period is impacted (potentially negatively or positively) by the work environment/atmosphere, collegial support and role modeling, collaboration and networking[1].

Structured onboarding programs should address specific goals of onboarding, critical organizational factors, organizational fit, written standard operating procedures and program components (e.g., checklists, schedules, and learning materials), and must consider the costs of onboarding[3]. A variety of methods (or combination of methods) for onboarding may be utilized, including the following:

- **Orientation checklists**[2,3] are helpful tools to ensure a standard and complete transition to new practice settings. Checklists should minimally include necessary completion of credentialing, review of policies and practices, organizational procedures, required safety and compliance training, departmental overview, and documentation guidelines.
- **Mentorship by an experienced provider**[4] offer low-cost opportunities to increase provider retention and improve patient care
- **Educational programs** including “boot camps”, procedural labs and longitudinal didactic learning[2]

Formal transition to practice, residencies and/or post-graduate fellowships offer additional opportunities to increase confidence and competence in the emergency nurse practitioner[2].

Hospital Credentialing & Privileges

In order to work in a hospital setting in the United States, all medical staff (including APRNs) are required to complete a credentialing process managed by the facility’s credentialing department. The credentialing and privileges process for APRNs has been described[5] as “credentialing is a formalized process that incorporates established guidelines to confirm that a health care provider possesses sufficient qualifications, licensure, training, and abilities to practice at a nationally approved standard of care. Privileging is a process that authorizes a provider to perform a specific set of care services that the agency determines the provider is qualified to perform” (p. 95). Once a nurse practitioner is licensed in a state to practice, and chooses to work in an acute care environment, the nurse practitioner must apply for privileges to work in the facility. Privileges will not be granted until the nurse practitioner’s credentials to practice have been verified and approved by Hospital Governing

bodies in accordance with Medical Staff Bylaws. Most commonly, this process takes a minimum of 3 months and may extend to six months[2].

Most often, providers must submit the following documents during the credentialing process: current curriculum vitae (CV), state license(s), Drug Enforcement Agency (DEA) number for prescribing controlled substances, National Provider Identifier (NPI) number provided by the US Center for Medicare and Medicaid Services (CMS), official academic transcripts, proof of advanced and/or continuing education, proof of medical malpractice insurance coverage, peer letters of reference/recommendation, and various other documents depending on area of practice and location.

One resource for credentialing staff considering privileges for APRNs is *2015 Core Privileges for AHPs: Develop and Implement Criteria-Based Privileging for Nonphysician Practitioners (*3rd ed.). It provides guidelines for each type of advanced practice provider in various areas of acute care practice including Emergency Medicine. Qualifications for Nurse Practitioners in Emergency Medicine (p. 80) include:

- Education and Training: completion of a master's/post-master's/doctorate from an NP program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Committee for Education in Nursing (ACEN)
- Certification: current certification by the American Nurses Credentialing Center (ANCC) or an equivalent body is required for initial applicants and those seeking reappointment (and usually for state licensure). Also, current Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), are most often required for initial applicants and reappointment.
- Licensure: current active license to practice as an advanced practice RN in the appropriate NP category/scope of practice in the same state as the facility as well as current RN licensure is required for initial applicants and reapplicants
- Required Current Experience for Initial Application:
    - GENERAL CORE: demonstrated current competence and provision of care, treatment, or services, to at least (N) patients in the past (N) months, or completion of master's/post-master's/doctorate degree program in the past (N) months, and experience and/or academic training must correlate to the privilege requested.
    - EMERGENCY MEDICINE with DIRECT SUPERVISION: Same as GENERAL CORE.
    - EMERGENCY MEDICINE without DIRECT SUPERVISION: completion of a master's/post-master's/doctorate degree program with an emergency medicine concentration in the last 12 months, OR specialty certification by the ANCC as an Emergency NP (ENP-BC) or equivalent training, experience, and documented current competence and provision of care, treatment, or services to at least (N) patients in the past (N) months. OR demonstrated current competence and provision of care, treatment, or services, to at least (N) patients in the past 12 months. In all, experience must correlate to privileges requested.
- Required current experience—renewal: an adequate volume of experience with (N) patients for the past 24 months and demonstrated current competence based on results of ongoing professional practice evaluation (OPPE) and outcomes. Experience must correlate to privileges requested for both the general and specialty specific cores.

- Ability to perform (health status): evidence of current ability to perform privileges as requested is required of all applicants.

While general core privileges vary by institution, procedural privileges within emergency care usually include wound closures, endotracheal intubation and extubating, interpretation of ECGs, arterial puncture/line placement, thoracentesis, paracentesis, lumbar puncture, fracture/dislocation reduction, procedural sedation. A list of procedures for which the ENP may be credentialed is available HERE. Documentation should be submitted with an application for privileges and then once vetted, will be presented to the medical staff credentialing committee and if approved, the NP applicant will be notified and at that time, allowed to practice. All new providers will be subject to a Focused Professional Practice Evaluation (FPPE) for at least the first appointment period depending on volume. Privileges should be renewed every 2 years at most facilities, with the understanding that privileges can be rescinded at any time for various reasons.

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Section 5. Global Presence of APRNs in Emergency Care

The International Council of Nurses (ICN) defines the nurse practitioner and the advanced practice nurse (APN) in the same way - as "…a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competences for expanded practice, the characteristics of which are shaped by the context and/or country in which she/he is credentialed to practice. A Master's degree is recommended for entry level" (p. 29)[1]. Despite the ICN stance, variations in advanced practice, education, and title protection exist. However, the role of the advanced practice nurse is rapidly evolving and expanding to improve the access to and delivery of health care globally for all populations.

Although the development of advanced practice nursing globally is influenced by many factors including improving the delivery and access to care for a variety of diverse populations, it is important to keep in mind that health care systems are unique to each country and advancements in one country may not be transferable to others. Support from international organizations such as the International Council of Nurses (ICN) and World Health Organization (WHO) and developing partnerships with Schools of Nursing are necessary for success.

In 2013, the Pan American Health Organization (PAHO) passed a resolution advocating for APNs to improve delivery and access to care for primary health care needs. Highlights of selected country specific initiatives and global regional developments for the APN role are listed below.

- **Africa** - In rural Sub-Saharan Africa, nurses with variable training in advanced practice skills of health assessment, pharmacology, and diagnosis deliver care although standardization of the advanced practice role does not exist. Thus, some nurses may become Clinical Officers (CO) which provide nurses the opportunity to advance practice in an accepted role as part of the medical team[2]. Although the emergency nurse practitioner role does not exist, the African Federation for Emergency Medicine (AFEM) has developed an emergency nursing curriculum to establish emergency care as a specialty[3].
- **Netherlands** - APNs in the Netherlands are masters prepared using a curriculum that follows the Canadian Medical Educational Directions for Specialists (CanMEDS). As the curriculum mirrors Netherlands Medical education, acceptance of the APN role has occurred. The seven CanMEDS domains are Clinical expert, Communicator, Collaborator, Organizer/leader, Health advocate, Scholar, and Professional. Studies are currently evaluating the effect of integrating Nurse Practitioners into Dutch ambulance care[4] which may lead the way to the development of the ENP role in the Netherlands.
- **United Kingdom** - While established roles of emergency nurse practitioners exist, a UK-wise curriculum and credentialing process for emergency care advanced clinical practitioners has recently emerged[5].
- **Australia** - Australia has been a leader in growing and utilizing the emergency nurse practitioner role since the early 1990s. By 2015, Australia developed standards of care for its Nurse Practitioner field including emergency Nurse Practitioners[6]. Recent efforts have resulted in NP led models of after-hours emergency care in rural areas of Australia[7]. Despite the resistance they have faced with legislative barriers to scope of practice issues, Nurse Practitioners in Australia are improving access to care.

- **Ireland** - The first Advanced Nurse Practitioner (ANP) in Ireland was in 1996. Since then, the role has expanded into specialties including managing minor injuries to rapid assessment and treatment (RATs) ANPS in emergency departments and emergency cardiology services among others[8]. A retrospective study examining the ANP Role at Beaumont Emergency Department in Dublin, Ireland concluded the need for the implementation of ANP roles across other emergency departments in Ireland to expedite care and improve patient outcomes[8].
- **Japan** - In Japan, a patient's length of stay in a secondary emergency department was found to be six minutes shorter with nurse practitioner-led care when compared to physician trainee-led care[9]. Some of the reasons for this may be the result of Japan NPs skills with interprofessional collaboration and RN experience in the hospital setting.

Barriers to the advancement of the role of the APN which in turn impacts the ENP specialty are present globally. Nursing leaders, international nursing organizations, and educational institutions must work together to break down the barriers that exist and hinder the advancement of the APN role. Only through role clarity and standardization of APN education can the ENP specialty grow to address the emergency care needs of global populations.

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Appendix

Glossary of Terms

This glossary provides a collection of commonly used terms and definitions regarding practice, regulatory agency, and advanced practice nursing.

AACN – American Association of Colleges of Nursing
AAENP – American Academy of Emergency Nurse Practitioners
AANP – American Association of Nurse Practitioners
AANPCB – American Academy of Nurse Practitioners Certification Board (offers the ENP certification exam)
ABEM – American Board of Emergency Medicine
ACEP – American College of Emergency Physicians
ACGME – Accreditation Council for Graduate Medical Education
ACNP – Acute Care Nurse Practitioner
AENJ – American Emergency Nursing Journal, societal journal for AAENP
AGNP – Adult Gerontology Nurse Practitioner
AHA – American Hospital Association
ANA – American Nurses Association
ANCC – American Nurses Credentialing Center
APN – Advanced Practice Nurse
APRN – Advanced Practice Registered Nurse
CDC – Centers for Disease Control
CE – Continuing Education
CME – Continuing Medical Education
Collaborative Practice – State practice and licensure laws reduce or restrict the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.
Consensus Model – The Consensus Model for APRN Regulation is a model and document created by the National Council of State Boards of Nursing to create consensus on licensure, accreditation, certification, and education for advanced practice registered nurses.
DEA – Drug Enforcement Agency
DNP – Doctor of Nursing Practice
ED – Emergency Department
EDBA – Emergency Department Benchmarking Agency
EMMP – Emergency Medicine Milestones Project
ENA – Emergency Nurses Association
ENP – Emergency Nurse Practitioner
ENP-BC – Emergency Nurse Practitioner – Board Certified (ANCC)
ENP-C – Emergency Nurse Practitioner – Certified (AANPCB)
EPA – Entrustable Professional Activities – specific tasks appropriate for clinical implementation which demonstrate specific competencies.
ESI – Emergency Severity Index

FNP – Family Nurse Practitioner
HRSA – Health Resources and Service Administration
IOM – Institute of Medicine
KSA – Knowledge, skills, and abilities
LACE – Licensure, Accreditation, Certification, and Education
LPN – Licensed Practical Nurse
MSE – Medical Screening Exam
NCSBN – National Council of State Boards of Nursing (NCSBN)
NEJM – New England Journal of Medicine
NHAMCS – National Hospital Ambulatory Medical Care Survey
NLN – National League of Nursing
NONPF – National Organization of Nurse Practitioner Faculties
NP – Nurse Practitioner
NTF – National Task Force
PNP – Pediatric Nurse Practitioner
RN – Registered Nurse
SIG – Special Interest Group
TEM – Topics in Emergency Medicine

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