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Unscheduled care

July 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

Agostinho J., et al. (2026) '[Effects of Emergency Department Overcrowding on Admitted Patient Outcomes: A Systematic Review of Etiology and Risk.](#)' *International Emergency Nursing* 87(pagination), Article Number: 101847. Date of Publication: 01 Aug 2026.

Objective: To determine the effects of emergency department (ED) overcrowding on the following outcomes of admitted patients: mortality; hospital length-of-stay (LOS); time to antibiotic; time to thrombolysis; and time to analgesic.

Method(s): Systematic review of etiology and risk including adult patients, aged 18 years or more, admitted to ED settings who were exposed to overcrowding. Search strategy ran in MedicLatina, CINAHL Complete, MEDLINE Complete, Cochrane Central Register of Controlled Trials, SciELO, Banco de teses da CAPES, RCAAP, and OpenGrey. Assessment of risk of bias, data extraction, and synthesis were performed by two reviewers independently.

Result(s): Out of 3500 records, 30 fulfilled the inclusion criteria. The results of the studies show that overcrowding in ED contributes to an increase in mortality, longer LOS and delays in the administration of antibiotics and analgesics. No evidence was found that overcrowding influences time to thrombolysis. However, seven of the studies concluded that overcrowding was not associated with increased mortality.

Conclusion(s): ED overcrowding has a negative impact on outcomes of admitted patients, highlighting its influence on the quality of care provided in ED settings. In

future research, it is important to understand which factors contribute to overcrowding to create strategies to overcome this public health problem. Copyright © 2026 The Author(s). Published by Elsevier Ltd. This is an open access article under the CC BY license. <http://creativecommons.org/licenses/by/4.0/>

Ahmed, H., et al. (2026) 'Reducing Delayed Discharges After Neck of Femur Fracture Surgery in a Major Trauma Centre: A Retrospective Quality Improvement Study.' *Cureus* 18(6)

Alamri W., et al. (2026) 'Interventions to Reduce Emergency Department Overcrowding and their Effects on Patient Outcomes: A Mixed-Methods Systematic Review and Meta-Analysis.' *BMC Emergency Medicine* 26(1) (pagination), Article Number: 169. Date of Publication: 01 Dec 2026.

Background: Overcrowding in emergency departments (EDs) leads to inadequate patient outcomes and increased operational costs. These complications contribute to heightened stress on healthcare systems thus, effective methods to reduce ED overcrowding are necessary to improve patient flow and overall care quality.

Aim(s): This mixed-method systematic review and meta-analysis evaluates the effectiveness of interventions such as Fast-Track, Team Triage, and Point-Of-Care Testing (POCT) in reducing ED overcrowding and improving patient flow metrics, including ED length of stay (LOS), wait times, and discharge times, to provide evidence-based recommendations for policy and practice in emergency healthcare.

Method(s): This review complies with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Three databases (PubMed, ScienceDirect and Google Scholar) were systematically searched for studies published between 2015 and 2025 assessing interventions to reduce ED overcrowding. A structured risk-of-bias assessment (RoB 2, ROBINS-I, JBI, MMAT) indicated overall acceptable methodological quality, with expected limitations related to non-randomized designs and limited blinding. Mean LOS was pooled using random-effects meta-analysis in RevMan, with heterogeneity assessed and secondary outcomes summarized narratively. This study is registered with the International Prospective Register of Systematic Reviews (PROSPERO 2025: CRD42025634351).

Result(s): This review included 15 studies, 6 eligible for meta-analysis. Fast-Track significantly reduced ED length of stay (MD = - 20.89 min; 95% CI: - 37.05 to - 4.33; p = 0.01). POCT (MD = - 65.50 min; 95% CI: - 137.54 to 6.53; p = 0.07) and Team Triage (MD = - 46.11 min; 95% CI: - 120.59 to 28.38; p = 0.23) demonstrated variable reductions in ED LOS, with pooled effects influenced by substantial between-study heterogeneity. All analyses exhibited significant heterogeneity. Qualitative synthesis further suggested improvements in waiting times, patient throughput, and departmental efficiency.

Conclusion(s): Our findings highlight the importance of targeted interventions to alleviate ED overcrowding; Fast-Track showed consistent effectiveness, while POCT

and Team Triage showed variable and, often context-dependent effects. These findings offer practical and evidence-based strategies to support ED flow improvements, though further high-quality research is needed.

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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* 30(33) (pagination), Date of Publication: 2026.

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.

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Gauci, P., et al. (2026) '[Implementation of Early Postnatal Discharge within 24 H in France: Safety, Satisfaction, and Feasibility Trial Supported by a Connected Home Monitoring Application \(NICE-BIRTH Study\).](#)' *Women and Birth* 39(3), 102205.

Habbouche S., et al. (2026) '[Evaluation of the Implementation Process of a New Emergency Triage System: West Coast System for Triage \(WEST\).](#)' *Plos One* 21(6 June) (pagination), Article Number: e0350323. Date of Publication: 01 Jun 2026.

Background Emergency Department (ED) crowding has escalated globally and has been associated with delayed treatment and increased short-term mortality. In western Sweden, several EDs transitioned from the Rapid Emergency Triage and Treatment System (RETTSC) to the West coast system for triage (WEST), based on principles of the South African Triage Scale. While WEST was introduced and spread rapidly and may have potential benefits, reports suggested challenges during its implementation. Objective This study examined the implementation of WEST at the first two EDs (ED1 and ED2) and identified barriers and facilitators. The study focused on the transition from RETTSC to WEST and explored staff experiences across implementation stages. Methods The study used a qualitative descriptive design with a mixed-methods approach and included semi-structured individual interviews with 36 triage nurses from two hospitals (ED1 n = 17; ED2 n = 19). Interviews explored experiences with WEST, implementation challenges, and comparisons with RETTSC, using Rogers' "Diffusion of Innovations" as a sensitizing framework and treating each ED as a distinct social system. A deductive qualitative content analysis guided by Rogers' Diffusion of Innovations was conducted, with inductive coding of unexpected themes from the final open question. Descriptive

analyses of Likert-scale items complemented the qualitative analysis. The study received ethical approval, and written informed consent was obtained from all participants before interviews. Results ED1 participants expressed great enthusiasm and perceived WEST as a notable improvement. ED2 responses were more varied, with reservations commonly targeting the implementation process and concurrent organizational changes. Across both sites, most nurses (30/36) perceived WEST as more accurate than RETTS© in identifying critically ill patients. Conclusions Implementing WEST was feasible but context dependent. Information, motivation, and consensus-building, education, and organizational readiness emerged as important factors in the implementation process. Viewing each ED as a distinct social system, with its own culture and readiness for change, helped explain why adoption of WEST varied between sites.

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He H., et al. (2026) 'Efficacy and Safety of Hospital-at-Home Versus Traditional Hospital Care in Older Patients: A Systematic Review and Meta-Analysis of Randomized Controlled Trials.' *Gerontology* 72(5), 384–396.

Abstract - Introduction: This systematic review and meta-analysis aimed to evaluate the effectiveness and safety of the Hospital-at-Home (HaH) model compared to traditional hospital care for older patients.

Method(s): We comprehensively searched PubMed, Embase, Medline, Cochrane Library, SinoMed, Scopus, and ClinicalTrials.gov for randomized controlled trials (RCTs) published up to April 15, 2024. The primary outcomes were length of stay (LOS) and readmission rates. Secondary outcomes included total cost, mortality, adverse events, and instrumental activities of daily living (IADL).

Result(s): Eleven RCTs involving 3,301 patients were included. The HaH group demonstrated a significantly shorter LOS (SMD = -0.45; 95% CI: -0.62 to -0.28; $p < 0.01$) and lower total healthcare costs (SMD = -0.40; 95% CI: -0.52 to -0.28; $p < 0.0001$) than the traditional care group. HaH was also associated with a reduced risk of readmission, with subgroup analyses showing consistent benefits at 1, 3, and 9 months. Additionally, patients receiving HaH showed modest but significant improvements in IADL scores (SMD = -0.15; 95% CI: -0.26 to -0.04; $p < 0.0001$). However, no significant differences were found between the two groups in terms of mortality (RR = 1.03; 95% CI: 0.49-2.18; $p = 0.93$) or adverse event rates (RR = 1.01; 95% CI: 0.43-2.36; $p = 0.084$).

Conclusion(s): For a selected group of older patients, HaH appears to be a viable alternative to traditional hospitalization, offering advantages in reducing LOS, healthcare costs, and readmission rates, while potentially improving functional recovery without increasing risks to patient safety. Further research is warranted to

confirm these findings and refine implementation strategies.

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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 and Palliative Care* 16(3), 635–640.

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.

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McGowan L.J., et al. (2026) '[Commissioners' Views and Experiences of Implementing Virtual Wards in Integrated Care Systems in England: A Longitudinal Qualitative Study using the Consolidated Framework for Implementation Research \(CFIR\).](#)' *BMC Health Services Research* (pagination), Date of Publication: 27 May 2026.

BACKGROUND: Virtual wards (VWs) have been rapidly adopted within the National Health Service (NHS) in England, showing promise for reducing hospital admissions and length of hospital stays. Additionally, VWs are reportedly highly acceptable to patients and may be preferable to physical wards (PWs) in some instances.

However, little research exists on how to optimise the implementation of VWs from a strategic perspective. The current study aimed to investigate commissioners' perceptions and experiences of implementing VWs in integrated care systems (ICSs)

in England, with a particular focus on changes and continuities in implementation influences over time.

METHOD(S): A longitudinal qualitative design was adopted. Semi-structured interviews were conducted via Teams with commissioners involved in the implementation of VWs at two timepoints (TP) six months apart; TP1 (n = 20) and TP2 (n = 14). Interviews focused on perceptions and opinions of the VWs programme, including barriers and facilitators to successful implementation. Data were analysed using the Consolidated Framework for Implementation Research (CFIR) in line with the Framework Method. The CFIR comprises five domains: Innovation, Outer Setting, Inner Setting, Individuals, and Implementation Process.

RESULT(S): Implementation progress diverged across sites at follow-up, with some scaling back due to challenges while others expanded their VW programs. On a domain level, Inner Setting (ICS) constructs appeared most influential on implementation over time, with constructs in the Individuals domain seemingly becoming less important. The main barriers to implementation included: limited staff capacity, recruitment issues, and inefficient communication and interoperability of systems (Inner Setting); uncertainty around long-term funding (Outer Setting); inequalities in patients' home circumstances and lack of buy-in from clinicians (Individuals); and lack of detailed implementation planning (Implementation processes). Key facilitators included: building on existing similar services (Innovation); collaborative working (Inner Setting); and national guidance (Outer Setting) with flexibility to adapt to local contexts (Implementation Process). Commissioners perceived patient acceptability to be generally high, with a reported preference for receiving care at home.

CONCLUSION(S): Buy-in from clinicians, collaboration, detailed advanced planning on an ICS level, and sustainable funding are particularly important for implementation of VWs. To avoid generating inequalities, tailored additional support should be provided to disadvantaged patients. Directions for future research includes exploring the perspectives of clinicians.

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Nguyen H.M., et al. (2026) '[Hospital-at-Home for COPD: A Retrospective Comparison with Brick-and-Mortar Settings.](#)' *Journal of Hospital Medicine* 21(6), 645–649.

The recent Acute Hospital Care at Home (AHCaH) initiative has increased Hospital-at-Home (HaH) access and utilization, but it is unknown how care delivery differs between AHCaH-compliant HaH programs and brick-and-mortar (BaM) inpatient care-specifically for common, costly hospital conditions like chronic obstructive pulmonary disease (COPD). In this retrospective cohort study, we compared management and outcomes for adults hospitalized with COPD treated in HaH and BaM settings in 2022. We analyzed EHR data from 297 adults who were eligible for HaH, including 119 who remained in BaM and 178 in HaH. HaH patients had higher

likelihood of orders for supplemental oxygen (risk ratio [RR]: 1.04, 95% confidence interval [CI]: 1.01-1.09) and bronchodilators (RR: 1.12, 95% CI: 1.04-1.20), compared to BaM. HaH patients also had higher mean 30-day acute care-free days alive (mean ratio [MR]: 1.04, 1.01-1.08). Our findings suggest similar or improved guideline-directed therapy and outcomes for COPD patients treated in HaH.

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Xiong, E., et al. (2026) 'Targeted Interventions to Improve Discharge Times in a Cardiology Department: A Quality Improvement Project in Australia.' *British Journal of Healthcare Management* 32(6), 1–10.

Zaboli A., et al. (2026) 'Frailty Stratification in the Emergency Department using the Triage Frailty and Comorbidity Tool.' *American Journal of Emergency Medicine* 109, 1–8.

Introduction: Frailty is increasingly recognised as a key determinant of adverse outcomes and resource use in the Emergency Department (ED), yet pragmatic, scalable strategies for timely identification and management are lacking. We evaluated a workflow-compatible frailty stratification model by embedding the Triage Frailty and Comorbidity (TFC) Tool into routine triage for low-acuity patients.

Method(s): We conducted a multicentre observational study in two Italian EDs. Adult patients triaged as Manchester Triage System (MTS) green/blue were eligible. As part of triage completion, nurses completed the TFC Tool; TFC $\geq 5\%$ defined positivity. For TFC-positive patients, the waiting-list order was prioritised within the same MTS category. Primary outcome was time from triage completion to medical evaluation; secondary outcome was hospitalisation.

Result(s): Among 40,568 eligible visits, 1269 (3.1%) were TFC-positive (0.3% in 18-65 years; 9.8% in ≥ 65 years). In adjusted models, TFC positivity was associated with a + 1.45 (95%CI 1.19-1.70) minute longer triage duration but reduced waiting time to medical evaluation by -15.06 min (95%CI -20.85 to -9.27). Hospitalisation occurred in 19.4% of TFC-positive vs 4.8% of TFC-negative patients; TFC $\geq 5\%$ was independently associated with admission (adjusted OR 1.69, 95%CI 1.43-1.99), and TFC as continuous increased admission odds per 1% point (OR 1.05, 95%CI 1.04-1.06).

Conclusion(s): Routine implementation of the TFC Tool within standard triage was associated with shorter waiting times to medical assessment among vulnerable low-acuity patients, while maintaining acuity-based prioritisation. TFC positivity was also associated with higher odds of hospitalisation.

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