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Overview of Patient Boarding Time At the Emergency Installation of Toto Kabila Hospital

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ABSTRACT

Boarding time is an important indicator of the quality of emergency room services that describes the length of time from the time the patient is designated for hospitalization until he is transferred to the treatment room. Prolonged boarding time can lead to delays in further treatment, increase the risk of complications, and impact patient safety. This study aims to find out the description of the boarding time of patients in the Emergency Installation of Toto Kabila Hospital. The research design is descriptive quantitative with a single variable boarding time. The population amounted to 1132 emergency room patients, with a sample of 92 respondents using purposive sampling techniques. Data were collected through direct observation and verification of medical records, then analyzed in univariate analysis. The results of the study showed that 53 respondents (57.6%) experienced boarding time ≤ 6 hours, while 39 respondents (42.4%) experienced boarding time > 6 hours. The main cause of boarding time is the limited number of beds in the inpatient room. Other contributing causes are extra work of nurses, administration and documentation and patient or family factors. These findings show that patient transfers have gone quite well, although some patients are still experiencing delays. Toto Kabila Hospital is recommended to improve boarding time monitoring and improve the bed availability information system. Further research is suggested to develop other variables to gain a more comprehensive understanding of boarding time.

INTRODUCTION

The Emergency Installation is a health service unit that has an important role as the main gateway in handling patients with critical conditions. As the front line of hospital services, the emergency room must be able to provide fast, precise, and coordinated services in order to minimize the risk of complications and death. The speed and accuracy of this service is the main key in maintaining patient safety and improving the quality of hospital health services (Kurniawan et al., 2024). However, it is important to remember that not all patients who come to the emergency department require immediate treatment. In this room, priority will be given to patients with the most serious or urgent conditions (Angky et al., 2024).

The minimum service standards in the emergency room have been regulated in the Decree of the Minister of Health Number 856 of 2009. In this regulation, it is stated that emergency room services must always be available at all times, seven days a week. This is especially important for handling emergency, resuscitation, and stabilization cases (Indriono, 2020). Patients who have received services and undergone initial and diagnostic examinations at the emergency facility will be determined their follow-up status whether to be outpatient or inpatient according to their clinical conditions and medical assessment (Alenany & Cadi, 2020).

Patients who have been designated for hospitalization need to immediately receive follow-up services and be transferred from the emergency unit to the treatment room so that the treatment process is not delayed. But in practice, patients often experience delays in transfer to the inpatient room, known as Boarding Time (Kappy et al., 2024)

Boarding time itself is the time needed by emergency room patients to start when the patient is decided to be hospitalized until the patient is transferred to the inpatient room (Dwisari et al., 2024). In the year 2024, Emergency Department Benchmarking Alliance (EDBA) report average measurement results Emergency boarding time. Emergency departments with between 80,000 and 100,000 patient visits per year have the highest wait time, which is about 110 minutes. Meanwhile, emergency departments with fewer than 20,000 patient visits per year show a shorter average waiting time of 63 minutes. These findings suggest that the Boarding Time is one of the important benchmarks in assessing the quality of services in the emergency room. According to Joint Commission International (JCI) and Centre For Medicare & Medical Service (CMS)) that Boarding Time ideally no more than 4 hours to ensure patient safety and minimize the risk of complications (Mohr et al., 2020).

In Indonesia itself, although there is no standard that specifically regulates the waiting time for moving (Boarding time) after the hospitalization is determined in the minimum service standard (SPM) of the hospital, but in PMK No. 129 of 2008 regarding the time limit for patients to be in the emergency room until they are transferred to inpatient services in the hospital is 6 to 8 hours after the patient enters the emergency room (Abbas et al., 2024).

Related issues Boarding Time This is often complained by patients when receiving treatment in the emergency room or when they are transferred to the inpatient room. This delay is caused by several factors, such as limited bed capacity, laboratory examinations, fluctuations in the number of available health workers, surge in the number of patients, and the complexity of applicable administrative procedures (Rochana & Djogotuga, 2020).

Based on recent research, it is shown that delays in moving patients from Emergency Departments to intensive care units can negatively impact patient clinical outcomes, including increasing the risk of death and prolonging the length of hospitalization. Factors such as limited facilities and medical personnel, are often the main causes of transfer delays. Patients who experience these delays generally exhibit poorer clinical conditions, require longer mechanical ventilation, and have longer stays than patients who are immediately transferred to the intensive care room (Bosco et al., 2023).

Ineffectiveness of the service flow in the Emergency Installation can cause the occurrence of Boarding Time that is prolonged (Mosleh et al., 2023). Based on data from the Toto Kabila Regional General Hospital, the number of emergency room patient visits for the period January to December 2024 is 16,890 people and the number of inpatients is 13,591 people with an average monthly of 1132 patients. As for the length of time the patient was in the emergency room from the time the patient was determined until he was actually transferred to another unit/inpatient room, it was not found cumulatively in the SIMRS.

In a study conducted by Novita et al. (2023) entitled Analysis of Factors Affecting Patient Waiting Time in the Emergency Installation of the General Hospital dr. Zainoel Abidin Banda Aceh, that the approach used is a quantitative method with an approach Cross-sectional and analytical descriptive design. This study found that the length of patient waiting time in the emergency room is greatly influenced by several important factors, such as the process of laboratory examinations, radiological examinations, and the process of transferring patients to the treatment room. These three factors have been proven to have a significant influence on the duration of the patient's stay in the Emergency Department.

Based on research conducted by Kadir (2025) with the title "Factors Related to the Length of Waiting Time for Emergency Room Patients to Be Transferred to the Inpatient Room of Toto Kabila Hospital", this study uses a design Cross-sectional with a sample of 82 patients who entered the emergency room of Toto Kabila Hospital. The results showed that there was a significant relationship between several factors and the length of patient waiting time. The overcrowded emergency room had the strongest relationship (p-value = 0.001), followed by the length of supporting examination (p-value = 0.03) and the time of consultation with the doctor in charge of the patient (DPJP) (p-value = 0.001).

Based on the results of initial observations carried out on June 10, 2025 at the Emergency Installation of Toto Kabila Hospital, it was found that 10 patients experienced an extension of boarding time in the emergency room, which ranged from 8 to 10 hours. Of the 10 patients, as many as 3 people experienced an extension of boring time caused by extra work of room nurses where there were no officers available to transport patients who would be transferred to hospitals.

In addition, 3 other patients experienced boarding time because there was no room in the inpatient room, so the transfer process was delayed. Meanwhile, 4 other patients experienced long boarding times due to the accumulation of patient factors such as the length of time the patient and family made decisions to be hospitalized and administration as well as documentation that experienced obstacles such as the availability of beds in the inpatient room and biometric verification.

As a result of the interview with the Head of the Emergency Installation Room of Toto Kabila Hospital, it is known that the maximum waiting time limit for the transfer of inpatients from the Emergency Installation to the treatment room at Toto Kabila Hospital is 6 hours from the time the decision on the inpatient decision is set.

Based on the discussion above, the researcher is interested in conducting research on "Overview of Boarding Time with Patients in the Emergency Installation of Toto Kabila Hospital". This study is expected to provide a clear understanding of the condition of patients' boarding time in the emergency room, including the distribution of the length of waiting time for transfer from the emergency room to the inpatient room. The results of this research are also expected to be the basis for evaluation for patient transfer time management, so that boarding time can be reduced according to service quality standards and the quality of emergency installation services can be increased.

RESEARCH METHODS

This research was carried out at the Emergency Installation of Toto Kabila Hospital on October 7–14, 2024. The research uses a quantitative approach with a descriptive design. The population in this study was all patients who came to the emergency room as many as 1,132 patients, and the sample was determined using the Slovin formula with an error rate of 10% so that 92 respondents were obtained. The sampling technique uses purposive sampling based on the inclusion and exclusion criteria that have been set. The research instrument used an observation sheet to measure boarding time, namely the duration from the determination of inpatient to the transfer of patients from the emergency room to the inpatient room. Data was collected through observation and documentation of medical records, then analyzed univariately to illustrate the distribution of frequency and percentage of patient boarding time in the emergency room of Toto Kabila Hospital.

RESEARCH RESULTS

Respondent Characteristics

Table 1. Characteristics of respondents by age

Yes	Age	Quantity	Percentage
1	Toddlers, 0-5 years old	14	15,2
2	Children, 6-11 Years	4	4,3
3	Early teens, 12-16 years old	2	2,2
4	Late teens, 17-25 years old	8	8,7
5	Early Adult, 26-35 Years	6	6,5
6	Late Adult, 36-45 Years	11	12
7	Early Seniors, 46-55 Years	15	16.3
8	Late Seniors 56-65 Years Old	17	18,5
9	Senior >65 years old	15	16,3
Total		92	100

Source : Primary Data 2025

Based on the results in the table above, it shows that the respondents in this study consist of various age groups. From these results, the final elderly age group (56–65 years) was the most dominant with a total of 17 respondents (18.5%). Furthermore, it was followed by the early elderly (46–55 years) and seniors (>65 years) who each amounted to 15 respondents (16.3%), and toddlers (0–5 years) as many as 14 respondents (15.2%). Then, the late adult group (36–45 years) as many as 11 respondents (12.0%), and late adolescents (17–25 years) as many as 8 respondents (8.7%). Next, early adults (26–35 years) amounted to 6 respondents (6.5%), children (6–11 years) amounted to 4 respondents (4.3%), and the fewest were early adolescents (12–16 years) with 2 respondents (2.2%).

Table 2. Characteristics of respondents by gender

Yes	Gender	Quantity	Percentage
1	Male	38	41,3
2	Women	54	58,7
Total		92	100

Source : Primary Data 2025

Based on the results in the table above, it shows that most of the respondents are female, namely 54 people (58.7%), while the male respondents are 36 people (41.3%).

Table 3. Characteristics of respondents based on Diagnosis

Yes	Diagnosis	Quantity	Percentage
1	Abdominal Colic	1	21,7
2	Nausea	2	2,2
3	Febris	3	17,4
4	Gastroenteritis	4	7,6

5	Dyspepsia	5	3,3
6	Hydronephrosis	6	4,3
7	BPH	7	4,3
8	Sarcoma Neoplasm	8	1,1
9	Pharyngitis	9	1,1
10	Gouty Arthritis	10	1,1
11	Hypertension	11	1,1
12	Nephrolithiasis	12	3,3
13	CHF	13	1,1
14	GERD	14	1,1
15	Head Injury,Unspecified	15	1,1
16	CKD	16	2,2
17	TB	17	1,1
18	Cyst Of Kidney	18	1,1
19	Hemiplegia	19	1,1
20	Anemia	20	1,1
21	PPH	21	1,1
22	Pneumonia	22	1,1
23	DOC	23	1,1
24	Melena	24	2,2
25	Polyneurophaty	25	1,1
26	Appendicitis	26	1,1
27	Discomfort	27	1,1
28	Hemoptysis	28	1,1
29	Diabetes Mellitus	29	3,3
30	Diarrhea	30	2,2
31	Fracture Lumbar Spine	31	1,1
32	Dyspnea	32	2,2
33	Malignant Neoplasm	33	2,2
34	Neurogenic Bladder	34	1,1
Total		92	100

Source : Primary Data 2025

Based on the results in the table above, it shows that the respondents in this study have various types of medical diagnoses when it comes to the Emergency Installation. The most dominant diagnosis was abdominal colic, with a total of 20 respondents (21.7%). Furthermore, febris diagnosis ranked second with 16 respondents (17.4%). Then followed by gastroenteritis as many as 7 respondents (7.6%). In the next sequence, diagnoses of dyspepsia, nephrolithiasis, and diabetes mellitus were found in 3 respondents (3.3%) respectively. Meanwhile, the diagnosis of hydronephrosis and BPH was experienced by 4 respondents (4.3%) respectively. Several other diagnoses such as nausea, CKD, melena, diarrhea, dyspnea, and malignant neoplasms were recorded in 2 respondents (2.2%) each. Most other diagnoses showed a lower number, namely only 1 respondent (1.1%) in each category. These diagnoses include sarcoma neoplasm, pharyngitis, gouty arthritis, hypertension, CHF, GERD, head injury, tuberculosis, cyst of kidney, hemiplegia, anemia, PPH, pneumonia, DOC, polyneuropathy, appendicitis, malaise, hemoptysis, lumbar spine fracture, and neurogenic bladder.

Table 4. Characteristics of respondents based on Triage

Yes	Triage	Quantity	Percentage
1	Green	85	92,4
2	Yellow	6	6,5
3	Red	1	1,1
	Total	92	100

Source : Primary Data 2025

Based on the results in the table above, it shows that patients with green triage are the most dominant as many as 85 (92.4%), followed by patients with yellow triage as many as 6 (6.5%) and red as many as 1 (1.1%).

Table 5. Frequency distribution of inpatient bed limitations

Yes	Limitations of Inpatient Beds	Number of Patients	Percentage	Minimum Waiting Time	Maximum Waiting Time
				(in minutes)	
1	Bed Not Available	61	66.3	48	583
2	Beds Available	31	33,7		
Total		92	100		

Source : Primary Data, 2025

Based on the results in the table above, it shows that most of the respondents experienced an extension of boarding time due to limited beds in the inpatient room, namely as many as 61 patients (66.3%) out of 92 patients with a minimum waiting time of 48 minutes and a maximum of 583 minutes (9 hours and 43 minutes).

Table 6. Distribution Extra Frequency of Room Nurse Work

Yes	Extra work of a room nurse	Number of Patients	Percentage	Minimum Waiting Time	Maximum Waiting Time
				(in minutes)	
1	There is extra work	23	25	7	45
2	No Extra Work	69	75		
Total		92	100		

Source : Primary Data, 2025

Based on the results in the table above, it shows that as many as 23 patients (25%) out of 92 patients experienced an extension of boarding time due to extra work of room nurses with a minimum waiting time of 7 minutes and a maximum of 45 minutes while as many as 69 (75%) people did not experience this.

Table 7. Distribution of administrative frequencies and documentation

Administration and Documentation	Number of Patients	Percentage	Minimum Waiting Time	Maximum Waiting Time
			(in minutes)	
Administration and documentation	92	100	2	18
Total	92	100		

Source : Primary Data, 2025

Based on the results in table 7, it shows that as many as 92 patients (100%) of the patients experienced an extension of boarding time due to administration and documentation with a minimum waiting time of 2 minutes and a maximum of 18 minutes.

Table 8. Frequency distribution of patient and family factors

Yes	Patient and Family Factors	Number of Patients	Percentage	Minimum Waiting Time	Maximum Waiting Time
				(in minutes)	
1	There are obstacles	6	6,5	36	73
2	No Barriers	86	93,5		
Total		92	100		

Source : Primary Data, 2025

Based on the results in table 8, it shows that as many as 6 patients (6%) out of 92 patients experienced an extension of boarding time due to the Patient Factor itself with a minimum waiting time of 36 minutes and a maximum of 73 minutes. Meanwhile, as many as 86 patients (93.5%) did not experience resistance to this factor.

Univariate Analysis

Table 9. Variable Boarding Time Distribution

Yes	*Boarding Time*	Quantity	Percentage
1	≤ 6 hours	53	57.6
2	> 6 hours	39	42,4
	Total	92	100

Source : Primary Data, 2025

Based on the results in table 9, most of the respondents experienced boarding time ≤ 6 hours, namely 53 patients (57.6%), while respondents who experienced boarding time > 6 hours amounted to 39 patients (42.4%). All patients whose boarding time is not up to standard due to bed limitations where it takes about 43 minutes to 583 minutes to be transferred to the inpatient room.

DISCUSSION

Based on the results of the study that most of the patients in the Emergency Installation of Toto Kabila Hospital experienced boarding time ≤ 6 hours, the results of the study showed that 53 respondents (57.6%) experienced boarding time still according to the standard, which was ≤ 6 hours, while 39 respondents (42.4%) experienced boarding time above the standard > 6 hours. However, there is still a considerable proportion (42.4%) who require attention because it exceeds the maximum time set by the hospital.

The results of this study show that the majority of respondents are in the final elderly age group (56-65) as many as 17 people (18.5%). This shows that most of the patients who undergo the transfer process from the emergency room to the inpatient room are in the elderly group. The researcher assumes that the elderly are an age group that is vulnerable to various emergency conditions due to decreased physiological functions of the body and accompanying comorbidities, such as cardiovascular disease, respiratory disorders, and metabolic disorders. These findings are in line with the results of research conducted by Ogliari et al. (2022) that elderly patients often need follow-up care in the hospital because the severity of the disease tends to be higher than that of the younger age group.

Based on the results of the study, it was shown that most of the respondents were female, namely 54 people (58.7%), while 38 people (41.3%) were male. This illustrates that female patients experience more of the process of being transferred from the Emergency Installation to the inpatient room. Researchers assume that these differences may be influenced by different medical-seeking behaviors between men and women. Women tend to seek health services faster and are more proactive in reporting the symptoms they experience than men. This is in line with the results of research conducted by Mosleh et al. (2023) that female patients had higher rates of emergency room visits and showed better adherence to hospitalization recommendations. Thus, it can be concluded that although gender is not a direct determinant Boarding Time, but affects indirectly through help-seeking behavior and the level of adherence to medical recommendations.

Based on the results of the study, it was shown that patients who came to the Emergency Installation of Toto Kabila Hospital had a variety of medical complaints, such as abdominal colic, febris, gastroenteritis, dyspepsia, nephrolithiasis, diabetes mellitus, and several other non-specific diagnoses. This pattern of diagnosis variation indicates that the emergency room accepts patients with acute or chronic conditions that require rapid assessment to determine management and inpatient decisions. These findings are in line with research Erwander et al. (2024) Which explains that patients with non-specific complaints such as fever, abdominal pain, general weakness, or gastrointestinal disorders tend to be at higher risk of hospitalization because they require additional examinations before a final diagnosis can be established.

In addition, Studies by Osterwalder et al. (2023) which suggests that gastroenteritis is one of the most common diagnoses in patients with acute abdominal pain in the emergency room, in addition to non-specific abdominal pain, and that many of these patients require further observation or supporting examination before being decided on hospitalization. Thus, the variety of diagnoses found in this study illustrates that patients who undergo the process of being transferred to the inpatient room do not only come with one type of disease but come from various groups of specific medical conditions.

Researchers assume that patients who experience Boarding Time those that do not meet the standards or > 6 hours have an increased risk of complications or poor outcomes. This is in line with research by Thévrekandy et al. (2025) that the increase in duration Boarding Time in the emergency room is significantly related to the increased risk of mortality in hospitals.

This is reinforced by research Pearce et al. (2023) that Boarding With regard to an increased risk of medical error, prolonged length of hospitalization, and a possible decrease in the quality of care, therefore Boarding considered an indicator of patient safety risk. All patients who Boarding Time It is not after the standard due to the limited beds in the inpatient room. There are several other causes that contribute to prolonging Boarding Time in the Emergency Installation of Toto Kabila Hospital, namely the limited beds in

the hospital, extra work of nurses, administration and documentation as well as patient factors where they are hesitant to be hospitalized or wait for family approval.

The first cause that contributes to boarding time is the limited number of beds in hospitalization. Based on the results of the study, it was shown that as many as 61 respondents (66.3%) experienced delays because the inpatient room did not have empty beds with as many as 39 people experiencing boarding time > 6 hours. The results of the study show that the duration of boarding time due to the limitations of the inpatient ward varies quite a bit with the fastest time being 48 minutes and the longest being 583 minutes or 9 hours 43 minutes.

The researchers assume that this delay in transfers shows an imbalance between service capacity and the number of patients requiring follow-up care. When bed occupancy levels (Bed occupancy rate) high, patients who have received a hospitalization decision cannot be transferred immediately because the treatment room is still full. As a result, patients have to wait longer in the emergency room until an empty bed is available. This is in line with research conducted by Janke et al. (2022) that is, it was found that when the hospital occupancy rate exceeded 85%, the median time Boarding in the emergency room increased to about 6.58 hours, compared to 2.42 hours when occupancy was low. These results reinforce the findings of research at Toto Kabila Hospital that bed limitations have a strong relationship with length of time boarding. The longer patients are detained in the emergency room due to the lack of availability of inpatient rooms. This is also reinforced by research Greenwood-Ericksen et al. (2025) namely the increase in the number of patients waiting in the emergency room is directly proportional to the low availability of beds in the inpatient room.

According to Novita et al. (2023) patients who cannot move to the inpatient due to the unavailability of rooms and beds due to the limited capacity of the hospital so that patients have to wait and cause a long time of patient treatment in the emergency room. Thus, the limited number of beds in the inpatient room is the dominant factor that causes the length of time Boarding Time at the Emergency Installation of Toto Kabila Hospital.

The second cause that contributes to the extension of boarding time at the Emergency Installation of Toto Kabila Hospital is the extra work of nurses. Based on the results of the study, it was shown that as many as 23 respondents out of a total of 92 patients (25%) experienced an extension of boarding time due to the extra work of nurses in the Emergency Installation room. The elongated boarding time due to this factor was recorded with a duration of 7 minutes to 45 minutes. Although this number is lower than other causes such as limited beds in hospitalization, this condition still contributes to the total length of boarding time in the emergency room.

The work system at the emergency room of Toto Kabila Hospital stipulates that in each shift there are four to five nurses, and one of them is assigned as a transportation officer who is responsible for transferring patients from the emergency room to the inpatient room. However, when the number of patients to be transferred is large, the evacuation process is often not possible at the same time due to limited manpower. As a result, patients have to wait for their turn until the nurse in charge completes the previous transfer. Under certain circumstances, other nurses at the nurse station can help, but only if they are not caring for an urgent patient or performing other nursing measures.

The researcher's assumption that the high extra work of nurses at the time of an increase in the number of patients led to the prolongation of it Boarding Time Because nurses have to divide the focus between emergency measures and patient transport activities. Conditions like this illustrate that high nurse overwork and limited task distribution are one of the obstacles in the patient transfer process. This is in accordance with research Eikendal et al. (2025) that high extra work among emergency room nurses can slow down Throughput patients and increases the risk of delaying action, including transfer to the inpatient room. These results are also reinforced by previous research from Christina et al. (2020) which states that if the extra work of nurses is high and there are limited staff, the waiting time for transfers will also be longer because nurses have to divide the focus between handling emergency patients and the process of transferring patients that have been stable. Thus, a system that assigns only one nurse as a transportation officer pershift proven that it is not too efficient, especially when the volume of patients to be transferred to the inpatient room is quite high.

In addition to the extra work of room nurses, the results of the study also found that the administrative and documentation processes have contributed to the time of patient boarding at the emergency room of Toto Kabila Hospital. Based on the results of the study, it was shown that 92 respondents experienced a process of lengthening boarding time due to an administrative process that took time with a duration of 2 minutes to 18 minutes.

Based on the findings of the research, this condition is caused by the queue for new patient registration and inpatient registration to be carried out at the same operator, then for BPJS patients are also required to carry out biometric validation, namely fingerprints and face verification which is time-consuming also when fingerprinting and face printing tools It does not function quickly, then two medical records, namely manual and digital, are still used in this matter. Other conditions are also caused by the lack of updated availability of inpatient rooms by the administrative operator in charge of the inpatient so that patients will wait before being transferred to the inpatient room.

The researcher's assumption shows that administrative obstacles do not only come from the queue of patient registration, but also the integration of administrative and documentation systems real time between the emergency room and the inpatient unit. This is in line with research from Adriansyah et al. (2023) that lack of data synchronization between the enrollment department and the inpatient unit causes patients to wait longer before getting available beds. This is reinforced by research Yang et al. (2024) that the process Boarding often related to the inefficiency of hospital information systems in updating bed data in a timely manner. real time. In addition, biometric verification of patients who will be hospitalized also contributes to prolonging the Boarding Because the additional biometric verification process increases the complexity of the pipeline and can prolong the service time and network limitations can cause the verification process to fail to read (Fadillah & Widyaningrum, 2025).

The results of the study also showed that patient factors such as the length of time the patient made the decision to be hospitalized and waited for family approval in the process of transferring to the inpatient room were one of the causes of the lengthening of boarding time at the emergency room of Toto Kabila Hospital. Based on the results of the study, it was shown that there were 6 patients (6.5%) who experienced an extension of boarding time due to this factor, with a minimum waiting time of 36 minutes, a maximum of 73 minutes, and an average of 54 minutes.

The patient's hypothesis occurs because there is a process of family discussion regarding follow-up care decisions or waiting for the primary caregiver to arrive before signing an inpatient or specific medical procedure approval. This condition is in line with research Rochana & Djogotuga (2020) that is, the delay in transferring patients from the emergency room to the inpatient room is not always due to internal hospital factors, but can also be influenced by non-medical factors such as family decisions. This is also reinforced by research Sitanggang & Lin (2024) that the family is always involved in decision-making to ensure that the treatment options chosen are approved and confirmed by all parties involved.

In addition, there are also patients who have long made the decision to be transferred to the operating room when it is time to be moved. Based on research by Hastuti (2024) shows that psychologically the patient will feel doubtful and worried about the surgery. Other considerations are administrative costs such as the determination of the class of care and financing status also contribute to this factor. This is in accordance with research Harnita et al. (2022) that where indirect costs or out of pocket experienced by inpatients. This is reinforced by research Buowari & Ikpae (2025) that many patients economically do not have the "independence" to use the money they have, including the use of hospitalization. As a result, even though the patient has been medically declared fit to be transferred to the treatment room, the process is delayed until a final decision is agreed. Thus, the length of time the patient decides to be hospitalized when he or she is to be transferred is not only caused by himself but also related to economic considerations and family decisions.

This study also found several additional problems that slow down the flow of services, especially delaying patients to be assigned to be hospitalized or transferred. Based on the results of the study, it was shown that the most dominant patients with green triage were 85 (92.4%), this condition occurred due to the waiting time for laboratory results that exceeded 2 hours, DPJP response of more than 60 minutes or 1 hour and limited inpatient room capacity that was fully filled. Meanwhile, 6 patients with yellow triage and 1 person (1.1%) had yellow triage.

This condition is caused because the patient needs to be stabilized first before it can be moved and in patients with red triage, there are usually additional instructions such as the installation of medical equipment before being transferred to the intensive care unit. The results of this study are in line with the research conducted by Ramadina et al. (2023) That green triage is a category with the third priority, namely conditions that are not emergency and only require basic handling and services. Meanwhile, red triage is the category with the highest priority, where patients should get immediate action because delays in treatment can lead to disability and even death. In addition to triage, laboratory examinations and DPJP responses that were not up to standard also delayed patients to be assigned hospitalization. This is in line with research that has been conducted previously by Fatmawati. (2024) that laboratory results are the top priority in determining the clinical treatment of patients, if lab results come out late, the process of transferring patients from the emergency room to other rooms is also hampered. In addition, the DPJP as the main person in charge of the patient must ensure that the patient's condition is stable before giving approval to be transferred to another room.

CONCLUSION

Based on the results of the study, it is known that most of the patients have been transferred according to the standard emergency room service time, namely 53 respondents (57.6%) with a boarding time of ≤ 6 hours, while 39 respondents (42.4%) experienced a boarding time of more than 6 hours. These findings show that the patient transfer process in general has gone quite well, although there are still some patients who experience delays. The main cause that contributes to the extension of boarding time is the limited number of beds in the inpatient room. In addition, other contributing causes are extra work of room nurses, administrative and documentation processes, internal factors of patients or families on hospitalization decisions. Overall, the

results of this study provide an idea that the service system at the emergency room of Toto Kabila Hospital has been implemented well, but there is still a need to improve coordination between units and improve administrative flows so that the process of transferring patients can take place more optimally and on time.

ADVICE

For Hospitals

It is hoped that the management of Toto Kabila Hospital can strengthen the coordination system between units, especially between the Emergency Installation and the inpatient room, in order to speed up the process of transferring patients. Efforts that can be made include streamlining cross-section communication through electronic reporting systems and implementing a real-time bed availability monitoring system. Hospital management is also expected to carry out standard operating procedures (SOPs) for transferring patients so that boarding time can be minimized and the quality of service at the emergency room is more optimal.

For Health Workers

Health workers in the Emergency Installation are expected to improve coordination with the inpatient team and speed up the administrative and patient documentation process. Improving competencies through training on time management, collaborative communication, and the use of information technology is needed to shorten boarding time. In addition, health workers need to provide proper education to patients and families about the importance of moving to the inpatient room so that there are no delays due to doubts or lack of understanding.

For Patients and Families

Patients and families are expected to be more cooperative in the process of transferring to the inpatient room and understand the importance of accelerating the process for optimal continuity of care. It is expected that patients and families actively communicate with health workers to avoid doubts in making inpatient decisions that can extend boarding time.

For Educational Institutions

The results of this research are expected to be a learning reference and teaching materials in emergency nursing courses, hospital service management, and nursing service quality. The Nursing Science study program of Gorontalo State University is expected to make the results of this research as material for evaluation and enrichment of literature related to the implementation of time management and service efficiency in Emergency Installations. In addition, this research can be an inspiration for students to develop advanced research with the theme of emergency services and the quality of nursing services.

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