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Unscheduled care

June 2026

This monthly current awareness bulletin aims to highlight relevant reports and peer-reviewed literature in emergency and unscheduled care. The bulletin focuses on efforts to improve patient flow, reduce waiting times and alternative care models.

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References

Abady E., et al. (2026) **'Artificial Intelligence-Driven Triage in Pediatric Emergency Departments: Accuracy, Bias, and Impact on Clinical Outcomes: A Narrative Review.'** ***Sage Open Pediatrics 13*****(pagination), Date of Publication: 01 Jan 2026.**

AI-driven triage presents a transformative opportunity to address persistent challenges in pediatric emergency care, from overcrowding and waiting times to human error and outcome disparities. This narrative review demonstrates that AI systems can achieve high accuracy in predicting critical outcomes, with pooled AUROCs of 0.87 for hospital admission, 0.93 for ICU admission, and 0.93 for mortality, significantly outperforming traditional triage scales, while observational studies report associations with improved efficiency, reduced triage errors, and enhanced resource allocation. However, publication bias favoring positive results affects the available evidence, and studies reporting no benefit or performance degradation exist. The promise of AI is tempered by significant challenges: performance varies across pediatric subgroups, the risks of perpetuating and amplifying bias remain inadequately addressed, and workflow integration and medico-legal liability require careful navigation. AI augments clinical judgment, guided by robust governance frameworks, fairness auditing, and human oversight for more equitable emergency care.

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Alharbi A.A., and Altherwi, T. (2026) **'The Effect of Emergency Department Overcrowding on Patient Care Outcomes: Insights from a Systematic Review and Meta-Analysis.'** ***Eurasian Journal of Medicine and Oncology 10*****(2) (pagination), Article Number: 8319. Date of Publication: 2026.**

In many nations, overcrowding in emergency departments (EDs) is a serious public health issue that threatens the proper operation of health systems. Understanding the connection between overcrowding and delays in ED treatment provides decision-makers with valuable insights into the problem and supports the implementation of timely solutions. This meta-analysis adheres to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses standards and focuses on evaluating the impact of overcrowding in emergency departments (EDs) on patient care outcomes. Specifically, it synthesizes existing data to identify both the causes of ED overcrowding and its effects on patient outcomes. This review screened 11 articles published between 2010 and 2024, including a total of 3,084,344 patients. Among them, 14.7% were admitted to hospitals, with 49% male and 51% female. The average age was 35.9 years, ranging from 3.9 to 58 years, with a median age of 37.3 years. The minimum waiting time before the first examination was 30 min, with a maximum of 360 min and a mean of 234.0 +/- 21.7 min. The total length of stay (LOS) in the ED ranged from 123.5 to 540.0 min, with a mean of 245.8 +/- 95.9 min. Most patients were discharged home (67.6%), while 10.9% returned to the ED due to unresolved or worsening conditions. Additionally, 2.31% of patients died, 1.88% eloped, 3.08% left without being seen (LWBS), and 1.27% required ICU admission. This meta-analysis highlights the pervasive impact of ED overcrowding on patient outcomes, healthcare worker well-being, and care quality. Overcrowding prolongs waiting times and LOS, disproportionately affects low-acuity cases, and compromises critical care for high-severity patients. Adverse events, such as LWBS, revisits, and incomplete assessments, are consistently linked to overcrowded conditions. Healthcare workers experience significant stress and burnout, which contributes to medical errors and reduced service efficiency.
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Boga, E. (2026) **'Impact of Artificial Intelligence-Supported Triage Systems on Emergency Department Management: A Comparison of Infermedica, Emergency Severity Index, and Manchester Triage System.'** ***Western Journal of Emergency Medicine 27*****(2), 257–268.**

Objective: The surge in the number of emergency department (ED) visits due to a growing population, aging society, and easier access to healthcare highlights the

need for an effective triage process. Our goal in this study was to compare the clinical and operational performance of a triage system supported by artificial intelligence (AI) with two traditional methods-the Emergency Severity Index and the Manchester Triage System-in a high-volume ED.
Method(s): In this prospective study, 18,000 adult patients were randomized equally to one of the three triage systems. Primary and secondary outcomes included patient wait time, complication and mortality rates, resource utilization, medical errors, legal issues, and patient satisfaction.
Result(s): Compared with the Manchester Triage System, the AI-supported system was associated with significantly lower in-ED mortality (OR 0.39, 95% CI, 0.32-0.47; P < .001) and lower complication rates (4.42% vs 10.25%), as well as higher patient satisfaction scores (9.0 vs 7.0; P < .001). Resource utilization was also more balanced in the AI-supported triage cohort.
Conclusion(s): The AI-assisted triage system showed favorable clinical and operational patterns relative to traditional methods. However, the single-center design and short observation period limit generalizability, and causal inferences could not be firmly established.
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Buckingham N, P. K. (2026) **'‘No Man’s Land’: The Experience of Patients at the Interface between Health and Social Care.'**

Farmer C., et al. (2026) **'Artificial Intelligence Software to Help Detect Fractures on X-Rays in Urgent Care: An Early Value Assessment.'** ***Health Technology Assessment (Winchester, England) 30*****(33), 1–97.**
Background: Artificial intelligence algorithms have been developed to support clinicians in diagnosing fractures, with the intention to improve the diagnostic accuracy of clinicians reviewing X-rays. The purpose of this rapid early value assessment was to identify the existing evidence base for the technology and to assess whether there was a prima facie case for the technology to represent positive outcomes for patients and a value-for-money investment for people in the National Health Service.
Method(s): This early value assessment assessed the potential value of the use of artificial intelligence to aid clinician diagnosis of fractures in emergency care settings as compared to clinician-diagnosis alone. A rapid evidence review was conducted followed by 'light touch' early economic modelling to explore whether a plausible case could be made for cost-effectiveness at the prices charged by the companies. Evidence searches were conducted in June and July 2024 to identify clinical, diagnostic and service outcomes associated with the technology. A simple decision model incorporating prevalence, sensitivity, specificity and cost per scan for each of the technologies was developed to evaluate plausible cost-effectiveness for detecting ankle and foot, wrist and hand, and hip fractures, selected based on the

availability of evidence and their downstream costs and consequences.
Result(s): Sixteen studies identified evaluated the diagnostic accuracy of the technology. None of the included studies were conducted in the United Kingdom and all were associated with limitations. While the studies were not considered to be able to provide reliable estimates of diagnostic accuracy, there was a trend for the technology to improve sensitivity for detecting fractures. The technology had no discernible impact on the rate of false-positive diagnoses. Overall, most of the evaluated technologies were associated with a positive incremental net health benefit at willingness-to-pay thresholds of 20,000 and 30,000 per quality-adjusted life-year gained. Due to data limitations, it was not possible to compare technologies against each other. The results were mostly robust to scenario analyses.
Discussion(s): The evidence base for the technology is currently limited to studies evaluating diagnostic accuracy and it is unclear whether increases in fracture detection would translate into meaningful benefits for patients and services. While there are some fractures that, if missed, can result in significant harm to patients, it is plausible that the technology would improve diagnosis of more subtle fractures that may not require a change in management. Use of the technology would not eradicate the risk of missed fractures, meaning that health services would need to continue to take precautions to avoid the risk of a missed fracture in clinical practice. A simple decision tree analysis suggested that the technology was plausibly cost-effective at conventional National Institute for Health and Care Excellence thresholds.
Limitation(s): There are significant limitations in the available evidence leading to uncertainties about the diagnostic accuracy of the technology within NHS settings. Due to the pragmatic nature of the early value assessment and the available evidence base, the economic analysis included many gross assumptions and was unable to produce a definitive estimate of cost-effectiveness. Future work: The appraisal resulted in a number of research recommendations for evaluating the technology further. More detailed modelling in a full formal diagnostic assessment review is required to consider the longer-term costs and consequences of false negatives and positives, and how they are likely to impact the estimates of cost-effectiveness. Study registration: This study is registered as PROSPERO CRD42024574393.
Funding(s): This award was funded by the National Institute for Health and Care Research (NIHR) Evidence Synthesis programme (NIHR award ref: NIHR136024) and is published in full in Health Technology Assessment; Vol. 30, No. 33. See the NIHR Funding and Awards website for further award information.

Howells, K., et al. (2026) **'Shifting Boundaries of Risk-Work in Virtual Wards in North-West England: A Multisite Qualitative Evaluation.'** ***BMJ Quality & Safety***
BACKGROUND: Virtual wards (VWs) (also referred to as hospital at home (HaH)) are a key component of National Health Service (NHS) policy in England to shift

acute care from hospital to community settings. While evidence suggests these models can improve patient experience and safety, delivering acute care at home redistributes responsibility for safety across clinicians, patients and carers. The concept of *risk-work* captures the relational and contextual practices through which clinicians, patients and their carers interpret and mitigate risks associated with clinical care. However, there is limited evidence as to how risk-work is enacted in remote care, particularly when patients and carers undertake elements of that work. **METHODS**: We conducted a multisite ethnographic evaluation across four NHS VW services in North-West England (July 2024-February 2025). Data included 17 patient and five carer interviews, four patient observations, 43 staff interviews and 10 organisational level observations. Reflexive thematic analysis was guided by risk-work and Systems Thinking For Everyday Work as sensitising frameworks. **RESULTS**: *Three inter-related dimensions of risk-work were identified. Translating risk* describes how clinicians balanced protocolised guidance with tacit and relational knowledge when assessing eligibility, with decisions further shaped by workforce models. *Holding risk* illustrates the shared elements of risk-work, with temporal gaps in oversight, particularly out of hours and variation in workforce structures, shaping how risk-work was distributed between clinicians, patients and carers. *Living with and managing uncertainty* highlighted how clinicians, patients/carers navigated the unpredictability of acute illness at home. Governance structures, multidisciplinary teams and informal sense-checking provided collective safety-netting, although training and communication practices varied across sites. **CONCLUSIONS**: To our knowledge, this is the first exploration of risk-work within the context of VWs. These findings extend the previous theoretical framing of risk-work, which has focused predominantly on clinicians and in-person care. Our study demonstrates how in the context of remote acute care, risk-work is redistributed and shared with patients and carers.

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Kells E., et al. (2026) **'Learning from International Experiences Delivering Virtual Urgent Care Services through a Single Front Door: A Narrative Review.'** ***Studies in Health Technology and Informatics 336*, 2014–2018.**
As health systems increasingly adopt virtual care to improve access and reduce pressure on emergency and inpatient services, models such as single front doors (SFDs), that enable remote clinical triage, have emerged globally. Despite the growing interest in SFDs, limited evidence exists on barriers to their uptake. This narrative review identifies five key challenges including the need for seamless patient navigation, safe virtual assessment and triage, integrated patient records, workforce digital competency, and equitable digital access. Clear definition of service scope and target populations is critical to avoid service duplication and consumer

frustration. SFD models demand new workforce capabilities, including managing remote interactions and navigating fragmented information systems. Computerised triage offer promise but require ongoing evaluation to ensure clinical appropriateness and system efficiency.

Mou L., et al. (2026) **'Understanding the Relationship between Frequent Users of Emergency Departments and Primary Care Quality: A Retrospective Observational Study in England.'** ***Health Policy 171*****(pagination), Article Number: 105654. Date of Publication: 01 Se 2026.**
Background: Emergency department (A&E) crowding is a growing issue in many countries, negatively affecting patient outcomes. While demand and supply constraints are known drivers, the link between primary care quality and frequent A&E use remains unclear.
Objective(s): To explore the relationship between primary care quality and frequent A&E users in England.
Method(s): We conducted a retrospective observational study using national-level secondary data covering all major A&E attendances in England in 2016/17. We applied negative binomial regression to model the association between GP practice-level counts of frequent A&E users and nine primary care quality measures: the number of admissions with ambulatory care-sensitive conditions (ACSCs) per 1,000 registered patients, clinical performance under the Quality and Outcomes Framework (QOF), and seven GP Patient Survey-based experience indicators. Additional analyses examined total A&E users and total A&E attendances.
Result(s): Frequent A&E users were positively associated with admission rates for ACSCs and negatively associated with patient experience (the proportion of patients recommending their GP and the ability to get same-day appointments). In additional analyses, admission rates for ACSCs were similarly associated with increased total A&E users and total A&E attendance volumes. The ability to see or speak with a preferred GP was associated with a reduction in the total volume of A&E users.
Conclusion(s): The findings highlight the varying aspects of primary care quality that influence frequent A&E users. Policies aiming to reduce A&E demand could focus on improving primary care quality by reducing admission rates for ACSCs and improving patient experience at GP practices.
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NHS England. (2026) **Best practice guide for NHS frailty pathways.**

Nkhwashu J., et al. (2026) **'The use of Machine Learning in Emergency Care Units: A Systematic Review.'** ***Journal of Primary Care & Community Health 17*****, 21501319251414821.**
Emergency departments (EDs) are critical points of entry in healthcare systems

where timely and accurate decision-making is vital. Machine learning (ML) offers promising capabilities to enhance patient triage, optimize resource allocation, and improve clinical outcomes in these high-pressure environments. This systematic review investigates the application of ML in EDs, identifies commonly used algorithms and tools, examines their limitations, and provides recommendations for improvement. A structured literature search was conducted across 5 major databases: Google Scholar, Scopus, Web of Science, IEEE Xplore, and PubMed, yielding 1257 peer-reviewed articles. Studies were included if they were published between 2017 and 2024, written in English, and focused on ML applications in EDs within the fields of Computer Science, Engineering, Decision Science, or Mathematics. Exclusion criteria eliminated articles under 6 pages, inaccessible full texts, non-ML-focused studies, and publications such as proposals, abstracts, or book reviews. After screening and quality assessment by 2 independent reviewers, 27 studies were selected for in-depth analysis. Of these, 88.9% were journal articles, 7.4% book chapters, and 3.7% conference proceedings. Findings reveal that the various ML algorithms applied in EDs are context-dependent and use various evaluation metrics, while tools for data extraction and analysis include Python, Keras, TensorFlow, SQL, MATLAB, RStudio, and IBM SPSS. The identified limitations involved data complexity, model accuracy, lack of generalizability, and incomplete datasets. Recommendations across studies emphasized the need to broaden data sources, integrate additional predictors, and improve algorithmic comparisons. This review contributes to the growing body of knowledge on ML in emergency care by synthesizing current practices, highlighting critical challenges, and offering practical directions for future research and implementation.

Rasic D., et al. (2026) **'Perceived Emergency Department Avoidance Following Virtual Provider-to-Provider Consultation: A Cross-Sectional Study.'** ***Journal of Primary Care & Community Health 17*****, 21501319261455398.**
BackgroundLimited access to specialty care contributes to emergency department (ED) crowding in Canada. Virtual provider-to-provider consultation platforms may support primary care management and reduce unnecessary ED utilization. The purpose of this study was to assess primary care providers' perceptions of whether virtual peer-to-peer consultations prevented ED visits.MethodsWe conducted a cross-sectional analysis of post-consultation surveys completed by clinicians using the Virtual Hallway platform, an electronic consultation system enabling synchronous specialist advice to primary care providers, in Nova Scotia, Canada. Providers reported whether the consultation helped manage the patient's condition and whether it potentially prevented an ED visit. Urgency of avoided escalation was also recorded. Descriptive analyses examined responses by provider type, specialty, and geographic zone.ResultsAmong 587 respondents, 29.1% believed the consultation prevented an ED visit, 51.6% did not, and 19.3% were unsure. Perceived ED avoidance was higher in rural zones (35.0%) than in the urban Central Zone

(22.4%). Among avoided visits, 9.9% were classified as highly urgent, 53.2% moderately urgent, and 36.8% not urgent. Nearly all respondents (96.3%) reported improved patient management.ConclusionsVirtual peer-to-peer consultation was perceived to prevent ED visits in nearly one-third of cases, with greater impact in rural settings. These findings suggest potential system-level benefits in reducing avoidable emergency care utilization.

Santos Gomes B., et al. (2026) **'How are Handover Delays from Ambulances to Emergency Departments being Addressed in the United Kingdom? A Nationwide Survey of Ambulance Services and Emergency Departments.'** ***BMC Emergency Medicine 26*****(1) (pagination), Article Number: 134. Date of Publication: 01 Dec 2026.**

Background: Excessive waiting times and ambulance handover delays are of high concern to healthcare professionals and the public internationally. Ambulance services and emergency departments (EDs) have attempted to mitigate delays but the initiatives implemented have not been systematically described. To inform site selection for a national evaluation of such initiatives (the STALLED study), we set out to identify and describe initiatives that have been implemented at the ED entrance to address delayed ambulance handover in the United Kingdom (UK).

Method(s): Survey of current practice in all UK ambulance services (a total of 13) using a semi-structured questionnaire, distributed by email, focusing on initiatives based at the door of emergency departments, for completion and return by email or telephone interview. We also sent the questionnaire to a purposive sample of 24 EDs, identified from ambulance service responses. We summarised and coded initiatives reported and mapped them to the Systems Engineering Initiative for Patient Safety model, to support an understanding of where and how those initiatives influenced the healthcare system.

Result(s): Twelve of 13 ambulance services and 16 of 24 EDs responded to the questionnaire describing 34 and 36 initiatives respectively. All respondents reported having several (between two and 12 per service) initiatives in place to reduce handover delays, most commonly involving ambulance staff caring for groups of patients in ED corridors (8/12), coordinated patient handovers within a defined time period (7/12), and ED reconfiguration to facilitate rapid offload (10/16). Most initiatives focussed on changes which influenced the organisation of care, the introduction or revision of key tasks and roles for staff, as well as changes to the ED environment.

Conclusion(s): Ambulance services and EDs have implemented a variety of initiatives to reduce handover delays. Most of the initiatives involve multiple parts of the system, including tasks, staff, the organisation and the internal environment. These complex initiatives require careful study to understand how they work and how they can inform best practice.

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Scott L.J., et al. (2026) **'Clinical Acuity and National Early Warning Scores (NEWS2) of Remotely Monitored Patients on Virtual Wards: A Retrospective Cohort Study.'** ***Plos One 21*****(4 April) (pagination), Article Number: e0347678. Date of Publication: 01 Ar 2026.**

Background Virtual wards are an NHS priority, designed to deliver acute care, monitoring and treatment to people at home, providing an alternative to hospital admissions or facilitating earlier hospital discharge. The aim of this study was to understand the clinical acuity, care pathways and outcomes of people admitted to virtual wards in Bristol, North Somerset and South Gloucestershire (BNSSG) who were remotely monitored. Methods A retrospective observational cohort study of all remotely monitored patients aged 16 + years admitted to a virtual ward in BNSSG between October 2023-February 2025. Clinical observations (respiratory rate, oxygen saturations, systolic blood pressure, pulse rate and temperature) were collected, and National Early Warning Scores (NEWS2) were calculated. The area under the curve (AUC) of NEWS2 to predict hospital (re)admissions is presented. Results 2,533 admissions across five care pathways were included: respiratory (41%), frailty (18%), outpatient parenteral antimicrobial therapy (19%), heart failure (7%) and general (18%; pathways not mutually exclusive). Median virtual ward length of stay was 10 days (interquartile range 6-14). During the study period, 177 (7%) virtual ward admissions resulted in a hospital (re)admission and 9 (<1%) died. First NEWS2 = 0-2 in 1,651/2,479 (67%) admissions, NEWS2 = 3-4 in 569 (23%), NEWS2 = 5-6 in 204 (8%) and NEWS = 7+ in 55 (2%) admissions. Maximum NEWS2 was reasonably low during most admissions, with 800/2,479 (32%) NEWS2 = 0-2, 887 (36%) NEWS2 = 3-4, 568 (23%) NEWS2 = 5-6, and 224 (9%) NEWS2 = 7 +. The clinical acuity of most patients remained stable, with 964/2,331 (41%) deteriorating by 1-2 points and 696 (30%) not deteriorating at all. Both first NEWS2 and maximum NEWS2 had poor ability to predict hospital (re)admission (AUC 0.55 [95% CI 0.51-0.60] and 0.55 [95% CI 0.50-0.59], respectively). Conclusion Most remotely monitored patients had low clinical acuity on admission to virtual wards, however 10% had high clinical acuity with a NEWS2 value of at least 5. The distribution of NEWS2 on admission to virtual wards was very similar to the distribution of NEWS2 on admission to acute hospitals, as identified in the 2022 Society for Acute Medicine Benchmarking Audit. NEWS2 had poor predictive accuracy in this setting. However, hospital (re)admission rates were low (7%) so this should be interpreted with caution.

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Shaw M., et al. (2026) **'Real-World Outcomes from 2, 905 Episodes of Hospital at Home Care: A Propensity-Matched Cohort Study.'** ***Frontiers in Digital***

***Health 8*(pagination), Article Number: 1716319. Date of Publication: 2026.**
Background - Hospital at home (HAH) services within the UK have expanded rapidly over the last 5 years, but there is comparatively little evidence demonstrating their clinical effectiveness. In this study, we evaluated the clinical outcomes, safety, and cost-effectiveness of a comprehensive HAH service in England. Methods - We conducted a retrospective cohort study of patients admitted to our HAH service between December 2021 and May 2024, including pathways for heart function, airway disease, and acute respiratory infection. A 1:1 propensity score matched control cohort of patients admitted to inpatient care was created, using regression adjustment to derive doubly robust estimates of main outcomes. Primary outcomes included length of stay and total bed-day costs. Secondary outcomes included 30-day readmission rates, 90-day mortality, and patient experience and acceptability metrics. Results - We analysed 2, 972 HAH episodes, yielding, after exclusions, a total of 1, 488 inpatient-originated (IP) episodes that were matched 1:1 to controls, as well as 754 admission prevention episodes for a separate analysis. HAH reduced length of stay compared with matched inpatient controls (bed-day savings: 3.13 days, 95% CI 2.60-3.67, p $^{-29}$). Total bed-day savings were 13, 119 days, yielding net savings of 3.79 million over 33 months. All-cause 30-day readmission rates were significantly lower in HAH cohorts than in matched controls (OR 0.55, 95% CI 0.42-0.70, p). Total bed-day savings were 13, 119 days, yielding net savings of 3.79 million over 33 months. All-cause 30-day readmission rates were significantly lower in HAH cohorts than in matched controls (OR 0.55, 95% CI 0.42-0.70, p $^{-6}$), as was total time in hospital over 90 days from initial presentation (2.64 days fewer, 95% CI 1.87-3.40, p), as was total time in hospital over 90 days from initial presentation (2.64 days fewer, 95% CI 1.87-3.40, p $^{-11}$) and 90-day all-cause mortality (OR 0.43, 95% CI 0.35-0.53, p) and 90-day all-cause mortality (OR 0.43, 95% CI 0.35-0.53, p $^{-16}$). Conclusions - This large real-world evaluation demonstrates that HAH services significantly reduce length of stay, readmissions, and healthcare costs while maintaining safety and possibly reducing mortality. These findings support a wider implementation of HAH.
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TaylorRowan M., et al. (2026) **'Psychometric Evaluation of the Healthcare Improvement Scotland 'Think Frailty' Tool in Unscheduled Care Settings.'** ***Age and Ageing 55*(5) (pagination), Article Number: afag142. Date of Publication: 01 May 2026.**
Introduction: The Healthcare Improvement Scotland 'Think Frailty' tool (HIS-Frailty) was developed to allow frailty triage in unscheduled care. Development was iterative, with a change around assessment of support needs to improve completion. We evaluated the psychometric properties of HIS-Frailty.
Method(s): We used data from prospective, national audits of frailty screening.

Consecutive adults aged >=65 who presented as unscheduled admissions to hospital were assessed with the tool across three phases of data collection (2017-2023). Frontline healthcare workers completed HIS-Frailty and a reference standard of the Clinical Frailty Scale. We assessed concurrent validity (Pearson's correlations), discrimination (area under curve; AUC), feasibility (percentage of missing data), predictive validity for 30-day mortality and duration of hospital stay (regression), factor structure (maximum likelihood factor analysis), intra-rater reliability and inter-rater reliability (adjusted kappa).
Result(s): A total of 2447 older adults were included. HIS-Frailty scores were significantly correlated with Clinical Frailty Scale (r = 0.78, P < .001), discrimination was excellent (AUC: 0.93, 95% CI = 0.92-0.95). All domains of HIS-Frailty had <1.5% missing data. HIS-Frailty scores were associated with 30-day mortality (OR: 1.49, 95% CI = 1.32-1.69) and being in hospital at 30-days (OR: 1.73, 95% CI = 1.52-1.96). Factor analysis indicated a single underlying factor accounting for 43.4% variance. Intra-rater agreement was good (Kappa = 0.71, 95% CI: 0.53-0.88). Inter-rater agreement between specialist and non-specialist assessors was substantial (Kappa: 0.83, 95% CI: 0.68-0.97).
Conclusion(s): HIS-Frailty has good psychometric properties for 'front door' frailty screening and can be used consistently and effectively by non-specialist assessors.
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Travis, H. L. (2026) 'Redesigning the First Point of Contact for Walk-in Patients in the Emergency Department: A Service Evaluation of the First Encounter Model.' *Emergency Nurse : The Journal of the RCN Accident and Emergency Nursing Association 34*(3), 19–25.
In UK emergency departments (EDs), crowding, lack of inpatient beds and high patient acuity, compounded by triage 'bottlenecks', inconsistent streaming and fragmented communication between healthcare professionals, can compromise patient care, safety and experience. This article details the evaluation of a service improvement initiative - the First Encounter model - that aimed to address these issues through redesigning the first point of contact for walk-in patients. The initiative involved the co-location of two senior healthcare professionals - a band 6 or 7 senior nurse and the emergency physician in charge (EPIC) - at the ED entrance during peak hours. The aim was to improve the timeliness of patient assessment, strengthen patient experience and support staff's confidence in their clinical decision-

making. The findings revealed that the percentage of patients who received clinical engagement within 15 minutes of arrival at the ED more than doubled; the average triage time halved; compliance with the four-hour target improved modestly; waiting-room congestion reduced; and staff felt more confident in their clinical decision-making. The model appears scalable and adaptable to other EDs, although further evaluation is required to establish its sustainability and broader patient outcomes. Copyright © Royal College of Nursing of the United Kingdom (The) 2025. All rights reserved. Not to be copied, transmitted or recorded in any way, in whole or part, without prior permission of the publishers.

Vakkalanka J.P., et al. (2026) **'Outcomes Associated with Hospital at Home Vs Traditional Inpatient Stay.'** ***JAMA Network Open 9*****(5) (pagination), Article Number: e2610810. Date of Publication: 2026.**

Importance Inpatient care is costly, and an aging population, hospital bed shortages, and practitioner shortages stretch inpatient capacity. Alternative modalities of acute care delivery may support growing demands. Objective To compare outcomes of hospital at home (HaH) vs traditional inpatient hospital admissions and to assess facility-level variability in HaH utilization. Design, Setting, and Participants This propensity score-matched, retrospective, comparative effectiveness research study used data for age-qualifying (>=65 years) fee-for-service Medicare beneficiaries admitted from January 1, 2021, through December 1, 2022, within HaH-waivered US hospitals that had 12 or more HaH admissions. Analyses were completed from November 2024 to March 2026. Exposure HaH vs traditional inpatient hospitalization. Main Outcomes and Measures Primary clinical outcomes were in-hospital mortality and hospital readmissions and emergency department (ED) visits within 30 days of index admission discharge. Facility-level characteristics were assessed for facilities that had HaH admissions above and below the median (>=149 admissions). Conditional logistic regression was used for dichotomous outcomes, with adjusted odds ratios (aORs) and 95% CIs reported. Log-transformed linear regression was used for skewed continuous outcomes within matched pairs, with adjusted percentage changes and 95% CIs reported. Results Among 15 871 Medicare beneficiaries (4174 HaH and 11 697 traditional inpatient admissions), the overall mean (SD) age was 77.4 (8.0) years, and 8396 beneficiaries (56.2%) were female. Of 313 HaH-waivered hospitals, 68 were eligible for inclusion, and 11 hospitals accounted for approximately 50% of all HaH admissions. Compared with traditional inpatient admissions, HaH admissions were associated with lower in-hospital mortality (16 of 4174 admissions [0.4%] vs 423 of 11 697 admissions [3.6%]; aOR, 0.09; 95% CI, 0.06-0.16) and lower ED use within 30 days of discharge (366 of 4174 admissions [8.8%] vs 1164 of 11 697 admissions [10.0%]; aOR, 0.86; 95% CI, 0.76-0.97), with no significant difference in readmissions within 30 days of discharge (490 of 4174 admissions [11.7%] vs 1282 of 11 697 admissions [11.0%]; aOR, 1.07; 95% CI, 0.96-1.20). Conclusions and Relevance In this retrospective comparative

effectiveness research study of Medicare beneficiaries, HaH was associated with lower in-hospital mortality and ED use within 30 days of discharge, but not hospital readmissions within 30 days, compared with traditional inpatient care. These findings support HaH as an approach that may maintain similar or better short-term outcomes among appropriately selected patients; future studies should evaluate implementation and equity.
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Vanasse L., et al. (2026) **'Predictors of Bounce Back for Children Redirected by Triage Nurses from the Pediatric Emergency Department.'** ***Canadian Journal of Emergency Medicine 28*****(4), 318–329.**
Objectives: To address crowding, our pediatric emergency department (ED) implemented a triage nurse-led protocol to redirect non-urgent patients to external pediatric clinics, other healthcare providers, family physicians, or home. This study aimed to identify the proportion of redirected children who returned to the ED and identify predictors of return.
Method(s): We conducted a health records review study of children under 18 years redirected from the ED of a tertiary pediatric hospital in Montreal, Canada. A random sample of 150 return visits and 300 controls was selected for a nested case-control study. The primary outcome was a return visit to the ED within 7 days. Potential predictors included demographic information, disease characteristics, triage level, and initial orientation. We calculated the proportion of return visits and performed univariate and multivariable analyses of identified predictors.
Result(s): Between September 2023 and August 2024, 80,221 children were triaged, of whom 6,556 (8.2%) were redirected. Within 7 days, 372 (5.7%) returned. Among the 150 reviewed return visits, 127 (85%) were related to the initial complaint: 64 (43%) were due to persistent symptoms, 49 (33%) to clinical deterioration, 6 (4%) were sent back by a physician, and 5 (3%) were for new symptoms. Seven patients (4.7%) required hospitalization on their return visit. Predictors associated with a lower probability of return included ear, nose, throat, and dental complaints, as well as redirection to specialized or pediatric clinics.
Conclusion(s): Approximately, 6% of redirected children returned to the ED within 7 days, most often for persistent or worsening symptoms. Identifying predictors of return visits provides evidence to refine redirection guidelines and enhance the safety and effectiveness of triage nurse-led redirection strategies.
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Williams M., et al. (2026) **'Optimising Emergency Care in a Primary Care Network.'** ***The British Journal of General Practice : The Journal of the Royal College of General Practitioners 76*****(Supplement 1) (pagination), Date of Publication: 01 May 2026.**

BACKGROUND: Emergency care is a primary care challenge, where low-frequency, high-acuity events require safety and excellence. Enhancing these services aligns with organisational values and Care Quality Commission (CQC) standards. This project sought to identify and address gaps in care delivery, stock management, and staff training for the 90 000 patients and 300 staff of all seven Brownlow Health primary care network sites in Liverpool, England. AIM: To improve emergency care delivery across Brownlow Health for patient benefit.
METHOD(S): Structured interviews were conducted with stakeholders, site checks performed, and reflective practice considered. A fishbone diagram was used for root-cause analysis across domains of environment, methods, clinical guidelines, equipment, and people. A driver diagram outlined change theories focusing on aligning protocols with authoritative guidance, staff development, and resource availability. Plan-Do-Study-Act cycles guided implementation. Digital stock check processes were established for ongoing audits.
RESULT(S): Emergency protocols were developed and distributed. Emergency bag stock was revised. Educational meetings received positive feedback. Subjective results included increased awareness of emergency procedures, increased confidence to follow guidelines, and improved knowledge of equipment locations. Audit data demonstrated improved protocol access and training uptake. Clinician oversight ensured stock and clinical checks. Digital processes objectively improved stock control and pharmacy supply. Change embedded by establishing monthly managerial site visits.
CONCLUSION(S): This project successfully embedded emergency care enhancements, fostering staff engagement and CQC alignment. Key learning is that pursuing unexpected root causes and leveraging broad stakeholder engagement can have expansive impact. Future annual reviews facilitated by digitalisation will likely sustain improvements.
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Zou C., et al. (2026) **'Impact of Announced Wait Time Information on Emergency Department Overcrowding Mitigation: A Simulation Study.'** ***Journal of the American Medical Informatics Association 33*****(6), 1112–1120.**
Objective: Despite widespread implementation of predicted patient wait time information systems in hospital emergency departments (EDs), the relationship between quality of announced wait time information and ED overcrowding mitigation remains unclear. This study investigates how prediction accuracy, update frequency, and patient adoption rates affect ED overcrowding level.
Material(s) and Method(s): A data-calibrated simulation model was developed using patient visit records from three metropolitan EDs in Hong Kong. We systematically varied patient adoption rates and evaluated seven wait time prediction methods across four update frequencies. Key performance metrics included the mean and standard deviation of patient wait times and percentage of patients left without being

seen (LWBS rate).
Result(s): Accurate prediction methods combined with frequent updates significantly reduced the mean and standard deviation of patient wait times and LWBS rate as patient adoption rate increased. Conversely, inaccurate prediction methods exhibited a U-shaped performance curve. Specifically, when the patient adoption rate was sufficiently high, these methods significantly increased the mean and standard deviation of wait times and LWBS rate, compared to the case with no predicted wait time.
Conclusion(s): Implementing information systems to display predicted patient wait times requires carefully balancing prediction accuracy, update frequency, and patient adoption. Accurate and timely updates can help redistribute patient load across hospital networks and improve efficiency, while poor accuracy or infrequent updates risk worsening ED congestion, especially when patient adoption rate is high. Our study calls for immediate attention from ED managers to carefully evaluate the impact of announced wait time system before wide implementation.
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Zou M., et al. (2026) 'Facilitators and Barriers to Triage Efficiency in Adult Emergency Departments: An Integrative Literature Review.' *Australasian Emergency Care 29*(2), 119–124.
Purpose Triage is a critical process for patient prioritisation in emergency departments (EDs) that aims to rapidly allocate patients to the appropriate level of emergency care commensurate with clinical urgency. Triage completion is expected within two to five minutes while ensuring patient safety. The purpose of this review is to identify the facilitators and barriers to triage efficiency in EDs and provide an overview of how these factors impact the triage process. Procedures An integrative literature review was conducted with a structured search across six databases, including CINAHL, Embase, Medline, Scopus, ProQuest, and PubMed. Twenty studies met the inclusion criteria and were narratively synthesised. Findings Factors affecting triage efficiency were grouped under four themes. Process-related factors such as workflow designs, electronic triage support decision tools, "quick look" triage approaches, and system inefficiencies; nurse-related factors like experience, educational attainment, cognitive approach, and fatigue; environmental and system-

related pressures such as interruptions, high patient volume, overcrowding, and availability of adequate triage spaces and equipment; and patient factors, including patient complexity, all shaped triage efficiency. Conclusion Triage efficiency is a dynamic and context-sensitive outcome shaped by multiple factors. Some factors are modifiable, and further studies are needed to explore targeted interventions and their impact on triage efficiency in emergency care.
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