Manual of good practices to humanise the emergency department

2020 edition

HUCI Humanizando los Cuidados Intensivos

HURGENCIAS Humanizando las Urgencias Hospitalarias

Manual of good practices

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HURGENCIAS Humanizando las Urgencias Hospitalarias

Prologue

Humanising healthcare has become a challenge for healthcare services all over the whole world. Although we have spent six years transforming and designing healthcare services focused on the demand of the main players (patients, families and professionals), it seems that we have had to go through a pandemic to reach a turning point. Now more than ever, what for many has been invisible is now visible.

Humanisation is another discipline of knowledge and everyone needs to collaborate to make it happen: patients, families, healthcare staff, managers and health authorities. Humanisation is culture, politics, society, economy, ethics and justice. And it is not only humanisation of people and our behaviour that is needed. Humanisation is not only related to attitude, but we also need to have that H that humanisation stands for in material and technical structures.

Humanisation is about movement, not only studying a technique or a procedure and putting it into practice. It involves a profound reflection. Humanisation involves being aware of ourselves: Where am I? What can I do? And going on a journey within the inside of human beings: it is an important personal commitment to improve each person's reality, our relationships and surroundings.

This *Manual of good practices to humanise the emergency department* has been created with great pride and joy. It includes different lines of research and work developed through active listening, as well as collecting the opinions and wishes of the main players. And it is in this way, through joint work and collaborative research, we at the HU-CI Project believe the system must be redesigned to be truly focused on people. Action and scientific evidence must go together. A specific method had to be created to humanise the emergency department and, thanks to the relentless and altruist work from an amazing group of experts, we now have this simple map to follow and change the culture of our organisations.

This task of listening is essential if we want to transform our reality towards a friendlier model that focuses on respecting people's dignity. If we feel that it is necessary to change our current reality towards a humanistic and excellent model, this is the only way. It is our responsibility to transform the reality of the system towards a better one.

Gabriel Heras.

Director of the HU-CI Project.

Introduction

Emergency healthcare in Spain is a unique resource within the services offered by the Spanish National Health System and it has been available to citizens for years. Emergency services is the third type of healthcare service offered alongside specialised and primary healthcare services. Most importantly, it is often the door to the health system, not only for patients who request healthcare through emergency services, but also for everyone who has used the other types and has not been able to solve the problem properly or within the time frame.

Emergency services has different levels. Nonetheless, the aim of this manual is to draft and present a series of good practices to transform the emergency departments into more humanised places. Nothing more and nothing less. The other contexts, due to their special characteristics, will be addressed in future projects.

> *Its volume of work reaches really surprising figures. Official data [2017] indicate a total of 56.7 million emergency consultations are held per year in the Spanish National Health System, of which 29.4 million were at the emergency department (80% in the public system). 25% of the population served is over 65 years of age, with one or more chronic illnesses. Admission is around 11%.*
> *Both these data and the annual variable growth are an important cause of significant seasonal and non-seasonal overcrowding. In 2019, preliminary data indicate around 30 million patients were treated at the emergency department, which is around 80,000 daily emergencies and 3,000 patients every hour.*

Until now, the emergency department has not been a friendly place. It is rather a place of passage through which all patients on the spectrum "circulate", from the mildest to those with the most serious or urgent illness. After a greater or lesser initial delay (triage), all of them will see the clash between the hectic pace of the emergency department, which ignores and overshadows people, and the forced waiting times that the rest of the hospital and the very emergency department impose on their admission or discharge, respectively. In fact, the emergency department is where time takes over. A hostile place where healing the body involves dictatorship over the patient's other needs.

Similarly, the emergency department is also a passing place for healthcare and non-healthcare professionals who rush from one place to another, sometimes temporarily. Even staff in training are in passing as part of programmes of other specialities and interests. Working at the emergency department involves endless shifts, covering nights, holidays, etc., and over time it becomes a heroic task in all senses. There is a lack of specific training and support for professionals' profile, which must be resolved throughout the year in which the "emergency medicine specialisation" is promised to become a reality and, sooner or later, ends up affecting all professionals.

Several decades have seen many changes take place since everything began in those damp and dark basements, with a spirit of commitment and sacrifice. Even after that first institutional support (Joint Study of the Ombudsman, 2015), many of the original deficiencies continue.

However, as always, shadows only speak of the sun that creates them. Difficulties often make people braver. In this document we want to believe that it is this spirit that has not changed, the one that, from its origins, allowed to capture the dream of a group of visionaries who organised themselves to be able to care for any patient, for any cause, at any time of the day. (*Anyone, anything, anytime.* Zink 2005.)

Given the reality, the environment in which patients, families and teams fight, it is surprising that a group of professionals from different places and with a variety of profiles have been able to share their dreams in order to share them with you, dear reader.

Personally, now that no one can hear us, I must tell you a secret. Due to their special sensitivity, they have all been involved in searching for human treatment that goes beyond the norm for years, a closer language, lost looks, the hands that take care of and stay on the skin of patients.

We are close. Society is demanding it urgently. References support it. Professionals make it possible. Humanised emergency departments desired by everyone should be a meeting place for

people who look after people, and these people should be accompanied by friends and their loved ones. People who try to look for a solution to the patients' and friends' problems, beyond the biopsychosocial model. I believe that this time we will be able to design tools to achieve this change.

After months of hard work even in the current pandemic, we can now show you this project. A shared, brave and selfless project.

The methodology has enabled us to grow with the strength offered by the group. We have tried to collect the work and vision of all professionals who work in the emergency department, involving people with different interests, professional profiles and human potential, but with one common goal. And of course without forgetting the patients' voices.

After an in-depth review shared among the members, the task has been structured in multiple lines of work to make it possible to distribute it. Thus, we refer to seven strategic lines, including flexibility in accompaniment, communication with patients and families, caring for professionals and patient well-being. All of them have been designed, drafted and debated in different stages, seeking consensus from everyone regarding the most practical indicators capable of bringing humanisation to the care and relationships between those involved in the day-to-day life of the emergency department.

The framework and support borrows its structure from the "HU-CI Project", which deserves recognition for its initial and continuous support. Without HU-CI, this project would not have seen the light of day.

It is necessary to show our appreciation and admiration to the whole team, to each and every one of you, for your dedication, for your time away from your families.

Now it is time to enjoy the work that has been done, to let good practices emerge from others, and new ones ... The lines are independent. Well, maybe not quite, maybe not at all. In any case, you can start reading any one of them, the one that seems best, the one with which you are most comfortable, the one that interests you the most.

Send us your comments. We count on your commitment to review future editions, because this project has just begun.

NOTE: Good practices have been categorised into **Basic (B), those that are considered obligatory in order for the department to have a basic level of humanisation; **Advanced (A)**, those that are mandatory to reach a higher level of humanisation; and **Excellent (E)**, those that are desirable to reach a maximum level of humanisation.*

Alfredo Serrano Moraza

Summa 112 Madrid

STRATEGIC LINES

Strategic line 1	**EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT: PRESENCE AND INVOLVEMENT OF FAMILIES AND CARERS IN CARE**	AWARNESS AND TRAINING OF PROFESSIONALS
		ACCESSIBILITY
		CONTACT
		PRESENCE AND INVOLVEMENT IN PROCEDURES AND CARE
		EMOTIONAL, SPIRITUAL AND PSYCHOLOGICAL SUPPORT FOR THE FAMILY AND CARERS
		IDENTIFYING AND APPROACHING VULNERABLE PATIENTS' CARERS

Strategic line 2	**COMMUNICATION**	COMMUNICATION IN THE TEAM
		COMMUNICATION WITH THE TEAM OF OTHER DEPARTMENTS
		COMMUNICATION AND INFORMATION FOR FAMILIES, PATIENTS AND CARERS

Strategic line 3	**PATIENT WELL-BEING**	PHYSICAL WELL-BEING
		PSYCHOLOGICAL AND SPIRITUAL WELL-BEING
		PROMOTING PATIENT AUTONOMY
		ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST

Strategic line 4	**CARING FOR PROFESSIONALS**	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
		PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING
		CONFLICT PREVENTION AND COMPREHENSIVE MANAGEMENT IN THE EMERGENCY DEPARTMENT

Strategic line 5	**VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT**	GENERAL VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH
		SPECIFIC VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH
		IDENTIFICATION, ASSESSMENT AND APPROACH OF GENDER VIOLENCE AND ABUSE

Strategic line 6	**END-OF-LIFE CARE**	PROTOCOL FOR END-OF-LIFE CARE
		END-OF-LIFE ACCOMPANIMENT
		SUPPORTING NEEDS ACCORDING TO PATIENTS' VALUES IN END-OF-LIFE CARE
		LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL AND REJECTING TREATMENT
		MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT AND REJECTING TREATMENT
		CHECKING ADVANCE DIRECTIVES, ADVANCE DECISION PLAN AND THE HEALTHCARE ETHICS COMMITTEE

Strategic line 7	**HUMANISED INFRASTRUCTURE**	PATIENT PRIVACY
		COMFORT: GENERAL
		COMFORTABLE SURROUNDINGS FOR PATIENTS, CARERS AND FAMILIES
		PATIENT ORIENTATION
		COMFORTABLE AND FUNCTIONAL CARE AREA
		COMFORTABLE ADMINISTRATION AND STAFF AREA
		PATIENT DISTRACTION

GOOD PRACTICES

STRATEGIC LINE 1

FLEXIBLE ACCOMPANIMENT: PRESENCE AND INVOLVEMENT OF FAMILIES AND CARERS IN CARE

Unlike the prevailing scientific and technical culture in the emergency department, which is based on technology, skills and efficiency, in recent years progress towards a more inclusive model focused on the needs of the patient has been increasingly undeniable. In fact, the whole process begins when a patient or their family decides to go/take them to the emergency department.

This presumed new approach that these pages echo intends to open all minds to assessing the emotional and psychosocial impact on the patient, family and healthcare team, as well as favouring the use of detection tools and establishing a mechanism for a comprehensive approach and, preferably, assessing the impact.

In vulnerable situations, which can often be life-threatening, patients can be restless, anxious, agitated, scared, etc., or have difficulty to concentrate or collaborate easily in their own care. Sometimes, their behaviour can be risky for themselves, their families, the team and the rest of the staff at the emergency department.

Having qualifications and specific training in soft skills can help to identify these kinds of patients, detect their emotional needs, assess their surroundings and optimise treatment through close and continuous personal contact. These have obvious benefits in care and healing. Several qualitative studies seem to show this is productive. The benefits of these interventions go beyond the acute stage, improve anxiety and psychosocial disorders and reduce the level of emotional lability, dependence and aggressiveness, self-harm and/or dependency behaviours.

Since the early days of the emergency department, both the presence and involvement of family members in care have been an unsolved problem for decades. In fact, it is even more so after the recent COVID-19 pandemic. With the exception of paediatric emergency services, visits from families were anecdotal and infrequent. Contact with teams was often limited to rushed conversations in corridors to share some information, often with unacceptable waiting times.

Naturally, the most purely human needs of patients, families and carers have currently reached the emergency department to create an environment that allows families to be present and involved in patient care.

In particular, it is essential to highlight teams' growing interest in recognising the way in which patients and families should be protected in order to be involved in making their own decisions, whether with an informed consent model or alternative tools in the case of vulnerable or incompetent patients, etc.

Part of the work has been levelled out in recent years in CPR, using a more qualitative language based on patient and family care in pioneering studies led by nurses and multidisciplinary teams. This was especially possible in paediatric CPR, where the presence and support of families improves a number of psychological and emotional indicators.

Beyond this, from 2000 in the USA and Europe, lines of work were described that involved and had the presence of carers in the emergency department in order to improve communication between all groups and continue with care. There are many difficulties in assessing anxiety and the emotional impact on adult carers. This is often due to a lack of staff training and behaviour. In this sense, several interventions have tried to find evidence from isolated clinical reports due to the clinical heterogeneity of the day-to-day in the emergency department.

On the other hand, some studies seem to relate the lack of empathy and professional demotivation to a lack of quality care and, especially, less ability to prevent self-harm behaviours in patients.

Patients, families and carers are part of a team that collaborates in the emergency department in space and time. As informed agents of change and with methodological tools based on evidence, it is the objective of this set of good practices to provide emergency department professionals the tools to detect, measure, assess and establish active recommendations in order to improve healing and care.

Strategic line 1	**EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT: PRESENCE AND INVOLVEMENT OF FAMILIES AND CARERS IN CARE**	AWARNESS AND TRAINING OF PROFESSIONALS
		ACCESSIBILITY
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Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	AWARNESS AND TRAINING OF PROFESSIONALS
Offer awareness activities and training for the team on the benefits of introducing a flexible accompaniment model at the emergency department.		
Good practice 1.1	Specific information/work sessions are organised represented by all members of the healthcare team, analysing limits, facilitating elements and agreeing on strategies to introduce the new model.	
Good practice 1.2	There is an interdisciplinary work group in charge of coordinating and monitoring compliance with flexible visiting hours.	
Good practice 1.3	Continuous training in human tools (communication skills, managing conflicts, etc.) is carried out and aimed at the healthcare team in order to facilitate introducing the flexible accompaniment model in the emergency department.	

Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	ACCESSIBILITY
Offer activities that enable accessibility of families and carers of patients who are at the emergency department, with the patients' prior consent.		
Good practice 1.4	There is a continuous accompaniment procedure for patients in the patient waiting room, if desired.	
Good practice 1.5	There is a protocol that recognises and allows for flexibility in accompanying patients admitted to the observation ward in the emergency department, if desired.	
Good practice 1.6	The carer/companion is identified, recognised and respected, and granted continuous access to accompany the patient in the waiting room and observation ward in the event of cognitive and motor impairment, risk of falls, fear, anxiety.	
Good practice 1.7	There is an information guide (paper, digital) to welcome families/carers of patients admitted to the observation ward in the emergency department that includes instructions on how to access the department, and it is available in different languages.	

Good practice 1.8	There is an information poster (paper, digital) in different parts of the emergency department and in different languages on the possibility of accompanying a patient.	

Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	CONTACT
Introduce measures to promote contact and the relationship of carers and families with the patient during their stay at the emergency department.		
Good practice 1.9	Breastfeeding is facilitated when the conditions of the mother and infant allow so.	
Good practice 1.10	Virtual or physical contact is allowed and enabled with isolated patients.	

Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	PRESENCE AND INVOLVEMENT IN PROCEDURES AND CARE
Offer families to be involved in caring for the patient and certain procedures.		
Good practice 1.11	There is a healthcare protocol available regarding family involvement in the basic care (food, hygiene and moving) provided to the admitted patient.	
Good practice 1.12	Families and carers are considered and allowed to accompany the patient for certain procedures if desired.	
Good practice 1.13	Families and carers are considered and allowed, when requested, to accompany the patient in the critical care area and/or during CPR with prior agreement of the team with the family/carer and patient, if possible. This decision is recorded in the patient's medical record.	
Good practice 1.14	Patient consent (verbal/written) is recorded for carers/companions to be involved in certain procedures, if applicable.	

Good practice 1.15	In the event that the patient's condition incapacitates them, decision-making regarding treatment and care is consulted in the registry of advance directives or their medical record where the advance decision plan is detailed, as applicable. This information is shared with the necessary people. In the event of there being no record or specifications on decision-making, it is shared with the family or carer.	

Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	EMOTIONAL, SPIRITUAL AND PSYCHOLOGICAL SUPPORT FOR THE FAMILY AND CARERS
Detect and support emotional, spiritual and psychological needs of the family and carer.		
Good practice 1.16	Tools are used to identify and approach emotional, spiritual and psychological needs of the family and carer.	
Good practice 1.17	Families and carers are allowed to have a regulated use of mobile phones and other devices (to encourage contact with family).	
Good practice 1.18	There is a multi-faith, personal and accessible room that is marked and people are informed on it.	

Strategic line 1	EMERGENCY DEPARTMENTS WITH FLEXIBLE ACCOMPANIMENT	IDENTIFYING AND APPROACHING VULNERABLE PATIENTS' CARERS
Carers of vulnerable patients are identified and their needs are addressed.		
Good practice 1.19	There is a procedure in place to identify carers of vulnerable patients in the emergency department.	
Good practice 1.20	There is a protocol to attend to carers of vulnerable patients in the emergency department that includes continuous accompaniment measures (comfortable chair, food if needed, bathroom if necessary).	
Good practice 1.21	There is a structured comprehensive assessment that allows to assess the carer of vulnerable patients and address their needs.	

Good practice 1.22	There is a protocol to refer the carer to the case manager or social work unit if necessary.	
Good practice 1.23	Associations, support groups and other non-healthcare resources are offered, available and used for carers.	

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STRATEGIC LINE 2

COMMUNICATION

When we talk, we communicate. When we are silent, we also communicate. There is nothing more subjective than an objective communication. Communication is a process that goes beyond the use of just language. It involves behaviour, expression and understanding. It is based on an attitude of respect, empathy and compassion. It is not just about providing information, but transmitting it; it is about providing clear, precise and sufficient content to the recipients; it is about sharing and actively, assertively and emotionally listening, giving realistic expectations that result in trust and satisfaction with the treatment received.

It is an inherent function of human beings that, in contexts such as the COVID-19 pandemic, has highlighted how essential and humanly necessary it is, in any of its forms and in any situation.

Taking this context into account, in a specific manner and in relation to communication, we can observe how perceptions and feelings of vulnerability, fragility and concern prevail in the emergency department in patients and families/carers, as they connect with reality from an emotional side rather than a cognitive side. This is due to uncertainty, isolation, fear, pain and environmental stress which the person perceives and/or is subjected to. Thus, it is important to establish effective strategies so that everyone feels accommodated to, informed, accompanied and heard.

A patient/family member/carer who is informed, heard and accompanied, with the perception of being accommodated to, is an empowered person in terms of dealing with the process they are going through and they are also a collaborator/facilitator in a professional sense. By contrast, a lack of communication becomes a source of conflict and it is one of the most highlighted points for dissatisfaction in emergency services. Therefore, we should provide information in a structured manner, dominate non-verbal language, offer a personalised service, address the patient by their name, introduce ourselves, ensure privacy, use understandable language and involve families/carers in caring for the patient. We should make an effort to allow the patient to have a companion, facilitate care continuity, listen, discover and interpret the meaning the patient has for each part of their care, their fears, their concerns and their joy. On balance, we need to make care dignified, while strengthening and facilitating communication.

Indeed, an interdisciplinary team in the emergency department should manage communication, as well as having the necessary scientific and technical knowledge. We know the need not only to establish infrastructures and structured procedures that facilitate this, but also to have communication skills that facilitate the demanding work in this department, where there is a lot of pressure, with highly variable and technical assistance and different types of conflicts and dilemmas, and where a large number of professionals with different roles intervene. All of this outlines the need to generate meeting spaces to reflect, using communication as a key tool for team growth. Let's support communication in its broadest sense, training ourselves in communication skills, so that our weaknesses become the driver of change, because there is nothing more human than the act of communicating.

Strategic line 2	COMMUNICATION	COMMUNICATION IN THE TEAM
		COMMUNICATION WITH THE TEAM OF OTHER DEPARTMENTS
		COMMUNICATION AND INFORMATION FOR FAMILIES, PATIENTS AND CARERS

Strategic line 2	COMMUNICATION	COMMUNICATION IN THE TEAM

Relevant information about the patient, their family and caregiver is correctly transferred among all members of the emergency department's interdisciplinary team and tools are used that promote teamwork.

Good practice 2.1	There is a structured procedure to transfer clear and effective information on the patient's care.	
Good practice 2.2	There is a patient localisation system in place within the emergency department that allows their location to be known in a quick and simple way, as well as providing relevant data of their care.	
Good practice 2.3	Training activities are conducted for emergency department professionals on teamwork and effective communication, using tools such as clinical simulation and Crisis Resource Management.	
Good practice 2.4	Specific tools are used to improve effective communication: daily goals/verification lists/briefings/real-time randomised security analysis/SBAR technique.	
Good practice 2.5	Structured spaces/areas are established for professionals to share information and discuss treatment options with the patient, family/carer.	

Strategic line 2	COMMUNICATION	COMMUNICATION WITH THE TEAM OF OTHER DEPARTMENTS

Relevant information about the patient, family and carer is correctly transferred between the emergency department team and other healthcare departments, and tools that encourage teamwork are used.

Good practice 2.6	There is a structured procedure in place to transfer clear and effective information on the patient to another ward.	
Good practice 2.7	There is a structured procedure in place to transfer clear and effective information on the patient when transferring them from the out-of-hospital area, with a telephone number and person of contact.	

Good practice 2.8	There is a structured procedure in place to transfer clear and effective information on the patient when transferring to other healthcare structures.	
Good practice 2.9	Frequent meetings are arranged between the different teams to improve communication and teamwork.	

Strategic line 2	COMMUNICATION	COMMUNICATION AND INFORMATION FOR FAMILIES, PATIENTS AND CARERS
Provide elements that help to establish appropriate, effective and empathetic communication with patients, families and carers by all members of the emergency department team in order to reach a satisfactory relationship of help and accessibility to information.		
Good practice 2.10	An institutional style guide exists, is known and is used, or in its absence, the department's own protocol, as a guidance model of the relationship style of professionals with users, as well as a care and treatment guide (identification of professionals, empathic communication ...).	
Good practice 2.11	There are suitable physical spaces to give patients, families and/or carers information.	
Good practice 2.12	There is an information coordinator/healthcare professional of reference so that the family/carer knows who to talk to when needed.	
Good practice 2.13	There is an information procedure by the doctors/nurses for patients and/or families/carers that is frequent, clears doubts and reduces uncertainty regarding the health situation according to competencies and with a comprehensive perspective.	
Good practice 2.14	Training activities are organised on non-technical and helping relationships skills, covering giving bad news, conflictive situations and grief.	
Good practice 2.15	There is a communication protocol in place on giving bad news.	

Good practice 2.16	In competent patients, the will that the family, carer or relatives be informed is explored with the patient and this decision is recorded.	
Good practice 2.17	There is a system in place so patients can call healthcare professionals when necessary.	
Good practice 2.18	There is a procedure in place to call patients/families/carers and it is applied in the emergency department.	
Good practice 2.19	There is a procedure for unequivocal identification of the patient in place as established by the Joint Commission or another validated procedure.	
Good practice 2.20	There is a procedure in place to favour communication with patients who have difficulties in communicating due to cognitive, hearing, visual or language impairments.	
Good practice 2.21	There is a procedure in place to communicate with patients, families or carers with a language barrier.	
Good practice 2.22	Patient and family satisfaction is periodically assessed with validated tools in relation to the care received.	
Good practice 2.23	A procedure is in place and is applied that facilitates family/carer communication with patients in isolation: video calls, audio messages, symbolic elements.	
Good practice 2.24	A procedure is in place and is applied that facilities non-contact medical information according to specific cases and situations.	

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STRATEGIC LINE 3

PATIENT WELL-BEING

Going to the emergency department is usually an experience that is not desired by someone who is not well. It fills them with fears and uncertainty of a possible illness and the consequences of it.

Situations can be very diverse, from short visits for a more ordinary illness to those more serious patients who may have to undergo many tests that involve long stays even on the observation ward. Yet, they all have one thing in common: being in a hostile environment that is probably overcrowded and surrounded by ill people.

Patients are affected in a physical, psychological and spiritual sense. Therefore, a holistic and formalised approach is necessary to care for all needs and problems. Long waits, devices, pain, loneliness, fear, discomfort, dependency of those who are most vulnerable, lack of privacy, noise, loss of autonomy, loss of contact with the outside world and loved ones, as well as the physical symptoms of the illness can make an experience aimed at healing and relief a very inhumane experience all at the same time.

Paying attention to the surroundings, guaranteeing patients are accompanied, reassessing their state and needs regularly, providing the appropriate spiritual and psychological support that may be needed, keeping dignity in waiting and observation areas, avoiding restraints and lack of natural light, guaranteeing quality sleep, keeping them informed, guaranteeing autonomy, being in contact with loved ones, controlling pain with analgesia and sedation protocols ...

In order to humanise emergency department services, we must acquire the right knowledge and standardise measures, formalising them and introducing them into the DNA of the healthcare professionals in the emergency department to guarantee maximum well-being of patients while they are with us.

Strategic line 3	**PATIENT WELL-BEING**	PHYSICAL WELL-BEING
		PSYCHOLOGICAL AND SPIRITUAL WELL-BEING
		PROMOTING PATIENT AUTONOMY
		ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST

Strategic line 3	PATIENT WELL-BEING	PHYSICAL WELL-BEING	
Promote measures to avoid and reduce physical discomfort.			
Good practice 3.1	There is an agreed protocol to admit patients to observation in the emergency department and/or a ward.		
Good practice 3.2	Maximum times are established for the patient in observation to be sat (in a chair or on a stretcher) and once that time has passed, the patient is moved to a bed.		
Good practice 3.3	A stretcher/bed is facilitated for patients who are identified as vulnerable patients with disabling motor impairments and taken to specific locations during their care.		
Good practice 3.4	There are action protocols for the most prevalent or serious illnesses, frequent care and techniques and they are known and used by all members of the emergency department in a homogeneous way and with low variability according to the most recent scientific evidence.		
Good practice 3.5	There is a standardised and computerised triage protocol with five levels.		
Good practice 3.6	A standard procedure exists and is applied to reassess patients in the waiting room.		
Good practice 3.7	There is a protocol in place for analgesia and sedation according to recent evidence.		
Good practice 3.8	There is a mechanical restraint protocol, paying special attention to the dignity of the patient and carer/family.		
Good practice 3.9	Early walking and sitting is favoured in the observation ward of the emergency department, if possible.		
Good practice 3.10	There is a protocol in place on changing position for bedridden patients.		

Good practice 3.11	There is a hygiene and bathroom protocol in place for bedridden patients.	
Good practice 3.12	The care needs of admitted patients are assessed in a structured way and measures are established so they are satisfied in terms of care continuity.	

Strategic line 3	PATIENT WELL-BEING	PSYCHOLOGICAL AND SPIRITUAL WELL-BEING
Promote actions aimed at reducing the patient's psychological suffering and meet spiritual needs.		
Good practice 3.13	There is a patient information procedure.	
Good practice 3.14	Psychological and spiritual needs of patients admitted to the observation ward are assessed in a structured way and measures are established regarding them in terms of care continuity.	
Good practice 3.15	The regulated use of entertainment means are facilitated for patients (reading, multimedia devices, radio, TV).	
Good practice 3.16	The possibility is offered for patients to talk to a psychologist on site.	

Strategic line 3	PATIENT WELL-BEING	PROMOTING PATIENT AUTONOMY
Patient autonomy: establish measures that promote patient autonomy.		
Good practice 3.17	Patient participation is facilitated in procedures and care according to functional capacity.	
Good practice 3.18	The use of the emergency department bathroom is facilitated in conditions of hygiene and dignity, even when it is for collective	

	use, with an emergency call system and adapted for accessibility according to current regulations.	
Good practice 3.19	The use of a portable toilet is facilitated in the observation ward of the emergency department.	

Strategic line 3	PATIENT WELL-BEING	ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST
Environmental well-being: promote measures that facilitate sleeping and night-time rest, as well as other measures.		
Good practice 3.20	Measures to control background noise are defined and promoted.	
Good practice 3.21	Room temperature is maintained depending on the time of day.	
Good practice 3.22	There is a night-time rest protocol in place.	
Good practice 3.23	There are decibel meters in the observation ward of the emergency department with a light warning when the established limits are exceeded.	
Good practice 3.24	Natural light is favoured during the day and, when not possible, virtual windows are available.	
Good practice 3.25	Interventions are carried out related to music.	
Good practice 3.26	Sleep quality is assessed and monitored.	

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STRATEGIC LINE 4

CARING FOR PROFESSIONALS

Occupational burnout is an inadequate response to chronic emotional stress with physical, psychological and emotional exhaustion, a cold and impersonal attitude towards others and a feeling of inadequacy when carrying out tasks. Burnout is added to other syndromes, such as moral suffering or compassion fatigue.

Healthcare professionals who work in the emergency department are subject to different elements that make them the ideal candidates to suffer from these syndromes: pressure, different schedules, working at night so sleep patterns are altered, living with human suffering on a daily basis, high levels of demand, lack of human and technical resources, training deficits, inadequate facilities, interprofessional conflicts or with patients, lack of recognition ... these are just a few that they face on a daily basis.

The last consequences are the loss of physical and psychological health, which affects their social and family relationships, as well as losing self-esteem or developing depression and anxiety. This has a direct result in patient care, which is impaired, and can create a vicious circle that is difficult to identify and break.

The prevailing idea is not to have tools to treat burnout, but the true challenge is to prevent it. Healthcare centres and human resource departments must have sufficient and frequent strategies available to identify and prevent burnout. These should be based on standardised measures within the centre. They must pay attention to the working conditions of the employees of a service as complex and exposed as emergency departments, providing them the necessary means to guarantee their physical and psychological well-being. Healthcare institutions have an ethical and moral duty to provide a global and comprehensive humanised service. In order for this to reach patients, healthcare professionals need to be motivated, healthy and have optimal working conditions.

Strategic line 4	CARING FOR PROFESSIONALS	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
		PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING
		CONFLICT PREVENTION AND COMPREHENSIVE MANAGEMENT IN THE EMERGENCY DEPARTMENT

Strategic line 4	CARING FOR PROFESSIONALS	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
Improve knowledge on occupational burnout to favour its visibility.		
Good practice 4.1	Training activities are carried out related to understanding and managing burnout, the associated factors and promoting engagement to acquire the knowledge and skills to face stress and conflictive situations (resilience, positive attitude, assertiveness, emotional self-regulation, problem solving, time management, as well as the relationship with work).	
Good practice 4.2	The process of burnout and engagement is assessed frequently using validated tools.	

Strategic line 4	CARING FOR PROFESSIONALS	PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING
Prevent burnout and promote engagement.		
Good practice 4.3	Staff and shifts are sufficient, complying with the standards proposed in the references.	
Good practice 4.4	There is a protocol in place to increase staff in periods with more patients or an increase in unexpected demand.	
Good practice 4.5	There is a welcome plan for new professionals to help them become part of the team.	
Good practice 4.6	Organisational changes are promoted to reduce the emergence and/or impact of burnout on staff over 55 years of age.	
Good practice 4.7	The possibility to change shifts and have a schedule adapted to individual needs (flexible schedule) is enabled.	
Good practice 4.8	Learning, training and research activities are facilitated and they are considered to be part of the work schedule.	

Good practice 4.9	Participation and opinion of professionals is encouraged within the department's organisational culture, as well as management and reaching objectives.	
Good practice 4.10	An appropriate rest area is available for professionals in their breaks, as well as drinks and snacks.	
Good practice 4.11	Work material and devices are available to move patients, therefore minimising injuries.	

Strategic line 4	CARING FOR PROFESSIONALS	CONFLICT PREVENTION AND COMPREHENSIVE MANAGEMENT IN THE EMERGENCY DEPARTMENT
Prevention and management measures are in place for conflictive situations in the emergency department.		
Good practice 4.12	Specific training is available for professionals to learn to manage conflictive situations.	
Good practice 4.13	Regular meetings are arranged between local representatives (patient-family associations/carers, local political representatives) and professionals from the department to identify improvements in the emergency department.	
Good practice 4.14	The work environment of the department is regularly assessed through a validated questionnaire and lines of improvement are proposed and introduced.	
Good practice 4.15	Tools to favour interdisciplinary participation, identification and resolution of conflicts between emergency department professionals are in place and solutions are proposed.	
Good practice 4.16	Tools to favour interdisciplinary participation and identification and resolution of conflicts between emergency department, hospital department and out-of-hospital professionals are in place and solutions are proposed.	
Good practice 4.17	There is a suggestion box for professionals, patients and families.	

Good practice 4.18	A psychologist is available for professionals to manage emotions and conflicts.	

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STRATEGIC LINE 5

VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT

Emergency departments are highly visited places with an extremely varied casuistry and whose structural and functional characteristics are generally aimed at the patient's physical condition, without taking into account other needs.

However, the problems that arise in these departments in an increasingly complex society go beyond the biological aspects of a patient, making it necessary to restructure this biological reductionism, focusing on the person and respecting their dignity. On the one hand, this entails leaving many ideas and work dynamics behind and, on the other hand, proposing and creating new ways to care for and approach patients, as well as their surroundings, thus characterising patients as a biopsychosocial and emotional being.

Taking this idea as a reference, we can say that caring for vulnerable patients in the emergency department is essentially necessary, as they are people who, due to their special condition and situation, need to be identified and addressed in a unique, differentiated and comprehensive way to ensure dignified care from a moral perspective. This goes beyond the healthcare benefits in terms of satisfaction, economy or clinical safety that other studies highlight.

Therefore, it seems unavoidable to define vulnerability from this new perspective and in this specific context. A vulnerable patient could be defined as a person with insufficient personal resources to adapt to their surroundings, due to variable reasons and circumstances, and for this reason they are exposed to physical and/or moral risks. Therefore, their healthcare requires a special approach.

Accepting this global conception gives rise to terms that are specifically related to vulnerability. Therefore, we can talk about vulnerability when a patient is fragile, dependent, has sensory, communicative or cognitive impairments, chronic motor difficulties, when there is a language barrier or they are of extreme ages (children or adults over 65 years of age), victims of abuse/gender violence and if they have social/mental health problems.

To conclude, this change in work culture is possible, but participation from patients, families, professionals and institutions is necessary in order to reflect, learn and reach a consensus. A series of good practices are proposed below that we hope will help this process.

Strategic line 5	**VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT**	GENERAL VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH
		SPECIFIC VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH
		IDENTIFICATION, ASSESSMENT AND APPROACH OF GENDER VIOLENCE AND ABUSE

Strategic line 5	VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT	GENERAL VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH
Active identification of vulnerable patients by approaching their needs based on a direct and general observation, primarily from triage.		
Good practice 5.1	There is an identification, assessment and management procedure for patients requiring help and/or supervision from another person and/or device due to permanent inability or difficulty to move which poses a real or potential risk to their autonomy and safety in the emergency department. The presence or not of a companion/carer is recorded.	
Good practice 5.2	There is an identification, assessment and management procedure for patients with permanent cognitive and/or mental problems which make it impossible or difficult for them to understand and/or interpret language and develop behaviours adapted to their surroundings and pose a real or potential risk to their autonomy and safety in the emergency department. The presence or not of a companion/carer is recorded.	
Good practice 5.3	There is an identification, assessment and management procedure for patients with permanent visual, auditory and/or linguistic impairments which pose a real or potential risk to their autonomy and safety in the emergency department. The presence or not of a companion/carer is recorded.	
Good practice 5.4	There is an identification, communication and management procedure for patients with language barriers.	
Good practice 5.5	There is a procedure to refer general vulnerable patients to the social work department or case manager if necessary in order to guarantee social-healthcare services for “general vulnerable” patients when discharged.	
Good practice 5.6	There is a community and social resources guide (associations, support groups ...) available and it is offered to “general vulnerable” patients.	
Good practice 5.7	Training activities are carried out to learn how to deal with “general vulnerable” patients.	

Strategic line 5	VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT	SPECIFIC VULNERABILITY: IDENTIFICATION, ASSESSMENT AND APPROACH

Active identification of vulnerable patients by approaching their needs based on a detailed assessment, primarily from the OBSERVATION ward.

Good practice 5.8	There is an identification, assessment and management procedure for fragile patients.	
Good practice 5.9	There is an identification, assessment and management procedure for dependent patients.	
Good practice 5.10	There is an identification, assessment and management procedure for palliative patients.	
Good practice 5.11	There is an identification, assessment and management procedure for hyperfrequent patients.	
Good practice 5.12	There is a differentiated paediatric procedure in the case of the emergency department where the adult and paediatric population is cared for.	
Good practice 5.13	There is an identification, assessment and management procedure for patients with social problems.	
Good practice 5.14	There is an identification, assessment and management procedure for patients with mental health problems.	
Good practice 5.15	There is a procedure to refer specific vulnerable patients to the social work department or case manager if necessary in order to guarantee social-healthcare services for “specific vulnerable” patients when discharged.	
Good practice 5.16	There is a community and social resources guide (associations, support groups ...) available and it is offered to “specific vulnerable” patients.	
Good practice 5.17	Training activities are carried out to learn how to deal with “specific vulnerable” patients.	

Good practice 5.18	There is a social work department with continuous service.	

Strategic line 5	VULNERABLE PATIENTS IN THE EMERGENCY DEPARTMENT	IDENTIFICATION, ASSESSMENT AND APPROACH OF GENDER VIOLENCE AND ABUSE
Identification and approach to the needs of suspected/victims of abuse and gender violence.		
Good practice 5.19	There is an identification, assessment and management procedure for gender violence.	
Good practice 5.20	There is an identification, assessment and management procedure for child abuse.	
Good practice 5.21	There is an identification, assessment and management procedure for elder abuse.	
Good practice 5.22	A local resource guide is available and offered to women victims of gender violence, child and elder abuse.	
Good practice 5.23	Training activities are carried out to learn how to deal with situations of gender violence, child and elder abuse.	

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STRATEGIC LINE 6

END-OF-LIFE CARE

We live in a social and healthcare context where the concept of curative medicine prevails, where the diagnostic and therapeutic effort is imposed to extend life and avoid death. However, sometimes the price of dehumanisation is paid.

When we talk about end-of-life care, we all think of our biological life, which is what all living beings have and what we lose when we die. Ortega and Gasset differentiated two meanings of the word "life": our biological life and our biographical life. Medicine has always treated disease as a biological phenomenon, but from a humanisation perspective, we cannot forget that the biographical sense is an inherent part of human beings.

The end of someone's life is a process that will depend to a great extent on our values and which are often in the hands of strangers. Disease is a cultural construction and if this construction is directly related to our values and the society in which we live, we cannot ignore the variability in our end-of-life care as we live in a pluralistic society. The only common link is to respect the values of the specific person to whom we are providing care. A dignified life cannot be different to a dignified end of life and death.

In this sense, healthcare professionals have the duty to help plan a dignified end-of-life care for our patients and their families. And this is not only possible in that final stretch, but we can and must anticipate it when the opportunity emerges, and this requires learning and training.

In the emergency department, where the people seen to suffer from acute and exacerbated chronic diseases whose end, in many cases, is irreversible in a greater or lesser time, we have a unique opportunity from the perspective of humanisation to be able to start to inquire into their values and make note of it in their medical record. Planning in advance begins before the patient registers their advance directives together with their representative, understanding this as a process and not as an act in itself.

The patient's vision will help us in the future (whether it be near or far) to make decisions, ensuring their autonomy and respecting their values and will, accompanying them at every step, including the family in this process if they wish, limiting our efforts and hearing what they wish to reject; in short, providing the best possible palliative care, thus covering their physical, emotional, social and spiritual needs.

In this difficult and sensitive process, we are not alone in making prudent decisions, as we can count on Healthcare Ethics Committees that are created to advise professionals and users in clinical practice when ethical conflicts arise, as well as provide training in bioethics for healthcare professionals to improve the quality of healthcare. Humanisation and bioethics are inseparable colleagues.

Strategic line 6	**END-OF-LIFE CARE**	PROTOCOL FOR END-OF-LIFE CARE
		END-OF-LIFE ACCOMPANIMENT
		SUPPORTING NEEDS ACCORDING TO PATIENTS' VALUES IN END-OF-LIFE CARE
		LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL AND REJECTING TREATMENT
		MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT AND REJECTING TREATMENT
		CHECKING ADVANCE DIRECTIVES, ADVANCE DECISION PLAN AND THE HEALTHCARE ETHICS COMMITTEE

Strategic line 6	END-OF-LIFE CARE	PROTOCOL FOR END-OF-LIFE CARE
Carry out healthcare interventions aimed at improving patients' quality of life from a comprehensive approach when they are at the end of their lives.		
Good practice 6.1	There is an interdisciplinary end-of-life care protocol adapted to recommendations from scientific associations.	
Good practice 6.2	There is a procedure in place to identify the patient's needs when needing end-of-life care in the emergency department.	
Good practice 6.3	There is a service specialised in palliative care available for consultations and specific management of cases (admissions to palliative care units, managing home visits ...).	
Good practice 6.4	The procedure established in the department for palliative sedation is recorded and followed.	

Strategic line 6	END-OF-LIFE CARE	END-OF-LIFE ACCOMPANIMENT
Allow a companion for end-of-life patients.		
Good practice 6.5	Continuous accompaniment is allowed for end-of-life patients.	
Good practice 6.6	There is the possibility of taking the patient and carer/family to an individual room in order to preserve their privacy and confidentiality.	
Good practice 6.7	Training in support and grief is provided to professionals involved in caring for the patient/carer/family.	

Strategic line 6	END-OF-LIFE CARE	SUPPORTING NEEDS ACCORDING TO PATIENTS' VALUES IN END-OF-LIFE CARE
Detect and provide the emotional and spiritual needs of patients and relatives in end-of-life situations, taking into account the patient's values.		
Good practice 6.8	The patient's values are recorded in their medical record to facilitate applying emotional support strategies.	

Good practice 6.9	Emotional support strategies are applied for patients and relatives in end-of-life situations according to their values.	
Good practice 6.10	Emotional support and help for professionals who participate in end-of-life care is offered with the aim of reducing syndromes, such as moral suffering, the perception of inappropriate care or compassion fatigue.	

Strategic line 6	END-OF-LIFE CARE	LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL AND REJECTING TREATMENT
There is a limitation/adaptation of life-sustaining treatment protocol available that follows the recommendations by scientific associations, and an adequate register is available for patients/representatives to exercise their right to reject treatment.		
Good practice 6.11	There is a limitation/adaptation of life-sustaining treatment protocol.	
Good practice 6.12	Organ and tissue donation in end-of-life care is included in cases when indicated according to the department's protocol.	
Good practice 6.13	There is a record on rejecting treatment, which is registered in the patient's medical record (respect for the patient's autonomy).	
Good practice 6.14	Safe transfer is facilitated of patients who do not want to die in the emergency department and want to go home, accompanied by a carer/family.	

Strategic line 6	END-OF-LIFE CARE	MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT AND REJECTING TREATMENT
Guarantee participation from all professionals involved in limitation/adaptation of life-sustaining treatment and the patient, family and/or representative in the case of rejecting treatment.		
Good practice 6.15	Decisions on limitation of life-sustaining treatment are made with all the professionals involved in caring for the patient, seeking the highest possible consensus from the healthcare team.	

Good practice 6.16	Treatment rejection is done by respecting the patient's decision and, if wished, together with people related to them (family or legally related). In the case of incapacitated patients, their representative will be in charge of this.	
Good practice 6.17	There is an interdisciplinary work group related to end-of-life care and limitation/adaptation of life-sustaining treatment.	

Strategic line 6	END-OF-LIFE CARE	CHECKING ADVANCE DIRECTIVES, ADVANCE DECISION PLAN AND THE HEALTHCARE ETHICS COMMITTEE
Checking the advance directives record, advance decision plan and Healthcare Ethics Committee to make shared decisions in the event of conflicts is facilitated.		
Good practice 6.18	The healthcare professional assesses the patient's level of information about their process and their ability to make clinical decisions.	
Good practice 6.19	The advance directives are systematically checked, as well as checking the advance decision plan in the medical record for critical or end-of-life patients who cannot decide for themselves or at the request of their representative, if incapacitated.	
Good practice 6.20	When there are no advance directives or a written record of an advance decision plan in the medical record, the decision-making process for incapacitated patients will be shared with the representative or people related to them (family or legally-related).	
Good practice 6.21	There is a consultation procedure with the Healthcare Ethics Committee in cases of disagreement.	
Good practice 6.22	Specific training is provided for professionals on bioethical and legal aspects related to decision-making and end-of-life care.	

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STRATEGIC LINE 7

HUMANISED INFRASTRUCTURE

Perceptions of anxiety and fear coexist in the emergency department due to the physical consequences from having an illness and the uncertainty of its cause and prognosis. The emergency department's physical environment should care for the physical and psychological state of patients, professionals and their families, as well as improving the patient's reason for going.

Therefore, this strategic line encourages creating spaces where technical efficiency and human quality work together to preserve well-being and cover everyone's needs. A suitable design to help reduce professional errors and improve patient results is required, as well as reducing conflicts with patients and families who are emotional due to the adverse surroundings.

Patient privacy and orientation are also included in this strategic line. Without the necessary privacy and with a loss of temporal orientation and circadian rhythm, patients can feel discomfort and restlessness, which can progress to agitation and delirium. Flexible policies that allow patients to be distracted also contribute to this goal. Other stressful factors can be due to non-ergonomic, light and acoustic conditions or due to inadequate decoration and furniture.

Another issue is the comfort of spaces for families. Furniture and space to accompany vulnerable patients or minors next to their bed should be studied in depth as families can use them for long periods of time. A basic aspect is the design of the lounge areas (not waiting rooms) that include private spaces for family groups, motivating decoration, comfortable furniture, appropriate distraction and covering basic (food and drinks) and technical needs, such as TV, telephone and Wi-Fi.

On a professional level, ergonomic work areas with optimal light and sound conditions should be available, access to healthcare spaces and medical devices should be adequately designed, and this should be combined with functional furniture and suitable computer technology to introduce or retrieve information as quickly and efficiently as possible. We must not forget the appropriate conditioning of the communal and individual rest areas where staff can regain strength when they can.

The measures indicated are intended to create human spaces adapted to how the emergency department works. Spaces with maximum possible functionality, but that help to create a place where healthcare goals are reached alongside human warmth are needed. Therefore, and due to the high costs of changes in infrastructure, the existing structures will try to be adapted the best way possible, but taking into account the economic or strategic conditions of each centre in the changes or redesign.

Strategic line 7	**HUMANISED INFRASTRUCTURE**	PATIENT PRIVACY
		COMFORT: GENERAL
		COMFORTABLE SURROUNDINGS FOR PATIENTS, CARERS AND FAMILIES
		PATIENT ORIENTATION
		COMFORTABLE AND FUNCTIONAL CARE AREA
		COMFORTABLE ADMINISTRATION AND STAFF AREA
		PATIENT DISTRACTION

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT PRIVACY	
Guarantee patient privacy and intimacy.			
Good practice 7.1	There is a privacy protocol/procedure in place and applied for patients and monitoring is assessed.		
Good practice 7.2	There is a coded patient call procedure that preserves anonymity.		
Good practice 7.3	There are consultations, rooms or, when there are not, screens, curtains or other separation elements that are made from antibacterial materials and can be easily cleaned, making it possible to create an independent space that favours privacy and intimacy due to the patient's medical and/or case needs.		
Good practice 7.4	There are accessible bathrooms for patients, including portable toilets in the observation ward, that guarantee minimal privacy and avoid embarrassment. There is an emergency call system in them.		
Good practice 7.5	There are individual rooms in the observation ward.		

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORT: GENERAL	
Guarantee environmental comfort in the emergency department.			
Good practice 7.6	The decoration of the different areas of the department contributes to creating a pleasant environment for patients, families/carers and professionals.		
Good practice 7.7	There is a light control system, including an intensity regulator, in all sensitive areas of the emergency department.		
Good practice 7.8	Measures are applied to control environmental noise, trying to keep the space as little noisy as possible in the different areas of the emergency department.		
Good practice 7.9	Background music in the emergency department is available with the possibility of regulating it.		

Good practice 7.10	Suitable cleaning of the facilities exists that includes recycling and waste management.	
Good practice 7.11	There is a temperature control system in the emergency department that can be independently regulated according to the area.	

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE SURROUNDINGS FOR PATIENTS, CARERS AND FAMILIES
Guarantee environmental comfort for patients, carers and families.		
Good practice 7.12	There is suitable furniture that is correctly distributed to create a functional space with optimal circulation, avoiding inconveniences and unnecessary obstacles.	
Good practice 7.13	There is a lounge area for carers and families with comfortable furniture, a bathroom and food and drinks machines. This area is correctly marked.	
Good practice 7.14	Distraction measures are included in the lounge areas: television with health recommendations, newspapers, free Wi-Fi, music, library.	

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT ORIENTATION
Promote communication and patient orientation.		
Good practice 7.15	Watches and mobiles are allowed according to conditions of use of the department.	
Good practice 7.16	When there is no natural light and/or window in the observation ward or the waiting room, virtual windows are used.	
Good practice 7.17	There are visible wall calendars and clocks for patients/families/carers.	

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE AND FUNCTIONAL CARE AREA
Guarantee a comfortable and functional care area.		
Good practice 7.18	There are ergonomic, adaptable work spaces with alternative entrances and with the necessary facilities, material resources and technology to carry out the normal healthcare activity.	
Good practice 7.19	Adequate access to documentation is possible with sufficient computers to check medical records.	
Good practice 7.20	There is a clinical information system adjusted to the emergency department's work flow that enables working on the internet.	
Good practice 7.21	There is a computerised work map where information on complementary tests, care, nursing and medical records, clinical record, location and movements of the patient is collected.	
Good practice 7.22	There is a central monitoring system on the observation ward that collects all data from the department's monitors. They are controlled by doctors and nurses and are easily accessible.	
Good practice 7.23	There are appropriate visualisation systems of the patient from different work stations.	
Good practice 7.24	There is a call system on screen with acoustic and visual signals for patients/families from different work stations.	
Good practice 7.25	The different rooms in the department are clearly and visibly marked for carers/families, patients and professionals.	
Good practice 7.26	There is an easily accessible and activated alarm system through which the emergency department professionals can be notified of CPR or clinical alert of a patient.	
Good practice 7.27	The ambulance reception areas are flexible and adapted, with proper signs and ventilation of combustion gases, etc., and with the possibility of enabling additional entrances.	

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE ADMINISTRATION AND STAFF AREA
Guarantee comfort in the administration and staff area.		
Good practice 7.28	There are rooms for staff on call, with appropriate and comfortable spaces.	B A E
Good practice 7.29	There is a lounge area for staff with quick access to the department.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT DISTRACTION
Encourage patient distraction.		
Good practice 7.30	Light is available so patients admitted to the observation ward can read.	B A E
Good practice 7.31	Regulated use of books, newspapers, radios, tablets, laptops and mobiles is allowed.	B A E
Good practice 7.32	Free Wi-Fi connection is available to use tablets and mobiles so the patient admitted to the observation ward can be distracted and communicate with others. Use is with due regulation.	B A E
Good practice 7.33	Access to distraction means in the paediatric area is available.	B A E

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Good practices in humanisation in the emergency department

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