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Competencies in Swedish emergency departments – The practitioners' and managers' perspective

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ABSTRACT

The task of emergency departments (EDs) is to provide safe emergency healthcare while adopting a caring, cost-effective approach. Patients attending EDs have different medical and caring needs and it is assumed that practitioners have the requisite competencies to meet those needs. The aim of the present study is to explore what kind of competencies practitioners and managers describe as necessary for the practitioners to perform their everyday work in EDs.

Methods: This study used a qualitative, exploratory design. Interviews were conducted in two EDs. Data were analysed using inductive content analysis.

Results: The competence focus in everyday work in EDs is on emergency and life-saving actions. There is a polarisation between medical and caring competencies. There is also tension between professional groups in EDs as well as hierarchical boundaries that influence the ability to develop competencies in everyday work. Medical competencies are valued more and caring competencies are subsequently downgraded. A medical approach to competencies consolidates the view of necessary competencies in everyday work in EDs.

Conclusions: The study shows that the competencies that are valued consolidate the prevailing medical paradigm. There is a traditional, one-sided approach to competencies, a hierarchical distinction between professional groups and unclear occupational functions.

Introduction

The task of emergency departments (EDs) is to provide safe emergency healthcare while adopting a caring and cost-effective approach. This includes assessment, diagnosis, treatment and caring, all within an acceptable timeframe in relation to the patients' needs (The Swedish Code of Statutes, 1982; Sbaih, 1998; Baldursdottir and Jonsdottir, 2002; Institute of Medicine, 2006; Cassidy-Smith et al., 2007; The National Board of Health and Welfare, 2011a).

In Sweden, there are currently 74 EDs with an estimated catchment area of 50,000–750,000 inhabitants per ED (The National Board of Health and Welfare, 2011b). The number of visits to EDs has increased over the last few years, from 1.8 million per year in 2006 (Säfwenberg, 2008) to 2.5 million in 2011 (The National Board of Health and Welfare, 2011b). Some 710,000 ED visits are injury-related (The National Board of Health and Welfare, 2009). An average ED has around 34,160 patient visits per year (range: 10,000–95,000) and the majority of EDs see both children and adults (Andersson and Nilsson, 2009). Approximately 30% of patients are admitted to the hospital (The National Board of Health and Welfare, 2011b).

Patients use EDs for minor to very severe health problems. They present with different signs and symptoms that involve both medical needs and caring needs. Medical needs, for example, refer to wound care and medication, whilst caring needs refer to the provision of food and drink and emotional and psychosocial support. Patients generally make their own way to the ED and their condition is usually considered non-urgent, i.e. a condition that is not life threatening and does require immediate attention (Tsai et al., 2010; Göransson et al., 2012). There is also variation in terms of age, from the young to the elderly (Muntlin, 2009; Hou et al., 2012). There is a growing need in an ageing population for emergency healthcare as the risk of illness increases with age (Samaras et al., 2010). Furthermore, visits to ED are frequently unplanned

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and the patients often have a feeling of fear and anxiety (Baillie, 2005).

The task of EDs should be related to developments in the emergency healthcare sector. Nationally and internationally, the number of patients visiting EDs is rising and the number of EDs is falling, resulting in a changing workload in the remaining EDs (Institute of Medicine, 2006; Säfwenberg, 2008; The National Board of Health and Welfare, 2011b; Marco et al., 2012). This trend presents new challenges and requires work procedures designed to reduce throughput time in EDs and thus improve patient satisfaction (Cassidy-Smith et al., 2007). In this situation, it is essential that practitioners have the necessary competencies to deliver safe, effective emergency healthcare to meet different patient needs. In Sweden, 'practitioners' include assistant nurses (ANs), registered nurses (RNs) and medical doctors (MDs).

The term 'necessary' refers to the competencies that practitioners and managers, i.e. clinical managers (CMs), head nurses (HNs), deputy head nurses (DHNs) and healthcare developers (HDs), state are necessary to perform the work in ED. However, descriptions of competencies can vary (Watson et al., 2002; Delamare Le Deist and Winterton, 2005). In this study, the word 'competencies' means the capability to integrate and use a range of knowledge, skills and attitudes to manage situations in a way that an expected level of quality or a standard is maintained (Eraut, 1998). An important part of the task of EDs is to provide emergency healthcare and this takes place in everyday work. In this study, everyday work means situations that occur regularly and related to patients' non-urgent conditions without being outstanding or dramatic. Everyday work in an ED requires practitioners to interact with each other, using different competencies to complement each other in order to achieve the best outcome for the patients.

There are competencies that are necessary to ensure quality and safety in everyday work in EDs. Practitioners should provide patient-centred care, operate in interdisciplinary teams, provide evidence-based practice, apply quality improvement initiatives and make use of informatics (Institute of Medicine, 2003; Cronenwett et al., 2007). Earlier research shows that practitioners need different competencies in their everyday work. In order to provide holistic emergency healthcare, practitioners need both medical competencies i.e. disease-oriented competencies, and caring competencies to ensure the patients' medical and caring needs are met. This could take the form of incision and drainage of abscesses, generating a differential diagnosis and supporting patient-coping strategies (Farion and Morrison, 2001; Hogan et al., 2010; McCarthy et al., 2013). The extent to which these competencies are required differs from one professional group to another. To handle patients' needs, practitioners also require communicative competence (Pytel et al., 2009; Creswick et al., 2009) and ethical competence (Pauls and Ackroyd-Stolarz, 2006; Aacharya et al., 2011) in order to involve patients, relatives and other professionals and demonstrate respect for them. Practitioners need pedagogical competencies (Wei and Camargo, 2000; Williams et al., 2007; Smith et al., 2008) in order to inform and educate patients and their relatives based on the needs that caused them to visit the ED. The capability to organise, co-ordinate and manage everyday work requires practitioners to possess leadership competence (Goldman et al., 2011). Finally, practitioners need academic competence (Pallen and Timmins, 2002; Burke et al., 2005; Fink et al., 2005) not only to be critical of science, research and scientific knowledge but also to implement and evaluate evidence-based improvement and quality management.

To ensure that practitioners have the necessary competencies, it is essential for EDs to have systems in place for competence development (The Swedish Code of Statutes, 2010; The National Board of Health and Welfare, 2011a). Competence descriptions have been drawn up specifically for RNs and MDs working in EDs (The National Board of Health and Welfare, 2008; Swedish Emergency Nurses Association, 2010; The College of Emergency Medicine, 2010; Faculty of Emergency Nursing, 2013). Competence descriptions concretise the competencies required in emergency healthcare. If the necessary competencies are not ensured, there is a risk that practitioners will perform tasks that remain incomplete or unperformed. However, these competence descriptions are only recommendations and there is no obligation for practitioners to possess specialist competencies in emergency medicine or emergency nursing in order to work in Swedish EDs. It is the CMs who individually decide which competencies are necessary to work in EDs (The National Board of Health and Welfare, 2011a).

To develop a better understanding of the competencies required for everyday work in Swedish EDs, there is a need to explore the nature of necessary competencies. The aim of the present study is to explore what kind of competencies practitioners and managers describe as necessary for the practitioners to perform their everyday work in EDs.

Methods

Design and ethical approval

A qualitative, exploratory design was selected for the present study. This design is appropriate when exploring a phenomenon about which little is known (Polit and Beck, 2012). To gain a better understanding of the competencies practitioners and managers deem necessary in an ED, data was collected by means of group and individual interviews.

The Regional Ethics Committee in Gothenburg (Ref. 639-08) granted consent for the study. All the participants received an information letter about the study together with a consent form. All the participants gave their informed consent. They were each given an identification number to ensure confidentiality.

Setting

The research setting for this study was two EDs in western Sweden. The selection criteria for the EDs were: (1) presence of MDs with and without specialist competencies in emergency medicine; (2) differences in the number of patient visits per year; (3) open around the clock; (4) provision of emergency healthcare with surgical, orthopaedic and internal medicine specialisations. The main differences between the two EDs were the number of patient visits per year, the number of beds at the hospital and the presence of MDs with specialist competencies in emergency medicine. See Table 1 for details of the differences between the two EDs.

Participants

The participant group comprised 31 practitioners and seven managers. The inclusion criteria were a willingness to share their views on competencies necessary in everyday work in order to highlight the aim from different viewpoints. The majority of the participants were women and the mean age was 40.8 years (Table 2). Although most of the participants had more than

Table 1
Overview of differences between the two EDs.

ED	A	B
Patient visit per year	29,000	43,000
Beds at the hospital	200	360
MDs with specialist competencies in emergency medicine	No	Yes (during the daytime)