NR 534 Week 5: Organizational Culture and Climate on Group Process and Team Building - Group B Discussion

Individual:

You are the unit director of the emergency department and part of an ad hoc interdisciplinary committee newly formed to address a 30% rise in arrival-to- provider time over the past six months. Six months ago, the ED consistently recorded an arrival-to-provider time less than the national benchmark of twenty minutes. The arrival-to-provider time is presently over one hour. A root cause analysis study finds that arrivals to the ER have increased by 50% and the lobby is usually filled to capacity. Often patients must stand due to lack of adequate seating. FTEs have not been added and staffing is consistently short due to call-offs. Patients are not being discharged from inpatient beds in a timely manner. The task for the committee is to propose a solution for the problem. Looking at this through the lens of an evidence-based quality improvement process, what would you propose as the PICOT for this initiative? Who are the stakeholders represented in your group? (Remember, this is an internal organizational issue, and while patients are impacted by the issue and are the beneficiaries of the work done, they would not be included in this type of task force)

An appropriate PICOT question for this quality-improvement initiative is:

> *In adult patients presenting to an overcrowded emergency department (P), how does implementing a multifaceted patient- flow and throughput bundle—comprising split- flow/fast- track triage, dedicated waiting- room nursing coverage with improved seating capacity, and real- time inpatient bed- management processes to expedite discharges (I)—compared with current standard triage, staffing, and bed- management practices (C) affect mean arrival- to- provider time and the proportion of patients seen within 20 minutes (O) over a six- month period (T)?*

According to Thobaity (2025) this question is aligned with evidence that the major bottlenecks in ED flow are triage-to-doctor and doctor-to-decision intervals, and that improving staffing, consultation processes, and diagnostic turnaround times reduces length of stay and delays. It also reflects findings that overcrowding, prolonged waits, and inadequate waiting-room conditions drive patients to leave without being seen, underscoring the need to address both throughput and physical capacity.

Thorbaity (2025) also shares that key internal stakeholders on the committee would include the ED unit director and charge nurses (who understand operational workflow and staffing gaps), triage and staff nurses (who experience triage-to-provider delays and waiting-room crowding), ED physicians and advanced practice providers (who are central to doctor-to-decision time), and inpatient unit leaders or a bed-management/throughput coordinator (who influence discharge