EDITORIAL

Emergency nurses – A resource-tiered approach

The African Journal of Emergency Medicine (AJEM) recently posed the following question via social-media service Twitter: “How do we define a low-resource acute care setting? Trying to establish a research checklist for a systematic reviews focus”. Lilian Mark-Johnson (@LilianMJohnson) replied, “Unavailability of basic resuscitation tools and ignorance of the health care workers to basic life support”, whilst Andrew Corley (@limp_bisquick) added, “Essential competencies for nurses and allied health professionals in regions without adequate numbers of MDs?” In this issue, the focus turns to the human resource cadre of nurses, specifically, differentiating the skills required to be an emergency nurse (i.e. a nurse trained to take care of acute patients) from nurses trained to be a mid-level cadre of independent practitioners in the ED. Bysiewicz et al. examine the proficiency of nurses in Tanzania at triage, one of the core tasks of emergency nursing. A high percentage of nurses in this study were unfamiliar with triage concepts and frequently did not record basic vital signs such as respiratory rate. DiFazio et al. describe the development of Advanced Practice Registered Nurses (APRN) in a resource-rich setting and the implications for Africa. Frank et al. demonstrate that already in certain areas, nurses indeed are being provided the skills and equipment to practice independent, high-quality emergency care and can produce remarkable outcomes.

What are we to do then with these conflicting reports? The backbone of the health workforce in sub-Saharan Africa (SSA) is composed of nurses, who make up the vast majority of the providers in SSA. There is a shortage of over 4.6 million global health workers, yet of the standard cadres, nurses are the most plentiful. Nations have attempted different strategies to combat the global health worker shortage, including physician “flood and retain”, task-shifting to midlevel cadres and the establishment of community health workers. Yet as Bysiewicz demonstrated, too often, the backbone of the health workforce is osteoporotic and strained to the breaking point.

One useful strategy to address this problem might be a resource-tiered approach. The best evidence supports an acute care team that does not rely exclusively on physicians. Rather, as is taught in protocols such as Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS), the physician is merely the team leader, coordinating a body of many parts. Midlevel providers, nurses, and technicians all combine to provide rapid, effective, high-quality care. Similarly, as noted in 2010 by the Emergency Nurses Society of South Africa (ENSSA), nurses can have a wide-variation in their degree of training. The highest tier therefore would be one where a national referral trauma centre Emergency Department is staffed by an emergency physician and aided by nurses with advanced emergency nursing skills (registered/professional nurse with additional standardized emergency nursing qualification).

The evidence for second- and third-tiers is lacking. In a regional referral hospital, the most desirable scenario would be one in which a similar group of highly trained personnel is available. However, given the limited recognition of emergency medicine as a specialty and the handful of emergency medicine residencies in SSA, it is unreasonable to view this as a realistic possibility in the short-term. Rather, these regional referral hospitals should focus on providing their physicians (likely generalists) and their ED nurses with specific short-courses to enable them to effectively triage patients and follow proven protocols such as ACLS and ATLS. These will impart essential skills such as airway protection, recognition of respiratory distress and circulatory shock, and the use of basic resources to properly manage these emergent conditions.

Finally, in rural district hospitals, it is often challenging for overburdened physicians to simultaneously manage the wards, run outpatient clinics and treat acutely ill patients. Indeed, many of these hospitals leave triage, treatment and disposition decisions entirely to nurses during physician coverage gaps. In some cases, midlevel cadres are tasked to the ED in an effort to reduce the patient burden on physicians. This is true in Kenya, where most of the EDs are, run by clinical officers who work independently or alongside medical officers to provide health-care services to largely rural population. However, these mid-level providers lack specific training in emergency medicine and accordingly are more likely to intervene on relatively healthy patients who are eventually discharged, than their more ill cohort who are admitted.

It is in these rural district hospitals where nurses can play their most vital role. First, even at the most basic certification level (enrolled nurse), the importance of vital signs and proper triage must be emphasized to all nurses regardless of their
practice location within the hospital. Second, hospital administration must establish an intake pathway that empowers nurses to seek a higher level of care for their sicker patients (i.e. send from outpatient clinic to the ED). Finally, nurses can be trained to become independent practitioners of emergency care. This is the model that DiFazio describes in the U.S. and Frank et al. examine at their ED in rural Uganda.

Standardizing midlevel cadres for advanced practice nurses in rural EDs will not be simple, but it is essential. DiFazio notes that the four types of APRNs in the US (nurse anaesthetists, nurse midwives, clinical nurse specialists and nurse practitioners) were created “to address emerging societal healthcare needs at different points in time” and the subsequent fragmentation continues to require “the concerted efforts of all parties” to resolve. In SSA, 25 of 47 countries had midlevel non-physician clinicians, including advanced practice nurses, which arose in a similarly organic process from nation-specific supply and demand. While there should be no expectation that cadres will be standardized across borders, organizations such as ENSSA can at least help provide a framework for how nurses can have different roles within a particular country. Other nations could then utilize this model to strategically develop a resource-tiered approach to nurse practice within their own borders.

This resource-tiered approach to the role of emergency nurses is not novel. It is the foundation for World Health Organization (WHO) Essential Trauma Care Project and their Guidelines for Essential Trauma Care. Consultants for the WHO have provided over 90 pages of recommendations denoting essential from desirable skills, resources and medications in a location-specific approach to trauma care. As we examine emergency care more broadly, let us build on this foundation to enhance the care provided by all members of the healthcare team, most especially our strong and upright nursing backbone.

Conflict of interest

The author declares no conflict of interest.

References


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Available online 29 January 2014