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NAVIGATING THE TWILIGHT ZONE: UNRAVELLING THE LIVED EXPERIENCES OF EMERGENCY ROOM NURSES IN RENDERING END-OF-LIFE CARE

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Abstract : This study explored the lived experiences of emergency room nurses in providing end-of-life care using Van Manen's hermeneutic phenomenological method. The research included fourteen emergency room nurses working at public and private hospitals in Midsayap, Cotabato, who were selected through purposive sampling. Data was gathered through detailed semi-structured interviews guided by Van Manen's six research activities and five existential lifeworlds. Critical analysis of transcripts showed that 14 essential themes emerged. Nurses' lived experiences were reflected through Grounded Commitment in the Middle of Emergency, At the Crossroads of Action and Acceptance, Struggling with the Unseen Battle, Navigating Priorities in a Triage World, Voices of Compassion in the Midst of Crisis, and Navigating Ethical Crossroads: Choices in Uncertainty. Coping strategies emerged through Silent Strength in a Fast-Paced Reality, Anchoring the Human Spirit, Dignity Amidst Urgency, Coping with Silent Burdens, and The Weight of Inadequate Support. Nurses also shared key insights through Fastened in Compassionate Initiative, Barriers Within the System, and Growing Through Support and Experience. The study noted that emergency room nurses usually hold onto emotional and ethical issues while making important care decisions and facing different challenges in their environment. Many people called for improved knowledge and reforms within institutions. It is recommended that end-of-life care training be offered, that peer support among staff be encouraged, and that there be enough personnel, medications, and private areas for emergency patients.

IndexTerms **- Health, End-of-life care, Hermeneutic Phenomenology, Cotabato.**

I. INTRODUCTION

INTRODUCTION

Nurses in emergency rooms find it challenging to assist with urgent medical care and relieve the emotional and spiritual issues of people who are nearing the end-of-life. The demands are further increased because emergency departments are often busy, unpredictable, and crowded. In the Philippines, a shortage of staff, limited materials, and insufficient training in specific areas add more difficulties to delivering health care. Dael et al. (2024) emphasized that nurses struggle to provide high-quality care to patients at the end of their lives in low-resource regions without proper education and resources.

End-of-life care is challenging in the emergency department because it focuses primarily on aggressive resuscitation measures to prevent death. Most emergency departments across China lack suitable settings for peaceful end-of-life care, which impedes efforts to achieve peaceful deaths (Y. Li et al., 2024). In an Australian survey, the combination of an unfavorable emergency department setting and unclear guidelines and policies creates substantial obstacles to delivering quality end-of-life care, according to Burnitt et al. (2024). According to Aquino et al. (2022), the emergency care culture, nurses' personal attributes, patient death trajectory, and resource availability determine whether nurses offer deep end-of-life care or maintain professional distance.

Worldwide recognition of end-of-life care is increasing; however, the Philippines faces restricted understanding and underdeveloped practical implementation of this concept (So, 2024). Ho et al. (2023) found that three main obstacles, including insufficient palliative care professionals, expensive healthcare costs, and restricted opioid availability, reduce the quality and availability of palliative care services. Corpuz (2023) explained that the Philippines' palliative and supportive care services operate through fragmented systems

that fail to integrate properly into the national healthcare framework. Mari et al. (2024) examined how patients, their families, and caregivers understood the death of a patient in a Philippine hospital. They noted that hope, feeling in control of their life, and spiritual help were valuable at the point of death. It emphasized that palliative care must respect the values and wishes of Filipinos. Conwi et al. (2024) concluded that Filipino ER nurses who exhibit *malasakit* (compassionate caring) will foster a sense of purpose and fulfillment in delivering service. These studies collectively demonstrate the unique problems experienced by Filipino emergency room nurses, as well as the essential interplay of cultural and institutional factors that shape their experiences.

The research examines the real-life experiences of Filipino emergency room nurses who deliver end-of-life care by analyzing their challenges, coping mechanisms, and ethical challenges. The research examines these experiences to guide policy development, which will enhance nursing support systems and create a stronger workplace environment based on resilience and compassion. Research about end-of-life care has received extensive attention. Nevertheless, few specific studies on Filipino emergency room nurses limit the development of culturally appropriate end-of-life care practices (So, 2024). The end-of-life care process remains insufficiently understood, according to Bayou et al. (2021).

NEED OF THE STUDY.

This study fills the research gap by exploring hidden realities that Filipino emergency room nurses face, which will lead to the development of evidence-based policies to improve care quality and nurse welfare.

3.1Population and Sample

A total of 14 registered nurses working in the emergency rooms of selected hospitals participated in the study in Midsayap, Cotabato. Purposive sampling served as the selection method because it fits well with qualitative research by enabling the researcher to choose participants with extensive relevant experience. These nurses directly participated in end-of-life care delivery and agreed to participate in one-on-one interviews or focus group sessions about their experiences.

The study included nurses who worked in the emergency department and had firsthand experience with end-of-life care cases. It excluded workers who did not perform emergency room duties, staff without sufficient experience, non-licensed personnel, including interns and aides, and employees who either could not or refused to consent. The final number of participants was guided by data saturation, at which no new themes emerged. This ensured that the findings reflected a rich and accurate portrayal of nurses' experiences delivering end-of-life care in a high-stress emergency room environment.

3.2 Data and Sources of Data

This study employed van Manen's (2016) hermeneutic phenomenological approach to analyze the lived experiences of 14 emergency room nurses in rendering end-of-life care. The researcher performed in-depth interviews with five participants and ran a focus group discussion with the remaining nine to draw rich data to uncover the experiences of emergency room nurses in rendering end-of-life care. Before starting data collection, the researcher created an interview guide with three core questions supported by five to six follow-up questions. The ethics committee reviewed and approved this guide to ensure its validity.

The researcher conducted in-depth interviews with participants to gain detailed knowledge about their experiences with end-of-life care challenges and their emotional and perspective-related data. The researcher developed the focus group discussion method to receive community-based perspectives and discover how different participants interacted for deeper insights. The research's primary data source involved participants' narratives, but secondary data came from scholarly literature, articles, and journals.

3.3 Theoretical framework

The research foundation draws from Jean Watson's Theory of Human Caring and Ruland and Moore's Peaceful End-of-Life Theory. According to Watson (2008), nursing requires human connection with compassion alongside holistic care. The theory highlights the importance of curative factors and caring moments to heal patients by providing genuine presence and empathy that addresses their physical, emotional, and spiritual needs. The Peaceful End-of-Life Theory delivers nursing interventions through family-centered care to obtain outcomes that include pain freedom and comfort, dignity and peace, and closeness with loved ones (Alligood, 2018). These theories create a holistic approach to analyzing both humanistic and clinical aspects of end-of-life care delivery in the acute healthcare environment.

The research studied emergency room nursing practices of establishing genuine patient relationships through Jean Watson's Theory while working in high-speed settings. The theory exposed both psychological and religious elements that appear in nursing care during end-of-life patient support. The Peaceful End-of-Life Theory evaluated nurses' achievement of their intended patient outcomes, including comfort, dignity, and peace, despite the unpredictable nature of emergency care. These frameworks demonstrated how emergency room nurses combine technical emergency procedures with compassionate care to support dignified, peaceful deaths.

RESEARCH METHODOLOGY

A qualitative phenomenological design method was used to comprehensively explore emergency room nurses' firsthand experiences in end-of-life care provision. The research used a hermeneutic-phenomenological approach for its methodology to combine studies of personal experiences with investigations that contemplate background factors and symbolic meanings. The approach provides an extensive human experience analysis by connecting perception to interpretation so researchers can describe experiences and interpret them through broader contextual understanding (Stewart, 2024).

Hermeneutic phenomenology proved suitable for this research to understand emergency room nurses' real-life end-of-life care experiences because this role demands emotional intensity and ethical sensitivity. The researcher's dual role as an emergency room nurse enabled deeper interpretive understanding because it allowed the researcher to bring their professional experience into the analysis process. The researcher conducted detailed one-on-one interviews and focus group discussions to allow participants to present their experiences. A thematic data analysis revealed caregiving behaviors, moral conflicts, coping methods, and insights.

The researcher maintained reflexivity throughout the study to guarantee an accurate representation of nurse voices, which led to practice and policy improvements (van Manen, 2016).

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IV. RESULTS AND DISCUSSION

4.1 Results of Descriptive Statics of Study Variables

This chapter describes and explains the experiences of emergency room nurses who provide end-of-life care. Using Van Manen's approach to study, the research team hoped to reveal the true meaning and deeper thoughts hidden in the experiences of those caring for dying patients in high-pressure emergency departments.

This hermeneutic phenomenological study's objective was accomplished by collecting data from fourteen participants. Nine participants participated in focus group discussions, while the remaining five participants were involved in one-on-one, in-depth interviews—all of the interviews were audio-recorded to ensure accurate documentation.

Before the participants signed the informed consent, the researcher gave a brief overview of the objective of the study to each of the participants. The researcher also emphasized that the interview was voluntary and the participant had the right to withdraw from

the study anytime he/she felt uncomfortable without any consequences. The researcher explained both the risks and benefits to participants before they participated in the study.

Additionally, each participant's privacy and confidentiality were protected, and they stayed anonymous. All data collected was kept confidential and stored securely, and all responses in the native dialect or language were properly transcribed into English. After transcription, the data gathered were analyzed thematically. Fourteen themes were formed based on participants' responses to the lived experiences of the emergency room nurses.

Profile of the Participants

All fourteen participants were emergency room nurses in private and public hospitals. Five nurses worked in the private hospital, while nine worked in the public hospital. In terms of gender, ten were female, and four were male.

Table 1. Participants Profile

Code	Gender	Hospital Type	Occupation	Study Group
N1	F	Private	Nurse	IDI
N2	F	Private	Nurse	IDI
N3	F	Private	Nurse	FGD
N4	F	Private	Nurse	FGD
N5	M	Private	Nurse	FGD
N6	F	Public	Nurse	IDI
N7	M	Public	Nurse	FGD
N8	F	Public	Nurse	FGD
N9	F	Public	Nurse	FGD
N10	M	Public	Nurse	FGD
N11	F	Public	Nurse	FGD
N12	M	Public	Nurse	FGD
N13	F	Public	Nurse	IDI
N14	F	Public	Nurse	IDI

Guided by Van Manen's hermeneutic phenomenological approach, a reflective process was sought to uncover the essence of emergency room nurses' lived experiences in rendering end-of-life care. According to Bertomeu and Esteban (2023), the main goal of hermeneutic phenomenology is to reveal essential meanings within experienced realities through clarification and reflection for better accessibility.

The researcher systematically analyzed the coding responses that reflect the participants' experiences. The researcher also did an immersive reading of transcripts to familiarize herself with the data gathered until she had a grasp on the essence of the research topic. The study's objectives were emphasized through thematic structures that summarized the essential meanings of the phenomenon. The research themes were structured through Van Manen's existential framework by analyzing spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived relation) (Van Manen, 1990).

The participants' responses regarding their experiences, coping, and insights were shared through six steps. After identifying a strong personal and professional interest in understanding how emergency room nurses navigate the challenges of providing end-of-life care, the researcher used purposive sampling to select 14 emergency room nurses with direct experience in this field. Each interview was audio-recorded, transcribed verbatim, and supplemented with field notes capturing nonverbal cues and emotional expressions. The data gathered from participants made it possible to gain a richer understanding of what was being investigated.

Table 2. Examples of Significant Statements and Related Formulated Meanings

Significant Statements	Formulated Meanings
"Provide emotional support to both the patient and their family." ***(SS 2, Participant N12, Lines 50 to 51***	The nurse must create a caring and open environment to provide comfort and support so that the patients and families will feel secured understood and accepted.
Just do deep breathing. It's the reality, so just accept it. ***(SS 102, Participant N4, Lines 387 to 388*)**	Death requires individuals to accept what happens while they regulate their emotions. The approach demonstrates a functional and automatic method for managing emotional stress within demanding professional environments.
ER nurses must quickly identify interventions to alleviate the patient's condition and minimize unnecessary interventions. ***(SS 127, Participant N6, Lines 595 to 596)***	Nurses who understand their patients' physical state can select proper medical treatments and safe procedures to help reduce physical discomfort during end-of-life care.

Meanings were developed by reflecting on the significant statements using van Manen's hermeneutic phenomenology principles. The researcher converted deep statement meanings into short interpretive statements and focused on extracting fundamental core meanings instead of typical summaries from these experiences.

The researcher used Van Manen's lifeworld existentialism to organize their presentation of a holistic understanding of the phenomenon. The approach preserved the emergency room nurses' original voice patterns while at the same time unveiling common patterns of meaning across their experiences.

The fourth step was that the researcher used thick descriptions to present themes while integrating participant direct quotations with their interpretive insights. Through reflective interpretation of the nurses' narratives, essential themes were drawn from significant statements and their formulated meanings, capturing the core of their lived experiences in providing end-of-life care in the emergency room. The themes suggest not only what emergency room nurses face but also what helps them manage their silent strength, difficult decisions, and lasting compassion.

Table 3. Examples of Formulated Meanings with their Associated Theme Cluster

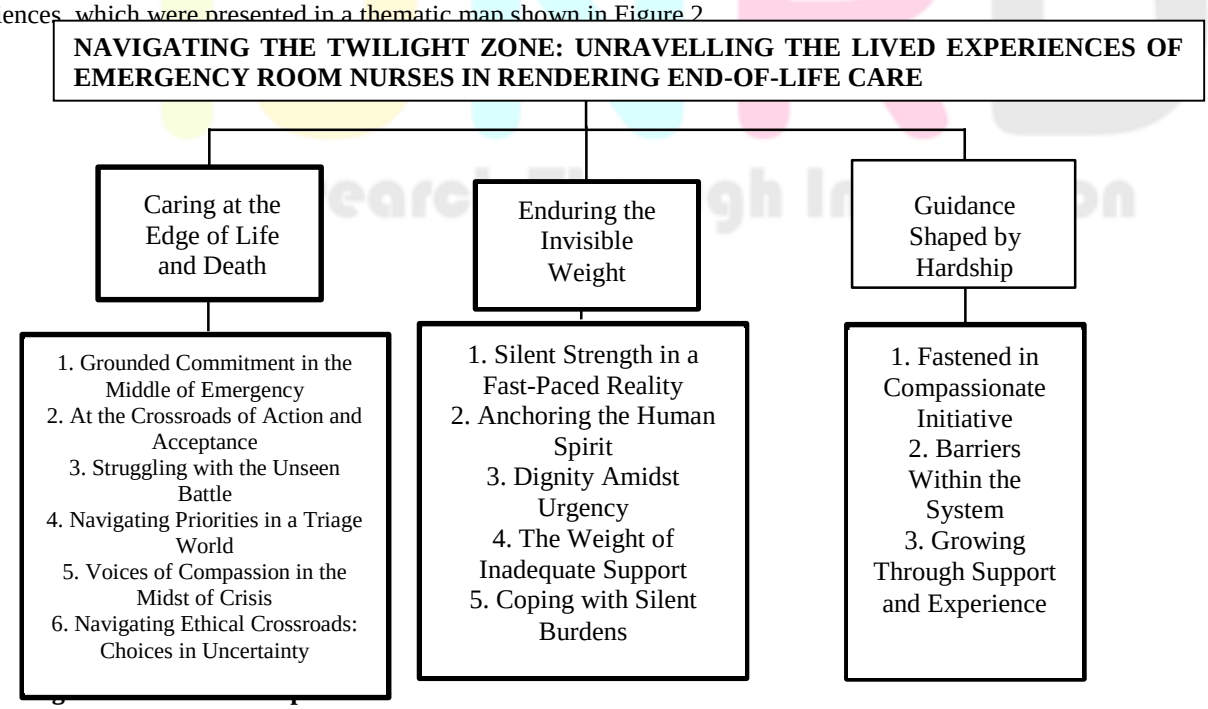
Formulated Meanings	Cluster Theme
Unwavering dedication to dignified end-of-life care despite urgent conditions, limited resources, and emotional strain. Their commitment is driven by compassion, ethical values, and a deep sense of professional responsibility, reflecting a steadfast devotion to human dignity amid the chaos of emergency care.	***Grounded Commitment in the Middle of Emergency***
The quiet resilience of emergency room nurses who remain composed and compassionate while managing urgent, high-pressure situations. Their strength is internal, shown through calm presence, emotional control, and unwavering dedication to end-of-life care, often without recognition.	***Silent Strength in a Fast-Paced Reality***
Emergency room nurses evolve through hands-on exposure and emotional support. With time and teamwork, they build resilience, deepen empathy, and enhance their ability to handle end-of-life care, turning challenges into personal and professional growth opportunities.	***Growing Through Support and Experience***

The fifth step was throughout the research process, the researcher verified thematic alignment and phenomenological integrity by continuously referencing analysis and writing stages to the central research question. Lastly, the research themes were structured using Van Manen's lifeworld existential to create a coherent and deep understanding—the thematic framework successfully combined personal experiential variations with universal meanings discovered within the phenomenon. The researchers combined their findings to create a single portrayal that accurately depicted the nurses' real-life experiences.

The research provides a comprehensive view of how emergency room nurses handle technical and emotional aspects alongside ethical challenges in end-of-life situations. The research showcases the depth of their clinical experiences and the personal meanings that emerge from emergency medicine practice.

By transcribing the audio recordings from the interviews and translating the transcriptions, a total of 12 pages back-to-back transcripts created. 75 responses were created from the IDI Group, while a total of 135 responses were from the FGD Group. Eighty-one (81) significant statements were extracted from the IDI group. In contrast, one hundred fifteen (115) significant statements were extracted from the FGD group, which gave a total of one hundred ninety-six (196) significant statements from both groups, followed by analyzing the transcript and identifying significant statements to come up with essential themes.

A visual model demonstrates the relationships between themes that represent personal and shared meanings found in participants' experiences, which were presented in a thematic map shown in Figure 2.



Providing end-of-life care in the emergency room was a difficult experience for nurses in the emergency room. The accounts of nurses giving end-of-life care included many emotions and dilemmas. They showed that taking care of dying patients in the emergency room is not just an ordinary clinical task. Nevertheless, it involves personal contact driven by a need to act quickly, empathy, and moral responsibility. The results present the challenges of their group experience, as well as the tension between urgent medical care and receiving palliative quality treatment.

Emergent Theme 1: Caring at the Edge of Life and Death

Emergency room nurses must often be ready for fast, urgent care as well as for gentle care for patients nearing the end of life. Because of this, nurses must deal with pressure to finish medical work quickly and still give humanistic attention to patients.

A recent study by Umubyeyi et al. (2024) points out that emergency room nurses have to control their emotions to maintain professionalism in high-pressure situations. When nurses are unable to give the compassionate care, they wish to give, emotional restraint can lead to exhaustion and a feeling of stress.

Healthcare must acknowledge the distinct problems that emergency room nurses encounter. When nurses have the right training and emotional support, they are more able to provide efficient and compassionate care.

Cluster Theme 1.1. Grounded Commitment in the Middle of Emergency

Nurses serve as emotional and ethical anchors in a chaotic setting such as the emergency room. There are so many scenarios that occur daily, and one of them is providing end-of-life care to patients in the emergency room, where there are lots of emotional scenarios. There were distressed family members, lives were balanced, and decision-making should be made in a hurry. Even with these challenges, emergency room nurses continue to represent an unswerving commitment to providing compassionate and ethical care in the midst of the chaos they are operating in. This constant commitment is formed not only in a professional way but also through the researcher's deep human experiences that resonate with van Manen's lifeworld existential.

Recognizing intrinsic and extrinsic motivations is one of the main factors of nurse retention. Although emergency nursing presents certain adversities that nurses must deal with, many nurses find some of the aspects of their work motivating and fulfilling, which helps them cope with the demands of their work (Rantung et al., 2024).

Emergency room nurses often face situations that go beyond their usual nursing responsibilities. They need to address both medical needs and the emotional and psychological welfare of the patients and their families. They handle everything from direct nursing care to patient flow management in an environment of interdependencies between many actors. The problem of patient safety and surveillance is of paramount importance for nurses working in emergency departments, particularly in the context of the connection between the patient flow and direct nursing care. Emergency nursing has been defined in different ways. However, generally, it is the ‘care of individuals of all ages with perceived or actual physical or emotional alterations of health that are undiagnosed or that require further interventions. Although patient case-mix and annual patient visits per year are relatively stable over time in the emergency departments, emergency nurses have to deal with the complexity of the emergency department environment (Göransson et al., 2024).

The emergency room nurses' reflections revealed that they found themselves going beyond their normal practice to encounter the sacred moment of death by demonstrating bravery, compassionate care, and a peaceful demeanor. The emergency room typically presents itself as a sterile area with fast-paced urgency. However, nurses transform the medical environment into a compassionate area for emotional support, even though the emergency room remains filled with disorder.

> *“You have to be patient, vigilant or be sensitive so that you can provide comfort and support that they needed.”*
> *(SS 1, Participant N1, Lines 4 to 5)*
>
> *“Provide emotional support to both the patient and their family.”*
> *(SS 2, Participant N12, Lines 50 to 51)*

While the emergency room is characterized by emergency, instability, and noise, it changes when it comes to end-of-life care. This is not a physical change, but purposeful human interventions in the form of relationships and affection from the members of the nursing staff have brought it about. Participant N1 pointed out the need to be patient, vigilant, or sensitive so that you can provide the comfort and support that they needed,' which underlined the purposeful attempt at providing safety amidst the chaos. Participant N12's statement shows how the nurses not only attend to the patient but also the family members who may be mourning, thus creating an environment that respects life and death.

In this study, the emergency room was constructed based on the nurses' activities and presence. They are able to provide comfort and support and make patients and families feel that they are not alone in their fight.

The emotional burden of patient death manifests in the body through physical tension, composure, and physical presence. Nurses hide their grief to maintain a composed and reassuring presence.

> *“It still hurts, especially when the patient is someone you know.”*
> *(SS 3, Participant N5, Lines 27 to 28*
>
> *“When facing a difficult situation, you don’t just respond as a nurse but also as a human being, expressing your feelings for the patient.”*
> *(SS 4, Participant N8, Lines 35 to 36)*

The following two statements by Participant N5 and Participant N8 show how emotionally involved nurses are during end-of-life care. They are physically there, emotionally vulnerable, and involved in the suffering and grief of the characters. In the emergency room, where the imperativeness of actions tends to prevail, such gestures of human frailty reveal how care is made through both doing and feeling. Nurses are compassionate, and thus, grief, empathy, and pain are part of the nurses' experience and the nursing practice. The lived body shows that end-of-life care is as much about being with the patient as it is about doing for the patient.

These experiences further show that the nurses are not just playing roles. Here, the body functions as a vehicle that demonstrates clinical capabilities, emotional strength, and empathetic skills to show the physical experience of caring for terminally ill patients. These experiences can be related to van Manen's notion of the lived body since the caregiver's physical and emotional touch is sensed, especially when the caregiver is able to develop an intimate relationship with the patient that prolongs the grieving process.

> *"You feel sorry for the patient, but there's nothing more you can do. You can only give pain relievers to help ease their pain, if they have any."*
> *(SS 20, Participant N9, Lines 38 to 39)*

> *"…it becomes a form of palliative care, where the family has come to terms with their passing."*
> *(SS 21, Participant N10, Lines 43 to 44)*

The narratives provided by Participants N9 and N10 highlight the essential role of relationships in the experience of end-of-life care within the emergency department. The above statement of N9 highlights the emotional struggle that emergency nurses experience when treatment becomes futile and the only focus is to offer comfort. This statement highlights the dual responsibility of professional obligations to decrease the degree of suffering by the nurse and the actual sense of helplessness toward dying, on the other. It is in those cases that the contact between the nurse and the patient concerns empathy and emotional support, demonstrating the role of human contact in the care offered.

Cluster Theme 1.2. At the Crossroads of Action and Acceptance

In emergency departments, the critical environment means that nurses are caught between urgent medical intervention and natural patient condition deterioration. In emergencies, nurses need to decide quickly on life-saving interventions. They, in turn, will have to ensure they can postpone the time when they start providing palliative care for the patients' maintenance of dignity and comfort. Recent studies have highlighted the stressful circumstances that nursing staff are encountering.

End-of-life care concerns a short period preceding death and involves consideration of medical technologies and decision-making. The patient's condition at the time of imminent death is so individual to each case that decisions are ultimately driven by clinical judgment and experience (Luna-Meza et al., 2021).

The emergency department is not for availability to support death but for oversight of life-saving activities. The place becomes a small sanctuary in the final hours of life; it is where patients pass away, and families grieve, all the while under the harsh fluorescent lights and the constant noise of the medical industry.

> *"I called his wife, holding the ECG result that showed asystole. I just stayed beside her, allowing her to grieve. I tapped her to offer comfort."*
> *(SS 22, Participant 14, Lines 133 to 135)*

> *"It's really hard when you know the patient personally. When my other aunt signed the DNR form, it was heavy for me, but I had to control my emotions. But when the time came and she passed away in the ER, I couldn't stop myself from crying."*
> *(SS 23, Participant N13, Lines 123 to 126)*

The emergency room, typically seen as a purely clinical setting, becomes a place of deep intimacy and emotional content when it comes to end-of-life care. N14's narrative shows how the space is transformed through the acts of presence, absence, and empathy. During these times, the emergency department is not just where someone receives medical care; it is also a communal emotional area where grief, loss, and care intersect.

For instance, Participant N13's narrative illustrates the indistinctness of the spatial boundaries between professionalism and personal emotion. The emergency room, usually viewed as an elite, high-tech space, becomes emotionally semipermeable when the caregiver is linked to the dying patient on a personal level. This transformation of experience illuminates Van Manen's (2016) concept of lived space as a felt/inward and subjective sphere where the nurse's inner world comes to resonate with the outer clinical world.

These experiences occur to everyone. In these narratives, the co-creation of meaning emerges from a mutual recognition of the ways in which the space around death is subtly inhabited and transfigured, not only in a physical sense but also on the emotional and spiritual planes.

> *"There was even a time when the doctor scolded me because I lost my presence of mind…I was left unsure of what to do."*
> *(SS 35, Participant N12, Lines 117 to 120)*

The participant's narrative depicts a deeply vulnerable moment to point out the stress and disorientation of the body in an emergency room environment. This existential theme of the "lived body" portrays the external pressure and relational dynamics that challenge the nurse's personal cognitive and emotional balance, causing physical and emotional disorganization.

Nurses working in the emergency room are often faced with high-stress situations, such as time pressure, situational decision-making, and hierarchical authority within high-stakes environments. These situations can give rise to moral distress, which is a state marked by recognition of the correct course of action but with an inability to act, leading to a state of psychological disequilibrium and emotional distress (Virani, 2021). This anguish is not just cognitive dissonance but physical, affecting the visceral being of the nurse and the ability to act systemically.

Being reprimanded by a physician can increase feelings of inadequacy and shame, which can affect the nurse's embodied sense of self. Studies show that hostile interpersonal contact within clinical environments may result in self-conscious emotions of guilt and embarrassment, which are keenly anchored in the body and detrimental to professional performances (Mahat et al., 2022). Such feelings are not separate psychological occurrences; rather, they are connected with the state of the nurse's body and affect the body position, movements, and body image in the clinical environment.

In addition, emergency room nurses' burnout is a well-known reality; emotional exhaustion, depersonalization, and lack of personal accomplishment are some of the reasons. These factors ultimately deplete the nurse's physical and emotional resilience, inhibiting the capacity to be fully present with patients and among peers (Grant et al., 2023). The effects of this, in conjunction with other stressors, can place the nurse in a disembedded state where the nurse feels removed from her body and her actions, such as with the participant who sensed she lost her presence of mind. The nurse's emotional unevenness at this time demonstrates the fragile line between professionalism and humanity, adding richness to the nurse's experience.

Cluster Theme 1.3. Struggling with the Unseen Battle

Emergency room healthcare professionals demonstrate professionalism while secretly facing significant mental and emotional burdens. Emergency room nurses bear their grief, moral distress, and emotional exhaustion in silence when they encounter end-of-life situations. The hidden emotional conflict that nurses face in the emergency room represents their ongoing fight between their professional responsibilities and their emotional state.

Meanwhile, reports of the incidence of moral distress among emergency nurses are on the rise. Issues such as the long-term psychological impact on the workforce of emergency nurses of moral distress need to be considered. However, the root causes of moral distress in the emergency department may be different from those reported in other clinical settings. A better understanding of how moral distress impacts the intention to leave could help to target and guide interventions to meet the needs of those most at risk in order to reduce moral distress, support nurse retention, and organizational sustainability of health services (Boulton & Farquharson, 2023).

Emergency room nurses often pour their emotions and energy into patients who are facing end-of-life care. The continuous use of empathy causes a condition known as compassion fatigue, which develops independently from the presence or absence of empathy. Nurses need to maintain professional composure while experiencing the accumulation of grief and ethical challenges. The subtheme shows that beneath nurses' professional appearance, they function as wounded healers who handle their human frailty while performing lifesaving work.

The environment worsens compassion fatigue because it denies healthcare workers the opportunity for quiet reflection and dignified farewell rituals.

> *"Privacy is an issue because the ER is crowded and noisy… Staff is also a challenge because no one is able to monitor the patients."*
> *(SS 38, Participant N14, Lines 201 to 203)*

The physical conditions create emotional barriers that prevent nurses from providing meaningful care and inhibit their ability to process their emotions. The participant's concern foregrounds certain existential issues in the emergency room, especially concerning lived space. It can play a major role in terms of patient care and staff health. Crowding and noise in the emergency room violate patient privacy and dignity. Sodha (2025) highlights incidents in which patient care was provided in corridors and storerooms, which resulted in undignified care and high stress for nurses.

These problems are exacerbated by understaffing. One systematic review by Kooktapeh et al. (2023) identified that poor staffing leads to burnout among nurses, limiting their supervision of patients. Physical barriers, such as portable curtains, could help mitigate privacy concerns. Additionally, better room design is said to decrease patient falls and increase observations.

In short, solving the problems of overcrowding, noise, and personnel shortages in emergency departments is critical to increasing patients' satisfaction, privacy, and care. Structural innovation and appropriate staffing may be supportive for both patients and healthcare workers.

Nurses experience emotional exhaustion just like any other professional group. The stress penetrates their bodies regardless of their attempts to maintain professional composure. The constant physical demands and emotional labor lead to exhaustion, numbness, and guilt.

> *"Of course, it's a challenge to balance between your skills and emotions. As nurses, we're not stone-cold. We're still affected by what happens."*
> *(SS 39, Participant N8, Lines 166 to 167)*

Participant N8's reflection illustrates the difference between professionalism and emotional involvement in nursing practice. This notion echoes the 'lived body' notion that nurses enact their work not only with their bodies, in the physical sense, but also emotionally and psychologically.

In highly stressful settings, such as the emergency room, nurses likely perform emotional labor, such as controlling emotions, to offer compassionate care. Nurses' emotional intelligence is important to their experience of coping with the emotional stress of the nursing occupation. Alsufyani et al. (2024) proved that the more nurses perceive themselves as emotionally intelligent, the lower the occupational stress nurses will be, so a higher level of emotional intelligence will lead to less occupational stress. Also, Jawabreh (2024) found a significant, moderate positive correlation between emotional intelligence and coping among ICU nurses and considered emotional intelligence an important factor in acquiring good coping strategies in a stressful environment.

The tension between professional competence and personal involvement is a challenge in nursing practice. Developing emotional intelligence and encouraging genuine emotional expression could increase nurses' emotional resilience to the emotional demands of their roles, ultimately benefiting their mental well-being and patient care.

> *"Time constraints… Sometimes patients are not assessed properly… There was one time… the watcher asked me to check their patient because it seemed like the patient wasn't breathing anymore… we couldn't revive him."*
> *(SS 46, Participant N13, Lines 191 to 192, 194 to 195 and 197)*

> *"We don't always have the time to conduct a thorough assessment compared to the ward… we mainly focus on facilitating the necessary interventions before endorsing the patient."*
> *(SS 47, Participant N2, Lines 145 to 147)*

Participants N13 and N2's comments underscore an important ramification of time pressure in emergency room settings: the potential for suboptimal patient assessments that can result in delayed identification of patient deterioration and, in some tragic cases, patient deaths that could potentially have been prevented. They also illustrated the delicate balance of the demand to intervene quickly and that the same demand is matched by an equal need to evaluate the patient entirely. Studies have shown that emergency nurses are frequently interrupted and forced to multitask, which can compromise the completeness and accuracy of patient assessment.

For instance, Kwon et al. (2021) reported that emergency nurses must coordinate several tasks at the same time, which can result in care quality being compromised. In addition, emergency nursing is a highly cognitive workload, adding to strain and possible burnout. Surendran et al. (2024) highlighted the importance of strategies to cope with this workload to protect both patients and nurses.

The growing use of task-oriented care in the emergency setting, in which nurses concentrate on facilitating immediate interventions rather than conducting a comprehensive assessment, has been proven to have an adverse effect on continuity and quality of care (Toney-Butler & Thayer, 2023). This literature is consistent with the experience of Participant N2, where the time pressure to intervene overrides the requirement for full clinical assessment prior to patient handover.

Nurses in high-acuity areas such as the ER have to make split-second decisions about the most time-consuming details of the body when patient volume and acuity are high. Such a process is, however, both required at a minimum in order to triage and stabilize such patients and also one that can reinforce the tendency to miss clinical signals when staff are overwhelmed (Willman et al., 2021). As Participant N13 said, a worsening patient was not recognized until a relative became worried; this is one way in which time constraints may compromise vigilance and professional judgment.

Moral distress breaks down trust relationships between nurses and themselves, nurses and their patients, and nurses and the healthcare system. Systemic problems that affect patient care led to feelings of guilt among healthcare providers.

> *"With medications, if we don't have them in our pharmacy, the watcher has to buy them outside… but what about patients who don't?"*
> *(SS 54, Participant N13, Lines 197 to 199)*
>
> *"It's really important to continuously upgrade our learning…If you lack the necessary skills, it will be difficult to provide proper care…"*
> *(SS 55, Participant N12, Lines 120)*

The discrepancy between desired expectations and actual performance has created a tension that nurses must face when dealing with their perceived failures and moral trauma. This statement N13 draws attention to a serious problem with the availability of necessary prescription drugs, which has an immediate effect on patient treatment. The participant is raising concerns regarding the availability of pharmaceuticals at the pharmacy and the strain on the patient's guardians or family members (referred to as "watchers") to purchase the drugs outside of the hospital. Patients may face a number of difficulties as a result, especially those who are low-income and cannot afford to buy medicines.

The account of Participant N13 demonstrates the inequality of healthcare accessibility. It raises a big ethical question: What will happen to vulnerable patients who, for financial or logistical reasons, cannot buy or access needed drugs? The debate of possible solutions, such as government intervention, cooperation with private pharmacy enterprises, or improvement of the internal medical service system, might focus on the drug shortage at a systemic level and how it affects patients' overall health conditions.

The significance of ongoing professional development in the healthcare industry is reflected in the statement of participant N12. The participant emphasizes that in order for healthcare providers to give good care, they must update their knowledge and abilities. Improvements in medical procedures, technology, and therapies are always changing in the healthcare industry. It is, therefore, imperative that healthcare providers are kept up to date on new knowledge, tools, and practices. Without the requisite skills, medical personnel might not be able to provide high-quality care, which could negatively affect patient outcomes, the statement claims. The significance of education and training in healthcare settings, the difficulties professionals have in keeping up with rapid developments, and methods for encouraging a culture of ongoing learning and development within healthcare teams might all be covered in this conversation. These remarks highlight the dual problems of professional capability and resource provision in healthcare. They call for structural reforms in both to ensure that all patients get the help and care they need in order to have better health outcomes.

Maunder et al. (2023) state that prior research indicates that moral distress plays a role in nurses and other healthcare workers' burnout. Organizational restrictions, unit or team dynamics, patient and family circumstances, and the initial focus of moral distress are all general categories into which causes of moral discomfort among healthcare personnel can be classified.

Healthcare workers who are committed to helping or caring for others encounter high levels of stress, primarily due to their unique work qualities. Tension, frustration, worry, despair, disappointment, desertion, and demotivation are some of the feelings

that health professionals experience when they are under stress. Protecting patients from harm, delivering care that avoids complications, and preserving a healing psychological environment for patients and their families are some of the difficulties confronted by nursing practitioners (Salas-Bergüés et al., 2024).

Cluster Theme 1.4. Navigating Priorities in a Triage World

In a chaotic emergency room setting, nurses face challenges in prioritization. They are bound to make quick and critical decisions for the good of the patients. Triaging is the foundation of prioritization in the emergency room. Nurses evaluate patients according to the severity of their conditions.

Triage competence in emergency nursing is a broad term that comprises not only the correctness of triage but also the outcome of the patient, the correct emergency care provided, and the assessment and re-evaluation of the impression. Emergency room nurses make assessments of the need for treatment during this period and play a central role in decisions involving patient planning of care. Beginning with triage in emergency rooms, accurate decision-making based on efficient clinical reasoning should be prioritized in emergency care. Emergency nursing competency is significantly impacted by clinical reasoning abilities (Oh & Jung, 2024).

Through compassionate practices and by observing medical procedures, emergency department nurses learn how to give patients compassionate care. To show that end-of-life care involves not only technical procedures but also interpersonal relationships and moral considerations, nurses incorporate medical protocols into their compassionate care approach. Emergency room nurses create quiet spaces in the open and chaotic world to preserve the dignity and respect of dying patients.

> *"Triage and prioritization should always be followed… I always make sure to close the curtains so others can't see because that's part of patient's privacy."*
> *(SS 57, Participant N5, Lines 222 and 224 to 225)*

Triage and prioritization are essential to providing prompt and efficient care in the emergency department, a dynamic and frequently unpredictable setting. Participant N5 pointed out that the capacity to thoroughly evaluate and classify patients according to the severity of their illness is essential to ensure that limited resources are allocated to the people who need them the most.

The core concept of triage is that medical professionals should give priority to patients who have the most critical requirements, regardless of when they arrive at the emergency department. Medical personnel have to make important choices regarding who needs treatment right away when time is of the essence.

Along with the need for immediate decisions, Participant N5 emphasized that emergency nurses must also protect patients' privacy and dignity. Recent work indicates how important patient privacy is for improving the quality of care. It is estimated that patients in emergency rooms have a loss of privacy and a loss of dignity, which worsens their psychological pain (Rodriguez & Willson, 2022). Nurses can minimize these effects and enhance patients' experiences by creating a sense of privacy and intentionally making private spaces, such as using screens or closing curtains. Al Dossary (2023) further pointed out that privacy also supports dignity and trust, especially in sensitive situations such as physical examination, surgery, or end-of-life care. The actions show how medical facilities can be transformed into sealed places that preserve patients' dignity while protecting them as they pass away.

> *"No matter how busy it gets, take a small moment to show the patient that you care, even just by holding their hand."*
> *(SS 58, Participant N6, Lines 231 to 232*

> *"Even if there is no more hope for the patient's condition, we still provide the necessary medications or pain relievers to ensure their comfort."*
> *(SS 59, Participant N9, Lines 240 to 241)*

Nurses show empathy in high-stress situations by making little bodily gestures that convey both emotional and physical support. Time-sensitive medical responses are desperately required in the emergency room; however, even in this stressful environment, emotional support is important. In the emergency room, there is an urgent need for rapid medical responses, and yet, even in this high-pressure environment, it is crucial to provide emotional support to patients. Obviously, this cannot be done with a mere "How are you feeling?". Inquiries when seconds matter, and lives are in danger. Even in the short, often clipped conversations that happen at critical moments, some studies indicate that simple empathy from medical personnel improves patient satisfaction and can help with healing.

Participants N6 and N9 articulated their sentiments so well that they powerfully and precisely reflect the compassion and presence nurses convey in the kinds of situations we studied. When we think of the lived body, as Van Manen has described it, we might consider how far ER nurses push the limits of embodied compassion and presence. They are everyday angels who work against the ever-present struggle of making a meaningful physical connection in the high-tech, high-pressure world of end-of-life care.

Studies demonstrate that physical touch has therapeutic value in healthcare systems. Palming or hand-holding has been found to relieve pain and alleviate anxiety in hospitalized patients undergoing procedures. Lin et al. (2023) argue that comfort is a major objective of the goal of patient care, a goal of monumental significance in terms of the patient experience. Comfort, although important, is a hard-to-grasp concept even for those in the field of nursing. In truth, the very process of identifying it causes one to wonder what is being measured and why it should be standardized. Nurses work along the entire spectrum of comfort, with specified dimensions ranging from physical and emotional to less tangible psychological. They are also in a one-of-a-kind position to be able to institute comfort-enhancing interventions of a nature that is more holistic in an attempt to increase comfort, including music therapy, which has records of its effects on increasing comfort. Tian (2023) emphasizes the key role of nursing and communication in increasing patients' comfort in the social setting.

According to Virdun et al. (2023), even when a cure is no longer possible, physical presence, including hand-holding, can markedly eliminate discomfort and restore the emotional well-being of terminally ill patients.

The nurse's body is a reservoir of comfort to provide simple but meaningful contact that means reassurance.

The grounded account of Participant N9 illustrates such a framework of the body's obligation to reduce suffering by attempting to regulate its symptoms continuously, even when the prognosis is dying. This story will be written from the perspective of the moral and ethical duty that the emergency room nurse feels to offer relief with medicines.

According to Wilson et al. (2022), pain management in the final days of life is not simply a medical application but also the abject testimony of empathy and esteem grounded in the palliative principle, particularly in unusual scenarios such as emergency wards.

These narratives framed by the "lived body" illustrate the way in which emergency room nurses employ their bodies as instruments to span the urgent and frequently disordered nature of emergency care and the stern protocols that must accompany the stern but compassionate treatment that these nurses feel every patient deserves. They tell a story of caring that outgrows the short-hand sentences of the urgent-care protocol for the sort of whole-caring, human experience that occurs only in emergencies.

The fast-paced and fragmented nature of emergency rooms do not stop nurses from dedicating time to support dying patients and their families. Such intentional moments reveal how investing in quality time beats quantity time when it creates significant farewell moments from rushed opportunities.

> *"We must ensure that they still receive the care they deserve, even if the situation is overwhelming."*
> *(SS 60, Participant N13, Line 256 to 257)*

Participant N13's narrative shows how emergency room nurses conceptualize, cope with, and act on time pressure around end-of-life care, particularly in high-intensity settings where urgency predominates. Even with the overwhelming emergency room, the participant's claim shows a deep desire to slow the pace of time so that they can offer compassionate, dignified care to patients in their last moments. The concept of lived time also recognizes the experience of time for patients and their families while they are dying. Time may seem illusory to the dying, slow in the pinch of pain, or quick when nearing death. Nurses, by their attuned presence, facilitate such an experience and prevent such final moments from being hurried or ignored.

According to Stokoe et al. (2023), the slow, gentle, attentive (even a little) nurses give the experience the feeling of temporal dignity that makes room for meaning and connection at the end of life. This viewpoint reflects the notion that providing effective care during stressful times requires making meaningful use of time rather than having more of it. Participant N13 shows a fundamental principle in emergency nursing. Even under extreme time constraints, the dying requires acts of care meant to place value on the dying and their humanity.

In addition, the statement reflects the moral realization of duty in ER practice. Despite pressure, nurses attempt to maintain human dignity and continuity of care, particularly for patients at the end of life. According to Walsh et al. (2022), the integration of patient-centered care into emergency medicine may be critically important for clinical practice. In the emergency department, this does not mean that only medical intervention is involved.

Dignified care has to be a non-negotiable priority regardless of overwhelming or high-pressure clinical situations. From this perspective, the researcher holds the view that the level of the emergency room environment should not affect the quality of end-of-life care, especially when the system is under strain. Thus, vulnerable patients dying might be unable to fend for themselves due to a lack of care. Instead, these call for an upward state of mind enshrined in compassion and ethical devotion. The lived body of the ER nurse is a place for advocacy, and such a small thing as giving and taking comfort medication, holding a hand, or simply looking into the eyes of our patient all become a way to affirm the patient's worth. The researcher supports the idea that when exhausted, the nurse's presence and words can still convey care in ways that powerfully translate the emergency room beyond merely a crisis location into a place of compassion and respect at the end of life.

> *"Communicate sensitively and clearly with the patient and their watcher. Guide them through the process of dying while focusing on meaningful interactions with the patient."*
> *(SS 61, Participant N12, Lines 253 to 254)*

Nurses establish trust, convey clarity, and make emotional connections with patients and their families regardless of medical emergencies. Participant N12's words describe the relational nature of end-of-life care in the emergency room context and correspond to the existential theme of lived relations. The emergency nurse's responsibilities go beyond clinical ones and include establishing a human connection that can establish trust, emotional support, and the presence of a compassionate coworker. Care in the lived relation dimension has much to do with the interpersonal world – how nurses are with patients and their families – and what these relations contribute to the end-of-life experience. Communication at such a point is not simply informative. It is an act of relating with the patient that protects him or her from humiliation and has emotional significance. The emergency room nurse becomes a means of connecting the strange medical world and the emotional space of the family through voice, posture, and presence, generating a space of mutual understanding and compassion.

It is a relational act of maintaining the dignity of the patient. Recent literature confirms the towering role of relational communication in emergency end-of-life care. McCallum et al. (2022) state that productive interactions between clinicians and families reduce fear, confusion, and distress, particularly in high-stakes, time-limited situations such as the ER. Nurses providing nonjudgmental, clear, well-meaning support in dying situations create the minds and souls of families at peace (Virdun et al., 2023). These are relationally loaded interactions, and members of the family do remember them many months later, which shapes the family's grieving process.

Furthermore, in the emergency room, there are frequent and abrupt transitions, and the families may have no idea that death may happen suddenly. Nurses, by means of relational communication, counsel the emotional experience of dying by describing what is to be expected, providing reassurance, and affirming emotions. These activities both promote patient-centered care, as well as the nurse's own emotional labor and relationship commitment (Wilson et al., 2022).

The statement captures the nurse's embodiment of relational ethics—deciding to authentically connect with both patient and family in time-constrained, emotionally heated environments. Participant N12's words express something the researcher, as an emergency

room nurse, firmly affirms to be critical. This perspective is consistent with the researcher's professional and ethical mandate to see the emergency room environment from a relational, empathetic, and patient-oriented perspective, even within the strapped-for-time ambiance of the emergency room. The researcher is of the view that this clear, compassionate communication is not nice to have in emergency care but is actually critical, particularly where patients and families are at their most vulnerable in end-of-life care. Death in the emergency room tends to occur so suddenly and unexpectedly that families are unaware. For this reason, the ER nurse is vital in connecting clinical intervention with emotional presence to ensure that the patients get not only treated but also surrounded with dignity and humanity.

Moreover, the researcher holds that a real interaction at the bedside can turn the dying process from a single process to a contact of joy, peace, and closure. This act means the nurse must be fully present not only physically but relationally and emotionally with both of them. In doing so, the ER nurse makes the dying process more humanized, affirming the patient's value in their last days. Medical limitations do not prevent the development of deep relationships that protect the human dignity of patients and their family members.

Cowley et al. (2025) identified emotional effects felt by emergency nurses when delivering end-of-life care. Although end-of-life care could be a source of distress, it also had the potential to give emergency nurses a sense of doing something meaningful for the patient and their family. That meaningfulness was especially noted when considering the nature of the emergency department—a place of constant change and unpredictability.

The nurses in the emergency rooms are at a tough decision point. They must make emergency clinical decisions to save lives while offering dignified end-of-life care in the process. Delivering decisive care on a daily basis imposes a suffocating cycle on the nursing staff between life-saving options and dignifying at-the-last-minute choices. The nursing staff is aware of the importance of clarified communication and caring for the patients; however, the nurses' chores include conducting quick communication with a patient who is being switched from active cancer treatment to comfort care. Healthcare facilities need nurses to dissociate from their emotions. However, nurses are supposed to explain the reasons for their decisions to themselves and patients' relatives because they aim to treat patients humanely.

Emergency medical services workers often find themselves in hazardous and unpredictable circumstances, and the complexity of the accident site significantly shapes their clinical judgment. The study indicates that the clinical expertise, experience, and ability of emergency medical service personnel greatly influence their reasoning ability to make wise choices under circumstances of duress. Latent confusion can be prevented if there is strong collaboration and time management skills, especially while managing many fatalities. Improved clinical decision-making, the research states, promotes resilience and adaptability in intense and unpredictable situations beyond the generation of better decisions (Bijani et al., 2021).

The lived relation (relationality) develops since nurses fulfill their job while building emotional connections with their patients and their families as well. To the nursing staff, good communication is as important as compassion, even as an act of having to have quick discussions while transitioning from treatment to comfort care. Healthcare facilities demand that nurses disengage emotionally, yet they are supposed to tell reasons for their decisions to themselves and in-laws' relatives as they attempt to be humane.

> *"Balancing compassionate end-of-life care while managing critical emergencies is one of the biggest challenges... but end-of-life should not be neglected also... Delegate the task..." (SS 65, Participant N6, Lines 228 to 230)*

> *"We must prioritize patients who need immediate care... we need to communicate with the patient or their significant others about the situation." (SS 66, Participant N1, Lines 208 to 209)*

The quotes from Participant N6 and Participant N1 shed light on the delicate balance that emergency nurses must achieve between responding to acute medical crises and providing compassionate care that addresses the end of life. These thoughts relate to the existential concept of lived relation and underline the relational dynamic and ethical requirement in the emergency nurse's practice. In the emergency department, nurses battle to provide excellent end-of-life care in acute medical cases, which requires effective communication and task shifting so that people who are dying receive the attention and dignity they deserve.

A study by Cowley et al. (2025) highlights the emotional burden on emergency nurses providing end-of-life care during COVID-19, emphasizing loneliness and the necessity of teamwork in addressing such highly complex care situations. The integration of the palliative care approach within the emergency setting improves the patient's and family's experiences. Through developing dialogues and embracing multidisciplinary care, the emergency nurse can negotiate between the opposing roles of acute care and end-of-life care to deliver holistic and humane care to all patients (Coats et al., 2221).

The researcher, as an emergency room nurse, is acutely aware of the tension between lifesaving, urgent interventions and using such care at the end of life. Participant N6's and Participant N1's responses highlight this common ethical responsibility of emergency room nurses to prevent dying patients from being abandoned, even when they are overwhelmed. Transferring care to reliable team members is not a failure. However, a professional decision to keep end-of-life care dignified and of high quality and to continue with other urgent cases. In these trying circumstances, the researcher also emphasizes the importance of having candid and sympathetic conversations with patients and their families. Transparent updates can inform families about changing priorities with respect to the need for emergency care while maintaining trust and emotional connection. In the end, the author advocates for a balanced, team-based model that allows ER nurses to provide compassionate and urgent care, working within a professional framework while infusing end-of-life care with a sense of respect and honor for patients.

In the high-pressure context of emergency care, urgent clinical decisions need to be made under acute time constraints. Triage—prioritizing patients based on the severity of their condition—is a complex juggling act between immediate needs and longer-term effects. Such decisions are not only clinical but also moral, as care providers walk the line between interventions that save lives and facilitate comfort for those reaching the end of their lives. The burden of these critical choices is compounded by the reality of limited resources and the need to prioritize care. The following quotes demonstrate the weight of such decisions as

participants consider how they negotiate prioritization, trying to juggle waiting times with the understanding that there is also an obligation to care for our fellow man when they are dying.

Hinds et al. (2025) claimed that good clinical decision-making not only results in better choices but also enhances the stability and flexibility of the system to cope with challenging and diverse applications. The study also specifies that professional and organizational management and ethical issues are all significant factors that affect clinical decision-making and individual performance in emergency care. Hence, this research stresses the need for pre-hospital care managers to elevate the clinical decision-making skills of emergency medical service personnel to deliver proper service.

> *"We need to balance and prioritize those who need immediate care. At the same time, we shouldn't neglect our end-of-life patients."*
> *(SS 62, Participant N13, Lines 255 to 256)*
> *"Balancing is all about prioritization. You really have to decide who to attend to first... if one has obviously passed while another still has a chance, you prioritize the one who can still be saved."*
> *(SS 63, Participant N7, Lines 233 to 235)*
> *"Emergency cases should always come first… there should be no bias… but naturally, we put more effort into cases where intervention can still make a difference."*
> *(SS 64, Participant N10, Lines 246, 248 to 249)*

However, the comments of Participants N13, N10, and N7 exemplify the ethical and affective challenges that emergency nurses experience when juggling life-saving treatment with end-of-life care for patients who are unlikely to survive. These thoughts situate the existential aspect of 'lived time,' highlighting the time constraints and moral tensions in emergency nursing. Emergency room nurses are frequently faced with challenges that require quick evaluations and decisions regarding patient acuity and potential outcomes. This situation requires hard decisions when resources are scarce, and many patients need urgent care. It is common practice to prioritize patients with a higher likelihood of survival, and it does raise some ethical concerns about the equitable treatment of patients with little or no life. Ethical frameworks are vital in coming to such decisions, as has been argued recently in the literature.

For instance, Akdeniz et al. (2021) highlight that open dialogue and shared decision-making among healthcare professionals, patients, and families can facilitate ethical decision-making in end-of-life care. They advocate for the appropriate use of the ethical concepts of autonomy, beneficence, nonmaleficence, and justice to guide patients toward a comfortable end of life.

Nurses face emotional tolls when making critical decisions, and this cannot be overlooked. Research shows that nurses often experience moral distress when they feel that they can't or do not provide the level of care they think is appropriate, especially during end-of-life situations. Moreover, this is not just a problem for the nurses who are in these situations and making these decisions. It can have long-term effects on the nursing profession. Increasingly, we are seeing evidence of the nursing shortage, especially in certain areas of the country and in certain specialties. We have long known that inadequate staffing can harm not only patients but also nurses. Part of the reason nurses are leaving the profession these days is that they cannot tolerate the conditions anymore.

Communicating effectively with patients and their families matters as much. In conclusion, the narratives shared by the participants demonstrate the complex nature of balancing urgency and compassion in emergency nursing. By following ethical standards, seeking organizational backing, and engaging in dialogue, nurses can better face these challenges and provide adequate and dignified care for all patients. Participant quotes conveyed a heavy emotional and ethical burden, which the researcher understands. These contemplations highlight the frequently inevitable conflict of critical care attunement and the duty to offer dignified end-of-life care.

The researcher acknowledges from a professional and caring perspective that the pace of an emergency setting dictates that prioritization must be maintained and patients with life-threatening, treatable conditions must be seen first. This policy is not based on prejudice but on the moral imperative to save lives where they still might be saved.

However, the researcher also agreed the needs of dying patients should not be ignored. When one is drawing near to an unavoidable death, one would like to be treated with respect and, ideally, humanely. Although they may no longer be the priority, interventions ought, therefore, to involve the provisions of comfort, communication, and presence. The researcher believes this is a parallel—and not secondhand—endeavor. So, the researcher's position is balanced. Triage must be ethical, and critical care must be provided efficiently and effectively, but end-of-life patients cannot continue to be ignored; they must be seen, recognized, and supported. It is a delicate dance of priorities, one in which survival and human dignity are equally celebrated.

The hidden weight of decision-making in the ER becomes apparent through this existential tension because nurses must handle ethical decisions while performing rapid triage and preserving life and dignity despite limited time and resources.

Afenigus and Sinshaw (2025) state that ethical challenges in emergency and critical care nursing frequently require difficult choices that affect team dynamics, patient outcomes, and the emotional health of healthcare professionals. Enhancing nursing methods and outcomes for patients in this setting requires an understanding of these difficulties and the decision-making procedures involved. These dilemmas caused moral discomfort, burnout, and ethical exhaustion, as described by nurses who reported emotional and professional effects. In order to overcome these obstacles, nurses stressed the value of interdisciplinary cooperation and formalized decision-making processes. A major barrier, was noted to be the inconsistent availability of peer support and ethical consultations when it was needed most.

Despite the clinical urgency, emergency room nurses use gentle and compassionate gestures to convey care and presence. These seemingly simple actions become powerful expressions of understanding, especially during end-of-life care. Powerful expressions of understanding and support can be made in small ways. Holding a patient's hand, offering a comforting smile, or providing a warm blanket can convey powerful messages when interactions must be kept brief for time reasons. The studies emphasize the tremendous influence these non-verbal signals have.

Nacak and Erden (2023), for instance, emphasized that through kind care, the nurse makes the patient die with dignity by eliminating the suffering of the patient. In addition, examples from reality demonstrate how important they are. A patient in the emergency department of the University of Iowa Hospitals and Clinics recently had their experience transformed when a nurse set up a bouquet and anniversary card to make the family's visit memorable. This action indicates how easily gestures can make patients and their families experience an unforgettable day (University of Iowa Health Care, 2024). Instances like these affirm that, even in the face of clinical urgency, the small, compassionate acts of nurses are key to delivering holistic and empathetic care at the end of life.

The existential perspective examines human relationships in the social world. Nurses explained their emotional workload while providing care to patients and their families throughout end-of-life treatment. Their communication methods were characterized by gentleness and honesty, and they aimed to assist others in achieving death with clarity and calmness.

> *"The family usually already understands their loved one's condition, so we just need to explain the situation to them."*
> *(SS 67, Participant N8, Lines 237 to 238)*

> *"Communicate sensitively and clearly with the patient and their watcher. Guide them through the process of dying while focusing on meaningful interactions with the patient."*
> *(SS 68, Participant N12, Lines 253 to 254)*

The narratives from Participant N12 and Participant N8 highlight the importance of sensitive communication and family participation in the delivery of end-of-life care in the emergency department. These reflections highlight the relational dimensions between nurses, patients, and relatives in the care of patients at the end of life. The comments made by participants are consistent with the existing literature that highlights the importance of sensitive communication and family involvement in end-of-life care in the emergency department. By emphasizing these connectivity aspects, the emergency nurse may act as an advocate of compassion and reverence to the patients and their families during their most acute moments.

The researcher agrees with the insights of Participants N12 and N8. These statements suggest an appreciation of the relational nature of end-of-life care and the importance of sensitive, honest, and compassionate communication with patients and their families. The researcher agrees that although the emergency room setting is fast-paced, orienting families through the dying trajectory and having valued interactions are not only manageable but ethically necessary.

Likewise, an integrative review by Y. Kim and Kim (2024) supports the success of interventions targeting family EOL care involvement. Such efforts are shown to improve patient comfort, family satisfaction, and communication. This effort implies that even when the family knows about the patient's health issue, the nurse is important in confirming and clarifying their knowledge without overwhelming them with details.

From the researcher's professional vantage, it is also known that at the time families come to the emergency room, they already know, either explicitly or in their hearts, how serious the condition of their loved one is. Therefore, the nurse's responsibility is to validate the person's perception, enlighten without providing too much information, and be a stabilizing force by providing calm and empathy. Communication is now more than a self-report of numbers of patients; it becomes a human connection as families comprehend the reality of imminent loss with gravity and dignity. The author contends that such presence and relational attentiveness, characterized by honesty, eye contact, touch, and tone, is the heart of meaningful end-of-life care in the emergency department.

These narratives demonstrate that emotional connections achieved through words or presence were equally important to medical treatments. Nurses developed mutual comprehension with families while accompanying them through their mourning process.

Due to conditions that restricted verbal communication, the nurses used their physical presence to comfort patients and establish emotional connections.

> *"No matter how busy it gets, take a small moment to show the patient that you care, even just by holding their hand."*
> *(SS 69, Participant N6, Lines 231 to 232)*

The nurse delivered a brief touch that served as both a grounding force and a silent message of reassurance to the patient. This nursing practice demonstrates how healthcare professionals employ their physical presence to deliver care through their bodies despite maintaining silence.

The researcher captures an important component of comprehensible emergency treatment. This way of engaging at the moment supports the central concept of nursing presence. Even if these are very basic acts like touching the patient's hand, this could also be the way professionals "show" their patients that they have empathy and that they care.

From the perspective of the researcher, such acts are more than symbolic -they are a conscious affirmation to uphold the dignity and humanity of patients at some of the most vulnerable times. In the high-stakes context of the ER, where time is seconds, minutes, life or death, making even the briefest gesture of emotional comfort that could penetrate a patient's heart requires intention and a kind of slow-down. This kind of comforting encounter feels rare in the world of fast-paced medicine. However, the researcher who has researched this kind of encounter said these brief moments — moments that can be as short as a minute or two in the emergency room — are part of care for the whole person, nonetheless.

The physical limitations of emergency rooms, such as overcrowding and noise, did not stop nurses from creating therapeutic spaces through their deliberate actions.

> *"I always make sure to close the curtains so others can't see because that's part of patient's privacy… I just explain to the other patient, 'Just a moment, Sir/Ma'am, we have an emergency. You're still breathing anyway.' I use*

humor to lighten the mood… That's really my icebreaker to make them feel at ease."
(SS 70, Participant N5, Lines 224 to 227)

This narrative is an example of how nurses create private sacred space in an active healthcare environment. Respectful use of humor serves as a mechanism for relieving tensions, enabling nurses to establish relationships with others as human beings.

Delivering healthcare that is respectful and responsive to patients' and caregivers' needs is critical to drive favorable care outcomes and quality of care perceptions, thus meeting an important condition of patient-centered care. For treatment and recovery, interactions between a patient and a healthcare provider are essential. Therefore, patient-centered communication is essential for achieving the best health outcomes. It supports long-standing nursing beliefs that care should be tailored to the individual patient and be responsive to a patient's health concerns, beliefs, and situation.

Improved patient adherence to drug treatment and treatment plans, as well as enhanced safety and patient satisfaction in care provision, are some of the positive outcomes associated with social support (Kwame & Petrucka, 2021). Chelly et al. (2022) concluded that humor is a valid form of communication in healthcare, as it alleviates stress, anxiety, and emotions. It has to be used carefully, but humor is good for health and resilience, especially for nurses who are so repeatedly exposed to death and suffering. It may frequently be a means of coping where participating clinicians have common experiences and emotional histories from clinical work.

The researcher is aware of the dilemma of valuing patient privacy versus working in the high-pressure area of the emergency department. Conversely, humor as an "icebreaker" is considered to be an effective form of communication that breaks down barriers between the patient and the healthcare provider, relieving tension, building trust, and alleviating feelings of discomfort. Through behaviors that maintain privacy and reassure participants, the researcher underscores the continued value of dignity even as immediate clinical issues are addressed. This behavior is human-intensive care, in which emotional support accompanies medical action in a hectic environment.

The "little signs" represent deep person-centered care that becomes especially important during brief life spans near death. Within urgent situations, nurses use these actions to protect dignity while strengthening connections and ensuring fundamental understanding.

Cluster Theme 1.5. Voices of Compassion in the Midst of Crisis

The emergency room environment, with its urgent demands, turns communication into a compassionate pathway that connects patients to life, death, and the unknown. Nurses in end-of-life settings maintain a fundamental role by leading discussions between families and healthcare personnel who must harmonize medical evidence with cultural traditions and family needs.

The voice of compassion emerges through emergency nurses who care for patients who have lost their ability to communicate. Emergency nurses function as empathetic channels who provide both clinical truth and emotional support throughout the most delicate life moments by listening to and validating the healthcare facts and family needs.

According to Paterson and Maritz (2024), nurses make an effort to support and understand families in spite of obstacles. To efficiently satisfy the needs of patients and their loved ones, healthcare providers must be prepared with emotional and end-of-life training materials.

Emergency room nurses perform a continuous transition between technical precision and compassionate empathy when speaking to patients' family members. The nursing professional must deliver terminology that meets the requirement to explain sophisticated medical points and manage intense emotional trauma. Nurses serve as both medical interpreters of healthcare events and emotional support for families who face death possibilities.

During such moments, nurses become the compassionate link that connects patients with their families while interacting with healthcare professionals.

"You need to explain the doctor's term in a way they can understand, using their language… It's like telling them to trust in God…"
(SS 71, Participant N8, Lines 190 to 191 and 193)

"We must avoid conflicts with the family because we serve as their bridge to the doctors… Stay calm and focused."
(SS 72, Participant N9, Lines 297 to 299)

"Open communication is also key… helps create a harmonious atmosphere in the ER."
(SS 73, Participant N10, Lines 302 to 304)

Nurses in the emergency room develop trust and understanding by meeting families at their emotional and cultural levels. The nursing connection creates a pathway for clinical realities to meet human emotional understanding.

During patient interactions, nurses must focus on their physical and emotional presence. The way nurses communicate their messages through their voice and physical gestures, and their ability to pay attention are equally important as the words they speak.

"We must communicate clearly with a soft, calm voice… Patience is important… especially when we have to explain things repeatedly."
(SS 74, Participant N13, Lines 310 to 312)

> *"Prioritize open, honest, and empathetic conversations. Actively listen to their concerns and provide clear explanation."*
> *(SS 75, Participant N12, Lines 308 to 309)*

Nurses express compassion through their entire being rather than through verbal communication alone. The nurses use their peaceful composure, gentle voice, and patient approach to provide unspoken comfort to grieving families. Nurses maintain clinical expertise while showing genuine empathy to protect the dignity of patients during their dying process and guide them through challenging times.

The researcher emphasizes the importance of clear, empathic, and respectful communication with patients and relatives. When tensions in the emergency room are high, and the language is fast-paced, explaining complicated medical terms in lay terms is a necessity. This form of reasoning not only supports decision-making but also promotes patient trust and decreases patient and family anxiety. In addition, the researcher points out that the nurse is a mediator between the medical team and the patient's family. Keeping communication lines open helps avoid miscommunications and conflicts, allowing families to feel heard and be a part of their loved one's care. Actively listening and explaining appropriately play an important role in maintaining a comfortable emergency room atmosphere and can affect patient satisfaction and prognosis in the emergency room.

This perspective is supported by recent literature. Hafifi et al. (2025) demonstrated a highly significant positive relationship between effective communication and patient satisfaction in the emergency department, showing that enhanced communication yields higher levels of patient satisfaction. Similarly, Alshalawi et al. (2025) emphasize that nurse-patient communication is critical to healthcare, especially in the emergency department, where time-sensitive decisions and treatment are imperative. Good communication is not just good for reaching the correct diagnosis and treatment plan. It is also linked with patient satisfaction and all healthcare decisions that are made.

High-quality emotional support and care for patients and families should be provided safely. Both the clinical and affective dimensions of care need to be attended to in order to enhance the patient experience. This support includes understanding the patient's cognitive needs, knowing their values, and acting with kindness to reduce suffering. Institutions should develop mechanisms and processes that facilitate and support healthcare workers in doing this routinely. These comprise the adoption of relevant models of care, efficient use of resources, training of staff, provision of enabling leadership, and embedding patient-centeredness (Bradshaw et al., 2022).

Emergency room nurses serve as the vital link that unites doctors with patients, their families, and other staff members. They use communication as a care practice that requires both clarity, compassion, and cultural sensitivity beyond fact-sharing. During demanding situations, this cooperative communication approach is necessary because it drives both understanding among participants and coordinated responses.

Terminally ill patients and their families greatly benefit from prompt and efficient communication regarding end-of-life matters, including discussions regarding prognosis and care objectives. Healthcare workers may have difficulty initiating and guiding these conversations, however, under the circumstances. Thus, end-of-life communication should be innovated by improving communication skills (Chen et al., 2022).

Emergency room nurses function as the relational foundation of end-of-life care because they develop connections with patients, their families, and all healthcare personnel.

> *"Clear, calm, and compassionate, Ma'am—both with the families and with colleagues. Make sure they are informed and that they understand. The collaboration with everyone is important."*
> *(SS 76, Participant N3, Lines 271 to 272)*
> *"You need to explain to the family members what the doctors want to happen, what the doctors want to be done. You have to explain it in a way that they can understand, using their language or dialect."*
> *(SS 77, Participant N7, Lines 283 to 284)*

The lived experience demonstrates that communication functions as a moral practice that depends on respect, empathy, and relationship-building. Nurses create understanding circles to establish harmony between people during emotionally intense situations.

The excerpt from Participants N3 and N7 illustrates a strong focus on compassionate communication, which was predominantly identified as one of the themes. At the end of life, particularly in the emergency room, which moves quickly and intensely, the presence of mind that nurses have to provide patients with an empathic hold and synthesize complex medical data into understanding that is accessible and culturally bound is necessary. As Van Manen (2016) emphasizes, lived experience is formed through relational and dialogical encounters—those moments in which meaning is made in the giving and receiving of care.

Participant N3's focus on being "clear, calm, and compassionate" underscores the relational responsibility of nurses to foster emotional safety and shared understanding. On the other hand, participant N7 also focuses on cultural sensitivity and linguistic accommodation, which are essential to respect the dignity of the patients and family members in the context of important conversations about prognosis and treatment. These experiences demonstrate how nurses function as essential intermediaries between medical teams and families, conveying information not only in a technically correct manner but also in an emotionally intelligent and accessible way to all. This narrative is consistent with the findings of Bressan et al. (2022), who discovered that emergency nurses in palliative settings cannot compromise on communication and empathy. Additionally, Ferrell et al. (2021) contend that during end-of-life decision-making, culturally competent communication improves trust and lessens family pain.

Based on the notion of corporeality, nurses have to reflect on their physical and emotional posture toward stressors. The nurses' tone and posture and the length of their silence speak powerfully, especially as the moment of death approaches.

> *"We must communicate clearly with a soft, calm voice, Ma'am, so we won't be misunderstood by the watcher and the patient. We should also avoid arguing with the watchers and patients. Patience is important, Ma'am. We shouldn't lose our patience, especially when we have to explain things repeatedly to them."*
> *(SS 78, Participant N13, Lines 310 to 312)*

The participant demonstrates the psychological effort required to restate medical information repeatedly while maintaining accuracy in clinical data. The participant's reflection—emphasizing the need to "communicate clearly with a soft, calm voice," avoid arguments, and exercise patience—epitomizes the emotional labor and self-regulation that nurses engage in to uphold therapeutic relationships during end-of-life care. This quote depicts how the nursing staff is working at creating a caring and emotionally safe ambiance, in spite of the fact that they frequently are required to reexplain intimate issues under stressful situations. Moreover, it reinforces their clinical and moral obligation – their societal as well as professional duty to protect patient dignity and family trust. This observation is consistent with those of Li et al. (2025), who discovered that nurses with high capacities in coping with death use increased constructive emotional labor strategies, including deep acting, which allows them to control their emotions and behave professionally in the context of distress. These strategies are essential for sustaining empathetic communication and reducing interpersonal tension in palliative scenarios, particularly in high-stress environments like emergency rooms.

The nurse uses their body as a channel to express compassion and creates trust through gentle body movements combined with quiet speech to calm anxious patients. The physical expressions of communication transform clinical interactions into emotional connections that create a sense of human connection.

Spatiality refers to how space feels within the human experience. The chaotic and crowded emergency room environment requires nurses to create small emotional safety areas where structured and respectful communication helps develop clarity and comfort.

> *"Establish a clear and compassionate communication. Assess the family's understanding. Collaborate with the healthcare team and keep the family involved and well informed about their patient's condition."*
> *(SS 80, Participant N6, Lines 281 to 283)*

> *"Every time we do something for a patient, we always communicate. Prioritization is important, especially since some watchers tend to ask a lot of questions. It's always better to secure their consent before performing any procedure."*
> *(SS 81, Participant N4, Lines 273 to 275)*

Nurses use clear, respectful interaction to turn medical facilities from treatment locations into spaces where human dignity and understanding thrive. The participants' focus on clear and compassionate communication, family presence, and procedural consent demonstrates a dialogue in which nurses are tending to the lived space of end-of-life care in the emergency setting. Even though this space might be physically clinical and even stressful, intentional communication and teamwork transform it into a setting of safety, transparency, and relational presence. Assuring that patients and families perceive the setting as one where their opinions count and where care is morally and compassionately delivered, the nurse's job becomes more than task-oriented.

Communication is a vital nursing ability that creates a therapeutic atmosphere in palliative care, giving families emotional comfort in the face of bodily discomfort, according to Wittenberg et al. (2020). Similarly, Zhou et al. (2023) found that when nurses prioritize getting consent and having conversations with the family, particularly during emergent care, they will feel less separated and more connected during the care experience. In addition to being influenced by the relational and affective tone that nurses create during patient interactions, this further demonstrates the idea that lived space is physical.

Temporality demonstrates how human beings perceive the duration of time. Time seems to compress itself during end-of-life situations. Nurses need to deliver their words with compassion and effectiveness while maintaining a sense of timeliness in all their communications.

> *"We explain the procedures, the medications given, their purpose, and the possible side effects… If we don't know the answer, we endorse it to the doctor…"*
> *(SS 82, Participant N1, Lines 264 to 266)*

The narratives made by Participants N1 and N7 demonstrate an essential aspect of emergency nursing practice, which informs us that clear communication is a vital skill in emergency nursing, framing complex medical data with patients and their families. Respecting the need for clarity, empathy, and cultural sensitivity is best for patient-centered care. This statement illustrates how nurses act as compassionate conduits of information during moments of clinical urgency, ensuring that patients and families are not left in uncertainty. The nurse's commitment to discuss protocols, medications and certain side effects is an ethical transparency and humility, respect for the professional interrelationship, and the will to take the expert's advice. In the existential lifeworld, the lived time of being the nurse anchors patients and families in a frail and emotionally accelerated moment where clarity, reassurance, and trust are paramount.

In fast-paced emergency care, time is condensed and saturated with emotion, and nurses' responsive communication may have a lasting impact on how families understand, endure, and recollect end-of-life events. As Cowley et al. (2025) found in their qualitative study, nurses who were able to provide clear, compassionate updates during crises offered families a sense of emotional grounding and dignity despite the temporal chaos of acute care.

This research documents how ER nurses negotiate the emotional ecology of end-of-life care in their work through quiet, caring, culturally competent communication. Remaining calm and fostering trust, for example, under the pressure of time, shows that communication is a clinical and therapeutic skill. According to the study by Engel et al. (2023), the majority of patients and

their families value medical personnel's attention to their personal lives and processes in addition to their medical concerns. In contrast, Babaei et al. (2022) point out that effective compassionate care is about more than just nurturing words; it is about genuine respect for the individual values, beliefs, and experiences of the patients. Second, it pertains to a nursing philosophy of care, including the holistic approach that stimulates the patient to take charge and participate actively in care and decision-making, as well as attitude and trust regarding respect for individuals. In addition, some participants in this study described the significance of speaking in the language and dialect of the family, highlighting the importance of cultural competency and linguistic competency in end-of-life communication.

In their study, Taylan & Weber (2022) suggest that essential elements are showing respect for cultural differences, using empathy, being able to introspect, and being flexible. Building trust with patients does not require being able to speak the same language but being able to listen actively and observe closely, as well as using resources such as interpreters when called for. Acknowledging and respecting cultural diversity also promotes safety and respect for patients.

In the end, it is the empathetic and culturally sensitive communication that nurses practice—honoring human dignity, imparting knowledge, and offering indispensable emotional support to families—during the most crucial and precarious times of patients' lives that truly matters in end-of-life care. In conclusion, these statements are consistent with existing evidence-based practices that encourage clear, empathetic, and culturally relevant communication in emergency nursing. Such strategies serve to increase patient and family satisfaction and generally improve the quality of care delivered in the emergency department.

Van Manen's existential analysis shows that collaborative communication is more than information exchange because it serves as an essential link to maintaining clarity, trust, and emotional safety in difficult situations. Nurses who act intentionally create a compassionate link between scientific understanding and human compassion within emergency room end-of-life care.

Cluster Theme 1.6. Navigating Ethical Crossroads: Choices in Uncertainty

End-of-life care in the emergency department frequently presents ethical challenges to nurses. Nurses face constant challenges regarding their level of medical intervention when patients have minimal survival prospects. The opposing forces between patient self-determination and medical professional duty of care create a strong ethical conflict throughout their stories. The nursing staff typically upholds patient preferences even when doing so involves discontinuing medical treatments. The ethical dilemma becomes most intense for nurses when they need to determine the appropriate amount of medical intervention. Nurses described how cultural and religious beliefs create additional challenges for decision-making processes by showing respect toward family religious preferences regarding deceased treatment.

End-of-life care presents a number of ethical dilemmas for medical personnel. Protecting the rights, dignity, and vitality of all persons involved in the clinical ethical decision-making process is crucial since the judgments that must be taken may affect not just the patients but also their families and society. Solving the issues they encounter in end-of-life care requires an understanding of the fundamentals of biomedical ethics. Decisions about resuscitation, mechanical ventilation, artificial nutrition and hydration, terminal sedation, withholding and withdrawing treatments, euthanasia, and physician-assisted suicide are the primary circumstances that present ethical challenges for medical personnel (Akdeniz et al., 2021).

The ethical conflict between respecting patient self-determination (autonomy) and providing what is best for them (beneficence) constitutes the "Autonomy vs. Beneficence" theme. Patients and their families often face this ethical conflict in emergency room end-of-life care by declining potentially lifesaving medical procedures.

Emergency room nurses regularly face conflicting ethical situations as they need to uphold both their patients' self-governance rights for medical decisions against doing what is best for the patient according to beneficence principles. Medical staff face crucial choices regarding life-support treatments, together with consent procedures and resource distribution in these situations.

Nursing relationality describes the professional connections nurses establish with their patients, their families, and healthcare team members. End-of-life care depends heavily on these relationships.

> *"As a healthcare provider, we are obligated to explain everything to our patients. Even if their beliefs prevent them from accepting certain treatments, we still need to inform them of all possible options… we should never force our own beliefs or preferences on the patients. Instead, we must respect their decisions."*
> *(SS 83, Participant N2, Lines 322 to 323 and Lines 325 to 326)*

> *"It's really difficult… because you don't know who to follow… we had to consult the doctor and involve a social worker to talk with the family. Since the patient had a poor prognosis, it was explained to them again in a way that they could understand, and they eventually decided to withdraw the treatment."*
> *(SS 84, Participant N14, Lines 375 to 378)*

The perspectives described by the participants focus on some of the ethical challenges for nurses when providing end-of-life care, including issues of patient autonomy, cultural awareness, and shared decision-making. Nurses have an ethical responsibility to relay all information to patients so that they can make informed choices, even when patients' own cultural or personal beliefs might result in a refusal of some interventions. This supports the approach of autonomy, which states that a patient has the right to decide about his/her treatment.

Participant N2 highlights that healthcare professionals have an ethical responsibility to respect informed consent and patient autonomy, as well as at the end of the life phase of treatment. It is a testament to the nurse's profession to offer patients a clear and complete set of facts about their treatment, regardless of whether they choose to reject or take a treatment (based on personal or cultural beliefs). The nurse further recognizes that personal values should not be forced on the patient but that respect should be shown for the patient's decision-making autonomy. The emphasis of this approach is trust, ethical integrity, and respect for the dignity of the patient.

Implied consent is frequently used as a form of consent for nursing care interventions. It considers the ongoing nature of care provided and the relationship between the nurse and the patient. However, implied consent is not to be inferred. The need for nurses to provide explanations is not simply to inform the patient about the procedure or process so that consent can be obtained; they are also to facilitate a process whereby the patient is provided the opportunity to decline the procedure (Aveyard et al., 2022).

Participant N14 describes the complications nurses face when it is unclear what is considered to be the right thing to do in an end-of-life setting. In these instances, doctors and social workers are indispensable in establishing communication with the patient's family. This team-based concept allows decisions regarding treatment withdrawal to be made in the context of an informed prognosis and in a way that the family can understand and accept.

The study by Silverman et al. (2022) indicates that a poor ethical environment for decision-making contributes significantly to moral distress among healthcare providers. This multidisciplinary approach permits the decision to withhold treatment to be taken in the light of an informed prognosis and in a manner that the family can comprehend and accept.

Akdeniz et al. (2021) emphasize that the primary objective of end-of-life care is to alleviate suffering while honoring the preferences of patients nearing the end of life. However, healthcare providers often face ethical dilemmas in this situation. These choices frequently transcend the patient and affect those close to him, as well as society in general. It is, therefore, important to respect the rights, dignity, and general welfare of all parties engaged in an ethical decision-making process. The authors further assert that many of these ethical dilemmas can be mitigated through transparent communication and collaborative decision-making among healthcare providers, patients, and their families.

Participants' narratives show that great emphasis should be placed on respectful dialogue and teamwork among medical staff, patients, and their families. Nursing professionals help generate understanding and consensus between patients and healthcare providers to respect patient freedom, family involvement, and healthcare team participation.

> *"Consent is really important for any procedure, and it should be properly explained to the family… we must respect their decision."*
> *(SS 85, Participant N9, Lines 352 to 354)*

The physical presence and actions of nurses through corporeality help express empathy alongside support and professionalism when caring for patients in emotional circumstances. As one of the participants narrates, family autonomy remains central since health decisions, especially about sensitive medical treatments, need recognition of their rights to decide—nurses who maintain a certain physical demeanor and communication style influence both information reception and decision-making processes. Maintaining calmness and patience helps patients and their families cope with end-of-life decision stress.

The environment where care delivery takes place is referred to as spatiality. The emergency room environment, with its rapid pace and disorderly nature, affects the decision-making process.

> *"The fast-paced nature of emergency medicine combined with the emotional and medical complexities of death often creates a situation when ethical decisions are difficult to navigate… Nurses sometimes have to prioritize care based on who has the best chance of survival. This can be heartbreaking when a dying patient needs attention but critically ill patients who can be saved require immediate intervention."*
> *(SS 86, Participant N6, Lines 339 to 344)*

The participant faces a beneficence dilemma that requires weighing between performing life-saving actions for patients who could survive against respecting the self-determination of a dying patient. Rush decision-making during emergency room operations creates complexities for ethical decision-making processes. Nurses should make decisions between emergency procedures while maintaining respect for patients' freedom and offering compassionate treatment.

> *"It's really a matter of autonomy versus beneficence. One of the main challenges here is when patients refuse treatment or procedures. In terms of autonomy, we have to respect the patient's decision, even if it may lead to complications in their health."*
> *(SS 87, Participant N1, Lines 319 to 321)*

> *"There have been times… when a patient or watcher refuses to follow the treatment plan of the physician. We must respect their decision… It's also important to have them sign a refusal form to ensure that the responsibility doesn't fall back on us."*
> *(SS 88, Participant N13, Lines 368 to 372)*

Emergency settings require swift decision-making, which depends heavily on the perception of time, known as temporality. Emergency care settings create time-related pressure points that affect both patients and healthcare providers. The urgency of the situation must not override the need to follow ethical practices, including obtaining proper consent and respecting patient choices. Materiality encompasses the healthcare tools and technological systems that care, providers, use for documentation and equipment, which affect ethical decision-making.

One of the participants shows a scenario that demonstrates an ethical problem concerning patient consent autonomy when patients lack decision-making capacity due to intoxication.

> *"The challenge is when we can't proceed with any intervention without a signed consent form. This is a clear example of an ethical dilemma—who should sign the consent, especially when the patient is intoxicated?"*
> *(SS 89, Participant N5, Lines 336 to 338)*

Another participant directly addressed the ethical dilemma between family autonomy in refusing resuscitation and healthcare provider beneficence in saving the patient.

> *"For example, in resuscitation, if the patient has a DNR order and the family refuses resuscitation, we must respect their decision."*
> *(SS 90, Participant N12, Lines 366 to 367)*

The practice of ethics requires medical tools and legal documents, including consent forms and DNR orders. Nurses need to handle these with care to protect patient rights and ensure ethical and legal compliance. The voices of emergency room nurses in this study illuminate the ethical challenges of delivering end-of-life care in fast-paced clinical settings. Central to the debate is how to respect patient autonomy and obtain informed consent when patients or families refuse treatments that have been recommended based on personal and cultural values. The nurses stressed that it was their duty to lay out all the options to the family without bias of any kind.

Da Silva Duarte et al. (2023) discuss the conceptual and legal challenges in nursing practice, indicating that it is necessary to work towards clarifying legal ambiguities derived from existing law. Those issues could have implications for legal certainty for healthcare providers.

Cheraghi et al. (2023) highlight, in their integrative review, the fact that the clearer a definition and approach to the principle of beneficence in nursing practice, the better the outcomes that can be achieved for the patient. When nurses prioritize patient care actions, this ethical commitment may result in improved health outcomes, reduced mortality rates, and improved patient satisfaction. Furthermore, emphasis on humanity in nursing has supported the preservation of the dignity and respect of people, enhancing the humanitarian foundation of nursing care. The findings provide a forceful validation of beneficence as a tool for enhancing effectiveness and ethical quality in patient-centered care.

Nurses also frequently experience ethical dilemmas as a result of patients' incapacity to consent or the opposition of their families to medical decisions. Time pressures associated with emergency care frequently require rapid decision-making, which can exacerbate the conflict between doing good and honoring the patient's autonomy. In such cases, working together with doctors and social workers is crucial. Legal documentation, including refusal forms, also acts to safeguard the rights of patients and to protect healthcare workers' accountability.

De Brasi et al. (2020) argue that nurses' moral distress is frequently related to bad communication and failure to fulfill patients' last wishes, particularly with patients in once-hematological wards. Early identification and management of these causes are essential to avoid distress and to provide good end-of-life care. Healthcare providers need to respect their patient's autonomy and fulfill their duties to benefit their patients without harming them. Beneficence requires physicians to defend the most useful intervention for a given patient (Akdeniz et al., 2021).

Both the autonomous rights of patients and their caregivers versus the nursing obligation to do well create numerous layers of ethical complexity in emergency end-of-life care, as described by Van Manen's existential themes. Nurses need to excel at relationship management while keeping compassion alive, working within emergency space limitations, and making quick decisions and responsible tool usage. The need for ethical nursing practice in emergency settings becomes evident through the requirement to balance patient autonomy with doing good.

The delivery of care by emergency room nurses faces numerous legal and institutional barriers that limit their practice. End-of-life care becomes more complex because of institutional requirements that demand consent forms and patient or family refusal. An analysis using Van Manen's existential themes demonstrates how these challenges appear in emergency room practice each day.

During consent-related dilemmas, professionals need to use respectful, professional, and clear communication to help people make decisions even when there is disagreement or tension.

> *"There have been times when I've experienced ethical dilemmas, especially when a patient or watcher refuses to follow the treatment plan of the physician. If they really don't want to proceed, even after we've explained everything and exhausted all possible explanations, there's nothing more we can do. We must respect their decision."*
> *(SS 96, Participant N13, 368 to 371)*

The participant's response faces difficulties in respecting patient autonomy when families or patients reject treatment after receiving detailed medical information.

> *"There are patients and watchers who refuse treatments, and there's nothing we can do about it. No matter how much we explain, if they still refuse, we have no choice."*
> *(SS 97, Participant N11, Lines 363 to 364)*

The statement demonstrates the institutional difficulty in obtaining consent and respecting patient treatment choices, even after they receive information and decide against treatment. Disagreement between family members about medical decisions creates a systemic challenge during healthcare situations. It can lead to confusion among healthcare staff and create complications during consent procedures when some family members agree, but others refuse. This statement highlighted this scenario.

> *"There was also one time, Ma'am, when the watchers had different opinions. One wanted the procedure done, while the other didn't. It's really difficult, Ma'am, because you don't know who to follow."*
> *(SS 98, Participant 14, Lines 373 to 375)*

Nursing professionals often find themselves trapped between their ethical obligations and family dissent during healthcare decisions. However, nurses maintain dignity and mutual respect through their calm and compassionate approach even when they fail to reach a consensus.

Legal barriers that block intervention during critical life-or-death situations create a helpless feeling in nurses who are willing to assist.

> *"The challenge is that we can't proceed with any intervention without a signed consent form… especially when the patient is intoxicated."*
> *(SS 99, Participant N5, Lines 336 to 337)*

A broader institutional issue is illustrated here around consent procedures when a patient does not have capacity because of alcohol intoxication. The legal context and nurses' obligations are important in these circumstances.

On the other hand, one of the participants emphasized that the healthcare system needs documented refusal forms and DNR orders to guarantee team compliance with patient wishes and legal protections during critical situations, including resuscitation.

> *"For example, in resuscitation, if the patient has a DNR order and the family refuses resuscitation… To protect ourselves legally, we should have them sign a refusal and DNR form."*
> *(SS 102, Participant N12, Lines 339 to 341)*

Nurses experience emotional and physical distress because they cannot act when they know the clinical best practice. The nurses ' controlled behavior serves as an indicator of the struggle between compassionate care and organizational regulations.

Consent challenges halt the smooth operation of medical care by turning safe intervention spaces into legal and ethical dispute zones.

> *"The fast-paced nature of emergency medicine combined with the emotional and medical complexities of death often creates a situation when ethical decisions are difficult to navigate… For instance, in a mass casualty event, nurses sometimes have to prioritize care based on who has the best chance of survival."*
> *(SS 101, Participant N6, Lines 339 to 343)*

The decision process in this situation creates conflicts between patient autonomy and consent rights, particularly when patients or their families cannot give consent because of the chaotic conditions. The need to prioritize patient care emerges from resource limitations that occur during emergencies such as mass casualty incidents.

Moral distress emerges from consent-related delays that occur in the time-constrained environment of emergency rooms. Working in an emergency room requires accomplished clinical abilities paired with ethical responsibility and urgent situation management skills.

Time in the emergency room is compressed. Moments matter. Nurses face the challenge of delayed intervention when consent procedures interrupt their actions, which sometimes leads to preventable patient outcomes.

> *"The decision is still theirs. If they refuse, we can't do anything about it. We must respect their decision, knowing that beliefs vary, whether religious or tribal."*
> *(SS 100, Participant N10, Lines 357 to 358)*

This narrative demonstrates the nurse's experiences in tension between medical necessity and ethical obligations, specifically in the context of an emergency department. Although end-of-life decisions are often quick or urgent, scenario decision-making, nurses realize that patients and families may require time to absorb information, reflect on their values and beliefs, and make choices based on what is important to them. This aspect of time-waiting and deferring to decisions with life-or-death implications indicates the nurse's participation in moral decision-making at the crossroads between medical urgency and cultural or religious deliberation. It shows the necessity of taking time when there is no time in order to respect the dignity and the rights of the patient.

This situation demonstrates how healthcare providers face difficulties when patients or their families decline medical procedures due to personal convictions. It demonstrates how medical protocols and patient autonomy rights create a conflict within healthcare systems.

Emergency nurses are routinely faced with ethical issues, especially when patients or family members decline necessary treatments. In these instances, nurses are confronted with the dilemma of respecting patient autonomy while fulfilling their professional responsibility to treat. Zolkefli (2024) stated that rejecting medical treatment has put healthcare providers in a very

difficult situation while respecting autonomy and upholding the ethical concerns of providers. In situations where a patient is considering refusal of life-prolonging treatment, nurses have the responsibility to confirm that patients are making decisions with a full understanding of the consequences, but nurses must be cautious not to rob patients of their autonomy and become coercive.

The difficulty of these ethical decisions is compounded in high-acuity settings such as emergency departments. According to Afenigus & Sinshaw (2025), emergency and critical care nurses are frequently confronted with ethical challenges that have implications for patient outcomes and their emotional experiences.

The application of structured frameworks, such as the Four Box Method, may assist nurses in methodically approaching such dilemmas with reference to the standards of life, patient decisions, clinical signs, and contextual factors. This approach fosters an equitable, integrated view so that nurses can more clearly and confidently negotiate moral crossroads.

Finally, emergency nurses need to skillfully manage ethically ambiguous situations by respecting patient autonomy, using structured decision-making tools, and involving patients and families in a dialogue. In this way, they can ensure that ethical maxims are upheld despite the nuances and urgencies characteristic of emergency medical conditions.

This situation demonstrates how healthcare providers face difficulties when patients or their families decline medical procedures due to personal convictions. It demonstrates how medical protocols and patient autonomy rights conflict within healthcare systems. Failure to meet the accepted standards of consent can be considered medical negligence, which has legal and professional implications.

In general, valid consent requires three core components: (1) the presence of mental capacity – characterized by the patient's ability to comprehend, retain information, weigh options, and communicate the decision; (2) adequate information disclosure – based on the 'reasonable physician' or 'reasonable patient' standards and (3) voluntariness in decision-making. Nonetheless, informed consent is not always optimally achieved in real-world clinical settings due to various patient, contextual, and systemic factors (Ng, 2024).

This subtheme demonstrates how nurses encounter institutional obstacles that challenge their ethical commitment according to Van Manen's existential framework. Emergency care providers need to handle consent issues while maintaining respect, legal awareness, and emotional sensitivity in their limited, time-sensitive situations. These situations demonstrate both the profound moral duty of nurses and the intricate nature of actual nursing ethical dilemmas.

Emergent Theme 2: Enduring the Invisible Weight

In this theme, emergency room nurses show great emotional strength and resilience while caring for dying patients. The unseen burden includes the feelings, hard choices, and mental stress nurses face daily, usually without help or recognition.

Aguero (2025) describes the everyday struggles of living with fatigue and shame. He says that mental health problems such as PTSD and depression can be just as hard to cope with as physical conditions or injuries. People often keep these struggles within themselves, which causes others to make wrong assumptions. These internal battles often remain hidden, leading to misconceptions and judgments from others.

Cluster Theme 2.1. Silent Strength in a Fast-Paced Reality

Emergency departments are high-pressure sites where health providers must make quick choices under limited resource availability while managing unpredictable waves of patients. Emergency room nurses must deliver end-of-life care in this setting because they need strong clinical skills and deep emotional strength.

Because of the hard nature of their work, nurses who provide palliative and end-of-life care encounter many emotional difficulties. Healthcare institutions can improve resilience by implementing resilience training, delivering counseling services, creating a friendly environment, and providing opportunities for professional growth. Attending to nurses' emotional needs is essential for their well-being and the provision of compassionate care (Alodhialah et al., 2024).

"Just do deep breathing. It's the reality, so just accept it."
(SS 102, Participant N4, Lines 387 to 388)

The nurse's body becomes a stressor, as well as a resource, in this process. Deep breathing is a fundamental way to physiologically manage emotional overwhelm. Acceptance becomes embodied in the practice of the nurse quietly feeling death-related emotions and not being disconnected.

Participant N4's narrative highlighted how ER nurses adopt deep breathing and acceptance as important coping strategies for managing the emotional distress involved in their work. These strategies help with emotional and psychological regulation and resilience in high-stress situations. Serrano-Gemes et al. (2022) have established that practices based on mindfulness, such as breathing techniques, contribute to the well-being and maintenance of mental health, enabling healthcare providers to cope with the emotions inherent to emergencies, thus ensuring quality care to the patients.

The nurse's body becomes a stressor and a tool for dealing with the situation. Deep breathing is a simple way to regulate your body during emotional overload. Acceptance becomes an embodied discipline, demanding that the nurse attunes to death-related effects in silence while maintaining composure.

"I'd drink beer… just to get some sleep."
(SS 103, Participant N5, Lines 395 to 396)

An excerpt from Participant N5 shows a maladaptive strategy for coping with the stress and psychological impact of emergency room work that an emergency room nurse shared. These remarks emphasize occupational burnout, sleep disturbances, and dysfunctional coping strategies of healthcare workers, which are particularly characteristic of healthcare workers employed in stressful departments like emergency settings.

Working odd hours, facing lengthy shifts, and the burden of stressful, emotional responsibilities often cause poor circadian rhythm and increased sleep disturbance among nurses. Zhu et al. (2025) recently found in their study that the presence of social jetlag, or the difference between an individual's natural rhythms and shift work, is directly correlated with shift nurse burnout. The

relationship is moderated by stress and flawed sleep, showing that pressures of the nursing profession directly impact moods, health, and well-being.

Though it might help temporarily, relying on alcohol to sleep will increase sleep problems and contribute to an addiction to it. Low energy, high fatigue, and greater alcohol use may be early symptoms of the decline in mental health among nurses, tied to depression and burnout (George Mason University, 2024). Furthermore, Childers et al. (2023) discovered that 1 in 3 nurses experienced risky alcohol use during the pandemic and that time spent caring for patients with COVID-19 was a predictor of alcohol dependence.

The researcher wants to underscore the immediate need for systematic approaches to prevent stress and burnout in nursing. Using alcohol for sleep is not coping- it is self-medicating, and it is bad for the nurse's health, but it is dangerous to the patients as well.

Hospitals and health systems should prioritize mental health care for their workers, including access to services such as counseling and programs to manage stress and ensuring that staffing is sufficient so the burden of care does not fall on a few overburdened individuals. Encouraging healthy mechanisms such as mindfulness, regular exercise, and peer support groups is important. Moreover, normalizing mental health and substance abuse problems in the industry could provide nurses with the relief that they can get the help they need without having to worry about being judged or retaliated against professionally.

One of the participants revealed the mental distress that nurses bring back from their emergency room work.

"We really need to take care of our mental health."
(SS 104, Participant N12, Line 419)

The words of participant N12 show the great influence on the emotional and physical lives of emergency room nurses. From the perspective of a researcher and practicing emergency room nurse, this explains the high importance of mental healthcare for healthcare workers in stressful conditions.

The special environment of emergency rooms, the continuous pressure, the constant encounters with trauma, and quick decision-making substantially increase the stress, burnout, and psychological suffering of nursing staff. Jachmann et al. (2025), in a systematic review, revealed high prevalence rates for workers in the emergency department of stress, depression, and burnout, to which specific interventions aiming to be resilient and to decrease stress levels would be necessary.

In addition, fostering resilience is important for developing positive workplace cultures and improving patient care. Resilience, defined as the ability to adapt to adverse conditions, equips nurses with positive coping strategies, ultimately reducing burnout and promoting well-being.

Ultimately, in the reflection of Participant N12, there is evidence of urgent cross-system changes required in terms of mental well-being, resilience building, and supporting effective coping mechanisms to maintain staff morale and patient care standards.

The body shows emotional strain by experiencing sleeplessness and psychological unrest. Nurses frequently turn to simple coping tools because they need rest, so they choose to drink beer as a symbol of this behavior.

"The ER is chaotic… we can't really provide a space just for them to have privacy."
(SS 105, Participant N13, Line 54)

The emergency room setting influences how nurses understand care delivery, their responses to grief, and their respect for human dignity. Participant N13's comment addresses a fundamental issue in the emergency department: maintaining patient privacy in busy and overcrowded environments. The emergency department is described as a chaotic environment with problems of crowding, constriction, urgency to make decisions, and large patient loads. These issues can undermine the provision of privacy, with potential breaches in confidentiality and, therefore, a negative patient experience.

Manukumar et al. (2025), in one study of patient privacy in emergency departments in Newfoundland and Labrador, Canada, found that many patients reported concerns about feelings of privacy invasion from the physical structure and crowdedness of the emergency department. Moreover, lack of privacy could have psychological effects on the patients, and they would be less inclined to disclose private and sensitive details, which is essential for proper diagnosis and treatment. Rufo (2024) reported the neglect of patient and caregiver concerns as a leading patient safety threat for 2025, calling for healthcare systems to focus on patient-centered care and communication.

The chaotic arrangement of emergency rooms prevents patients from obtaining dignified spaces to die. Nurses must provide compassionate care within the boundaries of noise, movement, and overcrowded spaces because sacred spaces are absent in their practice. The frustration remains hidden, but nurses bear it with determination.

The researcher recognizes the fast-paced and frequently overcrowded nature of the emergency department. However, the researcher steadfastly believes patient privacy is a fundamental right and necessary for providing quality care. Though structural constraints are acknowledged, creative solutions to advocate for and establish practices for enhancing a sense of privacy are discussed, including the use of portable room dividers, the creation of private spaces to conduct sensitive conversations, and staff development programs to promote discretion in even the most open environments.

The researcher also underscores the significance of spending on emergency department infrastructure to facilitate more private and supportive spaces. Utilizing patient feedback to build or run emergency departments is considered a means to provide more patient-centered emergency medical care. In addition, the researcher emphasizes the importance of promoting a culture of health care that respects patient dignity and privacy, regardless of the difficulties of the situation.

Cluster Theme 2.2. Anchoring the Human Spirit

Emergency room nurses operate as silent pillars of support that stabilize patients' families and fellow nurses. These instances show how emergency room nurses maintain their emotional and ethical strength by building relationships, developing personally, and reflecting on their existence. This theme uses Van Manen's Lived Relation and Lived Human Existence to examine how nurses maintain their resilience and compassionate care through meaningful relationships and philosophical acceptance when facing constant suffering and death.

Death-related events frequently occur for emergency nurses, and such an experience of death may increase death anxiety, which may be associated with mental health problems and a reduction in job performance. Previous studies have indicated that

these nurses demonstrate resilience and death anxiety at moderate levels. A negative correlation was found between resilience and death anxiety; that is, the lower the resilience, the higher the death anxiety. This finding suggests the importance of mental healthcare promotion and resilience building in emergency nurses. By establishing a supportive work environment and providing mental health services, hospitals can help emergency nurses cope with these stressors to deliver quality care under stress (El-Ashry et al., 2025).

Mutual support functions as a healing force that helps nurses recover. Nurses release emotional stress through mutual understanding conversations and empathetic communications that reinforce how connection functions as a coping method and an essential element of nursing solidarity. One participant narrates about this situation through this statement:

"I just talk to my colleagues about my feelings so it wouldn't be too painful emotionally."
(SS 107, Participant N2, Line 478)

Participant N2's comment highlights the importance of social support and self-disclosure in dealing with emotional difficulties that emergency nurses experience. Nursing in high-stress settings, such as the emergency department, places nurses in direct contact with potentially traumatizing events that result in affective exhaustion, anxiety, and burnout. Talking with co-workers about the personal toll offers some relief and creates camaraderie as a means of coping.

Studies have shown that nurses' self-disclosure is a significant predictor of empathy and anxiety. A study by İbrahimoğlu et al. (2021) further discovered that nurses who openly express their emotions report a higher level of empathy, which may, in turn, influence anxiety experiences. Thus, providing a supportive environment encouraging nurses to express their emotions could improve their emotional health and work performance.

Moreover, peer support initiatives are identified as successful interventions for healthcare professionals affected by stress and trauma. The American Nurses Foundation (2023) states that formal peer support programs can equip nurses with tools to help them cope with workplace stressors, which can foster resilience and buffer against burnout.

This narrative recognizes the effects of peer support and self-disclosure on emotional resilience. In the demanding environment of the emergency department, sharing those experiences and emotions with workplace peers is priceless. Not only does such interaction relieve stress, but it also promotes team bonding and empathy. The researcher endorses the utilization of structured peer support programs in healthcare settings. Organizations can create an open, empathetic culture by providing structured channels for expressing emotion and support. This approach bears fruit not only on the level of individual nurses but also in higher-quality patient care because healthcare personnel are also taken care of emotionally and are able to fulfill their roles the way they should. The researcher highlights that formal peer support programs should be integrated into healthcare organizations.

"It really is different when you know the patient. You get tired for a long time, even when you're drenched in sweat, you don't care… the effort is immense… when you know the patient."
(SS 108, Participant N5, Lines 491 to 494)

When emotional closeness occurs, professional duty creates a profound personal impact. Nurses experience both caregiving and grief more intensely when they develop relational attachments because these bonds demonstrate that healthcare providers feel pain, too.

The statement from Participant N5 reflects the profound emotional impact of personal connections on emergency nurses. When nurses know their patients, the act of caregiving moves beyond task performance, frequently inciting more emotional labor and engendering a greater sense of accountability.

Emotional labor – the act of regulating feelings and expressions to meet a job's emotional demands–is a key aspect of nursing, especially in high-stress settings like the emergency department. The nurse-patient relationship mediated the relationship between emotional labor and job satisfaction (Xu & Fan, 2023). Two specific emotions (deep acting and naturally felt emotions) positively impacted nurse-patient relationships and job satisfaction, while surface acting had a negative impact. This emotion indicates that emotional commitment, which is likely to be greater if the nurses are familiar with their patients, is likely to intensify job satisfaction and weaken emotional well-being.

In addition, attachment to known patients may result in moral distress, particularly when results are negative. Moral emotions, like empathy and compassion, are very important in nursing care; they help nurses identify situations that might require changes in patient care and are really helpful in personal and professional development (Jiménez-Herrera et al., 2020).

The researcher recognizes the increased emotional labor associated with working with patients they know and the emotional toll this takes. Of course, this relationship can result in the delivery of more compassionate and individualized care, but it can also add to the emotional burden of the nurse. Institutional support structures, such as counseling services and peer support programs, are key to assisting nurses with the added emotional load. Promoting a culture that acknowledges and mitigates the emotional toll of nursing at the organizational level will benefit nurses' and patients' quality of care.

Nurses need equal support from within their organization and from outside sources. Nurses who understand each other through introspective practices maintain emotional sustainability, especially during multiple traumatic encounters. The statement below shows this reflection.

"Support for each other… self-care and reflection."
(SS 109, Participant N3, Line 386)

The connection between humans plays a vital role in processing emotions and achieving professional satisfaction. Nurses must face their death while understanding their ethical duties and the core meaning of their profession in human existence.

"Stay focused… remember the mistakes… so you can avoid repeating them."
(SS 110, Participant N7, Lines 401 to 402)

The participant demonstrates his commitment to personal and patient progress through reflective and humble professional development. When nurses admit their previous mistakes, they demonstrate their ability to learn, forgive, and improve themselves in demanding emotional situations.

"Learning happens every day."
(SS 111, Participant N10, Lines 111 to 112)

Nursing professionals develop lifelong learning into a spiritual and moral practice. Through this perspective, nurses can discover new insights about clinical work while learning about human nature.

A nurse must accept their mortality as an essential foundation for emotional stability. Mature understanding forms the basis of compassion so that nurses can maintain presence alongside patients without succumbing to emotional distress. Acceptance of death within nursing practice brings both mental tranquility and physical strength.

"This is reality. Patients will eventually die."
(SS 112, Participant N4, Lines 482 to 483)

Participants N3, N7, N10, and N4's comments are representative of emergency nursing: peer support, debriefing, personal care, reflection, learning from mistakes, endless education, and responses to patient death.

N3 subsequently talks about the unrivaled value of mutual support, self-preservation, and reflection, highlighting the need for peer support and self-awareness to help the emotional burden of emergency nursing. Nurses' self-efficacy and work engagement can be improved through reflective practice and supportive peers, which leads to better patient care outcomes (Zarrin et al., 2023).

Participant N7's advice highlights the importance of learning from mistakes in medical environments. Promoting a culture of constructive mistake analysis may help improve clinical decision-making and patient safety (Lervik et al., 2025).

Participant N10's statement accentuates the flexible character of emergency nursing work. Lifelong learning is required to adapt to rapid and complicated patient needs. Such continual learning is critical to providing high-quality care and to continued professional development (Berring et al., 2024).

Participant N4's statement addresses the inevitability of death in emergency settings. The recognition of this fact is of utmost importance for nurses to learn how to cope and engage themselves in compassionate end-of-life care, which could also counteract the emotional costs of patient deaths. The statement made by Participant N4 is illustrative of the powerful recognition of death with which emergency nurses are faced on a regular basis. Working on the front lines of the fast-paced emergency department, nurses can be exposed to life-and-death situations on a daily basis, requiring a balance of clinical detachment and sincere care—nursing attitudes about death impact on end-of-life care, according to research. A study by Fernández-Gutiérrez et al. (2024) found that nurses who perceive caring as an integral part of their role tend to have more positive attitudes toward caring for dying patients, which can enhance the quality of end-of-life care. Conversely, negative attitudes toward death can lead to increased moral distress and decreased palliative care competencies among nurses (Peng et al., 2025).

The research acknowledges the complex issues related to emergency nursing. It recommends providing institutional measures that encourage peer support programs, reflective activities, and lifelong professional learning to enhance nurse resilience and flexibility. Furthermore, nurses should be provided with resources and support for dealing with patient death to enable them to provide compassionate care and maintain their well-being.

Institutional support systems must address the emotional needs of nurses dealing with patient mortality. Debriefing sessions, access to mental health resources, and a culture of open communication may aid nurses in expressing their experiences and self-care. Incorporating palliative care education into nursing programs would prepare nurses with the knowledge and skills required for quality end-of-life care.

This theme demonstrates that emergency room nurses find their strength through maintaining relationships and practicing philosophical reflection. Nurses handle grief through their practice by embracing it rather than attempting to avoid it through the support of colleagues or personal moments of reflection. Through Van Manen's (2016) perspective, nurses demonstrate that the emergency room's life-saving chaos does not prevent them from creating spaces for both living and death.

Cluster Theme 2.3. Dignity Amidst Urgency

Emergency room nurses must balance urgent medical procedures with their fundamental responsibility to protect patient dignity because time constraints dominate their work environment. Under time constraints, nurses create space for both presence, consent, and respect. They quietly work to protect human dignity through overwhelming situations by making each decision, every touch, and every word a demonstration of care.

An emergency nurse will often find himself or herself in situations where the urgency of health care may take an unwitting toll on patient dignity. Overcrowding, insufficient resources, and the requirement for rapid decision-making may mean that patients receive treatment in hallways or elsewhere in non-private spaces, as described in reports of "corridor care practices. These are situations that not only breach patient privacy but also break the nurses' adherence to ethics-based moral principles.

Nurses in the emergency environment commonly experience situations where the acuity of care works against the preservation of patient dignity. Indeed, overcrowding, constrained resources, and the need for rapid decision-making may result in care being provided to patients in corridors and other non-private settings, as described in reports of "corridor care" practices. This type of environment affects the confidentiality of the patient but also challenges what is expected of nurses in terms of ethics (Valdez & Fontenot, 2023). Reports have focused on patients' experiences, such as overcrowding and poor confidentiality, and systemic reforms are necessary to alleviate these experiences (Royal College of Nursing, 2025).

Based on professional experience, the researcher recognizes the double-bind conflict between the requirement of timely medical care and the need to uphold patient dignity. Even within the limitations of the emergency department, the author reminds

us that patient decency is comprised of small gestures — like clear language, informed consent, and the fostering of privacy — that cannot be overlooked.

> *"If there's something we can still do… we should give our best."*
> *(SS 114, Participant N10, Lines 461 to 462)*

This short statement demonstrates a nurse's continuing dream of action and its ethical necessity. The message underscores the urgency in nursing — as well as the willingness to be kind no matter how the results unfold.

The statement by Participant N10 reflects the unwavering ethical dedication of emergency nurses who persist in giving their best, even under immense pressure. In the emergency setting, ethical dilemmas that nurses encounter include the struggle to maintain respect for patient autonomy, the obligation to administer life-saving treatments, and ethical decision-making in the face of scarce resources (Afenigus & Sinshaw, 2025). These circumstances may result in moral distress, which negatively impacts the mental health of nurses and their job satisfaction (Wu et al., 2025). To address these issues, emergency nurses rely on ethical principles and organizational structures that support decision-making and help maintain the standard of care.

Resilience is a critical characteristic that allows emergency nurses to cope with the emotional and psychological strain of a high-stress situation. Resilience protects from the impact of moral distress and allows for the ability to remain present and emotionally regulated in challenging clinical situations (Valdez, 2024). It takes much more than that to grow resilience: it comes from continual personal development, a great deal of peer support, and the capacity to regulate emotions.

In addition, teamwork and adaptability are integral to developing resilience, especially within this dynamic and unpredictable emergency department environment, as described by Hassan and Elsayed (2025). Collectively, these factors equip nurses to practice with compassion under the threatening nature of their work.

The physical interactions between nurses and patients reveal a deep knowledge of humanity and moral values.

> *"For me, Ma'am, respect their decisions. If they refuse, ask why because they might not fully understand. Every time a procedure is done, ensure consent and maintain privacy."*
> *(SS 115, Participant N13, Line 467 to 468)*

The participant understands how important dignity remains throughout a medical emergency, yet in the fast-paced environment of the emergency room. Privacy protection and consent security demonstrate an organizational standard of practice and respect for individual autonomy rights.

The report of participant N13 represents the cornerstone of the responsibility of nursing to honor autonomy and obtain consent, as with other emergencies. Torrey (2024) argues that informed consent is a fundamental ethical and legal precedent that rests on respect for patient autonomy. Shah et al. (2024) said that intelligent consent is the process by which patients are provided with clear information about the risks, benefits, and alternatives of an offered therapy so that they can make informed choices. The Association of Perioperative Registered Nurses (2024) notes the nurse is responsible for evaluating the knowledge of the patient and also being a patient advocate throughout the process.

The statement also emphasizes the importance of confidentiality, which can be challenging to maintain in emergency departments. Nurses need to make conscious efforts, such as using screens or speaking quietly to each other, to maintain patient dignity and confidence. Ethical considerations, including informed consent and privacy, are also influential in trust, satisfaction, and patient outcomes, even in the context of caring for critically ill patients.

> *"Even though the patient is… sick or has an unpleasant odor—we must treat them with dignity."*
> *(SS 116, Participant N9, Lines 455 to 456)*

The participant recognized the physical nature of patients. The nurse upholds the patient's human dignity through all physical circumstances that affect their comfort. The care delivery remains dignified, unjudging, and based on moral respect regardless of any conditions. As participant N9 adds, this can be an important aspect of nursing: treating all patients with respect, no matter their condition or appearance. It is the ethical responsibility of emergency department nurses to provide compassionate and respectful nursing care to patients who are often in a state of crisis.

A study shows that treating patients with respect and dignity greatly improves their chances of recovery and overall well-being, including recovery from severe illnesses and the management of chronic diseases (Yirga et al., 2025).

In the fast-paced environment of the ER, respecting the dignity of all patients can be difficult, but it is necessary for optimal care. Nurses have an essential function to allow patients to feel they are appreciated, regardless of whether such patients are in a position of vulnerability or are uncomfortable. Simple activities such as explaining the examination, speaking to the patient respectfully, and maintaining their privacy would promote dignity. Preserving patient dignity is not just an ethical requirement. However, it is also a component of quality care that establishes trust and improves patient outcomes.

According to De Beer et al. (2024), workplace dignity is a significant organizational phenomenon that can positively or negatively affect employee performance and well-being. Therefore, work environment infrastructures must prioritize workplace dignity.

Cluster Theme 2.4. Coping with Silent Burdens

Emergency room nurses maintain a reputation for emotional strength, which enables them to stay composed during critical situations. Under the surface of speed and efficiency within hospital emergency rooms exist unseen emotional burdens experienced by nursing staff. The theme investigates the emotional burden emergency room nurses experience from treating dying patients, especially when they develop strong bonds during short interactions. Professionals must appear composed and recuperate quickly, yet their human side confronts grief, contemplation, and exhaustion because of their work duties. The emotional burdens ER nurses carry remain unexpressed in most cases, yet they profoundly affect their lived experiences.

The emotional and psychological distress of emergency room nurses is one of the greatest untold and unacknowledged sad stories. These "silent burdens" may originate from high patient acuity, trauma, ethical issues, and the rapid course of emergency care. However, while they are not burning out on the ground, many nurses are internalizing these stresses, which presents a risk for burnout, anxiety, and depression. The situation was exacerbated during the time of the COVID-19 pandemic, when frontline nurses faced escalated levels of mental distress, who feared catching the virus, observed patients suffering, and struggled to deliver tough care decisions (Froessl & Abdeen, 2021).

Response to these challenges must be balanced at the system and personal level. Studies have demonstrated that when nurses feel supported by their organization, their psychological resilience increases, which is associated with a more positive patient care outcome. Other interventions, such as mindfulness-based programs, have also demonstrated efficacy in managing stress and enhancing mental well-being (Joseph & Jose, 2024). In summary, identifying and attending to the silent burdens of emergency nurses is critical for the health of emergency nurses and, therefore, for patient care and safety.

Nursing requires practitioners to maintain professional detachment yet naturally form human connections. Nurses who try to stay detached for better performance still form emotional connections with patients, particularly when they see aspects of themselves in their patients.

"I try to avoid getting too attached to my patients."
(SS 117, Participant N13, Line 522)

Participant N13's statement shows how the protective coping method functions as a self-protective measure to maintain efficiency and objective performance. Through this statement, the nurse shows her effort to shield herself against the emotional suffering that results from forming attachments. The defense mechanism of detachment protects nurses from experiencing profound emotional distress resulting from excessive patient involvement. The statement illustrates the nurse's dual desire to show compassion in care alongside maintaining their emotional protection. Participant N13's response embodies the attempt to preserve emotional boundaries in the stressful environment of emergency nursing. Emotional detachment is a common coping mechanism for these nurses to ensure they minimize psychological distress, especially in cases where traumatic and critical incidents occur frequently.

A study by J. Kim et al. (2020) proposed that distancing by taking the perspective of an observer can help nurses take care of patients without becoming distressed. Emotional distancing is not a lack of empathy but is intended to protect the mental state of the nurse by avoiding burnout. That said, finding the middle ground is important since too much disconnection can dilute empathy and patient care, while a lack of boundaries can result in compassion fatigue.

Creating psychological boundaries is essential to professional responsibility and self-care as an emergency nurse. The fast-paced and unpredictable nature of emergency care offers nurses exposure to potentially emotionally loaded contexts, and by drawing limits, they can keep their minds healthy to care with empathy. Such techniques as debriefing sessions, peer support, and mindfulness exercises could help nurses manage their emotions and help to reduce emotional labor. Organizations promoting supportive environments and encouraging self-care can enhance the resilience and well-being of nurses.

"If I know them, I can't even imagine the feeling."
(SS 118, Participant N4, Line 485)

The breakdown of professional boundaries occurs when personal relationships form, which leads to increased emotional distress. Participant N4's statement also illustrates such emotional difficulties during episodes when caring for patients with whom they are personally connected. Maintaining professional distance in high-stress emergencies is critical for the best care and to preserve the nurse's sanity. Professional boundaries support a therapeutic relationship, avoid over-involvement, and encourage rational decisions, as Suryani et al. (2023) highlighted. Personal emotional investment in patients can result in emotional engagement, potentially compromising clinical judgment and generating emotional distress.

On the researchers' level, as an emergency room nurse, treating known patients poses a different kind of challenge. Empathy is a cornerstone of nursing, but too close identification with a patient potentially limits clinical judgment and heightens emotional stress. To address these situations, it is necessary to set appropriate professional limits, consult with either colleagues or a supervisor or transfer care to another professional to remain unbiased and provide the best care for the patient.

"Sometimes I just remind myself that we're all headed there eventually."
(SS 119, Participant N7, Line 501)

Through a philosophical perspective of death, the nurse can manage repeated grief experiences by embracing mortality as an inherent aspect of being human. Participant N7's comment is indicative of a coping strategy that emergency nurses adopt in light of the high degree of exposure to death in their workplace. Admitting the inevitable is a mental device to remain emotionally stable amidst the chaos in emergency departments. Death anxiety is a common psychological problem among emergency room nurses, which may influence their psychological well-being and performance. According to El-Ashry et al. (2025), resilience is important in managing these effects, allowing a nurse to learn how to cope with stress and continue delivering high-quality care despite emotional stressors.

Thinking about death is something that happens on the job. Knowing death is part of life enables the nurse to be a caring individual instead of one saturated with sorrow. Nurses can process their feelings and protect their mental health using coping strategies such as resilience programs, peer support, and mindfulness exercises. Nurses' well-being can be improved through supportive working conditions and self-care at work, which ultimately positively impacts the empathetic and effective care of patients receiving health care provided in health institutions.

Patients create enduring emotional effects during any length of contact. The experience of emotionally intense moments stops time from moving forward as patients reveal their final words, dreams, and regrets to nurses, who must carry these unresolved feelings and memories afterward.

> *"I still can't forget what he told me: 'If I recover, I'll study hard."*
> *(SS 120, Participant N13. Lines 526 to 527)*

The nurse remembers a child's last words, transforming a brief meeting into a powerful emotional memory. During their shift breaks, nurses experience haunting stories that show the profound sadness they silently bear. Participant N13 illustrates the emotional links that can develop between nurses and their patients and highlights the human side of nursing. Such experiences of interfacing with patients as people with dreams can affect the nurse's career and personal life. Such connections are important for delivering compassionate care but can also be emotionally taxing, particularly when patients do poorly. Resilience-enhancing methods such as peer support or mindfulness are of great importance for nurses to face such emotional challenges (Alodhialah et al., 2024). Emotional intelligence is an important factor that can foster these relationships and enhance job satisfaction and patient care (Ayed, 2025).

These statements remind nurses of the 'lasting effect on patients' lives. Emotions can be a rich experience, but they need to be managed well so as not to get emotionally drained. Debriefing meetings and programs to build resilience can assist nurses in navigating their experiences and protecting their emotional health. Healthcare institutions can promote a mentally healthy setting to help nurses effectively care for patients without sacrificing their mental health.

Professionals build their coping strategies through a sequential five-stage process. Even though they are sequential steps, both can be returned in the future. First: starting with a happy outlook or excited feeling, fighting. Second: realizing one's vulnerability and wanting to shut it off. Third: Actively managing emotions with the help of workmates. Fourth: Developed an integrative way of caring and learned one's limitations. Fifth: anchor care in inner balance and a transcendent perspective. This step is a game-changer in a process, and clinical caseloads, teamwork, and self-care are also huge components. In this way, the sensations of emotional overload may sometimes invert since the professionals have learned how to take care of themselves (Arantzamendi et al., 2024).

Coping mechanisms help nurses to respond to the demands of the clinical situation. By utilizing good survival skills, nurses can improve stress management, reduce the risk of illness, and provide quality patient care. Strategies like seeking social support from colleagues, friends, and family; self-care via exercise or relaxation; mindfulness and stress reduction techniques; accessing professional counseling as needed; and maintaining a positive outlook all contribute to resilience and emotional health. Proper time management, setting limits, and prioritizing assignments are among the additional tools that can help nurses feel more in control and balanced in the face of the stress and difficult working conditions that are part of the job (Parvin et al., 2024).

Cluster Theme 2.5. The Weight of Inadequate Support

Emergency room end-of-life care presents both emotional and mental challenges to nurses while being strongly affected by physical resource limitations and staffing shortages. The delivery of quality care suffers from these resource limitations, which further increases the substantial weight that nurses must carry. The delivery of compassionate care becomes more complex when nurses lack physical resources such as medications and emotional and spiritual support. Nurses must make critical care judgments since they lack essential tools and assistance to deliver optimal medical care. The theme explores both the external resource limitations that nurses encounter and the emotional and moral distress they experience from dealing with these constraints.

Emergency department nurses practice in stressful environments, where they must make rapid decisions and provide immediate care, and inadequate support from institutions, which include inadequate staffing levels, limited resources, and inferior administrative support, contribute to burnout, job dissatisfaction, and patient safety. Haddad et al. (2025) identify such conditions to lead nurses away from the profession, while the International Council of Nurses (2025) warns that when the well-being of nurses is ignored the result is emotional exhaustion and loss of the workforce.

This lack of support also impacts the overall system, particularly in busy emergency departments, where exhausted nurses have higher risks of making mistakes and undermining care. AlZahrani et al. (2024) reported that emergency department efficiency is negatively impacted, and provider stress is aggravated when administrative support is poor. To address nurse well-being, healthcare organizations must optimize staffing, resources, and supportive work conditions.

The combination of insufficient staffing and physical constraints makes delivering excellent end-of-life care harder during emergencies. Within restricted environments and resource constraints, nurses experience frustration because they cannot deliver care at the quality level their patients need. The absence of necessary medications, combined with resource hunting between stations, generates excessive stress that worsens the feeling of being inefficient and helpless.

> *"We face a lack of resources… we have to search in other stations."*
> *(SS 121, Participant N1, Lines 534 to 535)*

Participant N1's comment raises an important resource-limited concern for emergency room nurses. In time-conscious, high-tension contexts such as the emergency room, shortages of needed medical supplies not only slow down the procedures but also add to the high-stress atmosphere and undermine the well-being of patients. The process is inefficient; care time is wasted looking for supplies in other units. A study by Nafe et al. (2025) reports that resource shortages might make error rates high and a patient safety culture weakens, requiring nurses to improvise, thus resulting in remarkably resilient behaviors, yet simultaneously revealing a systemic problem that must be corrected.

On the part of the researcher, limitations in resources create a daily frustration that interferes with the ability to provide timely care. Although nurses are frequently the subject of flexibility, improvisation should not become the norm in health care. Healthcare facilities must have adequate inventory systems and resilient supply chains to assist those on the front line. Solving these systemic issues would result in better patient outcomes and less work for emergency nurses.

Emergency settings face a critical problem because essential medications are not easily accessible during critical intervention periods. The absence of essential medications directly hinders nurses from delivering effective palliative care to their patients. The statement demonstrates powerlessness and moral distress because nurses experience the reality of being unable to provide the required treatments to patients due to medication shortages.

"Medications are not always available."
(SS 122, participant N10, Line 559)

The narrative of Participant N10 is a very problematic systemic problem in emergency care - not always having access to medications. Rapid medication delivery is essential in the emergency department to stabilize patients and provide appropriate escalation of care. When there is no medicine, it delays life-saving interventions, disrupts protocols for care, and places health workers in the position of making painful choices that may sacrifice care quality. According to Nafe et al. (2025), resources and drug shortages in the emergency department: a widespread crisis with adverse effects on patient care, nursing confidence, and a safety culture. Medication stockouts also increase the psychological burden on nurses, who must deal with these gaps with patient expectations and outcomes.

Practical and ethical issues arise when medications are not accessible. The patient may deteriorate and have a higher mortality secondary to the inability to promptly and adequately administer medications. Given the overwhelmed healthcare infrastructure, patients needing to be referred for additional therapy or facilities would further burden already overwhelmed healthcare, and deteriorate patient confidence. The author calls for preemptive action, such as better inventory control, greater transparency about shortages, and plans for how to respond if medications become unavailable and affect patient care.

Nurses face physical barriers and insufficient emotional, spiritual, and mental support in their work environment. The absence of complete support systems causes nurses to experience burnout and makes their feelings of moral distress more acute. Healthcare settings exhaust nurses, who remain unable to meet their patients' psychological and spiritual requirements because of emotional exhaustion.

"There's really nothing… sometimes they aren't provided."
(SS 123, Participant N12, Line 568)

N12's reply is indicative of a very serious issue that emergency room nurses face on a daily basis: the lack of adequate medical equipment or supplies. Such a reaction may even directly affect the ability of medical workers to treat seriously ill patients. The need for critical medical items in time-critical emergencies can also delay medical interventions and compromise patient care.

This narrative speaks to the daily challenges nurses face in high-acuity units. Insufficient resources continue to limit the ability to provide optimal care. Given that nurses consistently displayed remarkable flexibility and resilience in such scenarios, "making it up as we go along" cannot be the norm. The healthcare systems and hospitals could prioritize resource allocation, optimize their stock management systems, and develop an industrial supply system to support the staff working in the emergency room effectively. Attending to these systemic challenges can help to ease the burden on nurses and is likely to result in better care and decreased stress on healthcare providers.

"Spiritually, emotionally, and mentally—no."
(SS 124, Participant N8, Line 553)

This statement expresses deep frustration when nurses lack support in their work environment because they need emotional and moral backing. Nurses experience feelings of isolation when they receive no support because it eliminates both physical resources and emotional care, which prevents them from adequately caring for their patients and maintaining their well-being.

Participant N8's statements demonstrate the physical and emotional exhaustion that results from inadequate support, which fails to address nurses' physical needs and emotional, spiritual, and mental well-being. The lack of support causes nurses' emotional fatigue to worsen, along with their feelings of burnout. Lack of holistic support only heightens their suffering and makes it impossible for them to deliver compassionate patient care in any meaningful sense.

Countries, clinics, inherent and extrinsic circumstances, and other factors can all influence the causes of moral anguish. Understaffing, the institution's rules and priorities, aggressive treatment, insufficient or inappropriate use of resources, disagreements with the patient's and family's preferences, and the inability to prevent the patient's death are some of the causes. Moral anguish has a detrimental impact on the healthcare system and the standard of service, in addition to endangering the integrity of medical personnel. Adversely affecting nurses' physical, mental, and spiritual well-being can also lead to health issues. Compassion fatigue, emotional anguish, and decreased participation at work are associated. Otherwise, poor attention might result in burnout, work discontent, avoiding patient treatment, and intention to leave the position (Kızıltepe & Koç, 2025).

The insufficient physical resources and emotional backing support cause nurses who provide end-of-life care to experience severe moral distress alongside exhaustion. Emergency nurses experience suboptimal care delivery because they must manage critical shortages of essential medications and equipment. Nurses experience increased moral distress because they lack emotional support along with spiritual and mental backing, which creates feelings of isolation, fatigue, and burnout. Nurses struggle to maintain their resilience because of these physical and emotional challenges, which cause their moral distress to increase, thus adding to their silent caregiving burdens.

Emergent Theme 3: Guidance Shaped by Hardship

According to this emerging theme, emergency department nurses acquire extensive information and modify their procedures because they face numerous obstacles when providing end-of-life care. In the emergency room, nurses must routinely respond quickly in challenging situations, using limited resources and still caring for patients nearing the end of their lives.

Emergency room nurses' struggles in end-of-life situations push them towards growth and allow them to share advice based on experience and ongoing progress. Because of this development, nurses in tough areas can care for patients more effectively and enjoy their work more.

Loffredo et al. (2021) created a best practice document for primary palliative care in the United States' emergency departments. With an increased demand for palliative care in the emergency department, the authors gathered a group of experts to formulate an evidence-based guideline to enhance the quality of end-of-life care delivered by emergency practitioners. The guidelines stress that early patients with palliative care need identification, effective communication about goals of care, and incorporation of palliative principles into routine emergency care practice.

Cluster Theme 3.1. Fastened in Compassionate Initiative

End-of-life care in an emergency room requires more than medical expertise because it requires nurses to be present while taking initiative, showing empathy, and making timely decisions. This theme describes how ER nurses demonstrate their role through purposeful, compassionate leadership. The help of Van Manen (2016) Existential helps to investigate how nurses experience their responsibilities in end-of-life care.

According to registered nurses, providing end-of-life care in emergency rooms is a problematic experience. Emergency department nurses who provide end-of-life care rely on their aesthetic and personal knowledge to portray the dying patient as a person. The way death is conceptualized implies that to help with the shift from resuscitation to end-of-life care, empirical knowledge about aging, supportive medical care, and ethical knowledge are necessary. It is advised that aging and end-of-life care professionals enable shared clinical reflection on death in the emergency room (Burnitt et al., 2024).

Emergency room nurses utilize their bodies as both a practical application tool and a platform for showing empathy, readiness, and intuitive abilities. End-of-life care requires nurses to actively engage with patients through their senses while showing compassionate care. The physical involvement between nurses and patients determines their ability to take initiative by connecting their instincts with their planned actions.

> *"Initiative is really important. You need to have the proper mindset in everything you do because if you make a mistake, that's already an error."*
> *(SS 125, Participant N3, Lines 584 to 585)*

The description in N3 underscores the power of initiative and mindset in nursing, particularly in a high-stakes environment such as the emergency department. In this fast-paced setting where quick decision-making is required, nurses should sense patients' needs and possible complications without specific orders. A positive attitude combines alertness, skepticism, emotional strength, and conscious awareness to support nurses in giving care safely and properly, particularly in crisis or end-of-life decision cases.

Research has highlighted the significance of proactiveness and mindsets for emergency nurses. J. M. Kim et al. (2022) discovered that it is essential that the healthcare workforce proactively engages, and ethical sensitivity is a key aspect of managing crises, with nurses who have initiative and are patient-focused being better prepared for complex care. Lee et al. (2020) explored the contribution of ethical nursing education to moral decision-making in emergency care. Additionally, Cho et al. (2023) indicated that when nurse work environments foster psychological safety and open communication, nurses show initiative without fearing reprisal, reducing errors and improving patient safety.

Professionals must be proactive and focused in the clinical setting since life and death decisions must be made quickly in collaboration with other interveners to address patient needs. Mistakes are unavoidable, but they require a culture of constant awareness and responsibility to reduce these errors and make us safer.

One of the participants also quoted about the initiative in the emergency room. This statement below shows that a nurse's body automatically responds to uncertainty through their presence while maintaining a commitment to deliver optimal care for their patients.

> *"Even if you're not too familiar with a procedure, at least you take the initiative... Presence of mind is truly essential."*
> *(SS 126, Participant N4, Lines 587 to 589)*

Participant N4's statement represents the importance of initiative and situational awareness in emergency nursing. From the researcher's perspective, this shows the necessity of decisive action even if procedures are unknown. Taking the initiative is highly connected to sound clinical judgment, particularly in unpredictable and hectic settings. According to Trisyani et al. (2023), adaptation and management of acute critical cases are some of the key competencies that guarantee safe and responsive emergency care.

Situational awareness, or presence of mind, is also important in dealing with high-pressure situations. Laugesen et al. (2022) observed that during the COVID-19 pandemic, nurses relied heavily on their alertness and teamwork to make effective decisions. Collegiality was strong, which promoted shared responsibility, which assisted nurses in remaining clear in crises.

Finally, Participant N4's statement summarizes the core of emergency nursing. The ability to take action and remain calm under pressure is good fundamental skill. These competencies enable critical care nurses to manage the complexities of emergency care and intervene in a timely and effective manner that influences the outcomes of patients.

Clinical intuition works in harmony with bodily engagement since fast physical responses follow care practices that protect patients from harm. This statement below shows clinical intuition in the emergency room.

> *"ER nurses must quickly identify interventions to alleviate the patient's condition and minimize unnecessary interventions."*
> *(SS 127, Participant N6, Lines 595 to 596)*

The experience of Participant N6 highlights the efficiency of the ER nurse in quickly identifying and providing what is needed to mitigate the patient's status and avoid unnecessary interventions. The participant's narrative highlights the need for efficient clinical decision-making to optimize patient outcomes and resource utilization. Nurse-initiated interventions have been demonstrated to

decrease time-to-treatment and increase symptom relief, which in turn reduces admission rates and improves patient flow within emergency departments (L. Burgess et al., 2021).

Furthermore, the ability of emergency room nurses to discern the most effective interventions is strengthened by ongoing education and training. Educational programs focusing on triage accuracy and response times have demonstrated improvements in nurses' clinical practice behaviors, leading to better patient outcomes. Considering the improving knowledge and skills of ER nurses, they can justify their decisions based on comprehensive considerations of patient safety and quality of care that led to avoidance of unnecessary intervention and its adverse effects (Considine et al., 2023).

The emergency room environment creates both short periods and unpredictable conditions. Nurses operate within an immediate time frame, yet their initiative demands a deeper understanding of time to distinguish fast-paced action from moments that require careful precision and an empathetic approach. The nurses' connection to time transforms into a caring pattern that combines urgent needs and perceptive understanding.

The nurse's initial presence at the care threshold starts the patient's healthcare process. One of the participants stated about the nurse's initial presence to the patient, which shows in this statement,

"We are the first to have contact with the patient… even before the doctor arrives."
(SS 131, Participant N7, Lines 597 to 598)

"We can provide immediate care and do everything necessary on the spot."
(SS 132, Participant N11, Lines 614 to 615)

This statement shows prompt response, which demonstrates the ability to handle urgent situations because each passing second is crucial for compassionate action. The comments of Participants N7 and N11 highlight the key role of emergency nurses as the primary health professionals with the patient before the physician's intervention. The researcher figured that this narrative emphasizes the need for emergency nurses to have the capabilities to complete immediate assessments and implement timely interventions. The preparedness of emergency nurses to deliver early care is associated with their education and readiness. A study by Misan et al. (2024) discovered that the emergency department was under more stress during the COVID-19 pandemic, thus inducing nursing intervention, including assessment, triage, and workflow transformation. The study highlights the need for assessment and adjustment of the nursing process in order to ensure effectiveness and maintain service quality in such an emergency. Not only does this approach enhance patient management, but it also promotes the importance of the emergency nurse in the healthcare system.

Additionally, the availability of emergency nurses who can provide immediate care depends on the training and readiness of emergency staff. A study by Sari et al. (2024) reported that simulated-based education and basic life support (BLS) education are effective ways to promote response time and the resuscitation effectiveness of nurses in critical situations. That kind of training gives nurses the tools to be more proficient during an emergency _ and to get the proper treatment to a patient more quickly while they wait for a doctor to arrive on the scene. This pacesetting approach develops positive patient outcomes and further proves the emergency nurse's critical role in healthcare.

Despite the clinical and often chaotic setting of the emergency, nurses create intentional spaces for compassion. Their initiative is reflected in how they use and transform space—bringing dignity to final moments, making room for clarity in confusion, and cultivating peace even in constrained physical environments.

"If in case they die in the ER, we can give them a peaceful and dignified death."
(SS 135, Participant N14, Line 627)

Through this statement, the participant shows initiative to create an environment that brings both humanity and peace into a previously sterile and hectic area. Participant N14's narrative illustrates the importance of the emergency nurse in quality end-of-life care, even in a stressful situation. This narrative reinforces the need for compassionate and respectful care towards dying patients, which corresponds to the philosophy of "good death." Moreover, through the study done by Aksoy and Kasikçi (2023), it is reported that nurses also associate the following main attributes with a good death: 'peace,' 'spiritual needs satisfied,' and 'saying goodbye' to the family. These are important in emergency health care, where the nurse often has little time to deal with the complicated problems of the dying patient.

In addition, nurses' professional values and attitudes regarding end-of-life care affect their capacity to promote death with dignity. Research by Aksoy et al. (2024) reported that nurses' acknowledgment of their professional values was correlated with their perceptions of a good death. These values indicate that education for developing professional values and reflective practice may contribute to developing dignity in end-of-life care. Within the emergency department, fast decision-making is a priority, and promoting these values can allow nurses to put dying patients' comfort and dignity first, even in acute care.

"Sometimes, the way we explain the procedures to the family influences their decision."
(SS 136, Participant N9, Lines 605 to 606)

Nurses create emotional areas through which families can understand their options for decision-making. Participant N9 illustrates the important function of nurse-family communication in emergency care. The researcher also acknowledges that how procedures are described can significantly impact families' responses to patient care. It enables families to feel informed, develop trust, and work together in decision-making. Bissonette et al. (2024) stress that when nurses communicate in a clear, empathetic, and timely manner, they can reduce families' distress, improve satisfaction, and also make decisions in emergencies.

Nurses also need to individualize their communication according to each family's particular needs within the complexity of an emergency. Shin & Yoo's (2022) research also demonstrated that emergency nurses met with barriers in communication, primarily

when extreme cases such as the COVID-19 pandemic were concerned. However, despite these challenges, nurses were motivated to increase their communication skills when they realized the importance of providing families with clear and empathetic information as family members accompanied their loved ones through the dying process. Such flexibility and communicative ability are crucial in assisting families to make such difficult medical decisions in the emergency room.

Another participant shows that transforming the emergency room into a place where nurses use their initiative to determine the correct path of medical treatment. The statement below shows the narrative.

"We must thoroughly assess the patient. We are the first to see and evaluate them."
(SS 137, Participant N5, Lines 593 to 594)

Participant N5 emphasizes the role of emergency nurses in early patient triage and assessment. This "way of thinking" highlights the fact that the emergency nurse needs to have sufficient assessment skills in order to establish what an emergency department patient requires in terms of prompt interventions right from the beginning. A study by Fontenot et al. (2022) highlights that routine physical assessments on the admission of a nurse's shift would have detected changes in the patient's condition and prompted appropriate intervention to prevent clinical deterioration. Retraining nurses on standardized, complete physical assessments was associated with improvements in the timeliness and completeness of assessments and improved patient safety outcomes.

In addition, the accuracy of triage performed by emergency nurses is critical in prioritizing patient care and administering appropriate treatment. An evidence-based review of Suamchaiyaphum et al. (2023) found that nurses had triage accuracies of 59.3-82% and that experience in triage was related to an increased likelihood of being correct. The review found that the causes of under-triage are associated with nurse factors, patient-related issues, and a work environment. Improving triage accuracy through focused training and a supportive work environment may translate into better patient outcomes and more efficient functioning of the emergency department.

The experiences of emergency room nurses develop through their relational connections. The quality of patient interactions between nurses and their families and colleagues determines their capacity to provide empathetic care initiation. Compassionate initiative exists as part of a web that includes mutual trust along with shared responsibilities and responsive emotional understanding.

"We need to be compassionate in our explanations."
(SS 138, Participant N2, Line 579)

"Treat the patient with compassion, but without letting emotions affect your judgment." (SS 140, Participant N10, Lines 698)

"They should listen not only to themselves but also to their seniors and the patients."
(SS 141, Participant N1, Lines 667 to 668)

These statements show the initiative process, which requires nurses to connect with others' emotional realms through attentive and clear communication. Compassionate initiative requires nurses to maintain an equilibrium between showing empathy and staying focused on their professional duties. The initiative demonstrates humility through active listening, learning, and respecting the wisdom of relationships.

Initiating with compassion means acting with a clear purpose. Nurses in emergency departments develop their identity through their professional roles, which connect their identity to their service work. Emergency room nurses demonstrate their profound dedication to the essence of being an end-of-life nurse through their professional choices and nursing care delivery system.

The findings by Participants N2, N10, and N1 illuminated the importance of compassion, the need for emotional regulation, and shared listening in nursing. These are important to delivering patient-centered services, which need to be more than just a focus on clinical needs; they also need to focus on trust-building and emotional states. The literature highlights that compassion in nursing care relates to verbal and non-verbal communication, empathy, and respecting the patient's cultural values. Younas et al. (2023) emphasized the need for nurses to respect care in complicated patient scenarios that incorporate emotional involvement blended with professional boundaries, with care that is empathetic and compassionate, along with being effective. Additionally, if patients' views about compassion are considered, healthcare delivery could be optimized by helping patients feel embraced and respect their characteristics and fears (Ghaljeh et al., 2024).

A qualitative study by Babaei et al. (2022) also highlighted the features of compassionate care in cardiac wards among nurses. It underlined the importance of emotional presence, communication, and patient advocacy. These factors help to establish trust and enhance patient satisfaction. However, it can be challenging to provide compassion in practice due to, for example, heavy workloads or organizational issues. A systematic review by Robinson et al. (2023) found that strong leadership and staff environments were needed to overcome barriers to delivering compassionate care and to promote improvements in patient outcomes.

Communication and teamwork are equally important in nursing. Listening intently and working together across disciplines enables a holistic approach to care that respects each patient's needs. Bowen (2024) states that care models are focused on nurses working with other members of the care team, patients, and families to achieve care plans. This care model provides for better care and patient satisfaction. In addition, improving communication among nurses, especially new graduates, is needed. Leonard et al. (2022) showed that training programs for communication and teamwork skills significantly increase nurses' confidence and competency and improve the quality of patient care.

The researcher considers the participants' viewpoints as important aspects of competent and ethical ER nursing practice, particularly related to the provision of end-of-life care. The special focus on empathetic nursing, calming emotions, and listening together signifies a new, integrated model that brings together both the humanities and skills of nursing care. Using Van Manen's

phenomenological methodology and incorporating Jean Watson's Theory of Human Caring and Peaceful End-of-Life Theory, the researcher interprets these statements as mirroring essential elements of emergency room nurses' shared values and experiences.
Working as an emergency room nurse represents a sacred vocation where life meets death. The role of the emergency room nurse is assessment, stabilization, and coordination, which shows that the sense of self develops from professional duties and that initiative extends naturally from the nursing identity.

> *"Our role is significant because we are the first to provide care, whether at the start or the end of life."*
> *(SS 143, Participant N8, Lines 602 to 603)*

> *"Significant role of emergency nurse is assessment, stabilization, and coordination."*
> *(SS 144, Participant N12, Lines)*

The narratives depicted by Participants N8 and N12 provide holistic meanings of the roles of emergency nurses as primary care providers serving the lifespan of humanity, from birth to death. Participant N8 highlights that nurses are often the first to provide care at life's entry and departure, underscoring their emotional, ethical, and clinical involvement in holistic patient care. Participant N12 complements this by emphasizing that emergency nurses are responsible for rapid assessment, stabilization, and coordination—core functions that are essential in time-sensitive and high-pressure environments like the emergency room. Together, these insights reflect the dual nature of emergency nursing: immediate clinical action coupled with a continuous, compassionate presence throughout critical patient moments. Vadivala (2023) emphasized the significant contribution of nurses in palliative care, such as assessing and managing patients' pain and other symptoms, providing emotional support, and communicating with patients, families, and healthcare providers. In this holistic approach, patients are attentive to their physical, emotional, and spiritual needs. Additionally, nurses' beliefs and attitudes affect the quality of end-of-life care. Alshammari et al. (2023) performed qualitative research on how nurses' life experiences, cultural and religious beliefs, and professional background can influence their behavior and attitude toward end-of-life care. According to the research, nurses may be hindered from giving quality end-of-life care by their values and lack of specialist training. The central statements from these findings are the lessons learned about developing nurses' skills to promote compassionate care in the transition to end-of-life care and the necessity of focused education and support. By focusing on these issues, health systems can help nurses to better advise their patients and families through the challenges of end-of-life care.
Emergency nurses are critical partners in care for patients in all care processes, from life-saving interventions to compassionate end-of-life care. They also have roles as emotional presences, coordinators, and ethical care agents. The approach reinforces the big picture that emergency nursing is a life-and-death world and a profoundly human, caring, nod-to-the-human-spirit practice.
One of the participants shows that initiative derives from integrity because accuracy represents both professional correctness and ethical responsibility.

> *"We need to make sure that all the information we provide is accurate because the doctors' treatment will be based on that."*
> *(SS 145, Participant N13, Lines 622 to 623)*

The response by Participant N13 highlights the significance of documentation in the nursing practice in helping to deliver optimal patient care. The nurse in the emergency room is frequently the first to make patient contact and obtain important data that the physician must access and use for appropriate treatment measures. Misinterpretation, misdiagnosis, or patient safety can be compromised if the documentation is inaccurate or incomplete. Additionally, the high-quality nursing record is the backbone of the continuity of care for a patient because it facilitates other health professionals to have access to the patient'spatient's detailed information, thereby improving the patient'spatient's overall outcome. (Wilsonroy, 2024)
A study by Alruwaili et al. (2023) emphasizes that meticulous and precise documentation of patient care is essential for patient safety and good patient care. It reduces the risk of incorrect treatment and enhances collaboration between healthcare professionals from various departments. Inadequate charting can lead to an inaccurate assessment of the patient's condition and treatment history, which can harm the patient.
Documentation is an essential duty of the emergency nurse, as it affects patient safety, physicians' decision-making, and legal defense. It indicates professionalism and is an essential component of ethical and responsible nursing.
Nurses are essential in caring for people approaching the end of life and their families while being mindful of the current demands and challenges in health and social care services (Quinn, 2025).
The theme demonstrates that emergency room nurses actively lead medical situations while maintaining compassionate care, expert abilities, and strong determination. Van Manen's existential framework shows how emergency room nurses experience their roles as a complete whole because they perform through their bodies while managing time pressure in a limited space, forming meaningful human relationships, and reflecting on their identity. Being initiative means more than taking action because it represents a fundamental way of living.

Cluster Theme 3.2. Barriers Within the System

Emergency room nurses work in intense, stressful situations with emotional patients while trying to provide respectful end-of-life care. Delivering dignified end-of-life care becomes exceptionally challenging because institutions create multiple barriers that impede this process. The analysis uses Van Manen's five existential themes to understand how ER nurses experience and perceive institutional shortcomings through their bodies and their relationships with space and time.
Nurses' experience felt space as lived space, which shapes their perceptions of the care environment. The emergency room maintains a disordered spatial arrangement that fails to meet the peaceful requirements of end-of-life situations. Patients who die without properly designated areas lose their privacy while also missing both solemnity and dignity in their passing.

Privacy within the emergency room is essential to ethical and patient-centered care. However, it is an ongoing exigent problem because emergency medicine is open, dense, and fast-paced in-patient flow, affecting the quality of care. Some studies have demonstrated how privacy breaches can result in patients refusing the provision of information and/or the performance of examinations and tests, affecting the quality of care. For example, a study from a tertiary care hospital in Karachi reported that 15% of the patients' withheld history or examination information related to confidentiality issues. In comparison, 10% of patients refused the examinations because of privacy concerns (Saleem et al., 2022). Similarly, Manukumar et al. (2025) reported on a study in Canadian emergency departments, where breaches in privacy, particularly in crowded ER facilities, were cited as reasons why patients avoid treatment or withhold information. These results highlight the need for structural and procedural interventions supporting emergency department privacy.

> *"There should be enough staff and an extra room to ensure privacy for end-of-life patients."*
> *(SS 146, Participant N9, Line 645)*

> *"Maybe...a private space could be created for dying patients and their families."*
> *(SS 147, Participant N2, Line 719)*

> *"I hope there is a space in the ER just for these kinds of patients."*
> *(SS 148, Participant N13, Line 752)*

This quote suggests that nurses' attitude toward the sanctity of death explains why they request privacy. When patients don't have the privacy of death, in the final moment, they also don't get to experience the peace they and their families want and need. The nurse feels an ethical tension because they understand the appropriate humane treatment, yet the institutional environment blocks their actions.

The comments from participants N9, N2, and N13 bring to light an important issue in the emergency department. The need for privacy and dignity in end-of-life care is not a need but a right—the proposition for bedrooms and staffing levels that allow privacy and dignity to end-of-life patients. The hectic emergency department providing poor-quality emergency department end-of-life care makes it difficult to afford privacy and emotional support to patients and their families. Qualitative analysis was also performed by Tan et al. (2023), who noted that the absence of private areas in the emergency departments caused distress for patients and families. Hence, the provision flowing from establishing dedicated spaces for end-of-life care supported a more compassionate environment. Beyond physical privacy, these spaces grant families wanting time to grieve and surround the critically ill with loved ones, away from the high tension inside a busy emergency room.

Furthermore, the integration of family involvement in end-of-life care is paramount. An integrative review by Bayuo et al. (2022) reported that interventions involving families in end-of-life care in the emergency department significantly increased patient comfort and family satisfaction. Of these interventions, the ones that also provide support for decision-making and private spaces for families to witness the dying process of their loved one. The research further emphasizes that in the absence of staffing resources and defined space, end-of-life care in the emergency department is of low quality, with negative experiences for patients and families. Accordingly, to maintain patients' dignity nearing the end of life, such infrastructural and staffing issues in emergency settings must be tackled.

The researcher concurs with the call for designated private areas within emergency departments, which take into account the special needs of end-of-life individuals, one of which is believed to be fundamental in respecting patient dignity and providing humane care. A nurse who works in the emergency room, the researcher has seen how the absence of privacy during a patient's last moments of life can be traumatic for the patient and their family. Simply creating dedicated spaces for people to die, as well as staffing up, would radically raise the standard of the dying process and help guarantee that people have the emotional support, comfort, and dignity they need and want in their last moments.

The physical and emotional state nurses experience during their caregiving duties is called the lived body. Nurses' physical and emotional exhaustion in the emergency room worsens due to lacking equipment, outdated tools, and insufficient staffing.

> *"Hopefully, we can have complete resources… so we won't have to search in other stations to use equipment."*
> *(SS 150, Participant N2, Lines 632 to 633)*

> *"Broken and outdated equipment can be replaced to make it easier to provide interventions."*
> *(SS 155, Participant N13, Line 791)*

> *"With good facilities and well-functioning equipment, we can carry out our responsibilities efficiently."*
> *(SS 151, Participant N7, Lines 641 to 642)*

These statements reveal a fundamental conflict between needing things right away and being able to reach them easily. Nurses must avoid tool search delays because these delays convert their healing capabilities into restricted performance. The nurse states that quality tools enable quality care delivery, yet interventions suffer when these tools are absent. The focus on efficiency reveals the moral dilemma of possessing helpful skills while lacking the resources to execute them. Nurses are hopeful that they will have new, high-technology, and well-functioning equipment to give quality care to patients, not only for end-of-life patients but also for those patients who need care.

Concerns brought up by Participants N2, N13, and N7 emphasize the importance of having enough functional medical equipment in the emergency departments. Emergency nurses commonly encounter difficulties when equipment is lost or obsolete, resulting in delayed patient care and increased stress for the healthcare worker. The research of Woldeyohanins et al. (2025) found that the percentage of available medical equipment was only 55.93% in the surveyed hospitals on average and that 25.32% of the equipment was out of order, thereby indicating the grave effects of equipment shortages on the performance of health services. Pooling of such inadequacies delays the early treatment period and impedes patient care and parameters.

According to Martin et al. (2024), financial limitations are causing hospitals to lose the ability to reinvest in urgent physical facilities (e.g., medical instruments, operating facilities, and facilities). This lack of investment makes it more difficult for emergency departments to meet patient needs successfully and adds stress to healthcare providers. In other words, maintaining state-of-the-art, functioning medical equipment in EDs is essential for providing high-quality emergency care.

The researcher strongly believes that ready access to full-service, operational, and current medical equipment is critical to emergency care's practical and safe delivery. The researcher knows firsthand that a lack of or faulty equipment causes delays in caring for patients; lives can be lost during high-stress, time-sensitive situations. The author promotes long-term commitment to hospital infrastructure and resources, underlining that providing good patient care starts with providing healthcare workers with the relevant tools in their hands, who will work with confidence, effectiveness, and efficiency.

The experience of time differs from mechanical clock measurements because lived time represents how time feels. The time feels heavy with pressure for emergency room nurses when delivering end-of-life care. Systemic delays create a feeling of both time passing quickly and enduring painfully which erodes the nurse's ability to provide care during those unchangeable moments.

"I hope that all laboratory tests are available here to help improve the patient's condition."
(SS 161, Participant N11, Line 787)

"At least one ROD should stay in the emergency room at all times."
(SS 159, Participant N8, Lines 734 to 735)

The delay in a medical diagnosis creates existential regret because help should be available rather than becoming a barrier. The requirement for continuous physician presence creates a time vulnerability because nurses must wait for medical authority to arrive before taking any action.

The time lag in a medical diagnosis is an existential regret because help should be there, not an obstacle. The need for constant physician presence leaves a time vulnerability, as nurses have to wait for medical authority to come before they can do anything.

The statements by Participants N11 and N8 emphasize important aspects of emergency care, such as access to complete laboratory testing and the round-the-clock availability of a resident on duty in the emergency room. These elements are critical in the prompt diagnosis and management of patients.

The accessibility of necessary diagnostics in the Philippines is still an issue, especially in rural areas and areas lacking access to healthcare. A study by Alberto et al. (2022) emphasized the absence of testing capacity as a barrier to the delivery of timely and effective healthcare in the country. The study identified that although a variety of diagnostic tests are theoretically available in the national insurance scheme, several were not available in many primary care centers, as not all had the equipment and staff to carry out such tests, leading to lay detection and treatment.

Sephien et al. (2022) conducted a systematic review and meta-analysis about the 24-hour presence of residents on call in the emergency room. They found that shorter resident duty hours reduce emotional exhaustion and contribute to the overall well-being of residents without negatively impacting patient outcomes. This review indicates that an appropriate balance of resident duty hours is important for the provider's well-being and the quality of patient care.

Improving laboratory services and the emergency room with the regular presence of skilled medical staff is crucial in the early detection, successful management, and global enhancement of these patients' outcomes. It is vital to invest in infrastructure and human resources, as that would narrow the existing barriers and realize sound emergency care.

The emergency room measures time through its significance rather than through minutes because each passing second represents potential comfort and connection or final closure. The nurses' voices express their deep desire to defend the sanctity of dying moments. System inefficiencies, which include missing personnel, incomplete medical tools, and inaccessible diagnostic tests, prevent nurses from taking prompt, meaningful action. The delays create more than workflow interruptions because they destroy the core of compassionate care as nurses experience a distressing state of helplessness between urgent needs and limited capabilities. According to Van Manen, time transforms into an unspoken ordeal that creates pain for patients and nurses when barriers disrupt its flow.

Nurses establish lived relations through their connections with patients, their families, and healthcare team members. The strength of these connections depends on a well-supported system. The absence of proper protocols and communication creates relationship problems, which result in conflicts and disconnects while reducing empathy.

"There should be clear protocols for end-of-life patients… and debriefing sessions after providing care."
(SS 162, Participant N4, Line 636 to 637)

"Support for the family is important… especially the availability of medication."
(SS 164, Participant N9, Lines 771 to 772)

Participants N4 and N9's remarks reiterate the need to establish clear guidelines for end-of-life care and the need to help families, particularly with drug supply. These concerns represent larger difficulties in delivering palliative care in the emergency department.

The absence of structure creates dual problems for care delivery as well as emotional recovery. Without debriefings, there is no support for emotional recovery and relationship healing.

Well-defined guidelines for end-of-life care are needed to achieve uniform and sensitive patient care. The World Health Organization (2023) highlights the need to incorporate palliative care programs within national health systems and policies that enable access to essential medications and trained personnel to provide health care to young people in a way consistent with kids. Similarly, in OECD (2023), less than 40% of those in need receive necessary end-of-life care. This result reveals there is not enough standardization in training and procedures to raise both the level of care and the availability of healthcare.

Families should be provided with care and support at this time as well. According to Bowers and Wilson (2023), families have to deal with the unpredictable nature of monitoring drugs at home, with most family carers having minimal support. Establishing end-of-life care guidelines and family support measures is recommended. Protocols, a ready supply of drugs, and trained personnel should be in place to care for the dying. This will ensure that patients are treated with dignity and help allay some of the emotional and practical pressures on the family during the final stages of life.

In this context, the relational scope extends past the patient. The nurse recognizes families as shared victims of suffering, while medication serves as a symbol of both emotional and physical recovery.

Human connection is the central focus of end-of-life care because it remains delicate, holy, and prone to breaking. Nurses experience professional isolation when systems do not establish clear protocols, communication training, or emotional support systems because this prevents them from delivering patient and family care according to their preferences. The nurses' voices demonstrate their need for structured systems supporting clinical responsibilities and interpersonal connections. Systemic failures create significant relational breakdowns that turn off teamwork and destroy empathy between healthcare professionals, creating unhealed emotional suffering. Through Van Manen's lens, healthcare professionals understand that relationships form the essential foundation of compassionate care within emergency rooms. Strengthening these relationships will restore the human element that healthcare needs.

The inner world of nurses includes their identity, purpose, and moral compass. When systems fail to function properly, nurses doubt their professional values and ability to follow their ethical standards. They experience distress that extends beyond emotional pain to reach a level of existential crisis.

> *"By providing complete resources, a support system, and also training and education."*
> *(SS 166, Participant N1, Line 630)*
>
> *"Nurses need support in terms of equipment, salary, and working hours."*
> *(SS 167, Participant N11, Lines 651 to 652)*
>
> *"Our hospital has no protocol regarding end-of-life care."*
> *(SS 168, Participant N13, Lines 659)*
>
> *"I hope the emergency room staff can have stress management and debriefing sessions… to prevent misunderstandings."*
> *(SS 170, Participant N14, Lines 793 to 794)*

The participants need confirmation by demonstrating competence. These nurses link their professional value to being fully prepared and ready for work. Human beings have recognition as their fundamental psychological requirement. When nurses do not receive fair payment and humane scheduling policies, their feelings of worth decrease. The nurse faces existential drift when guidance is absent because they must navigate death without direction, which intensifies their emotional strain. The need to process emotions demonstrates that moral injury remains active. The broken self finds support through debriefing procedures.

The narratives of Participants N1, N11, N13, and N14 emphasized that an urgent comprehensive setup of the emergency nursing support system includes staff healthcare resources, resource allocation reorganization, equitable compensation, standardized guiding principles, and mental health support. The concerns verbalized are indicative of larger underlying systemic issues faced by the nursing profession, especially in high-stress environments such as the emergency department.

Emergency nurses often face challenges related to insufficient equipment, inadequate staffing, and extended working hours, leading to increased burnout and job dissatisfaction. A study by L. Z. Li et al. (2024) found that nurse burnout is associated with lower healthcare quality and safety, as well as decreased patient satisfaction. Moreover, the continued nursing shortage amplifies these challenges as estimates show a shortfall of more than 500,000 registered nurses in the US over the next decade, as precipitated by such reasons as an aging population and limited enrollment in nursing education (Elkins, 2025). There needed to be systemic changes to adequately address these grievances, such as better use of resources and something more competitive to keep the best nurses.

The absence of standardized end-of-life care protocols in emergency settings can lead to inconsistent patient care and increased stress among healthcare providers. The inclusion of palliative care in emergency departments has been demonstrated to result in better patient care and less unwarranted treatment (CAPC, 2024). Furthermore, psychological support, including stress management training and debriefing sessions, is important for the well-being of the nurse. In another study examining the impact of stress management training on emergency nurses, significant positive changes in job satisfaction and decreased levels of burnout were found (Sari, 2024). The adoption of such programs could strengthen the resilience and coping skills of emergency nurses.

The researcher advocates for a holistic approach to supporting emergency healthcare professionals. The researcher also stresses the need to supply enough resources, pay fairly, establish end-of-life protocols, and establish mental health networks. By investing in these areas, healthcare organizations could promote nurse retention, improve the quality of patient care, and create a sustainable and supportive working environment for emergency nurses.

The emergency room is often the opposite of the concepts that make the end of life peaceful and dignified for patients. People who visit the end-of-life care emergency room come for a range of reasons and levels of distress. Patients for whom the staff could give lower levels of triage and thus be left with delays in rapid assessment and symptom palliation. Inadequate education and training for nursing and other medical staff, lack of standardized protocols, time and space restrictions, work overload, decision-making, and the allocation of logistical resources are other barriers to adequate EOL care in the ED setting (Heufel et al., 2022).

Emergency room nurses must continuously adapt their "lived self" because of inadequate systems within their workplace. The nurses' dedication to their professional vocation faces moral dissonance because the system restricts their growth between their self-identity, their professional aspirations, and their actual capabilities. According to Van Manen's (2016) existential of lived self, these barriers attack both nursing tasks and the essence of what nursing means to the professional. The system needs to support nurses at the end of life by providing both practical tools and emotional recognition of their moral work. The empowerment of the lived self goes beyond efficiency and retention because it serves as a means to rehumanize the caregivers in their work.

Cluster Theme 3.3. Growing Through Support and Experience

Emergency room end-of-life care combines clinical responsibilities with profound human interactions. Emergency room nurses develop their professional and personal growth through continuous learning, reflective practice, and emotional resilience development. Through their lived experiences, nurses develop strength and clarity, which leads to professional development according to this theme. The analysis employs Van Manen's (2016) five existentials to demonstrate how professional and personal growth develops from space, body, time, relation, and self.

This theme depicts the containing vessel, which holds the emergent journey of becoming an emergency department nurse while experiencing the ambivalence of professional change through supportive patient care environments and reflective learning. The stressful settings of the emergency department may deplete nurses in terms of personal and professional resources; on the other hand, the distress encountered in this area can be turned into fuel for boosting resilience and proficiency.

Furthermore, the interplay between individual resilience and organizational support structures plays a pivotal role in fostering growth among emergency nurses. Studies have shown that when nurses perceive a strong support system within their workplace, including access to resources, mentorship, and opportunities for professional development, they are more likely to exhibit increased resilience and a commitment to their roles (Pu et al., 2024). Through this partnership, nurses' mental and emotional health improves, and the emergency department's responsiveness strengthens.

Lived space encompasses both physical environments and emotional and mental spaces, which enable nurses to process information, decompress, and grow. High-intensity environments such as emergency rooms require these spaces to help nurses manage stress and develop personally.

> *"The institution should prioritize the mental, emotional, and spiritual health of ER nurses, because this has a big impact."*
> *(SS 174, Participant N14, Lines 662 to 664)*

> *"Stress management and debriefing sessions can prevent misunderstandings."*
> *(SS 175, Participant N14, Lines 793 to 794)*

Participant N14 highlighted that institutional support is needed to develop healing spaces that require both healing practices and healing spaces to thrive. Emotional management developed within supportive environments produces stronger teams together with better communication. The presence of appropriate spatial elements facilitates nurses to analyze situations, develop interpersonal bonds, and achieve emotional wellness. Nursing professionals develop professionally and personally when opportunities for stress relief and debriefing are created, even in high-stress environments. Participant N14 also emphasizes the importance of institutions that must focus on the mental, emotional, and spiritual health of emergency room nurses. The high-stress nature of the work in emergency departments can frequently expose nurses to traumatic experiences, ultimately contributing to burnout and emotional exhaustion.

The integration of spiritual coping mechanisms has been identified as a valuable strategy for managing occupational stress among emergency healthcare providers. A study conducted by Soola et al. (2022) in Iran revealed that emergency department nurses and emergency medical services staff frequently employed positive spiritual coping methods, such as prayer and trust in a higher power, to navigate the challenges posed by the COVID-19 pandemic. These practices offered not only venting capabilities but also increased their coping factors and ability to be empathetic to care or compassion. Similarly, Alquwez et al. (2021) carried out a study in the Philippines that pointed out the significance of spiritual well-being in enhancing the mental health of nurses in times of crisis and stressed the significance of faith and support from the community in dealing with matters of misfortune.

It is recommended that a more comprehensive approach to employee wellness be taken—one that includes mental, emotional, and spiritual elements. Institutional support is really important for giving personnel resources like stress management training, debriefing sessions, and outlets for spiritual expression. The creation of an environment that promotes these elements may allow healthcare organizations to increase nurse resilience and ameliorate burnout, leading to positive patient care outcomes.

The lived body outlines how nurses experience both mental and physical challenges because of their caregiving responsibilities. After undergoing repeated exposure to suffering and loss, the body remains aware while it responds and carries the accumulated emotional burden.

"Prepare yourself physically, mentally, and emotionally so you won't get too attached."
(SS 176, Participant N8, Lines 692 to 693)

"Providing emotional and psychological support… makes a difference."
(SS 178, Participant N6, Lines 728 to 729)

Protective behavior during development becomes a skill that combines empathy with emotional limitations. The impact of emotional presence on patients and nurses matches the effects of clinical procedures. The statement of Participant N8 is the general feeling of clinicians who are more vulnerable to encountering emotionally challenging incidents. An attitude of psychosocial and emotional readiness is considered a common-sense approach to avoiding over-identifying with patients. Emotional disengagement may be a means to cope with the high workload, but it may also lead to compassion fatigue and work exhaustion.

The Campbell (2025) study revealed that 71% of all general practitioners in the UK experience compassion fatigue, which results in emotional and physical exhaustion and thereby reduces patient care levels. This result highlights the need to focus on the emotional well-being of healthcare professionals in order to maintain sustainable, compassionate care.

However, excessive detachment is cautioned against, as it may hinder the formation of meaningful patient-nurse relationships. A study by Brandão et al. (2023) on emotion regulation in dementia caregiving revealed that caregivers tend to suppress their emotions when facing neuropsychiatric symptoms, especially if they have lower levels of attachment avoidance. This result indicates that although some level of emotional detachment is important, full emotional disinterest could be detrimental to the caregiving experience and care quality. For this reason, the researcher also recommends a balanced way, which is argued to encourage emotional resilience at the same time as maintaining empathy.

Participant N6 acknowledges the role of compassionate care in nursing. Supportive-emotive nursing care has been demonstrated to decrease patient stress, anxiety, and feelings of aloneness, leading to enhanced patient adherence and health satisfaction (NurseLine Healthcare, 2024). This role is in line with the belief of researchers about the need for psychological and emotional support in nursing care. Evidence in favor of this is provided by Atta et al. (2024) reported a positive and significant relationship between empathy and caring behavior in nursing and proposed that the provision of emotional support can improve the giving of care in support of the patient. Furthermore, interventions, such as training sessions on mindfulness, the availability of peer support and emotional skills workshops, or youth resilience training, have been found to be effective in the reduction of burn-out and the promotion of emotional well-being in health and education professionals (Härkänen et al., 2023). Together, these results reinforce our understanding of the importance of emotional support in individual nursing practice as well as in larger healthcare systems.

Learning to endure compassionate care is the goal of growth through corporeality. Supportive institutional care, along with training and mindfulness, enables nurses to develop resilience and the ability to show compassion.

The experience of lived time integrates mechanical responsibility patterns with personal development time. The chaotic environment of the emergency room demands rapid processing while healthcare students learn and develop their nursing abilities.

"Keep learning because theory is different from the actual setup."
(SS 180, Participant N3, Lines 680)

"Don't stop learning because it will help you grow as an effective nurse."
(SS 181, Participant N14, Line 714)

"Education is important."
(SS 182, Participant N11, Lines 787 to 788)

These statements reflect that the experience provides depth to academic learning, which produces growth. The development of a personal lifelong learning philosophy links educational knowledge directly to improved patient care quality. Most of the participants expressed that education is the key to personal and professional growth. Lived time reveals the natural pattern of personal development. The development of a nurse extends beyond time in service because every training experience, reflective moment, and patient encounter creates permanent learning for the nurse in evolution.

The thoughts of Participants N3, N14, and N11 remind us of the importance of lifelong learning in nursing. Participant N3 raises this theory-practice gap, which supports the necessity of ongoing education for the purpose of preserving clinical competence and delivering quality patient care (Alruwaili et al., 2024).

Lifelong learning is not a choice but a necessity. Participant N14 agrees with this stance because continuous learning develops critical thinking, flexibility, and the ability to apply new knowledge to practice. Bekhet (2024) agrees with this and points out that continued learning is a basis of clinical proficiency and develops skills.

Participant N11 recognized the importance of education in nursing. Lifelong learning prepares nurses for best practice and provides opportunities for leadership and specialization. As Waite (2025) explains, continuing education is related to personal growth in one's career (or career development) and the development of the organization. However, it confirms that it is important to establish a learning climate in health care.

Nurses interact with patients' families and colleagues through lived relationships. Growth requires relational support because it thrives best when people show understanding and offer collaboration. Communication functions both as a method and develops an individual's sense of confidence alongside trust within relationships.

"Enhancing communication skills and collaboration… would help us become more confident."
(SS 186, Participant N3, Lines 634 to 635)

"Improve our approaches to patients and significant others… because the patient's reaction depends on our approach."
(SS 188, Participant N13, Lines 751 to 752)

Relational growth happens when caregivers practice communication alongside empathy while working in teams. Each interaction creates opportunities for healing, teaching, and transformation between caregivers and receivers. Participants N3 and N13 report the importance of good communication and teamwork in nursing practice. Enhancing communication skills and teamwork and increasing nurses' self-confidence: Participant N3 believes that improving communication skills and teamwork is an approach to increasing nurses' confidence.

This viewpoint is consistent with that of Leal-Costa et al. (2020), who found a positive relationship between the communication skills of nurses and their felt self-efficacy. In their study, they propose that nurses who have effective communication skills are more effective in their roles and are more confident and competent to perform their intended roles and better interact with patients as well as with the other members of the staff. In addition, simulation-based training by Mohammed and Shaban (2025) has been found to considerably enhance nurses' confidence to provide bad news and empathy toward patients, reiterating practical communication training in nursing education. The author suggests that ongoing enhancement of communication and interpersonal skills is key to effective nursing practice. Participant N13's finding that the patient's reaction is conditional in the way the nurse approaches the patient emphasizes the influence of communication on the patient.

Moreover, according to Thai et al. (2023), the integration of technology in healthcare settings has been shown to enhance patient-provider communication. User-centered technological aids may help with the development of rapport, exchange of information, and shared decision-making and help to improve healthcare outcomes in the end. When using these instruments and models of communication, nurses can enhance interactions with patients and families and foster trust and cooperation. For this reason, handing tools to develop communication skills and adopting the latest technologies are vital for improving how nurses care for their patients.

What people become and do in their work is dependent on their lived self. Professional care improves by using reflection combined with feedback and the deliberate pursuit of deliberate practice, which enables nurses to develop greater self-awareness in their care delivery.

"Be patient, and you should also be knowledgeable. Learn and reflect as well."
(SS 191, Participant N1, Lines 666 and 668)

"If you're unsure, don't hesitate to ask questions to avoid mistakes."
(SS 192, Participant N4, Lines 681 to 682)

"Be patient, and you should also be knowledgeable. Learn and reflect as well."
(SS 191, Participant N1, Lines 666 and 668)

"Our behavior and attitude toward them matter… Johari's Window can help us improve."
(SS 196, Participant N10, Lines 778, 781 and 783)

The nursing inner journey depends on time expenditure alongside wisdom application and contemplative evaluation. Self-growth occurs through the combination of humility and curiosity as two fundamental strengths. The development of relationships occurs through communication, empathy, and teamwork. Each encounter between caregivers and patients has the power to heal and teach as well as transform both parties involved. The core element of professional identity exists within the lived self. Nurses gain self-awareness and purposeful care approaches by reflecting on and receiving feedback from patients as they apply their clinical skills. Professionals in nursing need extensive time for contemplation and wisdom to complete their inner professional development. Intending to look inward, combined with a truthful evaluation of oneself, allows personal growth to flourish.

Participants N1, N4, and N10 stressed the importance of patience, lifelong learning, proactive communication, and self-awareness in professional growth. The focus of Participant N1 on patience and reflective learning corroborates with the findings of Barr et al. (2025), who carried out a long-term experiment with software engineering students. Their findings showed that it is the cumulative regular practice of reflective exercises that increases self-regulated skills and develops competencies by putting them into context. Likewise, Welch (2023) emphasizes the importance of reflective practice in developing both a flexible approach and a diverse repertoire in a changing work environment.

Participant N4's feedback about questioning to prevent errors also speaks to the importance of communicating effectively in the workplace. Duhigg (2024) also shares the idea of "super communicators," who engage in quality conversations utilizing strategies like deep questioning, admitting conversations, and listening with intent. They are also skills that can help avoid misunderstandings, foster trust, and enable deeper collegial friendships. The study indicates that the development of these communication skills is crucial for successful teamwork and decision-making.

Participant N10 references the Johari Window model as a tool for enhancing self-awareness and interpersonal relationships. Warsito & Widyastuti (2022) also worked on teenage children at Aisyiyah Orphanage, Sidoarjo, and found a significant influence of training in self-awareness with the Johari Window model on self-concept. The intervention entailed exercises to promote self-disclosure and feedback aimed at helping individuals gain an understanding of their strengths and weaknesses. This research will show how the Johari Window can assist an individual's personal growth and a group's progression.

In conclusion, the participants' statements are in line with more recent studies stressing the value of reflection, communication skills, and awareness of oneself in professionalism education. These competencies are interconnected and essential for personal growth, team cohesion, and organizational success.

Emergency room nurses develop their professional identity through technical competence, emotional understanding, relational abilities, and institutional backing. According to Van Manen's existential (2016), the nurses' growth process unfolds through their lived experiences, which include their physical spaces, emotional body strain, time spent learning and relationship building, and self-development. Healthcare institutions, alongside reflective practice from nurses, enable them to convert end-of-life care requirements into transformative learning opportunities for both personal and professional growth. For nurses to gain the clinical competence required to raise the standard of end-of-life nursing care, they must complete end-of-life care education. It is advised that all nurses working in end-of-life care get end-of-life nursing education to enhance their clinical competence, performance, attitude, and knowledge (Shushtari et al., 2022).

IMPLICATION AND RECOMMENDATION

The purpose of this study is to explore and understand the emergency room nurses' real-life experiences delivering end-of-life care while uncovering their professional and ethical and emotional difficulties in a demanding high-pressure setting.

Emergency room nurses regularly face situations that demand them to perform critical life-saving procedures while maintaining their responsibility to provide compassionate end-of-life care to their patients. They also face an intensified version of their dual responsibilities in the hectic environment of this department. The research investigation reveals how emergency room nurses carry emotional burdens and perform unseen work responsibilities.

The study emphasizes that emergency room nurses are central figures in the delivery of end-of-life care within chaotic, high-stress environments. Such nurses are essential in giving emotional and moral support at truly critical and human moments. This outcome means that nursing practices require immediate and effective institutional support. It must cover psychological debriefings, actions to increase workers' resilience, and counseling for addressing those who feel exhausted or burnt out emotionally. Enhanced clinical protocols are needed to permit nurses to substitute intensive treatments with palliative care as necessary and as soon as it is ethical. Additionally, providing nurses with the autonomy and resources to maintain emotional safety for all should be done in busy settings as well. Recognition of emotional labor through institutional policies and incentives can validate the invisible work nurses perform and encourage sustained professional engagement.

The participants' experiences make it clear that enhancing nursing education for end-of-life care in emergency departments should be a priority. Because nurses face so many ethical, emotional, and domestic difficulties, ongoing study and formal courses are vital for them. This research reveals that nurses receive insufficient education for end-of-life care in emergency medicine. Nursing curricula must be revised to include more comprehensive content on palliative and end-of-life care, emotional resilience, communication with families in grief, ethical decision-making, and coping strategies specific to emergency departments. Having simulation training that resembles actual scenes of death and dying helps students feel better prepared. Reflective tools, such as journaling and guided debriefing, need to be integrated into clinical rotations to assist students in processing experiences and building empathy. In addition, including interprofessional education can help people collaborate better during end-of-life care.

The study highlights the importance of additional studies that should focus on the high scope of experiences nurses have in emergency care. Researchers should examine the long-term mental and professional effects of ongoing end-of-life situations. The study must assess what works in emotional intelligence training, resilience activities, and debriefing workshops. Studies can focus on other complex issues, such as staff shortages, hospital settings, and limited resources, that stop nurses from providing proper care. In addition, such studies should lead to the creation of guidelines that guarantee the application of best practices in emergency end-of-life care, helping to ensure both quality care for patients and the well-being of nurses.

Recommendation for future research

This hermeneutic phenomenological study on emergency room nurses suggested several new research ideas to advance nursing, shape policies, and improve practice in the important area of end-of-life care. Since the emotional, ethical, and environmental problems discussed in this study are complex, further study should continue, considering various places and disciplines.

Additional studies should look into identifying and examining factors systemically hinders good end-of-life care in emergency departments. Among these factors are the institutional policies, staff adequacy, environmental limitations, and the absence of formal guidelines or inclusion of palliative care. Examining issues across different sites and comparing between different institutions increases our understanding of the problems within each system.

Long-term studies should be carried out to find out how repeated experiences of patient loss can affect the emotional state, identity, and morals of ER nurses. Observing mental health over time could result in inventing new programs for workers and helping them stay resilient.

The Philippines has such cultural and religious diversity. Future research could examine how these environments impact family decisions and influence how nurses care for patients at the end of life. Using patient and family experiences would deepen our understanding of good cultural care practices.

This research calls for further studies that examine the teamwork between nurses and other staff, including physicians, social workers, and those in spiritual care, during care at the end of life. By examining communication, job roles, and choices made by various disciplines, we can establish better ways for healthcare teams to work together.

Future researchers should assess how simulation-based education and organized training programs help nurses be ready for end-of-life care when emergencies happen. Quantitative and qualitative studies can examine how much is learned, how confident people are, and how they consider ethics while delivering care.

Adding intensive care units, medical-surgical departments, and community-based emergency services might help find comparisons. Paying attention to what patients and families think would provide a better understanding of the quality of care and the emotional value of nursing in the end.

Researchers in the future might use narrative techniques, ethnography, or art-based approaches to examine the emotional and subtle aspects of end-of-life care. Connecting nursing, psychology, ethics, and spiritual care would lead to an even deeper exploration of what people experience around death and dying in emergency situations.

These recommendations aim to guide future investigators in expanding experimental knowledge on emergency end-of-life care while still acknowledging nurses' experiences, feelings, and responsibilities in emergency contexts.

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REFERENCES

1. Afenigus, A. D., & Sinshaw, M. A. (2025). Ethical dilemmas and decision-making in emergency and critical care nursing in Western Amhara region, Northwest Ethiopia: a multi-method qualitative study. BMC Nursing, 24(1). https://doi.org/10.1186/s12912-025-02958-5
2. Aguero, W. (2025, May 4). Living with the invisible weight of fatigue and shame. Medium. https://medium.com/@waguero/living-with-the-invisible-weight-of-fatigue-and-shame-5d2aab15f794
3. Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. Journal of
    a. Medicine Surgery and Public Health, 2, 100051. https://doi.org/10.1016/j.glmedi.2024.100051
4. Aimbetova, G., Tursynbekova, A., Bapayeva, M., Issenova, B., Bekmuratov, A., Nukusheva, S., Omarova, K., Zhiyenbayeva, Z., Atabayeva, A., & Akhmetova, K. (2025). "Improving Palliative Care: Insights from Patient and Nurse Perspectives on Care, Environment, and Support." Bangladesh Journal of Medical Science, 24(2). https://doi.org/10.3329/bjms.v24i2.81717
5. Akdeniz, M., Yardımcı, B., & Kavukcu, E. (2021). Ethical considerations at the end-of-life care. SAGE Open Medicine, 9. https://doi.org/10.1177/20503121211000918
6. Aksoy, B., & Kasikçi, E. (2023). The Concept of a Good Death from the Perspectives of Nurses Caring for Patients Diagnosed with COVID-19 in Intensive Care Unit. OMEGA - Journal of Death and Dying. https://doi.org/10.1177/00302228231156945
7. Aksoy, F., Bayram, S. B., & Özsaban, A. (2024). Investigation of the effect of nurses' professional values on their perceptions of good death: a cross-sectional study in Türkiye. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-02290-4
8. Alanazi, M. A., Shaban, M. M., Ramadan, O. M. E., Zaky, M. E., Mohammed, H. H., Amer, F. G. M., & Shaban, M. (2024). Navigating end-of-life decision-making in nursing: a systematic review of ethical challenges and palliative care practices. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-02087-5
9. Alberto, N. R. I., Alberto, I. R. I., Eala, M. a. B., Dee, E. C., & Cañal, J. P. A. (2022). Availability of essential diagnostics in the Philippines. The Lancet Regional Health - Western Pacific, 19, 100375. https://doi.org/10.1016/j.lanwpc.2021.100375

10. Al Dossary, R. (2023). Emergency nurses' perspectives on dignity and privacy in high-acuity settings. Journal of Emergency Nursing, 49(1), 45–52. https://doi.org/10.1016/j.jen.2022.08.010
11. Alligood, M. R. (2018). Nursing theorists and their work (9th ed.). Elsevier Inc.
12. Alodhialah, A. M., Almutairi, A. A., & Almutairi, M. (2024). Exploring nurses' emotional resilience and coping strategies in palliative and End-of-Life care settings in Saudi Arabia: a qualitative study. Healthcare, 12(16), 1647. https://doi.org/10.3390/healthcare12161647
13. Alquwez, N., Cruz, J. P., & Balay-odao, E. M. (2021). Nurses' spiritual well-being and the COVID-19 pandemic: A thematic approach. *Journal of Nursing Management*, *30*(3), 604–611. https://doi.org/10.1111/jonm.13540
14. Alshalawi, S., Aljedaani, S., Fintyanh, D., Salim, S., Fairaq, W., & Refaei, S. (2025). The effect of Nurse-Patient communication on patient satisfaction in the emergency department. Journal of Nursing and Midwifery Sciences, 12(1). https://doi.org/10.5812/jnms-158740
15. Alshammari, F., Sim, J., Mcerlean, G., & Lapkin, S. (2023). Registered Nurses' beliefs about end-of-life care: A mixed method study. Nursing Open, 10(12), 7796–7810. https://doi.org/10.1002/nop2.2027
16. Alsufyani, A. M., Almalki, M. S., Khader, K. A., Stanford, P., Freeman, S., & Alsufyani, Y. M. (2024). The impact of perceived emotional intelligence on occupational stress among nurses: empirical evidence from a Saudi health cluster. Journal of Nursing Management, 2024(1). https://doi.org/10.1155/2024/8876168
17. Alruwaili, A. N., Alruwaili, M., Ramadan, O. M. E., Elsharkawy, N. B., Abdelaziz, E. M., Ali, S. I., & Shaban, M. (2024). Compassion fatigue in palliative care: Exploring Its comprehensive impact on geriatric nursing well-being and care quality in end-of-life. Geriatric Nursing, 58, 274–281. https://doi.org/10.1016/j.gerinurse.2024.05.024
18. AlZahrani, R., Thobaity, A. A., & Saleh, M. S. M. (2024). Identifying the obstacles facing emergency nurses regarding treating CTAS1 and CTAS2 in Saudi Arabia. BMC Emergency Medicine, 24(1). https://doi.org/10.1186/s12873-024-01044-4
19. American Nurses Foundation. (2023). Nurse Well-Being: Building Peer and Leadership Support. https://www.nursingworld.org/foundation/programs/nurse-wellbeing/
20. Aquino, J., Crilly, J., & Ranse, K. (2021). End-of-life care in emergency departments: A national cross-sectional survey of emergency care nurses. Australasian Emergency Care, 25(2), 161–166. https://doi.org/10.1016/j.auec.2021.09.001
21. Aquino, J., Crilly, J., & Ranse, K. (2022). The end-of-life care practices of emergency care
    a. nurses and the factors that influence these practices: An integrative review. International Emergency Nursing, 63, 101168. https://doi.org/10.1016/j.ienj.2022.101168
22. Arantzamendi, M., Sapeta, P., Belar, A., & Centeno, C. (2024). How palliative care professionals develop coping competence through their career: A grounded theory. Palliative Medicine, 38(3), 284–296. https://doi.org/10.1177/02692163241229961
23. Association of perioperative Registered Nurses. (2024, September 5). Important considerations when obtaining informed consent: Clinical Tips and Tricks, Developing Your Skills, The Stitch. Sara Angelilli, DNP, MS, RN, CNOR, NPD-BC. Retrieved May 12, 225 C.E., from https://www.aorn.org/article/important-considerations-when-obtaining-informed-consent
24. Atta, M. H. R., Hammad, H. A., & Elzohairy, N. W. (2024). The role of Empathy in the relationship between emotional support and caring behavior towards patients among intern nursing students. *BMC Nursing*, *23*(1). https://doi.org/10.1186/s12912-024-02074-w
25. Aveyard, H., Kolawole, A., Gurung, P., Cridland, E., & Kozlowska, O. (2022). Informed consent prior to nursing care: Nurses' use of information. Nursing Ethics, 29(5), 1244–1252. https://doi.org/10.1177/09697330221095148
26. Ayed, A. (2025). The relationship between emotional intelligence and coping behaviors among nurses in the Neonatal Intensive care unit. SAGE Open Nursing, 11. https://doi.org/10.1177/23779608251330097
27. Babaei, S., Taleghani, F., & Farzi, S. (2022). Components of Compassionate care in nurses working in the cardiac wards: A descriptive Qualitative study. Journal of Caring Sciences, 11(4), 239–245. https://doi.org/10.34172/jcs.2022.24
28. Babamohamadi, H., Katrimi, S. B., & Paknazar, F. (2021). Moral distress and its contributing factors among emergency department nurses: A cross-sectional study in Iran. International Emergency Nursing, 56, 100982. https://doi.org/10.1016/j.ienj.2021.100982
29. Bahceli, P. Z., Donmez, A. A., & Akca, N. K. (2022). Perceived barriers and motivators of undergraduate nursing students in end-of-life care: A qualitative study based on lived experiences. Perspectives in Psychiatric Care, 58(4), 2687–2696. https://doi.org/10.1111/ppc.13109
30. Barr, M., Nabi, S. W., & Andrei, O. (2025, April 29). The Development of Reflective Practice on a Work-Based Software Engineering Program: a longitudinal study. arXiv.org. https://arxiv.org/abs/2504.20956
31. Bayuo, J., Agbeko, A. E., Acheampong, E. K., Abu-Odah, H., & Davids, J. (2022). Palliative care interventions for adults in the emergency department: A review of components, delivery models, and outcomes. Academic Emergency Medicine, 29(11), 1357–1378. https://doi.org/10.1111/acem.14508
32. Bekhet, A. K. (2024). Promoting lifelong learning in nursing: Strategies for continuing education. *Journal of Intensive and Critical Care Nursing*, 7(1), 188. https://www.alliedacademies.org/articles/promoting-lifelong-learning-in-nursing-strategies-for-continuing-education-28247.html
33. Bentz, J. A., Brundisini, F., & MacDougall, D. (2023a, September 1). Perspectives and Experiences regarding the impacts of Emergency Department overcrowding: A Rapid Qualitative review. NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK599769/?utm_source.com
34. Berring, L. L., Andersen, I. C., Østergaard, L. B., Bygum, C. B., Christensen, L. M., Høgsgaard, D., Johannesen, A. R., & Simonÿ, C. (2024). Emergency department nurses' learning and evolving perspectives in interacting with patients who self-harm. An explorative interview study of the use of a mobile application. Health Informatics Journal, 30(4). https://doi.org/10.1177/14604582241301363

35. Bertomeu, P. F., & Esteban, M. P. S. (2023). The research question in Hermeneutic Phenomenology and Grounded Theory research. The Qualitative Report. https://doi.org/10.46743/2160-3715/2023.5715
36. Bijani, M., Abedi, S., Karimi, S., & Tehranineshat, B. (2021). Major challenges and barriers in clinical decision-making as perceived by emergency medical services personnel: a qualitative content analysis. BMC Emergency Medicine, 21(1). https://doi.org/10.1186/s12873-021-00408-4
37. Bissonette, S., Chartrand, J., Bailey, L., Lalonde, M., & Tyerman, J. (2024). Interventions to improve nurse–family communication in the emergency department: A scoping review. Journal of Clinical Nursing, 33(7), 2525–2543. https://doi.org/10.1111/jocn.17068
38. Bloomer, M. J., Yuen, E., Williams, R., Bouchoucha, S., Poon, P., Runacres, F., Mooney, C., & Hutchinson, A. M. (2023). Perspectives of family-centred care at the end of life during the COVID-19 pandemic: A qualitative descriptive study. Journal of Clinical Nursing, 32(15–16), 5173–5184. https://doi.org/10.1111/jocn.16627
39. Boulton, O., & Farquharson, B. (2023). Does moral distress in emergency department nurses contribute to intentions to leave their post, specialization, or profession: A systematic review. International Journal of Nursing Studies Advances, 6, 100164. https://doi.org/10.1016/j.ijnsa.2023.100164
40. Bove, D. G., Simonsen, S. S., Herling, S. F., & Timm, H. (2024). Emergency nurses' experiences of caring for brought-in-dead persons and their relatives—a qualitative study. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16371
41. Bowers, B., & Wilson, E. (2023). Managing medication at the end of life: supporting family carers. British Journal of Community Nursing, 28(1), 34–36. https://doi.org/10.12968/bjcn.2023.28.1.34
42. Bowen, C. (2024, June 26). 2.4 Collaborative Care - Clinical Nursing Skills | OpenStaX. https://openstax.org/books/clinical-nursing-skills/pages/2-4-collaborative-care?utm_source
43. Bradshaw, J., Siddiqui, N., Greenfield, D., & Sharma, A. (2022). Kindness, listening, and connection: patient and clinician key requirements for emotional support in chronic and complex care. Journal of Patient Experience, 9. https://doi.org/10.1177/23743735221092627
44. Brandão, T., Brites, R., Hipólito, J., Nunes, O., & Pires, C. T. (2023). Emotion regulation in Dementia caregiving: The role of neuropsychiatric symptoms and attachment orientation. *Journal of Geriatric Psychiatry and Neurology*, *37*(2), 146–156. https://doi.org/10.1177/08919887231195228
45. Bressan, V., Bagnasco, A., Aleo, G., Zanini, M., & Sasso, L. (2022). Emergency nurses' competencies in end-of-life care: A scoping review. International Emergency Nursing, 63, 101185. https://doi.org/10.1016/j.ienj.2022.101185
46. Burgess, L., Kynoch, K., Theobald, K., & Keogh, S. (2021). The effectiveness of nurse-initiated interventions in the Emergency Department: A systematic review. Australasian Emergency Care, 24(4), 248–254. https://doi.org/10.1016/j.auec.2021.01.003
47. Burnitt, E., Grealish, L. A., Crilly, J., May, K., & Ranse, J. (2024). Providing end of life
    a. care in the emergency department: A hermeneutic phenomenological study. Australasian Emergency Care, 27(3), 161–166. https://doi.org/10.1016/j.auec.2024.01.002
48. Campbell, D. (2025, January 8). Seven in 10 GPs in UK suffer from compassion fatigue, survey finds. *The Guardian*. https://www.theguardian.com/society/2025/jan/02/seven-in-10-gps-in-uk-suffer-from-compassion-fatigue-survey-finds?utm_source=chatgpt.com
49. Carcary, N. M. (2021). The Research Audit Trail: Methodological Guidance for Application in Practice. The Electronic Journal of Business Research Methods, 18(2). https://doi.org/10.34190/jbrm.18.2.008
50. Carlini, J., Riedel, A., Lehman, K., & Ranse, K. (2025). Transformative service in healthcare: understanding secondary vulnerability and coping mechanisms in end-of-life care. Journal of Service Theory and Practice. https://doi.org/10.1108/jstp-05-2024-0151
51. Carnesten, H., Gustin, L. W., Skoglund, K., & Von Heideken Wågert, P. (2023). Caring through barriers—Newly graduated registered nurses' lived experiences in emergency departments during the COVID-19 pandemic. Journal of Advanced Nursing, 79(6), 2269–2279. https://doi.org/10.1111/jan.15585
52. Castaldo, A., Lusignani, M., Papini, M., Eleuteri, S., & Matarese, M. (2022). Nurses' experiences of accompanying patients dying during the COVID-19 pandemic: A qualitative descriptive study. Journal of Advanced Nursing, 78(8), 2507–2521. https://doi.org/10.1111/jan.15195
53. Center to Advance Palliative Care (CAPC). (2024). Emergency Department: Integrating Palliative Care - Toolkit. https://www.capc.org/toolkits/emergency-department-integrating-palliative-care/
54. Chelly, F., Kacem, I., Moussa, A., Ghenim, A., Krifa, I., Methamem, F., Chouachane, A., Aloui, A., Brahem, A., Kalboussi, H., Maalel, O. E., Chatti, S., Maoua, M., Bannanou, S., & Mrizak, N. (2022). Healing humor: The use of humor in the Nurse-Patient relationship. Occupational Diseases and Environmental Medicine, 10(03), 217–231. https://doi.org/10.4236/odem.2022.103017
55. Chen, C., & Chen, J. (2024). Subjective rather than objective patient death experiences link with physicians' and nurses' professional quality of life. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-01724-3
56. Chen, W., Chung, J. O. K., Lam, K. K. W., & Molassiotis, A. (2022). End-of-life communication strategies for healthcare professionals: A scoping review. Palliative Medicine, 37(1), 61–74. https://doi.org/10.1177/02692163221133670
57. Cheraghi, R., Valizadeh, L., Zamanzadeh, V., Hassankhani, H., & Jafarzadeh, A. (2023). Clarification of ethical principle of the beneficence in nursing care: an integrative review. BMC Nursing, 22(1). https://doi.org/10.1186/s12912-023-01246-4
58. Childers, L. E., Lewis, E. J., Delawder, J. M., & Jones, M. A. (2023). Moral distress and alcohol use among nurses during COVID-19. Journal of Nursing Education and Practice, 13(8), 29. https://doi.org/10.5430/jnep.v13n8p29
59. Cho, H., Steege, L. M., & Knudsen, É. N. A. (2023). Psychological safety, communication openness, nurse job outcomes, and patient safety in hospital nurses. Research in Nursing & Health, 46(4), 445–453. https://doi.org/10.1002/nur.22327

60. Choi, E. K., Kang, J., Park, H. Y., Kim, Y. J., Hong, J., Yoo, S. H., Kim, M. S., Keam, B., & Park, H. Y. (2023). Moral distress regarding End-of-Life care among healthcare personnel in Korean university hospitals: features and differences between physicians and nurses. Journal of Korean Medical Science, 38(22). https://doi.org/10.3346/jkms.2023.38.e169
61. Coats, H., Doyon, K., Isaacson, M. J., Tay, D., Rosa, W. E., Mayahara, M., Kates, J., Frechman, E., Wright, P. M., Boyden, J. Y., Broden, E. G., Hinds, P. S., James, R., Keller, S., Thrane, S. E., Mooney-Doyle, K., Sullivan, S. S., Xu, J., Tanner, J., & Natal, M. (2023). The 2023-2026 Hospice and Palliative Nurses Association Research Agenda. Journal of Hospice and Palliative Nursing, 25(2), 55–74. https://doi.org/10.1097/njh.0000000000000935
62. Considine, J., Shaban, R. Z., Fry, M., & Curtis, K. (2023). Education interventions and emergency nurses' clinical practice behaviours: A scoping review. Australasian Emergency Care, 27(2), 119–135. https://doi.org/10.1016/j.auec.2023.10.004
63. Conwi, L. J., Acibron, A. M., Alberca, M. M., Jamili, C. K., Nabor, J. A., & Tena, L. E.
    a. (2024). The Heart of Healthcare: Development and Initial Validation of 'Malasakit' Scale in Healthcare Services. Journal of Interdisciplinary Perspectives, 2(9). https://doi.org/10.69569/jip.2024.0247
64. Corpuz, J. C. G. (2023). Access to palliative and supportive care in the Philippines: A call
    a. to action. Palliative & Supportive Care, 22(2), 421–422. https://doi.org/10.1017/s147895152300144x
65. Cowley, A., Morphet, J., & Crawford, K. (2025). Experiences of emergency nurses providing End-of-Life care during the COVID-19 pandemic. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16749
66. Creswell, J. W. (2009). Research design: Qualitative, quantitative, and mixed methods approaches. SAGE Publications, Inc. https://www.ucg.ac.me/skladiste/blog_609332/objava_105202/fajlovi/Creswell.pd
67. Dael, J. C., Erwin Faller, Graduate Studies, Saint Bernadette of Lourdes College, Rever Medical Center Inc., & Medecins Sans Frontieres, Doctors with no borders -Operation Center Amsterdam, Asia Pacific Region. (2024). Lived-Experiences of nurses in providing care for the dying and Terminally-Ill patients in the selected level one private hospital. In International Journal of Research Publication and Reviews (Vol. 5, Issue 9, pp. 2284–2292). https://ijrpr.com/uploads/V5ISSUE9/IJRPR33315.pdf
68. Da Silva Duarte, A. C., Chicharo, S. C. R., Da Silva, T. a. S. M., & De Oliveira, A. B. (2023). Ethical dilemmas and illicit acts in nursing: reflections on the legal (dis)order. Revista Brasileira De Enfermagem, 76(suppl 3). https://doi.org/10.1590/0034-7167-2022-0558
69. De Beer, J., Rawas, H., & Beheri, W. (2024). Workplace dignity amongst clinical nurses. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-02376-z
70. De Brasi, E. L., Giannetta, N., Ercolani, S., Gandini, E. L. M., Moranda, D., Villa, G., & Manara, D. F. (2020). Nurses' moral distress in end-of-life care: A qualitative study. Nursing Ethics, 28(5), 614–627. https://doi.org/10.1177/0969733020964859
71. Del Carmen Fernández-Gutiérrez, M., Benavente-Fernández, I., Jiménez-Luque, N., Lubián-López, S., López-Fernández, C., & Picardo-García, J. M. (2024). Nurses' Perception of Caring and Attitudes toward Caring for Dying Patients: Exploring the Relationship Using a Descriptive Cross-Sectional Design. Healthcare, 12(13), 1331. https://doi.org/10.3390/healthcare12131331
72. Drisko, J. W. (2024). Transferability and Generalization in Qualitative Research. Research
    a. on Social Work Practice. https://doi.org/10.1177/10497315241256560
73. Du, J., An, Z., Wang, C., & Yu, L. (2024). Nurses' self-regulation after engaging in end-of-life conversations with advanced cancer patients: a qualitative study. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-02016-6
74. Duhigg, C. (2024, February 20). How to have more meaningful conversations. *TIME*. https://time.com/6695336/how-to-have-meaningful-conversations-charles-duhigg-essay/?utm_source=chatgpt.com
75. Duma, D., & Aringhieri, R. (2023). Real-time resource allocation in the emergency department: A case study. Omega, 117, 102844. https://doi.org/10.1016/j.omega.2023.102844
76. Edvardsson, M., Forsbo, J., Gustafsson, L., & Söderman, M. (2024). End-of-life conversations when transitioning to end-of-life care in residential care: A web-based questionnaire survey of registered nurses' expressed experiences. Nordic Journal of Nursing Research, 44. https://doi.org/10.1177/20571585241276477
77. Egea, M. Z., Prieto-Ursúa, M., Toro, L. B., & Palmar-Santos, A. M. (2022). Dimensions of good palliative nursing care: Expert panel consensus and perceptions of palliative professionals. Journal of Clinical Nursing, 32(13–14), 3746–3756. https://doi.org/10.1111/jocn.16583
78. El-Ashry, A. M., Abdallah, H. M. M., Elsayed, S. M., Khedr, M. A., El-Sayed, M. M., & Ghoneam, M. A. (2025). A cross-sectional study on resilience and death anxiety among emergency nurses. BMC Nursing, 24(1). https://doi.org/10.1186/s12912-025-02980-7
79. Elkins, D. &. (2025, April 2). *Impact of nursing Shortage on Careers 2025: Challenges and solutions*. Davis & Elkins College. https://www.dewv.edu/impact-of-nursing-shortage-on-careers-2025-challenges-and-solutions/?utm_source=chatgpt.com
80. Engel, M., Kars, M. C., Teunissen, S. C., & Van Der Heide, A. (2023). Effective communication in palliative care from the perspectives of patients and relatives: A systematic review. Palliative & Supportive Care, 21(5), 890–913. https://doi.org/10.1017/s1478951523001165
81. Ferrell, B., Otis-Green, S., Dahlin, C., & Campbell, M. L. (2021). Nursing leadership in palliative care: A call to action. Journal of Nursing Management, 29(2), 219–225. https://doi.org/10.1111/jonm.13152
82. Fontenot, N. M., Hamlin, S. K., Hooker, S. J., Vazquez, T., & Chen, H. (2022). Physical assessment competencies for nurses: A quality improvement initiative. Nursing Forum, 57(4), 710–716. https://doi.org/10.1111/nuf.12725
83. Forero, R., Nahidi, S., De Costa, J., Mohsin, M., FitzGerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. BMC Health Services Research,18(1). https://doi.org/10.1186/s12913-018-2915-2

84. Froessl, L. J., & Abdeen, Y. (2021). The Silent Pandemic: The Psychological Burden on Frontline Healthcare Workers during COVID-19. Psychiatry Journal, 2021, 1–11. https://doi.org/10.1155/2021/2906785
85. Galiana, L., Sansó, N., Muñoz-Martínez, I., Vidal-Blanco, G., Oliver, A., & Larkin, P. J. (2021). Palliative Care Professionals' Inner life: Exploring the mediating role of Self-Compassion in the prediction of compassion satisfaction, compassion fatigue, burnout and wellbeing. Journal of Pain and Symptom Management, 63(1), 112–123. https://doi.org/10.1016/j.jpainsymman.2021.07.004
86. Garcia-Catena, C., Ruiz-Palomino, P., Saavedra, S., & Gonzalez-Sanz, J. D. (2023). Nurses' and midwives' perceptions and strategies to cope with perinatal death situations: A systematic literature review. Journal of Advanced Nursing, 79(3), 910–921. https://doi.org/10.1111/jan.15572
87. Gerace, A., Giles, T., Breaden, K., Hammad, K., Drummond, C., Bradley, S. L., & Muir-Cochrane, E. (2020). Nurses' perceptions of dealing with death in the emergency department. Collegian Journal of the Royal College of Nursing Australia, 28(1), 71–80. https://doi.org/10.1016/j.colegn.2020.06.002
88. George Mason University. (2024, January). Low energy, high fatigue, and increased alcohol use may be early signs of declining mental health in nurses. https://nursing.gmu.edu/news/2024-01/low-energy-high-fatigue-and-increased-alcohol-use-may-be-early-signs-declining-mental
89. Ghaljeh, M., Mardani-Hamooleh, M., & Pezaro, S. (2024). Nurses' perceptions of compassionate care in pediatric oncology: a qualitative interview study. BMC Health Services Research, 24(1). https://doi.org/10.1186/s12913-024-11661-1
90. Goh, J. L., Jaffar, J. L. Y., Xu, H., & Lum, V. W. M. (2020). A retrospective study on end
    a. of-life care in the emergency department of a tertiary hospital in Singapore. Proceedings of Singapore Healthcare, 30(2), 138–144. https://doi.org/10.1177/2010105820960175
91. Göransson, K. E., Drennan, J., Mainz, H., Skov, N. F., Amritzer, M., Berg, L. M., Andersen, K. V., & Lisby, M. (2024). The scope of emergency nursing viewed through the lens of complex adaptive systems: a discussion paper. International Journal of Nursing Studies Advances, 8, 100270. https://doi.org/10.1016/j.ijnsa.2024.100270
92. Grant, A., O'Brien, R., Douglas, F., Kennedy, C., Baldie, D., & Torrance, N. (2024). No backstage: the relentless emotional management of acute nursing through the COVID-19 pandemic. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16563
93. Guerrero, J., Alqarni, A., Cordero, R., Aljarrah, I., & Almahaid, M. (2024). Perceived causes and effects of overcrowding among nurses in the emergency departments of tertiary hospitals: a multicenter study. Risk Management and Healthcare Policy, Volume 17, 973–982. https://doi.org/10.2147/rmhp.s454925
94. Haddad, L. M., Annamaraju, P., & Toney-Butler, T. J. (2023, February 13). Nursing shortage. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK493175/
95. Haddington, P., & Stokoe, E. (2023). Social interaction in high stakes crisis communication. Journal of Pragmatics, 208, 91–98. https://doi.org/10.1016/j.pragma.2023.02.014
96. Hafifi, N. a. A., Suhari, S., & Yunita, N. R. (2025). The Correlation between Effective Communication and Patient Satisfaction in the Emergency Department. Health and Technology Journal (HTechJ), 3(1), 74–82. https://doi.org/10.53713/htechj.v3i1.309
97. Härkänen, M., Pineda, A. L., Tella, S., Mahat, S., Panella, M., Ratti, M., Vanhaecht, K., Strametz, R., Carrillo, I., Rafferty, A. M., Wu, A. W., Anttila, V., & Mira, J. J. (2023). The impact of emotional support on healthcare workers and students coping with COVID-19, and other SARS-CoV pandemics – a mixed-methods systematic review. *BMC Health Services Research*, *23*(1). https://doi.org/10.1186/s12913-023-09744-6
98. Hassan, E. A., & Elsayed, S. M. (2025). Exploring resilience in critical care nursing: a qualitative inquiry into continuous adaptation, collaborative unity, and emotional balance. BMC Nursing, 24(1). https://doi.org/10.1186/s12912-025-02844-0
99. Hetherington, D., Wilson, N. J., Dixon, K., & Murphy, G. (2024). Emergency department Nurses' narratives of burnout: Changing roles and boundaries. International Emergency Nursing, 74, 101439. https://doi.org/10.1016/j.ienj.2024.101439
100. Heufel, M., Kourouche, S., Lo, W. A., Thomas, B., Hood, L., & Curtis, K. (2022). End of
    a. life care pathways in the Emergency Department and their effects on patient and health service outcomes: An integrative review. International Emergency Nursing, 61, 101153. https://doi.org/10.1016/j.ienj.2022.101153
101. Hinds, A., Kay, S., & Evans, K. (2025). Refresher training for emergency department triage nurses – A scoping review. Australasian Emergency Care. https://doi.org/10.1016/j.auec.2025.03.006
102. Ho, F. D. V., De Luna, D. V., Cubarrubias, D. L. P. F., Ong, E. P., Abello, R. M. R., Ansay,
    a. M. F.M., Taliño, M. K. V., Robredo, J. P. G., Eala, M. a. B., & Dee, E. C. (2023). Palliative and Supportive Care in the Philippines: Systems, Barriers, and Steps Forward. Journal of Palliative Care, 39(2), 87–91. https://doi.org/10.1177/08258597231153381
103. Hodgson, N. R., Kwun, R., Gorbatkin, C., Davies, J., & Fisher, J. (2024). Emergency department responses to nursing shortages. International Journal of Emergency Medicine, 17(1). https://doi.org/10.1186/s12245-024-00628-y
104. İbrahimoğlu, Ö., Mersin, S., Açıkgöz, G., Çağlar, M., Akyol, E., Özkan, B., & Öner, Ö. (2021). Self-disclosure, empathy and anxiety in nurses. Perspectives in Psychiatric Care, 58(2), 724–732. https://doi.org/10.1111/ppc.12842
105. Jawabreh, N. (2024). The Relationship Between Emotional Intelligence and Coping Behaviors among Nurses in the Intensive Care Unit. SAGE Open Nursing, 10. https://doi.org/10.1177/23779608241242853
106. Jean Watson - Nursing Theory. (2016, June 14). Nursing Theory.
    a. https://nursingtheory.org/nursing-theorists/Jean-Watson.php
107. Jiang, P., Jia, Y., Yang, X., Duan, W., Ning, Y., Zhou, Y., Cao, Y., Du, J., Xi, F., & Huang, L. (2025). A systematic review of psychological distress reduction programs among nurses in emergency departments. BMC Nursing, 24(1). https://doi.org/10.1186/s12912-025-02814-6

108. Jiménez-Herrera, M. F., Llauradó-Serra, M., Acebedo-Urdiales, S., Bazo-Hernández, L., Font-Jiménez, I., & Axelsson, C. (2020). Emotions and feelings in critical and emergency caring situations: a qualitative study. BMC Nursing, 19(1). https://doi.org/10.1186/s12912-020-00438-6
109. Jimenez, O. B., Trajera, S. M., & Ching, G. S. (2022). Providing End-of-Life care to COVID-19 patients: the lived experiences of ICU nurses in the Philippines. International Journal of Environmental Research and Public Health, 19(19), 12953. https://doi.org/10.3390/ijerph191912953
110. Joseph, A., & Jose, T. P. (2024). Coping with Distress and Building Resilience among Emergency Nurses: A Systematic Review of Mindfulness-based Interventions. Indian Journal of Critical Care Medicine, 28(8), 785–791. https://doi.org/10.5005/jp-journals-10071-24761
111. Jung, S., & Lee, J. (2024). Development of Emotional Touch Nursing Competencies Model of 4th Industrial Revolution (Preprint). Asian/Pacific Island Nursing Journal, 8, e67928. https://doi.org/10.2196/67928
112. Kakar, Z. U. H., Rasheed, R., Rashid, A., & Akhter, S. (2023). Criteria for
    a. Assessing and Ensuring the Trustworthiness in Qualitative Research. International Journal of Business Reflections, 4(2), 150–173. https://doi.org/10.56249/ijbr.03.01.44
113. Karlsson, M., Pennbrant, S., & Kasén, A. (2023). Understanding nursing personnel's health while working in end-of-life care—A hermeneutical study. Scandinavian Journal of Caring Sciences, 38(1), 73–81. https://doi.org/10.1111/scs.13193
114. Khoddam, H., Modanloo, M., Mohammadi, R., & Talebi, R. (2023). From pervasive chaos to evolutionary transition: The experience of healthcare providers during the COVID-19 pandemic. Nursing Open, 11(1). https://doi.org/10.1002/nop2.2035
115. Kim, J., & Choi, E. (2022). Predictors of end-of-life care stress, calling, and resilience on end-of-life care performance: a descriptive correlational study. BMC Palliative Care, 21(1). https://doi.org/10.1186/s12904-022-00961-0
116. Kim, J., Kim, S., & Byun, M. (2020). Emotional distancing in nursing: A concept analysis. Nursing Forum, 55(4), 595–602. https://doi.org/10.1111/nuf.12475
117. Kim, J. M., Kim, N. G., & Lee, E. N. (2022). Emergency room nurses' experiences in Person-Centred Care. Nursing Reports, 12(3), 472–481. https://doi.org/10.3390/nursrep12030045
118. Kim, J., & Yoo, I. Y. (2020). Family-centered care in the emergency department: Perceptions of nurses and family members. International Emergency Nursing, 51, 100881.
119. Kim, Y., & Kim, D. (2024). Interventions for family involvement enhance end-of-life care for hospitalized patients: an integrative review. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-02538-z
120. Kızıltepe, S. K., & Koç, Z. (2025). Exploring Moral distress, related factors and coping in Emergency nurses: a mixed method study. Nursing Open, 12(1). https://doi.org/10.1002/nop2.70141
121. Kooktapeh, Z. G., Dustmohammadloo, H., Mehrdoost, H., & Fatehi, F. (2023). In the Line of Fire: A Systematic Review and Meta-Analysis of Job Burnout Among Nurses. arXiv (Cornell University). https://doi.org/10.48550/arxiv.2312.14853
122. Kostka, A. M., Borodzicz, A., & Krzemińska, S. A. (2021). Feelings and emotions of nurses related to dying and death of patients – a pilot study. Psychology Research and Behavior Management, Volume 14, 705–717. https://doi.org/10.2147/prbm.s311996
123. Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC Nursing, 20(1). https://doi.org/10.1186/s12912-021-00684-2
124. Kwon, Y. E., Kim, M., & Choi, S. (2021). Degree of interruptions experienced by emergency department nurses and interruption related factors. International Emergency Nursing, 58, 101036. https://doi.org/10.1016/j.ienj.2021.101036
125. Labrague, L. J., De Los Santos, J. A. A., & Falguera, C. C. (2021). Social and emotional loneliness, COVID-19 anxiety, and resilience among older adults during the COVID-19 pandemic. Archives of Gerontology and Geriatrics, 94, 104299. https://doi.org/10.1016/j.archger.2021.104299
126. Labrague, L. J. (2023). Emergency room nurses' caring ability and its relationship with patient safety outcomes: A cross-sectional study. International Emergency Nursing, 72, 101389. https://doi.org/10.1016/j.ienj.2023.101389
127. Laugesen, B., Albrechtsen, M. T., Grønkjær, M., Kusk, K. H., Nielsen, M. G., Jørgensen, L., Pedersen, B., Lerbæk, B., Haslund-Thomsen, H., Thorup, C. B., Jacobsen, S., Bundgaard, K., & Voldbjerg, S. L. (2022). Nurses' Clinical Decision-Making in a changed COVID-19 work Environment: a focus group study. Global Qualitative Nursing Research, 9, 233339362211098. https://doi.org/10.1177/23333936221109876
128. Leal-Costa, C., González, S. T., Ramos-Morcillo, A. J., Ruzafa-Martínez, M., Agea, J. L. D., & Román, C. J. V. H. (2020). Communication skills and professional practice: Does it increase Self-Efficacy in Nurses? *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.01169
129. Lee, W., Choi, S., Kim, S., & Min, A. (2020). A Case-Centered Approach to Nursing Ethics Education: A Qualitative study. International Journal of Environmental Research and Public Health, 17(21), 7748. https://doi.org/10.3390/ijerph17217748
130. Leonard, J., Whiteman, K., Stephens, K., Henry, C., & Swanson-Biearmann, B. (2022). Improving communication and collaboration skills in graduate nurses: an evidence-based approach. OJIN the Online Journal of Issues in Nursing, 27(2). https://doi.org/10.3912/ojin.vol27no02man03
131. Lervik, W., Solberg, M., Wiig, A. C., & Berg, H. (2025). Turning nursing students' mistakes into resources for learning in simulation-based training: facilitators' assumptions about providing feedback in debriefing. BMC Medical Education, 25(1). https://doi.org/10.1186/s12909-024-06628-z
132. Li, J., Arber, A., Chen, X., Chen, Y., Sun, C., Wu, J., & Chen, X. (2025). Latent class analysis of death coping ability among palliative care nurses and its association with their emotional labor. BMC Palliative Care, 24(1). https://doi.org/10.1186/s12904-025-01708-3
133. Li, Y., Zhu, H., Xu, J., & Yang, J. (2024). A questionnaire survey on the implementation

a. of palliative care in the emergency department in China. BMC Palliative Care, 23(1). https://doi.org/10.1186/s12904-024-01407-5
134. Lin, Y., Zhou, Y., & Chen, C. (2023). Interventions and practices using Comfort Theory of Kolcaba to promote adults' comfort: an evidence and gap map protocol of international effectiveness studies. Systematic Reviews, 12(1). https://doi.org/10.1186/s13643-023-02202-8
135. Lindfors, K., Flinkman, M., Kaunonen, M., Huhtala, H., & Paavilainen, E. (2022). New graduate registered nurses' professional competence and the impact of preceptors' education intervention: a quasi-experimental longitudinal intervention study. BMC Nursing, 21(1). https://doi.org/10.1186/s12912-022-01133-4
136. Liu, C., Wang, J., & Zhang, Y. (2024). Exploring nurses' emotional resilience and coping
a. strategies in palliative and end-of-life care settings: A qualitative study. Journal of
b. Palliative Nursing, 30(2), 85–92. https://doi.org/10.1016/j.jpn.2024.02.003
137. Loffredo, A. J., Chan, G. K., Wang, D. H., Goett, R., Isaacs, E. D., Pearl, R., Rosenberg, M., Aberger, K., & Lamba, S. (2021). United States best practice guidelines for primary Palliative care in the Emergency Department. Annals of Emergency Medicine, 78(5), 658–669. https://doi.org/10.1016/j.annemergmed.2021.05.021
138. Luna-Meza, A., Godoy-Casasbuenas, N., Calvache, J. A., Díaz-Amado, E., Rueda, F. E. G., Morales, O., Leal, F., Gómez-Restrepo, C., & De Vries, E. (2021). Decision making in the end-of-life care of patients who are terminally ill with cancer – a qualitative descriptive study with a phenomenological approach from the experience of healthcare workers. BMC Palliative Care, 20(1). https://doi.org/10.1186/s12904-021-00768-5
139. Mahat, S., Rafferty, A. M., Vehviläinen-Julkunen, K., & Härkänen, M. (2024). Registered nurses' emotional responses to medication errors and perceived need for support: A qualitative descriptive analysis. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16280
140. Manukumar, A. G., Miller, M., Patey, C., Mariathas, H. H., Anaraki, N. R., Walsh, A., Hurley, O., Senior, D., Etchegary, H., Norman, P., Wang, P., & Asghari, S. (2025). Privacy Matters: Experiences of rural and remote emergency department patients – a Mixed-Methods research conducted in Newfoundland and Labrador, Canada. Health Services Insights, 18. https://doi.org/10.1177/11786329251320431
141. Mari, C. G. S., Ofina, A. C. P., Go-Chu, L. H., Dela Paz, J. W., & Magno-Butiu, H. (2024). Perception of good death among palliative and hospice care patients, their caregivers, and bereaved family members in ospital NG Makati: A Cross-Sectional Analytical Study. THE FILIPINO FAMILY PHYSICIAN, 62(2), 303. https://thepafp.org/journal/wp-content/uploads/2025/01/PAFP-62-2-106-113.pdf
142. Martin, A. B., Hartman, M., Washington, B., & Catlin, A. (2024). National Health Expenditures in 2023: Faster growth as insurance coverage and utilization increased. Health Affairs, 44(1), 12–22. https://doi.org/10.1377/hlthaff.2024.01375
143. Maunder, R. G., Heeney, N. D., Greenberg, R. A., Jeffs, L. P., Wiesenfeld, L. A., Johnstone, J., & Hunter, J. J. (2023). The relationship between moral distress, burnout, and considering leaving a hospital job during the COVID-19 pandemic: a longitudinal survey. BMC Nursing, 22(1). https://doi.org/10.1186/s12912-023-01407-5
144. McCallum, K., Jackson, D., & Walthall, H. (2022). Communicating with families during end-of-life care in the emergency department: A qualitative study. International Emergency Nursing, 60, 101113. https://doi.org/10.1016/j.ienj.2021.101113
145. McCallum, K., Jackson, D., Walthall, H., & Aveyard, H. (2024). Death and dying in the emergency Department: a new model for End-of-Life care. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16561
146. Midsayap, Cotabato Profile – PhilAtlas. (1990, May 1). https://www.philatlas.com/mindanao/r12/cotabato/midsayap.html
147. Misan, N., Wilf-Miron, R., & Saban, M. (2024). Comparing emergency nursing measures before and during COVID-19: A retrospective study of assessment, triage, and workflow. SAGE Open Nursing, 10. https://doi.org/10.1177/23779608241274766
148. Mohammed, S. a. a. K., & Shaban, M. (2025). Enhancing communication and empathy skills in Geriatric care: Nurses' reflections on Simulation-Based Training for Patient Interaction and Education. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.17662
149. Moran, M. (2021, June 21). What is dependability in qualitative research and how do we
a. establish it? Statistics Solutions. https://www.statisticssolutions.com/what-is-dependability-in-qualitative-research-and-how-do-we-establish-it/
150. Nabirye, A. K., Munabi, I. G., Mubuuke, A. G., & Kiguli, S. (2025). Emotional and psychological experiences of nursing students caring for dying patients: an explorative study at a national referral hospital in Uganda. BMC Medical Education, 25(1). https://doi.org/10.1186/s12909-025-06708-8
151. Nacak, U. A., & Erden, Y. (2023). End-of-Life care and nurse's roles. Eurasian Journal of Medicine, 54(Supp1), S141–S144. https://doi.org/10.5152/eurasianjmed.2022.22324
152. Nafe, P., Habibi-Soola, A., Aghaei, M., & Mehri, S. (2025). The relationship between error experience and patient safety culture with safe activities of emergency nurses. Scientific Reports, 15(1). https://doi.org/10.1038/s41598-025-95191-8
153. Nelson, H., Murdoch, N. H., & Norman, K. (2021). The role of uncertainty in the experiences of nurses during the COVID-19 Pandemic: A phenomenological study. Canadian Journal of Nursing Research, 53(2), 124–133. https://doi.org/10.1177/0844562121992202
154. Ng, I. K. (2024). Informed consent in clinical practice: Old problems, new challenges. The Journal of the Royal College of Physicians of Edinburgh, 54(2), 153–158. https://doi.org/10.1177/14782715241247087
155. Oh, W., & Jung, M. (2024). Triage—clinical reasoning on emergency nursing competency: a multiple linear mediation effect. BMC Nursing, 23(1). https://doi.org/10.1186/s12912-024-01919-8
156. Ong, K. K., Yong, Y. B., & Kowitlawakul, Y. (2023). Nurses' perceptions about bereavement care in critical care units: A qualitative study. International Nursing Review, 70(4), 527–534. https://doi.org/10.1111/inr.12872

157. Pal, R. Y., Chua, M. T., Guo, L., Kumar, R., Shi, L., & Kuan, W. S. (2025). The Impact of Palliative and End-of-Life Care Educational Intervention in Emergency Departments in Singapore: An Interrupted Time Series analysis. Medicina, 61(2), 173. https://doi.org/10.3390/medicina61020173
158. Palmryd, L., Rejnö, Å., Alvariza, A., & Godskesen, T. (2024). Critical care nurses' experiences of ethical challenges in end-of-life care. Nursing Ethics. https://doi.org/10.1177/09697330241252975
159. Parvin, M. R., Sharmi, P. D., Kayesh, I., & Rony, M. K. K. (2024). "Patient dignity can be ensured by providing adequate health care": A phenomenological analysis on survival strategies of military nurses. Heliyon, 10(4), e25893. https://doi.org/10.1016/j.heliyon.2024.e25893
160. Paterson, L. A., & Maritz, J. E. (2024). Nurses' experiences of the family's role in end-of-life care. Health SA Gesondheid, 29. https://doi.org/10.4102/hsag.v29i0.2565
161. Peng, M., Guan, Q., & Zhu, X. (2025). Moral distress, attitude toward death, and palliative care core competencies among ICU nurses: a cross-sectional study. BMC Palliative Care, 24(1). https://doi.org/10.1186/s12904-025-01655-z
162. Pepito, J. a. T., Babate, F. J. G., & Dator, W. L. T. (2023). The nurses' touch: An irreplaceable component of caring. Nursing Open, 10(9), 5838–5842. https://doi.org/10.1002/nop2.1860
163. Pu, J., Wang, W., Li, G., Xie, Z., Fan, X., Zhan, N., Xu, Y., & Huang, H. (2024). Psychological resilience and intention to stay among nurses: the mediating role of perceived organizational support. Frontiers in Psychology, 15. https://doi.org/10.3389/fpsyg.2024.1407206
164. Quinn, B. (2025). End of life care: how nurses can use a compassionate approach. Retrieved April 23, 2025, from https://journals.rcni.com/nursing-standard/evidence-and-practice/end-of-life-care-how-nurses-can-use-a-compassionate-approach-ns.2024.e12260/abs
165. Rantung, G., Griffiths, D., & Moss, C. (2024). The social processes that emergency nurses use to achieve sustainability: A constructivist grounded theory. Journal of Advanced Nursing. https://doi.org/10.1111/jan.16297
166. Robinson, J., Raphael, D., Moeke-Maxwell, T., Parr, J., Gott, M., & Slark, J. (2023). Implementing interventions to improve compassionate nursing care: A literature review. International Nursing Review, 71(3), 457–467. https://doi.org/10.1111/inr.12910
167. Rodriguez, D., & Willson, D. (2022). Privacy in emergency departments: Exploring patient and nurse experiences. Journal of Clinical Nursing, 31(5–6), 811–821. https://doi.org/10.1111/jocn.16013
168. Royal College of Nursing. (2025). Corridor care: The normalization of crisis is shocking. The Guardian. https://www.theguardian.com/commentisfree/2025/jan/19/the-guardian-view-on-corridor-care-the-normalisation-of-crisis-is-shocking
169. Rufo, J. (2024, August 27). Acute care. ECRI and ISMP. https://home.ecri.org/blogs/ecri-news/dismissing-patient-and-caregiver-concerns-tops-annual-list-of-patient-safety-threats?utm_source=chatgpt.com
170. Salas-Bergüés, V., Pereira-Sánchez, M., Martín-Martín, J., & Olano-Lizarraga, M. (2024). Development of burnout and moral distress in intensive care nurses: An integrative literature review. Enfermería Intensiva (English Ed), 35(4), 376–409. https://doi.org/10.1016/j.enfie.2024.02.002
171. Saleem, S. G., Ali, S., Ghouri, N., Maroof, Q., Jamal, M. I., Aziz, T., Shapiro, D., & Rybarczyk, M. (2021). Patient perception regarding privacy and confidentiality: A study from the emergency department of a tertiary care hospital in Karachi, Pakistan. Pakistan Journal of Medical Sciences, 38(ICON-2022). https://doi.org/10.12669/pjms.38.icon-2022.5785
172. Sari, F. I., Purwaningsih, P., & Qur'aniati, N. (2024). Strategies to improve emergency nurses' response time through training programs. Indonesian Journal of Innovation Studies, 25(4). https://doi.org/10.21070/ijins.v25i4.1309
173. Sephien, A., Reljic, T., Jordan, J., Prida, X., & Kumar, A. (2022). Resident duty hours and resident and patient outcomes: Systematic review and meta-analysis. Medical Education, 57(3), 221–232. https://doi.org/10.1111/medu.14943
174. Serrano-Gemes, G., Garrido-Hernansaiz, H., & Ferrer-Cascales, R. (2022). Emotional regulation and coping strategies in emergency healthcare professionals: A mixed-methods study. International Journal of Environmental Research and Public Health, 19(4), 2418. https://doi.org/10.3390/ijerph19042418
175. Shah, P., Thornton, I., Kopitnik, N. L., & Hipskind, J. E. (2024, November 24). Informed consent. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK430827/?utm_source
176. Shahmari, M., Dashti, S., Jafari, M., & Belil, F. E. (2025). Nurses' lived experiences of self-control in emergency settings: a qualitative study. BMC Emergency Medicine, 25(1). https://doi.org/10.1186/s12873-025-01205-z
177. Shida, J., Uno, C., Soma, Y., & Matsuda, Y. (2023). End-of-life Care by Nurses in the
    a. Emergency Department in Japan: Application of Swanson's Middle Range Theory of Caring. International Journal of Nursing and Health Care Research, 6(3). https://doi.org/10.29011/2688-9501.101415
178. Shin, S., & Yoo, H. J. (2022). Emergency nurses' communication experiences with patients and their families during the COVID-19 pandemic: A qualitative study. International Emergency Nursing, 66, 101240. https://doi.org/10.1016/j.ienj.2022.101240
179. Shushtari, S. S. G., Molavynejad, S., Adineh, M., Savaie, M., & Sharhani, A. (2022). Effect of end-of-life nursing education on the knowledge and performance of nurses in the intensive care unit: a quasi-experimental study. BMC Nursing, 21(1). https://doi.org/10.1186/s12912-022-00880-8
180. Silverman, H., Wilson, T., Tisherman, S., Kheirbek, R., Mukherjee, T., Tabatabai, A., McQuillan, K., Hausladen, R., Davis-Gilbert, M., Cho, E., Bouchard, K., Dove, S., Landon, J., & Zimmer, M. (2022). Ethical decision-making climate, moral distress, and intention to leave among ICU professionals in a tertiary academic hospital center. BMC Medical Ethics, 23(1). https://doi.org/10.1186/s12910-022-00775-y
181. Simply Psychology. (2024, December 13). Credibility in qualitative research. https://www.simplypsychology.org/credibility-in-qualitative-research.html

182. Sodha, S. (2025, March 6). Burnout, shame, heartbreak: nurses are being crushed by our broken NHS. The Guardian. https://www.theguardian.com/commentisfree/2025/jan/19/burnout-shame-heartbreak-nurses-are-being-crushed-by-our-broken-nhs
183. So, R. (2024). Understanding Palliative and Hospice Care in the Philippines
— The Ruth Foundation. The Ruth Foundation.
b. https://www.ruth.ph/tmp/2024/2/27/understanding-palliative-and-hospice-care-in-the-philippines
184. Soola, A. H., Mozaffari, N., & Mirzaei, A. (2022). Spiritual coping of emergency department nurses and emergency medical services staff during the COVID-19 pandemic in Iran: an exploratory study. Journal of Religion and Health, 61(2), 1657–1670. https://doi.org/10.1007/s10943-022-01523-7
185. SooleenAbbas. (2024, May 20). The importance of establishing credibility in qualitative research. Sago. https://sago.com/en/resources/blog/the-importance-of-establishing-credibility-in-qualitative-research/
186. Stewart, L. (2024, December 12). Hermeneutic Analysis in Qualitative Research.
187. Suamchaiyaphum, K., Jones, A. R., & Markaki, A. (2023). Triage Accuracy of Emergency Nurses: An Evidence-Based Review. *Journal of Emergency Nursing*, *50*(1), 44–54. https://doi.org/10.1016/j.jen.2023.10.001
188. Surendran, A., Beccaria, L., Rees, S., & Mcilveen, P. (2024). Cognitive mental workload of emergency nursing: A scoping review. Nursing Open, 11(2). https://doi.org/10.1002/nop2.2111
189. Suryani, N. P., Agustina, H. R., Eriyani, T., & Setyorini, D. (2023). Professional boundaries in the relationship between nurses and patients in healthcare settings: A scoping review. Jurnal Aisyah Jurnal Ilmu Kesehatan, 8(2). https://doi.org/10.30604/jika.v8i3.2005
190. Takemura, N., Fong, D. Y. T., & Lin, C. (2022). Evaluating end-of-life care capacity building training for home care nurses. Nurse Education Today, 117, 105478. https://doi.org/10.1016/j.nedt.2022.105478
191. Tang, Q., Xu, T., Li, Z., Wang, M., Xu, L., Xu, G., & Yue, P. (2023). Bereavement and Professional Competencies: Exploring the personal experience of death among nursing students — a qualitative study. OMEGA - Journal of Death and Dying. https://doi.org/10.1177/00302228231167495
192. Tarberg, A. S., Landstad, B. J., Hole, T., Thronæs, M., & Kvangarsnes, M. (2020). Nurses' experiences of compassionate care in the palliative pathway. Journal of Clinical Nursing, 29(23–24), 4818–4826. https://doi.org/10.1111/jocn.15528
193. Taylan, C., & Weber, L. T. (2022). "Don't let me be misunderstood": communication with patients from a different cultural background. Pediatric Nephrology, 38(3), 643–649. https://doi.org/10.1007/s00467-022-05573-7
194. Tenny, S., Brannan, J. M., & Brannan, G. D. (2022, September 18). Qualitative Study.
a. StatPearls-NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK470395/
195. Thai, P., Flores-Cruz, G., & Roque, N. A. (2023). Leveraging healthcare technology to improve Patient-Doctor communication. Proceedings of the Human Factors and Ergonomics Society Annual Meeting, 67(1), 2317–2322. https://doi.org/10.1177/21695067231192641
196. Tiah, L., Chua, M. T., Kuan, W. S., Tan, A., Tay, E., Pal, R. Y., & Dong, C. (2023). Perspectives towards End-of-Life Care in the Emergency Department of Tertiary Public Hospitals—A Qualitative Analysis. Medicina, 59(3), 456. https://doi.org/10.3390/medicina59030456
197. Tian, Y. (2023). A review on factors related to patient comfort experience in hospitals. Journal of Health Population and Nutrition, 42(1). https://doi.org/10.1186/s41043-023-00465-4
198. Time for better care at the end of life. (2023). In *OECD health policy studies*. https://doi.org/10.1787/722b927a-en
199. Toney-Butler, T. J., & Thayer, J. M. (2023, April 10). Nursing process. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK499937/
200. Torrey, T. (2024, December 20). What is informed consent? Verywell Health. https://www.verywellhealth.com/understanding-informed-consent-2615507?utm_source
201. Trisyani, Y., Emaliyawati, E., Prawesti, A., Mirwanti, R., & Mediani, H. S. (2023). Emergency nurses' competency in the Emergency Department context: A Qualitative study. Open Access Emergency Medicine, Volume 15, 165–175. https://doi.org/10.2147/oaem.s405923
202. Umubyeyi, B., Leboul, D., & Bagaragaza, E. (2024). "You close the door, wipe your sadness and put on a smiling face": a qualitative study of the emotional labour of healthcare professionals providing palliative care in nursing homes in France. BMC Health Services Research, 24(1). https://doi.org/10.1186/s12913-024-11550-7
203. University of Iowa Health Care. (2024). A simple gesture: Nurse's compassion turns Emergency Department visit into a special memory for patient and their spouse. https://uihc.org/news/simple-gesture-nurses-compassion-turns-emergency-department-visit-special-memory-patient-andUniversity of Iowa Health Care
204. Vadivala, R. (2023). Navigating the End-of-Life Journey: The critical role of nurses in palliative care. www.walshmedicalmedia.com. https://doi.org/10.35248/2155-9627.23.14.456
205. Valdez, A. M. (2024). Burnout or Exploitation? Resiliency is Not the Solution. Journal of Emergency Nursing, 50(2), 165–166. https://doi.org/10.1016/j.jen.2023.12.014
206. Valdez, A. M., & Fontenot, J. (2023). Protecting lives and preserving dignity: Emotional safety in emergency nursing. Journal of Emergency Nursing, 49(5), 647–649. https://doi.org/10.1016/j.jen.2023.06.007
207. Van Manen. (1990). Supplemental Digital Content 3: van Manen's Existential Themes. https://cdn-links.lww.com/permalink/jfn/a/jfn_16_0_2019_12_23_lawton_jfn-19-090_sdc3.pdf
208. Van Manen, M. (2014). Phenomenology of Practice Meaning-Giving Methods in Phenomenological Research and Writing. Walnut Creek, CA Left Coast Press. - References - Scientific Research Publishing. (n.d.). https://www.scirp.org/reference/referencespapers?referenceid=1359733
209. Van Manen, M. (2016). Phenomenology of practice. In Routledge eBooks. https://doi.org/10.4324/9781315422657

210. Virdun, C., Luckett, T., Lorenz, K., Davidson, P. M., & Phillips, J. L. (2023). Priorities for care of the dying in the emergency department: A rapid review and thematic synthesis of recent evidence. Palliative Medicine, 37(2), 123–135. https://doi.org/10.1177/02692163221127991
211. Waite, R. (2025, March 17). Nursing and education: The role of continuous education in boosting career advancement. *Robin Waite Blog*. https://www.robinwaite.com/blog/nursing-and-education-the-role-of-continuous-education-in-boosting-career-advancement
212. Walsh, A., Bodaghkhani, E., Etchegary, H., Alcock, L., Patey, C., Senior, D., & Asghari, S. (2022). Patient-centered care in the emergency department: a systematic review and meta-ethnographic synthesis. International Journal of Emergency Medicine, 15(1). https://doi.org/10.1186/s12245-022-00438-0
213. Warsito, A. D. R., & Widyastuti, W. (2022). The effect of the Johari Window Self-Awareness Training on Teenagers' Self-Confidence at Aisyiyah Orphanage in Sidoarjo. *Jurnal Psikologi Pendidikan Dan Konseling*, *8*(2), 147. https://doi.org/10.26858/jppk.v8i2.41522
214. Welch, J. (2023). Visioning strategy through the "Johari window": discovering critical "unknowns" in a rapidly evolving context. Strategy and Leadership, 51(5), 30–35. https://doi.org/10.1108/sl-05-2023-0056
215. Willman, A., Bjuresäter, K., Nilsson, J., & Sandström, B. (2021). Nurses' experiences of barriers and facilitators to fundamental care in the acute care setting. Scandinavian Journal of Caring Sciences, 35(1), 225–233. https://doi.org/10.1111/scs.12837
216. Wilson, J., Vella, S., Hall, C., & McCloskey, R. (2022). Emergency nurses' experiences of providing end-of-life care: A qualitative study. Journal of Advanced Nursing, 78(5), 1541–1552. https://doi.org/10.1111/jan.15177
217. Wilsonroy, W. (2024). Improving nursing documentation quality: a vital pillar of patient care. NSUWorks. https://nsuworks.nova.edu/fdla journal/vol8/iss1/5/?utm_source.com
218. World Health Organization: WHO. (2020, August 5). *Palliative care*. https://www.who.int/en/news-room/fact-sheets/detail/palliative-care?utm
219. Woldeyohanins, A. E., Molla, N. M., Mekonen, A. W., & Wondimu, A. (2025). The availability and functionality of medical equipment and the barriers to their use at comprehensive specialized hospitals in the Amhara region, Ethiopia. Frontiers in Health Services, 4. https://doi.org/10.3389/frhs.2024.1470234
220. Wormuth, B. (2024, October 15). Using an Audit Trail to Demonstrate Trustworthiness in
    a. Qualitative Research. Statistics Solutions. https://www.statisticssolutions.com/using-an-audit-trail-to-demonstrate-trustworthiness-in-qualitative-research/
221. Wu, S., Sun, Y., Zhong, Z., Li, H., Ding, B., & Deng, Q. (2025). The effect of moral distress on emergency nurses' job burnout: the mediating roles of hospital ethical climate and moral resilience. Frontiers in Public Health, 13. https://doi.org/10.3389/fpubh.2025.1562209
222. Xu, D., Luo, D., Chen, J., Zeng, J., Cheng, X., Li, J., Pei, J., & Hu, F. (2022). Nurses' perceptions of barriers and supportive behaviors in end-of-life care in the intensive care unit: a cross-sectional study. BMC Palliative Care, 21(1). https://doi.org/10.1186/s12904-022-01020-4
223. Xu, Y., & Fan, L. (2023). Emotional labor and job satisfaction among nurses: The mediating effect of nurse–patient relationship. Frontiers in Psychology, 14. https://doi.org/10.3389/fpsyg.2023.1094358
224. Yirga, G. K., Abate, M. W., Ayenew, Y. E., Abere, Y., Dires, T., & Shiferaw, K. (2025). Provision of respectful care for human dignity in health care service and associated factors in South Gondar hospitals, northwest, Ethiopia, multicenter study. BMC Health Services Research, 25(1). https://doi.org/10.1186/s12913-025-12532-z
225. Younas, A., Porr, C., Maddigan, J., Moore, J., Navarro, P., & Whitehead, D. (2023). Implementation strategies to promote compassionate nursing care of complex patients: An exploratory sequential mixed methods study. Journal of Nursing Scholarship, 55(4), 805–824. https://doi.org/10.1111/jnu.12869
226. Zarrin, L., Ghafourifard, M., & Sheikhalipour, Z. (2023). Relationship between Nurses Reflection, Self-efficacy and Work Engagement: A Multicenter Study. Journal of Caring Sciences, 12(3), 155–162. https://doi.org/10.34172/jcs.2023.31920
227. Zhang, Y. H., De Silva, M. W. S., Allen, J. C., Lateef, F., & Omar, E. B. (2022). End-of
    a. Life Communication in the Emergency Department. Journal of Emergencies Trauma and Shock, 15(1), 29–34. https://doi.org/10.4103/jets.jets_80_21
228. Zhu, H., Zhou, Z., Xu, Y., Chen, J., Lin, D., Li, S., & Chen, X. (2025). Analysing the effect of social jetlag on burnout among shift nurse using a chained mediation model. Scientific Reports, 15(1). https://doi.org/10.1038/s41598-025-96399-4
229. Zolkefli, Y. (2024). Patient refusal of care: balancing patient autonomy and professional ethical duties. Journal of Client-centered Nursing Care, 10(3), 231–234. https://doi.org/10.32598/jccnc.10.3.63.1