# NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

## NIHS Program Requirements for Specialty Education in Emergency Nursing

*The Emirati Board in Emergency Nursing Residency Program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.*

*Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophical statements are not program requirements and are therefore not citable.*

**Issue Date: 22/09/2025**
**Draft Version 1**

## Table of Contents

## Introduction

### Int. A. Preamble

The UAE National Strategy for Nursing/Midwifery: A Roadmap 2026 focuses on human capital development highlighting the need to drive excellence in nursing/midwifery practice. One of the initiatives to achieve this is developing and implementing nursing/midwifery specialist programs.

Residency is defined as the stage of postgraduate training and education leading to a qualification of independent practice in a core specialty (NHIS 2020:4). Essentially the purpose of the residency program is to equip nurses and midwives with the knowledge, attitude, and skills essential for specialist practice (Raman et al., 2019).

The clinical competence of nurses plays a significant role in the quality of nursing care provision and patient outcomes and the clinical competence of nurses and midwives is inextricably linked to the foundational knowledge of the specialist area which is continuously strengthened through lifelong learning by practitioners.

### Int. B. Goals

The Goal of this program is to raise the quality of care through expanded knowledge and clinical expertise of registered emergency nurses.

The program's objectives are to develop and strengthen:

- Comprehensive knowledge, professional attitude, and clinical proficiency in systematic assessment, evidence-based care delivery, and accurate documentation for adult patients in emergency settings, functioning as autonomous and accountable practitioners.
- Critical thinking skills using health systems approach in problem-solving and make complex decisions in emergency contexts.
- Lead in the design, implementation, and evaluation of quality improvement processes in emergency units.
- Leadership of registered nurses as best practice and management role models in the delivery of care to patients in emergency units.
- Influencing the delivery of emergency nursing through engagement in policy development at an institutional, national, or international level.
- Development and implementation of teaching and learning strategies for own and staff development that can be implemented to support and enhance the field of emergency medicine/nursing.

### Int. C. Definition of Specialty

Emergency nursing science is a well-defined base of knowledge within the overall discipline of nursing. This program prepares nurses with specialist knowledge and skills

to address the emergency nursing needs of patients and support their families.

### Int. D. Length of educational program

The training of Emergency Nursing Residency program must be continuous for a minimum of 24 months in total. (Core)

## I. Oversight

### I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate nursing education, consistent with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.A.2. At least one site must be assigned for training to assume responsibility for the emergency nursing residency program. (Core)

I.A.3. Full training contract, the need for the program and pledged support must be available. (Core)

I.A.4. Timely and effective internal relationships with all program teams and stakeholders must be evidenced by documentation of meetings and protocols for communication. (Core)

### I.B. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

I.B.4. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

**I.C. Resources**

I.C.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education including lecture rooms, skills lab, recreation, and gender-sensitive amenities. (Core)

I.C.1.a) The program shall demonstrate the availability of educational resources, including the presence of medical or nursing residents in other specialties, to enhance the training of the emergency nursing residents. (Detail)

I.C.1.b) At every site in which the emergency department provides resident nursing education, the following must be provided: (Core)

I.C.1.b)(1) adequate space for patient care; (Core)

I.C.1.b)(2) space for clinical support services; (Core)

I.C.1.b)(3) diagnostic imaging completed and results

available on a timely basis, especially those required on a STAT basis; (Core)

I.C.1.b)(4) laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)

I.C.1.b)(5) instructional space; (Core)

I.C.1.b)(6) information systems; (Core)

I.C.1.b)(7) appropriate security services and systems to ensure a safe working environment. (Core)

I.C.1.c) Clinical support services must include medical, nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis. (Core)

I.C.1.d) Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)

I.C.1.d)(1) If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)

I.C.1.d)(2) Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)

I.C.1.e) The patient population must include patients of all ages and genders as well as patients with a wide variety of clinical problems. (Core)

I.C.1.f) The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)

I.C.1.f)(1) The primary clinical site should have a significant number of critically-ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)

I.C.1.g) Residents must be provided with prompt, reliable systems for communication and interaction with supervisory nurses or

physicians. (Core)

I.C.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.C.2.a) access to food while on duty; (Core)

I.C.2.b) security and safety measures appropriate to the participating site. (Core)

I.C.3. Residents must have ready access to emergency nursing and other appropriate reference material in print or electronic format. This must include: (Core)

I.C.3.a) access to electronic medical literature databases with full text capabilities. (Core)

I.C.3.b) access to institutional emergency medical/nursing resources and other relevant electronic databases. (Core)

I.C.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

I.C.4.a) A sufficient population of patients with a variety of demographic, socioeconomic backgrounds, and disease patterns to allow for effective and comprehensive training experiences. (Core)

I.C.4.b) Residents must be provided with software resources, training and technical support for research, scholarly activities and presentations or manuscripts and other written assignments. (Core)

I.C.5. The program must provide a positive learning environment in a flexible, compassionate culture promoting teamwork and interdisciplinary and interprofessional learning environment. (Core)

**I.D. Other Learners and Other Care Providers**

The presence of other learners and other care providers, including, but not limited to, interns, residents from other programs (including medical) must enrich the appointed residents' education. (Core)

I.D.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). (Core)

## II. Personnel

### II.A. Program Director

II.A.1. There must be one faculty member appointed as program director for the emergency nursing program with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

II.A.1.c) The Program Director position shall be assumed for a minimum of 3 years to ensure continuity. (Core)

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core)

II.A.2.a) Additionally, the program director must be provided with:

II.A.2.a)(1) Workspace, equipment and technology, administration support, resources. (Core)

II.A.2.a)(2) A stated clear job description defining expectations and accountability and reporting structure. (Core)

II.A.2.a)(3) An associate program director to support the management of the residency program. (Core)

II.A.3. Qualifications of the program director:

II.A.3.a) must include knowledge and/or experience in adult learning principles and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

II.A.3.b) must be licensed as an Emergency Nurse specialist and at least 3 years current continuous experience in the emergency department (Core)

II.A.3.c) must include appropriate staff appointment; (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; (Core)

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Competency domains; (Core)

II.A.4.a)(4) develop and oversee a process to evaluate preceptors prior to approval as program faculty members for participation in the residency program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which residents can raise concerns and provide feedback in a confidential manner as appropriate, without fear of

intimidation or retaliation; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend, dismiss, not to promote, or not renew the appointment of a resident; (Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(12) document verification of program completion for all graduating residents; within 30 days; (Core)

II.A.4.a)(13) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Program Requirements. (Core)

II.A.4.a)(14) ensure implementation of procedures for training faculty and administrative staff and address concerns timely and fairly. (Core)

II.A.5. Associate Program Director (APD):

II.A.5.a) The sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities. (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration. (Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.A.5.d) APD must be licensed as an Emergency Nurse Specialist and have knowledge and/or experience in adult learning principles. (Core)

**II.B. Faculty/Resident Facilitators**

Faculty or Resident facilitators provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations by demonstrating compassion, commitment to excellence in teaching and patient care,

professionalism, and a dedication to lifelong learning. By employing a scholarly approach to patient care, faculty members, through the education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

II.B.1. At each participating site, there must be enough faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.1.b) The ratio of faculty to residents must be a minimum of 1:1. (Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

II.B.2.g) At least one member of the faculty should support resident scholarly activities. (Core)

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must be licensed as emergency nurse specialists who hold a recognized postgraduate qualification or certification in emergency nursing (e.g., MSc in emergency nursing or board certification in emergency nursing). (Core)

II.B.3.b) Emergency nurses with at least three years of current experience in emergency setting, must be licensed as registered nurse to practice and hold an appropriate institutional appointment. They must also have prior experience in adult learning principles. (Core)

II.B.3.c) Emergency physicians or other members of the emergency interprofessional team may act as faculty ensuring they have the proper qualifications and clinical experience to support the attainment of the program goals. (Core)

II.B.3.d) Administrative staff must have qualifications and experience suitable for their roles. (Core)

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

II.B.4.a) Core faculty must be designated by the program director. (Core)

II.B.4.b) Core faculty must have minimum of 3 years of experience in emergency department and must be currently practicing in this field, must be licensed as Emergency Nurse Specialist. (Core)

II.B.4.c) Core faculty must complete the annual NIHS Faculty Survey. (Core)

II.B.4.d) Core faculty-to-resident ratio must be 1:4. (Core)

### II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

## III. Resident Appointments

### III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an NIHS-accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.b) Registered nurses who have completed their undergraduate program and transition to practice residency program; preferred one including exposure to emergency setting (Core)

III.A.1.c) RN with BSN and at least one year of full-time clinical experience and a current license to practice. (Core)

### III.B. Number of Residents

III.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.B.4. There must be a minimum of 4 residents registered in each year. (Core)

## IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in nursing education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful nurses who provide compassionate care.

### IV.A. Curriculum Components

The curriculum must include didactic sessions including ward rounds, clinical meetings, case presentations, morbidity and mortality reviews, journal clubs and evidence reviews, multidisciplinary meetings, workshops, videos, demonstrations, simulation, reflective and interactive activities. (Core)

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.2. There must be structured extensive clinical experience (with the curriculum contributing to the overall goal of the program) incorporating exposure to acute emergency settings. (Core)

IV.A.3. Overall educational goals for the program must exist and be communicated to residents and faculty. (Core)

IV.A.4. Competency-based goals and objectives for each educational experience are designed to promote progress on a trajectory to autonomous practice and must be available for assignments at each level. (Core)

IV.A.5. Residents must be provided with increasing responsibility in patient care and management, supervision, and administration according to the training stage. (Core)

IV.A.6. Residents must be equipped with essential research principles and competencies and residents and faculty must participate in research and scholarly activities. (Core)

> IV.A.6.a) There must be structured clinical experience with the curriculum contributing to the overall goal of the program providing learning opportunities in medical, surgical, and sub-specialty emergency units. (Core)

IV.A.7. Diversity of training experiences for residents must be made available through rotations through different services providing emergency nursing services. (Core)

IV.A.8. Residents must be provided with protected time to participate in structured didactic activities. (Core)

> IV.A.8.a) Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. (Core)
>
> IV.A.8.b) The program must include at least two of the following courses: (Core)
>
> - Advance adult resuscitation training such as advance cardiac life support (ACLS), advanced life support (ALS) or equivalent. (Core)
> - Advance pediatric resuscitation and structured training such as pediatric advanced life support (PALS). or emergency nursing pediatric course (ENPC) or equivalent. (Core)

- Emergency trauma training such as trauma nursing core course (TNCC) or advance trauma care for nurses (ATCN) or equivalent. (Core)

## IV.B. Competency for Emergency Nurse Specialist

### IV.B.1. Entry-level emergency nursing competencies (Months 1–12)

IV.B.1.a) Performs primary and secondary assessments (ABCDE): (Core)

- Performs comprehensive and focused assessments using primary (ABCDE). (Core)
- Conducts secondary survey including history collection, head-to-toe and focused assessments for trauma and medical cases. (Core)
- Analyses patient data to identify life-threatening conditions. (Core)
- Applies evidence-based algorithms (e.g., ACLS, PALS, sepsis bundles). (Core)
- Escalates care appropriately to interdisciplinary teams. (Core)

IV.B.1.b) Initiates basic emergency procedures. (Core)

- Demonstrates proficiency in Intravenous access insertion and care. (Core)
- Performs common emergency procedures: urinary catheter insertion, NG tube, EKG, wound care, splinting, basic airway management, etc. (Core)
- Participates in resuscitation (adult and pediatric): cardiac arrest, rapid response, trauma code, stroke code, etc. (Core)

IV.B.1.c) Administers emergency medications safely. (Core)

- Follows medication safety protocols and verifies high-alert medications. (Core)
- Safely administers emergency meds (e.g., epinephrine, nitroglycerin, sedatives). (Core)
- Monitors for adverse reactions and report as per protocol. (Core)

IV.B.1.d) Technology and informatics

- Uses Electronic medical record system accurately for documentation of assessments, interventions, and outcomes. (Core)
- Utilizes monitoring equipment: cardiac monitor and pulse

oximetry. (Core)

IV.B.1.e) Applies patient safety and safety protocols. (Core)

- Apply standard and transmission-based precautions consistently. (Core)
- Follows facility-based safety protocols such as fall prevention, medication safety, chemical spillage, etc. (Core)
- Reports, documents, and participate/implements improvement initiatives/projects on observed incidents according to institutional policies and procedures. (Core)

IV.B.1.f) Communication and collaboration

- Uses SBAR for handovers and interdisciplinary communication. (Core)
- Demonstrates therapeutic communication with patients and families. (Core)
- Lead or participate actively in team huddles and debriefs. (Core)

IV.B.1.g) Health education

- Identify patient and family learning needs. (Core)
- Define and provide health education based on identified leading needs. (Core)

IV.B.1.h) Professionalism and ethical practice

- Maintains patient privacy, and confidentiality. (Core)
- Demonstrate cultural competence. (Core)
- Demonstrates emotional control in emergencies and during shift pressures. (Core)
- Reflects on practice and integrates feedback for guidelines and protocols improvement. (Core)

IV.B.1.i) Engages in self-reflection and performance feedback. (Core)

- Reflects on own practice and seeks opportunities to improve own performance. (Core)

IV.B.1.j) Integrates evidence informed practice and research finding in patient care. (Core)

- Apply existing evidence-based protocols such as sepsis, trauma, stroke, care bundles, etc. (Core)
- Appraise available protocol in comparison with the latest

evidence and best practices. (Core)

- Critically analyses and discusses the findings of nursing research studies within the healthcare team in the field of emergency nursing to negotiate for applicable findings in own work environment. (Core)

IV.B.2. Specialist-level emergency nursing competencies (Months 13–24)

IV.B.2.a) Masters different nursing roles in emergency resuscitation situations: (Core)

- Exhibits in-depth knowledge of resuscitation protocols. (Core)
- Take up different resuscitation roles. (Core)
- Demonstrates effective team dynamics including clear communication, close–loop feedback, constructive intervention, etc. (Core)

IV.B.2.b) Performs complex emergency procedures: (Core)

- Executes of electrical therapy (defibrillation, cardioversion and pacing) based on protocol. (Core)
- Assist in advanced and definitive airway insertion. (Core)

IV.B.2.c) Interprets diagnostics and initiates early interventions: (Core)

- Interprets cardiac rhythms, labs, and point of care tests to guide nursing priorities. (Core)
- Initiates appropriate early interventions and responds effectively to patient response and prognosis. (Core)

IV.B.2.d) Manages multiple high-acuity patients safely: (Core)

- Applies effective assessment and care prioritization. (Core)
- Anticipate and facilitate transfer protocols to other levels of care (inter-facility and intra-facility). (Core)
- Delegate care to junior staff and/or practical nurses as appropriate. (Core)

IV.B.2.e) Recognizes behavioral crisis and provides de-escalation/crisis intervention: (Core)

- Identifies and supports patients with behavioral/mental health emergencies. (Core)
- De-escalates aggression using verbal and physical de-escalation techniques. (Core)

- Refers patients to crisis services or psychiatric teams. (Core)

IV.B.2.f) Practices safety protocols and risk management: (Core)

- Recognizes and mitigates safety risks during crowding, disasters, or aggression. (Core)
- Reports and documents on incidents according to policy. (Core)
- Identifies opportunities for department risk management improvement and acts accordingly. (Core)

IV.B.2.g) Participate in the professional development of junior staff: (Core)

- Guides junior staff through clinical reasoning, procedures, and professional behavior. (Core)

IV.B.2.h) Conducts triage using facility approved systems such as the emergency severity index (ESI), maternal fetal triage index (MFTI), etc.: (Core)

- Independently, it assigns triage levels based on clinical criteria and resources needed. (Core)

IV.B.2.i) Consultation and referral:

- Actively anticipate the need for consultation or referral to other clinical or professional services and implement activate related protocols when available. (Core)

IV.B.2.j) Participates in disaster and mass casualty management: (Core)

- Applies disaster triage (e.g. START triage). (Core)
- Supports surge capacity optimization and evacuations when required. (Core)
- Participates in disaster readiness drills. (Core)

IV.B.2.k) Participate in research. (Core)

- Promotes a climate of research and clinical inquiry in the emergency nursing setting. (Core)
- Contributes to advancement in nursing knowledge by conducting or participating in research. (Core)

IV.B.2.l) Contributes to quality improvement initiatives. (Core)

- Engages in clinical audits, incident reviews, and system

improvement projects. (Core)

IV.B.2.m) Professionalism and ethical practice

- Manages ethical dilemmas (e.g., refusal of care, end-of-life). (Core)

IV.B.2.n) Health promotion

- Evaluate the common emergency department presentations as basis for health promotion strategies development. (Core)
- Select/develop and implement evidence- informed strategies for health promotion and primary, secondary, and tertiary prevention. (Core)

IV.B.2.o) Leadership

- Promote the benefits of the nurse specialist role in client care to other healthcare providers and stakeholders. (Core)
- Propose strategies to optimize the nurse specialist role within healthcare teams and systems to improve client care. (Core)
- Coordinate inter-professional teams in the provision of client care. (Core)
- Create opportunities to learn with, from, and about other healthcare providers to optimize client care. (Core)

## IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Assignment of rotations must be structured with sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. (Core)

## IV.D. Scholarship

Scholarly activities must include discovery, integration, application, and teaching.

### IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities in a group peers and faculty consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice the scholarly approach to evidence-based patient care. (Core)

### IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in education, patient care, or population health
- Case-presentations
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, or case reports
- Creation of curricula, didactic educational activities, or electronic educational materials
- Contribution to professional committees, or educational organizations
- Innovations in education

### IV.D.3. Resident Scholarly Activity

IV.D.3.a) While in the program, residents must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, webinars, or service on professional committees. (Core)

IV.D.3.b) Residents must participate in scholarly projects. (Core)

IV.D.3.b)(1) Residents must complete a scholarly project relevant to the specialty which was conducted under supervision of a faculty member. (Core)

IV.D.3.b)(2) The project shall be presented at a local, national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of project presentation in a nursing/medical conference, will be part of the resident's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. (Core)

## V. Evaluation

### V.A. Resident Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work.
- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation, evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

A planned, defined and implemented system of resident assessment must be in place with clearly defined methods and identified level of the expected outcomes. (Core)

V.A.1. Formative evaluation

There must be a system of formative documented evaluation of resident's performance at the completion of the rotation and assignments. (Core)

V.A.1.a) The formative evaluator must:

V.A.1.a)(1) Assess residents' performance based on the seven professional practice standards namely person-centered care, ethical and legal practice, communication and collaboration, research and evidence-based practice, community and public health, leadership and management, and informatics and technology. (Core)

V.A.1.a)(2) Include a review of case volume to ascertain comprehensive coverage. (Core)

V.A.1.a)(3) Use formal in-service cognitive exams to monitor knowledge when appropriate. (Core)

V.A.1.a)(4) Use multiplicity in resident evaluation (e.g. faculty, self, peer evaluation. online and simulation). (Core)

V.A.1.a)(5) Document progressive resident performance improvement. (Core)

V.A.1.a)(6) Provide residents with a documented semi-annual evaluation on performance with feedback to guide their learning plans. (Core)

V.A.2. Summative evaluation

There must be a system of documented summative evaluation of resident performance at the end of the rotation/year/program to verify that the resident demonstrated sufficient competence to enter practice without supervision. (Core)

V.A.2.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

V.A.2.a)(1) More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation. (Core)

V.A.2.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.2.c) The program must provide an objective performance evaluation based on the Competencies, and must: (Core)

V.A.2.c)(1) use multiple evaluators (e.g., faculty members, peers, self, and other professional staff members). (Core)

V.A.2.c)(2) provides that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.2.d) The program director or their designee, with input from the Clinical Competency Committee, must: (Core)

V.A.2.d)(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress. (Core)

V.A.2.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. (Detail)

V.A.2.d)(2) Assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)

V.A.2.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

Residents who are experiencing difficulties with achieving progress may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.2.d)(4) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.3. Final Evaluation

V.A.3.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.3.a)(1) The specialty-specific Competencies, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in

autonomous practice upon completion of the program. (Core)

V.A.3.a)(2) The final evaluation must:

V.A.3.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.3.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; (Core)

V.A.3.a)(2)(c) consider recommendations from the Clinical Competency Committee; (Core)

V.A.3.a)(2)(d) be shared with the resident upon completion of the program. (Core)

V.A.4. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.4.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.4.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

V.A.4.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. (Core)

V.A.4.b) The Clinical Competency Committee must:

V.A.4.b)(1) review all residents' evaluations at least semi-annually; (Core)

V.A.4.b)(2) determine each resident's progress on achievement of the specialty-specific Competencies; (Core)

V.A.4.b)(3) meet after residents' semi-annual evaluations and advise the program director regarding each resident's progress, promotion, remediation, or dismissal; (Core)

V.A.4.b)(4) meet at least quarterly, keep minutes of their meetings and report to the Program Director. (Core)

## V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.B.4. The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. (Core)

## V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of residents and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is

a core faculty member, and at least two or more residents from different years. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(a) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(b) scholarly activity; (Core)

V.C.1.c)(5)(c) resident and faculty surveys; (Core)

V.C.1.c)(5)(d) written evaluations of the program. (Core)

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(a) board pass and certification rates; (Core)

V.C.1.c)(6)(b) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must: (Core)

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents; (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

V.C.1.f) A process must be in place to incorporate stakeholder perspectives and feedback, ensuring that confidentiality is maintained. (Core)

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. (Core)

V.C.3. The goal of NIHS-accredited education is to train nurses who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Core)

V.C.4. Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board to obtain the Board Certification. (Core)

## VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in safety and quality of care
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment;
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery.
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team.

## VI.A. Patient Safety, Quality Improvement, Supervision and Accountability

### VI.A.1. Patient Safety and Quality Improvement

Residents must demonstrate the ability to analyze the care they provide, understand their roles within healthcare teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

#### VI.A.1.a) Patient Safety

##### VI.A.1.a)(1) Culture of Safety

VI.A.1.a)(1)(a) The program, its faculty and residents, must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. (Core)

##### VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

##### VI.A.1.a)(3) Patient Safety Events

VI.A.1.a)(3)(a) Residents, faculty members, and other clinical staff members must:

- Know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

VI.A.1.b)(1)(a) A system must be in place for internal quality improvements. (Core)

VI.A.1.b)(1)(b) Documentation and reporting systems must be in place, including the production of guidelines, manuals, and reports. (Core)

VI.A.1.b)(1)(c) Residents and faculty must be involved in quality improvement processes as part of interprofessional teams. The results must be used to improve the program. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Supervision in the setting of nursing education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice and establishes a foundation for continued professional growth. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. The care provided by the residents shall be adequately supervised by the appropriate availability of the supervising faculty members. (Core)

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when the physical presence of a supervising nurse is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervisor is physically present with the resident during the key portions of the patient interaction. (Core)

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervisor is not providing physical or concurrent visual or audio supervision but is immediately available to the residents for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(3) Oversight: the supervisor is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.d)(1) Each resident must know the limits of their

scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care, authority and responsibility. (Core)

## VI.B. Fatigue Mitigation

VI.B.1. Programs must:

VI.B.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.B.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

VI.B.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.B.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

## VI.C. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.C.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on educational level, patient safety, resident ability, severity, and complexity of patient illness/condition. (Core)

VI.C.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate for the delivery of care in the specialty and larger health system. (Core)

VI.C.3. Transitions of Care

VI.C.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and

structure. (Core)

VI.C.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.C.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.C.3.d) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

## VI.D. Clinical Experience and Education

### VI.D.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 48 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

### VI.D.2. Mandatory Time Free of Clinical Work and Education

VI.D.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.D.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.D.2.b)(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 48-hour and the one-day-off-in-seven requirements. (Detail)

VI.D.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). (Core)

VI.D.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 12 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.b) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.c) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.5. Moonlight

Residents are not permitted to moonlight. (Core)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical/nursing educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical/nursing education.

## References


1. Emergency Nurses Association (ENA). Emergency Nurse Residency Program. The ENA provides a comprehensive residency program aimed at improving decision-making skills, clinical judgment, and sociocultural acclimation for nurses transitioning into emergency departments.

2. National Institution of Health Specialties (NIHS). 2020. General Requirements for Accreditation of Residency/Fellowship programs.

3. UAE Nursing and Midwifery Council 2018. Model for Nursing and Midwifery Specialization in the United Arab Emirates.

**Acknowledgement**

A special gratitude to the Emergency Nursing Residency Program Committee for their contribution in preparing NIHS Emergency Nursing Program Requirements.

**Chairman**:

Mr. Moayad Ahmad Wishah

**Members:**

Dr. Noordeen Shoqirat

Dr. Sija Binoy

Dr. Sultan Mahmmoud Mosleh

Mr. Nazir Ahmad

Mr. Nidal Al Namrawi

Ms. Asma Al Mesmari

Ms. Iman Yassin Othman

Ms. Manar Magdy


المعهد الوطني للتخصصات الصحية
NATIONAL INSTITUE FOR HEALTH SPECIALITIES