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Wanda Marie Haynes
Walden University

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Walden University

College of Nursing

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Wanda Marie Haynes

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and that any and all revisions required by
the review committee have been made.

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Walden University
2026

Abstract

Emergency Nurses' Perspectives on Workload, Stress, and Violence in the Context of the U.S. Nursing Shortage

by

Wanda Marie Haynes

MA, Walden University, 2022

BS, Marshall University, 2017

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

February 2026

Abstract

The nursing shortage is a critical global issue that significantly impacts emergency nurses (ER), leading to increased workloads, psychological stress, and heightened exposure to workplace violence (WPV). This phenomenon raises concerns among healthcare administrators and nurse leaders who seek strategies to improve retention and ensure quality patient care. The purpose of this qualitative study was to explore the meaning of workload, stress, and WPV among ER nurses during the U.S. nursing shortage. Guided by Herzberg's two-factor theory, the study employed a phenomenological approach to capture nurses' lived experiences. Data were collected through semi-structured interviews with eight ER nurses from diverse hospital settings. Thematic analysis revealed five overarching themes: (a) overwhelming workload and emotional strain, (b) normalization of WPV in emergency care, (c) perceived lack of organizational support and respect, (d) the dual nature of job fulfillment, and (e) solutions to ending the nursing shortage. Participants described how these factors diminished job satisfaction and contributed to intentions to leave the profession. Findings suggest that addressing WPV and improving administrative support are essential for enhancing nurse well-being and retention. Implications for positive social change include the potential for healthcare administrators and policymakers to implement supportive measures that may reduce nurse attrition and improve patient outcomes. By fostering safer and more respectful work environments, this study contributes to strategies that strengthen the emergency nursing workforce and promote sustainable healthcare delivery.

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Dedication

This study is dedicated to my mother, Oletta "Susie" Lee Aquino (December 7, 1943, to September 29, 2017), who always believed in me and was my number one fan. My mother gave me the strength to complete this study and to force positive change in the world. Furthermore, to my children, Terry and Cooper, for making me a better version of myself and teaching me to love correctly, and for being my mentor, motivator, and best friend. I love you, boys!

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I want to acknowledge *Dr. Hussey*, *Dr. Huehn*, and *Dr. Diener*, my committee members, for being by my side from the first word and encouraging me not to give up when times were tough. Thank you all! Moreover, to *my children*, for listening to me read my study over and over again to get their opinion, and for all the long nights I had to write and not "hang out" with them. Furthermore, *to my dad*, for supporting me from the very beginning when I said, "I am going back to school again!" He smiled and offered encouragement throughout this study. Thank you to my children and my dad. I love you all!

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Chapter 1: Introduction to the Study

Introduction

Nursing history is a transformative narrative that reflects the evolution of healthcare since the beginning, highlighting the pivotal roles that nurses have played in shaping patient care, advancing medical practice, and advocating for public health over centuries, dating back to the 1800s, from the founder of modern nursing, Florence Nightingale (Mackey & Bassendowski, 2017). The foundation of nursing was built on evidence-based practice and understanding the "nursing role." Over time, nursing has often been portrayed as undervalued and integral to healthcare worldwide, with nurses serving as caregivers, advocates, and educators (Mackey & Bassendowski, 2017).

Hodgson et al. (2024) reported that 98.5% of emergency rooms reported nursing shortages. Nustedlt et al. (2020) stated that 20% to 50% of nurses leave the profession within one year, and the nurses who leave the profession create a nursing shortage. By understanding the ER nurses' perspective and shedding light on these underexplored factors, this study seeks to raise awareness of the day-to-day lived experiences ER nurses endure that can create a sense of abhorrence towards the nursing profession. Although many factors contribute to the nursing shortage, this study's focus remains on substantial workloads, psychological stress, and workplace violence (WPV) among ER nurses.

This study highlights the continuous struggle for recognition, respect, and the unfavorable working conditions within the nursing profession. Understanding the nurse's perspective on their workloads, psychological stress, WPV, and how the nursing shortage

has affected the nursing profession will help illuminate the significant contributions nurses make to the health and well-being of their communities.

Background

Nurses play several crucial roles in healthcare, each carrying immense responsibility as patient care providers that involve physical, emotional, and psychological stress. Nurses are patient advocates, educators, researchers, and leaders at the forefront of public health initiatives promoting well-being and disease prevention. The responsibility of nurses extends beyond clinical tasks, encompassing emotional, ethical, and leadership, that require a deep commitment to patient welfare, professional integrity, and continuous learning (Saaiman et al., 2021).

A shortage of ER nurses has demonstrably negative consequences for ER nurses and patient care (Drennan et al., 2024). Hodgson et al. (2024) reported that 98.5% of emergency rooms reported nursing shortages, with 83.3% describing prolonged shortages lasting more than 12 months, with negative impacts such as misses/near misses 93.9% with increasing left without being-seen rates 90.9% and that the emergency rooms will need interventions such as retention strategies and increase pay to help elevate the nursing shortage. Nustedlt et al. (2020) stated that 20% to 50% of nurses leave the profession within one year, and the nurses who leave the profession create a nursing shortage, a significant concern suggesting bedside nursing is becoming extinct (Drennan et al., 2024).

ER nurses provide immediate life-saving interventions, but in providing care, they are exposed to trauma, severe acute and chronic illnesses, and life-and-death situations

that take a psychological toll on the ER nurse. ER nurses are also faced with the critical elements that contribute to the nursing shortage, such as environmental factors (Tamata et al., 2023), including the acuity of patients, the advancement and intensity in the development of acute and chronic diseases, verbal and physical abuse from patients, peers, and doctors (Ten Hoeve et al. 2017), increasing responsibilities from lack of secondary staff, and misuse of the nurse to doctor relationship (Saaiman et al., 2021).

Contributing factors, such as substantial workload and WPV, can cause constant pressure that puts ER nurses at risk of physical, emotional, and mental exhaustion, leading to psychological stress that causes anxiety, fatigue, and depression. Substantial workloads are heavy, demanding, or overwhelming in terms of volume, complexity, or time requirements in nursing and require nurses to manage multiple tasks, patients, and responsibilities within a given period, potentially leading to stress and reduced job satisfaction when demands exceed their capacity or resources (Kondrat & Tearer, 2018). Substantial workloads may compromise the effectiveness of ER nurses' patient care, decrease job satisfaction, and negatively impact overall well-being, thereby contributing to the nursing shortage (Hsieh et al., 2023; Saaiman et al., 2021). WPV is defined as an act of physical assault, threats, harassment, or abuse that occurs in a work environment involving employees, clients, or visitors, which includes a wide range of behaviors such as verbal threats, bullying, physical attacks, and homicide. WPV can impact the work environment, affecting productivity and employee retention (National Institute for Occupational Safety and Health, 2002). Furthermore, WPV is an increasingly contributing factor in ER settings. Hsieh et al. (2023) stated that WPV in emergency

departments can create an unsafe environment, contributing to a nursing shortage and psychological stress, which have become an emergent challenge for ER nurses (Hodgson et al., 2024).

Problem Statement

The problem that prompted the research is the ER nurses' perspective on the contributing factors, such as workloads, psychological stress, and WPV, that have created the ER nursing shortage. Hsieh et al. (2023) stated that the occurrence of WPV in ERs creates an unsafe environment, contributing to a nursing shortage. Although coping strategies are essential, there is a lack of information about the ER nurse's perception of specific contributing factors concerning their substantial workload, psychological stress, and WPV that have prompted the ER nurse to leave their workplace, thus contributing to the nursing shortage. A study performed by Hayward et al. (2016) revealed that the main contributors to nurses' decision to leave were stressful work environments, lack of support from their colleagues and peers, poor mental and emotional health, and feelings of disrespect, alongside abuse such as WPV. Little research has been conducted regarding the perception of the ER nurse's lived experiences and detailed occurrences of the contributing factors that can lead to the nursing shortage in the ER, including substantial workloads, psychological stress, and WPV in the United States.

Therefore, my study is important as it will provide valuable insights and awareness for policymakers and healthcare institutions by focusing on ER nurses' perspectives and daily challenges.

Purpose of the Study

The purpose of this study was to explore the lived experiences of emergency room (ER) nurses concerning workload, psychological stress, and WPV. To gain this perspective, ER nurses who remain in the ER setting and those who wish to leave the ER were recruited for the study.

Research Question

What are the lived experiences of emergency room (ER) nurses with workload, psychological stress, and WPV?

Theoretical and Conceptual Framework for the Study

The theories and concepts that ground this study include the nursing shortage, a critical issue affecting ERs globally. A nursing theory provides a framework that can help address and manage this shortage. One such theory is Herzberg's two-factor theory (Herzberg, 1976). This theory is relevant to addressing the ER nurses' perspective of the nursing shortage. Frederick Herzberg developed this theory, focusing on job satisfaction and motivation, identifying factors that lead to satisfaction and those that lead to dissatisfaction (Herzberg, 1976). Herzberg's two-factor theory consists of several subcategories, such as motivators, hygiene factors, and applications in nursing. Herzberg's two-factor theory posits that specific factors in the workplace can lead to satisfaction or dissatisfaction with one's environment; however, the theory suggests that satisfaction stems from the job itself (Herzberg, 1976).

Motivators

Motivators are intrinsic factors that contribute to job satisfaction and a sense of meaningfulness in one's work. Examples of motivators are recognition, responsibility, and advancement, which may increase job satisfaction. In nursing, ensuring that nurses receive recognition for their hard work and providing opportunities for career advancement can significantly improve job satisfaction (Staempfli & Lamarche, 2020). For instance, implementing recognition programs and career development pathways can make nurses feel appreciated and motivated to stay in their positions. Additionally, emergency departments are prone to increased incidents of WPV, and it has been shown that environmental and organizational changes may be most effective in reducing WPV in ERs (Wirth et al., 2021).

Hygiene Factors

Hygiene factors are elements that do not necessarily motivate employees to work harder or better but will cause dissatisfaction if they are lacking (Herzberg, 1976). Examples of hygiene factors include substantial workloads, which can cause ER nurses to become overwhelmed and experience mental and physical exhaustion. Other examples of hygiene factors include poor salaries, poor working conditions, unfavorable company policies, and challenging interpersonal relationships, which can lead to job dissatisfaction if not adequately addressed. Addressing hygiene factors is crucial for preventing job dissatisfaction among ER nurses.

Application in Nursing

Herzberg's two-factor theory divides job factors into motivators and hygiene factors, which is a framework for unfavorable occurrences such as workloads, psychological stress, and WPV within ER nurses' work environment that involves addressing the motivators and ensuring that hygiene factors are adequately managed. This study provides valuable insight into the ER nurses' perspective of the occurrences that increase the nursing shortage, the number of workloads they carry, the psychological stress of the job, and the infliction of WPV on ER nurses.

The logical connections between the framework presented and the nature of this study include understanding the lived experiences of an ER nurse and the factors that contribute to the nursing shortage. Identifying factors that lead to satisfaction and those that lead to dissatisfaction exposes the factors that can contribute to the nursing shortage in the ER (Herzberg, 1976). Herzberg's Two Factor Theory incorporates hygiene factors, including substantial workloads, psychological distress, and WPV. By articulating these contributory elements through the lens of an ER nurse, the theory will guide my study in exploring the ER nurses' perspectives on their workload, psychological stress, and WPV.

Nature of the Study

I conducted a qualitative study design using an interpretive and phenomenological approach. The interpretative phenomenology approach uses participants who meet predefined criteria, where the participants experience the phenomenon (Larkin et al., 2019). The interpretative phenomenological approach provides insights into how a

participant in a specific context makes sense of a particular situation and thoroughly examines their personal lived experiences.

Definitions

The following terms are defined to clarify the research question and provide details about the study.

Emergency room: An emergency room (ER) is a specialized department within a hospital designed to provide immediate medical care for patients experiencing acute illnesses or injuries that require urgent attention. The ER is equipped to handle a wide range of emergencies, from life-threatening conditions to less severe medical issues, and operates 24 hours a day, 7 days a week. The ER's primary goal is to stabilize patients, diagnose, and provide immediate treatment (American Hospital Association, 2020).

Emergency room nurse: An emergency room nurse is a healthcare professional who specializes in providing care to patients experiencing medical conditions in the emergency room. These nurses are trained to assess, triage, and provide immediate emergent care to stabilize patients in life-and-death situations, often traumas (American Nurses Association, 2015).

Nursing: Nursing is the protection, promotion, and optimization of health; the prevention of illness and injury; the alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in the care of individuals, families, communities, and populations (American Nurses Association, 2015).

Psychological stress: Psychological stress refers to the mental and emotional strain or tension that occurs when an individual perceives a situation as overwhelming,

threatening, or beyond their ability to cope with. External factors such as work demands or personal problems often trigger it. Prolonged or chronic psychological stress can lead to adverse health outcomes, including anxiety, depression, and physical health issues like high blood pressure or sleep disturbances (American Psychological Association. (2020).

Substantial workloads: Substantial workloads are workloads that are heavy, demanding, or overwhelming in terms of volume, complexity, or time requirements; in nursing, it requires nurses to manage multiple tasks, patients, and responsibilities within a given period, potentially leading to stress, reduced job satisfaction when demands exceed their capacity or resources (Kondrat & Tearer, 2018)

Workplace violence (WPV): Workplace violence is an act of physical assault, threats, harassment, or abuse that occurs in a work environment involving employees, clients, or visitors. Including a wide range of behaviors such as verbal threats, bullying, physical attacks, and homicide. WPV can impact the work environment, affecting productivity and employee retention (National Institute for Occupational Safety and Health, 2002).

Assumptions

In this study, the first assumption is that ER nurses want to share their perspectives on daily occurrences. Secondly, I can assume that the participants represent the studied population and will respond accurately and honestly to the interview questions, as the study utilizes anonymous data collection to provide confidentiality.

Scope and Delimitations

I explored the lived experiences of ER nurses regarding workload, psychological stress, and WPV. I considered conducting a descriptive quantitative study, but I chose not to, as the methodology of phenomenology aligns with its purpose of profoundly understanding the participants, their lived experiences, and their perspectives, rather than just their opinions or beliefs. Therefore, using a quantitative research approach was inappropriate for my study.

I chose Herzberg's Two Factor Theory to guide my study because this theory distinguishes between factors that lead to job satisfaction and factors that prevent job satisfaction. In my study, Herzberg's Two Factor Theory applies to the factors such as workloads, psychological stress, and WPV, all of which contribute to nurses wanting to leave the nursing profession; I considered Dorothea Orem's self-care theory (Tanaka, 2022), but I did not choose this theory because it would not relate to all contributing factors.

The inclusion criteria for my study are ER nurses who have been registered nurses (RNs) for 5 years or more and have worked in the ER for at least 5 years. My exclusion criteria are RNs with less than 5 years of experience who do not work in the ER.

Limitations

Ravitch and Carl (2021) suggested that researchers understand their role in the research study, and with this in mind, I was diligent about my feelings towards the "role of the nurse" in the ER setting. I acknowledged my opinions and values to avoid bias and gathered research from various ER nurses within the Appalachian Region in the United

States. I practiced self-awareness. An example of how to understand my role as a nurse researcher: I wrote a positionality statement highlighting my understanding of privilege, intersectionality, bias, and components of my worldview that have "shaped" my position regarding my scholarly work. This may be challenging when researching the nursing shortage, workloads, psychological stress, and workplace violence because it can be emotionally charged, and the participants might be hesitant to disclose their experiences out of fear of being judged or punished. As a result, I recognized the importance of informed consent and worked hard to establish an atmosphere of trust and safety, ensuring participants feel at ease discussing their experiences.

Significance

The results of my study have the potential to reveal the lived experiences of ER nurses and will provide new insights into the demands of a study that explores how ER nurses reflect on the challenges they face from patients, doctors, and peers, alongside the inherent demands of the profession. I raised awareness of the day-to-day experiences an ER nurse endures that can create a sense of abhorrence towards the nursing profession. My study provided valuable insight into the contributing factors, such as workloads, psychological stress, and WPV, that created the nursing shortage and the specific occurrences experienced by the ER nurse.

My findings can potentially affect significant positive social change, as I intended to generate awareness and inspire positive social change by analyzing ER nurses' lived experiences in the ER setting. Furthermore, by sharing these experiences with the public and healthcare communities, ER nurses may be able to avoid leaving the profession and

contribute to alleviating the national nursing shortage. Ultimately, the goal is to empower ER nurses to practice their profession as envisioned initially, thereby fostering a more fulfilling and sustainable career path by amplifying the voices of ER nurses regarding the trauma inflicted on the ER nurse and the critical nursing shortage (Hayward et al., 2016). There is a vital discussion about the necessity for improved work environments to maintain retention. My findings may offer valuable insights by capturing the lived experiences of ER nurses and investigating the factors that discourage them from staying in the ER. These insights can be leveraged to develop future studies that target strategies to alleviate the nursing shortage and ensure adequate staffing levels within emergency departments.

By understanding ER nurses' substantial workloads, psychological stress, and WPV, the ER nurse can gain recognition and respect for their labor and empower ER nurses. My findings revealed ER nurses' lived experiences in their workplaces and the demise of psychological abuse from patients, families, and peers. Increasing public awareness and understanding of ER nurses' challenges can cultivate a more supportive and respectful work environment, thereby helping address the nursing shortage (Staempfli & Lamarche, 2020). These findings provided new information on ER nurses' lived experiences with substantial workloads, psychological stress, and WPV, which affect positive social change.

Summary

ER nurses play a crucial role in healthcare by providing immediate, life-saving treatment to patients who experience trauma, acute illness, and injury. ER nurses are trained to respond and to use critical thinking skills to save lives. Although ER nurses respond quickly in emergencies, several factors can delay patient treatment, including substantial workloads that lead to fatigue and insufficient time to care for patients. ER nurses face psychological stress from demanding tasks and verbal and physical abuse from patients or families. WPV creates a fearful work environment. When an ER nurse is exposed to this type of environment, this can cause a rapid turnover and a nursing shortage (Drennan et al., 2024).

Understanding why ER nurses consider leaving the profession can provide valuable insights into the factors contributing to the broader nursing shortage. By exploring these perspectives, healthcare organizations can identify key areas of concern, understand ER nurses' perspectives, and eliminate the factors that contribute to them (Drennan et al., 2024). ER nurses have substantial workloads, with patients having more complex medical issues and higher nurse-to-patient ratios. ER nurses experience psychological stress from verbal, physical, and emotional abuse from patients. Additionally, ER nurses are faced with WPV from patients and peers. By gaining an in-depth understanding of these concerns, hospitals and healthcare administrators can implement change and improve the lives of ER nurses. Positive social change can be implemented by listening to the ER nurse about the deteriorating working conditions.

Chapter 2 presents the relevant literature, the need for the proposed research, and a detailed explanation of my theory and literature search strategies.

Chapter 2: Literature Review

Introduction

The critical shortage of emergency room (ER) nurses in the United States, along with the factors contributing to this shortage, poses significant challenges for the healthcare system (Morley et al., 2018). Therefore, ER nurses face new challenges during these times, such as working short-staffed, dealing with an increment of complex patients with substantial workloads, and being subjected to psychological stress as well as workplace violence (WPV) against ER nurses. Xu et al. (2021) noted that ER nurses work in a high-stress work environment; therefore, they advocate for reducing high workloads, psychological stress, and WPV through awareness and social change (Drennan et al., 2024).

Although the literature indicates that these problems exist in the workplace for ER nurses, little is known about the factors contributing to the nursing shortage (Hodgson et al., 2024). As such, conducting the interviews with ER nurses provided valuable insights into their lived experiences and the factors contributing to their intention to leave the profession. The purpose of this study was to explore the lived experiences of ER nurses concerning workload, psychological stress, and WPV. To achieve this, ER nurses who remain in the ER setting and those who wish to leave the ER were recruited for the study. By shedding light on these underexplored factors, the goal was to raise awareness of the day-to-day experiences ER nurses endure that can create a sense of abhorrence towards the nursing profession. This study provided valuable insight into the contributing factors

that created the nursing shortage and focused on specific occurrences experienced by ER nurses.

In Chapter 2, I present an exhaustive review of the literature to examine the causes of the nursing shortage and the contributing factors in the United States from the ER nurses' point of view. I also describe the literature search and detail 'Herzberg's two-factor theory, which is the theoretical basis of my study.

Literature Search Strategy

I searched the literature using the Walden University library databases and search engines, including EBSCO and Google Scholar. I accessed the following databases within the search engines to find related journal articles: simultaneous searches of CINAHL and Medline, CINAHL Plus with Full Text, the Cochrane Database of Systematic Reviews, ProQuest Central, and ScienceDirect. The Boolean search terms and combinations used include *nursing, emergency room, emergency room nurse, nursing shortage, workplace violence (WPV), patient acuity, workload, psychological stress, unrealistic professional expectations, misuse of nurses, peer relationships, doctor-patient relationships, nurse perspective*, and *nurse-to-patient ratios*. I searched for peer-reviewed articles that were initially reviewed from 2018 to the present but expanded the search to include earlier publications because there was limited literature about the nursing shortage from the perspective of the ER nurse. The review of literature on Herzberg's Two-Factor theory extended back to 1976 when the theory was first developed.

Theoretical Foundation

The theory guiding this study is Herzberg's Two-Factor theory, which informed my understanding of how ER nurses view the nursing shortage and its causes. Frederick Herzberg developed this theory, which focuses on job satisfaction and motivation, distinguishing between factors that lead to satisfaction and those that contribute to dissatisfaction (Herzberg, 1976). Herzberg's two-factor theory consists of several subcategories, such as motivators, hygiene factors, and applications in nursing. Herzberg's two-factor theory identifies certain factors in the workplace that can contribute to one's satisfaction or dissatisfaction with their environment; however, the theory suggests that true satisfaction is derived from the nature of the job itself (Herzberg, 1976).

Motivators

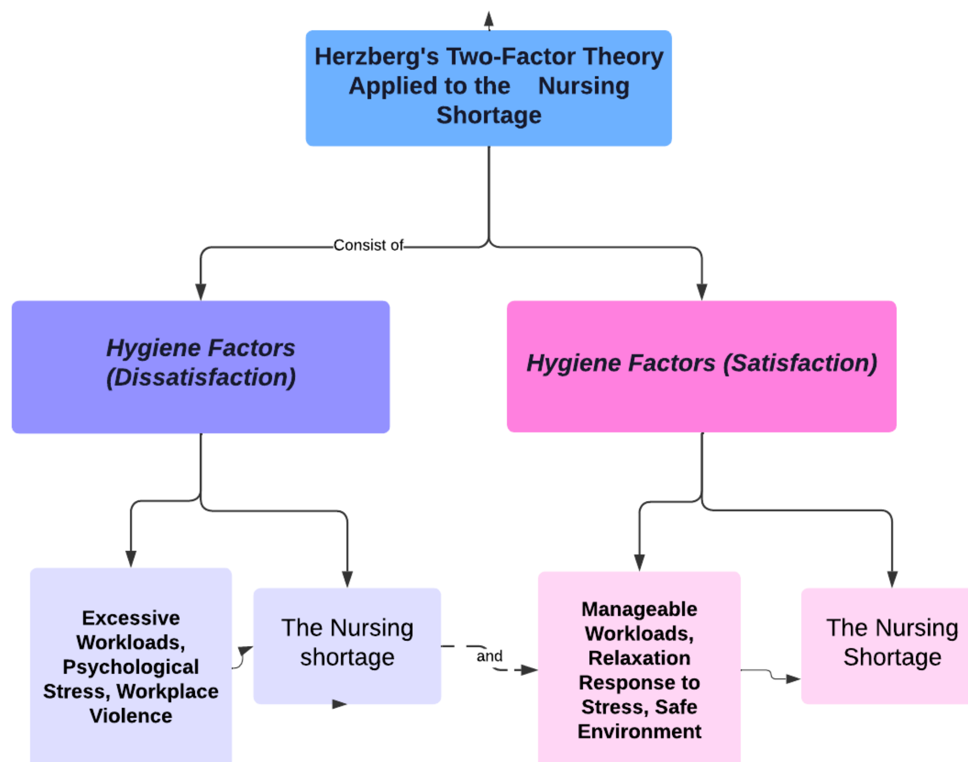
Motivators are intrinsic factors that can lead to job satisfaction when present, making work more fulfilling and meaningful, encouraging ER nurses to stay in their profession, and even inspiring others to join the profession. Motivators lead to job satisfaction and include aspects such as recognition, responsibility, advancement, and the nature of the work itself (Herzberg, 1976). Ensuring nurses receive recognition for their hard work and providing a safe environment from mental and physical abuse can significantly improve job satisfaction (Staempfli & Lamarche, 2020). For instance, implementing recognition programs and career development pathways can make nurses feel appreciated and motivated to stay in their positions.

Hygiene Factors

Hygiene factors are elements that do not necessarily motivate employees to work harder or better but will cause dissatisfaction if they are lacking (Herzberg, 1976). In nursing, these hygiene factors are excessive workloads, psychological stress, and WPV, which contribute to the shortage of nurses and create dissatisfaction among ER nurses. As shown in Figure 1, hygiene factors can encompass both dissatisfaction and satisfaction. Hygiene factors play a key role in the nursing shortage. Promoting manageable workloads, decreasing psychological stress, and providing a safe environment are essential for retaining nursing staff, as these efforts reduce the risk of dissatisfaction and the intent to leave (Staempfli & Lamarche, 2020). Applying Herzburgs's theory can identify the root causes of dissatisfaction and motivation in nursing. Improving hygiene factors can help reduce unfavorable experiences, while increasing motivators can increase ER nurses' sense of fulfillment when faced with challenges (Staempfli & Lamarche, 2020).

Figure 1

Herzberg's Two-Factor Theory; Hygiene Factors Applied to Nursing



Application in Nursing

Applying Herzberg's Two-Factor Theory, hospitals, particularly the ER, can enhance job satisfaction, which may reduce the nursing shortage among ERs, which means addressing key motivators while ensuring hygiene factors are adequately managed (Staempfli & Lamarche, 2020). Herzberg's Two-Factor Theory serves as the basis for this research, examining job satisfaction and motivation. Herzberg's Two-Factor Theory in nursing provides valuable insights into how theory has been applied to identify dissatisfaction and motivation in the work environment (Herzberg, 1976). Numerous

studies have applied Herzberg's theory to investigate the factors influencing nurse job satisfaction and dissatisfaction. For example, Holmberg et al. (2018) suggested that certain factors contribute to burnout. For example, Holmberg et al. (2018) suggested that factors contributing to burnout included long shifts and decreased motivation. The study suggested that improving hygiene factors, such as workload balance and creating a better work-life balance, could help mitigate unfavorable occurrences in nursing. Applying Herzberg's Two-Factor Theory to nursing research effectively identifies both sources of dissatisfaction and sources of motivation (satisfaction) in the profession. I am utilizing Herzberg's theory to explore hygiene factors such as substantial workloads, psychological stress, and WPV among ER nurses that create dissatisfaction, and that motivators (reversed hygiene factors) can increase job satisfaction, which may impact how ER nurses experience their work environment.

Herzberg’s Theory identifies significant factors contributing to the nursing shortage in the ER by pinpointing elements that cause both satisfaction and dissatisfaction. Herzberg's theory remains a valuable framework for understanding the unfavorable occurrences that ER nurses face, but it requires adaptation to reflect the diverse and evolving nature of the nursing profession.

Literature Review Related to Key Concepts

The key concepts include workloads, psychological stress, and WPV. I conducted a literature review of these key concepts to support their application in this study and to identify their limitations. The limitations identified acknowledged the gap in the literature regarding the key concepts that contribute to the nursing shortage in US ERs. This gap

highlights the need for this study to gain a deeper understanding of the nursing shortage and the contributing factors that influence ER nurses to leave the profession, as explained by the ER nurses themselves.

Workloads

The workload is the number of patients assigned to an ER nurse during a single assignment; it includes the number of rooms and the number of patients the ER nurse cares for in one shift. The increasing acuity level of patients presenting to the ER has significantly contributed to the workload of ER nurses (Morley et al., 2018). Advances in medical care have allowed individuals with chronic complex conditions to live longer, resulting in a higher number of patients with severe and multifaceted health issues requiring emergency care. As the complexity of patients' conditions increases, so do the time and resources required for their care, adding significant pressure on ER nurses who often manage these high-acuity patients. High-acuity patients can be defined as those who require specialized care and frequent observation to maintain stability, such as individuals involved in a motor vehicle accident, experiencing a heart attack, or a stroke, or cancer patients with unchanged or even reduced staffing levels, including little to no secondary staff availability (Morley et al., 2018).

The surge in patients presenting with severe conditions frequently leads to extended ER stays, exacerbating the workload for the ER nursing staff, creating psychological stress, and enraged patients that can lead to WPV being transferred to ER nurses (Buerhaus et al., 2022). Many factors can influence the ER nurses' workload, such as the nursing shortage, which creates insufficient staffing levels, patient factors, severity

of the illness, complexity of care, the professional experience of the nurse, and the demands of the ER.

One of the primary reasons ER nurses face substantial workloads without proportional increases in staffing is the ongoing shortage of qualified healthcare professionals (Buerhaus et al., 2022). Hospitals and healthcare facilities often operate under tight budgetary constraints, leading to insufficient hiring of additional staff despite the growing demand (Buerhaus et al., 2022). The nursing shortage is exacerbated by the inability of many institutions to recruit and retain experienced nurses due to burnout, dissatisfaction, and the competitive job market. Consequently, the existing nursing staff must manage higher patient volumes and acuity levels with limited support, leading to increased workloads and job stress (Buerhaus et al., 2022).

Psychological Stress

ER nurses experience considerable psychological stress, which is due to high patient volume, high acuity patients, time pressures where decisions need to be made quickly, and witnessing traumas. Psychological stress is caring stress, emotional stress, and exposure to aggression from patients, all of which are directly related to the nature of the patients for whom ER nurses provide care (Buerhaus et al., 2022). ER nurses frequently manage a high volume of complex patients, many of whom present with urgent or life-threatening conditions, adding to the intensity and pressure of their roles. The fast-paced environment and the need to make quick decisions can contribute to high-stress levels. Caring for patients with complex medical conditions or severe injuries can be emotionally straining. Patients with complex medical conditions or severe injuries

often require emergent, intense care and attention, which can be stressful for nurses (Buerhaus et al., 2022). Patients often present with substance abuse disorders or mental health issues, which can present challenging behaviors, including aggression, non-compliance, and difficulty managing symptoms, adding to the stress experienced by ER nurses.

ER nurses often deal with trauma, suffering, and death, which can lead to emotional exhaustion and compassion fatigue. The inability to predict or control outcomes increases psychological stress (Buerhaus et al., 2022). Lastly, the ER setting is inherently chaotic and unpredictable, which can lead to feelings of uncertainty and frustration among nurses. Limited resources and high-pressure situations can exacerbate these feelings (Buerhaus et al., 2022).

Workplace Violence (WPV)

ER nurses are more susceptible to WPV due to a combination of environmental, social, and patient-related factors. WPV is defined as physical, verbal, and psychological assaults and bullying among patients or peers (Hassankhani et al., 2018). Patients can display anger or confusion about their medical care or have mental health issues and an altered mental status due to substance abuse. Emergency rooms (ERs) are fast-paced, high-stress environments where patients often arrive in critical, emotionally charged conditions (Hassankhani et al., 2018). The high-stress environments of the ER lead to contributing factors to WPV, such as the urgency of care, long wait times, overcrowding, and heightened emotions (pain, fear, frustration), which can trigger aggressive behaviors from patients and their families (Hassankhani et al., 2018).

ER nurses frequently care for patients with mental health disorders and those who are under the influence of drugs or alcohol (Al-Natour et al., 2023). These conditions can impair judgment, alter perceptions, and increase the likelihood of violent outbursts and attacks. ER nurses are often perceived as gatekeepers to care, leading to frustration when patients experience delays or dissatisfaction with treatment, which can create tension among ER nurses and their peers (Al-Natour et al., 2023). Patients and families may wrongly take their frustrations out on ER nurses, seeing them as barriers rather than caregivers. Additionally, some patients have a rising sense of entitlement, driven by heightened patient advocacy efforts and the perception that ER nurses are obligated to meet their every demand (Al-Natour et al., 2023). This can lead to disrespectful behavior toward ER nurses, including verbal and physical abuse. While substance abuse and mental health issues are significant contributors, the problem of WPV extends beyond drug-addicted patients. A broader societal shift in expectations and a decline in respect for ER nurses, compounded by the stressful conditions in the ER, have also contributed to the rise in WPV (Aljohani et al., 2021).

This study explored the challenges faced by ER nurses dealing with substantial workloads, psychological stress, and WPV that contribute to the nursing shortage from the perspective of the ER nurse. This study compared factors such as perceptions of increased workloads as a factor in exacerbating psychological stress, and the stress that can lead to vulnerability to aggressive behavior from patients, families, or peers, thereby exposing ER nurses to WPV (Aljohani et al., 2021). Although studies have explored contributing factors to the nursing shortage, this aspect has not been examined in this

way. Tamata and Mohammod (2023) suggested that contributing factors create a nursing shortage due to a lack of policy-making, training for solutions, and patient education. This study focused on awareness of these occurrences, not solutions, but on understanding the day-to-day struggles explained in the words of an ER nurse. Nunstedt et al. (2020) explored ER nurses' dissatisfaction with their workloads, but not in this way. This study explores the impact of substantial workloads on psychological stress and vulnerability to WPV. Leaf and Murray (2023) explained that the nursing profession is stressful and discussed ER nurses' perspectives on a solution that focuses on the "joy" of the profession. Although these studies have examined workloads and stress levels, they have not focused on an ER nurse's perspective of traumatic occurrences, and these studies mainly occur in countries other than the United States.

Summary and Conclusions

Healthcare organizations are often slow to adjust staffing models to reflect changes in patient acuity and volume (Haddad et al., 2023). Many institutions rely on outdated staffing ratios that fail to reflect the increasing complexities of modern patient care. The relationship between contributing factors such as substantial workload, psychological stress, and WPV, in conjunction with the nursing shortage, is cyclical (Haddad et al., 2023). As more ER nurses leave the profession due to contributing factors and the nursing shortage, the remaining staff must carry an even more significant burden, increasing their workload. This cycle perpetuates the shortage, as overworked ER nurses are more likely to experience job dissatisfaction and eventually leave their positions (Haddad et al., 2023). Additionally, the public perception of nursing as a highly stressful

and demanding profession discourages potential new entrants, further limiting the pool of qualified candidates to fill vacancies (Haddad et al., 2023).

ER nurses face significant psychological stress due to several interrelated factors (Haddad et al., 2023). The high patient volume and acuity, combined with the complexity and severity of patients, contribute to the demanding nature of their work. Additionally, managing patients with behavioral issues or substance abuse disorders introduces further challenges, including aggressive behaviors, treatment, and non-compliance (Haddad et al., 2023). The emotional burden of witnessing trauma and suffering, coupled with the chaotic and unpredictable work environment, exacerbates stress levels. Understanding the ER nurse's perspective of the daily challenges and warzone struggles may help them gain respect for their expertise among patients, families, peers, and communities.

Although researchers have investigated this issue, the topic has not been explored in this way. The nursing shortage in the ER and its contributing factors have become an emergent challenge. However, little has been investigated on the perception of the lived experiences of the ER nurse and their detailed occurrences of the contributing factors, including workload, psychological stress, and WPV, in the ER in the United States.

There is a clear identification of a severe shortage of ER nurses, which has a negative impact on healthcare quality overall (Drennan et al., 2024; Hodgson et al., 2024). Contributing factors such as workload, psychological stress, and WPV are the leading causes of ER nurses' lack of retention and the intent to leave (Hsieh et al., 2023; Saaiman et al., 2021). Even though research proposes intervention practices like retention strategies and increased pay (Hodgson et al., 2024), there is a lack of exploration of

targeted solutions specifically focused on the ER environment. These solutions should start by assessing ER nurses' lived experiences and perspectives in their jobs. Once the challenges have been identified, potential solutions that revolve around improving work-life balance for ER nurses can help alleviate the nursing shortage (Seller-Boersma et al., 2023).

Little has been investigated regarding the perception of the ER nurses' lived experiences and the detailed occurrences of contributing factors that result in a high ER nursing shortage. A study by Hayward et al. (2016) found that the primary factors contributing to nurses' decisions to leave the profession were psychological stress and feelings of disrespect. Therefore, this study is important because it provides policymakers and healthcare institutions with valuable insights and awareness by focusing on ER nurses and the unique challenges they face every day.

In conclusion, ER nurses face challenges that have deep roots in healthcare staffing and policy problems. Outdated staffing models and the lack of resources for hiring and maintaining staff have led to heavy workloads and tremendous psychological stress. This stress increases due to the complexity of patients and their entitlement behaviors. This increases violence against ER nurses from patients and peers (Haddad et al., 2023). The nursing shortage continues to increase as ER nurses become stressed and leave the profession, making it challenging to retain experienced staff and train new nurses. My findings will raise awareness and foster social change among current and future ER nurses.

In Chapter 3, I present the research method, the role of the research, the methodology, threats to validity, and data analysis.

Chapter 3: Research Method

Introduction

The purpose of my study was to explore the lived experiences of emergency room (ER) nurses. In Chapter 3, I present the research design and rationale, the role of the researcher, the data collection method, the data analysis, and threats to validity.

Research Design and Rationale

I conducted a qualitative, intuitive phenomenological study for my research design. The guided question for this study is, ″What are the lived experiences of emergency room (ER) nurses with the workload, psychological stress, and WPV?" Using qualitative traditions focuses on understanding the phenomena using non-numerical data. I conducted interviews with open-ended and follow-up questions that encouraged participants to provide detailed explanations and personal perspectives, helping me understand the "why" behind their experiences. The interpretivist tradition focuses on understanding human behavior and the meaning of their experiences and perspectives (Birt et al., 2016). These traditions guided my selection of theory, methods, and data collection, and provided a framework for interpreting my findings and reflecting on the philosophical and intellectual contexts within which the research emerged.

Role of the Researcher

The role of a researcher is key in expanding knowledge of evidence-based practice and finding potential solutions to problems. Ravitch and Carl (2021) suggested that the researcher must understand their role in the study. As a nurse researcher, I understand my privilege, intersectionality, bias, and components of my worldview that

have "shaped" my position concerning my scholarly work. As mentioned, this may be challenging when researching the nursing shortage, workloads, psychological stress, and workplace violence because it can be emotionally charged due to my experiences as an ER nurse, and the participants might be hesitant to disclose their experiences out of fear of being judged or punished. As a result, I was aware of the need to remain open to the findings, avoid any leading interview questions, and refrain from influencing participants' responses in a particular direction. I adhered to ethical principles, gaining informed consent prior to data collection, and established an atmosphere of trust and safety, ensuring that participants felt at ease discussing their experiences.

Methodology

Selecting participants for a qualitative, intuitive phenomenological approach requires identifying individuals willing to share their lived experiences related to the study. Participants should feel safe and free to discuss unpleasant occurrences. The components of participation selection include inclusion criteria, which are specific conditions that the participants must meet.

I used purposive sampling to recruit eight ER nurses for semi-structured individual interviews. Inclusion criteria included RNs with at least 5 years of ER experience, as they demonstrated clinical competency and repeated exposure to ER patient scenarios, which allow ER nurses to develop mastery in critical thinking, confidence, and commitment. Interviewing continued until data saturation was reached, at which point repeating themes confirmed saturation rather than adding to my understanding. I recruited participants through social media platforms, such as Facebook

and Messenger, using a flyer with detailed information about the study (see Appendix C). Once the participants agreed, I confirmed the interview by email. I developed and used an interview guide to elicit participants' lived experiences of the phenomenon. I asked questions in an online Zoom meeting. The participants' identities remained confidential, and each received a coded identifier (e.g., P1).

Saturation was reached when the same responses and themes were repeated, and no new information emerged. Eight participants were the anticipated number needed to reach saturation, based on research reviewed prior to the study. However, data saturation was achieved by the fourth interview. Data collection continued through interview eight to ensure data truly reflected saturation. Sarfo et al. (2021) suggested that the researcher determine the sample size based on the nature of the study, the complexity of the research question, the population, and the point at which saturation is achieved.

Instrumentation

The primary data collection method was an interview with open-ended questions. I used journaling to reflect on my thoughts and feelings while interacting with participants and gathering data from the interview questions. The interview questions were drafted based on research, my questions, and the reviewed literature. The interview began with introductory questions focusing on the ER nurses' background, for example, "How long have you been working in this field?" I then engaged with participants by asking core questions, such as "Can you describe an experience where you felt particularly stressed at work?" Probing or reflective questions were asked to elicit

additional information. I adjusted my questions to ensure clarity, flow, and the generation of meaningful data (Appendix C).

Procedure for Recruitment, Participation, and Data Collection

A recruitment flyer (see Appendix A) was posted on social networking sites, such as Facebook and Messenger. Interested individuals emailed me to express their interest and arrange an interview. I responded to inquiries by email and arranged a convenient interview time within 48 hours to acknowledge their interest and arrange a Zoom Meeting.

When I spoke to the individual, I asked them the following screening questions.

- Are you a registered nurse?
- Have you worked in the ER for at least 5 years?

If the individual answered 'yes' to the question, I proceeded to the consent form. Individuals who responded ‘no’ to the screening questions were thanked for their interest and informed that they did not meet the inclusion criteria.

I reviewed the consent form with the individual. I provided an electronic consent form that allowed volunteers to indicate their consent by email. If the individual were interested, they did email back “I consent” or “I do not consent” to participating in the study. The consent form stated that the individual understands the study and wishes to participate.

The individual had the option to print a copy of their signed consent at that time. After submitting the online consent form, I arranged an online Zoom Meeting.

At the interview, participants completed the demographic data sheet (Appendix B). I recorded participants' responses to the demographic questionnaire and began the interview using a researcher-developed interview guide (Appendix C). All interviews were audio-recorded on Zoom, enabling verbatim transcription and subsequent data analysis. Each individual interview lasted between 30 and 60 minutes. If more time was needed, I alerted the participants that the 60-minute time was approaching and ensured that they were willing to continue. After completion of the interview, participants were offered a thank-you gift of a $15.00 e-gift card.

Next, after transcribing each interview and completing the initial coding, I verified transcription accuracy with each participant and asked additional clarifying questions. I then analyzed the data, coded and developed themes, and verified that I had accurately captured the participant's experience through member checking. Member checking can improve data quality by incorporating participants' feedback and insights. Member checking can help stimulate deeper reflection and uncover hidden aspects of the participants' experiences, thus providing a more in-depth understanding of the phenomenon (Birt et al., 2016).

Data Analysis

I analyzed the data using Saldana's (2021) coding and data theming methods to provide thematic analysis. The first step was to read through the transcription several times. The second step is initial coding, identifying significant phrases and sentences. I used descriptive coding to summarize the primary segments of the data. I developed a codebook listing all codes. The third step was to identify and classify relationships among

the codes (Saldana, 2021). I then developed themes and refined them by writing detailed descriptions of each theme and how they relate to the research questions. Lastly, I reviewed all the themes and data to understand the causes of the variations, which guarantees a comprehensive understanding of the phenomenon.

Issues of Trustworthiness

I used specific methods to ensure the rigor and validity of my study. These included credibility, transferability, dependability, confirmability, and reflexivity.

Credibility

Credibility enhances the value of the study and measures how well the researcher established the reliability and accuracy of their findings, reflecting the degree to which the findings are believable and trustworthy (Birt et al., 2016). To ensure credibility, I employed triangulation by incorporating responses from all participants to cross-check findings and ensure consistency in the results through the combination of interviews. I reviewed the transcripts with participants to accurately describe their interview answers (Birt et al., 2016).

Transferability

Transferability ensures that the findings can be applied in other situations, contexts, populations, and times (Birt et al., 2016). I provided detailed information about the research context, participants, and findings, which can be applied to other contexts. I provided detailed information to understand the themes, including quotes from the participants, the setting, and the participants' behaviors. This method enables researchers to replicate some of the processes and procedures used in other studies (Birt et al., 2016).

Dependability

Dependability refers to the consistency and reliability of the research process over time. It ensures that the same results or findings would be obtained if the study were repeated under similar conditions (Birt et al., 2016). The audit trailing records the research activities, including changes, recruitment, data collection, and analysis procedures. This process ensures transparency, allowing peer reviewers to trace the method and verify the credibility of the findings (Birt et al., 2016).

In this study, data collection, transcription, coding, and analysis were clearly documented. The study provided a clear rationale for the coding and themes and accurately reflected and confirmed the ER nurse's lived experiences. Furthermore, I spent time reflecting on the interviews and ensured they were conducted consistently, using similar approaches to maintain stability. By using these methods, I built confidence in my findings, which are a reliable representation of the ER nurses' rather than the artifacts of the research process.

Confirmability

Confirmability refers to the extent to which the findings of a study can be verified by others (Birt et al., 2016). Confirmability ensures that the collected data reflects the participant's experiences and does not reflect the researcher's personal biases and interpretations. To ensure the accuracy of this process, an audit trail was used in conjunction with a research journal, and member checking was employed to share the data with participants for verification purposes (Birt et al., 2016).

Reflexivity

Reflexivity enables the researcher to be aware of their biases, values, and perspectives, and how these might influence the research process and the interpretation of the data (Birt et al., 2016). I used journaling to reflect on my thoughts and observations of the research process, and I participated in discussions with my committee throughout the research experience to remain transparent and accountable.

Ethical Procedures

Before beginning data collection, I obtained IRB approval # 10-10-25-0991243. This study was voluntary, and participants could withdraw at any time during the data collection or analysis phase without consequences. Before informed consent was signed, I explained the research purpose and study to the participants.

Confidentiality was ensured to protect the participants' right to privacy. Additionally, all digital recordings, transcripts, and notes are stored on a password-protected computer, alongside physical documents stored in a locked cabinet. I will maintain confidentiality by assigning pseudonyms to each participant (eg, P1, P2). Lastly, I will permanently destroy the data by deleting computer data and shredding physical documents after 5 years.

Summary

This chapter outlined the methodology employed to investigate the lived experiences of ER nurses and the factors contributing to the nursing shortage in the US. The research employed a qualitative research design to understand how participants interpret their experiences as ER nurses and the contributing factors, such as workloads,

psychological stress, and WPV, that contribute to the nursing shortage in the US. Purposive sampling was used to recruit eight participants meeting the inclusion criteria. Interviews were conducted to collect data, and I used field notes and reflective journals to document the process. A thematic analysis was completed to identify and analyze themes. Consent from the Walden IRB was obtained prior to collecting data.

In Chapter 4, I present demographic data, data collection methods, and the findings of my study via thematic analysis.

Chapter 4: Results

Introduction

The purpose of this study was to explore the lived experiences of emergency room (ER) nurses.

In Chapter 4, I describe the study's setting, the demographic analysis, data collection, data analysis, evidence of trustworthiness, and the results of the thematic analysis.

Setting

The research setting of a qualitative study describes the natural environment in which the participants are placed. It includes the physical, social, and cultural aspects that characterize the location where the researcher conducts the study (Bhattacharya & Geertz, 2025). The participants of this study are the currently employed Registered Nurses (RNs) working in Emergency Departments in the United States. Nurses working in this setting usually experience high pressure, high workload, and unpredictable work schedules, and may work daytime, evening, or night shifts (Duhalde et al., 2025). Additionally, their socio-professional context subjects them to work-related pressures that significantly affect their working capacity. For instance, they experience interdisciplinary tensions as they work interdependently with professionals from other departments, such as radiology, intensive care units (ICUs), and other trauma centers (Assawat et al., 2024). Thus, ineffective collaboration may lead to workflow disruptions and job dissatisfaction. Nurses working in the ER are also expected to care for patients of varying acuity levels

(Fekonja et al., 2024). They attend to patients with mental health issues, drug and substance abuse, and chronic health needs, which may require urgent care (Riu et al., 2024). During data collection, Zoom Meetings was used because it offered a private, virtual setting that guaranteed participants' confidentiality and was more convenient.

Demographics

The study included eight (N=8) registered nurses (RNs) working in the emergency rooms (ERs). Six participants were female, while two were male. Most participants were 45 years of age or older, with the following age distribution: 25-34 years (N=1), 33-44 years (N=2), and 45-64 years (N=5). Eight participants identified as White or Caucasian. All participants were from the United States. Eight participants reported their job title as Registered Nurse, and all but one were employed full-time. Six participants held a Bachelor's degree as their highest level of education, while two held an Associate degree. The participants' years as RNs ranged from 6 to 35, with an average of around 15 years, suggesting they were experienced in their nursing roles. The distribution of years that the participants worked in an ER setting is as follows: 6 years (N=2), 7 years (N=2), 10 years (N=1), 11 years (N=1), 23 years (N=1), and 24 years (N=1). The range of years the participants worked in ERs was between 6 and 24 years.

Data Collection

The data collection for this study involved two major phases: (1) the collection of demographic data and (2) the collection of their lived experiences in the ER setting using semi-structured interviews. The questionnaire collected participants' details, including age, gender, place of birth, highest educational level, current employment status, job title,

ethnicity, country of origin, marital status, general health status, and years worked as an RN and in ERs (see Appendix B). The semi-structured interview included open-ended, non-leading questions (see Appendix C). Before beginning the interview, I greeted the participant to create a rapport and provided a brief overview of the study. During the interview, I ensured that the questions were unambiguous. This method helped ensure that the question was specific to the participant and clear. For example:

> Can you provide me an example of a substantial workload and describe the types of patients that you've seen when you are in the ER? Was it 4 to 1?
>
> 2 to 1, 3 to 1, 8 to 1. How was your workload?

Recruitment flyers (see Appendix A) were posted on professional nursing social networking sites, such as Facebook and Messenger. Individuals interested in participating in the interview emailed the researcher. I contacted them by email and arranged a convenient interview time within 48 hours. Each participant met the following criteria: (a) has been a registered nurse (RN) for 5 years or more, and (b) has worked in the ER for at least 5 years.

After confirming their availability, I sent them a demographic sheet and a consent form (see Appendix B). The consent ensured that the participant understood the purpose of the study, asked whether they agreed to share their demographic information, and provided assurance that the details would be kept confidential.

A semi-structured interview was conducted via Zoom, and information regarding the phenomenological study was captured. The interview was recorded, and transcripts were assigned pseudonyms (Participant ID: P1, P2, P3, …, P8). Field notes were used

before the interview to record the interviewee's scheduling day, time, and platform. I also used field notes to create a reflection on the interview and a general assessment of whether participants answered all questions satisfactorily. I also used journals to record personal reactions, tension, and rapport after every participant's interview.

Data Analysis

The data analysis approach for this study was guided by Saldana's (2021) coding framework. The purpose of this analysis is to understand the lived experiences of emergency room nurses regarding workload, psychological stress, workplace violence, and other factors contributing to the nursing shortage in the United States. The approach consisted of five major phases. The first phase was data familiarization, in which I reviewed each transcript and used memos to summarize the participants' responses. This phase allowed data immersion by deeply engaging with the data (Saldana, 2021). It marked the foundation of gaining insights into the data and identifying patterns in the earlier stages of thematic analysis.

The second phase was first-cycle coding, where I identified words and phrases relevant to the research question. In this stage, I used descriptive coding to assign codes and labels, an approach that helped to capture the surface-level meaning of the participant's experiences. NVivo software for qualitative analysis was used for the coding process. I imported the transcripts into NVivo and assigned labels to the meaningful sentences. For example, "I've taken care of medical emergencies, traumas, overdoses, burns, respiratory, cardiac" was coded as "Variety of Patients." These codes were powerful, unique, and recurring. These codes captured the essence of the data and the

true meaning of what an ER nurse represents. These initial codes help create a codebook that documents each code, which is crucial for the transparency and dependability of the thematic analysis process.

The third step was second-cycle coding, which involved refinement of codes and identification of relationships among them (Saldana, 2021). For example, the code "Variety of Patients" was refined to "Extreme Patient Acuity." After refining the codes, I categorized them by their relationships. For instance, the codes, "Extreme Patient Acuity," "Nurse-Patient Ratios," and "Sicker Population," were categorized as "Workload."

The fourth step was theme development from the categories created. Themes represent the recurring patterns and shared meanings of the participants' lived experiences (Saldana, 2021). The categories, "Workload," "Responsibility," and "Systematic Neglect in Staffing," all resulted in the theme "The Overwhelming Reality of ER Nursing." Then I reviewed the themes and wrote descriptions of what each represented and how they related to the research question. In addition, reviewing helped ensure that they captured the participants' actual reflections and sufficiently addressed the research question.

The next step was to conduct a comprehensive review of themes and supporting data, which helped clarify variation in experiences across participants. The final themes provided an extensive understanding of the lived experiences of nurses working in the ERs. The total number of themes after review was five.

Evidence of Trustworthiness

Credibility

To ensure that the findings reflected triangulation, the analysis and comparison of insights from eight participants' experiences, with participants from varied age groups and differences in total years worked in the ER, and cross-verification, which created similar themes (Birt et al., 2016). I engaged with the participants to develop and repeatedly read through the transcripts to gain a better understanding of their responses. Then I identified key patterns emerging from the participants that reinforced the consistency and believability of the findings. During the interview, I asked for clarification to ensure that I accurately captured the participants' responses.

Transferability

Transferability means that research methods can be used in other contexts (Birt et al., 2016). To achieve this, I described the research setting comprehensively, discussing the physical, organizational, and socio-professional contexts of the participants. I highlighted the participant's demographic characteristics, including gender, age, and years as an RN in an ER setting, among other details. In addition, the results were accompanied by direct quotes from the participants, further demonstrating that the findings were grounded in the data and represented the participants' lived experiences.

Dependability

Dependability refers to the stability of the research process, ensuring it can be replicated over time (Birt et al., 2016). To attain this, I established an audit trail that documented every stage of the research process. Recruitment emails, demographic data

sheet, original audio, transcribed files, coding files, and codebooks were documented to promote transparency of data collection. The analysis was conducted in NVivo, and a codebook was produced that contained descriptions of categories and themes to ensure consistency and facilitate easier comparison among participants.

Confirmability

Confirmability ensures that the findings are neutral, objective, and verifiable by other researchers (Birt et al., 2016). To accomplish this, I used reflexive memos to document personal assumptions and analytical reflections, ensuring that the findings reflected the participants' views rather than my bias. I also used the audit trail to show that the findings were drawn from the participants' accounts. In addition, themes were developed from the codes of different participants, and they were continually refined to ensure they aligned with participants' perspectives.

Reflexivity

Reflexivity represents the researcher's critical self-reflection and its influence on the research (Birt et al., 2016). I acknowledged my status as an RN, indicating I was aware of some nurses' lived experiences. However, I remained neutral and did not allow my thoughts to influence the participants' responses. This practice helped in maintaining transparency and accountability.

Results

Theme 1. The Overwhelming Reality of ER Nursing

Workload and Extreme Patient Acuity

The first theme represents the overwhelming nature of the nursing role in the ERs. This theme had three sub-themes: Workload, Responsibility, and Systematic neglect in staffing, which are potential factors for nursing shortage. The participants cited a heavy workload stemming from extreme patient acuity and diverse care needs. One participant noted:

> You see people in probably the worst times of their lives. So, some of the things you can get past, and some of them you can't, you know. People will come in crying and distressed, and they don't know what's wrong, and they want answers, and I can relate to that. I understand. People deal with things differently, but some people come in just angry. They're just angry, they're hurt, and angry, and they don't understand. [P1]

P6 added,

> We've seen a lot of inmates, a lot of overdoses, or stabbings. Well, what we called it was incarcerates, like people would get arrested, and they would say they had chest pain so that they could go to the ER. [P6]

Another participant highlighted that they received patients with severe conditions that required prompt treatment and added that this population consumed additional time in monitoring their signs, symptoms, and consulting with other professionals:

> Level 1 or level 2 patients. They weren't going to be a sprained ankle, or a nosebleed, or, you know, somebody with a laceration on their finger. Those were going to be your stroke patients, your STEMI (heart attacks) patients, your sepsis patients. If you got really sick patients who require every 15-minute vital signs

> monitoring, and that are requiring drip titrations of critical drips, and communications and consults with neurology, or with cardiology, and, you know, even in those kinds of situations, even only having 3 patients, that can be an overwhelming night in the emergency department. [P5]

Such responses make it clear that an excess of responsibilities and a lack of support are all too common in this profession.

High Nurse-Patient Ratio

The participants raised concerns about the high nurse-patient ratios, claiming an increased workload as they attended to more patients than recommended. When asked to provide an example of a substantial workload, the participants stated:

> The worst was 5. The best was when you got the ICU hold; it was one or two, but typically, it ended up anywhere between three or four. I'd say substantial was the one time I had 9, but they were all ER holds during COVID. [P4]

P5 added,

> I've been responsible for up to 7, 8, 9 patients at a time. [P5]

P7 added,

> And it was not uncommon, even though we were supposed to be 5 to 1, it was not uncommon for us to have 6 to 8 patients on multiple drips. [P7]

P8 added,

> It was typically 4 to 1 on the acute care side. There were occasions where there were lower than supposed to be. In theory, lower acuity patients, and you could take up to 5 or 6. [P8].

Sicker Population

Nurses in the ER setting also noted that the increasingly sick population is a significant factor in the high workload. Chronic diseases have increased, ERs have become overcrowded, and because of the subsequent burnout, some nurses opted to leave their jobs, enhancing the nursing shortage.

> In fact, there is still obesity, there is still diabetes, and there is still hypertension; these are still the three main reasons people come in. There is still COPD. [P1]

P6 added,

> And when I worked in the ERs in California, they were so overcrowded. That was really bad. They would have 150 people waiting on beds, and I hated the dignity, because they had everyone in these wheelchairs that would recline like a stretcher, so if they had to use the bathroom, you had to recline them and put, like, a partition around them. [P6]

P7 added,

> But we're just a sicker nation, so where it was unusual to have a sick patient come in the ER on a daily basis. Now we are getting 30 of them on a daily basis, and so that high acuity with the nursing shortages, with fewer support staff, I think that is what is burning people out, and is also contributing to the shortage. [P7]

More Nurse Responsibilities

The participants also discussed the increasing number of responsibilities that overwhelmed them. Sometimes they executed roles which were beyond their scope, as P1 said:

> You definitely have more responsibility. You're responsible for catching lab values ahead of time, even if they are or are not called to you; you're responsible for catching the doctor's mistakes, let us be honest. I mean, we have all caught those several times. You are everybody. You're the pharmacy, you are the dietitian, you are the med nurse, we're the MET team. For God's sake, half the time they don't have a MET team, so that it can go sideways, and you're it. You know? So, you wear a lot of hats, and we are transport too. [P1]

Other participants noted that responsibilities have increased due to nursing shortages, which affect patient outcomes.

> You have more responsibility as a nurse because of the staffing shortages, you are EKG techs, or you are phlebotomists, or you know, in-house pharmacy. There was a facility I worked at where, after 7 pm, we didn't even have an in-house pharmacy. We had to call a sister pharmacy 2 hours away to talk about mixing a med or dosing. So, making cuts like that, and your ancillary staff does not help, and that has been happening more and more. [P7]

P4 added,

> Short staffing is leading to increased patient dissatisfaction and poor outcomes. [P4]

One participant was concerned about the removal of housekeeping services in the emergency department, which made them assume responsibilities they were not supposed to, while another noted that the shortage was man-made because healthcare has become more profit-oriented.

> They cut out housekeeping in the ER. So, they actually gave us mops, brooms, and dustpans. You know, and wanted us to do it, and we were already cleaning our own beds and cleaning everything off, cleaning the trays and everything. The trash was piling up, and I think they realized that they had to bring them back to the ER. We did not have time to bag all the trash and mop the floors [P6].

P4 added,

> I say there probably is not a nursing shortage. It is man-made by management. Profits over patients. [P4].

Despite the increased workload, some participants also noted that they were under pressure from the administration to maintain patient satisfaction. Even when understaffed, nurses were still required to meet high patient demand.

> I think the biggest thing is this management push for patient satisfaction. [P4]

P8 added,

> However, if management is busy and there is a shortage in staff, then you are expected to keep productivity going; you know, you are supposed to keep things going. You do not want to delay, and I feel like everything is timed. [P8].

Theme 2. The Psychological Stress and Trauma That Nurses in the ER Undergo

Mental and Psychological Burnout

Nurses in the ER setting also reported cases where they experienced psychological stress. They were subjected to various stressors, including burnout, systematic understaffing, and pressure of maintaining a work-life balance. The participants said:

> So, you are a male ER nurse; they probably expect you to do a lot of lifting of patients, pulling patients up, pulling patients over from one cart to the other, or one stretcher to the other. The biggest reason I am considering leaving is that, increasingly, I see nurses not just expecting to do nursing work, but we are phlebotomists, we are EKG techs, we are CNAs, we are housekeeping, you know, we are, in some cases, the doctors, and not that I am qualified to be a doctor. I worked a shift at a hospital last weekend where I had a chest pain patient sitting (waiting) for hours. [P4]

P6 added the reasons for leaving:

> Mine was more personal. My kids at the time were, like, 6th grade and 8th or 9th grade, and it was just work-life balance. I never got out of work on time, and they would be home from school for hours alone. [P6].

In some cases, the psychological stress developed into anxiety and depression, as one participant noted:

> I do not think I noticed what it was doing to me when I was working in the ER. I think it was after I took a little hiatus that I realized. But there was quite a bit of stress, and I think that led to anxiety, some depression, and you compound that with everyday life and other things going on outside of work. [P8].

Psychological Trauma

Apart from the burnout, the ER setting subjected nurses to psychological trauma, which affected their well-being, such as receiving patients soaked in blood and seeing patients in their final days.

> There are a handful of things that stick with me, I will never forget them; one of which I had a patient who was offloaded from EMS, so we thought he had just something; he was 40-something, but it was just blood, there was just blood everywhere, and he is like, I need help, and all of a sudden, he starts desating, and I am like, I get it, you know, he can barely talk to me. So, I literally looked at him and said, "I need you to sit back in the bed, because I'm going to have to breathe for you." [P1]

P7 added,

> But they were much sicker patients, and the fact that they did not have family around, and when patients were dying every day, on us, we were having to fulfill the emotional role of the family, the stressful role of the family not being able to be there. Yeah. to see their loved ones, and of course, having patients die daily on us. [P7]

These traumatic events may have severe impacts on the nurses. One participant noted having developed Post Traumatic Stress Disorder (PTSD) during the coronavirus pandemic:

> I have PTSD from working. During COVID, I had many, many situations over those first 18 months of my career. I recall running down the hallway with armfuls of medications and just tears running down my face because. I was so overwhelmed, and I had no idea really what I was doing, what to do next, how to manage the caseload that I had. I have vivid memories of running into a hallway out of a patient's room as they are actively coding, and I'm the only one. [P5].

Coping Mechanism

While nurses working in ERs experience a psychological toll, some noted that they have developed survival mechanisms. One strategy is emotional detachment and embracing resilience, as noted by one participant:

> Gotta have thick skin. Cannot wear your heart on your sleeve. Because if you wear your heart on your sleeve, you are going to end up heartbroken. [P4]

Theme 3. Workplace Violence and Lack of Administrative Support

The third theme illustrated hostility toward nurses working in ERs. Participants described events where they suffered physical, verbal, and psychological abuse. However, they were concerned about the administration's reluctance to address the issues.

Physical Abuse

The participants noted several incidents in which they perceived they were harassed by patients and family members. They were subjected to physical attacks, making their working environment unsafe. The participants said:

> I have been physically assaulted by a couple of patients and family members. I have been disrespected. So, one in particular, she ended up having a frontal lobe stroke, and while we were trying to take care of her, she spit in my face, she kicked me in the chest, and she scratched me. [P3]

P6 added about WPV, and saving a man’s life from an overdose.

> I got knocked out one time by a patient that I gave Narcan to. But they were mad. The guy said, you took my high away. [P6]

P8 added about WPV,

> I have had all of the above, as far as verbal, mental, emotional, and physical abuse. Most often, it is the patient or the patient's family. There have been some occasions where physicians are bullying. They (patients) attempted to bite. I have been hit, punched, yelled at, and spit on. [P8]

Verbal and Physical Abuse

Nurses working in ERs also suffered verbal abuse, from insults to threats. At times, these verbal abuses escalated to physical abuse. The participants stated:

> I have had simple stuff like name-calling all the way up to threatening to kill, come back and kill. I had a mother who took a child out, and I followed her, and she tried to run over me with her vehicle. [P8]

P7 added,

> I had a patient the other day who was just nasty. Anything we did, she was not happy with. She was cursing us up one side down the other, telling us to get out of her room, telling us not to touch her, just being nasty. She went to swing at me. [P7]

Bullying

Nurses also mentioned that family members who feel they are not satisfied with the treatments and care provided bullied them. In other cases, the management team bullied them, as the participants noted:

> Family members can definitely be a problem, especially when you have a really protective family member. A lot of times, it is for the elderly. It is usually not as much for children as you would think it would be. It is mostly for elderly people.

> My grandpa, my grandma, my dad, and especially the people around dad and the mom. I do not understand why you are not letting them do this, or why you're not letting them do that. Sometimes I can sit down and take that extra 10 minutes to explain it to them, and they feel a little bit better about it, but initially, they are coming at you very upset, very angry. They are like, I do not understand why you do not have any results. What are you doing? What is your plan? [P1]

P5 added,

> I experienced a really significant bullying and gaslighting incident that actually came down from upper management. When I worked at that same facility, I was pigeonholed into the role of triage nurse after being out of nursing school for 9 months, which is completely inappropriate; 9 months is not enough time working in the emergency department to be a competent triage nurse at a level 2 trauma center. But that is the role I was put into, trained for, and then expected, after a couple of weeks of training, to be able to manage a waiting room full of very sick, very unhappy people. Me, a CNA, and a nurse practitioner, and there were three of us, and generally between 30 and 50 patients in the waiting room. [P5]

Psychological Abuse

Nurses in the ER setting also suffered psychologically, especially when patients who should be attended to in the primary care setting were directed to the Emergency setting. Some intoxicated patients also engaged in behaviors that participants perceived as degrading them. The participants said:

> But the big thing is, the primary cares are shelling stuff off on us (ER). Just because we are open, so they do not have to deal with them at primary care, just always telling patients, "go to the ER." And the urgent care does similar things; it is like, oh, well, we cannot do that, or oh, I am sorry, we are closing. We cannot see you. If you think it is an emergency, go to the ER and be seen. [P4]

P6 added,

> We would get alcoholics in, you know, and they were aggressive. They would throw poop at you, and we had a shower outside, and we would shower them off. [P6]

Lack of Institutional Support

Participants noted that they did not receive any support from those in authority; instead, administrative teams instilled fear among the nurses and were perceived as more concerned with patient satisfaction than with staff safety, especially after a WPV incidence.

> At no time did administration, at any point, acknowledge that or offer any kind of debriefing afterwards. It is just kind of like it is part of the job, and you go with it. You know, they might put a flyer up or a sign up, but it is a felony to assault a nurse, but there is no real punishment. No one is really held accountable. [P8]

P6 added,

> You have to be careful how you say anything, too, because then you will get in trouble with the administration. Why am I getting bad scores (patient satisfaction

surveys) from this person (patient) who thinks it is okay to curse you in the hospital. [P6]

Theme 4. The Dual Nature of Job Fulfillment

The fourth theme portrayed the nurses' internal conflict: at times, they are satisfied with the job, and at other times, they are not. The dual nature of nursing roles explains why some choose to remain and work, and others leave.

Job Dissatisfaction

Job dissatisfaction may stem from various sources, leading to reduced morale. Participants expressed their view that management and patients did not view them as humans but as resources, and the dehumanization extended from management and patients to the broader community. The expressed lack of appreciation from the patients, family members, and administration also caused dissatisfaction.

> Management sees us as a resource, not as humans. Does that make sense? And then patients also see us as a resource. [P3]

P5 added,

> I feel like we are a little bit of the black sheep of the nursing community. ER nurses are sometimes looked down upon as, like, lazy, or like, skimping, or, like, cutting corners, and it is not like that, I'm not. If I am sitting there on my butt twiddling my thumbs, yes, I am going to give the scheduled meds, yes, I am going to do the skin assessment. If I have nothing else to do, but the times that I have nothing else to do in the ER are essentially, it just does not happen. [P5].

P8 added,

> Up until the point where I wasn't (satisfied), it was just, like, flipping the switch, and I think a lot of that comes from a lack of appreciation from the patients you are taking care of, the families, and the administration. I think things have gotten worse over the last 20-some years; I can tell there is a lack of respect for medical professionals. [P8]

Job dissatisfaction also stemmed from the workplace, especially when a poorly handled patient was referred to the ER. Inheriting mismanaged patients is stressful, and the nurse had to repeat some procedures before initiating follow-up care. In addition, participants noted that in some circumstances, administrative leadership demotivated nurses. While laissez-faire administration may be appropriate in some workplace settings, one participant felt it was ineffective in the ERs.

> Probably the most dissatisfaction I get from work is when I get handed a patient from another nurse, or one who has been here for a little while, and they are an absolute train wreck, and nothing was done. I think it is like going into a kitchen, getting ready to cook dinner, and it is a mess. You gotta clean up first before you can even make progress. [P1]

P2 added,

> Just absolutely riddled with problematic staff and laissez-faire administration. And people in the administration who cannot see past their spreadsheets to get out on the floor and find out what the problem is. [P2]

Job Satisfaction

Amid the displeasure, nurses felt they had a professional duty to meet their patients' needs. They got fulfillment from their clinical competence, positive patient outcomes, and post-service gratitude. The participants stated:

> I am an ER nurse, and that is where I belong. It is what I am meant to do, because I feel like I have those skills, and I should not let the skills go to waste. That is the satisfaction I get from being a nurse, and especially being a nurse in the ER, to see people get better and go places. [P1]

P5 added,

> The most thing I frequently think about is changing my specialty and doing something else, but the reality is that I was drawn to the emergency department for a reason. It is knowing that I have the knowledge and the skill to help somebody in their most devastating moment; the knowing that I can see someone who has been shot or stabbed, I can see someone who is having a heart attack, or one who is having a stroke, and I know exactly what to do to help them. And then I can do that and see results. [P5]

P7 added,

> It is those good patients, those ones that, you know, are thankful that, you know, you have actually made a difference in their life. [P7].

Theme 5. Solutions to Ending Nursing Shortage

Fair Compensation

After documenting the issues contributing to the nurse shortage in the United States, this theme presents actionable solutions. The first solution is reviewing the

compensation structure for nurses working in the ERs. One participant stated that payment should align with the nurses' skills:

> I think nurses should get paid based on their skill set. I think if you are an ER nurse or an ICU nurse, you should get paid more than a med-surg nurse. I think there should be a scale to that, just like there is in every other profession. [P1]

Participants expressed the view that compensation should reflect nurses' experience as they assume greater responsibility, including their roles in training and mentoring recruits in the emergency department. Participants also noted the need to hire more nurses to improve healthcare and reduce workplace conflict.

> They need to start paying people with experience. As far as nurses and longevity, they need to show some appreciation to those people, because they are the ones who will be teaching the new ones coming in. If you want me to take a leadership role, you are going to have to give them some reimbursement for it. I'm not going to take a pay cut for longer hours and more responsibility. [P8]

P2 added,

> I mean, put more bodies on the job. Hospitals and corporations put more people and more money on man-hours to make less friction. [P2].

Structural Solutions

The participants also felt a need to strengthen cohesion between those in authority and the junior staff. Some believed in forming unions to promote fair compensation and improve working conditions, while others recommended employing adequate staff to reduce burnout. They said:

> I am not usually for a union, but I have noticed that, working in facilities where unions have been, the facility I am at is now union. That has made a huge difference, not only in pay, but also in maintaining those nursing ratios and not stretching them. It would also be nice if management said, we went from 4 to 2 (patients). [P7]

P5 added,

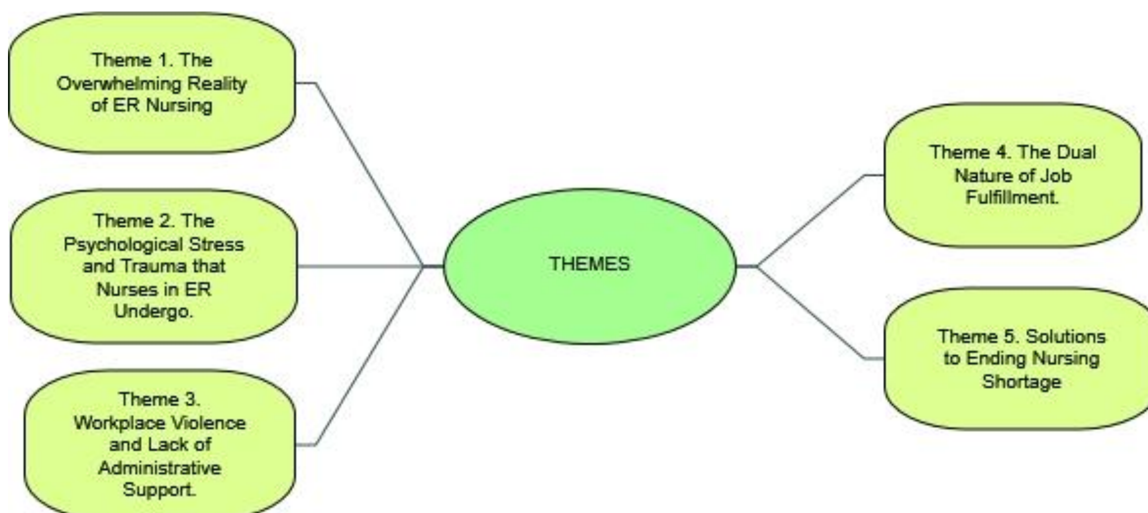
> Adequate support staff, so the hospital is not just being adequately staffed with nurses, but being adequately staffed with ancillary staff to perform all of the extra tasks that nurses are currently being charged with during shifts, and I think this comes down to administration implementing policies and programs to reduce burnout, to reduce compassion fatigue, to reduce PTSD from these trauma situations. [P5]

Participants noted that reforms are required in nursing education to ensure nurses can meet the diverse needs of patients and stay up to date with modern healthcare systems. One participant proposed a review of the nursing curriculum to better align with the contemporary ER environment.

> I think that a lot of people do not talk about is that nursing school is extremely prohibitive. And I think that the way that nursing programs, like nursing education, are structured is very backward and outdated, and I think that a lot of modifications could be made to the way nurses are trained that would improve. [P5]

Figure 2

Themes From the Findings



Summary

This chapter outlines the study's setting, demographic analysis, data collection, data analysis, evidence of trustworthiness, and the results of the thematic analysis. The study included registered nurses working in emergency departments, and they are appropriate for the study because they care for patients with varying acuities and are subject to high workloads. I collected data from eight participants across two stages: demographic details and nurses' lived experiences in the ER setting, via semi-structured interviews. The interviews were conducted via Zoom, and data analysis followed Saldana's (2021) coding framework. NVivo software for qualitative analysis was used to code and develop themes. The analysis process included the following stages: data familiarization, first-cycle coding, second-cycle coding, theme development, and, lastly, a comprehensive theme review.

The study's credibility was achieved through in-depth engagement with the data and the review of transcripts. Participants' context, including their physical and socio-professional aspects, was fully described to enhance transferability. The use of an audit trail throughout all stages of data analysis enhanced the study's reliability. Reflexive memos and audit trails also helped ensure the confirmability of the research. Lastly, the study attained reflexivity by preventing my biases and assumptions from influencing the participants' responses. Five themes were developed: (1) The Overwhelming Reality of ER Nursing, (2) The Psychological Stress and Trauma that Nurses in ER Undergo, (3) Workplace Violence and Lack of Administrative Support, (4) The Dual Nature of Job Fulfillment, and (5) Solutions to Ending Nursing Shortage.

In Chapter 5, I provided a discussion, a conclusion, and recommendations for my study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the lived experiences of emergency room (ER) nurses concerning workload, psychological stress, and WPV. To gain this perspective, ER nurses who remained in the ER setting and those who wished to leave the ER were recruited for the study. A qualitative study using a descriptive-phenomenological design was conducted in October 2025 with 8 participants.

Five themes emerged from an analysis of the data. These themes were: First theme, Second theme, Third theme, Fourth theme, and Fifth theme. In this chapter, I will discuss the following sections: the interpretation of the findings related to the theoretical framework and literature; limitations of the study; recommendations; implications; and conclusions.

Interpretation of the Findings

The Overwhelming Reality of ER Nursing

The study filled a gap by providing a deeper understanding of the factors that influence ER nurses' decision to leave the profession, as explained by ER nurses themselves. Nurses working in ERs report being overwhelmed by their workload because they care for patients of varying acuity. The research indicated that nurses working in ERs deal with patients at their worst times of life, some crying and others distressed. Others reported being angry and hurt, not understanding what was happening to them. These results aligned with Saaiman et al. (2021), who found that nurses in ERs care for patients of varying acuity. Juvé-Udina et al. (2020) also noted that patients with varying

acuities had distinct care and safety needs, a critical factor that increased nurses' workload in ERs. In particular, Juvé-Udina et al. (2020) highlighted that patients in step-down units (SDU), surgical floors, and combined medical-surgical step-down units (CMSU) were common and had high acuity. The study showed that at times, nurses in ERs care for high-acuity, unpredictable, and rapidly changing patient workloads that require specialized skills to maintain safety. However, adequate staffing is crucial to match high-intensity needs with appropriate staffing levels. These findings aligned with those of Maceri et al. (2019), who noted that nurses were concerned about receiving patients with needs they could not adequately address due to inappropriate staffing levels.

Moreover, the study confirmed prior research findings that the high nurse-to-patient ratio overwhelmed nurses in ERs. Some nurses claimed they could handle five or more patients at a time, which increased their burnout. These findings were similar to those of Haddad, Annamaraju, and Toney-Butler (2023), who found that healthcare centers with high patient-to-nurse ratios experienced higher nurse burnout and dissatisfaction, and that their patients received lower-quality services. Ismael et al. (2024) also found that high nurse-patient ratios led to patient dissatisfaction because available nurses could not meet patients' high demands.

Apart from the high nurse-to-patient ratio, the patient population presenting to ERs exhibits higher acuity, which increases their workload. The study showed that nurses were required to handle more patients because healthcare centers are overcrowded. Nurses in this study noted the rise of patients with obesity, heart failure, strokes, COPD, and, combined with the understaffing, the available nurses suffered from the resulting

workload. These records were similar to those of Salway et al. (2017), who noted that hospitals reached capacity, as patients were admitted in the morning and afternoon. Salway et al. (2017) further noted that overcrowding led to ambulance diversion and that nurses could not respond effectively to catastrophes.

Furthermore, nurses working in ERs also reported increased responsibilities, ranging from serving as “pharmacists” and performing EKGs to serving as phlebotomists and housekeepers, and placing numerous doctors’ orders. These findings were similar to those of Saaiman et al. (2021), who noted that nurses working in ERs performed duties beyond their scope, including clinical tasks, provided emotional support to patients, and provided leadership when necessary. These tasks put pressure on nurses in ERs, prompting them to leave their assigned roles and seek alternatives.

The Psychological Stress and Trauma That Nurses in the ER Undergo

The study found that nurses working in ERs experienced mental and psychological burnout, contributing to the shortage of nurses in the United States. Some notable stressors included taking on more duties, such as moving patients. Some participants also acknowledged having developed depression, anxiety, and post-traumatic stress disorder (PTSD). These results aligned with the findings of Jiaru, Yanxue, and Wennv (2023), who noted that nurses working in ERs had many responsibilities, including caring for severely ill patients, managing multiple diseases, and performing heavy rescue tasks. They further added that excessive occupational stress increased the nurses' risk of developing depression, which lowered their quality of life. The study also found that nurses working in ERs did not realize that they had developed mental health

issues because of the tight schedules. These findings were similar to those of Abu El-Kass et al. (2025), who found that occupational stress levels were high among nurses working in ERs and had adverse effects, including fatigue, anxiety, and absenteeism.

In addition, nurses working in ERs were exposed to traumatic events. The participants noted such events as dealing with patients soaked in blood and seeing patients dying every day. Consistent with the literature, these traumatic events overwhelmed the nurses; they caused emotional distress and low productivity (Buerhaus et al., 2022). The participants discussed that they had adopted coping mechanisms to deal with the substantial workload and psychological stress. One participant noted that they have developed thick skin, which they viewed as making them more resilient. These findings aligned with those of Stone and McMillan (2016), who reported that nurses developed thick skin to cope with extreme workplace pressures.

Workplace Violence and Lack of Administrative Support

The study also showed that workplace violence was a critical challenge that nurses working in ERs experienced. The participants reported physical, verbal, and psychological abuse. Participants noted that these attacks came from the patients and family members, with aggressive behaviors, frequently triggered by substance abuse. These findings aligned with the literature, which showed that nurses cared for emotionally charged patients and worked in high-stress environments (Hassankhani et al., 2018; Al-Natour et al., 2023). Some participants noted that patients and family members verbally abused them when they experienced delays and felt that the nurses were not delivering the services as they anticipated. As a result, nurses felt dejected and

undermined. These findings aligned with the literature, which showed that nurses are often regarded as gatekeepers and must deal with dissatisfied patients (Al-Natour et al., 2023). The issue of WPV had long-lasting consequences, as participants reported feeling their competence challenged, which demotivated them. These findings aligned with those of Jackson et al. (2025), who noted that WPV is associated with lower-quality care for patients and staff, leading to inefficiency. WPV contributed to the nurses' shortage, as unappreciative work increased their intent to leave their jobs (Hsieh et al., 2023).

However, the participants noted that the administrative lack of support worsened the situation. Seemingly, the administration had tolerated reported conditions and had inculcated a culture of WPV tolerance, leading to ERs being unsafe work environments. One participant noted that, despite reporting the matter, they did not receive any support from the administration and that no one was held accountable. The participants indicated that the administration was more concerned with achieving quality markers than with nursing safety. These findings aligned with those of Tamata and Mohammod (2023), who noted that the lack of policymaking had contributed to a nursing shortage. The administration overlooked issues affecting its staff, which reduced nurses' motivation to continue working.

The Dual Nature of Job Fulfillment

The dual nature of the nursing job was also a factor contributing to the nursing shortage in the United States. Job dissatisfaction stemmed from disrespect and a lack of appreciation despite working hard to meet patients' needs. Some participants noted that management, patients, and family members did not accord them the dignity they

deserved. Participants said that they were perceived as a resource rather than human beings and were called “lazy.” The findings aligned with those of Al-Natour et al. (2023), who noted that patients felt entitled to have their needs adequately addressed by nurses. Participants in this study also noted that some leadership approaches used by the administration, such as laissez-faire, demotivated nurses. Poor interpersonal relationships with patients and with administrators led to dissatisfaction and job turnover in the nursing industry. This is consistent with Herzberg's Two-Factor theory, which holds that factors that lead to dissatisfaction increase the likelihood of job turnover, further exacerbating the shortage (Herzberg, 1976).

However, not all situations caused dissatisfaction among nurses working in the ERs. Some participants noted that they derive fulfilment from working in ER settings. According to Herzberg's Two-Factor theory, motivators create a sense of meaningfulness in one's work (Herzberg, 1976). The study found that nurses felt motivated when they received recognition after caring for patients. These findings aligned with those of Staempfli and Lamarche (2020), who noted that nurses feel motivated after helping a patient recover and resume normal conditions.

The findings demonstrated the explanatory power of Herzberg's Two-Factor theory. Participating nurses noted that recognition is a critical factor in motivation, which aligns with Herzberg's Two-Factor theory. The presence of motivators promotes job satisfaction, and their absence may not cause active dissatisfaction but may lead to a lack of fulfillment (Herzberg, 1976). Nurses working in the ER setting reported feeling motivated when patients, family members, and administrators recognized their work.

These findings also resonate with those of Al Ahmari et al. (2023), who reported that recognition among nurses is an empowerment strategy that promotes their self-efficacy. Al Ahmari et al. (2023) noted that recognition is an essential element, especially for nurses facing emotional challenges, as it improves their well-being. Therefore, recognition is key for nurses working in ERs, as it enhances their performance and helps them overcome the emotional toll of heavy workloads and WPV.

Herzberg's Two-Factor theory laid a foundation for understanding the nature of work in ERs. Herzberg considered motivators to be internal desires that lead to meaningful accomplishment. The nurses also noted that they felt motivated when attending to patients and helping them return to normalcy in their lives. Others indicated that they felt obligated to use their skills and responsibilities to meet the health demands of people. These are examples of motivators, as listed by Herzberg, as internal pulls that help nurses perform their duties despite challenges they face, such as WPV and a lack of support from administrators. Intrinsic motivators also help reduce anxiety and depression among nurses, thereby enhancing their performance (Alahiane et al., 2023). In the presence of these motivators, nurses in working ERs are more devoted to their work, feel more engaged, and are more likely to benefit from psychological growth

Limitations of the Study

The study did have limitations. The sample size of eight participants was small, limiting generalizability. However, this study employed a qualitative approach, meaning its primary purpose was to gather information from ERs' firsthand experiences that contributed to the nursing shortage in the United States. Sarfo et al. (2021) noted that

researchers determine sample sizes based on the nature of the study; therefore, a sample of eight was sufficient to achieve data saturation with no new information emerging after the first four interviews.

A second, serendipitous limitation was that, although participant recruitment was conducted region-wide for this study, all participants were employed at one of the facilities of a multi-campus organization, further limiting generalizability. This illustrates the widespread effects of organizational practices, indicating that the discontent discussed by participants in this study most likely reflects system-wide practices.

Recommendations

The recommendations of this study were grounded in the participants' responses and suggestions for addressing the nursing shortage in the United States. One of the strategies includes fair compensation, as participants felt that nurses working in ERs are underpaid despite the heavy workload. These recommendations align with Hodgson et al. (2024), who note that increasing nurses' pay may help address the shortage.

Hospitals must consider hiring more staff to reduce the heavy workload on nurses in ERs, balancing the cost-benefit ratio of investment in personnel against the continual budget drain of turnover. Participants stressed that understaffing has resulted from additional responsibilities nurses in ERs are expected to perform, some of which are beyond their scope of practice. Adequate staffing releases nurses in the working ERs to focus on their work; thus, addressing the feeling of being overwhelmed by the job, which, in turn, causes dissatisfaction (Hayward et al., 2016; Staempfli & Lamarche, 2020).

Buerhaus et al. (2022) also support the idea of having adequate staffing to manage high patient volumes and reduce the associated stress.

The second recommendation is to introduce reforms in nursing education to meet the ever-changing needs of patients. The participants suggested a review of the curriculum so that nurses are adequately prepared for the job market. Working in the ER subjects nurses to pressure as they handle the high workload and ever-changing work schedules. Drennan et al. (2024) recommend that nurses have adequate, practical, and comprehensive skills to meet the growing demand for emergency care. Given the extreme patient acuity in ERs, nurses should be better equipped with knowledge and expertise to manage complex patient care in these settings.

Healthcare administrators need to introduce policies to address WPV, which was heavily cited as a challenge among nurses working in ERs. WPV is a profound challenge emanating from patients, family members, and even administrators. There is a need to establish training programs on conflict resolution and communication skills among nurses working in ERs (Drennan et al., 2024). This practice will improve interpersonal relationships and help nurses identify issues that may escalate into violence. The program should also focus on response and support by establishing clear reporting channels and providing psychological support to victims (Abdulwehab & Kedir, 2025). Abdulwehab and Kedir (2025) add that implementing a zero-tolerance policy against WPV, with clear actions to be taken against perpetrators, will help keep the workplace safe and free of harassment.

Lastly, the recommendations for future research are to study ER nurses and continue to obtain their views on their workloads, psychological stress, and the occurrences of WPV, and to listen to their stories, pain, and frustrations. Understand that ER nurses matter and that it is about their well-being, not the "numbers" or just the "patient satisfaction surveys," but about letting the ER nurses tell their side of the occurrences. Patients and family members must be educated to use patience and manners when visiting the ER and to refrain from abusing ER nurses, whether verbally, psychologically, or physically, emphasizing kindness and understanding that the nursing shortage is here to stay unless there is a change. More studies need to be conducted on the abuse that ER nurses face daily. This study is the foundation for future research to address workloads, psychological stress, WPV, and to find solutions, provide awareness in our communities, and social change, starting with hospital administration, patients, and family members. The ER nursing shortage will not go away until these issues are addressed and social change is created. Let change begin with compensation and respect.

Implications

The study identified issues that nurses working in ERs experience, including workload, psychological stress, and workplace violence (WPV), among other factors contributing to the nursing shortage in the United States. These findings have implications for multiple stakeholders, such as healthcare administrators, nursing professionals, and policymakers. For example, the results suggest a need for strategies that promote respect for nurses from patients, family members, and organizational leadership, particularly in contexts where nurses are perceived primarily as a resource

rather than as professionals. Additionally, the findings indicate that clearer role definitions and supportive organizational structures may help nurses focus on responsibilities within their scope of practice, thereby reducing role strain and improving retention.

The findings show that WPV is a critical challenge and poses a threat to the safety of their work setting. Supportive administration could provide structures for nurses to report WPV and hold the perpetrators accountable. This model would establish a zero-tolerance culture for violence, thus enhancing transparency and staff safety. In addition, the administration, together with relevant authorities, could develop a recognition and compensation policy by reviewing nurse salaries and benefits. They may also offer non-monetary rewards such as flexible working time, training and upskilling, and gifts to acknowledge the emotional experiences they endure. Besides, the administration could invest more in upstream care and hospital capacity and improve coordination of admissions and discharges. Such plans will reduce nurse burnout, lower turnover, and improve the quality of health care delivery.

The findings indicate that establishing safe nurse-to-patient ratios and ensuring adequate staffing are critical strategies for mitigating understaffing in emergency departments. Legislative measures at the federal level, such as those implemented by the Department of Health and Human Services, could provide standardized guidelines for staffing ratios to promote patient safety and reduce nurse burnout. Additionally, the results suggest that institutional support for educational programs focused on coping strategies may enhance nurses' ability to manage workplace stress and psychological

demands. These recommendations align with evidence from prior studies emphasizing the importance of structural interventions and professional development in improving retention and reducing turnover among emergency nurses.

Conclusion

This qualitative study examined the lived experiences of nurses working in emergency rooms, which contribute to the nursing shortage in the United States. The research revealed the complex human and systemic factors that drive nurses away. The findings show that nurses working in ERs face an overwhelming workload stemming from high patient acuity, a high nurse-to-patient ratio, and additional responsibilities that compel them to perform tasks beyond their clinical scope. In addition, the study revealed that the nurses experience psychological and emotional tolls arising from the mental burnout and trauma. Workplace violence heightens the internal crisis, but those in authority often do not offer the necessary support. Moreover, nurses feel demotivated by the disrespect and lack of recognition, despite their demanding work. Therefore, the nursing shortage is not just a human-related issue but a systemic failure that generates a crisis of safety, support, and respect. Nurses do not leave because they dislike their jobs; rather, unsustainable working environments undermine their professionalism and well-being. However, addressing these issues requires a coordinated effort by health administrators, policymakers, educators, and nursing professionals.

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Appendix A: The Flyer

ER Nurses Needed

CONDUCTING INTERVIEWS!!

Emergency Nurses' Perspectives on Workload, Stress, and Violence in the Context of the U.S. Nursing Shortage

QUALITATIVE study **ER NURSES** **5 YEARS**

You may be eligible if you have been an ER nurse for at least FIVE years!

The study is seeking ER nurses who are interested in participating in an interview. This study aims to tell the ER nurses' lived experiences in the ER setting, focusing on their excessive workloads, psychological stress, and workplace violence from patients and families. Tell your experiences to help aid in public awareness of the daily life of an ER nurse!

Appendix B: Demographic Data Sheet

Demographic Data Sheet

I used this demographic data sheet to collect essential background information from participants in my research study. Collecting demographic data will facilitate the analysis and interpretation of the results of my study, ensuring that the findings are applicable to the relevant population. All information provided by the participants will be kept confidential and used solely for research purposes.

Participant Information

- Participant ID: ________________________
- Date of Completion: ____ / ____ / __________
- Researcher/Interviewer Name: ________________________
- Study Title/Code: ________________________

Section 1: Personal Background

- Age:
- [ ] Under 18
- [ ] 18–24
- [ ] 25–34
- [ ] 35–44
- [ ] 45–54
- [ ] 55–64
- [ ] 65 or older
- [ ] Prefer not to say

2. Gender Identity:
[ ] Female
[ ] Male
[ ] Transgender Female
[ ] Transgender Male
[ ] Non-binary/third gender
[ ] Prefer to self-describe: ________________________
[ ] Prefer not to say
3. Pronouns: ________________________
4. Date of Birth: ____ / ____ / __________
5. Place of Birth (City, State/Province, Country): ________________________

Section 2: Contact & Residency

- 6. Address: ________________________

- 7. City: ________________________
- 8. State/Province: ________________________
- 9. Postal/ZIP Code: ________________________
- 10. Country of Residence: ________________________
- 11. How long have you lived at your current address?
- [ ] Less than 1 year
- [ ] 1–3 years
- [ ] 4–9 years
- [ ] 10 years or more

Section 3: Socioeconomic Information

- 13. Highest Level of Education Completed:
- [ ] No formal education
- [ ] Some primary school
- [ ] Primary/elementary school
- [ ] Some secondary/high school
- [ ] Secondary/high school diploma or equivalent
- [ ] Some college/university
- [ ] Associate degree
- [ ] Bachelor's degree
- [ ] Graduate or professional degree
- [ ] Prefer not to say

12. Current Employment Status:
[ ] Employed full-time
[ ] Employed part-time
[ ] Unemployed (looking for work)
[ ] Unemployed (not looking for work)
[ ] Retired
[ ] Student
[ ] Unable to work
[ ] Other (please specify): ________________________
13. Occupation/Job Title: ________________________

Section 4: Ethnicity, Race, and Cultural Background

- 14. Ethnicity/Race (choose all that apply):
- [ ] African or African American
- [ ] Asian or Asian American
- [ ] Hispanic or Latinx

- [ ] Middle Eastern or North African
- [ ] Native American or Alaska Native
- [ ] Native Hawaiian or Pacific Islander
- [ ] White or Caucasian
- [ ] Other (please specify): ________________________
- [ ] Prefer not to say

Section 5: Marital & Family Status

- 22. Marital Status:
- [ ] Single
- [ ] Married
- [ ] Domestic partnership
- [ ] Separated
- [ ] Divorced
- [ ] Widowed
- [ ] Prefer not to say

15. General Health Status:
[ ] Excellent
[ ] Good
[ ] Fair
[ ] Poor
[ ] Prefer not to say

Section 7: Additional Information
16. How many years have you been a Registered Nurse?
17. How many years have you worked in an ER setting?
18. Is there any additional information you wish to provide that may be relevant to this study?
[ ] Yes (please specify): ________________________
[ ] No

Section 8: Consent
Please read the following statement and sign below:
I confirm that I have read and understood the purpose of this research study. I agree to provide my demographic information voluntarily, and I understand that my data will be kept confidential and used only for research purposes.

- Participant Signature: ________________________
- Date: ____ / ____ / __________

Appendix C: Interview Questions

1. Are you a Registered Nurse, and how long have you worked in the ER for at least 5 years?
2. Can you provide an example of a substantial workload and describe the types of patients you cared for?
3. In detail, can you explain to me what psychological stress you have experienced working in the ER?
4. Can you provide a detailed experience where you experienced workplace violence (WPV), whether it was verbal abuse, psychological abuse, or physical abuse from a doctor, patient, or a family member? If so, how did the administration handle this occurrence?
5. Can you explain to me in detail the satisfaction and dissatisfaction of working in an ER environment?
6. As an Expert ER nurse, can you explain to me, from your perspective, why you would leave the ER profession, including how you are treated by doctors, co-staff, patients, family, and management?
7. If you had the chance to do it all over again, would you still want to be an ER nurse or another profession, and if not an ER nurse, what profession would you choose?
8. In your own words, are ER nurses treated with respect in their profession?
9. What would help the ER nursing shortage due to so many ER nurses leaving the profession?

10. Lastly, how has being an ER nurse changed in the last 5 years? Does the ER nurse have more responsibility? Do the doctors, patients, and families treat the ER nurse with respect? Furthermore, why do you think there is a nursing shortage?