

Using the Competency Framework for Registered Nurses in Emergency Care (Levels 1 and 2)

This document collates the questions raised at the launch webinar for the RCN Competency Framework for Registered Nurses in Emergency Care: Level 1 and 2 (publication code 012 222, May 2026). Answers draw on the published framework and on the discussion at the webinar. Page references given in the form 'p14' refer to pages of the framework itself, not of this document.

Quick Reference

Five points answer most of the questions raised about the framework:

- The levels are not linked to Agenda for Change bands or job titles.
- There is no absolute completion deadline — progression is individual, although the framework provides indicative developmental timeframes.
- Experienced nurses can self-assess against Level 1 and go straight to Level 2.
- Anyone appropriately skilled and competent in a given skill can assess and sign it off, including non-nurse colleagues.
- The framework is designed to be adapted — adopt the domains relevant to your setting and mark anything else 'N/A'.

Before starting, read pages 1 to 16 of the framework itself. These pages explain how to complete the competency tables column by column, the Benner stages of clinical competence used for self-assessment, the types of evidence that can be used, and who is an appropriate person to sign each competency off. Several of the questions below are covered there in more detail.

Competency link: [Competency Framework for Registered Nurses in Emergency Care: Level 1 and 2 | Publications | Royal College of Nursing](#)

Implementation and Local Adoption

1. How should the framework be mapped against existing local competencies and adapted for local settings?

Map, don't replace — gap-analyse and adapt the domains. Do not try to override your local framework — that is what your chief nurse and appraisal process recognise. Run a gap analysis instead: compare both documents and pull across the RCN sections your local framework covers weakly (commonly minor illness and injury). Use the RCN framework to strengthen an existing portfolio rather than replace it. Adaptation is

expected — the eight domains can be adopted individually, competencies that do not apply to your setting are marked 'N/A' (page 14 of the framework), and the document is described as a professional map rather than a fixed recipe.

2. How should a department introduce the framework across a workforce with mixed levels of experience?

Start small: one domain, engaged staff first, assessor capacity confirmed.

Resource it first: confirm assessor capacity and protected time, begin with staff who are engaged or finishing preceptorship, and consider one domain at a time (for example triage or minor injury). Set a departmental timeline so access is equitable and assessors are not overwhelmed. Experienced staff are not expected to work through Level 1 from scratch — p10 states it would be reasonable for them to go straight to Level 2 (see question 4). On assessor capacity in the early stages, see question 10.

Framework Structure and Progression

3. Have the previous Level 1 and Level 2 frameworks been combined into one document?

Yes — Levels 1 and 2 are now a single integrated publication. The previously separate Level 1 and Level 2 publications have been combined into a single integrated document (012 222, May 2026). Both levels now appear within every domain, side by side — Level 1 statements first, with Level 2 statements immediately after and shaded in a different background colour.

4. Do nurses have to reassess all Level 1 competencies when progressing to Level 2, and must experienced nurses complete Level 1 at all?

No — Level 2 adds to Level 1 rather than repeating it. For experienced nurses, it would be reasonable for them to go straight to Level 2 competencies rather than start with Level 1. In practice they should self-assess against Level 1, evidence it from existing courses and experience, and focus their effort on Level 2.

Please note, the level of clinical competence required for Level 1 and Level 2 is different. Everyone working to Level 1 must be formally assessed as 'competent' on Benner's stages of competence. Everyone working to Level 2 must be formally assessed as 'proficient' in Level 1 and Level 2 competencies.

5. How long should the Level 1 and Level 2 competencies take to complete?

No fixed rule — around two years to Level 1 for a newly registered nurse. The framework sets no time-bound progression limits. For newly registered nurses, p15 allows at least 12 months to consolidate registration and up to two years to reach

Registered Nurse (Level 1). Nurses new to emergency care with previous nursing experience should aim to complete Level 1 within 12 months, potentially sooner if coming from acute or critical care. No timeframe is set for Level 2. Progression is individual and should be agreed with your PDN or manager.

6. Are the competencies linked to Agenda for Change banding?

No — the levels are not linked to bands or job titles. p6 states the levels 'are seen as a supporting framework for your development and not associated to your band or job title'. The RCN no longer links competencies to Agenda for Change bands, so that pay band is not a barrier to developing greater clinical competence, and vice versa. Level 2 is not a senior-only tier — p16 states Level 2 nurses 'should form the largest nursing group in the emergency care setting'. In practice competence and banding often progress in parallel, but the framework does not attribute levels to bands or to role profiles.

Education, Career Development and Preceptorship

7. Should newly registered and internationally educated nurses complete preceptorship before starting Level 1, and how should they approach the competencies?

No need to wait — preceptorship and Level 1 run alongside each other. The glossary (p7) defines Registered Nurse (Level 1) as a nurse who 'has completed preceptorship, and has achieved the Level 1 competencies', and the developmental milestones (p15) expect a newly registered nurse to start developing Level 1 competencies across the clinical domains from around three months. p6 states that a period of structured support is vital for all nurses new to emergency care, and that core nursing skills should be assured locally before or alongside the framework. Build evidence progressively from routine practice, study days, clinical supervision, appraisals and reflective accounts rather than in one sitting — reflective accounts written for preceptorship or revalidation can be used directly as evidence. Suggested review points are one month, then three-monthly, with appraisal at 12 months (p14). The same approach applies to internationally educated nurses, with additional attention to local guidelines, escalation routes and documentation.

8. Is the self-assessment a baseline, with sign-off following education, training and assessment?

Yes — self-assessment sets the baseline, sign-off follows formal assessment. Self-assessment (column 3) uses Benner's stages (N, AB, C, P, E) to establish a baseline and identify individual learning needs. Sign-off (column 4) follows objective formal

assessment with individual professional feedback, and the evidence used is recorded in column 5. Level 1 requires formal assessment as 'competent'; Level 2 requires 'proficient' (p13). Accepted evidence types include direct observation of practice, case-based discussion, simulation, reflective report, question and answer, anonymised clinical case notes, colleague or patient feedback, and nationally recognised courses.

Assessment, Sign-off and Governance

9. Are senior nursing staff aware of these new competencies?

Partially — awareness is patchy. Dissemination has been via RCN channels, the UEC Forum, matron and PDN networks, RCN publications and the launch webinar, but feedback at the webinar indicated awareness is patchy. Members are encouraged to raise it with their line manager, matron or PDN.

10. Who can assess and sign off competencies, and can staff assess before completing the framework themselves?

Any registered professional who is appropriately skilled and competent in that skill, including non-nurse colleagues. Assessors may include paramedics, doctors, ACPs, physiotherapists or pharmacists, provided they hold the required knowledge and skill at the appropriate level. This mirrors the way non-nurses can contribute to revalidation. The preferred structure (p13) is a nurse supervisor a level above the learner: a newly registered nurse should have a Registered Nurse (Level 1) supervisor, and a Level 1 nurse should be supervised by someone beyond Level 2, typically a charge nurse or practice educator. Where a department is starting out and has too few signed-off nurses, p13 is explicit: 'a pragmatic approach should be applied and senior nurses should be allowed to supervise others commensurate with their current role'. So yes — experienced staff can assess before completing the framework themselves. As staff are signed off, the pool of assessors grows.

11. How can competency development and assessment be supported where there is no Practice Development Nurse (PDN)?

There should be a practice development resource — its absence is a workforce gap, not a settled position. The RCN Nursing Workforce Standards (2025) require that the nursing workforce 'must have access to nursing educators and professional development teams' (Standard 7f), and the RCN and RCEM Nursing Workforce Standards for Type 1 Emergency Departments (2020) specify a whole-time-equivalent dedicated Practice Development Lead for each ED. This framework also assumes the role exists (p8). Raise the gap with your matron or head of nursing on that basis. In the meantime, competencies can still be progressed: the assessor need not be a PDN, and

senior nurses, team leaders, ENPs, ACPs or appropriately competent colleagues from the wider team can sign off under the pragmatic approach at p13. Use appraisals, midpoint reviews and in-house study days as sign-off opportunities, and consider linking with a neighbouring ED's practice development team. Where direct observation is limited, question and answer, case-based discussion and reflective reports are all valid evidence.

Professional Standards, Resuscitation and Life Support

12. Why have Advanced Life Support (ALS), Immediate Life Support (ILS) and Paediatric Immediate Life Support (PILS) provider requirements been removed?

They have not been removed — course attendance is now one form of evidence rather than a requirement. Rather than mandating course attendance, the framework extracts the underlying skills and knowledge so they can be evidenced in more than one way; an ILS, PILS or ALS certificate remains acceptable evidence (a nationally recognised course, code RC) but is no longer the only route. The content is retained as competency statements, for example at Level 1 'Discuss the immediate life support (ILS) algorithms for managing abnormal cardiac rhythms associated with cardiac arrest' and 'Explain the indications and delivery methods of drugs used within the advanced life support (ALS) algorithm', and at Level 2 'Anticipate and prepare drugs as per ALS guidelines'.

Scope of Practice and Future Development

14. Will competencies be developed for Advanced Clinical Practitioners (ACPs), and are Level 3 competencies planned?

Not in this framework — ACP competencies sit with RCEM, and Level 3 is being scoped. p16 states that competencies for pathways beyond Level 2 are outside the scope of the document, and p6 directs readers to RCEM's ACP competencies, which the RCN has endorsed — so the RCN does not intend to duplicate them. There is, however, an identified gap between Level 2 and advanced practice for nurses taking a leadership or management route rather than an ACP route: leading resuscitation, undertaking appraisals, and corporate or managerial development. The Forum indicated at the webinar that it will begin scoping Level 3 competencies covering these leadership responsibilities and advanced skills timing TBC.

15. Does the framework apply to staff working in wider UEC services?

Not designed for NHS 111, but partly transferable. The framework is emergency department focused, with applicability across urgent and emergency care settings including UTCs and same day emergency care; remote and telephone triage is not one of the eight domains. Elements of patient assessment, prioritisation, mental health, children and young people, and older people would be relevant to 111 clinical staff, but no mapping exists and no work on 111 was described. Recommend confirming whether the Forum intends to look at this.

16. Can the framework be adapted for remote and rural urgent and emergency care settings?

Yes — the skills themselves are the same in a remote or rural setting, and this was confirmed at the webinar. The framework is deliberately split into eight domains so services can adopt only the parts relevant to their scope, competencies that do not apply are marked 'N/A' (p14), and the whole document is intended to be tailored to the setting. It also acts as a portable record if staff move to another emergency care workplace.

17. Will a similar framework be developed for Healthcare Support Workers (HCSWs) in Emergency Departments?

Not currently — the framework covers registered nurses only. Clinical support workers — including healthcare assistants, healthcare support workers, nursing assistants and assistant practitioners — are defined in the glossary (p7) but have no competencies within the document, and no HCSW framework was announced. The Forum's stated next priority is Level 3 competencies.

Digital Access and Resources

18. Will the framework be available to complete electronically, or hosted on a digital platform?

Not yet — PDF only for now. The RCN confirmed at the webinar that an online, tick-off-able version is wanted and that conversations are under way, but that the RCN does not currently have the platform capability to host it. No timeline is available. In the interim, some members have rebuilt the competencies locally in Excel or another local solution.

19. Will printed copies be available to order?

Yes — order by phone from RCN Direct. Hard copies of RCN publications can be ordered by calling RCN Direct on 0345 772 6100 and selecting option five (Monday to

Friday, 10am to 4pm, excluding bank holidays). A small charge may apply. The electronic version is free to download for all members.

Prepared September 2026. Answers refer to the Competency Framework for Registered Nurses in Emergency Care: Level 1 and 2 (RCN publication code 012 222, published May 2026, review date May 2028). Page references throughout are to that publication.
