Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Leading and Accelerating Change

Jessica Castner, PhD, RN, CEN, AE-C, FAEN, FAAN

For over a year, emergency nurses around the world have been at the forefront of the coronavirus disease pandemic response. The emergency care sector was already at the breaking point, especially in the United States, well before the onset of the pandemic.[1] The pandemic has led to a loss of life among the general population, the loved ones of our emergency nursing community, and our own health care workers. Public outcry about the need to change health care, fueled by problems exacerbated by the pandemic, has created an urgency and priority for care reforms and improvements.

Over 50 years ago, the Emergency Nurses Association (ENA) founders, Anita Dorr and Judith Kelleher, created the organization as a vehicle to advance training and skills among nurses in the emergency care setting and to institute widespread improvements in patient care.[2,3] Our founders' and our own subsequent collective efforts through ENA's first 50 years modeled for us how successfully and adeptly we can envision, create, and accelerate positive and meaningful change. Now, we are responding to the deadliest pandemic since the ENA's inception, which has continuously tested the knowledge, skill, endurance, and dedication of emergency clinicians beyond most human limits. We collectively lift up in solidarity each emergency clinician who has been surrounded by the prolonged physical, mental, emotional, and spiritual devastation and isolation of this global disaster. For some, the severity and scarcity inherent to this pandemic lifted their capabilities to new heights. The challenge awakened their tremendous personal and professional skill, strength, creativity, and tenacity. For many, the challenges of the pandemic have often seemed too much for any one person to bear. Too difficult to endure. Too demoralizing to soldier on.

After taking time to rest, to grieve, and to replenish, let us join together to recalibrate our perspective to envision what possibilities stretch beyond this last year's exhaustion, shortages, needs, and fatalities. We carry the struggles with us, not to be discouraged and dejected by these trials but to rededicate ourselves to the clearly unfinished work to optimize clinical care and patient outcomes in the emergency care setting. Providing emergency nursing care during the pandemic may have left scar tissue physically at infection sites, emotionally through loss, and spiritually as we press through times of potential cynicism and hopelessness. Collectively, one path to healing is finding new meaning and purpose in the challenges we share and overcome in any major disaster.

This editorial is my call that we not give in to cynically accepting the flaws and limitations of the health care system, so clearly evident under the pandemic's demands. Let's not give in to normalizing avoidably poor patient outcomes. Let's not give in to unacceptable working conditions. In the metaphorical ashes and aftermath of the coronavirus disease pandemic, let us dedicate ourselves anew to lifting up one another and accelerating the needed change to better emergency nursing care. It is now up to us to create important ways to honor those we lost in this disaster. It is up to us to emerge, look for strength within and among us, and dedicate ourselves collectively to continue to push for positive change. It is up to us to ensure a purpose in emergency nursing so that, in the words of Abraham Lincoln, "these dead shall not have died in vain."

Each emergency clinician can easily generate a list of system and unit changes that can improve their work environments and patient outcomes. Emergency clinicians also have the superb prioritization skills to determine the timeliness and importance of each of these problems, and to focus on the problems most likely to generate an impact. No one is exempt from the responsibility of organizational change and improvement. If every person at every level of a hospital or emergency care system is not leading the change in a positive manner, it is unlikely that any planned change will be sustainable long-term. Even though emergency nurses are often expert at identifying and prioritizing both organizational and patient problems, we often do not have the processes or tools at hand to lead and accelerate change. Kotter's

Jessica Castner, is Editor-in-Chief of *Journal of Emergency Nursing*, *Member, New York State ENA*. **ORCID identifier:** http://orcid.org/0000-0001-9889-3844. **Twitter:** @DrCastner.

For correspondence, write: Jessica Castner, PhD, RN, CEN, AE-C, FAEN, FAAN, Grand Island, NY; E-mails: jcastner@castnerincorp.com; jpcastner15@gmail.com.

J Emerg Nurs 2021;47:218-20.
0099-1767

https://doi.org/10.1016/j.jen.2021.01.006

8 steps of change is an excellent, shared mental model for leading successful, sustainable change.[4] Briefly, Kotter's 8 steps to lead and accelerate change are:[4]

- CREATE a sense of urgency
- BUILD a guiding coalition
- FORM a strategic vision
- ENLIST a volunteer army
- ENABLE action by removing barriers
- GENERATE short-term wins
- SUSTAIN acceleration
- INSTITUTE change

I first learned about Kotter's 8 steps of change as part of a hospital-system-wide TeamSTEPPS communication intervention.[5] A brief ebook is freely available at the author's website, along with additional tools and learning aids for emergency nurses who wish to apply the process of leading change in their organizations.

We emergency nurses, as part of a professional specialty organization, have a proud and successful history of leading and accelerating change. In the final manuscript in our ENA 50th Anniversary celebration, Milbrath and Snyder[3] provide a historical analysis of the top 3 policy issues addressed in the ENA's history: (1) provision of care for vulnerable populations, (2) trauma and injury prevention, and (3) patient quality and safety. Many of our in-person 2020 anniversary year celebrations were cancelled and delayed due to the pandemic. I am writing this editorial as vaccination campaigns are just beginning to protect our health care workers and vulnerable lay population. In the hopes that March of 2021 will mark the date when we can begin to emerge from our isolation to celebrate together once again, I envision that the pandemic can serve as the inflection point marking when ENA progresses from leading change to also accelerating the needed improvements in our health care system.

In This Issue of the *Journal of Emergency Nursing*

In addition to our 50th Anniversary celebration article, this issue of *Journal of Emergency Nursing (JEN)* includes a collection of articles focused on novel technology, coronavirus disease 2019 leadership, and cardiovascular care. Ivanov et al's research begins to bring emergency triage into the advanced digital age by testing the accuracy of a machine learning algorithm for assigning Emergency Severity Index acuity.[6] The results tantalize the imagination with a future where patient care is more accurate and precise with human decision-making augmented and supported by real-time supercomputing tools. As part of an ongoing quality improvement project to reduce blood culture contamination rates, Arenas et al[7] test the monthly outcomes as new initial specimen diversion devices are introduced into the unit supply chain. The compelling data demonstrate the need for further clinical trials and provide initial evidence to support device use as part of a quality improvement bundle at adult emergency care sites with baseline contamination rates above national benchmarks.

Binder, Torres, and Elwell[8] provide the reader insights into the initial ED leaders' response to the early and emerging pandemic in the United States in a suburb of New York City. The potential for unscheduled staff absences is part of any infectious disease surge capacity disaster planning, and the authors uniquely quantify that up to 18.5% of the scheduled nursing staff called in sick at their March 25, 2020 peak. This may serve as an important percentage for future infectious disease disaster response planning and estimated reserve staffing needs. By relaying how the facility leaders flexibly adapted structures and processes at their site in the face of uncertainty and little previous evidence, the authors provide an important contribution to the literature on considerations for emergency care leadership in future, major infectious disease disasters. Implementing telehealth is an important and noteworthy facility intervention in the Binder et al manuscript. Brown[9] provides an explanation of the policy changes to the Emergency Medicine Treatment and Active Labor Act, or EMTALA, that have been temporarily implemented in response to the pandemic. One crucial area for continued change leadership and change acceleration continues to be the use of telehealth, and specifically telenursing, as an extension or alternative to future emergency nursing services and emergency nursing work redesign.[10,11] Wendt et al[12] describe the patient outcomes associated with awake proning for non-intubated emergency department patients. This project is the subject of two invited commentaries to clarify the potential of occupational back injury and the proning procedure for the clinical reader.

Several manuscripts in this issue of *JEN* have implications for cardiac skills and training in the global emergency nursing workforce. Picard et al[13] measured cardiopulmonary resuscitation compression quality using the CPRmeter 2 device as part of their quality improvement project. The authors' findings indicate that clinicians may be poor judges of the quality of the compressions we deliver, and objective feedback using these devices in education or practice promises to enhance the quality of care delivered during resuscitation. Hight et al[14] tested the time-to-results differences between the point of care and in-laboratory biomarker troponin testing. At this site where high sensitivity troponins had not been incorporated, the point of care troponin result was obtained, on average, 29 minutes faster than when specimens were sent to the laboratory. Penalo et al[15] clarify priority electrocardiograph rhythms for emergency

nurse competency, professional development, and orientation education. Their findings can easily be translated into a priority order for cardiac rhythm teaching in the specialty. *JEN* continues to welcome case reviews of rare or unusual presentations associated with cardiac dysrhythmias. Uhm and Jung[16] demonstrate an important area where emergency nurses technically proficient in defibrillator use can contribute to overall hospital nursing care quality. Here, among hospital nurses, only 13.6% had experience using a defibrillator during patient resuscitation, and only 32% reported self-confidence in defibrillator use. In this South Korean setting, deference to the physician's role was an important, potentially contributing factor to the nurses' reluctance to use a defibrillator. The international emergency nursing community is in an important position to model and educate on the knowledge, skills, and behaviors to optimize the independent nursing role during resuscitation and defibrillator use. Aligned with the theme of cardiac dysrhythmia and emergency resuscitation skills, Adams and Adams[17] provide a technical review of transcutaneous pacing procedures while El-Hussein and Cuncannon[18] provide readers with a guide for evaluating patients who present with syncope. Last, the morbidity and mortality found in Hanifi, Rezaee, and Rohani's[19] retrospective cohort study of patients in Iran presenting to the emergency department with a myocardial infarction reminds readers of the importance of emergency nurses' role in population health education. The study's implications remind all emergency nurses around the globe to include discharge instructions for all patients with cardiovascular risk advising not to delay seeking treatment for cardiac symptoms, provide smoking cessation resources and behavior change interventions, and address hypertension control follow-up.

REFERENCES

1. Institute of Medicine. *Hospital-Based Emergency Care: at the Breaking Point*. The National Academies Press; 2007.
2. Anast GT. Winds of change: Anita N. Dorr memorial lecture. *J Emerg Nurs*. 2020;46(1):16-20. https://doi.org/10.1016/j.jen.2019.11.004
3. Milbrath G, Snyder A. The emergency nurses association: 50 years of advocacy and advancement. *J Emerg Nurs*. 2021;47(2):224-238.e1. https://doi.org/10.1016/j.jen.2020.11.007
4. Kotter J. 8 Steps to accelerate change in your organization. kotterinc.com Accessed Jaunary 6, 2021. https://www.kotterinc.com/8-steps-process-for-leading-change/
5. Ceravolo DJ, Schwartz DG, Foltz-Ramos KM, Castner J. Strengthening communication to overcome lateral violence. *J Nurs Manag*. 2012;20(5):599-606. https://doi.org/10.1111/j.1365-2834.2012.01402.x
6. Ivanov O, Wolf L, Brecher D, et al. Improving ED emergency severity index acuity assignment using machine learning and clinical natural language processing. *J Emerg Nurs*. 2021;47(2):265-278.e7. https://doi.org/10.1016/j.jen.2020.11.001
7. Arenas M, Boseman GM, Coppin JD, Lukey J, Jinadatha C, Navarathna DH. Asynchronous testing of 2 specimen-diversion deviced to reduce blood culture contamination: a single-site product supply quality improvement project. *J Emerg Nurs*. 2021;47(2):256-264.e6. https://doi.org/10.1016/j.jen.2020.11.008
8. Binder C, Torres RE, Elwell D. Use of the Donabedian Model as a framework for COVID-19 response at a hospital in suburban Westchester County, New York: a facility-level case report. *J Emerg Nurs*. 2021;47(2):239-255. https://doi.org/10.1016/j.jen.2020.10.008
9. Brown HL. Emergency care EMTALA alterations during the COVID-19 pandemic in the United States. *J Emerg Nurs*. 2021;47(2):321-325. https://doi.org/10.1016/j.jen.2020.11.009
10. Montandon DS, de Souza-Junior VD, Dos Santos Almeida RG, Marchi-Alves LM, Costa Mendes IA, de Godoy S. How to perform prehospital emergency telephone triage: a systematic review. *J Trauma Nurs*. 2019;26(2):104-110. https://doi.org/10.1097/jtn.0000000000000380
11. Nejadshafiee M, Bahaadinbeigy K, Kazemi M, Nekoei-Moghadam M. Telenursing: a step for care management in disaster and emergencies. *J Educ Health Promot*. 2020;9:204. https://doi.org/10.4103/jehp.jehp_8_20
12. Wendt C, Mobus K, Wiener D, Eskin B, Allegra JR. Prone positioning on non-intubated COVID 19 patients in hypoxic respiratory distress: single site retrospective health records review. *J Emerg Nurs*. 2021;47(2):279-287.e1. https://doi.org/10.1016/j.jen.2020.12.006
13. Picard C, Yang BG, Norris C, McIntosh S, Douma MJ. Cardiopulmonary resuscitation feedback: a comparison of device-measured and self-assessed chest compression quality. *J Emerg Nurs*. 2021;47(2):333-341.e1. https://doi.org/10.1016/j.jen.2020.10.003
14. Hight M, Conklin K, Archer B, Sutherland J, Sakai B, Arnold D. Implementing point-of-care troponin testing in the emergency department: impact on time to result. *J Emerg Nurs*. 2021;47(2):299-304. https://doi.org/10.1016/j.jen.2020.06.014
15. Penalo L, Pusic M, Friedman J, et al. Importance ranking of electrocardiogram rhythms: a primer for curriculum development. *J Emerg Nurs*. 2021;47(2):313-320. https://doi.org/10.1016/j.jen.2020.11.005
16. Uhm D, Jung G. Factors affecting attitudes toward defibrillator use among clinical nurses in South Korea: a cross-sectional study. *J Emerg Nurs*. 2021;47(2):305-312. https://doi.org/10.1016/j.jen.2020.07.001
17. Adams A, Adams C. Transcutaneous pacing: an emergency nurse's guide. *J Emerg Nurs*. 2021;47(2):326-330. https://doi.org/10.1016/j.jen.2020.11.003
18. El-Hussein MT, Cuncannon A. Syncope in the emergency department: a guide for clinicians. *J Emerg Nurs*. 2021;47(2):342-351. https://doi.org/10.1016/j.jen.2020.11.002
19. Hanifi N, Rezaee E, Rohani M. Time-to-treatment and its association with complications and mortality rate in patients with acute myocardial infarction: a prospective cohort study. *J Emerg Nurs*. 2021;47(2):288-298.e4. https://doi.org/10.1016/j.jen.2020.05.013