Commentary

Emergency Department Boarding: An Inevitable Phenomenon or Crucial Quality Indicator?

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The phenomenon of boarding in emergency departments has represented one of the most significant challenges for contemporary healthcare systems over the past 30 years. (Pines, 2025; Sartini, 2022). The term "boarding" refers to the patient's stay in the emergency department after the decision to admit them while awaiting a hospital bed (Iozzo et al., 2024; Sartini, 2022). This interval is now recognized as a critical element in hospital management with both clinical and organizational implications (Joseph et al., 2024). International literature has highlighted that boarding cannot be considered a mere side effect of emergency-urgent care activities but rather a potential indicator of the quality and safety of care (Sartini, 2022; Singer, 2011). In a study conducted in Israel, over 250,000 emergency department visits were analyzed over five years. This is a large sample, allowing for precise observation of clinical dynamics. Among all these patients, approximately 1,200 experienced a documented clinical error, and here comes the crucial data: 61% of these patients were boarding. The question arises as to whether it should be interpreted as an unavoidable phenomenon inherent in the complexity of healthcare systems or as a key parameter for evaluating the efficiency and quality of care (Kolikof, 2025). In recent decades, numerous healthcare systems have reduced the number of hospital beds, moving towards a model of community-based healthcare and public spending containment (Pines, 2011). This reduction, while justified by economic sustainability goals, has increased pressure on hospitals, contributing to patient accumulation in emergency departments. The progressive aging of the population leads to an increase in demand for hospital admissions and the clinical complexity of cases (Joseph et al., 2024). Furthermore, numerous studies have confirmed that older and frail patients require longer hospital stays, thus reducing bed availability for new admissions (Lewis, 2020; O'Caoimh et al., 2019). Another determinant is the difficulty in ensuring timely and safe discharge. The lack of facilities such as hospices or concrete alternatives in the community for consistent care continuity slows downward turnover, generating cascading congestion in emergency departments (Kolikof, 2025). Seasonal epidemics, heatwaves, and other sudden emergencies produce exceptional access flows to emergency departments, further exacerbating the already fragile system.

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Admission is frequently perceived as the responsibility of the emergency department, but it is not. Rather, it is a matter related to hospital productivity, staff availability, and correct resource allocation (Sartini, 2022). The shortage of nursing staff and closure of hospital beds have widened this gap. Emergency departments are the release valves of a system that no longer has room to maneuver (Pines, 2025). Boarding contributes to overcrowding in emergency departments, hindering the care of new patients and increasing staff workload. This phenomenon generates professional stress, burnout, and a reduction in the perceived quality of care (Pines, 2011). From an ethical standpoint, holding patients for prolonged periods in environments not designed for inpatient care raises issues of dignity, equity, and distributive justice, as frail individuals are disproportionately penalized (García-Peña, 2018; Iozzo et al., 2025; Singer, 2011). Boarding has documented consequences for the quality of care and clinical outcomes (Joseph et al., 2024). Numerous studies have highlighted an association between prolonged boarding times and an increased risk of adverse events, including falls, healthcare-associated infections, and death (Boudi et al., 2020; Joseph et al., 2024; Lewis, 2020; Olson et al., 2024; Pines, 2025). In a study conducted on 1,406 adults aged ≥ 60 years, admitted to two general hospitals in Mexico City (García-Peña, 2018), the mortality recorded in the sample was 21.8%. The analysis showed that the duration of boarding is associated with an increased risk of death; each additional hour spent in the emergency department increases this risk. Some authors argue that boarding is inevitable within certain limits. In a complex system, characterized by limited resources and variable demand, moments of congestion are physiological (Boudi et al., 2020; Joseph et al., 2024; Singer, 2011).

From this perspective, boarding constitutes an acceptable compromise. However, this view risks legitimizing a condition that, if prolonged, compromises patient safety and quality of care. Therefore, considering boarding as an unavoidable phenomenon can translate into a form of managerial abdication of responsibility. Conversely, an increasingly widespread perspective interprets boarding as a crucial indicator of quality (Coil, 2016; Kolikof, 2025; Mohr et al., 2020; Sartini, 2022). Reduced boarding times testify to the efficiency of admission and discharge processes, coordination capacity between the emergency department, wards, and community services, and effectiveness of hospital governance. In this sense, boarding can be likened to a "litmus test" for the healthcare system: its extent reflects the quality of the organization and the structural and managerial resilience of the hospital. Numerous international experiences have shown that boarding can be reduced through targeted strategies, such as centralized bed management (e.g., bed manager), planned discharges, strengthening of community care, and predictive flow analysis (Coil, 2016; Joseph et al., 2024; Pines, 2011; Sartini, 2022). Therefore, boarding in the emergency department constitutes a complex phenomenon at the crossroads of hospital organization, healthcare planning, and patient safety. While a minimum level may be considered physiological, boarding must not be accepted as an inevitable outcome. In contrast, it represents a crucial quality indicator that is useful for monitoring system efficiency and guiding improvement policies. Addressing boarding implies a systemic approach that integrates internal hospital organizational strategies aimed at accurate bed management with interventions to strengthen community care. Only a comprehensive vision oriented towards efficiency and dignity of care can reduce the incidence of this phenomenon and ensure safer, higher-quality assistance.

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