REUE | Original Article

Implementing good practices for humanizing work in a hospital Emergency Department

Benjamín Yáñez-Caballero[1], José Manuel Velasco-Bueno[2], Francisco Rivas-Ruiz[3], Alberto José Gómez-González[4], José Carlos Canca-Sánchez[4]

OBJECTIVE. To describe the process of creating a manual of good practices for humanizing work in a hospital emergency department (ED), and to determine the level of implementation of principles outlined in the manual.

MATERIALS AND METHODS. Qualitative study to gain the consensus of experts, complemented by an observational study with descriptive statistics.

RESULTS. We created a manual of good practices for humanizing work in the ED, identifying 7 strategic lines in 32 sections and 169 good practices. On studying the implementation of the manual's recommendations in the ED of Hospital de Benalmádena, Spain, we found that 51% of the good practices were implemented, 33% were not, and 16% were in the process of being implemented. We saw a high degree of implementation of recommendations related to "vulnerability" (strategic line 5), for which 78% of the good practices were evident. In contrast there was poor implementation for "care of professionals" (strategic line 4), a category in which 78% of the good practices were not being applied. Strategic line 2 ("communication") had the highest proportion (46%) of good practices in the process of being adopted. Compliance with good practices categorized as essential was high (67%).

CONCLUSIONS. The manual facilitates an integrated evaluation of an emergency department's implementation of good practices to humanize care that meets the needs of patients, families, professionals, and the institution. The studied ED's implementation of the good practices was moderate, indicating there is a wide margin for improvement.

Keywords: Hospital emergency department. Vulnerability. Humanizing care. Good practices.

Proceso de implementación de buenas prácticas de humanización en un servicio de urgencias hospitalarias

OBJETIVO. Describir el proceso de creación de un Manual de Buenas Prácticas de Humanización de los servicios de urgencias hospitalarias (SUH) y conocer el nivel de implementación de este manual en un SUH.

MATERIAL Y MÉTODOS. Estudio cualitativo de consenso de expertos complementado con metodología descriptiva observacional.

RESULTADOS. Creación del Manual de Buenas Prácticas de Humanización de los SUH, con 7 líneas estratégicas, 32 apartados y 169 buenas prácticas. En relación al estado de humanización del SUH del Hospital de Benalmádena, el 51% de las buenas prácticas del manual estaban implementadas, 33% no, y el 16% estaban en proceso. Destacó por su alto porcentaje de implementación la línea 5 "Vulnerabilidad" (78% de buenas prácticas activas) y, por su bajo porcentaje de cumplimentación, la línea 4 "Cuidados al profesional" (72%). La línea 2 "Comunicación", fue la línea con un mayor porcentaje de buenas prácticas en proceso (46%). Las buenas prácticas categorizadas como esenciales presentaron un alto grado de cumplimentación (67%).

CONCLUSIONES. Este manual permite evaluar de forma integral la humanización de los SUH, e implementar buenas prácticas para el desarrollo de una atención humanizada que facilite alinear las necesidades de pacientes, familiares, profesionales y organizaciones. En el SUH estudiado, el grado de implementación de estas buenas prácticas es moderado, existiendo margen de mejora.

Palabras clave: Urgencias hospitalarias. Vulnerabilidad. Humanización de la asistencia. Buenas prácticas.

Author Affiliations: [1]Servicio de Urgencias, Hospital de Alta Resolución de Benalmádena, Málaga, Spain. [2]Hospital Universitario Virgen de la Victoria, Málaga, Spain. [3]Unidad de Investigación e Innovación, Hospital Costa del Sol, Marbella, Málaga, Spain. [4]Facultad de Ciencias de la Salud de la Universidad de Málaga (UMA). Spain.
Corresponding Author: José Manuel Velasco-Bueno. Hospital Universitario Virgen de la Victoria. Campus de Teatinos, s/n. 29010 Málaga, Spain.
E-mail: jm.velasco@proyectohuci.com
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Introduction

Health care operates within a predominantly biomedical model—highly technical and fragmented—which effectively addresses the physical dimension of health but appears insufficient to meet the psychological, social, emotional, and spiritual aspects inherent to it. This limitation generates negative experiences and dissatisfaction, leading to the dehumanization of health care[1] and reducing its quality and efficiency.

A new paradigm of health care seems necessary—one that aligns the needs of patients, families, professionals, and institutions.[2] The humanization of health care, understood as a process aimed at ensuring the dignity of all involved, aligns these needs by proposing person-centered care that considers the individual and their environment from a holistic perspective,[3,4] while also integrating the well-being of health professionals.[5]

In Spain, some autonomous communities have recognized this need and have developed various humanization plans.[6] Several authors have also proposed different strategies or models to humanize health care.[7-10] Notably, the Humanization Project for Intensive Care Units (HU-CI) stands out for its practical, comprehensive, and transferable approach.[11] In the specific context of emergency departments (EDs), the HURGENCIAS Group for the Humanization of Emergency Services was created, which, following the same methodology, developed a Manual of Best Humanization Practices for EDs.[12]

EDs face significant care pressure.[13] In Spain, 31,342,724 people were treated in EDs in 2019, and 79% of respondents rated the care as "very good," according to the 2019 National Health System Barometer.[14] However, issues related to privacy, information, resources, infrastructure, and communication skills have been identified, extending beyond clinical aspects and highlighting the need to humanize EDs.[15]

Studies addressing humanization in EDs are scarce and typically focus on specific aspects.[16] Research that comprehensively evaluates these elements could improve understanding of humanization in this context.

The primary endpoint of this study was to describe the process of developing the Manual of Best Humanization Practices for Emergency Departments (MaBePUrgH) by the HURGENCIAS Group. The secondary endpoint was to assess the level of implementation of humanization best practices in the emergency service of a High-Resolution Hospital (HARE) using this manual.

Materials and methods

To develop the MaBePUrgH, we applied a qualitative methodology through expert consensus and external advisor review between November 2019 and September 2020.

The work was conducted in sequential phases using the Moodle platform and virtual meetings due to the COVID-19 pandemic and the geographical dispersion of the team.

Initially, a multidisciplinary group of experts (HURGENCIAS Group) was selected, composed of the director and training manager of the HU-CI Project as advisors, 12 professionals from various professional categories in management and clinical care in emergency, intensive care, and prehospital emergency services, as well as 2 psychologists.

In the first phase, we conducted a literature review. Given the lack of comprehensive and structured studies on humanization in EDs, the HU-CI Project Manual of Best Humanization Practices was chosen as a reference,[8] and a preliminary manual draft was developed and distributed among the group. Members selected the strategic lines they would work on, forming working groups (Table 1).

In the 2nd phase, each expert, based on targeted literature searches and their experience, conducted an individual evaluation of the base questionnaire. For each statement, they indicated whether they agreed, disagreed, or would modify it, and could add new strategic lines, sections, or best practices with justification. Based on the results, a second evaluation was performed to reach consensus on the strategic lines, sections, and best practices that would constitute the final questionnaire statements.

In the 3rd phase, with the final questionnaire, criteria for measuring best practices were defined first individually and then by consensus. These were categorized as basic, advanced, or excellent, according to their degree of obligatoriness, to allow for different levels of humanization accreditation.

In the 4th and final phase, the questionnaire was reviewed by hospital emergency experts and patients. The proposed modifications were discussed, and the final manual was written and structured (Table 2).

To assess the humanization status of the ED of the HARE in Benalmádena, a descriptive observational study was conducted in 2021 by that department's humanization group using the MaBePUrgH. The working group included 9 members (4 nurses, 2 physicians, 2 nursing care assistants [NCAs], and 1 administrative staff member).

The HARE of Benalmádena, in the province of Málaga (Spain), is a public hospital under the Andalusian Health Department, serving a population of 70,000 people, with a large seasonal floating population and an average of 150 emergencies per day. The staff includes 5 administrative workers, 10 orderlies, 11 NCAs, 21 nurses, and 26 physicians.

Each of the manual's best practices was evaluated individually through an online questionnaire (SurveyMonkey) by the team members, who indicated whether each practice was fulfilled, unfulfilled, or in progress, providing justification for their responses. The results were determined based on the highest level of consensus among responses for each best practice. Practices without consensus were evaluated by two external professionals together with the group coordinatorto determine their classification. After this process, the percentage of implementation of best practices was calculated globally, by strategic line, category, and section.

Results

Manual development

Table 1 illustrates the HU-CI Manual of Best Practices, the first version of the MaBePUrgH, and the final manual,

Table 1. Comparative table of best practice manuals for the humanization of intensive care units and emergency departments by strategic lines, number of best practices, and categories

HU-CI humanization manual		First version of ED humanization manual		Final ED humanization manual	
Strategic lines	Number of best practices	Strategic lines	Number of best practices	Strategic lines	Number of best practices
Line 1. Open ICU: presence and participation of family members in care	26	Line 1. ED with flexible accompaniment: presence and participation of family members in care	16	Line 1. EDs with flexible accompaniment: presence and participation of caregivers and family members in care	23
Line 2. Communication	17	Line 2. Communication	14	Line 2. Communication	24
Line 3. Patient well-being	28	Line 3. Patient well-being	17	Line 3. Patient well-being	26
Line 4. Care for professionals	14	Line 4. Care for professionals	15	Line 4. Care for professionals	18
Line 5. Post–intensive care syndrome	19	Line 5. End-of-life care	11	Line 5. Vulnerable patients in EDs	23
Line 6. End-of-life care	23	Line 6. Humanized infrastructure	26	Line 6. End-of-life care	22
Line 7. Humanized infrastructure	33	Line 7. Frailty, vulnerability, and caregivers in emergency care	11	Line 7. Humanized infrastructure	33
Total	160	Total	110	Total	169
Categorization of best practices: • Yes Basic, advanced, and excellent		Categorization of best practices: • No		Categorization of best practices: • Yes Basic, advanced, and excellent	

ICU: intensive care unit; ED: emergency department.

in relation to their distribution by strategic lines, number of best practices, and their categorization. All 3 manuals were structured around 7 strategic lines.

In the ED manuals, 2 strategic lines from the HU-CI manual were replaced: the "Post-ICU Care" line was replaced with a line focused on vulnerability, and the "Open ICU" line was replaced with a line addressing flexibility in patient accompaniment. In the final versions of both the HU-CI and ED manuals, best practices were categorized into 3 levels, although they were labeled differently. In the initial version of the ED manual, best practices were not categorized.

Table 2 illustrates the HU-CI Manual of Best Practices, the first version, and the final version of the ED manual, with respect to their distribution by sections. Unlike the HU-CI manual, the ED manuals incorporated specific aspects related to vulnerability (addressed in much greater detail in the final version of the ED manual) and the prevention and management of conflict situations. The MaBe-PUrgH also added a section on communication with other areas and expanded the sections on end-of-life care.

Practical application

Regarding the state of humanization of the Benalmádena ED, out of the 169 best practices included in the manual, 51% were implemented, 33% were not implemented, and 16% were in progress.

When analyzing the degree of compliance of best practices distributed by strategic lines, lines 1, 3, 7, and especially line 5, showed compliance levels > 50%. Lines 4 and 6 did not exceed 50%, with line 4 showing the lowest performance. Line 2 stood out for having a high number of best practices still in progress (Table 3).

By category, basic best practices were notably well implemented. Excellent practices showed low levels of implementation, while advanced practices showed intermediate results (Figure 1).

Considering the specific sections within each strategic line (Table 4): in line 1, "Identification and management of vulnerable caregivers" achieved the highest compliance; in line 2, "Communication and information for patients, families, and caregivers" stood out; in line 3, "Physical well-being" and "Promotion of patient autonomy" were notable; in line 5, "Management of general vulnerability: identification, assessment, and intervention" and "Identification, assessment, and management of gender-based violence and abuse" were well implemented; in line 6, "Standardization of care in patients with treatment limitation/withdrawal or treatment refusal" stood out; and in line 7, "Comfort and functionality in the care and treatment area" showed the highest performance.

Sections with low compliance levels included: in line 1, "Presence and participation in care."; in line 3, "Environmental well-being and nighttime rest."; in line 4, "Awareness of professional burnout syndrome" and "Comprehensive prevention and management of conflict situations in the ED."; in line 6, "Accompaniment in end-of-life situations" and "Interdisciplinary involvement in decisions and implementation of life-support limitation or withdrawal measures."; and in line 7, "Comfort: general aspects."

The sections in progress toward implementation included: in line 2, "Team communication and communication between the team and other care areas."; in line 6, "Support for patient needs based on their values in end-of-life situations"; and in line 7, "Environmental comfort for patients, families, and caregivers."

Discussion

This work describes, to our knowledge, the first manual of best practices for the humanization of EDs developed in Spain.

In EDs, there are often restricted areas for accompaniment, and facilitating such accompaniment is one of the main requests from patients and families to improve care.[14,15] The structural characteristics of EDs, work overload, professional reluctance to being observed or evaluat-

Table 2. Comparative table of best practice manuals for the humanization of intensive care units and emergency departments by sections

HU-CI humanization manual	First version of ED humanization manual	Final ED humanization manual
Sections	Sections	Sections
Line 1 • Professional awareness. • Accessibility. • Contact. • Presence and participation in procedures and care. • Support for emotional, psychological, and spiritual needs of family members.	Line 1 • Team awareness and training. • Accessibility. • Contact. • Presence and participation in procedures and care. • Support for emotional, psychological, and spiritual needs of family members.	Line 1 • Awareness and training of the care team. • Accessibility. • Contact. • Presence and participation in procedures and care. • Support for emotional, psychological, and spiritual needs of family members and caregivers. • Identification and management of caregivers of vulnerable patients.
Line 2 • Communication within the team. • Communication with family. • Communication with the patient.	Line 2 • Communication with the team. • Communication and information for the patient and family.	Line 2 • Communication within the team. • Communication of the team with other areas. • Communication and information for the patient, family, and caregivers.
Line 3 • Physical well-being. • Psychological well-being. • Promotion of patient autonomy. • Environmental well-being and nighttime rest.	Line 3 • Physical well-being. • Psychological well-being. • Promotion of patient autonomy. • Environmental well-being and nighttime rest.	Line 3 • Physical well-being. • Psychological and spiritual well-being. • Promotion of patient autonomy. • Environmental well-being and nighttime rest.
Line 4 • Awareness of burnout syndrome and related factors. • Prevention of burnout and promotion of well-being.	Line 4 • Awareness of burnout syndrome and related factors. • Prevention of burnout and promotion of well-being. • Prevention and comprehensive management of conflict situations in EDs.	Line 4 • Awareness of burnout syndrome and associated factors. • Prevention of burnout and promotion of well-being. • Prevention and comprehensive management of conflict situations in EDs.
Line 5 • Prevention and management. • Follow-up.	Line 5 • Standardization of end-of-life care. • Physical symptom support. • Accompaniment in end-of-life situations. • Support for emotional and spiritual needs and preferences. • Protocol for limitation of LLST. • Multidisciplinary involvement in decision-making and implementation of LLST measures.	Line 5 • General vulnerability: identification, assessment, and management. • Specific vulnerability: identification, assessment, and management. • Identification, assessment, and management of gender-based violence and abuse.
Line 6 • Standardization of end-of-life care. • Physical symptom control. • Accompaniment in end-of-life situations. • Coverage of emotional and spiritual needs and preferences. • Protocol for limitation of life-support treatments. • Multidisciplinary involvement in decision-making and implementation of LLST measures.	Line 6 • Patient privacy and intimacy. • Environmental comfort for patients and families. • Patient orientation. • Comfort and functionality in the emergency work area. • Comfort in administrative and professional areas. • Patient distraction.	Line 6 • Standardization of end-of-life care. • Accompaniment in end-of-life situations. • Support according to patients' values at end-of-life stages. • Protocol for care of patients with limitation/withdrawal or refusal of life-support treatment. • Multidisciplinary involvement in decision-making and implementation of treatment limitation/withdrawal measures. • Consultation of advance directives, advance care planning, and ethics committees.
Line 7 • Patient privacy. • Environmental comfort for the patient. • Patient orientation. • Comfort in family areas. • Comfort and functionality in care areas. • Comfort in administrative and staff areas. • Patient distraction. • Creation of outdoor or garden spaces. • Signage and accessibility.	Line 7 • Identification and management of frail and/or vulnerable patients. • Identification and management of caregivers.	Line 7 • Patient privacy and intimacy. • Comfort: general aspects. • Environmental comfort for patients, caregivers, and families. • Patient orientation. • Comfort and functionality in the care and treatment areas. • Comfort in administrative and professional areas. • Patient distraction.
Total: 31	Total: 25	Total: 32

ICU: intensive care unit; ED: emergency department; LLST: limitation of life-support treatment.

ed, and the lack of training in non-technical skills may explain this.[18] These factors make it difficult to implement flexible accompaniment policies, even though such policies can improve care, increase efficiency, and facilitate discharge.[13] Moreover, they enhance satisfaction and the experience of patients, families,[18,19] and professionals,[20] all of which contribute to the humanization of health care.[6]

Therefore, the manual proposes flexible accompaniment strategies, especially for vulnerable patients, to foster therapeutic alliances. These alliances are essential given

Table 3. Degree of compliance with best practices by strategic line in the Emergency Department of Benalmádena Hospital

	Degree of compliance with best practices by strategic lines						
	Line 1 N = 23	Line 2 N = 24	Line 3 N = 26	Line 4 N = 18	Line 5 N = 23	Line 6 N = 22	Line 7 N = 33
Yes	52%	46%	58%	22%	78%	45%	52%
No	35%	12%	30%	72%	22%	41%	27%
IPI	13%	42%	12%	6%	0%	14%	21%

IPI: In process of implementation.

the increasing prevalence of issues related to population aging, chronic illness, and social or mental health problems.[15,21] Thus, identifying and managing vulnerable patients appropriately becomes a priority for humanization. The manual adopts the concepts of vulnerability described by Da Silva *et al.*[22] and the definition of patients with complex needs from the National Academy of Medicine,[21] both of which encompass the main characteristics of such patients frequently cited in the literature.[23-25]

End-of-life care is also of great importance, as an increasing number of people die in EDs due to terminal stages of chronic illnesses.[26,27] Families and professionals have identified the need to improve privacy, comfort, care times, emotional and spiritual support, communication, and interdisciplinary collaboration[27-29]—along with training, specific protocols, and integration of palliative care units. The manual, consistent with proposals from several medical societies,[26] provides concrete solutions to address these aspects.

Humanization also requires the evaluation and improvement of communication and well-being, from a holistic and integral perspective, so that professionals and organizations can balance technical-scientific and human components[30]—which are often unbalanced in highly stressful and overburdened environments such as EDs.[13] Therefore, it is not only about addressing the physical dimensions of well-being but also the non-physical needs associated with deficiencies in communication, information, infrastructure, environment, and organization,[31-33] which depersonalize care and can generate conflict.

Implementing structured strategies for frequent procedures, techniques, and care—especially for pain management—along with interdisciplinary teamwork,[1] the integration of psychologists and social workers, the provision of clear and timely information,[30,31] and the development of non-technical skills,[4] improves clinical outcomes and the experience of patients, families, and professionals,[31,32] facilitating the humanization of EDs.[6] Equally important are ergonomic, comfortable, and welcoming spaces[34,35] that promote communication, privacy, and integration, as well as the use of technology to enhance distraction, patient orientation, and professional workflows. These elements create humanized environments that yield physical, psychological, emotional, and economic benefits.[35,36]

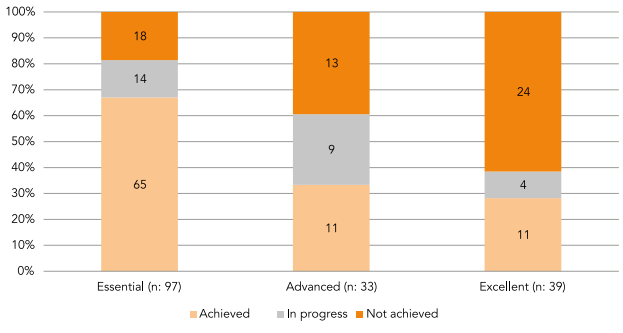

Figure 1. Degree of compliance with best practices by category

However, to expect empathy, active listening, and emotional understanding from health professionals, it is necessary to first care for their own well-being[1,5]—especially in areas with high rates of burnout, which reduce efficiency[37,38] and foster dehumanization.[5]

Assessing professional well-being and implementing strategies that promote participation in organizational decisions, teamwork, autonomy, effective leadership, adequate human and material resources, fair working conditions,[39] and training in social skills[34]—as proposed in the manual—have been shown to reduce burnout.[16]

Regarding the Benalmádena ED, it is the first to be evaluated using the MaBePUrgH. Approximately half of the best practices were implemented. The prior development of a humanization plan within the hospital, specifically in the ED, may have contributed to this. Similarly, being a high-resolution hospital with a smaller volume of emergencies likely facilitated implementation. Nonetheless, these results also highlight that there is still significant room for improvement.

A restrictive accompaniment policy remains in place in the observation area and during procedures, which, according to patient and family reports,[15,17] is common across many EDs. Accompaniment is allowed, however, in the waiting room with one family member and in observation for vulnerable patients.

Although there are protocols for effective communication, a lack of awareness and adherence—especially among professionals—was identified. Communication problems are related to insufficient training in communication and conflict management, work overload, and deficiencies in interdisciplinary work, as reported in other studies.[7,15]

In terms of patient well-being, best practices addressing physical aspects were widely implemented. However, pain management, along with non-clinical factors such as uncertainty due to waiting times, lack of information,[40] and insufficient privacy or comfort, were observed as sources of dissatisfaction and negative experiences—consistent with other reports.[15,31-33] These issues, compounded by poor communication skills, can depersonalize care.

The "Vulnerability" strategic line showed the highest number of implemented best practices, particularly in rela-

Table 4. Degree of compliance by sections

	Yes	No	IPI
Line 1			
Awareness and training of the care team	0%	67%	33%
Accessibility	60%	0%	40%
Contact	50%	50%	0%
Presence and participation in procedures and care	20%	80%	0%
Support for the emotional, psychological, and spiritual needs of family members and caregivers	67%	33%	0%
Identification and management of caregivers of vulnerable patients	100%	0%	0%
Line 2			
Communication within the team	20%	20%	60%
Communication of the team with other areas	25%	0%	75%
Communication and information for the patient, family, and caregiver	60%	13%	27%
Line 3			
Physical well-being	83%	20%	8%
Psychological and spiritual well-being	50%	50%	0%
Promotion of patient autonomy	100%	0%	0%
Environmental well-being and nighttime rest	0%	71%	29%
Line 4			
Awareness of burnout syndrome and associated factors	0%	100%	0%
Prevention of burnout syndrome and promotion of well-being	33%	56%	11%
Prevention and comprehensive management of conflict situations in EDs	14%	86%	0%
Line 5			
General vulnerability	86%	14%	0%
Specific vulnerability	64%	36%	0%
Identification, assessment, and management of gender-based violence and abuse	100%	0%	0%
Line 6			
Standardization of end-of-life care	50%	50%	0%
Accompaniment in end-of-life situations	33%	67%	0%
Support according to patients' value scales at end-of-life stages	0%	33%	67%
Standardization of care for patients with limitation/withdrawal or refusal of life-support treatment	100%	0%	0%
Interdisciplinary involvement in the decision and implementation of limitation/withdrawal of life-support treatment	33%	67%	0%
Consultation of advance directives registry, advance care planning, and ethics committee	40%	40%	20%
Line 7			
Patient privacy and intimacy	60%	20%	20%
Comfort: general aspects	33%	67%	0%
Environmental comfort for patients, families, and caregivers	33%	0%	67%
Patient orientation	67%	33%	0%
Comfort and functionality in the care and treatment areas	70%	20%	10%
Comfort in administrative and professional areas	50%	0%	50%
Patient distraction	25%	25%	50%

IPI: In process of implementation; ED: emergency department.

tion to gender-based violence and abuse, likely due to sustained awareness and training campaigns.

Although end-of-life situations are relatively rare in this ED, accompaniment is permitted and protocols exist to address such cases. However, there is no individual room, and advance directive consultations and palliative care consultations are underdeveloped, as highlighted by various professional societies.[32]

In contrast, care for professionals remains the area with the greatest margin for improvement. Although some measures have been implemented—such as staff reinforcement during peak demand and rest areas for disconnection—there is no regular evaluation of staff well-being, no training in psychosocial risk management, no onboarding plan, and staffing levels are perceived as insufficient for the existing workload. Interdisciplinary work and participation in organizational decisions are also areas for improvement.[5,34,39]

Regarding infrastructure, although there are comfortable rest rooms and IT systems that facilitate work, issues were noted with patient visibility in observation areas and a lack of examination boxes. Additional improvements were suggested in noise control, nighttime lighting, free Wi-Fi, and environmental design, all of which enhance satisfaction and the care experience.[31,32]

Among the limitations of this work, the variability and idiosyncrasies of Spanish EDs stand out, which may require local adaptations of the manual for broader implementation. Moreover, since the Benalmádena ED is the first center where the MaBePUrgH was applied, this limits the critical generalization of results, though it provides a foundation for future benchmarking studies in humanization. Additionally, a potential Hawthorne effect among evaluators cannot be ruled out.

Conclusions

This manual enables the evaluation and implementation of best practices for humanization in EDs in a comprehensive manner, serving as a tool to understand these services from a new perspective and address many of their

challenges, thus facilitating their transformation into more compassionate environments that improve the experience of patients, families, and professionals.

Using this manual, a moderate level of implementation of humanization best practices was observed in the studied ED. The "Vulnerability" line showed the highest level of implementation, whereas the "Care for Professionals" line showed the lowest, suggesting that this latter aspect should be prioritized—both in the studied ED and likely in other Spanish EDs.[5]

Future studies evaluating the humanization status of other EDs could expand existing knowledge, standardize assessments based on this manual, and guide improvements and updates to it.

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