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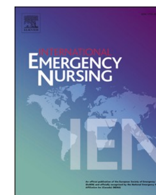

Guidelines for patient care used by registered nurses in the emergency room: Mapping of Swedish governing documents

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ABSTRACT

Introduction: Guidelines are important for guiding clinical practice and governing registered nurses' work in an emergency room to enable them to secure quality of care and patient safety in a life-saving situation. However, guidelines are not always systematically prepared, or evidence based. This study aimed to map and describe the content of Swedish guidelines governing the registered nurses' work in emergency rooms.
Methods: A descriptive cross-sectional design, together with a thematic synthesis of content of the submitted guidelines. The data were analyzed with descriptive statistics and a thematic synthesis. Quality of the guidelines was measured using a modified version of the AGREE II instrument.
Results: The result is based on 190 included guidelines, collected from 37 participating emergency departments. The registered nurses' work in emergency rooms was guided by an instrumental and task-oriented approach to care, with a wide variation in how the registered nurses' work was described in the guidelines. The quality of the guidelines was poor. The registered nurse was reported as target user in 15 % (n = 29) of the guidelines. None of the guidelines described the population to whom they were meant to apply. In 17 % (n = 32) there was an explicit link between recommendations and supporting evidence.
Conclusions: There is a need to improve guidelines to support registered nurses in assessing, treating, and providing fundamental care for patients with life-threatening illnesses in an equal, evidence-based, and person-centered way. Registered nurses should play an active role in the development of the guidelines governing their work.

1. Introduction

Evidence-based healthcare is established as a core element and a key indicator of high-quality patient care [1]. Evidence-based clinical practice guidelines aim to assist registered nurses (RNs) in their assessments of and interventions for patients, and is needed to secure quality of care and patient safety [2]. When guidelines are followed, benefits can be achieved, such as improvements in the quality of patient care, consistency in care, and better quality of clinical decisions made. Adherence to guidelines also emphasizes the assessment of available evidence [3]. Yet, Tegelberg, Muntlin [4] indicate that healthcare staff members tend to disregard guidelines; instead, they use their personal experiences and common sense to guide their care for patients. In addition, implementation of poor-quality guidelines may not only result in little or no benefits for the RN using them, but also cause ethical problems and non-equal care [5,6]. As synonymous words and phrases are used interchangeably (e.g., clinical practice guidelines, guidelines, checklists, care programs, memos, and standard care plans), the broader term 'guidelines' is used hereafter, considering that they may be called by different names in documents.

1.1. Background

In an emergency department (ED), an 'emergency room' (called a

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resuscitation room in some countries) is intended for patients with life-threatening illnesses and injuries. The initial assessment in the emergency room is based on national guidelines—that is, the airway, breathing, circulation, disability, and exposure (ABCDE) concept, as well as Advanced Trauma Life Support (ATLS)—which provide an evidence-based, systematic, and organized way of working to provide optimal care [7]. Patients arrive at the emergency room in different ways and at varying alarm levels [8]. For example, Trauma Level 1 means an alarm for the highest level of preparedness, with a full trauma team (e.g., specific healthcare professionals with various specializations) present. Each alarm has guidelines for patient assessment and treatment. There are also different guidelines for assessment, depending on the patient's symptoms and diagnosis, as well as the emergency room's organization. While national guidelines are evidence based and structured [9], many guidelines are locally developed and adapted. Locally developed guidelines are designed by and for the specific department and can range from a one-sheet of instructions to a multifaceted document. The locally developed guidelines are not always based on a systematic review of the existing evidence. In addition, these are not always developed by RNs even though they apply to the RN's work [10].

1.2. The ED nurse and guideline use

Patient assessment in the emergency room is unique as patients may present a variety of non-specific signs and symptoms, often without a prior medical diagnosis [11]. The emergency room is a challenging healthcare environment placing high demands on RNs' ability to prioritize their work and make correct decisions under time pressure, without compromising patient safety or quality of care [12]. Although lifesaving procedures are prioritized, they should be complemented by meeting the patients' personal and fundamental care needs [13]. A previous study in this context has shown that patients experience sufferings, such as pain, anxiety or worry, uncertainty, hunger or thirst, and mobility problems [14]. Therefore, providing fundamental care for patients in the emergency room is important to relieve their suffering and prevent both physical complications, such as pressure injuries from breathing masks and spine boards, and psychological complications, such as post-traumatic stress disorder [15].

Guidelines are used for managing clinical practice and governing RNs' work in an emergency room. However, Muntlin Athlin, Juhlin [10] indicate that while RNs are the target users, the guidelines focus mainly on tasks, with detailed descriptions of the medical treatment. Lam, Kwong [16] state that guidelines can be difficult to use in practice, due to inadequate organizational support. To evaluate the quality of guidelines, the AGREE II instrument has been developed, which has become an internationally accepted standard for evaluating the methodological quality of guidelines. The AGREE II instrument aims to assess the quality of guidelines, provide a methodological strategy for developing guidelines, and state which information and how information should be reported in guidelines. The AGREE instrument can be used on guidelines developed locally, regionally, and nationally [17,18]. In Sweden, there is no legal requirement for guidelines regarding the RN's work in emergency rooms. Nor is there a database where this type of guidelines is publicly available.

1.3. Person-centered fundamental care

Healthcare organizations' responsibility for ensuring updated guidelines and promoting a healthcare culture where patients are respected and cared for is a vital part of RNs' provision of optimal patient care. Person-centeredness is emphasized as a key component of good quality care and a core competency for all healthcare personnel, which entails a paradigm shift in the way that health services are funded, managed, and delivered [19]. However, previous research has shown that managers in emergency care do not perceive themselves as responsible for the guidelines but trust that those used are based on evidence of the best quality [20]. Healthcare organizations' role in improving the delivery of fundamental care and guiding RNs accordingly can be highlighted through the Fundamentals of Care framework [21]. This empirically developed yet theoretical framework can explain, guide, and potentially predict practice around person-centered fundamental care [22]. The framework constitutes three interrelated dimensions: establishing a caring relationship with the patient; assessing and delivering physical, relational, and psychosocial fundamentals of care; and delivering these elements in a broader care context. None of the dimensions can be excluded in order to achieve person-centered care that meets the patient's fundamental needs [21,23]. The dimension context of care encompassing both system and policy level factors, could either facilitate or impede the provision of high-quality fundamental care [21,22]. Contextual care conditions are considered key factors for delivering person-centered fundamental care, and a direct decisive factor entails the organizations' prioritization and creation of these conditions [21]. The Fundamentals of Care framework is shown in Fig. 1.

In sum, evidence-based guidelines aim to guide the RNs' patient assessments and interventions; however, recent research [24] has shown a lack of guidance for RNs in emergency rooms. It is unclear whether there are specific guidelines for the RNs' work in emergency rooms in Sweden and if so, what their content is – supporting that a national mapping of guidelines is needed. Therefore, this study aimed to map and describe Swedish guidelines governing the RNs' work in emergency rooms by asking the following research questions:

1. Are there guidelines governing the RNs' work in the emergency rooms?
2. What is outlined and in focus in the guidelines?
3. How is nursing performance described in the guidelines?
4. Do the guidelines include a person-centered perspective?

2. Methods

2.1. Study design

This study used a descriptive cross-sectional design, together with a thematic synthesis of the guidelines governing the RNs' work in Swedish emergency rooms.

2.2. Sample and setting

A total sample approach was used. The purpose of the sampling procedure was to obtain a national view of what governed the RNs' way of working in emergency rooms/with alarm patients, covering a wide geographic range. All hospital-based EDs for adults in Sweden, covering both university hospitals and county hospitals, were eligible for participation. County hospitals are smaller and have fewer specializations compared with university hospitals, but EDs are open on a 24/7 basis. University hospitals are responsible for particularly complicated or rare injuries and diagnoses, manage trauma patients to a broader extent than county hospitals do, and have teaching and research assignments. In total, 66 EDs, open around the clock and based in university hospitals (n = 7) and county hospitals (n = 59), were identified, and approached for inclusion.

2.3. Data collection and procedure

To identify and map the existence of any guidelines regarding the work of RN's in emergency rooms/with alarm patients, an e-mail describing the study was sent to the managers of each ED in Sweden (n = 66). The email inquired whether such guidelines were in place and, if so, requested their submission. Two reminders were sent at a four-week interval. Four weeks after the second reminder, those who had not

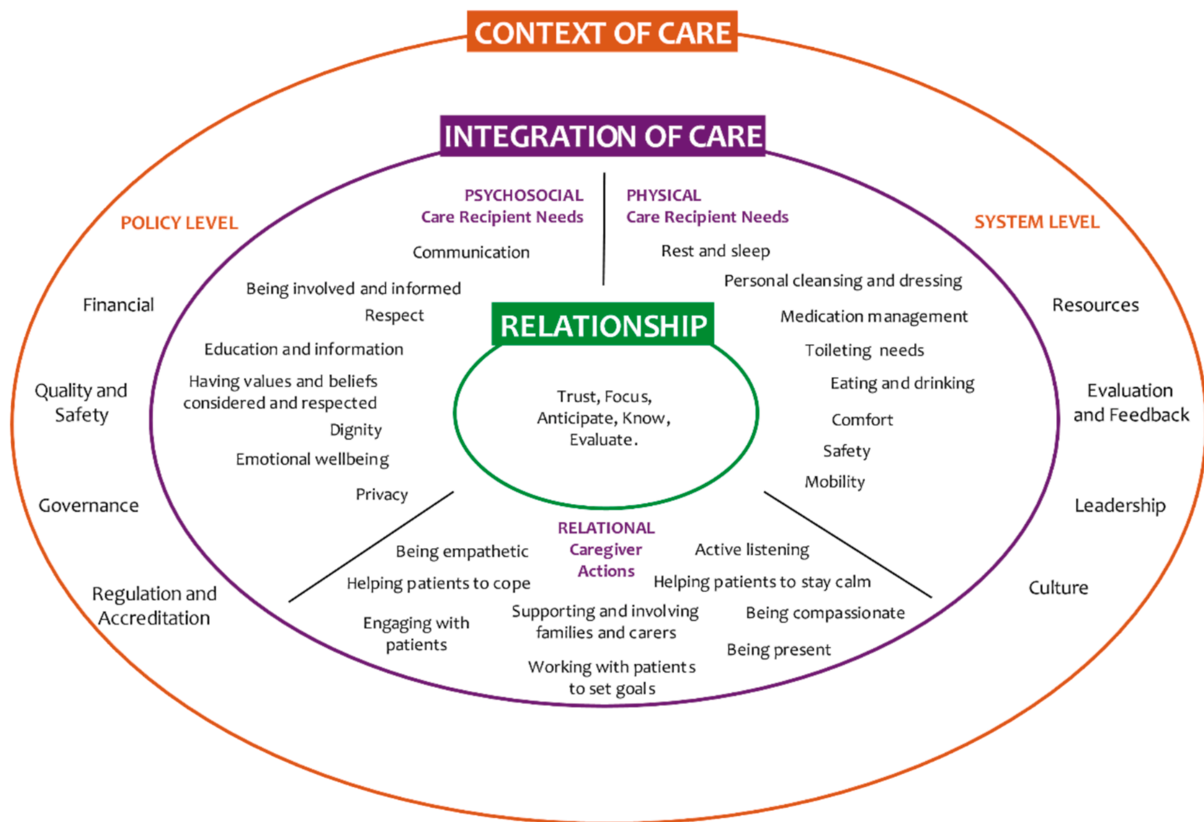

Fig. 1. The Fundamentals of Care framework (Source: Feo et al. (2018), reprinted with permission).

responded to the e-mail were contacted by telephone. In total 357 guidelines were received, the retrieved guidelines were manually reviewed. The criteria for inclusion and exclusion are specified in Table 1. The data were collected between January and May 2022.

The submitted guidelines ranged from national guidelines to locally developed department specific guidelines for RNs' work in emergency rooms/with alarm patients. The guidelines that did not concern the emergency room context (n = 73) and the RN perspective / performance (n = 73), as well as the guidelines regarding children (n = 21), were excluded. Thus, in total, 167 guidelines were excluded. The remaining guidelines (n = 190) were first sorted on an Excel spreadsheet, with information about the name of the hospital, the name of the ED, the name of the guidelines, the author, and brief content of the guidelines, and then reviewed in two steps. The guidelines were first read independently by the first author (VP) and subsequently re-read and discussed by (VP) and (ÅM) until a consensus was reached. The included guidelines were then sorted on a new Excel spreadsheet with information about whether they were RN specific, team specific, alarm focused, diagnosis focused, and national or locally adapted. They were also marked with an asterisk if they in any way described nursing care and/or had a person-centered perspective in the text, considering the research objectives. The inclusion process is presented in a flow chart (Fig. 2).

The guidelines varied considerably in form and content. Therefore, to follow a validated structure, the guidelines were reviewed and described using a modified version of the AGREE II instrument [18]. This instrument consists of 23 items, organized under 6 domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence [18]. The items in the instrument's quality categories were answered with yes or no (whether an item was present or not in the guidelines), instead of the rating scale of 1–7. The quality of the guidelines was first reviewed independently by VP and ÅM and subsequently together by VP and ÅM.

Table 1
Criteria of inclusion and exclusion.

Criteria of inclusion	Clarification
Guidelines regarding the RN's way of working in the emergency room / with alarm patients	
Criteria of exclusion	**Clarification**
Guideline is not relevant for the emergency room context	Excluded guidelines concern prehospital care, intensive care, anesthesia care
Guideline does not concern the nursing performance in the emergency room	Excluded guidelines concern documents referring to another document, telephone lists, competency descriptions
Guideline is not relevant for the RN in the emergency room	Excluded guidelines concern the work of the physician, the work of the assistant nurse, the ambulance nurse
Guidelines regarding children	Excluded guidelines concern children, only hospital based ED's for adults were asked

2.4. Data analysis

The data were analyzed with descriptive statistics—using frequencies and percentages for nominal-level data. A thematic synthesis according to Thomas and Harden [25] was used to analyze the qualitative data. In the guidelines, each unit of the qualitative data ranged from a few words to a couple of sentences. All guidelines were carefully read; based on the research questions, any text that in some way described the RNs' work in the emergency room/with alarm patients and/or included a person-centered perspective was marked and extracted. The extracted texts were sorted on an Excel spreadsheet and coded inductively according to each one's meaning and content. Similarities and differences among the codes were searched to start grouping them into descriptive themes; subsequently, analytic themes were generated.

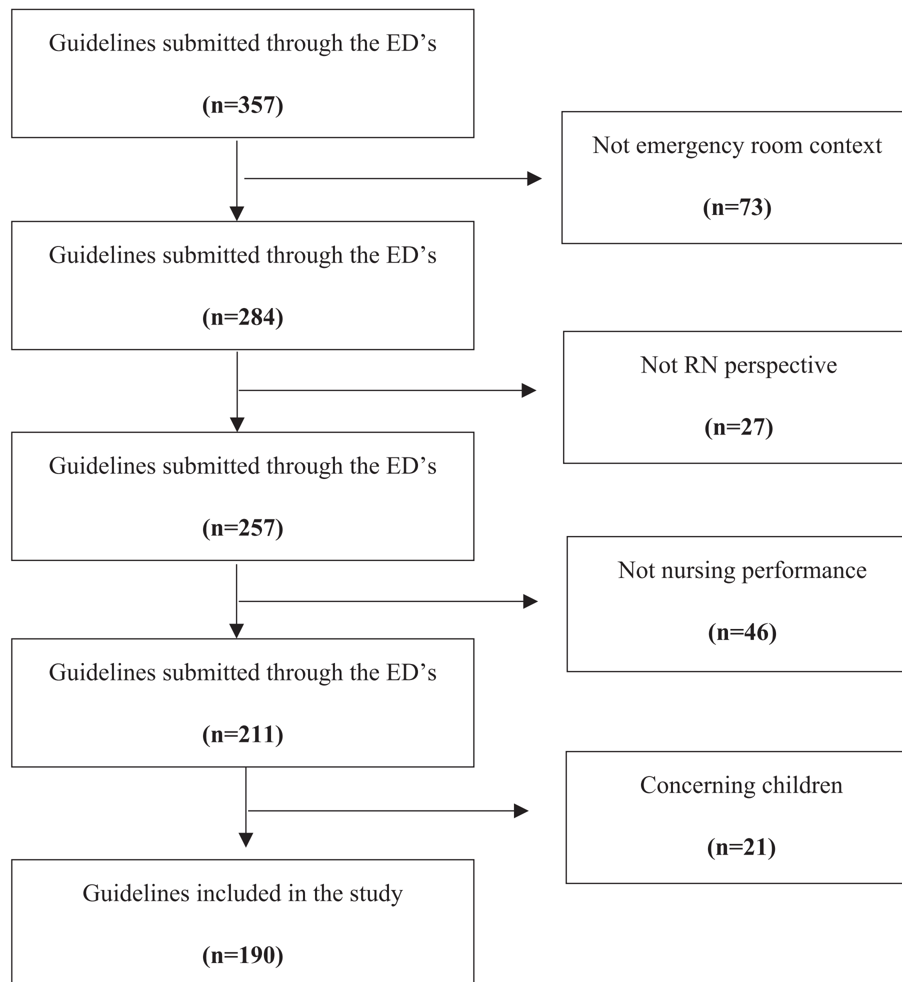

Fig. 2. Flow chart of the inclusion process of guidelines.

2.5. Ethical considerations

Ethical guidelines were followed [26]. According to Swedish regulations, as no personal information or sensitive details about human beings were collected during this study, no ethical approval by a committee or a governmental authority was necessary [27]. An ethical approach was adopted to ensure that no material was fabricated, falsified, and plagiarized. Information about the study was provided to all ED managers in Sweden. Informed consent on providing relevant guidelines for patient care in the emergency room was obtained from each ED manager.

3. Results

All (n = 66) EDs responded to the e-mail or the phone call. In total, 61 % (n = 40) agreed to participate; of these, 93 % (n = 37: university hospitals [n = 4] and county hospitals [n = 33]) sent guidelines. Despite reminders, three EDs who indicated the existence of guidelines did not provide them. The remaining 39 % (n = 26) of the EDs responded but declined to participate, citing their heavy workload. The results obtained from the 190 included guidelines collected from the 37 participating EDs are presented below.

3.1. Outline and focus of guidelines

The analysis showed that the guidelines governing the RNs' work in emergency rooms varied in design and content within and among different emergency rooms. The RNs were clearly reported as the target users in 15 % (n = 29) of the guidelines. In 13 % (n = 25) of the guidelines, each one's development group did not clearly state whether an RN had been involved. None of the guidelines specifically described their target population but referred to the diagnoses/conditions of the patients. In total, 84 % of the guidelines were dated (n = 160); however, 7 % (n = 13) had expired. In 17 % (n = 32) of the guidelines there was an explicit link between recommendations and supporting evidence (see Table 2). The guidelines had various names (e.g., routine, guideline, care program, protocol, checklist, instruction). Most of the guidelines were locally adapted (85 %, n = 165) and focused on processed-focused alarms (53 %, n = 101). The included guidelines ranged from a one-sided sheet, describing who should stand where in relation to the patient in the event of an alarm, to a 107-page document containing the entire trauma procedure for all categories of healthcare professions. Some national guidelines fulfilled the criteria for inclusion in this study. However, no hospital submitted any national guidelines separately, but some were included in a compendium or a manual. A vast number of the guidelines consisted of bullet lists, which made them clear to read; however, the guidelines did not follow a uniform structure, even in the same emergency room (see Table 3).

3.2. Thematic synthesis of provided guidelines

As for the description of nursing performance, the thematic synthesis resulted in three themes, which are presented in the following subsections. Examples from the three themes: Instrumental work,

Table 2
Guidelines appraised with the AGREE II domains and items.

Domain 1 Scope and purpose	Domains and items present, in % **Yes (%)**	**No (%)**
- Overall objective specifically described	32 %	68 %
- The health question covered by the guideline specifically described	76 %	24 %
- The population to whom the guideline is meant to apply is specifically described	0 %	100 %
Domain 2 Stakeholder Involvement		
- The guideline development group includes individuals from all the relevant professional groups	87 %	13 %
- The views and preferences of the target population have been sought	0 %	100 %
- The target users of the guideline are clearly defined	15 %	85 %
Domain 3 Rigour of Development		
- Systematic methods were used to search for evidence	0 %	100 %
- The criteria for selecting the evidence are clearly described	0 %	100 %
- The strengths and limitations of the body of evidence are clearly described	0 %	100 %
- The methods for formulating the recommendations are clearly described	0 %	100 %
- The health benefits, side effects, and risks have been considered in formulating the recommendations	0 %	100 %
- The guideline has been externally reviewed by experts prior to its publication	0 %	100 %
- There is an explicit link between the recommendations and the supporting evidence	17 %	83 %
- A procedure for updating the guideline is provided	6 %	94 %
Domain 4 Clarity of presentation		
- The recommendations are specific and unambiguous	42 %	58 %
- The different options for management of the condition or health issue are clearly presented	12 %	88 %
- Key recommendations are easily identifiable	64 %	36 %
Domain 5 Applicability		
- The guideline describes facilitators and barriers to its application	0 %	100 %
- The guideline provides advice and/or tools on how the recommendations can be put into practice	0 %	100 %
- The potential resource implications of applying the recommendations have been considered	0 %	100 %
- The guideline presents monitoring and/ or auditing criteria	33 %	67 %
Domain 6 Editorial Independence		
- The views of the funding body have not influenced the content of the guideline	0 %	100 %
- Competing interests of guideline development group members have been recorded and addressed	0 %	100 %

Table 3
Types of guidelines regarding RN's work in the emergency room.

	Included guidelines in total, n = 190 (%)	**University hospital, included guidelines in total, n = 17 (%)**	**County hospital, included guidelines in total, n = 173 (%)**
National guidelines	–	–	–
Local guidelines	162 (85 %)	13 (76 %)	149 (86 %)
Combination of national and local guidelines	28 (15 %)	4 (24 %)	24 (14 %)
Process-focused alarm guidelines	**101 (53 %)**	**12 (70 %)**	**89 (51 %)**
- *Acute alarm*	17	3	14
- *Alarm (not specified)*	17	1	16
- *Sepsis alarm*	11	2	9
- *Stroke alarm*	13	1	12
- *Surgery alarm*	1	–	1
- *Trauma alarm*	42	5	37
Diagnose-focused guidelines	**38 (20 %)**	**2 (12 %)**	**36 (21 %)**
- *Acute abdominal pain*	1	–	1
- *Acute asthma*	1	–	1
- *Acute caesarean section*	1	1	–
- *Amputation injuries*	3	–	3
- *Angio edema*	2	–	2
- *Anaphylaxis*	6	–	6
- *Burn*	2	–	2
- *Chemical accident*	1	–	1
- *Chest pain / infarction*	4	1	3
- *Diving accident*	1	–	1
- *Gastrointestinal bleeding*	2	–	2
- *Hanging*	1	–	1
- *Hypoglycemia / Ketoacidosis*	2	–	2
- *Intoxication*	2	–	2
- *Meningitis*	1	–	1
- *Pulmonary edema*	1	–	1
- *Sepsis*	1	–	1
- *Snake bite*	1	–	1
- *Spleen injuries*	1	–	1
- *Status epilepticus*	1	–	1
- *Stroke*	3	–	3
Medical-technical focused guidelines	**51 (27 %)**	**3 (18 %)**	**48 (28 %)**
- *Medical technical guidelines*	18	1	17
- *Medication management*	3	–	3
- *Room maintenance guidelines*	9	–	9
- *Work instructions (not alarm/diagnose focused)*	21	2	19

Organizational work and Work without the patient's perspective are provided in relation to the types of guidelines regarding the RN's work in the emergency room and cited in Table 4.

3.2.1. Instrumental work

In the guidelines, nursing performance was described as instrumental and task oriented. The guidelines regarding assessment and treatment were based on the initial care of the patient; in the emergency room (according to the guidelines), this was a medical assessment based on the ABCDE concept, without further guidance on how the RN should care for the patient after the initial assessment. In the emergency room guidelines, nursing performance was presented as a bullet list of tasks to be ticked/checked off. The bullet lists contained a wide range of points, often related to specific interventions to be done (e.g., insert peripheral catheter, assist the physician) rather than an assessment of the patient. The lists clearly stated what the RNs were supposed to do, but not how tasks should be done in patient assessment and treatment.

The guidelines regarding medical-technical equipment and procedures were presented as a bullet list of steps to be followed, supplemented with clarifying pictures. These guidelines did not state in which part RNs were responsible, as they referred to both RNs and physicians. The guidelines for medication management presented dosages, the storage location, and which pharmaceuticals the RNs were allowed to administer without a prescription and for which conditions. Nursing performance involved strategies for the use of analgesics and sedatives, as well as documentation procedures in connection with medication management.

3.2.2. Organizational work

A number of guidelines regarding nursing performance had an organizational perspective. These were provided on an overall level and were not specifically aimed at the direct assessment and care of patients. These guidelines were commonly named 'work instructions,' and nursing performance was described as a set of responsibilities for patient flow, patient caseload and workload, and personnel resources, not

Table 4
Exemplification of themes in relation to the different types of guidelines.

Type of guideline	Description
Process-focused alarm guideline *Trauma alarm*	The RN on Trauma alarm should: prepare the emergency room make sure that the right personnel are in the right place unlock lockers ensure adequate protective clothing for the team assist physician in A-E assessment peripheral venous catheter and blood sampling medication administration documentation ID marking intravenous fluids assist the assistant nurse undress the patient prepare for transportif necessary, accompany the patient to the ward / ICU /OR / X-rayrestore the emergency room
Diagnose-focused guidelines *Chest pain / infarction*	The RN performs the following: patients with chest pain have the highest priority the patient is immediately admitted to an emergency room and a physician is called oxygen on nasal cannula if saturation below 90%, ECG, blood pressure, pulse, respiratory rate, peripheral venous catheter, blood samplingconnect to monitoring with 12 electrodes
Medical-technical focused guidelines *Work instructions (not alarm/diagnose focused)*	When working as RN in the emergency room: having a coordinating role being responsible for patient-flowbeing responsible for personnel resourceshandle different situations as they occur

directed to a specific alarm or diagnosis. The guidelines stated that RNs should assess and handle patients with life-threatening illnesses and in need of immediate care by performing a coordinating role. None of the guidelines defined nursing care.

3.2.3. *Work without the patient's perspective*

A few guidelines stated that care should be person-centered, but this was not elaborated in the text. The patient was commonly referred to by this generic term instead of being personalized, for example, *'ID-mark wrist'* (guideline III from hospital IV). When the patient was made more visible, this can be exemplified by this statement: *'Introduce yourself to the patient, not only by name but also by role'* (guideline XI from hospital VI). It was more common for the patients' physical needs to be addressed rather than their relational and psychosocial needs, which were, in fact, not mentioned. The guidelines for how to care for patients' relatives in case of a traumatic event and/or unexpected death focused on relational and psychosocial aspects.

4. Discussion

This study provides a national view of what guides the RNs' work in emergency rooms and what is missing, showing that although there are plenty of documents, they rarely refer specifically to the role of the RN and overall, reflect an instrumental and task-oriented approach to care that lack a patients- perspective.

4.1. *Outline and focus of guidelines*

The guidelines governing Swedish emergency rooms lack quality, as defined in the AGREE II instrument [18], because these guidelines, among others, are unclear about the evidence on which they are based, their target population, and the available options for the management of an existing condition or health issue. The submitted guidelines had various names (e.g., routine, guideline, care program, protocol, checklist, instruction). In line with recent research findings [4], the guidelines that lack quality, are ambiguous, or do not address what they are intended for may force RNs to conduct assessments or interventions based on their personal judgment of prerequisites. An interview study [24] on the RNs' prerequisites and work approach to meeting fundamental care needs in emergency rooms shows that RNs structure their work approach based on prevailing organizational prerequisites, as well as personal judgment of prerequisites. The understanding of evidence-based work has been shown to vary widely among RNs [28]. This poses the risk that patients might not receive equal care on equal terms.

4.2. *Organizational work*

Notably, the initial care for patients in life-threatening conditions in the emergency room is structured and systematic through the ABCDE concept and ATLS [7], this present study finds a lack of structure and clarity regarding fundamental care. The guidelines have no consensus on how (or even on the fact that) patients' fundamental care needs should be met in the emergency room or what RNs' roles and responsibilities are in the emergency room. This might be explained by the fact that the RNs are clearly stated as the target users in only 15 % of the guidelines and that 13 % of the guidelines explicitly mention that RNs are included in the development group. It is puzzling that RNs are not involved in developing the guidelines for the work they perform and are responsible for. Kitson [22] states that the organizational structure plays a crucial part in either helping or hindering the delivery of person-centered fundamental care, and the direct decisive factor is that there is an organization that prioritizes and creates the conditions. In the Fundamentals of Care framework, the context of care should be perceived in terms of the prerequisites and resources needed to ensure safe and high-quality fundamental care [21]. The theoretical perspective of person-centered care describes the importance of the whole healthcare organization striving for such an approach [29]. Previous research has shown that leadership and organizational culture are factors creating barriers to RNs' use of guidelines [30]. The guidelines that are not structured make them difficult to use, which in turn can contribute to the RNs using their personal judgment of prerequisites instead. Therefore, RNs' involvement in developing guidelines is vital.

4.3. *Instrumental work*

The current study shows that the guidelines governing Swedish emergency rooms do not support RNs in making comprehensive patient assessments, and it is evident that the guidelines have not been developed with the entire care process in focus. This is in line with Falchenberg, Andersson [31], showing that guidelines for medical emergency services focus on medical assessments, excluding the patients' psychosocial and relational needs. Furthermore, a study on guidelines for the treatment and care of frail elderly people in EDs indicates that such guidelines focus on physical needs, and no nursing actions related to relational needs are addressed [32]. The present study's results further show that the guidelines consist of bullet lists of single words, without further guidance for conducting appropriate interventions. This presupposes a certain pre-understanding of RNs so that the guidelines neither become difficult to interpret nor subjective. As the 'how' is not mentioned in the guidelines, it might be concluded that RNs are expected to know the procedures. When guidelines focus primarily on checking off specific tasks and meeting physical needs, there is a risk of overlooking the multidimensional needs of patients with life-threatening conditions. An instrumental, task-oriented approach is known to increase the risk of neglecting fundamental care in cases of acute care [33], and to challenge the person-centered approach [29]. In emergency care, it is common to focus on medical interventions and physical needs [10,34]. However, not having their personal needs met can have consequences for patients, not only physical ones but also psychological ones, such as feeling abandoned and objectified [15,34]. To make it easier for RNs to meet patients' needs in emergency rooms, the Fundamentals of Care framework [21] might be used as a guide when developing guidelines to care for patients in a person-centered

way, even in life-threatening situations. Together with using the AGREE II tool, the systematic work and the structure around it, with guidelines governing emergency rooms, could be improved [18].

4.4. Work without the patient's perspective

The guidelines included in the present study fail to address the patients and instead refer to the diagnoses/conditions from which the patients suffer. The results are supported by those of studies on guidelines regarding comprehensive patient assessment in emergency care [31] and guidelines regarding the management of patients with acute abdominal pain across the acute care delivery chain [10], showing a lack of the patient's perspective. Without a holistic perspective in the guidelines, patient care risks not being personalized; on the contrary, the patient becomes a name or a condition to be removed from a list as quickly as possible. Nevertheless, it is noteworthy that the guidelines aiming at meeting relatives of patients in the emergency room have been written from a holistic perspective rather than with an instrumental approach.

Another notable result is the university hospitals' lack of RN-specific guidelines. University hospitals focus more on complex medical diseases and conditions, while nursing care is less prioritized. Guidelines have the potential for guiding clinical practice and governing RNs' work to ensure the quality of care and patient safety [1,2]. However, according to how the guidelines in the present study have been developed and designed, it can be assumed that the healthcare organization does not adequately address nursing care and the nursing profession in the emergency room. When organizations do not prioritize nursing, neither will RNs. When managers provide sufficient resources to enable holistic, person-centered nursing work, it might become more evidence based [23].

5. Limitations and strengths

As some submitted guidelines were not about the emergency room/alarm patients and therefore had to be excluded from the screening process, the authors might not have specifically stated the inclusion criteria when requesting for the guidelines. The research team's pre-understanding of the emergency room context might have contributed to their ability to sort out the guidelines when many were unclear. Thus, more guidelines could have been included if there was no pre-understanding of the context. Another limitation of the study might be the assessment of the included guidelines based on the AGREE II items with yes/no choices (whether an item was present or not in the guidelines), instead of the 1–7 rating.

The strengths of this study are its coverage of both university and county hospitals and the included EDs' wide geographic range. Another strength might be that this study exposed some important gaps within aspects of guidelines, and lack of evidence-based practice, in Sweden.

6. Conclusions

This national mapping and description of guidelines identifies the RNs' work in Swedish emergency rooms as guided by an instrumental and task-oriented approach to care. There is a lack of guidance in providing for patients' fundamental care needs, and the focus is on the initial assessment. The patient's perspective is missing, and the guidelines governing Swedish emergency rooms do not support the RNs in conducting holistic, comprehensive patient assessments and interventions. Guidelines have poor quality. There is a need for improvements in guidelines before the RNs can assess and treat patients with life-threatening illnesses and fulfill their fundamental care needs in an equal, evidence-based, and person-centered way. Giving RNs an active role in the development of the guidelines governing their work might be one way to achieve this goal. In addition, all guidelines should be evidence based.

Ethical statement

Mälardalen University approved this study. According to Swedish regulations, as no personal information or sensitive details about human beings were collected during this study, no ethical approval by a committee or a governmental authority was necessary.

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CRediT authorship contribution statement

Veronica Pavedahl: Writing – review & editing, Writing – original draft, Visualization, Validation, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Inger K Holmström:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Martina Summer Meranius:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Ulrica von Thiele Schwarz:** Writing – review & editing, Validation, Supervision, Methodology, Formal analysis, Data curation, Conceptualization. **Åsa Muntlin:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Project administration, Methodology, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ienj.2024.101536.

References

[1] Lehane E, Leahy-Warren P, O'Riordan C, Savage E, Drennan J, O'Tuathaigh C, et al. Evidence-based practice education for healthcare professions: An expert view. Evid Based Med 2019;24(3):103–8.

[2] Beauchemin M, Cohn E, Shelton RC. Implementation of clinical practice guidelines in the health care setting: A concept analysis. Adv Nurs Sci 2019;42(4):307–24.

[3] Woolf S, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: Potential benefits, limitations, and harms of clinical guidelines. Br Med J 1999;318(7182):527–30.

[4] Tegelberg A, Muntlin Å, Juhlin C, Jangland E. Engagement under difficult conditions: Caring for patients with acute abdominal pain across the acute-care chain: A qualitative study. Int Emerg Nurs 2020;52:1–7.

[5] Guerra-Farfan E, Garcia-Sanchez Y, Jornet-Gibert M, Nuñez JH, Balaguer-Castro M, Madden K. Clinical practice guidelines: The good, the bad, and the ugly. Injury 2022.

[6] Murad MH. Clinical practice guidelines: A primer on development and dissemination. Mayo Clin Proc 2017;92(3):423–33.

[7] American College of Surgeons. Advanced trauma life support: student course manual. 10 ed. Chicago, IL: American College of Surgeons; 2018.

[8] Henricson J, Ekelund U, Hartman J, Ziegler B, Kurland L, Björk WD. Pathways to the emergency department - A national, cross-sectional study in Sweden. BMC Emerg Med 2022;22(1):1–9.

[9] National Board of Health and Welfare. National guidelines: What are they? 2015 [Available from: Retrieved 2021 Nov 3rd, from https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/nationella-riktlinjer/2015-6-6.pdf.
[10] Muntlin Athlin Å, Juhlin C, Jangland E. Lack of existing guidelines for a large group of patients in Sweden: A national survey across the acute surgical care delivery chain. J Eval Clin Pract 2017;23(1):89–95.
[11] Sweet V, Foley A. Sheehy's emergency nursing: principles and practice. St. Louis, MO: Elsevier; 2020.
[12] Kuster T, Nickel CH, Jenny MA, Blaschke LL, Bingisser R. Combinations of symptoms in emergency presentations: Prevalence and outcome. J Clin Med 2019; 8(3):1–10.
[13] Feo R, Kitson A. Promoting patient-centred fundamental care in acute healthcare systems. Int J Nurs Stud 2016;57:1–11.
[14] Body R, Foex B, Kaide E, Kendal S. Not all suffering is pain: Sources of patients' suffering in the emergency department call for improvements in communication from practitioners. Emerg Med J 2015;32(1):15–20.
[15] Joseph NM, Benedick A, Flanagan CD, Breslin MA, Simpson M, Ragone C, et al. Prevalence of posttraumatic stress disorder in acute trauma patients. OTA Int 2020; 3(1). Article e056.
[16] Lam SKK, Kwong EWY, Hung MSY, Pang SMC. Bridging the gap between guidelines and practice in the management of emerging infectious diseases: A qualitative study of emergency nurses. J Clin Nurs 2016;25(19–20):2895–905.
[17] Brouwers MC, Kerkvliet K, Spithoff K, Consortium ANS. The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. 2016.
[18] AGREE NSC. The AGREE II Instrument [Electronic version]2017. Available from: http://www.agreetrust.org Accessed 14 March, 2023.
[19] World Health Organization. People-centred health care: A policy framework. WHO Regional Office for the Western Pacific; 2007.
[20] Tegelberg A, Jangland E, Juhlin C, Muntlin AÅ. Who is in charge of the care of patients with acute abdominal pain? An interview study with managers across the acute care chain. J Clin Nurs 2019;28(19/20):3641–50.
[21] Feo R, Conroy T, Jangland E, Muntlin Athlin Å, Brovall M, Parr J, et al. Towards a standardised definition for fundamental care: A modified Delphi study. J Clin Nurs 2018;27(11–12):2285–99.
[22] Kitson A. The fundamentals of care framework as a point-of-care nursing theory. Nurs Res 2018;67(2):99–107.
[23] Kitson A, Conroy T, Kuluski K, Locock L, Lyons R. Reclaiming and redefining the fundamentals of care: Nursing's response to meeting patients' basic human needs. Adelaide, South Australia: School of Nursing, the University of Adelaide; 2013.
[24] Pavedahl V, Muntlin Å, Summer Meranius M, von Thiele SU, Holmström IK. Prioritizing and meeting life-threateningly ill patients' fundamental care needs in the emergency room-An interview study with registered nurses. J Adv Nurs 2022; 00:1–10.
[25] Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Method 2008;8:1–10.
[26] World Medical Association. World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects 2013 [Available from: Retrieved 2020 March 23rd, from https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/.
[27] SFS. Lag om etikprövning av forskning som avser människor [Act on Ethical Review of Research InvolvingHumans]: Socialdepartementet; 2003:460 [Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2003460-om-etikprovning-av-forskning-som_sfs-2003-460 2022, February 23.
[28] Karlsson A, Lindeborg P, Gunningberg L, Jangland E. Evidence-based nursing-How is it understood by bedside nurses? A phenomenographic study in surgical settings. J Nurs Manag 2019;27(6):1216–23.
[29] McCormack B, McCance T. Person-centred practice in nursing and health care: Theory and practice. Chichester: Wiley Blackwell; 2017.
[30] Jun J, Kovner CT, Stimpfel AW. Barriers and facilitators of nurses' use of clinical practice guidelines: An integrative review. Int J Nurs Stud 2016;60:54–68.
[31] Falchenberg Å, Andersson U, Wireklint Sundström B, Bremer A, Andersson H. Clinical practice guidelines for comprehensive patient assessment in emergency care: A quality evaluation study. Nordic J Nurs Res 2021;41(4):207–15.
[32] Ekermo D, Ronnås M, Muntlin Å. Fundamental nursing actions for frail older people in the emergency department: A national cross-sectional survey and a qualitative analysis of practice guidelines. J Adv Nurs 2023:1–12.
[33] van Belle E, Giesen J, Conroy T, Mierlo M, Vermeulen H, Huisman-de Waal G, et al. Exploring person-centred fundamental nursing care in hospital wards: A multi-site ethnography. J Clin Nurs 2020;29(11/12):1933–44.
[34] Svensson C, Bremer A, Holmberg M. Ambulance nurses' experiences of patient relationships in urgent and emergency situations: A qualitative exploration. Clin Ethics 2019;14(2):70–9.