

Waiting Rooms, Not War Zones

Turning ED Chaos into a Controlled, Compassionate Emergency Care

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BUILDING HEALTH, **TOGETHER.**

HASA QUALITY SUMMIT AND CONFERENCE 2026

Waiting Rooms, Not War Zones

“Before I begin, I would like to declare that I have no financial or commercial conflicts of interest related to this presentation.

The affiliations and collaborations relevant to this work are disclosed.

This presentation is intended for scientific, clinical and educational purposes.”

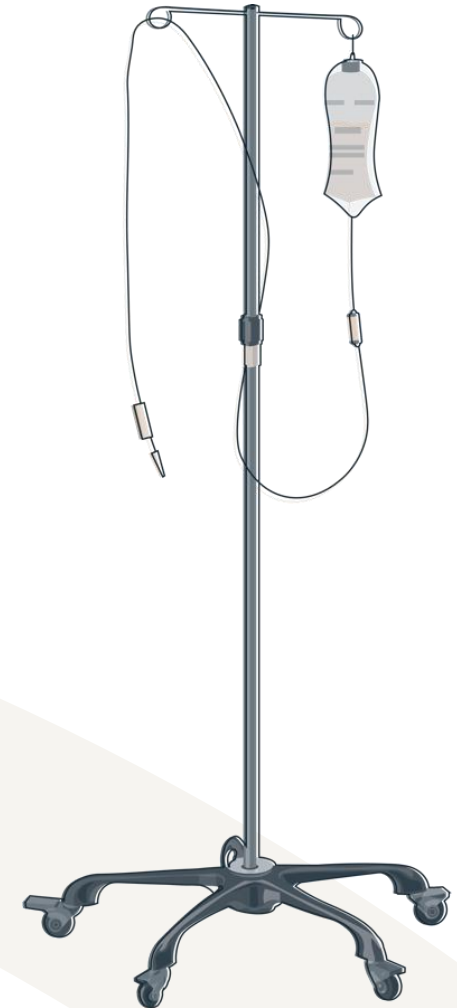


Overcrowding and Waiting Times

IFEM

The International Federation for Emergency Medicine (IFEM) recognizes emergency department (ED) overcrowding and long waiting times as a critical global crisis.

OVERCROWDING **KILLS**



Overcrowding Literature Plus Operational Reality



Research shows that when ED's are over-crowded, chaotic and stressful patient harm and even death occurs, through delays and mistakes resulting from an impossible workload. It means that patients have no privacy or dignity. Patients or their families can become aggressive towards staff. Staff morale becomes poor, and when the situation is there day after day, burnout happens. If staff leave, the situation deteriorates further.

Emergency department (ED) waiting rooms are perceived as unavoidable chaos, yet evidence shows that crowding and prolonged waits in this space drive delays to triage and treatment, increase length of stay, adverse outcomes and deepen patient dissatisfaction. The waiting room is, a frontline patient safety environment, not a benign holding area.

This review deliberately combined two perspectives: international evidence on emergency department crowding and waiting times, and real-world operational data from a high-volume private emergency network.

The literature review focused on the relationship between ED occupancy, queuing, time to triage, time to first clinician, total length of stay, left-without-being-seen rates, and mortality in time-sensitive conditions such as sepsis, stroke, and acute coronary syndromes.

That evidence base was then interpreted alongside system-wide operational data collected through a structured flow programme, where every emergency department reports monthly waiting times, Door-to-Doctor performance, length of stay, and bed-utilisation metrics, with outliers actively flagged for intervention.

ED overcrowding is a system failure with clinical consequences. It delays time-sensitive care, increases boarding and length of stay, drives patients to leave before assessment, degrades experience and staff safety, and is associated with increased mortality in many studies.

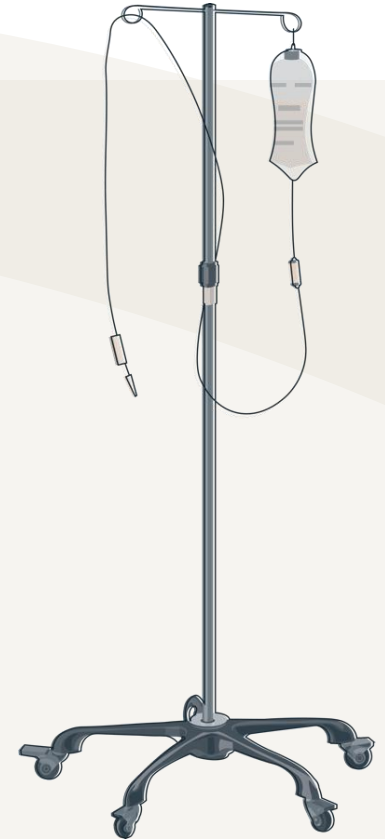
What was measured and why it matters

The operational lens was intentionally practical and patient-centred. We examined triage-stratified Door-to-Doctor times, including around 9 minutes for red patients, approximately 40 minutes for yellow patients, and 45 to 60 minutes for green patients, alongside combined arrival-to-disposition stretch targets of roughly 180 to 210 minutes.

These internal targets are tighter than many published international benchmarks, which is important because waiting time is not just a service metric; it is a safety metric.

The programme also incorporated time-critical pathway measures such as stroke and acute coronary syndrome response times, antibiotic hang time, EMS drop-off metrics, and patient-experience indicators covering journey, communication, compassion, and pain.

The key message is that crowding must be understood as a whole-system problem: it affects speed, safety, experience, and ultimately outcomes.



“In other words, crowding is not a throughput inconvenience; it is a measurable patient-safety risk.”

Scale of the Problem

A PRISMA-based systematic review published in 2026 screened 23,408 studies and included 226, identifying high attendance, poor primary-care access, staffing shortages, diagnostic delays, boarding and late discharge as major drivers of crowding.

A 2018 systematic review identified 102 eligible studies, of which 40 examined the consequences of crowding; it concluded that poorer outcomes and failure to deliver guideline-recommended treatment were well established.

ED OVERCROWDING: THE PATIENT AT THE CENTRE



**Crowding is a patient-safety
problem — not just a throughput problem.**

What the Research says

MORTALITY - A 2026 systematic review found increased mortality among the recognised adverse effects of crowding; an earlier review found that most retrospective studies assessing inpatient mortality reported worsening mortality as crowding increased, although not every study found an independent association.

DELAYED TREATMENT - Crowding is linked to delays in analgesia, antibiotics, stroke assessment, trauma care, and sepsis management, as well as poorer adherence to guideline-recommended care.

BOARDING HARM - A 2026 review of 21 US studies found prolonged ED boarding associated with worse mortality, morbidity, length of stay, medication errors, treatment delays, staff stress, and safety risks,

LONGER STAY - Crowding is associated with longer ED and inpatient length of stay, creating a reinforcing cycle of further crowding.

LEAVING WITHOUT CARE - Systematic reviews repeatedly associate crowding with higher left-without-being-seen rates.

PATIENT EXPERIENCE - Reduced satisfaction, poorer communication, loss of privacy, and dissatisfaction with pain management are recurring consequences.

THE ED WAITING ROOM BAROMETER

From System Stress to Safe Patient Flow

BAROMETER INDICATORS (WHAT IT TELLS US)



LONGER WAITS

Rising wait times signal system congestion and delays.



OVERCROWDING

High volumes strain capacity and increase risk.



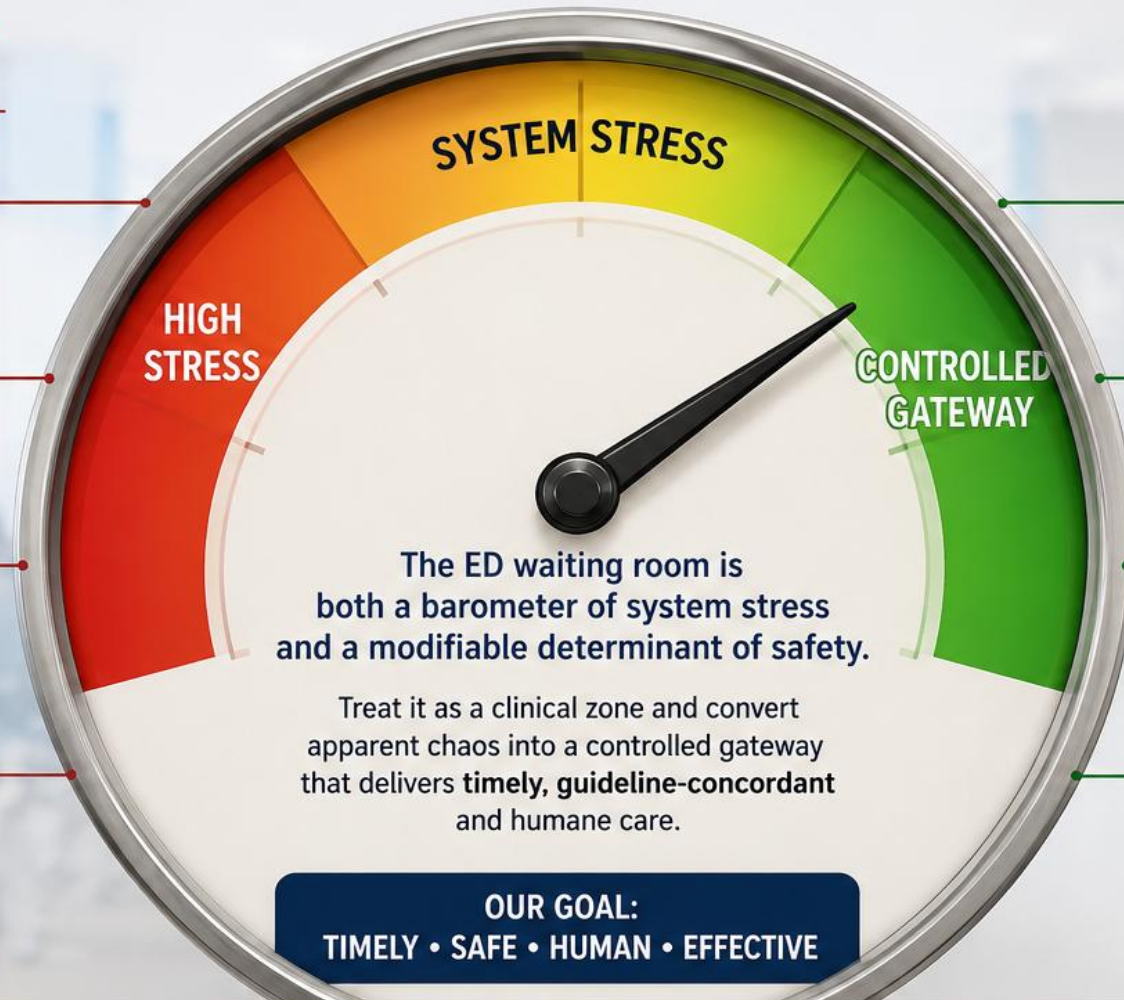
SAFETY RISKS

Overcrowding and delays increase deterioration and adverse events.



PATIENT EXPERIENCE

Anxious, uninformed patients experience lower satisfaction and trust.



MODIFIABLE DETERMINANTS (WHAT WE CAN CONTROL)



RAPID TRIAGE

Identify urgency early and prioritise care appropriately.



VISIBLE FLOW OWNERSHIP

Clear leadership and accountability keep patients moving.



CLEAR COMMUNICATION

Keep patients informed about waits and next steps.



STANDARDISED PROCESSES

Consistent workflows across sites drive reliability and equity.



THE IMPACT: Turn the waiting room from a source of stress into a controlled clinical gateway.



Timely Care



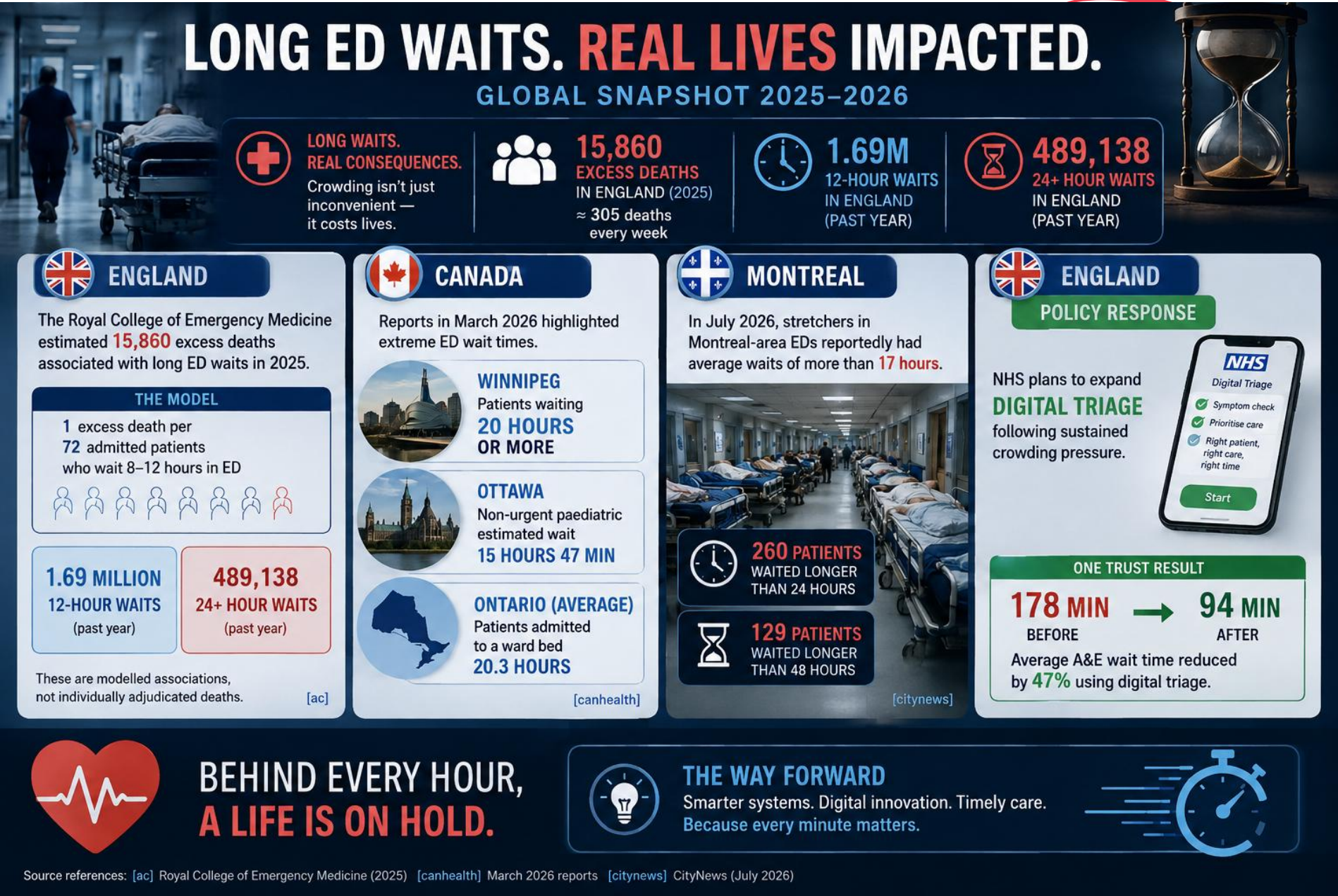
Safer Patients



Guideline Concordant



Humane Experience



South African Data

South African evidence confirms that ED boarding is primarily an access-block problem. At a Gauteng central hospital, boarded patients had a median ED stay of 2.81 days and 80% waited approximately three days for ward transfer. Delays in admission decisions and ward-bed availability were the principal drivers.

ED BOARDING REPORT

1 APRIL – 30 SEPTEMBER 2025

AT A GLANCE (6 MONTHS)

54,496
BOARDING EPISODES
(patients boarded in ED)

323,659
TOTAL BOARDING HOURS
(time ED beds occupied by boarded patients)

183
DAYS
(1 April – 30 September 2025)



THE AVERAGE BOARDING TIME ACROSS ALL FACILITIES



**5 HOURS
56 MINUTES**
AVERAGE BOARDING TIME
PER BOARDED PATIENT



On average, a patient who has completed their ED phase of care remains in the Emergency Department for almost 6 hours while awaiting inpatient bed placement.



These delays mean ED beds are used for patients who no longer require emergency care, reducing our ability to see and treat new patients.

BOARDING AT SCALE



More than
54,000
patients experienced
ED boarding over this
6-month period.



Collectively, this represented
**324,000
HOURS**
of ED capacity occupied by
patients awaiting definitive
inpatient placement.



ED boarding consumes valuable
resources, contributes to overcrowding
and increases pressure across the
entire hospital system.

THE IMPACT OF ED BOARDING



REDUCED ED CAPACITY
Beds are occupied by patients
awaiting placement, limiting
availability for new patients.



INCREASED AMBULANCE DELAYS
Longer offload times impact
prehospital response and
community access.



LONGER PATIENT WAIT TIMES
More boarding contributes to
crowding and longer waits for
patients still in ED.



OPERATIONAL PRESSURE
Additional hours create strain
on staff, resources and overall
hospital flow.



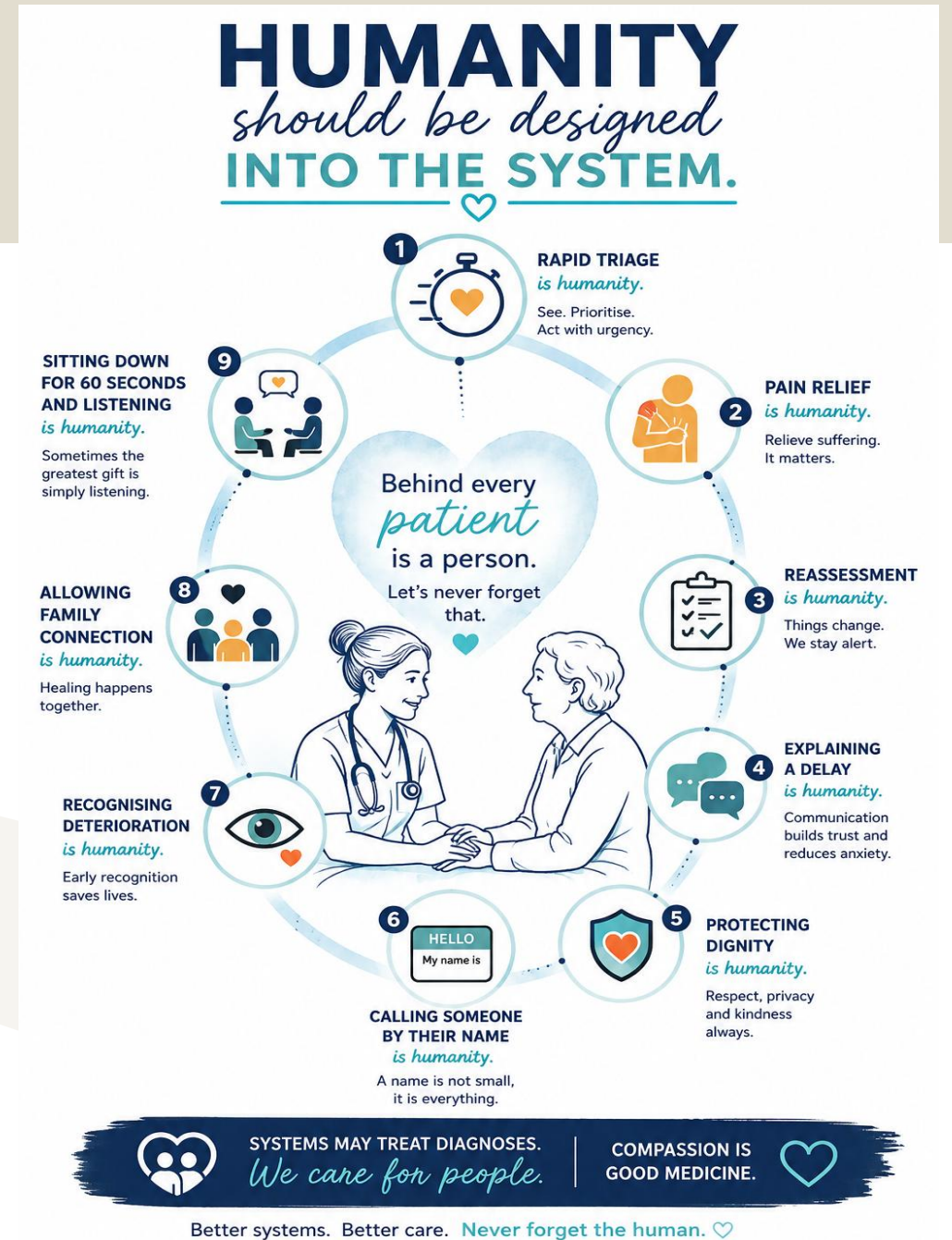
Between April and September 2025, more than 54,000 patients experienced ED boarding, with the average boarded patient remaining in the Emergency Department for almost 6 hours. Collectively, this represented approximately 324,000 hours of ED capacity occupied by patients awaiting definitive inpatient placement.



Source: Netcare ED Boarding Report | Data extracted: 1 October 2025

“The greatest risk of an overcrowded healthcare system is not only that patients wait longer.

It is that, somewhere in the pressure to move patients through the system, we stop seeing the person who is waiting.”



“The lesson is not that emergency departments must somehow absorb unlimited demand more efficiently. The lesson is that crowding exposes failures in the wider system: access to beds, diagnostics, decision-making, discharge processes and community care.

Our responsibility is therefore to stop treating waiting as invisible time. Every minute in the waiting room is part of the patient’s clinical journey. By measuring it, managing it and responding to it with urgency and compassion, we can create emergency departments that are safer for patients and more sustainable for staff.”

A crowded emergency department is not only a busy department—it is an early warning signal that the whole healthcare system must respond.

WHEN DID THE PATIENT BECOME A PROCESS?

From Person to Process ... and back again

THE DEHUMANISING JOURNEY

1 PERSON

- Unique story
- Family, fears, hopes
- Needs care

2 NUMBER

- Patient ID
- Waiting time
- Targets

3 DIAGNOSIS

- Condition
- Pathway
- Protocols

4 BED REQUEST

- Bed search
- Ward allocation
- Throughput

WHAT GETS LOST...

- ♥ Dignity
- 💬 Communication
- 👁️ Visibility
- 🧠 Emotional wellbeing
- 👨 Family connection
- 👤 The human being

THE HUMANISING JOURNEY BACK TO PERSON-CENTRED CARE

1 SEEN AS A PERSON AGAIN

- Known by name
- Story matters
- Respected

2 CLEAR COMMUNICATION

- Explained
- Kept informed
- Reassured

3 TIMELY CARE

- Rapid triage
- Pain relief
- Reassessment
- Recognised deterioration

4 DIGNIFIED EXPERIENCE

- Comfort
- Privacy
- Family connection
- Humane care

WHAT WE RESTORE...

- ✓ Dignity
- ✓ Trust
- ✓ Safety
- ✓ Better outcomes
- ✓ Satisfaction
- ✓ Hope

*The same patient.
Two different experiences.*

Because healthcare is not just about what we do ...
It's about *how we make our patients feel* while we do it.

Never forget the human.



People-centred systems



Safer care



Better outcomes



Healthier teams



A more humane healthcare system

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- XVIII. **Factors contributing to extended length of stay in the emergency department and potential strategies for improving patient flow in a central hospital in the Gauteng Province, South Africa (2025).**
This South African study analysed 2,927 patients with ED stays over 48 hours and reported a **median ED LOS of 2.81 days**, providing important local evidence for the presentation

Thank You!



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