Interventions to improve patient flow in emergency departments: an umbrella review

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ABSTRACT

Objectives Patient flow and crowding are two major issues in ED service improvement. A substantial amount of literature exists on the interventions to improve patient flow and crowding, making it difficult for policymakers, managers and clinicians to be familiar with all the available literature and identify which interventions are supported by the evidence. This umbrella review provides a comprehensive analysis of the evidence from existing quantitative systematic reviews on the interventions that improve patient flow in EDs.

Methods An umbrella review of systematic reviews published between 2000 and 2017 was undertaken. Included studies were systematic reviews and meta-analyses of quantitative primary studies assessing an intervention that aimed to improve ED throughput.

Results The search strategy yielded 623 articles of which 13 were included in the umbrella review. The publication dates of the systematic reviews ranged from 2006 to 2016. The 13 systematic reviews evaluated 26 interventions: full capacity protocols, computerised provider order entry, scribes, streaming, fast track and triage. Interventions with similar characteristics were grouped together to produce the following categories: diagnostic services, assessment/short stay units, nurse-directed interventions, physician-directed interventions, administrative/organisational and miscellaneous. The statistical evidence from 14 primary randomised controlled trials (RCTs) was evaluated to determine if correlation or clustering of observations was considered. Only the fast track intervention had moderate evidence to support its use but the RCTs that assessed the intervention did not use statistical tests that considered correlation.

Conclusions Overall, the evidence supporting the interventions to improve patient flow is weak. Only the fast track intervention had moderate evidence to support its use but correlation/clustering was not taken into consideration in the RCTs examining the intervention. Failure to consider the correlation of the data in the primary studies could result in erroneous conclusions of effectiveness.

Key messages

What is already known on this subject
- Patient flow is a major issue in ED service improvement.
- An extensive volume of literature exists on the interventions to improve patient flow.
- An umbrella review provides a comprehensive analysis of the evidence from existing systematic reviews on the interventions that improve ED patient flow.

What this study adds
- The evidence supporting the interventions to improve patient flow is weak.
- Only the fast track intervention had moderate evidence to support its use but clustering of data was not taken into consideration in the randomised controlled trials examining the intervention.
- Failure to consider the clustering of data may produce misleading conclusions regarding the effectiveness of the intervention.

INTRODUCTION

Patient flow and crowding are two major issues in ED service improvement. Although previously published literature have used these terms interchangeably, in order to suggest better quality improvement measures, it may be necessary to distinguish between the two terms. In 2006, Asplin advocated for a shift in focus from ED crowding to patient flow.[1] In Asplin's view, measuring crowding may be unproductive and suggested a shift from crowding to flow measurements, recognising that measuring patient flow may be more achievable and useful to improve ED care.[1]

Consensus definitions and measures of ED patient flow and crowding do not yet exist. For this review, patient flow may be described in terms of the progressive movement of patients through care processes from arrival until the patient physically leaves the ED, with movement referring to the conversion of an input into an output.[2 3] ED crowding may be described in terms of an imbalance between the demand and capacity to provide care.[4]

Hwang *et al* further simplify crowding measurements, categorising it as flow and non-flow, where non-flow leads to crowding.[5] Asplin suggested that the 'fundamental metric of patient flow is throughput', which may be measured using ED throughput time, that is, time from patient arrival to exit in the ED.[1] In terms of metrics, it may be inferred from Hwang *et al* that patient flow may be measured using time-intervals, while non-flow (crowding) be measured by using numerical counts.[5]

ED quality indicators from Hospital Episodes Statistics UK and the National Ambulatory Medical Care Survey in the USA include measures such as

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time to treatment, time to initial assessment, total time in the ED.[6 7] This is consistent with Asplin's measure of ED throughput time and suggestions by Hwang *et al* to use time intervals to measure patient flow.

Although this review attempts to separately consider patient flow and non-flow (crowding), a close relationship does exist between the two. A crowded ED may result in poor patient flow because of the demand for care. In other words, the number of patients exceeds the capacity to match that demand and consequently this will lead to a downstream effect on the progressive movement of patients, thus hindering patient flow.[8] In an ED with poor patient flow, patients may not move through the processes of care at an adequate rate, which eventually may result in ED crowding.[8] Thus, it is possible that identifying factors that optimise patient flow may also address crowding.

A substantial amount of literature exists on the interventions to improve patient flow and crowding. An initial quick search in Medline for studies exploring ED patient flow, identified 266 primary studies, 18 systematic reviews and 11 other review types. Reviews assessed specific interventions, making it difficult for policymakers, managers and clinicians to be familiar with all the available literature and identify which interventions are supported by the evidence. Hence, to improve the ED in a holistic manner, policymakers, managers and clinicians may have to familiarise themselves with all the available literature. This may prove to be a difficult task for managers and clinicians.

A comprehensive review of the literature should assist in identifying and assessing the evidence base, and subsequently choosing effective interventions to improve ED patient flow. One method to accomplish this is to compile the evidence from existing systematic reviews. The Cochrane Collaboration describes this as an overview of reviews or Cochrane Overviews.[9] The Joanna Briggs Institute, an international research institute in Australia, uses the term umbrella review, defined as 'an overview of existing systematic reviews'.[10] An umbrella review synthesises the evidence from published systematic reviews, selecting reviews based on predetermined criteria without delving much into the quality of the individual primary studies included in the original systematic review.

A systematic review systematically searches for, appraises and synthesises evidence, usually following specific guidelines.[11] Hence, an umbrella review should encompass all similar systematic reviews on a specific topic, crystallising the evidence, in an attempt to assist managers and clinicians to improve their departments in an evidence-based manner.

With this background, this umbrella review aims to summarise the evidence from systematic reviews on the interventions that improve patient flow in EDs.

METHODS

We compiled evidence from systematic reviews that analysed quantitative primary studies addressing interventions to improve ED patient flow.

Eligibility criteria

Reviews were eligible if they satisfied the following criteria:

- Full-text systematic reviews published between 2000 and 2017 in English language.
- Searched at least two electronic databases.
- Systematic reviews and meta-analyses of quantitative primary studies (systematic reviews including both quantitative and qualitative data were included only if the data werec analysed separately).
- ED must be the primary study site.
- Must include any intervention, strategy that targeted ED throughput.
- Outcome measures (as metrics of patient flow) must have been defined; described in terms of any time interval, for example, length of stay (ED LOS) and any of its submeasures.

Reviews were excluded if any of the following were present:

- Focused on disease-specific conditions.
- Intentionally focused on country-specific literature.
- Primary focus was ED crowding (eg, outcomes were crowding measures, defined as numerical counts such as number of patients in ED).
- Non-systematic reviews.
- Qualitative evidence syntheses.
- Systematic reviews based on theoretical studies, opinions, editorials, commentary.

Search strategy

A comprehensive search strategy, restricted from January 2000 to April 2017, was used to identify articles. Six databases were searched: Medline via Ovid (1946 to present), EMBASE (1974 to July 2016), CINAHL (1982 to present), Cochrane Library, JBI for Systematic Reviews and Implementation reports, Proquest. Three search concepts were used: 'emergency department', 'patient flow' and 'crowding'. Systematic review search filters were applied to the search strategy as outlined by Lee *et al*[12] and Lunny *et al*[13] (see online supplementary 1 for sample search strategy).

OpenGrey and Google Scholar were searched for grey literature. Citation tracking was conducted in Google Scholar, Web of Science and Epistemonikos. Reference lists of the included articles were reviewed. Conference proceedings identified in the electronic database search were checked for full-text versions and authors contacted if necessary.

Data extraction and quality appraisal

Two authors (LD and SH) independently reviewed the systematic reviews extracting data using a data extraction form developed by the Joanna Briggs Institute[10] and ranked the quality using A Measurement Tool to Assess Systematic Reviews (AMSTAR 2) tool (online supplementary 2).[14] Differences were settled after discussions to reach a consensus. The quality appraisal of the primary studies identified in the systematic reviews was extracted from each systematic review. The authors of the umbrella review did not perform a new quality appraisal for these primary studies as an umbrella review usually only includes a quality appraisal of the systematic reviews rather than the quality of the primary studies.

Data synthesis

The results were summarised and presented in a tabular form supported by a narrative synthesis. The results were presented based on each intervention and outcome measure. Given the high heterogeneity across the reviews, no additional statistical analyses were conducted.

Analysis of the appropriateness of the statistical analyses was undertaken in a subset of primary studies, to explore the issue of whether potentially correlated data had been addressed. Measures of patient flow, like measures of ED crowding, may be subject to substantial correlation between individuals, which if not taken into account could lead to the wrong conclusion being drawn. This statistical review was performed by SH and LD.

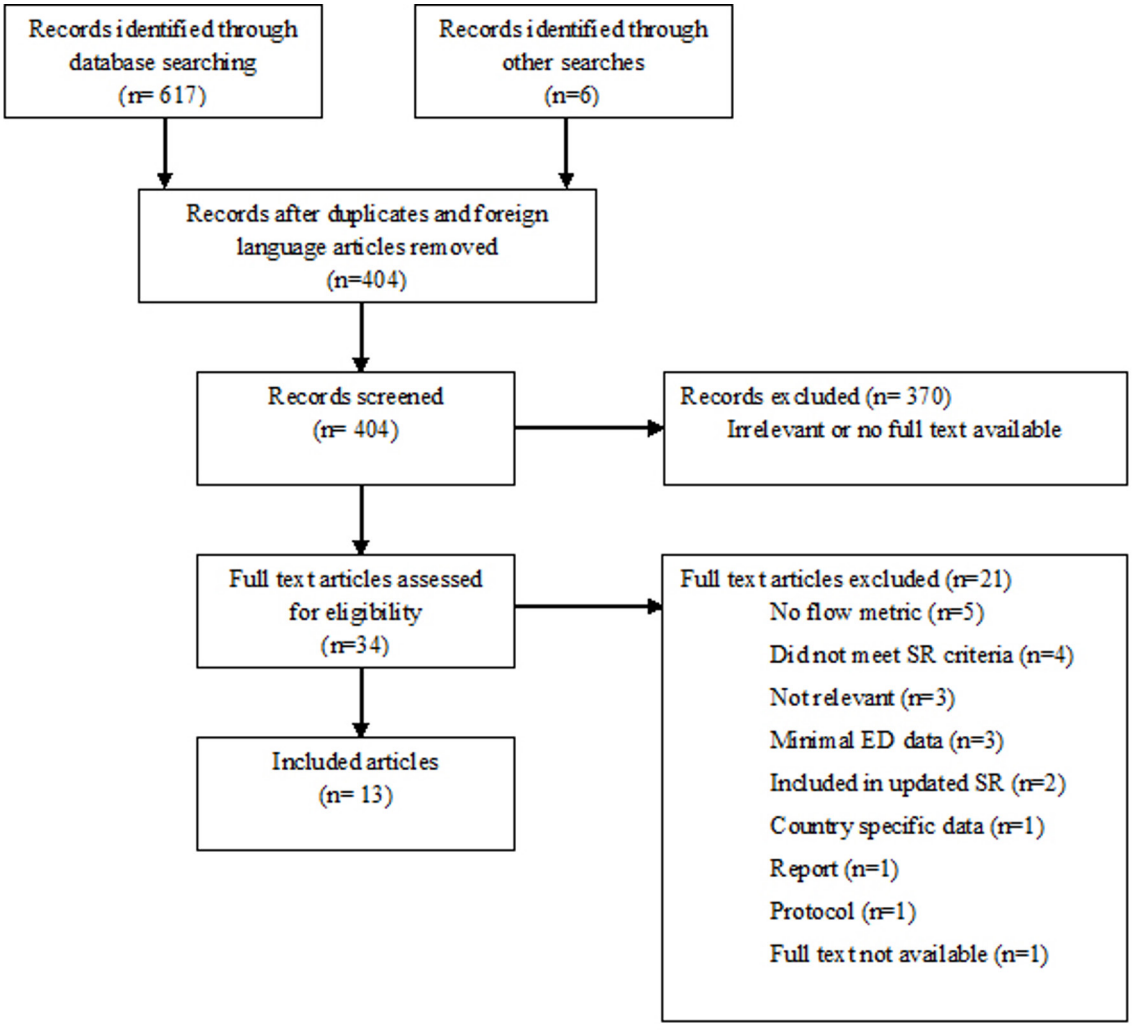

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart of study selection. SR, systematic review.

RESULTS

Results of the search process

Six hundred seventeen articles were retrieved from the six databases. Six studies were found through reference lists and citation searching. Four hundred four articles were screened at the title stage. Thirteen full-text articles were included in the final review. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart of the study selection[15] is depicted in figure 1.

Description of included systematic reviews

The publication dates of the 13 reviews ranged from 2006 to 2016.[16–28] The publication dates of the primary studies ranged from 1995 to 2015. Six of the reviews used the term 'crowding' in their titles but had time interval outcome measures which made them suitable for assessing patient flow.[17 18 21 26–28] There were 20 randomised control trials (RCT) and 200 non-RCTs. Of these non-RCTs, 125 studies had before-after (BA) designs. The primary studies originated from 20 countries. Participant numbers totalled over 2 million.

The general characteristics of the systematic reviews are presented in table 1. The majority of the reviews were graded as moderate to high quality based on the AMSTAR 2 score. Many of the primary studies were weak, mostly belonging to the BA study design. The systematic reviews conducted by Elder *et al*,[19] Georgiou *et al*[20] and Jennings *et al*[23] did not present quality assessments of the primary studies. The review by Bond *et al*[17] presented a quality assessment but an interpretation of the scores was not provided. The publication agency for that review was not able to provide further information on the quality assessment.

A summary of the quality appraisals of the primary studies and the AMSTAR 2 scores is presented in online supplementaries 3 and 4.

Review findings

Description of interventions

The 13 systematic reviews evaluated 26 interventions: full capacity protocols, computerised provider order entry (CPOE), scribes, streaming, fast track and triage. Interventions with similar characteristics were categorised as follows: diagnostic services, assessment/short stay units, nurse-directed interventions, physician-directed interventions, administrative/organisational and miscellaneous. A description of the interventions based on the information presented in the study(s) that assessed it is presented in table 2.

Statistical evidence from primary RCT studies

The correlation of observations in the ED is a potential issue in the statistical analyses of the reviews and primary studies.[29 30]

Table 1 General characteristics of the systematic reviews

Systematic review	Aim	Period of study	No. of primary studies	No. of participants	Countries	Study designs	Intervention	Analysis method	Flow metric
Abdulwahid *et al*[16]	Impact of senior doctor triage vs the standard single nurse triage	1994–2014	25	690 232 (24 studies)	12 USA 5 Australia 2 UK 2 Canada 1 each Hong Kong Jamaica Singapore Sweden	4 RCT 2 CCT 3 Cohort 16 BA	Senior doctor triage	Meta- analysis	ED LOS Waiting times
Bond *et al*[17]	Effects of interventions designed to reduce or control ED overcrowding	Until December 2004	66	Not available	29 USA 13 Canada 9 UK 5 Australia 3 Spain 1 each Hong Kong Israel New Zealand Singapore Sweden Switzerland Turkey	2 RCT 7 CCT 7 Cohort 50 BA	Fast track, multifaceted interventions, staffing changes, triage, physician order entry, short stay units, unique interventions	Descriptive	ED LOS Waiting times
Bullard *et al*[18]	Impact of rapid assessment zones/pods to mitigate ED overcrowding	1966–May 2009	4	23 189	2 Canada, 1 New Zealand 1 Saudi Arabia	1 RCT 1 CCT 2 BA	Rapid assessment zones/pods	Descriptive	ED LOS Physician initial assessment
Elder *et al*[19]	Effectiveness of three current models of ED care	1980–2014	21	105 413 (20 studies)	7 Australia 6 UK 3 Canada 2 USA 1 each Ireland Singapore Sweden	1 SR 4 RCT 1 QE 2 CCT 3 Retro 2 Pro 1 Sur 6 BA	Expanding nursing roles Physician-assisted triage Medical assessment units	Descriptive	ED LOS, Patient off stretcher times
Georgiou *et al*[20]	Effect of computerised provider order entry on clinical care and work processes	1 January 1990–31 May 2011	22	61 851 (18 studies)	20 USA 1 Korea 1 France	2 RCT 2 Pro 2 TS 16 BA	Computerised provider order entry	Descriptive	ED LOS
Guo *et al*[21]	Effectiveness of strategies to reduce ED overcrowding	September 1993–December 2005	25	Not available	9 USA 7 Australia 4 Canada 1 each UK Spain Switzerland	2 SR 1 RCT 2 Cohort 20 BA	ED staffing/reorganisation, fast track, access to diagnostic services, system-wide interventions	Descriptive	ED LOS Waiting times
Heaton *et al*[22]	Effects of scribes on patient throughput, billing and patient and provider satisfaction	1946–May 2015	17	231 129 (10 studies)	14 USA 1 Canada 1 Germany 1 Australia	1 RCT 5 Retro 4 Pro 1 Sur 6 BA	Medical scribes	Meta-analysis	ED LOS Door to room Room to doctor Time to disposition Patients per hour

Continued

Table 1 Continued

Systematic review	Aim	Period of study	No. of primary studies	No. of participants	Countries	Study designs	Intervention	Analysis method	Flow metric
Jennings *et al*[23]	Impact of emergency nurse practitioner on cost, quality of care, satisfaction and waiting times in ED	2006–2014	14	36 621	6 Australia 1 New Zealand 2 UK 1 USA 1 The Netherlands 1 Canada	2 SR 2 RCT 1 Cohort 2 Pro 2 Audit 3 Sur 1 CC 1 CS	Nurse practitioners	Descriptive	Waiting times
Ming *et al*[24]	Impact of team triage on ED patient flow	Start of database–30 June 2015	4	14 772	2 Canada 1 USA 1 UK	4 RCT	Team triage	Meta-analysis	ED LOS Waiting times
Oredsson *et al*[25]	Explore which interventions improve ED patient flow	1966–31 March 2009	33	503 770	9 Australia 7 USA 5 UK 4 Canada 1 each New Zealand Northern Ireland Spain Singapore Turkey Saudi Arabia	9 RCT 1 cct 21 BA	Triage-related interventions (fast track, streaming, team triage, POCT, nurse requested X-ray)	Descriptive	ED LOS Waiting times
Rowe *et al*[26]	Effectiveness of triage liaison physicians on mitigating the effects of overcrowding in EDs	1966–December 2005	28	406 184 (20 studies)	17 USA 4 UK 2 Hong Kong, 2 Australia 2 Canada 1 Singapore	2 RCT 7 CCT 1 ITS 2 Pro cohort 16 BA	Triage liaison physician	Meta-analysis	ED LOS Physician initial assessment time
Rowe *et al*[27]	Effectiveness of triage nurse ordering on mitigating the effect of overcrowding in EDs	1966–December 2005	14	24 096	3 USA 3 Canada 2 UK 2 Australia 1 each Singapore Denmark The Netherlands Hong Kong	3 RCT 1 CCT 2 Retro cohort 3 Pro cohort 2 CC 3 BA	Triage nurse ordering	Descriptive	ED LOS Physician initial assessment time
Villa-Roel *et al*[28]	Effectiveness of full capacity protocols on overcrowding	1966–May 2009	5	128 082 (4 studies)	3 Canada 1 USA 1 UK	1 CCT 1 ITS 3 BA	Full capacity protocols	Descriptive	ED LOS

BA, before-after; CC, case-control; CS, case series; CCT, controlled clinical trial; ITS, interrupted time series; LOS, length of stay; Pro, prospective; QE, quasi-experimental; RCT, randomised controlled trial; Retro, retrospective; Sur, survey; SR, systematic review.

Table 2 Description of interventions

Intervention	Definition
Full capacity protocols	*A method to distribute admitted patients throughout the hospital, usually to temporary areas, when EDs have reached maximum capacity.*[28]
Computer provider order entry	*An electronic system used to enter patient data.*[20]
Scribes	*Non-medical persons whose role is to assist clinicians with non-clinical aspects of patient care such as documentation of patient notes and retrieval of investigations.*[22]
Streaming	*The categorisation of patients with similar characteristics (complaint or likely disposition status) into distinct pathways where they can receive tailored care.*[25]
Fast track	*A separate pathway for patients with minor complaints.*[17 25]
Triage	*The process of sorting patients based on acuity and urgency of illness.*[17]
Diagnostic services	
Point-of-care testing	*Laboratory analysis that occurs in the ED.*[25]
Advanced triage	*A triage nurse who is allowed to order diagnostic tests.*[21]
Assessment and short stay units	
Rapid assessment zones	*Distinct spaces in the ED for patients with ambulatory complaints who can be treated without using a bed.*[18]
Short stay units	*Designed for patients who require a short period of observation before a disposition decision can be made.*[17]
Medical assessment units	*Areas for patients with complex medical conditions who likely require admission.*[19]
Nurse-directed interventions	
Nurse practitioner	*An independent nurse who is qualified to assess, diagnose and treat certain medical complaints.*[23]
Triage nurse ordering	*Nurse-initiated activities at triage (nurses may or may not have had training).*[27]
Nurse-requested X-rays	*X-rays for limb injuries requested by nurses.*[25]
Clinical initiative nurse	*An advanced nursing role where nurses can initiate activities.*[19]
Physician-directed interventions	
Physician-assisted triage	*Presence of a physician at triage who is able to expedite patient throughput.*[19]
Triage liaison physicians	*Physicians and triage staff work together to manage patients at the point of triage.*[26]
Senior doctor triage	*Placement of a senior doctor in triage to assist in the management of patients prior to being seen in the main ED.*[16]
Team triage	*A triage team that includes a physician*[25] *or triage performed by a team composed of at least two medical personnel, either a nurse or physician.*[24]
Administrative and organisational interventions	
Multifaceted	*Multiple strategies such as structural reorganisation, implementation of coordinators, changing staffing numbers or introducing longer opening hours for other services.*[17]
System-wide interventions	*Interventions that addressed more than one component in Asplin's three-component model.*[21]
Staffing changes/ED staffing/reorganisation	*Interventions that focused on changing staffing numbers or restructuring the ED.*[17 21]
Miscellaneous	
Dedicated ED radiology staff	*Technical radiology staff dedicated to the ED.*[17]
Electronic board tracking	*An electronic system that provides up-to-date information on patients' status.*[17]
Bedside registration	*Registration occurring at the patient's bedside.*[17]

Many standard statistical tests assume that the observations are independent.[29 30] An independent observation assumes, for example, that the waiting time of one patient is not correlated with the waiting time of another but this is unlikely to be true in the ED since patients arriving at similar times are also likely to have similar waiting times. Therefore, it is important to consider the dependent nature of the observations when analysing data. Using tests that do not consider dependency or correlation may result in the incorrect estimation of the p value with misleading conclusions.[29]

Ming *et al*[24] discussed the correlation issue in their review. Since only one systematic review made reference to the issue, the statistical tests used in a subset of primary studies were examined. Given the substantial number of primary studies that would have to be assessed together with the complexity of the statistical issue, the decision was made to focus only on RCTs. RCTs have stronger study designs that can provide reliable evidence once analysed appropriately. While non-randomised designs are likely to be at an even greater risk for correlation and clustering issues, these designs, particularly the BA studies, are already at high risk of bias even if analysed appropriately. In each systematic review, RCTs that assessed a flow metric were extracted and included. Fifteen RCTs assessed the outcome measures of interest and 14 articles were located (S1-14) (see online supplementary 5 for the statistical review of RCTs).

Summary of findings

A summary of findings for each intervention, based on each outcome measure, is presented in tabular form together with a narrative synthesis. Overlap of primary studies in reviews assessing the same intervention is highlighted in the summary tables.

The summary of findings for full capacity protocols, CPOE, scribes, streaming, fast track, triage, diagnostic services, assessment and short stay units are presented in table 3; nurse-directed and physician-directed interventions are presented in tables 4 and 5; administrative/organisational and miscellaneous interventions are presented in table 6.

Full capacity protocols

This was evaluated in one BA Canadian study from one systematic review. The full capacity protocol significantly improved ED LOS for all admitted patients.[28] However, as the review was based on one weak quality study, in abstract form, it is difficult to draw conclusions.

Computerised provider order entry

Two reviews examined the effect of CPOE on patient flow.[17 20] The results were derived from studies conducted in the USA and Canada. Bond *et al* reported a decrease in ED LOS in two non-RCT studies and an increase seen in one BA.[17]Two BA studies in the review by Georgiou *et al* reported decreases in LOS (−1.94 hours, 95% CI 0.79 to 3.09 hours; −30 min, 95% CI 28 to 33 min) while two reported increases in LOS (17.4, 95% CI 8.7 to 26.2 min; 36 min, 95% CI 26 to 46 min).[20] The review by Georgiou *et al* concluded that CPOE had inconsistent effects on ED LOS.[20]

Scribes

The impact of scribes on patient flow was examined in one review that compared services with scribes with those without.[22] The settings included six academic and two community EDs across the USA (six), Canada (one) and Australia (one). The primary studies were based on non-RCT designs and those assessing LOS had a high (one) and moderate (four) risk of bias. Meta-analyses

Table 3 Summary of effects of interventions

Intervention (author)	Outcome	Study design	No. of participants	Results
Full capacity protocols (Villa-Roel)	ED LOS	1 BA	61 329	ED LOS decreased: 18.9 vs 13.9 hours, p<0.001 (for all admitted patients)
Computerised provider order entry	ED LOS	*Georgiou* 3 BA	52 501 (2 studies)	Two studies each showed decreases and increases in ED LOS
		Bond 1 cohort, 2 BA	Not available	Two studies (cohort, BA) showed decreased LOS; one study showed increased LOS (BA)
	Other	*Georgiou* 3 BA	Not available	Decreased door to physician, physician to disposition decision, disposition decision to discharge times from one study
Scribes (Heaton)	ED LOS	2 retrospective matched, 3 BA	31 970 (4 studies)	No difference in ED LOS: MD −1.6 min, 95% CI (−22.3 to 19.2) I^2=87.62%, p<0.0001
	Provider to disposition time	1 retrospective matched, 2 BA	25 543 (2 studies)	No difference: MD 18.8 min, 95% CI (−7.3 to 44.6), I^2=85.1%, p<0.0001
	Number of patients seen per hour	1 prospective matched, 1 retrospective matched, 2 BA	6878 (2 studies)	Increase: 0.17 more patients per hour, 95% CI (0.02 to 0.32), I^2=94.9%, p=0.000
Streaming (Oredsson)	ED LOS	2 BA	141 017	Median reduction in ED LOS of 9.5 min (min 0–max 11)
	Waiting time	3 BA	240 429	Median reduction in ED LOS of 31 min (min 14–max 48)
Fast track	ED LOS	*Oredsson* 2 RCT*, 8 BA	>100 000	Median reduction in ED LOS of 27 min (4 min–74 max)
		Bond 1 RCT, 4 CCT, 5 cohort, 6 BA†	Not available	15 studies showed improvement in ED LOS; two studies showed no difference
		Guo 3 BA‡	Not available	ED LOS decreased
	Waiting time	*Oredsson* 1 RCT§, 8 BA	>90 000	Median reduction in waiting time of 24.5 min (2 min–51 max)
		Bond 3 CCT, 1 cohort, 6 BA¶	Not available	Eight studies showed decreased waiting times; one study showed an increase
		Guo 1 BA‡	Not available	Decreased waiting times
Triage (Bond)	Waiting time	3 BA, 2 CCT	Not available	Decreased waiting times in 2 BA; increased in 3 (2 CCT, 1 BA)
Diagnostic services				
Point-of-care testing	ED LOS	*Oredsson* 2 RCT, 3 BA	18 401	Median reduction in ED LOS of 21 min (−8 min–54 max)
		Bond 1 RCT, 1 BA	Not available	ED LOS decreased
		Guo 1 RCT**, 1 BA**	Not available	ED LOS decreased
Advanced triage	ED LOS	*Guo* 1 Cohort	Not available	ED LOS decreased
Assessment and short stay units				
Rapid assessment zones/ pods (Bullard)	ED LOS	1 RCT, 1 CCT, 1 BA	22 989	*ED LOS decreased* RCT: MD −20 min, 95% CI (−47.2 to 7.2) BA: MD −192 min, 95% CI (−211.6 to −172.4) Acuity level 5 RCT: MD −34 min, 95% CI (−68.6 to 0.6) CCT: MD −20 min, 95% CI (−23.1 to −16.9)
	Physician initial assessment	1 RCT, 1 CCT, 2 BA	18 722	*Physician initial assessment time decreased* RCT: MD −8.0 min, 95% CI (−13.8 to −2.2) BA: MD −33 min, 95% CI (−42.3 to −23.6) BA: MD −18 min, 95% CI (−22 to −13.8) Acuity level 5 RCT: MD −14 min, 95% CI (−33.5 to 5.5) CCT: MD - 11.1 min, 95% CI (−12.4 to −9.8)
Short stay unit (Bond)	ED LOS	1 BA	Not available	Decreased for treat and release patients
Medical assessment unit (Elder)	Other	1 retrospective cohort	894	Mean time from medical assessment to decision: 170.2 min

*Two RCTs in Oredsson-labelled CCT in Bond.
†Two of the six studies also in Oredsson for LOS.
‡Same study in all three SRs.
§One RCT in Oredsson was labelled CCT in Bond.
¶Three of the six studies also in Oredsson.
**Same studies seen in Bond and Oredsson.
CCT, controlled clinical trial; LOS, length of stay; MD, mean difference; RCT, randomised controlled trial; SR, systematic review.

Table 4 Summary of findings for nurse-directed interventions

Intervention	Outcome	Study design	No. of participants	Results
Nurse directed				
Nurse practitioners (Jennings)	ED LOS	1 cohort, 2 descriptive, 2 audit, 1 case series, 1 case-control	32 419	ED LOS decreased in five studies; three studies showed no difference
	Waiting time	1 RCT, 1 cohort, 2 audit, 1 descriptive, 1 case series, 1 case-control, 1 BA	9592	Waiting time decreased in five studies; four studies showed no difference
Nurse practitioners/ clinical initiative nurse (Elder)	ED LOS	1 RCT, 2 cohort, 1 BA, 1 case-control	22 331 (4 studies)	ED LOS decreased in four studies; one study showed no difference
	Waiting time	1 RCT, 2 cohort, 1 case-control, 1BA	23 933	Waiting time decreased in four studies; one study showed no difference
Triage nurse ordering (Rowe)	ED LOS	3 RCT, 1 CCT, 3 cohort, 3 BA, 2 case-control	22 084	*ED LOS decreased* 1RCT: MD −37.2 min, 95% CI (−44.1 to 30.3), p<0.00001 3 Non-RCT: MD −50.9 min, 95% CI (−56.3 to −45.5); I^2=92%, p<0.00001
	ED LOS (patients with fractures)			3 RCT: MD −20 min , 95% CI (−37.48 to −1.91); I^2=92%, p=0.03 5 Non-RCT: MD −18.2 min , 95% CI (−23.2 to −13.2); I^2=28%, p <0.00001
	ED LOS (patients with no fractures)			2 RCT: MD 0.9 min 3, 95% CI (−5.44 to 7.31); I^2=0%, p =0.77 2 Non-RCT: MD −33 min, 95% CI (−71.13 to 3.26); I^2=94%, p=0.07
	Physician initial assessment time	2 RCT, 1 cohort	4141	*Physician initial assessment time decreased* 2 RCT: MD −3.0, 95% CI (−6.9 to 0.9), I^2=0%, p=0.14 Cohort: 10 min reduction
Nurse-initiated X-rays (Oredsson)	ED LOS/waiting time	3 RCT	2682	Median reduction of 10 min (min 6–37 max)

BA, before-after; CCT, controlled clinical trial; LOS, length of stay; MD, mean difference; RCT, randomised controlled trial.

performed by the review authors found that scribes had no difference on ED LOS and provider to disposition time.

There was a statistically significant but small increase in the number of patients seen per hour. There were no pooled results comparing the effect of scribes in academic versus community EDs, so it is unclear if the type of ED setting affected the results. The review concluded that evidence was limited for the use of scribes.[22]

Streaming

Streaming was assessed by one review whose studies were conducted in Australia (two) and the USA (one).[25] The primary studies were all moderate-quality BA designs. Pooled results from these studies showed decreased ED LOS and waiting time. One primary Australian study examined the effect of streaming in the different triage categories and found improved ED LOS for lower acuity patients (14 and 18 min less for level 4 and 5 patients, respectively).[25] Although streaming had a positive effect on flow metrics, the review concluded that there was weak evidence to support its use.[25]

Fast track

Three reviews examined the effect of fast track on flow metrics.[17 21 25] Studies were conducted in the USA (seven), Canada (seven), the UK (five), Australia (five) and one each from New Zealand, Saudi Arabia, Turkey and Spain.

Pooled results from Oredsson *et al* found that fast track reduced both ED LOS and waiting times.[25] These results for ED LOS were based on seven moderate (two RCT, five BA) and three low (BA) quality studies while those for waiting times were based on six moderate (one RCT, five BA) and three low (BA) quality studies. In the study by Bond *et al*, 15 primary studies showed improved ED LOS and 8 showed improved waiting times.[17] The quality of these studies was not known. The results from Guo *et al* also showed decreases in ED LOS and waiting times. These were based on low (BA) quality primary studies. The reviews by Oredsson *et al* and Bond *et al* concluded that there was moderate evidence to support the use of fast track.[17 25]

Three RCTs assessed the fast track intervention. Two were cluster RCT designs but there was no evidence to suggest that a cluster analysis was performed (S7, S8). The third RCT was an individual-level RCT that used appropriate statistical analyses but did not consider clustering in the analysis (S14).

Triage

The use of triage systems was assessed by one review with studies conducted in the USA (three) and the UK (two). The quality of these studies is not known. The results were mixed—two BA studies showed a decrease in waiting times while three studies (two controlled clinical trial (CCT), one BA) showed an increase. The review concluded that the results were inconclusive.[17]

Diagnostic services

Three reviews assessed diagnostic services which included point-of-care testing[17 25] and advanced triage.[21] Point-of-care testing was evaluated in the USA (three), the UK (one) and Canada (one); all three reviews showed a reduction in ED LOS. The review by Oredsson *et al* had three moderate (one RCT, two BA) and two low (one RCT, one BA) quality primary studies and concluded that there was limited evidence to support use of point-of-care testing.[25] Guo *et al* assessed advanced triage in one good quality cohort study, which showed a reduction in LOS.[21]

Table 5 Summary of findings for physician-directed interventions

Intervention	Outcome	Study design	No. of participants	Results
Physician directed				
Physician-assisted triage (Elder)	ED LOS	1 RCT, 3 BA	64 815	ED LOS decreased in 1 RCT and 3 BA
	Waiting time	2 CCT, 1 BA	24 545	Waiting time decreased in 1 CCT and 1 BA studies; no result for 1 CCT
Triage liaison physician (Rowe)	ED LOS	2 RCT, 4 CCT, 11 BA, 1 ITS, 1 cohort	3 67 828 (13 studies)	ED LOS decreased in 2 RCT: MD −36.8, 95% CI (−51.1 to −22.8), I^2=0%, p<0.00001
	Physician initial assessment	1 RCT, 2 CCT, 6 BA	171 185 (7 studies)	*Physician initial assessment time decreased* 1 RCT: MD −30 min, 95% CI (−56.9 to −3.0) 8 Non-RCT: median absolute improvement −19 min (IQR −26 to −11)
Senior doctor triage (Abdulwahid)	ED LOS	4 RCT, 1 CCT, 3 cohort, 11 BA	605 931	*ED LOS decreased* RCT 1: MD −122, 95% CI (−133.38 to −110.62) RCT 2: MD −36, 95% CI (−50.97 to −21.03) RCT 3: MD −45, 95% CI (−91.48 to 1.48) *ED LOS increased* RCT 4: MD 6, 95% CI (−11.58 to 23.58) 12 Non-RCT: median decrease in ED LOS of −26 min (IQR −6 to-56)
	Waiting time	2 RCT, 3 cohort, 8 BA	275 254	*Waiting time decreased* 2 RCT: MD −26.1, 95% CI (−31.6 to −20.6), I^2=0%, p<0.00001 11 Non-RCT: median decrease in waiting time of −15 min (IQR −7.5 to −18)
Team triage	ED LOS	*Rowe* 1 cohort, 3 BA	82 297 (3 studies)	*ED LOS decreased* 4 Non-RCT: MD-22.7, 95% CI (−24.3 to −21.0), I^2=0%, p<0.00001 13 Non-RCT: median absolute improvement −36 min (IQR −46 to 21 min)
		Oredsson 2 RCT* , 2BA	29 674	Median reduction in ED LOS of 40.5 min (min 0– max 55)
		Ming 4 RCT	14 772	*ED LOS decreased* RCT 1: MD −24 min, p =0.005; RCT 2: MD −36 min , p =0.001 RCT 3: MD −21 min, p =0.168; RCT 4: MD −45 min, p =0.057
	Waiting time	*Oredsson* 3 BA	25 927	Median reduction of 18 min (min 16–max 20)
		Ming 2 RCT	7328	Waiting time decreased: RCT 1: MD − 26 min , p < 0.001 ; RCT 2: MD − 30 min, p = 0.029

*Same RCT in Ming.
BA, before-after; CCT, controlled clinical trial; LOS, length of stay; MD, mean difference; RCT, randomised controlled trial.

Table 6 Summary of findings for administrative/organisational and miscellaneous interventions

Intervention	Outcome	Study design	No. of participants	Results
Administrative/organisational interventions				
Multifaceted(Bond)	ED LOS	7 BA	Not available	Seven studies showed decreased ED LOS; one showed increase
	Waiting time	3 BA	Not available	Decreased waiting times in all
Staffing changes(Bond)	ED LOS	4 BA	Not available	ED LOS decreased in three studies; no difference in one study
	Waiting time	5 BA	Not available	Decreased waiting time in five studies; one reported increase for urgent cases
ED staffing/reorganisation(Guo)	ED LOS	1 cohort, 2 BA	Not available	ED LOS decreased
	Waiting time	2 BA	Not available	Waiting time decreased
System-wide interventions(Guo)	ED LOS	1 BA	Not available	Decreased ED LOS with a mean 27 min preintervention vs 22 min postintervention (p<0.001)
	Other	1 BA	Not available	Time from arrival to exam room: 27 min preintervention vs 22 min postintervention (p<0.001) Time from exam room to physician: mean 20 preintervention vs 18 postintervention (p<0.001) Time from physician evaluation to discharge: mean 100 min preintervention vs 99 min postintervention (p=0.33)
Miscellaneous interventions(Bond)				
Electronic tracking board	ED LOS	1 BA	Not available	ED LOS decreased
Dedicated ED radiology staff	ED LOS	1 BA	Not available	ED LOS decreased
Bedside registration	Other	1 BA	Not available	Time from triage to room decreased No effect on mean time from room to disposition

BA, before-after; LOS, length of stay.

Two individual-level RCTs assessed point-of-care testing (S12, S13). The statistical tests used were considered appropriate for the design but did not consider clustering/correlation of the data.

Assessment and short stay units

Three reviews examined assessment and short stay units.[17–19] Studies were conducted in the USA (one), Canada (three), New Zealand (one) and Saudi Arabia (one). Short stay units showed a reduction in ED LOS for treat-and-release patients from a BA study.[17] Bullard *et al* assessed rapid assessment zones and found shorter ED LOS based on one RCT and BA study both rated as low quality.[18] The authors concluded that there was insufficient evidence to support rapid assessment zones.[17 18]

Nurse-directed interventions

Nurse-directed interventions consisted of various interventions relating to nursing activities. Four reviews contributed to this category.[19 23 25 27] The primary studies were conducted in Australia (eight), the UK (six), Canada (five), the USA (three) and one study each in New Zealand, Hong Kong, Singapore, the Netherlands and Sweden.

Two systematic reviews from Jennings *et al*[23] found that nurse practitioners led to shorter waiting times and LOS. Those findings were based on low-quality studies and the authors concluded that the evidence was limited.

Rowe *et al*[27] examined the impact of triage nurse ordering. The primary studies compared nurse-initiated X-rays with ED physician-initiated X-rays. The primary studies assessing the ED LOS were all weak three RCT, one CCT, two case-control (CC), three cohort and three BA). One RCT found a statistically significant reduction in ED LOS with triage nurse ordering.[27] Oredsson *et al* looked at nurse-requested X-rays and found a decrease in ED LOS/waiting times based on three RCTs.[25] The primary studies by Oredsson *et al* assessing ED LOS were moderate (one RCT) and low (one RCT) quality while those assessing waiting times were moderate (one RCT) quality. The review concluded that evidence was limited.[25]

Four of the primary studies assessing nurse-directed interventions were RCTs. One used a cluster RCT design (S6) and three were individual-level RCTs (S9–S11). There was no evidence to suggest that any of the RCTs performed an analysis that considered clustering/correlation.

Physician-directed interventions

Physician-directed interventions assessed the role of physicians in triage. Five reviews contributed to this category.[16 19 24–26] The study settings included the USA (19), Australia (5), the UK (3), Canada (3), Hong Kong (2) and 1 each in Northern Ireland, Jamaica, Sweden and Singapore.

Meta-analyses on triage liaison physician compared with nurse-led triage showed statistically significant reductions in ED LOS.[26] These findings were based on 3 strong (1 RCT, 2 CCT), 2 moderate (1 ITS, 1 BA) and 14 (1 RCT, 2 CCT, 1 cohort, 10 BA) weak quality primary studies. Two RCTs examining senior doctor triage found statistically significant decreases in ED LOS while one showed a statistically non-significant increase.[16] Meta-analyses also showed reductions in waiting times for senior doctor triage.[16] The results for ED LOS for senior doctor triage were based on four strong (three RCT, one BA), nine moderate (one CCT, two cohort, six BA) and six weak (one RCT, one cohort, four BA) quality primary studies. The results for waiting times were based on one strong (RCT), five moderate (two cohort three BA) and seven weak (one RCT, one cohort, fiveBA) quality studies. Although senior doctor triage showed improvements in flow metrics, the study concluded that the evidence was not strong enough.[16]

Team triage was assessed by three reviews which all found decreased ED LOS and waiting times.[24–26] Ming *et al* compared team triage with single nurse triage and found non-significant reductions in ED LOS in four RCTs which were all assessed as low quality.[24] Rowe *et al* performed a subanalysis on four non-RCT studies, comparing team triage and single physician triage and found a statistically significant reduction in ED LOS with team triage.[26] These results were based on weak quality primary studies (one cohort, three BA). The primary studies from Oredsson *et al* assessing ED LOS consisted of three moderate (one RCT, one CCT, 1BA) and one low (RCT) quality. Those assessing waiting times from Oredsson *et al* consisted of one moderate (BA) and two low (BA) studies. Ming *et al*[24] and Oredsson *et al*[25] both concluded that the evidence to support the use of team triage was limited.

Of the primary studies assessing physician-directed interventions, five were RCTs. Four of the RCTs used a cluster randomised design that used appropriate cluster analyses considering clustering and correlation (S1–S4). The fifth RCT was a cluster randomised design but there was no evidence to suggest that a cluster analysis was performed (S5).

Administrative and organisational interventions

Administrative and organisational interventions included a range of strategies such as increasing clinical and non-clinical staff numbers, increasing cubicles/treatment rooms, structural reorganisation, implementation of coordinators.[17 21] Studies were conducted in the USA (seven), Australia (three), Spain (two), Canada (two) and one each in Hong Kong, Israel, Sweden and Switzerland. Overall, there were improvements in ED LOS and waiting times. However, these results were based only on BA studies rated as either good or low quality by Guo *et al*.[21] The reviews concluded that there was insufficient evidence to support these interventions.[17 21]

Miscellaneous

Bond *et al* assessed electronic tracking boards, dedicated ED radiology staff and bedside registration.[17] These studies were all US-based BA designs; all three interventions reduced ED LOS, triage to treatment and triage to room times.

DISCUSSION

This umbrella review summarised evidence from systematic reviews and meta-analyses on interventions that improve ED patient flow. Overall, the evidence supporting the effectiveness of the interventions was weak (as reported by the systematic review authors). Only one intervention had moderate evidence to support its use—fast track. However, one review author noted that, although the evidence was sufficient, there were other factors such as physical limitations in the ED, limited human resources and cost-effectiveness that could affect the implementation of fast track.[17]

The interventions were not standardised with different terms possibly representing the same intervention. For example, Oredsson *et al*[25] examined nurse-requested X-rays, an activity performed by nurse practitioners[19 23] and seen in triage nurse ordering.[27] In some instances, the same primary studies provided evidence for a range of interventions as seen with senior doctor triage, triage liaison physician, physician-assisted triage and team triage.[16 19 24–26] Reviews that included paediatric settings did not

differentiate between adult and paediatric EDs to determine if this affected the intervention effect. The heterogeneity in the intervention and control groups could affect how interventions were implemented in different settings, a factor which may affect the ability to generalise findings.

Another potential factor limiting generalisability was the overlap of interventions. The multifaceted interventions were based on the implementation of combined strategies. Since no direct comparisons were made between the single intervention and the combination of strategies it is unknown which one was responsible for the observed effects. This was also a factor in fast track, which in some studies was either nurse or doctor led and in others was combined with streaming or rapid assessment zones.[17 25] Again it is unclear which factor (nurse-led or doctor-led fast track, streaming or assessment zones) contributed to the effect.

A 2011 overview examined interventions to mitigate ED crowding.[31] Although the overview did not meet criteria for inclusion in the umbrella review, it did measure flow metrics and identified additional interventions that are worth mentioning. These included bedside ultrasound, computerisation, clinical decision and observation units, bed coordination and multifaceted interventions (eg, UK 4-hour target). These interventions also showed benefits to improving flow metrics but like the interventions identified in the umbrella review, there was still insufficient evidence to support the implementation of any of the interventions.[31]

Although this umbrella review identified interventions that could improve patient flow, an understanding of how and why these interventions produced (or did not produce) their desired effect, is still unclear. This is important because the studies were conducted in countries with different models of emergency care. The majority of studies were in countries with developed emergency care systems and a dedicated emergency medicine specialty (the USA, the UK, Australia, Canada). Thus, generalising the findings to other models of ED care may still be difficult; an exploration of the mechanism underlying the intervention or the patient flow process may be beneficial.

Lastly, the uncertainty surrounding the appropriate use of statistical tests in the cluster RCTs affects the conclusions drawn on the effectiveness of the intervention. The RCTs using individual patient designs appeared to use appropriate tests; however, the potential importance of clustering/correlation in individual patient RCTs is an issue that should be considered in future trials of patient flow.[32] This is particularly important for the fast track intervention, which was the only intervention with evidence supporting its implementation but for whom clustering/correlation was not considered in the RCTs that examined the intervention.

Limitations

There are several limitations to this review. Measures of patient flow were not standardised across the included systematic reviews. The most common outcome measures were ED LOS and waiting times. Two primary studies from one review presented different definitions of ED LOS (arrival to physical departure vs triage to physical departure). This was not unexpected since there is no universal definition for patient flow and crowding terms and measures.

Although the majority of the systematic reviews were graded as either high or moderate quality, within the systematic reviews there was a predominance of weak primary studies and study designs. Many of the systematic review findings were based on primary studies with non-RCT designs; almost two-thirds were BA studies, which are known to produce bias.[33] The Cochrane Effective Practice and Organisation of Care (EPOC) guidance recommends against the inclusion of uncontrolled BA study designs in systematic reviews.[33]

Some systematic review findings were based on a small number of primary studies and several reviews included abstracts rather than peer-reviewed full-text articles. Some systematic reviews examining the same intervention had overlap of the primary studies contributing to the outcome measure. Thus, it was not always new evidence being presented for each intervention.

The authors of the systematic reviews also noted the high heterogeneity seen with study settings, designs, populations, interventions and outcome measures, which prevented the pooling of results and performance of meta-analyses.

CONCLUSION

The evidence to support implementation of the majority of the interventions was considered weak. Future studies should distinguish between non-flow (crowding) and flow and the respective measures. Stronger study designs are also required, as well as an exploration of the patient flow process, how these interventions work and why some interventions work in some settings and not others. Furthermore, the issue of correlation of observations when conducting statistical analyses should be considered in all future studies. ED patient flow is a complex phenomenon and a greater understanding of the patient flow process could assist in the development of effective interventions.

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