The Emergency Nurses Association: 50 Years of Advocacy and Advancement

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Abstract:

To commemorate the 50th anniversary of the Emergency Nurses Association, this article describes the 3 most enduring and impactful policy initiatives in the organization's history. These initiatives were identified through a comprehensive review of the articles published in the *Journal of Emergency Nursing* as well as in other publications of the Emergency Nurses Association, including position statements and press releases. The top 3 policy issues throughout the Emergency Nurses Association's history were identified as provision of care for vulnerable populations, trauma and injury prevention, and patient quality and safety. The Emergency Nurses Association also worked hard to professionalize emergency nursing within the realms of nursing and emergency services during the first half of its history, and since then the Emergency Nurses Association has promoted issues related to the emergency nursing workforce and to ensuring a safe and sustainable environment in which nurses practice. This article includes critical constructs such as the professionalization of emergency nursing; advocating for vulnerable populations such as children, older adults, and people experiencing sexual violence or human trafficking; improvements in trauma care and injury prevention; promoting quality and safety through nursing certifications, efficient and accurate nurse triage, and disseminating best practices in evidence-based care; and supporting the nursing workforce by championing issues such as workplace violence, ED crowding, and healthy work environments.

Keywords: emergency nursing | health policy | nursing history

Article:

Introduction

The year 2020 was a historic year for nursing. This year was globally recognized as the Year of the Nurse and Midwife; it was the year of the historic coronavirus disease 2019 (COVID-19) pandemic; and it also marked the 50th anniversary of the Emergency Nurses Association (ENA). The mission of the ENA is "to advance excellence in emergency nursing," and it does so through a variety of initiatives and organizational beliefs.[1] The ENA is committed to collaborating with other health care partners; promoting compassion in emergency nursing; embracing diversity and inclusivity; promoting excellent, high-quality patient and nursing standards; and fostering a culture of inquiry and lifelong learning among its thousands of members worldwide.[1]

As part of this celebration of the ENA and emergency nurses, the ENA commissioned this review of the *Journal of Emergency Nursing* (*JEN*) to highlight some of ENA's most important contributions to nursing and health care over its 50-year history. The purpose of this article was to identify and analyze the publications that have informed the top 3 policy initiatives of enduring and ongoing impact over the 50-year history of the ENA. The objectives were as follows: (1) to identify the top 3 policy initiatives, (2) to analyze these initiatives using a historical framework within the context of their relative importance at the time of ENA's development, and (3) to discover how these initiatives have shaped emergency nursing and health policy over time.

Methods

A combination of qualitative and historical methods was used to identify and analyze ENA's top policy initiatives over the past 50 years. Qualitative methods were used to identify the content areas most frequently published in *JEN* after a comprehensive review of the journal's publications, and historical methods were used to describe and analyze these results within the appropriate historical context over time.[2] The authors of this manuscript were provided with a comprehensive list of every article published in *JEN* since its inception in 1975[3] through articles published in 2019, totaling 4883 articles. The authors were selected because of their extensive experience in historical research and emergency nursing. Together, the authors have more than 40 years of experience in emergency nursing, and both are published nurse historians. One author has been a member of the ENA since 1988 and is a Fellow in the Academy of Emergency Nursing.

Initially, the authors used deductive coding to jointly create a list of codes on the basis of their knowledge of emergency nursing and the ENA. As each article was assessed, the code book evolved with additional codes added as needed during the article review processes. The authors coded collaboratively for 2 hours, covering dozens of articles to develop these codes and establish interrater reliability. The 2 authors discussed each code and how it would be applied to ensure consistency between the reviewers during the coding process. The remaining articles were divided equally between the 2 authors, with 1 author coding articles from 1975 to 1999 and the other coding articles from 2000 to 2019. These codes were organized using a standard electronic spreadsheet containing the title of the article, year published, number of citations, assigned code(s), and any additional notes. During and after the coding process, each author noted articles for full review that would be potentially relevant to the purpose and objectives of this manuscript. Each article was coded with a maximum of 3 codes per article. Codes were applied on the basis of the title of the article. For titles that were ambiguous, abstracts were reviewed to more accurately code the articles. The authors also examined the subject matter of the top 10 most highly cited articles in each decade. This process resulted in 33 codes. The implications for policy of the most frequent and consistent codes were assessed after the coding process. The codes were reorganized, and similar categories were combined into broader themes, resulting in 27 categories reflecting the data. For example, the "Self-Care/Safety" and "ER RN Workforce" codes were collapsed together to form "Nursing Workforce." Once all articles were coded, the total number of codes per category were calculated (Table). The authors identified the top 3 most enduring and impactful policy initiatives from the codes with the highest frequency. In addition,

2 highly impactful initiatives that were relevant during the first and second halves of the 50-year history of the ENA were also included.

Table. Reviewed article codes from the *Journal of Emergency Nursing,* 1975 to 2019

Category	1975 to 1979, n = 207 n (%)	1980 to 1989, n = 785 n (%)	1990 to 1999, n = 1280 n (%)	2000 to 2009, n = 1276 n (%)	2010 to 2019, n = 1335 n (%)	Totals
Special populations	18 (8.7)	76 (9.7)	158 (12.3)	188 (14.7)	209 (15.7)	649
Professional development	18 (8.7)	67 (8.5)	55 (4.3)	175 (13.7)	235 (17.6)	550
Trauma	36 (17.4)	133 (16.9)	120 (9.4)	145 (11.4)	97 (7.3)	531
Case studies	2 (1.0)	40 (5.1)	175 (13.7)	154 (12.1)	85 (6.4)	456
Medical	40 (19.3)	102 (13)	66 (5.2)	114 (8.9)	85 (6.4)	407
Patient quality and safety	6 (2.9)	21 (2.7)	51 (4.0)	147 (11.5)	177 (13.3)	402
Pharmacology and toxicology	8 (3.9)	66 (8.4)	81 (6.3)	106 (8.3)	115 (8.6)	376
Editorial	5 (2.4)	38 (4.8)	123 (9.6)	75 (5.9)	121 (9.1)	362
Nursing workforce	4 (1.9)	6 (0.8)	63 (4.9)	106 (8.3)	128 (9.6)	307
Law and ethics	25 (12.1)	81 (10.3)	61 (4.8)	62 (4.9)	12 (0.9)	241
Education	4 (1.9)	25 (3.2)	81 (6.3)	55 (4.3)	67 (5.0)	232
Triage	8 (3.9)	17 (2.2)	38 (3.0)	73 (5.7)	87 (6.5)	223
Environment of care	0	0	61 (4.8)	70 (5.5)	82 (6.1)	213
Injury prevention	0	6 (0.8)	34 (2.7)	68 (5.3)	83 (6.2)	191
Leadership	4 (1.9)	51 (6.5)	43 (3.4)	31 (2.4)	44 (3.3)	173
International	0	5 (0.6)	42 (3.3)	54 (4.2)	70 (5.2)	171
Research	2 (1.0)	25 (3.2)	56 (4.4)	36 (2.8)	50 (3.7)	169
Prehospital	12 (5.8)	52 (6.6)	56 (4.4)	22 (1.7)	21 (1.6)	163
Procedures	10 (4.8)	24 (3.1)	52 (4.1)	34 (2.7)	37 (2.8)	157
Policy	1 (0.5)	12 (1.5)	20 (1.6)	81 (6.3)	42 (3.1)	156
Psychiatric	9 (4.3)	24 (3.1)	25 (2.0)	34 (2.7)	46 (3.4)	138
Disaster nursing	3 (1.4)	6 (0.8)	43 (3.4)	48 (3.8)	34 (2.5)	134
Technology	1 (0.5)	8 (1.0)	32 (2.5)	33 (2.6)	28 (2.1)	102
Patient education	2 (1.0)	21 (2.7)	9 (0.7)	10 (0.8)	14 (1.0)	56
End-of-life	5 (2.4)	9 (1.1)	5 (0.4)	16 (1.3)	19 (1.4)	54
Advanced practice nursing	0	5 (0.6)	16 (1.3)	15 (1.2)	16 (1.2)	52
Rural	3 (1.4)	9 (1.1)	6 (0.5)	5 (0.4)	18 (1.3)	41

Each article had the potential to be listed in up to 3 categories.

The 2009 Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines were used when appropriate while refining the sources for inclusion (Supplementary Figure).[4] A total of 354 of the 4883 articles did not fit into any category and were excluded. Articles that were not within the identified top policy areas and articles within the appropriate content area but not relevant to policy or the historical analysis were also excluded. This left 59 articles for the final analysis. An additional 49 sources were included from ENA policy statements, resolutions, practice guidelines, and other publications; ENA archival sources; relevant state and federal legislation; published white papers; ENA General Assembly resolutions; and other relevant documents.

The authors manually reviewed the identified articles and included additional articles that may be relevant given the selected initiatives. Articles from 1970 to 1981 that were not available online or in the authors' libraries were requested from the ENA. The review was somewhat limited, however, owing to archives and libraries being closed because of the COVID-19 pandemic during the research period. The authors reviewed the full texts of these selected

articles as primary source information, and additional sources were evaluated to analyze these initiatives within an appropriate historical context. The first 3 boxes of ENA historical archives were accessed during a previous historical review and contributed to this work.

The purpose of this article was to identify and analyze the 3 most enduring and impactful policy initiatives that the ENA has championed in its 50-year history. An initiative was considered to be enduring if it was consistently present within the journal over its 50-year history and has continued to have implications for policy on a national (and sometimes international) level. The impact of an initiative was evaluated on the basis of its ability to influence nursing practice or policy through legislation, position statements, collaboration with other professional organizations, or practice changes. Both of these factors were considered when identifying the top 3 initiatives.

Ethical Considerations

This study used historical research and was a review of publicly available publications and documents. This was not reviewed by an institutional review board because this type of research does not constitute human subjects research.

Results

The Table shows the results of the review of the articles published in *JEN* since its inception. "Special Populations" articles included content related to pediatrics, geriatrics, and people experiencing intimate partner violence or human trafficking. "Professional Development" included articles such as review questions for the Certified Emergency Nurse (CEN) examination, clinical practice guidelines, practice updates, or other articles with the intention of informing the reader on the assessment, management, or treatment of a particular illness or injury. Articles coded with "Nursing Workforce" had content related to compassion fatigue, burnout, staffing challenges, workplace violence, or nurse safety and well-being. The "Education" category referred to articles describing nurse or health provider training, education, or orientation. "Environment of Care," which was more frequent during the last 20 years, described articles regarding the physical space and issues such as boarding patients, crowding, moving patients through the emergency department, and patient satisfaction. "International" referred to articles written by United States–based nurses providing humanitarian aid abroad or articles written about emergency nursing abroad.

After the review, the top 3 most enduring and impactful policy initiatives were identified as the provision of care for vulnerable populations, trauma care and injury prevention, and patient quality and safety. These were selected from the top 6 most frequently used codes. The codes "Professional Development," "Case Studies," and "Medical" were excluded because these types of articles did not have any direct relevance to policy. The development and impact of the selected initiatives will be further explored in the following section and are presented in order on the basis of their frequency of appearance in the literature review. In addition to the 3 policy initiatives, 2 additional ENA initiatives were included as highly impactful but not enduring. The ENA led the charge to professionalize emergency nursing within the realms of nursing and emergency services during the first half of its history, and since then the ENA has promoted

issues related to the emergency nursing workforce, ensuring a safe and sustainable environment in which nurses practice. Although professionalization and workforce support did not meet the criteria for enduring policy initiatives, these topics were some of the most highly impactful during the first and second halves, respectively, of ENA's history. The professionalization of emergency nursing is discussed first because it lays a foundation on which the other policy initiatives have been founded. This is followed by the discussion of the top 3 policy initiatives identified (the provision of care for vulnerable populations, trauma care and injury prevention, and patient quality and safety). Finally, ENA's recent role in addressing emergency nursing workforce concerns is discussed.

Discussion

Professionalization of Emergency Nursing

Throughout the mid-20th century, emergency care gained recognition and attention as a necessary part of the US health care system, with hospitals establishing emergency rooms and physicians receiving special training in the care of emergencies. After World War II, physicians began to specialize beyond medicine or surgery, and the supply of general practitioners declined.[5] The 1960s and 1970s were decades of rapid growth toward modern-day emergency services. The 1966 National Highway Safety Act helped to address emergency service improvement and included funding for first responder training courses, spawning modern-day prehospital providers. The American College of Emergency Physicians (ACEP) was formed in 1968 with 2 primary goals: (1) recognize emergency medicine as a specialty, and (2) develop and establish emergency medicine residency programs. The Emergency Department Nurses Association (EDNA) was formed 2 years later as a voice and platform for emergency nursing advocacy and education. When the EDNA was formed in 1970, emergency medical services (EMS) in most communities were lacking or inefficient.[6] To address this need, with the support of the newly formed EDNA, the Emergency Medical Service Systems Act of 1973 provided funding to develop comprehensive EMS systems.[7] Under this act, approximately 4000 nurses were trained, some of them as advanced practice nurses specializing in emergency care.[7]

With the expansion and organization of professional emergency services, demand for these services increased, although patients were seeking nonurgent health care services just as often as emergency services. The 1965 Medicare and Medicaid amendments to the Social Security Act provided health services for older adults and the poor by providing co-payments for their care to hospitals (House Resolution 6675).[8] In the 1970s, approximately half of all patients presenting to emergency departments were using the emergency department as an outpatient care facility[9] because many physicians in private practice did not accept government insurance, and the emergency department was available during off-hours when private practice was closed.[10] However, when Americans went to the emergency department, they often found a nurse rather than a physician as the frontline provider. Finke in 1975 stated, "The demands placed upon emergency departments today as primary care and emergency care facilities mean that to treat the emergency patient as a total person, emergency nurses must be trained as an emergency nurse practitioner, to work in unobstructed cooperation with physicians."[11] It was clear that emergency nurses would need specialized training beyond what hospital nurses typically received owing to the comparative independence and autonomy that nurses experienced in early

emergency departments. The first nursing core curriculum skills list included interpretation of laboratory results and x-rays and other skills and decisions normally relegated to physicians, but nurses were performing these skills in the emergency department.[12] Advanced training programs specializing in emergency nursing varied from several months of education in certificate programs to graduate-level programs.[13] Emergency medical technicians functioned as an extension of the emergency department.[5] The 1975 position paper "Roles, Responsibilities and Relationship of EDNA to Emergency Medical Technicians and the System of Prehospital Emergency Care" reflected the EDNA's commitment to the entire emergency health services system.[14] By the early 1980s, emergency medical technicians often supplemented the nursing staff in hospital emergency departments rather than responding to emergency calls in the community.[15]

As the necessity for emergency services continued to grow with more and more nurses and other assistive personnel working in this environment, the ENA further delineated the role of the emergency nurse in the 1994 position statement, "Role of the Emergency Nurse in the Clinical Setting": "Although the primary role of the emergency nurse will continue to be the delivery of direct patient care, increasing emphasis will be placed on coordination and facilitation of care and direction of assistive personnel."[16] In 2011, emergency nursing was formally recognized as a nursing specialty by the American Nurses Association (ANA), and the ANA approved the "Emergency Nursing Scope and Standards of Practice."[17] The formation of the EDNA, later changed to the ENA in 1985, was critical to the establishment and advancement of emergency nursing as a recognized nursing specialty. The EDNA's early commitment to nursing education, political advocacy, and recognition created a firm foundation on which the ENA has been able to expand its reach, relevancy, and impact for nurses and their patients.

Provision of Care for Vulnerable Populations

In this analysis, the most commonly applied code was "Special Populations," reflecting a strong commitment toward improving care for those most requiring unique attention. These vulnerable groups included children, older adults, and people experiencing sexual violence or human trafficking, among others. Although the ENA has focused on addressing concerns for several special populations, it has also stressed that nurses should stay current on best practices to ensure that all patients receive the best care possible.[18]

Pediatrics

Articles related to the care of pediatric patients have featured prominently in *JEN* throughout its history. Pieces such as "The Preschooler in the Emergency Department," "Salicylate Poisoning in Children," and "Transporting High-Risk Infants" provided timely education to emergency nurses caring for children.[19, 20, 21] The number of publications related to pediatric emergency nursing increased dramatically in the 1980s, no doubt owing to nursing recognizing the need for special care for this vulnerable group. In 1987, the ENA created several special interest groups, 1 of which was focused on pediatrics. The goal of this group was to promote pediatric emergency nursing through pediatric programming at the scientific assembly and a list of experts who could be consulted.[22] To increase the competence and confidence of emergency nurses in pediatric care, a special course that focused on the assessment, treatment, and management of pediatric

patients was created in 1993.[23] The Emergency Nursing Pediatric Course was initially released in the US, but quickly spread internationally to Australia, New Zealand, and beyond.[23]

The ENA has a long history of collaboration with other organizations vested in the safe care of pediatric patients. For example, "Guidelines for Pediatric Equipment and Supplies for Emergency Departments" was copublished with the National Emergency Medical Services for Children Resource Alliance.[24] Since 2001, the ENA has worked alongside the American Academy of Pediatrics and the ACEP on several joint policy statements promoting the health and safety of children. In 2001, the ENA joined the American Academy of Pediatrics and the ACEP as coauthor of a revision to a joint policy statement—"Guidelines for Care of Children in the Emergency Department"—and has been a part of each revision since then.[25,26] These 3 organizations worked together again in 2014 to create the "Death of a Child in the ED" policy statement[27] and in 2015 to coauthor 2 technical reports on "Patient- and Family-Centered Care" and "Best Practices in Patient Flow for Pediatric Patients in the Emergency Department."[28,29] More recent position statements have focused on "Child Passenger Safety in the United States" and "Pediatric Readiness in the ED."[30,31] The ENA adopted the "Weighing Pediatric Patients in Kilograms" position statement in 2012, to improve safety when administering medications to pediatric patients.[32] As ED crowding and boarding of intensive care unit (ICU) patients in the emergency department has increased, a call for action was issued in March 2020 to address best practices for boarding pediatric patients in the emergency department.[33] Through promoting new research, education, practice guidelines, and political advocacy, the ENA has been a strong voice for pediatric emergency care.

Older Adults

As the US population continues to age and seek care in the emergency department, older adults are a population at high risk of morbidity and mortality. In 1981, a team of researchers sampled EDNA members to assess emergency nurse perceptions on the use of the department by the older population and about their preparation to meet the needs of older adults in the department. Emergency nurses felt that their nursing programs did not adequately prepare them to care for older adults in the emergency department.[34] Throughout its history, *JEN* has continued to disseminate best practices for caring for older adults on critical topics such as triage, assessment, medication safety, pain management, appropriate trauma care, disaster planning, and managing aggressive behavior. A decade after the launch of the Emergency Nursing Pediatric Course, the first Geriatric Emergency Nurse Education program was offered in 2004, addressing the needs of the older population. ENA's activism continued through adopting the "Specialty Nursing Association Global Vision Statement on Care of Older Adults" in 2011.[35,36] When considering trauma care and injury prevention, the ENA created the Thoughtful Adults Keep Enlightened care program. It covered medication interactions, alcohol use, doctor/patient relationships, and highway safety concerns for older adults (alcohol use and driving, safety belts, and pedestrian safety).[37] Through education and injury prevention efforts, the ENA has been an advocate for best practices in the care of older adults in the emergency department.

People Experiencing Sexual Assault

As early as 1978, the ENA was educating nurses on the complexities of caring for people who experienced a sexual assault. The article by Moynihan and Coughlin[38] shared Yale New Haven Hospital's model program developed in 1974 to provide comprehensive care (medical, emotional, and legal) to victims of sexual assault. A 1991 article detailing the roles and responsibilities of a sexual assault nurse examiner (SANE) prompted members to request more information, and the journal started a resource list of sexual assault programs with a description of each.[39] In 2001, the ENA published highlights from the inaugural National Sexual Assault Response Team Training Conference.[40] In 2010, the ENA authored a position statement on "Sexual Assault and Rape Victims" to guide emergency nurses caring for this specialty group.[41] This statement was updated in 2016 to include adolescent victims of sexual assault and continues to advocate for specially trained SANE nurses to provide the highly specialized care needed for this vulnerable population.[42] In 2019, only 20% of the acute care hospitals had SANE programs, and the ENA has continued to advocate for legislation and support of training programs to increase the number of SANE nurses to care for victims of sexual assault.[43] The May 2020 *JEN* issue was themed "Forensic and Interpersonal Violence," highlighting problem solving and improvements to screening for interpersonal violence, treatment of the victim of sexual assault, and evidence collection, demonstrating a continued commitment to educate emergency nurses to care for these victims.[44]

People Experiencing Human Trafficking

Recently, emergency departments across the US started implementing assessment and screening programs to help recognize and rescue people experiencing human trafficking. Peters educated nurses on human trafficking and encouraged them to "become actively involved at the legislative level by joining a state or national organization dedicated to ending (modern) slavery."[45] The ENA continued to inform and educate emergency nurses on this topic. In 2016, the ENA released the position statement "Human Trafficking Patient Awareness in the Emergency Department Setting" to address the emergency nurse's critical role in recognizing, stabilizing, and referring people who are trafficked to appropriate community resources.[46] ENA's publications continue to educate nurses on signs of human trafficking, techniques to approach victims, and resources to help them, providing emergency nurses with the tools to support people experiencing human trafficking, intimate partner violence, and sexual assault.[47] Education and increased awareness programs for emergency nurses include topics such as sex trafficking, labor trafficking, and domestic servitude,[48] and they empower nurses to take a stand for this special population.

Trauma Care and Injury Prevention

The prevention and treatment of trauma have always been, and will mostly likely continue to be, top priorities for emergency nursing. It was in the setting of a US nationwide focus on trauma that the precursor to the ENA, the EDNA, was formed with a focus on the education of emergency nurses. In 1966, the National Academy of Sciences published a white paper entitled "Accidental Death and Disability: The Neglected Disease of Modern Society," kickstarting a decades-long movement to prevent and improve morbidity and mortality from traumatic injuries.[49] The EDNA collaborated with multiple organizations, including the American Academy of Orthopedic Surgeons and the American College of Surgeons Committee on Trauma

(ACSCT) to develop innovative ways of addressing this public health crisis.[23] The first convention, "Challenge to Change: Chimera or Commitment," in 1972, was in collaboration with the University of the State of New York and the ACSCT.[23] However, trauma continued to be the leading cause of premature death in the first 3 decades of life throughout the 1970s.[50] Early guidance in 1976 by the ACSCT provided a list of essential items required to care for patients with trauma,[50] and in 1978 the American College of Surgeons piloted the first Advanced Trauma Life Support course and launched it nationally in 1980.[51] Although initially concerned with physician education, the American College of Surgeons recognized that nursing was a critical link in the chain of survival for patients with trauma. Emergency nurses were invited to participate in a pilot of a physician-nurse Advanced Trauma Life Support course in Maine in 1982.[50]

Seeing a need for trauma education specific to nursing, the ENA developed the trauma committee with an initial charge to develop a trauma course specifically for nurses. As a result, the first Trauma Nursing Core Course (TNCC) was delivered in 1986.[52] This course, disseminated throughout the US in 1987,[53] prepared all nurses to work with patients with trauma using a systematic approach. By 1992, the ENA was piloting TNCC internationally in Australia and Canada.[23]

The ENA continued to prioritize trauma care throughout the 1990s, revising its guidelines as the science advanced and forming partnerships and interest groups around improving trauma care.[54,55] In 1990, the Trauma Care System Act appropriated $5 million for trauma system development. A new framework, the Model Trauma Care System, was developed to create statewide integrated trauma care systems, with the ENA providing input and reviewing the initial draft.[56] The ENA led emergency nursing education in trauma care through courses, publications, and sessions at each annual conference. After the success of the TNCC, the ENA developed the Course in Advanced Trauma Nursing to teach beyond the basics of trauma care. It debuted in 1995, the same year that the ENA produced the *International Journal of Trauma Nursing*.[23] This journal informed nurses caring for patients with trauma until 2002, when the title changed to *Disaster Management and Response* after the 9/11 terrorist attacks. The journal was retired in December 2007, and its content topics transitioned back to *JEN*.

Although nursing has always been at the forefront of providing quality care to patients who are hospitalized, nursing also recognizes the power of preventing illness and injury. As such, the ENA has always promoted injury prevention as an important aspect of trauma care. Even the 1975 position paper on "Emergency Medical Services Problems, Programs and Policies" discussed the role of emergency nurses and physicians in providing prevention measures to consumers.[57] The ENA's Government Affairs Standing Committee (established in 1988) helped support topics critical to injury prevention, including the Brady Bill and legislation for mandatory use of seat belts and motorcycle helmets, ED violence, firearm safety, domestic and violent crime, and trauma-funding reauthorization.[23] The ENA assumed responsibility for Emergency Nurses Cancel Alcohol Related Emergencies, Inc, in 1995 to further public education for injury prevention. Initially founded to prevent alcohol-related injuries, the ENA rebranded it into Emergency Nurses Care to encompass all aspects of injury prevention.[23] The name was later changed to the ENA Institute for Injury Prevention in 1999, highlighting issues such as firearm safety, car safety, and bicycle safety.[58]

In 2006, the ENA Institute for Injury Prevention released the National Scorecard on State Highway Laws to reach lawmakers on 5 key issues: a primary enforcement seat belt law, a child passenger safety law, graduated driver licensing, a universal/all-rider motorcycle helmet law, and the establishment of statewide trauma systems for injury response.[59] ENA's resources complemented the National Scorecard on State Highway Laws with the "Injury Prevention" position statement, the "Injury Prevention/ENCARE (Emergency Nurses Cancel Alcohol Related Emergencies)" program, the "Choices for Living" safe driving education program, and fact sheets on child passenger safety and car seat use.[60] In 2010, the blueprint was revised to advocate for transformative public policy initiatives alongside complementary resources for members. This included position statements on motor vehicle safety; motor vehicle occupant protection; a new alcohol screening toolkit (Screening, Brief Intervention, and Referral to Treatment [SBIRT]); and *The Washington Update,* ENA's e-newsletter on legislative and regulatory issues of concern.[61] This blueprint provided advocacy guidance for ENA state councils, chapters, and members to create an impact on public policy in their respective states. Starting in 2008, the ENA developed a health care reform platform to evaluate and address congressional health care reform proposals.[62] Two new laws in 2010 supported many of ENA's priorities, including regionalization of trauma care systems and financial support for trauma centers. Eventually, the Institute for Injury Prevention was combined with the Institute for Quality and Patient Safety to form the Institute for Quality, Safety and Injury Prevention.

Most recently, the ENA supported the "Stop the Bleed" national campaign to educate the public on actions to control a bleeding emergency.[63] In 2018, the ENA approved "The Role of the Emergency Nurse in Injury Prevention," followed by "Firearm Safety and Injury Prevention and Trauma Nursing Education" in 2019,[63, 64, 65] continuing its tradition as a leader in injury prevention and quality trauma care. The ENA promotes injury prevention through education of the public, media, and state and national legislators. The organization's persistence and progress, measured through its educational programs and legislative successes, have made trauma care and injury prevention 1 of the most enduring and impactful legacies of the organization.

Patient Quality and Safety

Since the formation of the EDNA, defining and implementing a high standard of quality emergency care has been foundational to the organization's mission.[66] Over time, however, this goal has changed on the basis of the state of the specialty and needs of the patients. The ENA has advanced patient quality and safety in 3 major ways throughout its history: professional development of nurses through education and certification, defining and standardizing the role of triage, and supporting and disseminating best practices in emergency nursing.

Professional Development and Certification

ENA's founders, Anita Dorr and Judith Kelleher, recognized emergency nursing practice to be distinct from other types of hospital nursing practice, and as such nurses required specific education and training to be competent. Nurses with specialized training, education, and experience would be crucial to ensure patient quality and safety in the emergency department. The ENA and *JEN* have curated hundreds of different opportunities for nursing professional

development through ENA's conferences; continuing education offerings; specialty courses in pediatrics, trauma, and geriatrics; and thousands of journal articles related to emergency nursing practice and proficiency. Kelleher also realized the value of recognizing those nurses who showed competency in emergency nursing through certification.[67] In an article published in the first year of *JEN*, the EDNA identified the need to develop a standard curriculum and certification for emergency nurses to improve knowledge, competency, and health care delivery in the emergency department.[68] The dues were increased by $10 to help raise funds for the certification examination; however, with costs estimated to be nearly half a million dollars, the EDNA was not able to raise enough funds for the examination at that time.[69,70] The certification initiative was revisited in September 1978, with the formation of a separate committee on certification in the summer of 1979. In 1980, the committee established an organization with the sole focus of implementing and maintaining the emergency nursing certification examination. The first CEN examination was given less than 1 year later, in July 1980, to more than 1000 emergency nurses. By September 1983, there were more than 7800 CENs.[70] Although not the first specialty certification in nursing, the CEN examination is the certification for emergency nursing worldwide, with more than 39 000 nurses who hold the specialty certification.[71] In addition, certifications are available for pediatrics, flight nursing, critical care ground transportation, and trauma nursing.[71]

Triage

Nursing has long accepted patient assessment as a foundational aspect of the profession, especially in the emergency care setting. Emergency nurses have always required efficient, accurate assessment skills, especially in those responsible for triage. Appropriate triage is one of the most critical decisions an emergency nurse makes that can influence patient care quality and outcomes. Overtriage can divert necessary resources from more acute patients, and undertriage can result in a dangerous delay of care or underestimation of illness severity. Since the beginning of the ENA, nurses have recognized the importance of a quick, accurate assessment. In 1976, an article described an outline of a rapid (90-second) head-to-toe assessment.[72] Triage nurses were expected to be able to accurately assess a patient's needs as emergent, urgent, and nonemergent, and to refer nonemergent cases to other hospital departments or community resources.[73] By 1979, there were 5 types of triage identified in the literature: nonprofessional, basic, advanced, physician, and team. Triage could be performed by a variety of people, from unlicensed personnel using a book to guide decision-making to physicians or a team of a nurse and a physician.[74] Tips for triage at this time included providing patient privacy and stressed the importance of a focused, nonjudgmental initial interview with the patient about their presenting complaints.[75]

As emergency departments continued to see increasing numbers of patients with both acute and nonacute needs, appropriate triage became a critical piece of an emergency nurse's role; however, processes continued to vary widely. Some emergency departments would refuse to treat or evaluate patients without insurance or even those with insurance who had a contract with a different hospital, often referred to as "patient dumping." In response to this unsafe and highly unethical practice, the federal government implemented the Emergency Medical Treatment and Active Labor Act in 1986, essentially requiring that all hospitals that receive federal dollars provide medical screening and stabilization for all patients seeking care.[76] This legislation

created universal access to health care for the first time in the US and a huge win for patient quality and safety. That same year, *JEN* started a column entitled "Triage Decisions" in recognition of the importance of triage in emergency nursing.[77] In early 1989, *JEN* published an article educating nurses on how best to comply with these new standards and condemning "financial triage," where patients would be asked to provide a deposit before seeing a physician.[78]

Triage had become a fundamental and unique piece of emergency nursing. The ENA *Standards of Emergency Nursing Practice, 2nd Edition,* published in 1994, included triage as a standard. Standard VII describes the importance of an emergency nurse triaging all patients to prioritize patient care on the basis of physical, psychological, and social needs.[79] The development, validation, and adaptation of 5-level triage systems such as the Emergency Severity Index (ESI) or the Canadian Emergency Department Triage and Acuity Scale throughout the early 2000s helped standardize triage assessment across the US and around the world.[80,81] In 2010, and revised in 2011 and 2018, the ENA released the "Triage Qualifications and Competencies" position statement, advising that triage nurses have specific experience, training, and evaluation of their triage skills to ensure triage is performed safely, appropriately, and efficiently.[82] In 2019, the ENA acquired the ESI, the most widely used 5-level triage program, promoting the ESI course and offering free triage resources to emergency nurses.[83]

Supporting Evidence-Based Practice

As nursing research has grown in recent years, so have the number and variety of research and quality improvement projects in emergency nursing. Today, evidence-based practice drives practice changes that improve quality and patient safety; however, this is a relatively new phenomenon for emergency nursing. For the first 30 years of *JEN*, only 2% to 4% of the published articles were related to patient quality and safety; however, this jumped to 12% to 13% in the most recent 20 years, with more nurse researchers, more nurses with bachelor's degrees in the workforce, and a greater national focus on patient safety and quality in health care. From Dorr's invention of the "crash cart" in her garage in 1967[84] to innovating solutions to the challenges of today's complex health care system, emergency nurses have created unique solutions to pressing clinical challenges. In the 1990s, research published in *JEN* paved the way in best practices related to family presence during cardiopulmonary resuscitation,[85,86] leading to the publication of an ENA position statement advocating for family presence during resuscitation[87] and an eventual clinical practice guideline, "Family Presence During Invasive Procedures and Resuscitation."[88] Dozens of other practice guidelines and improvements, including the use of capnography, difficult intravenous access, intimate partner violence screening, orthostatic vital signs, preventing blood culture contamination, and many others were developed.[89,90] These clinical practice guidelines guide emergency nurses and educators to perform nursing duties at the highest standard available. Although the ENA has supported dozens of policy and practice initiatives to improve quality and safety, the authors have chosen to spotlight psychiatric care in the emergency department as 1 example.

Providing quality psychiatric care in emergency departments has been challenging because most emergency departments were designed to provide care for physical emergencies, not necessarily psychiatric emergencies. In the 1970s and '80s, articles published by *JEN* primarily focused on

proper psychiatric assessment and tips for providing care for a patient with suicidal ideation, overdoses, and/or substance abuse, often focusing on the medical aspects of their psychiatric crisis. In the 1990s, emergency nursing began exploring different models for providing psychiatric care, including dedicated crisis teams or specially trained psychiatric nurses in the emergency department.[91,92] As community funding for mental health decreased in communities across the US, emergency departments were often the only access point for care, especially for those without private health insurance coverage.[93] As the volume and complexity of patients with psychiatric illness seeking emergency care increased, emergency nurses and the ENA recognized the need for continued improvements in the quality of care for this population. In 2007, the ENA assembled the Psychiatric Patients Work Team to formulate public policy recommendations to improve care of ED patients with mental or psychiatric illness. This group advocated for improvements in standardizing guidelines for practice, emergency nursing education, and workforce development, specifically for patients with psychiatric illness, developing systems of community collaboration, and advocating for improved safety and security for patients and ED staff.[94] The ENA also advocated for implementing SBIRT programs throughout emergency departments in the US and cosponsored a national conference.[95] The ENA developed a joint position paper with the International Nurses Society on Addictions, supporting SBIRT programs in emergency departments in 2013 and advocating for nurses to deliver SBIRT programs to decrease the prevalence of alcohol use disorders across the lifespan.[96]

Emergency Nursing Workforce

The ENA has always been dedicated to supporting the emergency nursing workforce; however, in recent decades, this role has shifted from establishing and professionalizing emergency nursing to maintaining an adequate workforce and advocating for safe and sustainable working conditions. For example, most recently, owing to the COVID-19 pandemic, the ENA provided timely educational opportunities and wrote letters to the US Congress advocating for critical personal protective equipment for frontline health care workers, encouraging a substantial public health response to ensure that emergency nurses have the tools they need to protect themselves and their patients.[97] Over the last 25 years, the ENA has advocated for promoting professional resilience, decreasing workplace violence for emergency nurses, and finding creative solutions for crowded emergency departments.

Workplace Violence

Workplace violence in the emergency department has been a concern of the ENA since the early 1990s. A highly cited study published in 2002 revealed that 100% and 82.1% of the emergency nurses surveyed reported experiencing verbal or physical assault, respectively, within the last year.[98] The ENA first developed a position statement about violence in the workplace in 1991 and has revised this statement every 3 to 5 years to reflect the current health care environment. In the statement “Violence in the Emergency Care Setting,” the ENA stated that health care organizations have a responsibility to provide safe environments, and emergency nurses have the right to protect themselves and their patients from violence.[99] The ENA is not the only nursing organization that has concerns about workplace violence against nurses; it has collaborated with other organizations, including the International Council of Nurses and the ANA, to advocate for safe workplaces for nurses and other health care workers. The ENA and the International

Council of Nurses have offered proactive guidelines for the protection of staff within the departments, such as mandatory incident reporting, tracking assaults, reviewing the security team's responsibility, and consistent incident follow-up from leadership.[99]

During the late 2000s, the ENA promoted advocacy for laws to make injuring a health care worker a significant offense.[100] In many cases, these episodes of violence are now considered a felony. A resolution entitled "Supporting Felony Criminal Penalties for Assaults against Emergency Healthcare Workers" was introduced at the 2010 ENA General Assembly, empowering the ENA at the national and state council levels to support felony legislation as a recourse for violence in the emergency department. For example, the Virginia ENA chapter advocated for harsher penalties for people committing violence against health care workers, ultimately resulting in a new law enacted in mid-2011 that "is one of the first workplace violence laws that carries mandatory jail time."[101]

Professional Resilience

Emergency nurses are often on the front lines of a community crisis, including potentially traumatic events such as natural disasters, mass shootings, terrorist attacks, mass casualty scenarios, and pandemics, which can cause significant psychological stress.[102] Work stress among emergency nurses is associated with symptoms of posttraumatic stress disorder,[103] burnout, and compassion fatigue.[104] Because of an emergency nurse's high exposure to potentially traumatic events, emergency nurse researchers have paved the way for others in this important workforce issue. At the time of this writing, an article comparing compassion satisfaction, burnout, and compassion fatigue among emergency nurses and other types of nurses had been cited more than 750 times.[104] The ENA supports a healthy work environment for all nurses and advocates for implementing best practices in fostering resilience in staff. This includes supporting a "just culture," condemning bullying, protecting meal times, and debriefing after critical events.[105]

Crowding

Crowding has been a policy issue for numerous health care organizations since the early 1990s, including the ENA, the ACEP, and the Institute of Medicine. Crowding in the emergency department is usually a symptom of a larger system-wide problem, resulting from increased ED volumes, nursing shortages, high staff turnover rates, fewer ICU beds, and fewer hospital beds owing to hospital and unit closures.[106] In the 1990s, the ENA developed a position statement related to crowding,[107] which has been regularly updated and revised, indicating the issue's continued importance.[108] In 2003, the General Accountability Office (GAO) completed a landmark study of emergency departments, measuring crowding.[109] In 2005, the ENA made crowding a strategic priority of the organization,[110] and the Institute of Medicine followed soon after, highlighting crowding as a major problem in its 2006 report, "The Future of Emergency Care."[111]

As part of ENA's strategic plan in the 2000s, an ED Crowding Work Team was formed to develop national standards and metrics to measure crowding and develop partnerships with other stakeholders addressing the issue. The work team provided key insights about the emergency

nursing perspective to the GAO in its updated report.[111] The new GAO study was published in 2009, and the findings were similar or worse, with ED wait times nationally increasing, often to unsafe levels, on the basis of acuity.[106] Local strategies, including advanced bed requests, improved communication within and outside hospitals and emergency departments, the creation of permanent hall beds, and an increase in staffing[107] were short-term fixes to a national, multifaceted symptom of an overburdened health care system. In 2015, the ENA General Assembly rated improving ED throughput, especially decreasing the time from admission to bed placement, as 1 of the 3 priority issues for the ENA to address.[112] Although hospital and ED crowding continue to plague hospitals across the US, the ENA has consistently leveraged its resources to best inform members and policy makers of best practices and needed reforms to address this issue.

Limitations

The study limitations include that each article was limited to the 3 most relevant codes; however, the 3 most relevant codes were chosen when categorizing the articles. There is the potential that more codes could have affected the outcome of the leading themes. The articles analyzed were provided by the ENA directly on the basis of a database it maintains of the articles published in *JEN*. It is possible that some articles were not included in this list and, thus, were not included in our review. In addition, historical reviews are not meant to be comprehensive reviews of every available resource, and there were many other potential resources that were not included as sources for our historical analysis. The historical thesis as well as the constraints regarding what is archived, collected, and available dictate what sources are, and are not, used. It is possible that with different sources and a different methodology, someone else may have come to a different conclusion because historical research requires the writer to make a judgment and curate sources to support the chosen argument.

Conclusion

From its inception, the ENA has advocated for safe emergency nursing practice through education, position papers, publications, and policy initiatives. Building on the foundation laid by founders Dorr and Kelleher to create a professional emergency nursing organization, ENA's leaders have consistently monitored and addressed emergency nursing concerns. The ENA has grown and thrived. The provision of care for vulnerable populations, trauma and injury prevention, and patient quality and safety were the most enduring and impactful policy initiatives in the first 50 years of the ENA. Most recently, the ENA has promoted strategies to maintain the emergency nursing workforce and ensure a safe and sustainable environment for emergency nurses to practice. The success of the ENA is member-driven. During this historic year of the COVID-19 pandemic and Year of the Nurse and Midwife, the ENA has helped showcase emergency nurses to the world, demonstrating extreme resiliency in a world of uncertainty, determining best practices, and maintaining the health care safety net for the most vulnerable populations.

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Dedication

We dedicate this article to Anita Dorr and Judith Kelleher for their vision for the Emergency Nurses Association and to all the emergency nurses who work tirelessly for their communities, making our founders' dreams a reality.

Author Disclosures

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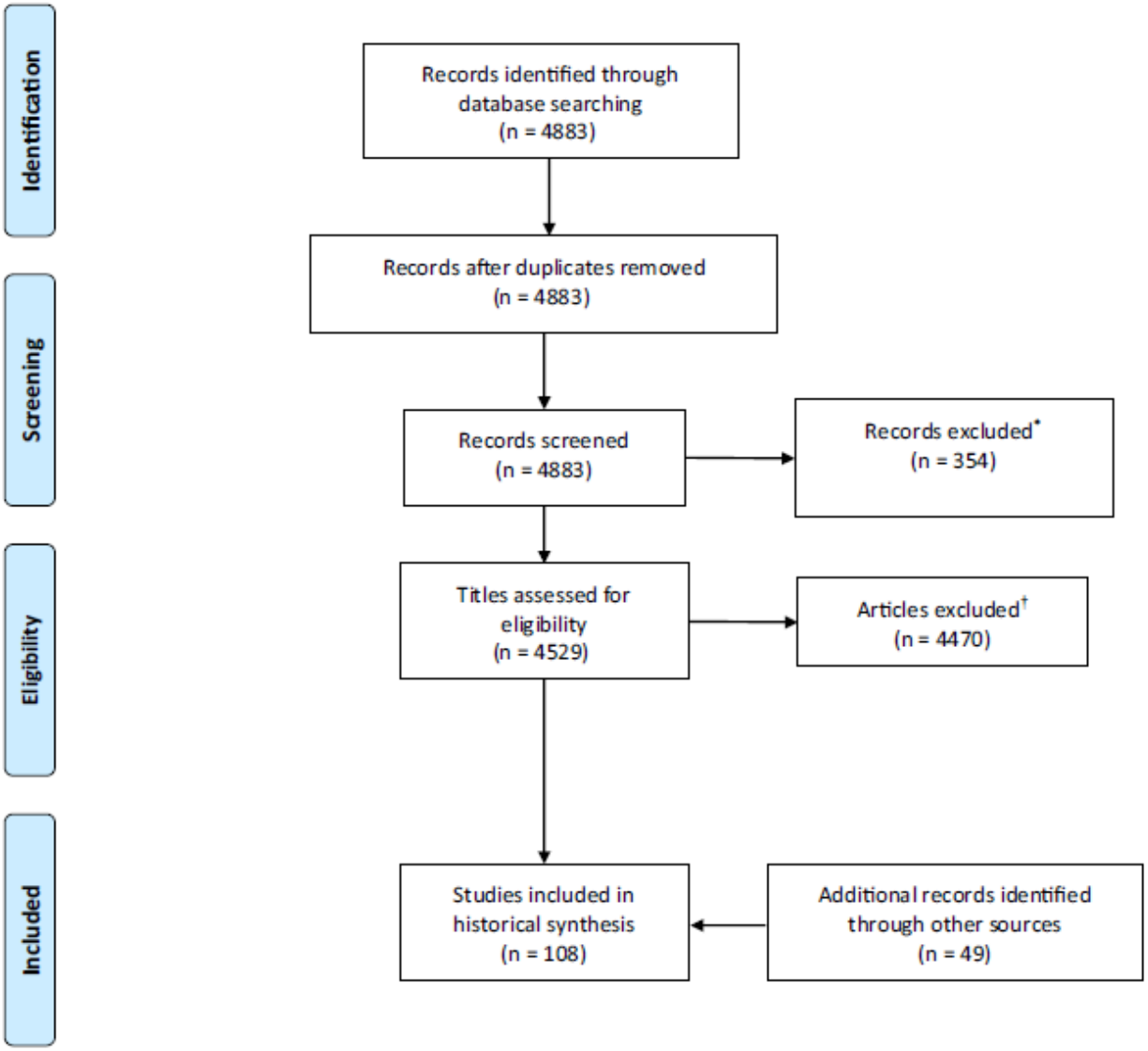

Supplementary Figure. Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram. ∗Articles excluded owing to title/abstract topic being outside of the defined codes. †Articles not within the identified top policy areas were excluded. Articles within top policy areas but not relevant to policy were excluded.