Emergency Room Challenges: Bases For Enhancing Patient Care and Safety

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ABSTRACT

Objectives: This study evaluated the challenges encountered by healthcare personnel in the emergency departments of hospitals within the 5th District of Camarines Sur. Specifically, it investigated respondents' profiles, assessed challenges in emergency rooms across five domains, such as triage and assessment, staff training and competency, resource allocation and equipment availability, communication and coordination, and patient volume, and examined the relationship profile and challenges to inform strategies to enhance patient care and safety.

Methods: A descriptive-correlational research design was utilized. Employing a total enumeration sampling technique, data were gathered from 55 multidisciplinary emergency department personnel, predominantly nurses (74.55%), alongside resident physicians, midwives, nursing aides, and triage officers, across five participating hospitals using a structured survey questionnaire. To ensure institutional compliance, formal ethical approval was obtained from the relevant research ethics committee prior to data collection. Data analysis was performed using frequency counts, percentages, weighted means, and the Chi-square test of independence.

Results: The profile analysis revealed a workforce consisting mostly of female college graduates (80.01%) with short tenures, with 45.45% having only 1 to 5 years of service. While basic life support compliance was universal (100%), specialized advanced certifications were significantly lacking. The overall assessment showed that patient volume (WM=3.71) and resource allocation/equipment availability (WM= 3.42) were the top-ranked institutional challenges. Communication, staff training, and triage were moderately agreed upon as lesser challenges, frequently driven by frontline stress and ethical decision fatigue. Critically, Chi-square analysis proved that there is no significant relationship between any of the respondents' profile variables and the challenges faced.

Conclusions: The uniform non-significance across all profile variables indicates that emergency room bottlenecks are driven by systemic and institutional stressors rather than individual demographic or professional differences. Consequently, effective enhancement strategies must transcend individual training by prioritizing structural organizational reforms, including physical infrastructure expansion, dynamic resource planning, and systemic workload management.

Keywords: Emergency Room Challenges, Patient Care, Safety

INTRODUCTION

Globally, the World Health Organization (WHO, 2023) underscores that emergency care systems are a cornerstone of universal health coverage, yet an estimated 4.5 billion people lack access to timely care each year, threatening the achievement of Sustainable Development Goal 3. In response to universal challenges like overcrowding, resource limitations, and inefficient patient flow during disasters, hospitals worldwide are adopting comprehensive strategies, including risk assessments, standardized communication protocols, and strategic resource management, to maintain patient safety (Janhavi et al., 2023). In the Philippines, the

Department of Health (DOH) has institutionalized these efforts through Administrative Order No. 2010-0029, which mandates disaster preparedness plans, the establishment of 24/7 Operations Centers (OPCEN), and the adoption of an Integrated Code Alert System to coordinate rapid emergency responses across the health sector.

Despite these national mandates, hospitals in the 5th district of Camarines Sur face compounded vulnerabilities due to geographic barriers, resource constraints, and frequent exposure to natural disasters like typhoons, floods, and volcanic activity. Operationalizing local emergency preparedness requires maximize available assets, establishing robust referral networks, and ensuring that even smaller facilities possess the capacity to stabilize patients before transferring them to higher-level care. Consequently, emergency departments in this region rely heavily on hazard-specific planning, regular simulation drills, and strong collaborative partnerships with local government units (LGUs) and disaster response agencies to bridge resource gaps and maintain institutional readiness.

At the clinical frontline, emergency room nurses encounter significant operational barriers, including severe time constraints, communication breakdowns, and prominent language barriers that hinder thorough patient assessments and jeopardize patient safety. Navigating a fast-paced environment with limited specialized training and inadequate resources restricts a nurse's ability to deliver optimal triage and person-centered care, particularly during mass casualty incidents. By investigating these specific localized challenges, this study aims to provide an empirical basis for enhancing patient care and safety, ultimately fostering a more resilient nursing workforce through targeted clinical competencies, optimized resource allocation, and strengthened communication frameworks.

METHODOLOGY

The study assessed the challenges encountered by nurses in emergency departments in hospitals in the 5th District of Camarines Sur Specifically, it sought answers to the following: the profile of the respondents in terms of age, sex, civil status, educational attainment, position, length of service, and training/seminar; the challenges in emergency room along with triage and assessment, staff training and competency, resource allocation and equipment availability, communication and coordination and patient volume and; the significant relationship between the profile and the challenges in emergency room and the strategies may be developed to reduce the emergency room challenges.

A descriptive-correlational research design was employed to capture the current situation and investigate the relationships between variables. The primary data-gathering instrument was a structured survey questionnaire. To ensure compliance with institutional research standards, ethical approval was formally obtained from the relevant research ethics committee prior to data collection, ensuring that the rights, anonymity, and informed consent of all human participants were strictly protected.

To ensure a comprehensive assessment of the emergency care environment, the study employed a total enumeration sampling technique, securing 55 respondents who actively rotate through the emergency departments. This multidisciplinary sample consisted of nurses, resident physicians, midwives, nursing aides, and triage officers. The distribution of respondents across the participating healthcare facilities in the 5th District was as follows: Sta. Maria Foundation Hospital (n=15), Villanueva-Tanchuling Maternity and General Hospital (n=10), Our Lady of Mediatrix Hospital (n=10), Medical Mission Group Hospital (n=10), and CHMSC Lourdes Hospital (n = 10).

Data analysis was conducted using both descriptive and inferential statistics. Frequency counts and percentages were used to summarize the demographic profile, while weighted means were calculated to evaluate the severity of the emergency room challenges. Finally, the Chi-square test of independence was used to assess the significance of the relationship between respondents' profiles and their experienced challenges.

RESULTS AND DISCUSSIONS

Profile of the Respondents

A profile is a set of characteristics used to describe a certain population segment or group. It also refers

to the socio-economic characteristics of a population. Table 1 presents the profiles of the 55 respondents who are emergency room healthcare personnel in selected hospitals in the 5th District of Camarines Sur. The profile variables include age, sex, civil status, educational attainment, position, length of service, and seminars/training attended.

Table 1. Profile of the Respondents

Profile	Frequency	Percentage
Age		
25 years old and below	12	21.82
26–30 years old	10	18.18
31–35 years old	8	14.55
36–40 years old	15	27.27
41–45 years old	5	9.09
46–50 years old	3	5.45
50 years old and above	2	3.64
Total	**55**	**100.00**
Sex		
Male	16	29.09
Female	39	70.91
Total	**55**	**100.00**
Civil Status		
Single	27	49.09
Married	26	47.27
Widowed	0	0.00
Separated	1	1.82
Divorced	1	1.82
Total	**55**	**100.00**
Educational Attainment		
College Graduate	44	80.01
Master's Degree	4	7.27
Master's with Units	4	7.27
Doctorate Degree	3	5.45
Total	**55**	**100.00**
Position		
Resident Physician	6	10.91
Nurse	41	74.55
Midwife	1	1.82
Triage Officer	2	3.63
Nursing Aide	5	9.09
Total	**55**	**100.00**

Length of Service		
Less than 1 year	15	27.27
1–5 years	25	45.45
6–10 years	9	16.36
11–15 years	4	7.27
16 years and above	2	3.65
Total	**55**	**100.00**
Seminars/Training		
Basic Life Support (BLS)	45	42.46
Advanced Cardiac Life Support (ACLS)	25	23.58
Pediatric Advanced Life Support (PALS)	8	7.55
Trauma Nursing Core Course (TNCC)	9	8.49
Emergency Nursing Pediatric Course (ENPC)	7	6.60
Triage-specific training programs	9	8.49
Pain management training	3	2.83
Total	**106**	**100.00**

Age. Of the 55 respondents, the largest group is those aged 36–40 years, representing 15 or 27.27%. This is followed by individuals aged 25 and below with 12 or 1.82%, and the 26–30 age bracket at 1 or 18.18%. Respondents aged 31–35 have eight or 14.55%, while those in the older brackets of 41–45 (five or 9.09%), 46–50 (three or 5.45%), and 50 and above (two or 3.64%) represent the minority.

Sex. The respondents are predominantly female, comprising 39 (70.91%), while males account for 16 (29.09%).

Civil Status. The respondents are nearly evenly split between single individuals at 27 or 49.09% and married individuals at 26 or 47.27%. Both respondents who are divorced (1.82%) and separated got one or 1.82%.

Educational Attainment. The majority of respondents, with 44 or 80% are college graduates. Four, or 27.7%, pursued further education, including Master's degree holders and those with Master's units. There are three or 5.45% of respondents who hold a Doctorate degree.

Position. Nurses represent the core of the respondent group with 41 or 74.55%. Other roles include Resident Physicians (six or 10.91%), Nursing Aides (five or 9.09%), Triage Officers (two or 3.64%), and Midwives (one or 1.82%).

Length of Service. Tenure in the emergency room is relatively short, with 25 or 45.45% having served for 1–5 years and 15 or 27.27% having less than one year of service. Mid-to-senior staff with 6–10 years with 9 or 16.36%, 11–15 years with 4 or 7.27%, and 16 years above with 2 or 3.64% constitute a smaller portion of the team.

Seminars/Training. Training data show universal compliance with Basic Life Support (100%). However, advanced specialized certifications are less frequent: Advanced Cardiac Life Support (ACLS) is held by 34.55%, Trauma/TNCC by 8.49%, and Pediatric/PALS by 6.60%. Other training areas, such as Pain Management (3.77%) and Disaster Management (4.72%), are also in the minority.

The profile findings collectively describe an emergency room workforce that is educationally qualified, predominantly composed of early-career nurses, and female. The concentration of staff in the 1–5 year experience bracket suggests a workforce with technical foundational competence but limited institutional

memory. While BLS compliance is commendable, the uneven distribution of advanced certifications, particularly ACLS (23.58%), TNCC (8.49%), and PALS (7.55%), reveals a critical gap in specialized emergency preparedness.

This pattern implies that the department is in a continuous cycle of professional development, where new entrants receive basic training but are not systematically advanced into higher certification levels. The challenge is not academic qualification but the translation of educational background into sustained, specialized clinical competency. It can be inferred that the emergency room relies on a physically energetic and academically prepared workforce. However, the reliance on staff in their first five years of service means the department is in a constant state of professional development. The "preparedness" of the unit is currently anchored in basic emergency response, and there is a significant opportunity to enhance safety by bridging the gap between basic and advanced specialized clinical training.

The literature consistently shows that while academic background is essential, years of experience as an emergency nurse and specific disaster training are the strongest predictors of objective preparedness. Ardabil (2021) emphasizes that knowledgeable nurses help minimize harmful effects during disasters, yet few studies find nurses feel fully prepared in all specialized knowledge areas. A study by Mubarak et al. (2024) found that in rapidly evolving healthcare landscapes, the retention of mid-level experienced nurses (5–10 years) is the single most critical factor in maintaining consistent triage accuracy and department-wide safety.

Furthermore, Mubarak et al. (2024) identified that mid-career nurses with 5–10 years of emergency room experience are the strongest predictors of triage accuracy and department-wide safety. In this study, such mid-career nurses represent only 16.36% of the workforce, creating a structural vulnerability where institutional expertise is thin. The findings of Mubarak et al. thus underscore the urgency of retaining experienced staff and accelerating the professional development trajectory of the 1–5-year cohort to bridge the experiential gap in emergency care delivery.

Challenges in the Emergency Room

This section shows the challenges in emergency room preparedness among nurses in hospitals in the 5th District of Camarines Sur, including triage and assessment, staff training and competency, resource allocation and equipment availability, communication and coordination, and patient volume.

Triage and Assessment. Table 2 presents the challenges in the emergency room along triage and assessment, which were moderately agreed upon by the respondents with an average mean of 3.32.

Table 2. Challenges in the Emergency Room along with Triage and Assessment

Indicators	WM	Interpretation	Rank
1. Balancing utilitarian and egalitarian ethical considerations in triage prioritization, leading to delays in decision-making.	3.60	Agree	1
2. Poor on-site case management causes deterioration of patient conditions before hospital admission.	3.44	Agree	2
3. Inadequate pre-hospital emergency care delays critical initial assessment and treatment.	3.35	Moderately Agree	3
4. Limited trained personnel to perform rapid and accurate triage under pressure.	3.20	Moderately Agree	4
5. Lack of standardized triage protocols and training for emergency scenarios	3.00	Moderately Agree	5
Average Weighted Mean	**3.32**	**Moderately Agree**	

The healthcare providers agreed that the ethical complexity of balancing utilitarian and egalitarian considerations in triage decision-making (3.60) and poor on-site case management (3.44), while moderately agreeing that inadequate pre-hospital emergency care (3.35), Limited trained personnel (3.20), and the absence of standardized triage protocols (3.00) are challenges in the emergency room.

The data reveal that the primary obstacles in triage are cognitive and ethical rather than purely technical. The highest mean in the triage assessment is ethical decision-making, which is rarely addressed in standard training curricula but profoundly affects the speed and quality of triage. The relatively low score for the lack of standardized protocols suggests that protocols exist to some degree, but the staff's ability to apply them rapidly and uniformly under pressure remains constrained by exhaustion and ethical dilemmas. The data imply that the human element, specifically the stress of choosing who to treat first in a resource-limited environment, is the primary bottleneck in efficient ER preparedness.

Amini et al. (2023) found that inconsistent triage categorization, often rooted in human cognitive overload rather than protocol absence, is among the leading causes of preventable mortality in emergency rooms, and that standardized digital triage support tools can reduce decision errors by 15–20%. This directly resonates with the study's finding that the ethical burden of triage ranking is the most prominent barrier, pointing to the need for decision-support frameworks that reduce cognitive load.

Additionally, Park and Kim (2024) identified the pre-hospital-to-hospital care transition as the most fragile segment of emergency response, characterized by triage lag due to inadequate real-time communication, which corroborates this study's second-ranked challenge: poor on-site case management.

Staff Training and Competency. Table 3 presents challenges in the emergency room, along with staff training and competency, with an average mean of 3.34, indicating moderate agreement among respondents.

Staff physical and mental exhaustion (3.67) reflects the most acutely felt challenge in this domain. The difficulty in rapidly upskilling staff during surge periods (3.36), inadequate nurse empowerment for critical decision-making (W3.31), lack of scenario-based training (3.25), and insufficient professional development (3.09) were moderately agreed upon by the respondents as challenges in the emergency room.

Table 3. Challenges in the Emergency Room along with Staff Training and Competency

Indicators	WM	Interpretation	Rank
1. Lack of intensive, scenario-based training programs for emergency and disaster situations.	3.25	Moderately Agree	4
2. Difficulty rapidly upskilling staff during surges in demand, leading to competency gaps.	3.36	Moderately Agree	2
3. Insufficient ongoing professional development focused on emergency care competencies.	3.09	Moderately Agree	5
4. Staff physical and mental exhaustion reducing effectiveness and decision-making ability.	3.67	Agree	1
5. Inadequate authority and empowerment for nurses and staff to make critical decisions in emergencies.	3.31	Moderately Agree	3
Average Weighted Mean	**3.34**	**Moderately Agree**	

The findings underscore that competency erosion in the emergency room is driven predominantly by fatigue rather than knowledge deficits alone. The physical and mental exhaustion signals that staff are regularly operating at or beyond sustainable capacity. This implies that the performance gap between optimal and actual care delivery is not primarily a training problem but a wellness problem, one that requires institutional interventions in workload management, shift scheduling, and psychological support. Furthermore, the

inadequate empowerment of nurses to make autonomous decisions is a structural barrier rooted in hierarchical clinical culture that delays time-sensitive emergency interventions.

It can be inferred that clinical preparedness is as much about staff wellness as it is about clinical knowledge. The results imply that even highly trained staff will exhibit competency gaps when physically and mentally exhausted, suggesting that enhancing preparedness must include strategies for workload management and psychological support.

The study of Gao et al. (2022) found that traditional training is insufficient for emergency readiness; instead, high-fidelity simulation and mental resilience drills are required to maintain competency in high-stress environments. Similarly, O'Reilly et al. (2025) noted that decision fatigue among ER nurses is a byproduct of high-acuity environments, where staff feel overwhelmed without a clear, practiced framework for autonomous action.

Resource Allocation and Equipment Availability. The assessment of resource-related challenges in the emergency room highlights several critical areas of concern among respondents as shown in Table 4.

Table 4. Challenges in the Emergency Room along with Resource Allocation and Equipment Availability

Indicators	WM	Interpretation	Rank
1. Limited human resources and specialized personnel to meet surge demands.	3.42	Agree	3
2. Shortage of essential medical equipment and supplies, including PPE and rescue vehicles.	3.51	Agree	2
3. Financial constraints limiting hospitals' capacity to enhance emergency readiness.	3.56	Agree	1
4. Poor infrastructure and outdated facilities hampering timely care delivery.	3.29	Moderately Agree	5
5. Inefficient dynamic resource planning leading to delays in resource deployment during crises.	3.36	Moderately Agree	4
Average Weighted Mean	**3.42**	**Agree**	

The challenges in the emergency room, along with resource allocation and equipment availability, were agreed by the respondent with an average mean of 3.42. Financial constraints (3.56), shortages of essential medical equipment and PPE (3.51), and limited human resources and specialized personnel (3.42) were agreed upon by the respondents as challenges faced in the emergency room, whereas moderately agreed on inefficient dynamic resource planning (WM=3.36) and poor infrastructure and outdated facilities (3.29).

The findings point to a tangible and pervasive hard-resource crisis. Unlike challenges related to training or communication that may be addressed through behavioral or procedural interventions, the resource challenges identified here are structural and financial requiring capital investment and policy-level decisions. Financial scarcity functions as a root-cause variable: it limits equipment procurement, reduces the capacity to hire specialists, and prevents infrastructure upgrades. The top three indicators confirm that this is not a marginal issue but a widely shared operational reality experienced across respondent groups.

Thompson et al. (2023) identified staffing-induced risk as the paramount challenge in contemporary emergency room operations, finding that deficits in specialized personnel generate higher rates of clinical error regardless of equipment availability. This supports the study's third-ranked indicator, limited specialized personnel, as a critical operational vulnerability.

Additionally, Zeng and Lopez (2026) argued that static, annual-cycle budgeting models are inherently misaligned with the unpredictable demand patterns of emergency medicine, and that hospitals must adopt

dynamic, real-time budget allocation to sustain resilience during surge periods, directly reinforcing the study's finding that inefficient dynamic resource planning constitutes a significant operational limitation.

Communication and Coordination. Table 5 shows that the respondents moderately agreed that c in communication and coordination were challenges in the emergency room, with a mean of 3.38.

Table 5. Emergency Room Challenges along Communication and Coordination

Indicators	WM	Interpretation	Rank
1. Weak interpersonal relationships and lack of prior liaison reducing situational awareness and information sharing.	3.31	Moderately Agree	4
2. Technical failures and human errors disrupting emergency communication systems.	3.24	Moderately Agree	5
3. Stress, fatigue, and change of routine impairing clear communication among staff during emergencies .	3.62	Agree	1
4. Lack of unified communication platforms and backup systems causing coordination gaps.	3.38	Moderately Agree	2
5. Poor coordination between hospital units and external emergency organizations affecting patient transitions and care continuity.	3.35	Moderately Agree	3
Average Weighted Mean	**3.38**	**Moderately Agree**	

Stress, fatigue, and disruption of routine were identified as the primary barriers to clear communication (3.62). Absence of unified communication platforms (3.38), poor external coordination (3.35), weak interpersonal relationships (3.31), and technical failures (3.24) were moderately agreed upon by respondents as challenges in the emergency room.

Communication breakdown is fundamentally a human problem rather than a technological one. The highest-rated indicator, stress and fatigue impairing communication, confirms that even when systems and protocols are in place, the cognitive and emotional state of staff determines the actual quality of information exchange. This is a critical insight for emergency preparedness: investments in communication technology alone are insufficient if the staff are too exhausted or anxious to use them effectively. The lower rating for technical failures suggests that hardware and systems are relatively functional, but the human interface remains the bottleneck.

The data suggest that even if technical systems are functional, information will not flow if staff are too fatigued or stressed to process it, highlighting a need for team-building and stress-management protocols.

Miller and Sanchez (2024) documented that interpersonal communication is the first operational function to deteriorate during hospital surge events, attributing this to cognitive overload caused by elevated patient-to-nurse ratios, a finding that directly supports this study's identification of stress and fatigue as the leading communication challenge.

Furthermore, Hassan et al. (2026) provided evidence that digital communication platforms produce optimal outcomes only when implemented within a culture of psychological safety, where staff are supported and encouraged to communicate critical information without fear or hesitation. This reinforces the study's finding that the absence of psychological safety manifested as weak interpersonal relationships and poor liaison compounds communication failures even when technical tools are available.

Patient Volume. Table 6 presents challenges related to patient volume with the highest mean across all five domains at 3.71. Respondents agreed that patient volume is the topmost challenge in the emergency room.

Table 6. Emergency Room Challenges along with Patient Volume

Indicator	WM	Interpretation	Rank
1. Surge in patient numbers exceeding available space and staff capacity.	3.78	Agree	2
2. Overcrowding causing delays in triage, assessment, and treatment.	3.69	Agree	3
3. Insufficient infrastructure to accommodate mass casualty incidents or disaster scenarios.	3.80	Agree	1
4. Strain on existing resources leading to compromised quality of care and increased morbidity.	3.64	Agree	4.5
5. Ethical dilemmas in resource allocation and prioritization under conditions of overcrowding.	3.64	Agree	4.5
Average Weighted Mean	**3.71**	**Agree**	

The respondents all agreed on insufficient infrastructure for mass-casualty incidents (3.80), patient surges exceeding available space and staff capacity (3.78), overcrowding-induced triage delays (3.69), resource strain leading to compromised quality of care (3.64), and ethical dilemmas in resource allocation (3.64) as challenges in the emergency room related to patient volume.

It signals a crisis-level consensus among respondents. The emergency room has effectively reached a physical and operational ceiling; the existing infrastructure, staffing configuration, and resource inventory are misaligned with the actual demand. Mass-casualty preparedness reveals that the gap between actual and required capacity widens exponentially during disasters, making the facility acutely vulnerable precisely when it is most needed. The indicators of resource strain and ethical dilemmas reflect a tragic convergence, when physical resources are exhausted, ethical tensions inevitably escalate.

Savino et al. (2023) documented the post-pandemic phenomenon of "boarding," the practice of placing patients in hallways and non-clinical spaces due to overcrowding, as a global patient safety crisis that has contributed to a 30% increase in adverse events in emergency settings. This finding is directly reflected in this study's high-consensus challenges of patient surge and overcrowding-related triage delays.

Chen and Richards (2025) further argued that emergency room overcrowding constitutes a form of "systemic ethical failure," wherein healthcare institutions can no longer fulfill their foundational obligation to allocate care equitably, because the demand structurally exceeds the supply, echoing this study's finding that ethical dilemmas in resource allocation (WM=3.64) are not incidental but are embedded in the institutional reality of overcrowded emergency rooms.

Summary of Challenges Faced in the Emergency Room. Table 7 presents the challenges in the emergency room.

Table 7. Summary Table of Challenges in the Emergency Room

Indicators	WM	Interpretation	Rank
Triage and Assessment	3.32	Moderately Agree	5
Staff Training and Competency	3.34	Moderately Agree	4
Resource Allocation and Equipment Availability	3.42	Agree	2
Communication and Coordination	3.38	Moderately Agree	3
Patient Volume	3.71	Agree	1
Average Weighted Mean	**3.43**	**Agree**	

Results show that the respondents agreed that patient volume (3.71) and resource allocation and equipment availability (3.42) are the topmost challenges, while communication breakdown and coordination (3.38), staff training and competency (3.34) and triage and assessment (3.32) are the least three challenges moderately agreed upon by the healthcare workers.

The overcrowding is the most pressing concern in the emergency room. This means the high patient influx likely places pressure on staff, space, and workflow, making it harder for the unit to respond efficiently. Resource limitations also stand out as a major issue, indicating that even when personnel are available, insufficient equipment and supplies can weaken preparedness. The moderately agreed ratings for delayed triage, communication problems, and staff competency imply that these are still important concerns, but they may be less severe than overcrowding and resource constraints.

Emergency room preparedness is challenged more by system-level and operational pressures than by a single isolated issue. The results point to the need for stronger patient flow management, better staffing and training support, improved coordination among personnel, and more reliable allocation of emergency resources. Addressing these areas could help reduce delays, improve response capacity, and strengthen readiness in high-demand situations.

Test of Significant Relationship Between the Profile of the Respondents and the Challenges in the Emergency Room

Table 8 presents the statistical relationship between respondents' profiles and the challenges in emergency room preparedness.

Table 8. Test of Significant Relationship Between the Profile of the Respondents and the Challenges in the Emergency Room

Profile	df	X^2 Computed Value	Tabular Value	Decision on H_o	Interpretation
Age	24	21.84	36.415	Accepted	Not Significant
Sex	4	3.56	9.488	Accepted	Not Significant
Civil Status	12	10.22	21.026	Accepted	Not Significant
Educational Attainment	12	11.45	21.026	Accepted	Not Significant
Position	16	15.28	26.296	Accepted	Not Significant
Length of Service	16	13.91	26.296	Accepted	Not Significant
Training/Seminar	24	20.15	36.415	Accepted	Not Significant

The chi-square (x^2) analysis shows that for all profile variables, including age, sex, civil status, educational attainment, position, length of service and training/seminar with computed values of 21.84, 3.56, 10.22, 11.45, 15.28, 13.91 and 20.15 are less than the tabular value of 36.415, 9.488, 21.026, 21.026, 26.296, 26.296 and 36.415, respectively at 0.05 level of significance. Consequently, the null hypothesis is accepted for every category; therefore, there is no significant relationship between the profile of the respondents and the challenges in the emergency room.

The non-significance of all profile variables is a finding of considerable theoretical weight. It reveals that the challenges encountered in this emergency room setting are not differentially experienced based on who the healthcare worker is, their age, sex, educational level, professional role, years of experience, or training profile. A first-year nursing aide and a doctoral-prepared nurse manager perceive the same magnitude of systemic challenge.

This uniformity of experience points decisively away from individual-level explanations and toward institutional, environmental, and system-level causes. It implies that the obstacles to emergency preparedness

are embedded in the structure and resources of the ER itself, not in the characteristics of the people working within it. Consequently, improvement strategies that target individual staff development alone will be insufficient; the evidence demands organizational and structural reform.

Miller and Sanchez (2024) articulated this phenomenon through the concept of the "universal stressor," arguing that in high-acuity emergency environments, systemic failures, particularly overcrowding and resource depletion, neutralize individual differences in experience and expertise, placing even seasoned veterans at equivalent risk of error as newly hired staff. This theoretical framework is directly supported by the uniform non-significance across all profile variables in the present study.

Hassan et al. (2026) further substantiated this finding by demonstrating that when hospital resources fall below a critical threshold, demographic variables and individual competency indicators cease to function as meaningful predictors of care preparedness; the prevailing environmental constraints override individual capacity. Together, these studies confirm that the path to meaningful improvement in emergency room preparedness lies not in calibrating individual attributes, but in the systemic transformation of the institutional environment its infrastructure, resource systems, and cultural foundations.

Strategies to Reduce the Emergency Room Challenges

The results indicate that enhancing emergency room preparedness requires a multi-layered strategy: infrastructure expansion and dynamic resource planning at the macro level, combined with simulation-based training, workload management, and the development of a communication culture at the operational level. No single intervention will be sufficient; only a coordinated, institution-wide response can address the complexity of the challenges identified.

To improve emergency room preparedness, the development of integrated strategies addresses the multifaceted challenges identified in the study, ranging from clinical competency gaps to systemic infrastructure deficits. While the workforce is educationally qualified and possesses universal basic life-saving skills, there is a significant lack of advanced certifications, including ACLS, TNCC, and PALS, underscoring the need for specialized training programs and high-fidelity simulations. Furthermore, because the primary barriers to effective care, such as overcrowding, resource scarcity, and staff exhaustion, are systemic stressors that affect the entire workforce regardless of experience, enhancement strategies must prioritize broad institutional reform over individual improvements. These strategies include infrastructure expansion to prevent the ER from becoming a physical bottleneck, dynamic resource planning to address financial and equipment shortages, and implementing mental resilience drills to mitigate performance erosion and communication breakdowns caused by chronic stress. By bridging the gap between basic and advanced clinical training and integrating workload management and psychological support, the department can enhance patient safety and maintain operational integrity during unpredictable surges.

CONCLUSION

The majority of the respondents are female nurses and college graduates, and are all single. Most of the respondents are 36-40 years old, with 1-5 years of service, and have BLS and ACLS training. The respondents agreed that patient volume and inadequate resource allocation and equipment availability are common challenges faced in the emergency room, while moderately agreeing on communication and coordination, staff training and competency, and triage and assessment. All the respondents' profiles in terms of age, sex, civil status, educational attainment, position, length of service, and training/seminars do not affect the common challenges they faced in emergency room preparedness. Therefore, there is no significant relationship between respondents' profiles and the challenges faced in the emergency room. Strategies can be developed to reduce emergency room challenges.

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