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ENA
EMERGENCY NURSES ASSOCIATION

SHEEHY'S EMERGENCY NURSING

PRINCIPLES AND PRACTICE

SEVENTH EDITION

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UNIT I

Foundations of Emergency Nursing

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1

Emergency Nursing Practice

Sarah Berry

A BRIEF HISTORY OF EMERGENCY NURSING

After World War II, the practice of medicine and the focus of hospitals were changing. At the time, most care was delivered in the community, and prehospital care was ill-defined. Private hospital emergency departments (EDs) were underutilized and staffed on an "as-needed" basis. Only public hospitals, serving predominately indigent patients, devoted staff resources to their EDs. Interns and resident physicians in training provided most of the medical care. In the 15 to 30 years after World War II, an increase in use of EDs was due to the changing dynamics of health care. The prewar medical practice of the "family doctor" primary care provider model changed into one of directing patients to EDs for after-hours care. Hospitals were becoming a community resource for help and information instead of institutions only for the seriously ill and injured.[1] As more patients arrived in EDs, hospitals were forced to assign increasing numbers of nursing staff to provide care. Even though the role of ED nursing was not well defined, only the most experienced nurses were selected for ED "duty" because of the unexpected, episodic nature and acuity of patient care.

At the same time EDs were becoming more recognized as prominent care delivery areas in hospitals, transport of patients to hospitals for care was also gaining attention. Community leaders and the medical community realized that the lessons learned from World War II and the Korean conflict about triage, field care, and rapid transport could be translated into civilian practice. The military had developed training programs for field medics to initiate care and had refined transport strategies. In addition to use of ground ambulances, helicopter transport of injured soldiers was initiated in Korea. Legislation was created in the 1960s to establish community and educational programs leading to modern emergency medical services. Development of space-age technology, such as telemetry and portable defibrillators, also contributed to the growth of emergency care. As a result of these historical dynamics, emergency medicine and emergency nursing became recognized specialties.

A NEW NURSING SPECIALTY: DEFINING THE SCOPE OF PRACTICE

By definition, emergency nursing is the care of individuals of all ages with perceived or actual physical, emotional, or psychological alterations of health that may be undiagnosed or require further interventions.[2] Emergency nursing care is episodic, primary, and usually acute and occurs in a variety of settings.[3]

Alliance or affiliation with a specific body system, disease process, care setting, age group, or population defines most specialty nursing groups. In contrast, emergency nursing is defined by diversity of knowledge, patients, and disease processes. Emergency nurses care for all ages and populations across a broad spectrum of diseases and injury prevention and lifesaving and limb-saving measures while addressing crisis intervention, forensic, palliative, and end-of-life issues.[2] Emergency nursing practice requires a unique blend of generalized *and* specialized assessment, intervention, and management skills. The multiple dimensions of emergency nursing specify roles, behaviors, and processes inherent in the practice and delineate characteristics unique to the specialty. Practice area, patient population, and the variety of those who provide care are as diverse in emergency nursing as in the nursing profession as a whole. Emergency nursing practice is systematic and includes nursing process, nursing diagnosis, decision making, and analytic and scientific thinking and inquiry. Professional behaviors inherent in emergency nursing practice require acquisition and application of a specialized body of knowledge and skills, accountability and responsibility, communication, autonomy, and collaborative relationships with others.

The scope of emergency nursing practice encompasses assessment, diagnosis, treatment, and evaluation. Resolution of problems may require minimal care or advanced life support measures, patient and/or family education, appropriate referral, and knowledge of legal implications. Care delivery occurs whenever and wherever a person requires rapid assessment and stabilization of illness and injury that could be related to multiple aspects of the person's self.[2] Box 1.1 identifies multiple practice areas for emergency nursing.

Nursing roles include patient care, research, management, education, consultation, and advocacy. Emergency nursing practice is defined through specific role functions, as delineated in the Emergency Nurses Association's (ENA's) *Emergency Nursing Scope and Standards of Practice*.[2]

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BOX 1.1 Emergency Nursing Practice Settings.

Hospital-based emergency department (ED)
Freestanding ED
Prehospital services
Air and ground transport services
Military-based centers
Urgent care center
Retail health clinic
Health maintenance organization
Ambulatory services
Schools and universities
Business/industry
Correctional institution
Occupational health clinics
Clinical decision units
State and federal disaster management response teams
Mobile-integrated health care
Telemedicine
Poison centers

THE EMERGENCY NURSES ASSOCIATION

The development of emergency nursing as a specialty is intertwined with the rich history of the Emergency Department Nurses Association (EDNA; later called the Emergency Nurses Association), which was chartered in 1970 (Box 1.2 and Fig. 1.1). Rapid growth of association membership, interest in defining emergency nursing, and recognition from community, medical, and legislative groups led to many initiatives. Within 5 years of its inception, EDNA developed a core curriculum for emergency nurse education, taught emergency nurse courses, and participated in every major program dealing with emergency care throughout the country.[4] In the mid-1970s, the status of the specialty of emergency nursing continued to grow within the nursing community. EDNA published seminal works, the first *Core Curriculum, Standards of Emergency Nursing Practice* (with the American Nurses Association), and the *Journal of Emergency Nursing.* By 1978, EDNA had determined that independent management for the organization was essential and established its own office with dedicated staff in Chicago, Illinois. At the end of this busy decade, EDNA continued to validate the specialty of emergency nursing by funding a certification committee to begin the development process for a national certification credential.[5] ED nurses were beginning to further define their roles in flight nursing, mobile intensive care nursing, and advanced practice. Master of science in nursing programs with an emergency nursing major were established for specializing in advanced practice, administration, and education and in providing much-needed research.

In 1985, the association name was changed to the Emergency Nurses Association (ENA), recognizing the practice of emergency nursing as role-specific rather than site-specific. The *Standards of Emergency Nursing Practice* were updated, and the certification committee evolved into the Board of Certification for Emergency Nursing.[6] Another important

BOX 1.2 History of the Emergency Nurses Association.

In 1968, Anita M. Dorr, RN, and Judith C. Kelleher, RN, working at opposite sides of the United States, perceived a need for nurses involved in emergency health care to pool their resources to set standards and develop improved methods of effective emergency nursing practice. In addition, they wished to provide continuing education programs for emergency nurses as well as a united voice for nurses involved in emergency care. By 1970, Ms. Dorr had formed the Emergency Room Nurses Organization on the East Coast and Ms. Kelleher had formed the Emergency Department Nurses Association on the West Coast. The two groups joined forces, and the Association was initially incorporated as the Emergency Department Nurses Association (EDNA) in Rochester, NY, on December 1, 1970. The first National Association meeting was held in New York in 1971.

educational program, the Trauma Nursing Core Course (TNCC), was developed, which standardized the core level of knowledge needed in implementing the trauma nursing process. TNCC became one of the ENA's most successful programs, creating a model for measuring competency. As other countries adopted TNCC, the ENA established liaisons with other emergency nursing organizations internationally. In the latter part of the decade, the ENA created Emergency Nurses Day and began to explore the formation of an Emergency Nursing Foundation for the purpose of education and research.

As emergency nursing entered the 21st century, practice problems of ED crowding, holding patients, rising costs, safety in the workplace, and a nursing shortage continued. In addition to EDs, new practice areas included urgent care centers, clinical decision units, and occupational care centers. Protecting and providing resources to emergency nurses was a major focus of the ENA. Internet technology expedited communication and resource acquisition. Important new education programs, such as the Geriatric Emergency Nursing Education (GENE), were introduced. After the events of 9/11, bioterrorism and weapons of mass destruction became new professional and educational initiatives for emergency nurses and the emergency care community. In addition, the topics of five-level triage and staffing and productivity in EDs were among the many issues addressed by position statements.[7] In the past decade, growing national issues affecting health care have been addressed by the ENA, such as the assessment and identification of human trafficking victims, the use of mobile devices and social media, the opioid crisis, and behavioral health care. To meet future challenges, the ENA once again examined itself and reorganized around the core competencies of administration, advocacy, membership, professional development, research, and practice. Originally aimed at teaching and networking, the organization has evolved into an authority, advocate, lobbyist, and voice for emergency nursing. The ENA continues to grow, with members representing more than 32 countries around the world.

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Fig. 1.1 Emergency Nurses Association Cofounders Judy Kelleher *(left)* and Anita Dorr *(right)*. (*ENA Archives;* artwork by Bruce Sereta [brucesereta.com].)

NURSING PRACTICE MISSION AND VALUES

The specialty practice of emergency nursing is guided by the association's vision and mission statement to "advocate for patient safety and excellence in emergency nursing practice." The ENA's vision is to be the global emergency nursing resource and advocate for "Safe Practice and Safe Care." The vision and mission are accomplished by standards of emergency nursing practice, which include standards of practice and professional performance.

STANDARDS OF EMERGENCY NURSING PRACTICE

The following standards of emergency nursing practice are authoritative statements developed by the ENA that (1) reflect the values, priorities, and duties for emergency nurses; (2) provide direction for professional emergency nursing practice; and (3) provide a framework for evaluation of the practice.[8] The standards of emergency nursing are categorized in two areas: Practice and Professional Performance. Practice standards include assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Professional performance standards include ethics, culturally congruent practice, communication, collaboration, leadership, education, evidence-based practice and research, quality of practice, professional practice evaluation, resource utilization, and environmental health. Each standard has accompanying competencies in which proficiency is expected, and the competencies are evidence of compliance with the standard. Competencies for the standards are defined by the role of registered nurses (RNs), graduate-level prepared RNs, and advanced practice registered nurses (APRNs).

COLLABORATIVE PRACTICE

The achievement of a healthy work environment is multifactorial and requires the support of the health care workers through an environment of positive commitment and coworker satisfaction. Collaborative practice brings together health care professionals with distinct and complementary knowledge and skills (e.g., prehospital providers, ED physicians and nurses, trauma surgeons, respiratory therapists, radiologists, and pharmacists) to enhance the delivery of emergency care.[9] This practice can address complex patient needs within a framework of quality, cost, and access. The primary commitment is to the patient, family, groups, and the community.[10]

Coalitions are fundamental for creating successful changes within patients, families, groups, and communities. Commonly, a joint purpose or activity or clinical dilemma may result in the formation of a permanent or temporary team that is likely to embrace collaborative practice. Coalitions may be built around any issue and on any scale, from neighborhood to national impact. The ENA has successfully drafted several position statements and department guidelines after the formation of a coalition of professional organizations. Successful coalition building is more likely to occur when the following are present[10]:

- Goals are similar and compatible.
- Working together enhances the ability of all to reach their goals.
- Benefits of coalescing are greater than costs.

POSITION STATEMENTS AND CLINICAL PRACTICE GUIDELINES

The ENA provides national and international leadership in emergency nursing care by identifying the standards of

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BOX 1.3 ENA Position Statements and Clinical Practice Guidelines.

Position Statements

Access to Quality Health Care (July 2016)
Advanced Practice in Emergency Nursing (February 2012)
Care of patients with chronic/persistent pain in the emergency setting (January 2014)
Crowding, Boarding, and Patient Throughput (December 2017)
Cultural Diversity in the Emergency Setting (May 2012)
Healthy Work Environment (March 2013)
Human Trafficking Patient Awareness in the Emergency Center (February 2015)
Intimate Partner Violence (August 2015)
Mobile Electronic Device Use in the Emergency Setting (September 2013)
Mitigating Violence in the Workplace (January 2015)
Palliative and End-of-Life Care in the Emergency Setting (September 2013)
Patient Transfers and Handoffs (March 2018)

ENA Clinical Practice Guidelines

Family Presence During Invasive Procedures and Resuscitation (2012)
Intranasal Medication Administration (2016)
Geriatric Emergency Department Guidelines (2013)

Emergency Nurses Association. *ENA position statements.* https://www.ena.org/practice-resources/resource-library/position-statements. Accessed July 26, 2018.

quality care. This leadership is set forth in the form of position statements and clinical practice guidelines, which are used to support the improvement of patient care at all levels. The position statements listed in Box 1.3 represent the organization's official stand on a variety of issues; the full listing may be accessed at http://ena.org.

COMMUNITY EDUCATION

Emergency RNs are active in prevention education and harm reduction in the clinical setting and within the community. Emergency nurses are actively involved in community education programs because they serve to reduce the risk and consequences of disease, illness, and injury. The ultimate outcome is achieved through primary, secondary, and tertiary prevention[11]:

- Primary prevention attempts to avert disease or injury by reducing risk factor levels (e.g., child safety seat distribution and education).
- Secondary prevention aims to detect disease early to control or limit its effects (e.g., human immunodeficiency virus [HIV] and sexually transmitted infection [STI] testing for those with risky behaviors).
- Tertiary prevention focuses on treating disease and injury in an effort to reduce disability and preserve function (e.g., referral to treatment programs for substance use).

PATIENT SAFETY CONCEPTS[12]

The Joint Commission's Board of Commissioners annually publishes and updates a list of National Patient Safety Goals (NPSGs). The NPSGs are developed after a systematic review of the literature and available databases by patient safety experts and clinicians in a variety of health care settings. Emergency nurses integrate these safety goals into the care delivered to their ED patients. Table 1.1 provides an abbreviated list of the approved 2018 NPSGs for hospitals.

Quality, Safety, and Injury Prevention[13]

The ENA's Institute for Quality, Safety and Prevention (IQSIP) focuses on issues related to practice, quality, safety, injury prevention, and wellness. Charged with developing resources, programs, and leading projects, the IQSIP collaborates with local, regional, and national organizations. The IQSIP Advisory Council consists of member experts who participate on committees, including ED operations, a Position Statement, and the Lantern Award and Annual Achievement Awards. The scope of practice for the IQSIP includes developing evidence-based practice resources; raising awareness on issues of quality, patient/staff safety, and injury prevention; and advocating for ED nurses in discussions with external stakeholders and organizations.[12]

EMERGENCY NURSING VALIDATION OF KNOWLEDGE

Nursing is both a scientific discipline and a profession. Nursing science is a domain of knowledge concerned with the adaptation of individuals to actual or potential health problems, the environments that influence health, and the therapeutic interventions that promote health and affect the consequences of illness.[14] Emergency nursing is clearly one area of specialization in which there are specific clusters of phenomena of concern. The knowledge required for nursing can be seen as a synthesis of what is known about the person, environment, health, and nursing. Therefore, the discipline has a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry and knowledge.

Two established venues to validate specialty nursing knowledge are through certification and further education. Professional nursing certifications are increasingly viewed as a standard assurance that the nurse has acquired the specific body of knowledge to practice in the specialty. Furthering education may include a bachelor's degree or graduate program, such as a master's degree or APRN certification from established institutions, such as universities.

VALIDATION OF KNOWLEDGE THROUGH CERTIFICATION

One means of validating emergency nursing knowledge is through certification. The opportunity for certification in a nursing specialty dates back to 1945, when the American

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TABLE 1.1 2019 National Patient Safety Goals.

Goal 1	**Identify patients correctly.**
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
NPSG.01.03.01	Make sure that the correct patient gets the correct blood when he or she gets a blood transfusion.
Goal 2	**Improve staff communication.**
NPSG.02.03.01	Get important test results to the right staff person on time.
Goal 3	**Improve the safety of using medications.**
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups, and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG 03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines with new medicines given to the patient. Make sure the patient knows which medicines to take when he or she is at home. Tell the patient it is important to bring his or her up-to-date list of medicines every time he or she visits a doctor.
Goal 6	**Use alarms safely.**
NPSG 06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Goal 7	**Reduce the risk of health care-associated infections.**
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
NPSG.07.03.01	Use proven guidelines to prevent infections that are difficult to treat.
NPSG.07.04.01	Use proven guidelines to prevent infection of the blood from central lines.
NPSG.07.05.01	Use proven guidelines to prevent infection after surgery.
NPSG 07.06.01	Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.
Goal 15	**Identify patient safety risks.**
NPSG.15.01.01	Find out which patients are at risk for suicide.
Universal Protocol	**Prevent mistakes in surgery.**
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

Modified from The Joint Commission. Patient safety. The Joint Commission website. http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals. Accessed April 24, 2019.

Association of Nurse Anesthetists first initiated certification. Most certifications in nursing, however, were established within the past three decades. An increase in the number of nursing specialty organizations has been a major factor in the proliferation of nursing certifications.

The Board of Certification for Emergency Nursing (BCEN) identifies an additional purpose, which is to validate, based on predetermined standards, an individual's qualifications and knowledge for practice in a defined functional or clinical area of nursing.[15]

Consequently, the certification process benefits both the individual nurse and the employer while serving society's interest. Achieving certification may lead to greater respect from employers and colleagues, salary increases, and perhaps greater self-esteem and a sense of professional pride. Employers and potential employers also benefit from nursing certification. Certification provides an objective measure of an employee's knowledge base and valuable information about prospective employees.

The nursing profession, as a whole, benefits from certification. Because of the certification process, bodies of specialty nursing knowledge are defined and examined. Certification demonstrates to other health care disciplines that nurses are able to articulate a defined body of knowledge and establish levels of specialty competence based on that knowledge. An individual's preparation for the certification examination also benefits nursing. Successful certification requires thorough study of the body of knowledge of the specialty. Certification renewal encourages the practicing nurse to remain current in all aspects of specialty nursing practice.

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There are three ways to obtain certification. One method is certification by a state or government agency. State certification represents legal endorsement of a nurse's ability to function in certain expanded nursing roles. Certification by a state usually refers to a specific aspect of nursing practice beyond the level addressed in a state board examination for registration. State certification is often based on prior certification by a nurse certification body, completion of an educational program, or both. In some instances, a certifying examination is administered by a state agency. Requirements for state certification vary, so certification by one state may not be recognized by another. Examples of state certifications include emergency communications registered nurse (ECRN), mobile intensive care nurse (MICN), and trauma nurse specialist (TNS).

Certification may also occur through an institution. The institution may be a health care facility or an educational system. This type of certification is usually based on successful completion of an educational offering, often varying in length and characteristics. Most often, the state or profession does not control content or requisites for such certification. Because of program variability and lack of oversight by a national body, this type of certification may have limited appeal or applicability outside of the particular certifying institution.

The most common way to obtain certification in a nursing specialty is through a professional organization. Many types of certifications are offered by the American Nurses Credentialing Center (ANCC). Most nursing specialty organizations have also developed, or are in the process of developing, a certification process in their specialty. These efforts are testimony to the belief that knowledge beyond the level of safe basic nursing practice is required for specialty nursing practice.

EMERGENCY NURSING CERTIFICATION

The first emergency nursing certification examination was administered on July 19, 1980. Approximately 1400 nurses took the first examination, with 900 successfully passing and obtaining the certification. The examination was composed of 250 questions, all of which were calculated into the score. The correct number necessary for a passing score and certification was consistent at 175. Over time, the certification examination has evolved into a more sophisticated measure of emergency nursing knowledge. All question-and-answer sets are now pretested on actual examinations for accuracy, clarity, and reliability before inclusion in the test bank. This process tests the validity and reliability of the proposed certification examination questions. Items being pretested are not included in scoring of the examination. Currently, each examination contains 25 pretest items and 150 scored items. The Accreditation Board for Specialty Nursing Certification (ABSNC) has 18 standards that must be met for a certification to be accredited. These standards address board structure, testing security, test development, autonomy, the appeals process, and proof of specialty practice. In February 2002, ABSNC approved the CEN certification for accreditation and was most recently reaccredited in 2017.

Certification and Renewal

To ensure that the certification examination reflects current emergency nursing practice, role delineation studies (RDSs) are completed by the BCEN. The RDSs are research studies, also known as a practice analysis or job analysis, that are conducted by examination committees of subject matter experts. The most recent RDS results[15] were published in 2015. The blueprint for the examination is based on clinical categories. Within each of those categories, questions may focus on aspects of assessment, analysis/diagnosis, intervention, or evaluation.

The BCEN is responsible for receiving and approving all applications for the CEN examination. Successful examination candidates will receive a card and a certificate that are valid for 4 years. These individuals may use the certification mark "CEN." Unsuccessful candidates are eligible to reapply for the examination 3 months after the initial date of testing. CEN certification renewal may be achieved by completing one of two options: (1) examination—successfully passing the computer-based test offered through the network of testing centers, or (2) continuing education—submitting a log listing 100 continuing education hours, with a minimum of 75 hours of clinical content. More information on CEN certification, as well as the certified flight registered nurse (CFRN) certification, the certified transport registered nurse (CTRN) certification, the certified pediatric emergency nurse (CPEN) certification, and the newly developed Trauma Certified Registered Nurse (TCRN) certification, is available at https://bcen.org/.

Advanced Practice Certification

General skills and competencies for two APRN roles, clinical nurse specialist (CNS) and nurse practitioner (NP), often utilized in emergency settings have been established by professional organizations, such as the ENA.[16] Education, accreditation, and certification are necessary components of an overall approach to preparing the APRN for practice. However, the licensing of APRNs is governed by state regulations and statutes. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry into advanced practice, and the certification examinations accepted for entry-level competence assessment.[17] APRN practice requires specialized knowledge and skills gained through graduate-level education. Certification of APRNs is gained through successful completion of a rigorous examination, granting the credential of "board certified" in the practice specialty. For the emergency setting, APRNs can practice effectively in an emergency environment and use their abilities, knowledge, and specialized skills to meet the needs of patients and their families at the point of crisis or need, and they should be involved with extending their responsibilities to community outreach, including prevention of injury and illness.[18]

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SUMMARY

Emergency nursing practice has evolved and become recognized as a specific specialty practice area for medicine and nursing. Nursing has formally defined the scope of practice and specialization in the ANA social policy statement. Emergency nursing has further defined the specialization through research and has outlined the standards of practice in the ENA's *Scope and Standards of Practice.* The practice of emergency nursing results in an empowerment of our discipline to significantly affect the health needs of society.

Emergency nursing continues to become more complex and demanding. An increasing demand for emergency care, for both critically ill and noncritical patients, requires innovations in care methodology and technology. As emergency nurses care for more critically ill patients for longer periods, the need for sophisticated monitoring equipment increases. Technology previously reserved for the critical care unit is now commonplace in the ED. As care becomes more complex, the emergency nurse's knowledge must continue to expand to make increasingly complex decisions about patient care.

The development of the ENA as a cohesive professional organization has truly played a tremendous role in advancing emergency nursing as a specialty and providing guidance on best practice. The resources that the ENA offers include practice guidelines, educational courses, and community and policy advocacy opportunities to further enhance emergency nursing practice. Validation of knowledge for emergency nursing can be done through professional certification in several categories and advanced graduate-level education with board certification.

The nursing profession and how it is perceived will continue to evolve. As nursing becomes more active in the decision-making process and speaks with a single voice, these changes in health care become shining opportunities. Emergency nurses must continue to join together with new energy, speak with inspired voices, and maintain their prominence as partners in the emergency health care arena.

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Legal and Regulatory Constructs

Tamara C. McConnell

The health care industry is one of the most highly regulated sectors in the United States, as evidenced by the vast array of laws and regulations related to health care access, quality, licensing, eligibility, safety, and cost. Health care regulations are developed and enforced by all levels of government—federal, state, and local—and also by private organizations. Each state has its own regulatory structure reflective of various public-private partnerships comprising working professionals with technical expertise and governmental oversight agencies. Several layers of law have blended to form statutes, rules, regulations, case law, codes, and opinions that vary between states and other jurisdictions. It is incumbent upon emergency nurses to understand the general principles of law related to the industry, recognize professional standards of care, and have the ability to access appropriate state or federal laws applicable to their practice setting.

SOURCES OF LAW

Legal issues relevant to emergency nursing are predicated on a variety of sources of law. The sources of law having an effect on nursing include constitutional law (federal and state), common (case) law, statutory law (federal and state), ordinances, and administrative (regulatory) law (Table 2.1). To maintain a balance of power and prevent abuse, the US Constitution divides the federal government into three branches: the legislative branch (to write laws), the executive branch (to execute laws), and the judicial branch (to interpret laws). The legislative branch[1] is Congress, divided into the House of Representatives and the Senate. The executive branch[2] consists of the president and the administration. The judicial branch[3] is composed of the court systems. Each branch plays a constitutionally determined role in determining the law and is prevented from becoming too powerful by the checks and balances provided by the other two branches. Each state system mirrors that of the federal system with its governor, legislature, and court system.

At the federal level, Congress proposes laws that, once enacted, become statutes that are controlling throughout the nation. The statutes may be accompanied by federal funding, such as the Homeland Security Act or Medicare and Medicaid, or they may be "unfunded mandates," such as the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). State legislatures propose and enact state laws in the same manner.

The president and governors are responsible for enforcing the laws, and such enforcement is performed in large part through administrative agencies.[4] Agencies such as the Drug Enforcement Agency (DEA), the Federal Bureau of Investigation (FBI), the Environmental Protection Agency (EPA), and the National Transportation Safety Board (NTSB) have considerable political influence and are able to promulgate, interpret, and enforce agency rules. In contrast to federal agencies, the states also have administrative agencies for state-specific issues, such as education, public health, transportation, labor law, and so on. These agencies are mirror images of the respective federal agencies but are not entitled to create rules and regulations that go against those created by their federal counterparts.

Federal agencies such as the Centers for Medicare and Medicaid Services (CMS), the Occupational Safety and Health Administration (OSHA), the National Labor Relations Board (NLRB), and the Food and Drug Administration (FDA) are responsible for oversight of issues that affect emergency departments (EDs). At the state level, state licensing boards, state health departments, offices of the attorney general, and child protective services are examples of state agencies regulating many issues that affect emergency nursing.

The judicial system is divided into federal and state courts. The federal courts resolve disputes regarding federal law or the US Constitution and are divided into district courts sitting in each state. Each district court's decisions may be appealed to one of 10 respective circuit courts. The US Supreme Court is the final authority for circuit court conflicts. Again, the state systems mirror the federal system, with trial, appellate, and final appeals courts. State courts hear disputes regarding state laws, including civil cases such as medical malpractice.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

As an amendment to the larger Consolidated Omnibus Budget Reconciliation Act (COBRA), Congress enacted EMTALA[5] in 1986. The statute was intended to prohibit the practice of "patient dumping," which involved hospitals' refusal to undertake emergency screening and stabilization for patients who sought emergency care, typically because of