



**Library and
Knowledge Services**

Saving you time so you can save lives



Unscheduled care

March 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.

If you require specific information, please [contact us via email](#).

References

Altun M., et al. (2026) '[Impact of Transition Units on Emergency Department Crowding: A before-and-After Study.](#)' *Journal of Emergency Medicine* 81, 68–77.

Background Emergency department (ED) crowding is a major operational problem driven by access block. Transition units (TUs) have been proposed to mitigate boarding delays, but their quantitative impact remains insufficiently characterized. **Objectives** To evaluate the effect of implementing medical and surgical TUs on ED crowding, measured by the National Emergency Department Overcrowding Scale (NEDOCS). **Methods** This single-center prospective study evaluated crowding in a tertiary academic ED before and after TU implementation. NEDOCS scores were prospectively measured 6 times daily between April 23 and May 31, 2025, when both medical and surgical TUs were fully operational. Data from identical calendar periods in 2021 (pre-TU) and 2023 (medical TU only) served as comparators. The primary outcome was the NEDOCS score; secondary outcomes were NEDOCS parameters and categorical level distributions. **Results** The median NEDOCS score in 2025 was 85.6 (IQR 66.2-117.0), significantly lower than 2021 (137 [IQR 114.0-173.0]) and 2023 (132 [IQR 108.0-181.0]) (both $p < 0.001$). Overcrowded or worse conditions (Levels IV-VI) decreased from 81.5% (2021) and 80.6% (2023) to 38.4% (2025) ($p < 0.001$). Boarding numbers and longest boarding times also fell significantly, whereas overall patient inflow to the ED remained comparable across years. **Conclusions**

Implementation of dual TUs was associated with substantial reductions in ED crowding severity, as reflected by lower NEDOCS scores and improved operational metrics. Expanding TU capacity across specialties is an effective structural strategy to relieve access block in high-volume EDs.

Copyright © 2025 Elsevier Inc.

Cooper B.L., et al. (2026) ['The Dugout: Reimagined Team-Based Triage in the Emergency Department.'](#) *Journal for Healthcare Quality : Official Publication of the National Association for Healthcare Quality* 48(1) (pagination), Date of Publication: 01 Jan 2026.

BACKGROUND: Emergency department (ED) crowding is a crisis of an overstrained health care system that is associated with poor patient outcomes and dissatisfaction. We aimed to assess the effect of an interdisciplinary, provider-led triage team, "the Dugout," on ED length of stay (LOS), door-to-provider (DTP), and left without being seen (LWBS) rates.

METHOD(S): We used a before-and-after design. The setting is an urban, teaching, adult and pediatric 63-bed emergency department with a total annual volume more than 90,000 and an admission rate of 35%. Data were collected on adult patients (18 years and older) who presented during a similar 6-month period before (October 2023-March 2024) and after (October 2024-March 2025) implementation of the Dugout.

RESULT(S): There were 34,106 and 31,704 adult encounters in the pre- and postimplementation periods, respectively. The Dugout was associated with a reduction in LWBS from 14.1% to 3.0% ($p < .001$). DTP decreased from a median of 59 to 38 minutes ($p < .001$). The median overall ED LOS decreased from 448 to 429 minutes ($p < .001$), and the LOS for discharged patients decreased from 407 to 344 minutes ($p < .001$).

CONCLUSION(S): The introduction of a dedicated, interdisciplinary team stationed in the triage area was associated with reduced LWBS, DTP, and ED LOS.

Copyright © 2025 National Association for Healthcare Quality.

Durando F., et al. (2026) ['Impact of Early Blood Testing on Emergency Department Length of Stay during Overcrowding.'](#) *International Emergency Nursing* 85(pagination), Article Number: 101772. Date of Publication: 01 Mar 2026.

Background: Emergency Department (ED) overcrowding significantly impacts patient care, increasing wait times and delaying treatment. This study evaluates a quality improvement project involving the implementation of an early nursing care protocol designed to optimize patient management during overcrowding by enabling nurses to initiate blood tests during triage. **Local Problem:** In our high-volume urban ED in Northern Italy, recurrent overcrowding particularly affected patients with non-urgent triage codes, resulting in prolonged door-to-treatment times and decreased patient satisfaction. Nurses were underutilized in early diagnostic workflows.

Method(s): The study assessed the effectiveness of a protocol involving a predefined set of blood tests performed during the post-triage waiting period under overcrowding conditions in adult patients presenting with chest or abdominal pain and a triage level 2 to 5 at the ED of Santa Croce e Carle Hospital in Cuneo, Italy, from January 1, 2024, to June 20, 2024. The primary outcome was the reduction in ED treatment time and length-of-stay (LOS) during overcrowding among patients managed with the protocol.

Intervention(s): The intervention consisted of nurse-initiated blood draws using predefined criteria and an electronic lab test panel. The protocol was activated only during predefined periods of severe ED crowding, based on local operational thresholds.

Result(s): 3,857 patients were included, with 38% undergoing early blood testing due to overcrowding; patients in the early testing group (i.e. patients managed during overcrowding) experienced a significantly longer waiting time (142 min vs. 48 min, $p < 0.001$). However, their treatment time was significantly shorter (132 min vs. 162 min, $p < 0.001$), resulting in a less pronounced increase in total ED LOS. Subgroup analyses confirmed consistent reductions in treatment time across different triage levels and presenting symptoms.

Conclusion(s): Early nursing-led blood testing during ED overcrowding enhances efficiency by reducing treatment times, enabling earlier clinical decision-making, and improving patient monitoring. Despite increased total ED LOS due to overcrowding, this increase appears to be lower than what the prolonged waiting time due to overcrowding itself might have suggested. This quality improvement initiative highlights the potential for advanced nursing roles to optimize emergency care delivery. Further research should assess patient satisfaction and cost-effectiveness.

Copyright © 2026 Elsevier Ltd

Ehrlington S.M., et al. (2026) '[Frailty Alerts Reduce Waiting Time and Length of Stay in the Emergency Department.](#)' *Academic Emergency Medicine* 33(2) (pagination), Article Number: e70239. Date of Publication: 01 Feb 2026.

Background: Prolonged emergency department waiting times are associated with increased mortality among older patients. In January 2025, the ED of Linköping University Hospital, Sweden, implemented a low-resource routine to expedite the workup of older patients living with frailty by prioritized physician assessment and subsequent workup.

Aim(s): To investigate if a frailty alert using the Clinical Frailty Scale followed by prioritized clinical assessment influences ED operating metrics.

Design(s): This was an observational before and after study of a pre-implementation group (control) and a post-implementation group (intervention) between October 2024 and February 2025. **Setting/Participants:** Consecutive patients aged > 64 years, with a documented CFS assessment during the ED visit at the Linköping University Hospital, Sweden, who consented to participation, were included.

Method(s): Standard ED operating metrics, Time to physician, ED length of stay (LOS), and admission rates were compared between a pre-implementation group and a post-implementation group.

Result(s): A total of 542 ED visits were analyzed (248 pre-implementation, 294 post-implementation). Time to physician was shorter in the post-implementation group at 31 min (IQR 15, 65) versus 44 min (IQR 20, 94) ($p < 0.001$). ED LOS was reduced from 352 (IQR 266, 515) to 319 (IQR 240, 458) minutes ($p = 0.014$). The admission rate was unchanged at 59% and 60% ($p = 0.4$).

Conclusion(s): Frailty alerts based on the CFS with prioritized workup reduced ED LOS and time to physician in older patients living with frailty in this single center study and may be a low-resource intervention to reduce the risks of adverse events in the ED. Trial Registration: ClinicalTrials.gov identifier: NCT06869148.

Copyright © 2026 The Author(s). Academic Emergency Medicine published by Wiley Periodicals LLC on behalf of Society for Academic Emergency Medicine.

European Observatory on Health Systems and Policies. (2026) [Dealing with the challenges in urgent and emergency care: What are the policy options? Policy brief 74.](#)

Holdsworth E., and Rayment, C. (2026) '[Responsive Emergency Assessment and Community Team: An Acute Palliative Medicine Virtual Ward with Emergency Department in-Reach.](#)' *BMJ Supportive & Palliative Care* (pagination), Date of Publication: 18 Feb 2026.

OBJECTIVES: More than 50% of people who die in England and Wales use an ambulance at least once in their last 3 months of life, and around 50% attend the emergency department (ED). In Bradford, an estimated 1000 patients a year are not recognised as being within the last year of life and do not access palliative care services. We aimed to improve access to palliative care and reduce hospital admissions and days spent in hospital during the last year of life.

METHOD(S): We created the Responsive Emergency Assessment and Community Team (REACT), comprised of both ED palliative medicine in-reach and a community virtual ward. The virtual ward accepts patients as 'step-down' from the hospital and 'step-up' from primary care to avoid hospital admissions through intensive holistic support.

RESULT(S): Between June 2022 and March 2025, REACT received 1656 referrals. Within the last 12 months, 83% of referrals received face-to-face review. 64% of patients seen by the service had a non-cancer palliative diagnosis, and those seen by REACT were representative of the local population both by ethnicity and by deprivation index. By March 2025, patients known to REACT had a reduction in the number of days spent in hospital in the last year of life by 55%.

CONCLUSION(S): REACT has a valuable impact on patient care, autonomy, quality of life and reduces health inequity for patients with life-limiting illnesses. By reducing

time spent in the hospital in the last year of life, the service creates additional capacity across the entire healthcare system.

Copyright © Author(s) (or their employer(s)) 2026. No commercial re-use. See rights and permissions. Published by BMJ Group.

Howlett N., et al. (2026) '[Medical Patient Boarding in the Emergency Department as a Source of Crowding and Delay-Related Harm, Impacting Patient Outcomes and the Efficiency of Urgent and Emergency Care.](#)' *Emergency Medicine Journal* (pagination)

Background Previous studies have indicated that crowding within the emergency department (ED) is associated with longer lengths of stay in the ED and higher mortality. Boarding, the time patients spend waiting for an inpatient bed after ED assessment, represents a clinically unproductive delay and occupies scarce ED resources. We explore the association of medical patient boarding not only with their outcomes but also indirectly for other patients in the ED and those in and awaiting ambulances. **Methods** A retrospective cohort study using routine data for 3 EDs in England from July 2023 to May 2025 was performed. Direct, delay-related harm outcomes of medical patient boarding time were investigated: inpatient length of stay and 30-day re-admission and mortality rates. Indirect, crowding-mediated outcomes of medical patient boarding levels consisted of time in ED for non-admitted patients, ambulance handover times and Category 1, Category 2 and Category 3 ambulance response times. Mixed-effects regression analysis modelled each relationship while controlling for potential confounding. **Results** The study examined 49 034 medical admissions, 210 334 non-admitted ED patients, 88 633 ambulance handovers and 146 278 ambulance responses. Medical patients, accounting for two-thirds of ED admissions, constituted 81% of total ED boarding time. Regression analysis showed that for a typical 25-bed ED, each additional five medical boarders was associated with an extra 7.9 min and 51.9 min ambulance response times for Category 2 and Category 3 calls and an extra 9.9 min of extra ambulance handover time. For admitted medical patients, each additional 4 hours of boarding time was associated with an extra 8.6 hours of inpatient length of stay and an 8.4% increase in the odds of 30-day mortality. **Conclusion** Boarding medical patients in the ED is associated with a significant increase in their risk of harm, including higher mortality and longer hospital stays. It also adversely affects other patients by delaying ambulances and reducing overall bed availability through extended inpatient stays.

Copyright © Author(s) (or their employer(s)) 2026. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ Group.

Mason A., et al. (2026) '[Nurse-Led Visits Reduce in-Person Referral from Urgent Care Telehealth.](#)' *Pediatric Emergency Care* 42(2), 114–120.

Objective: - To evaluate the impact of nurse-led visits on in-person referrals for clinical evaluation from pediatric urgent care telehealth.

Method(s): - We conducted this quality improvement study within our 3 freestanding

in-person pediatric urgent care clinics and telehealth service. In May 2022, we implemented nurse-led visits to offer diagnostic and therapeutic interventions including rapid group A streptococcal testing, urinalysis, respiratory viral testing, and intramuscular antibiotic injections without requiring an additional clinical evaluation following a telehealth encounter. We measured the percentage of telehealth encounters with in-person referrals as the primary outcome. We tracked the percentage of encounters with nurse-led visits and return visits within 72 hours as process and balancing measures, respectively. We used control charts to identify special cause variation over time.

Result(s): - In-person referrals following telehealth visits decreased from 23.0% to 12.3% after implementing nurse-led visits. The use of nurse-led visits increased over time from 4.0% to 6.8%. Rapid group A streptococcal testing accounted for most nurse-led visits (64.0%). Only 2.8% of nurse-led visits resulted in return visits within 72 hours. Nurse-led visits were associated with shorter length of stays (32 min) compared with in-person clinical evaluations (69 min) and had an average cost-savings of \$135 compared with visits of similar medical complexity.

Conclusion(s): - Integrating nurse-led visits into urgent care telehealth encounters provides a safe and effective option for diagnostic and therapeutic interventions in the virtual setting. The results support the use of nurse-led visits to expand access to high-quality acute care, reduce unnecessary referrals, and promote evidence-based practice.

Copyright © 2025 Wolters Kluwer Health, Inc. All rights reserved.

Moloney E., et al. (2026) '[Development of a Novel Frailty Trigger for use at Triage in the Emergency Department.](#)' *Academic Emergency Medicine* 33(2) (pagination), Article Number: e70165. Date of Publication: 01 Feb 2026.

Background: Emergency Department (ED) Triage identifies patients with urgent needs. Frailty is not routinely identified and older patients presenting atypically may be inappropriately triaged as low priority. The introduction of a frailty modifier at triage is recommended in international guidelines, but is not yet widely-adopted.

Method(s): A Frailty Trigger was developed following a systematic review and two-round eDelphi. To investigate diagnostic test accuracy for frailty, we recruited consecutive adults aged ≥ 70 attending a university hospital ED between December 2021 and February 2022, comparing the Trigger to the Clinical Frailty Scale (CFS), Variable indicative of Placement (VIP), and PRISMA-7. An independent comprehensive geriatric assessment (CGA) determined frailty status.

Result(s): In total, 313 adults aged ≥ 70 years were available, median age 78 +/- 9 years and 46% were female. Half (51%) were frail based on the CGA. The Frailty Trigger had excellent diagnostic accuracy for frailty, Area Under the Curve (AUC) of 0.822, 95% confidence interval (CI): 0.780-0.865, similar to the VIP (AUC 0.820, $p = 0.937$), although significantly lower than the PRISMA-7 (AUC 0.896) and CFS (AUC 0.946). Mean administrative time was 25.5 s (SD +/-10.9 s). Scoring positive on the

Frailty Trigger was associated with increased length of stay (LOS), median 6.4 versus 2.3 days ($p < 0.001$). After adjustment for age, sex, and co-morbidity, a positive score was associated with reduced survival at 1 year (Hazard Ratio 2.2; 95% CI 1.15-4.33, $p = 0.017$).

Conclusion(s): When applied as part of ED triage, the Frailty Trigger showed excellent diagnostic accuracy for frailty when compared to validated screens and was quick to use. It predicted LOS and mortality. Studies are required to examine feasibility and its effect on frailty pathways from triage.

Copyright © 2025 The Author(s). Academic Emergency Medicine published by Wiley Periodicals LLC on behalf of Society for Academic Emergency Medicine.

Morita K., et al. (2026) 'Patient Outcomes After Triage by Emergency Departments with Or without Advanced Practice Nurses in Japan: A Retrospective Cohort Study using a Nationwide Inpatient Database.' *International Journal of Nursing Studies* 177, 105371.

BACKGROUND: Nurses play an important role in triage and delivering emergency care. According to previous studies, advanced practice nurses may be associated with better patient outcomes in emergency departments. However, existing evidence is limited, largely derived from high-income Western countries. Thus, the results may not be applicable to other regions. Broader and contextually diverse evidence is needed to inform international workforce planning and policy.

OBJECTIVE(S): To determine whether the presence of advanced nursing roles (certified nurses and certified nurse specialists) in emergency departments is associated with patient outcomes among adults undergoing triage. DESIGN:

Retrospective cohort study using a nationwide inpatient database. SETTING: Acute care hospitals across Japan. PARTICIPANTS: A total of 440,420 patients admitted after emergency department triage at 1012 hospitals between 2013 and 2022.

METHOD(S): In-hospital mortality and length of stay were evaluated using multivariable regression with generalized estimating equations, adjusting for detailed patient and hospital characteristics and accounting for within-hospital clustering. To address potential heterogeneity across clinical contexts, the analyses were stratified by the International Classification of Diseases, 10th Revision major diagnostic categories, and random effects meta-analysis was used to synthesize pooled estimates.

RESULT(S): In-hospital mortality was significantly lower in hospitals with certified nurses and/or certified nurse specialists in the emergency department for specific diagnostic categories, including certain infectious and parasitic diseases (adjusted odds ratio, 0.57; 95% confidence interval, 0.38-0.84) and endocrine, nutritional, and metabolic diseases (adjusted odds ratio, 0.65; 95% confidence interval, 0.45-0.94). By contrast, the overall pooled association between certified nurses/certified nurse specialists and in-hospital mortality was not statistically significant (adjusted odds ratio, 0.88; 95% confidence interval, 0.77-1.01). However, the pooled estimate

suggested a potential protective effect. Regarding length of stay, no consistent association was observed.

CONCLUSION(S): Despite the absence of a significant pooled effect across all patients, the presence of certified nurses and/or certified nurse specialists in emergency departments was associated with lower in-hospital mortality in selected diagnostic groups. These findings suggest the potential value of advanced nursing roles, even in systems where prescriptive and diagnostic authority is limited, and may help to inform future discussion regarding workforce deployment and policy in Japan and other healthcare systems with similar structures. **REGISTRATION:** Not registered.

Copyright © 2026 The Authors. Published by Elsevier Ltd.. All rights reserved.

NHS England. (2026) [The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital.](#)

Olawade D.B., et al. (2026) ['The Role of Digital Twin Technology in Modern Emergency Care.'](#) *International Journal of Medical Informatics* 208(pagination), **Article Number: 106229. Date of Publication: 15 Mar 2026.**

Background: Emergency care is operationally defined as time-critical acute care across pre-hospital services, emergency departments, and critical care units (excluding routine urgent care and elective admissions), demanding rapid decision-making under pressure. Digital twin technology, creating real-time virtual replicas through continuous data integration, represents a transformative shift in managing acute conditions, resource allocation, and outcome prediction in emergency medicine.

Aim(s): This review examines the current applications, benefits, challenges, and future directions of digital twin technology in emergency care and medicine, highlighting its potential to revolutionise emergency healthcare delivery.

Method(s): A comprehensive narrative literature review was conducted using PubMed, IEEE Xplore, Scopus, and Web of Science databases. Studies published between January 2015 and June 2025 focusing on digital twin applications in emergency departments, trauma care, critical care, and prehospital emergency services were included. Grey literature, conference proceedings, and technical reports were also reviewed to capture emerging developments.

Result(s): Digital twins demonstrate significant utility across multiple emergency care domains including patient monitoring, resource allocation, workflow optimisation, predictive analytics, and training simulations. Key applications include real time patient condition prediction, emergency department capacity management, trauma response coordination, and personalised treatment planning. Despite promising outcomes, implementation challenges persist, including data integration complexities, computational requirements, and regulatory considerations.

Conclusion(s): Digital twin technology holds substantial promise for enhancing

emergency care delivery through improved decision support, resource optimisation, and predictive capabilities. Continued research, standardisation efforts, and interdisciplinary collaboration are essential for successful clinical integration and widespread adoption.

Copyright © 2025 The Authors

Tartaglia R., et al. (2026) 'Implementing a Hospital at Home Televisitation Program Run by a Tertiary University Hospital: Applying Failure Modes and Effect Analysis (FMEA) for Improving Patient Safety and Sustainable Care.' *Safety Science* 196(pagination), Article Number: 107096. Date of Publication: 01 Ar 2026.

The World Health Organization (WHO) emphasizes the importance of digital solutions such as telemedicine for improving care quality and safety. Recent surveys reveal the limited adoption in many countries including Italy, particularly in regions with mature healthcare systems. The aim of our study was to identify the critical barriers to the implementation of telemedicine home visits and propose robust solutions to mitigate the risks associated with the successful rollout and utilization of sustainable hospital care at home program. We assessed the introduction of telemedicine services for remote follow-up care for chronic gastrointestinal inflammatory bowel disease (IBD) and measured its impact on the risks of patient hospitalizations. We used the Failure Mode and Effects Analysis (FMEA) method to measure the clinical process and identify potential failures and assigned a Risk Priority Number (RPN) to each step. FMEA is a systematic dynamic risk management tool that involves selecting defined processes, assembling a multidisciplinary team, and analyzing potential failures by establishing links between failure modes, their effects, and causes. The team included medical and nursing leaders and coordinators, and human factors methodology experts, who mapped the care processes and identified potential failure modes for each process. We ranked the failure modes based on severity, frequency, and detectability, and proposed clinical process redesigns to mitigate or prevent failures that could lead to patient harm. We identified 6 main process phases for introducing a televisiting service for patients with chronic inflammatory bowel disease (IBD). The FMEA risk analysis highlighted the criticalities as steps with the highest priority: failure to conduct the visit due to programming error (RPN 450), failure to send the final report (RPN 390), privacy issues during the visit (RPN 350), and appointment booking problems (RPN 340) at the central booking center. Implementing a telemedicine program requires a comprehensive approach to hospital care at home that includes identifying key clinical and organizational issues impacting system usability; targeted training of healthcare staff; developing clear policies and procedures; enhancing digital skills and addressing access concerns among citizens using the system; prioritizing patient care and integrating seamlessly with existing systems within the hospital. The disparities between hospital managers and physicians in evaluating the failure risks

highlight the key differences in their risk perceptions. Comparisons with similar cases in the literature are necessary.

Copyright © 2025 Elsevier Ltd.

van Dam P.M.E.L., et al. (2026) '[Machine Learning for Risk Stratification in the Emergency Department \(MARS-ED\): A Randomized Controlled Trial.](#)' *Nature Communications* 17(1) (pagination), Article Number: 242. Date of Publication: 01 Dec 2026.

Emergency department (ED) crowding necessitates rapid, accurate risk stratification to optimize care and resource allocation. Traditional clinical prediction tools like NEWS, APACHE II, and SOFA score have limited generalizability or rely on extensive inputs, including vitals. We developed RISK^{INDEX}, a machine-learning tool predicting 31-day mortality using routine laboratory values, age, and sex. To evaluate the clinical impact of a machine learning-based risk score in routine care, we conducted an investigator-initiated, open-label, randomized, non-inferiority trial (MARS-ED) at the Maastricht University Medical Center+ ED. Adult patients (≥ 18 years) assessed by an internal medicine specialist and with ≥ 4 laboratory tests were eligible. Patients were randomized 1:1 using computer-generated permuted blocks to standard care ($n = 659$) or standard care plus access to the RISK^{INDEX} ($n = 644$). No blinding was possible because physicians needed to view the RISK^{INDEX}. The primary outcomes for this study were the prognostic accuracy for 31-day mortality and clinical impact of the RISK^{INDEX}. In total, 1303 participants were analyzed. RISK^{INDEX}'s prognostic accuracy matched or outperformed clinical intuition (AUROC 0.84 vs. 0.73-0.76) and was statistically higher than NEWS, APACHE II, and SOFA prediction tools (AUROC 0.65-0.75). RISK^{INDEX} predictions aligned with clinicians' expectations in only about half of cases, with highest discordance among less experienced physicians. Despite its prognostic accuracy, the RISK^{INDEX} did not alter treatment plans (1/644 changes; 0.16%) or clinical outcomes, and clinicians perceived low added value. No adverse events related to the intervention occurred, and recruitment was completed as planned. These findings show that prognostic accuracy alone is insufficient to achieve clinical impact in the ED and that user-centered, actionable model design is needed to ensure relevance, trust, and responsiveness. ClinicalTrials.gov registration: NCT05497830.

Copyright © The Author(s) 2025.

Weber, E. J. (2026) '[Understanding Corridor and Escalation Area Care in 165 UK Emergency Departments: A Multicentre Cross-Sectional Snapshot Study.](#)' *Emergency Medicine Journal* 43(2), 72–80.

Introduction Emergency department (ED) crowding is an international concern. It results in care being delivered in non-standard treatment spaces including corridors, termed escalation areas in the UK. Limited data suggest their use is widespread. This study aimed to establish the prevalence of UK escalation area use at a national level. Methods A prospective cross-sectional point prevalence study was carried out

in 165 UK EDs over five snapshots in March 2025 selected to represent a range of expected ED activity. The primary outcome was the proportion of patients receiving care in escalation areas. Secondary outcomes were the number of patients awaiting an inpatient bed, ED occupancy and resuscitation capacity. The presence of paediatric patients and those with mental health presentations in escalation areas is also reported. Results Across the five snapshots, 17.7% (n=10 042) of ED patients were receiving care in escalation areas. At each snapshot there were more patients awaiting an inpatient bed than patients in escalation areas. The percentage of escalation area patients in non-clinical areas such as corridors ranged from 54.5% to 61.1%. ED occupancy (patients per cubicle space) ranged from 1.0 (IQR 0.7-1.4) to 2.4 (IQR 1.8-3.1). There was no available resuscitation cubicle at 10.5% (n=17/162) to 26.2% (n=43/164) of sites. Paediatric and mental health patients were receiving care in escalation areas across all time points. Conclusion Almost one in five ED patients was experiencing escalation area care during the five snapshots. National guidance states escalation area use is not acceptable; this research demonstrates it is routine. This study supports the hypothesis that, to address ED escalation area care, the focus should be on facilitating the flow of patients who require an inpatient bed out of the ED. Further research should consider the effect of escalation area care on patient level outcomes and the effectiveness of interventions to reduce ED crowding.

Copyright © Author(s) (or their employer(s)) 2026. No commercial re-use. See rights and permissions. Published by BMJ Group.

Yoon H.J., et al. (2025) '[gEDWIN: A Simple and Practical Index for Real-Time Monitoring of Emergency Department Crowding.](#)' *BMC Emergency Medicine* 25(1) (pagination), Article Number: 244. Date of Publication: 01 Dec 2025.

Purpose: To propose a generalised Emergency Department Work Index (gEDWIN) as an alternative to the traditional Emergency Department Work Index (EDWIN), which is impractical for real-time warning due to its complexity and data requirements. gEDWIN offers a more efficient, adaptable, and scalable approach for monitoring emergency department (ED) crowding in real time.

Method(s): The relationships between various emergency department crowding indices-including Bed Ratio (BR) or Occupancy Rate (OR), Acuity Ratio (AR), and EDWIN-are thoroughly investigated. By leveraging these relationships, we propose a new gEDWIN. Currently, BR is considered one of the most effective ED crowding indices. A simulation study was performed to validate the effectiveness of the gEDWIN. A comprehensive comparison between BR (or OR), gEDWIN, and the traditional EDWIN was conducted to evaluate their performance using real Emergency Department data from three hospitals (two large and one medium-sized) in Australia.

Result(s): The results demonstrated that gEDWIN performed well. Despite the lack of

standardised measurement tools, gEDWIN provided a promising metric for ED crowding and shows potential for broader applicability across different ED settings. The comparative evaluation indicated that gEDWIN provides performance comparable to EDWIN, while offering a simpler and more practical approach to estimating ED occupancy rate. In addition, gEDWIN distinguishes itself with its simplicity and practicality, allowing for real-time monitoring of ED crowding. Its design makes it suitable for use across various hospital settings, regardless of their size or physician volume.

Conclusion(s): gEDWIN's simplicity and practicality suggest it may be a valuable tool for real-time monitoring of ED crowding across hospitals of varying sizes and physician volumes. However, its broader adoption across diverse healthcare environments will require further validation in varied clinical contexts. Clinical trial number: Not applicable.

Copyright © Crown 2025.

End of Document