EDITORIAL

The complex task of organizing an emergency department

ANTONI JUAN PASTOR

Dirección Clínica de Urgencias, Medicina Interna y Enfermedades Infecciosas, Hospital Universitario Josep Trueta, Girona, Spain.

The word "organization" can refer to the action of organizing something, or the resuelt or object. The act of organizing consists of coordinating the work of different people through the establishment of defined tasks or roles for each, as well as the structure or manner in which they are related for the achievement of an objective or goal. If we refer to the word organization as an object, we refer to the environment, the place where these people achieve their objectives[1]. This definition, extracted from the field of business management, allows us to introduce the topic of the difficulty of organizing a hospital emergency department (ED).

The main difficulty lies in the heterogeneity of the group to be coordinated. The professionals that participate in emergency healthcare may be ED staff members, specialists from other departments, medical residents in training and non-medical staff. All these groups have different unresolved problems, some of which will be discussed here, which affect ED organization. Finally, the fact that in most cases it is the patient who decides when and where to consult[2-5], constitutes an added difficulty.

With regard to the physicians, some of their unresolved problems include understaffing, poor working conditions and the need for specialized training[6], all of which complicate ED organization. Nursing staff have other difficulties, such as the coverage of less attractive shifts by qualified personnel, generational replacement and specific training. With regard to professionals ceded to the ED by other departments or acting as consultants in the ED, their unequal involvement and their tendency to defend the interests of their own departments generate organizational problems. As for the medical interns, the fact that accident and emergency medicine is still not a specialty means we cannot train our own future specialists and this too creates various problems. Most specialty training programs involve spending time in the ED during the period in which residents are least experienced, which means an extra workload for the regular professionals. Once residents acquire a certain level of autonomy, they begin doing shift work in their specialty, and this creates problems between them and the regular ED professionals. Non-medical staff (clerks, orderlies, cleaning and security personnel) play a key role key in the outcome of the ED care process and neither they nor their supervisors are always fully aware of this fact, so the degree of commitment varies.

All this complex and heterogeneous organization of professionals must be oriented to the care of patients who often do not use this resource properly. Our health system is valued for its accessibility, but in reality free accessibility twenty four hours a day every day of the year is only guaranteed by the ED[5]. This is one of the main reasons for excessive demand and ED overcrowding[7,8]. Regarding the different mechanisms to control such demand, there are differences of opinion on their appropriateness and their short/medium term effectiveness, and there are few published works describing interventions with a beneficial impact[9].

When we consider the notion of organization as an "object", the ED is definitely the most complex hospital department, since it must be prepared to respond to diverse health problems, both medical and surgical, with different levels of severity, which could fall within the scope of highly specialized or general conditions. The ED must also respond to peaks in demand[3], whether daily, weekly or seasonal[10], and even exceptional mass emergencies and

CORRESPONDENCE: Antoni Juan Pastor. Director Clínico de Urgencias, Medicina Interna y Enfermedades Infecciosas. Hospital Universitario Josep Trueta. Avenida de Francia, s/n. 17007 Girona, Spain. E-mail: a.juanpastor@gmail.com
RECIEVED: 18-2-2013. **ACEPTED:** 19-2-2013.
CONFLICT OF INTEREST: The author declares no conflict of interest in relation with the present article.

catastrophes[11]. To do this, one must have appropriately equipped spaces, well-defined circuits[12] and a high level of coordination with other departments and areas of the hospital, such as surgical rooms, the laboratory and the imaging service.

Although there is abundant literature on the problems of organizing an ED[2,8], there is little that offers solutions and addresses the effects of the measures to be taken[13]. Hence the importance of the work by Sanchez et al. published in this issue of EMERGENCIAS[14], which presents the effect of a rearranging an ED's care spaces using a classical structure, with ED areas and professionals distributed according to different specialties.

The organizational change outlined in this article gives greater prominence to ED personnel and less to other specialists, with attention and care spaces organized according to patient severity, stratified by the Spanish Triage System (SET in Spanish)[15,16]. The result of this is improved effectiveness and both objective and subjective quality. This, in our view, is the major contribution of the work by Sanchez et al. Any intervention in the ED should be aimed at improving care outcomes. Following the example of Hospital Clinic, rearranging ED areas according to triage levels should contribute to this. Each ED should be able to calculate the number of attention points for each severity level and the number of professionals required, and thus comply with SET quality standards. In fact, triage systems are also a tool for ED managers for daily running and planning future structural and staff requirements.

In conclusion, although we are aware of the difficulties involved, the physical layout and distribution of professionals according to care areas should cease to be a problem for those in charge of organizing the ED; it should rather become a solution for urgent patient attention.

References

1 Cambio, organización y entorno (Consultado Febrero 2013). Disponible enhttp://www.eumed.net/libros/2005/ags-coe/0301.htm.
2 Llorente S, Arcos PI, Alonso M. Factores que influyen en la demora del enfermo en un servicio de urgencias hospitalarias. Emergencias. 2000;12:164-71.
3 Benayas M, Aznar JM, Montoya M, Martínez L, Martínez A, López M. Evolución de la frecuentación en el servicio de urgencias del Hospital Torrecárdenas S.A.S. Almería. Años 1990-94. Emergencias. 1998;5:290-5.
4 Cano MI, Rabanaque MJ, Feja C, Martos MC, Abad JM, Celorrio JM. Estudio de la frecuentación de un servicio de urgencias extrahospitalario. Emergencias. 2008;20:179-86.
5 Moreno E. ¿Y si adaptáramos los servicios hospitalarios de urgencias a la demanda social y no a las necesidades de salud? Emergencias. 2008;20:276-84.
6 Toranzo T, Aramburu FJ, García-Castrillo L, Algarra J, Navarro F, Tomás S, et al. Predisposición de los aspirantes a médico interno residente (MIR) a escoger la especialidad de Medicina de Urgencias y Emergencias y factores relacionados. Emergencias. 2010;22:323-30.
7 Flores CR. La saturación de los servicios de urgencias: una llamada a la unidad. Emergencias. 2011;23:59-64.
8 Jariod M, Carretero J, Closa R, Allué X. La densidad horaria de pacientes acumulados como indicador de saturación en urgencias. Emergencias. 2006;18:215-8.
9 Mínguez J, Ruiz J, Millán J, Trescoli C, Tarazona E. Gestión integral del área de urgencias y coordinación con atención primaria. Emergencias. 2008;20:8-14.
10 Castro R, Arcos P, Rodríguez A. Sistema sanitario y *triaje* ante una pandemia de gripe: un enfoque desde la salud pública. Emergencias 2009;21:376-81.
11 García JA, Romero S, Camiña M, Habed N, Jiménez JF, Touza B, et al. Respuesta inmediata ante grandes emergencias: modelo matemático basado en redes neuronales y árboles de decisión. Emergencias. 2012;24:175-80.
12 Montero FJ, Calderón de la Barca JM, Jiménez L, Berlango A, Pérula L. Situación actual de los Servicios de Urgencias Hospitalarios en España (I): Descripción general y análisis de la estructura física y funcional. Emergencias. 2000;12:226-36.
13 Juan A, Enjamio E, Moya C, García C, Castellanos J, Perez JR, et al. Impacto de la implementación de medidas de gestión hospitalaria para aumentar la eficiencia en la gestión de camas y disminuir la saturación del servicio de urgencias. Emergencias. 2010;22:249-53.
14 Sánchez M, Asenjo M, Gómez E, Zabalegui A, Brugada J. Reorganización asistencial de un área de urgencias en niveles de urgencia: impacto sobre la efectividad y la calidad. Emergencias. 2013;25:85-91.
15 Gómez J, Boneu F, Becerra O, Albert E, Ferrando JB, Medina M. Validación clínica de la nueva versión del Programa de Ayuda al *Triaje* (web_e-PAT v3) del Modelo Andorrano de *Triaje* (MAT) y Sistema Español de Triaje (SET). Fiabilidad, utilidad y validez en la población pediátrica y adulta. Emergencias. 2006;18:207-14.
16 Gómez J. Urgencia, gravedad y complejidad: un constructo teórico de la urgencia basado en el triaje estructurado. Emergencias. 2006;18:156-64.