Original Research

Emergency Department Nurses' Experiences with the Early Care Pathway (ECP) Model: An Interpretative Phenomenological Study

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Abstract

Introduction. The Early Care Pathway (ECP) model was recently introduced in some emergency departments (EDs) in Northern Italy to enhance patient care through earlier nursing intervention. Although its benefits are recognized, little is known about how nurses experience and adapt to this organizational innovation. This study explores emergency nurses' lived experiences with the ECP model, focusing on its impact on practice, professional identity, and interprofessional collaboration.

Methods. A qualitative study was conducted using Interpretative Phenomenological Analysis (IPA). Seventeen nurses (12 females, 5 males; age range 24–55) with direct experience of the ECP model participated in semi-structured interviews between July and August 2024. Participants were purposively

selected based on criteria including ECP training and at least three months of experience using the model. Interviews were audio-recorded, transcribed verbatim, translated into English, and analyzed following the IPA framework. Rigor was ensured through bracketing, audit trails, member checking, and triangulation.

Results. Five interrelated themes emerged: (1) Deepening the nurse-patient connection – The ECP model enhanced the quality of interaction, promoting empathy, trust, and patient satisfaction through focused, uninterrupted time; (2) Empowerment and professional identity growth – Nurses reported increased autonomy, recognition, and decision-making capacity. The model reinforced their clinical judgement and enabled a more meaningful expression of their role; (3) Streamlining care through organizational innovation – ECP improved care efficiency by transforming waiting time into active care, promoting faster interventions and optimized workflows; (4) Fostering communication and team synergy – The model enhanced interdisciplinary collaboration and improved nurse-doctor dialogue. Nurses experienced more fluid team communication and greater involvement in early care decisions; (5) Navigating challenges and overcoming barriers – Implementation obstacles included resistance from physicians, ambiguity in role delineation, and workload concerns. However, most nurses expressed that these challenges were outweighed by the model's benefits.

Conclusion. The ECP model has a transformative impact on emergency nursing, fostering deeper patient relationships, enhancing professional identity, streamlining care, and strengthening teamwork. While implementation challenges exist, nurses overwhelmingly view the model as a valuable innovation that enriches both patient care and their professional experience. Understanding these lived experiences is essential for guiding future implementations and addressing contextual barriers.

Keyword: Emergency Service, Hospital, Nursing, Qualitative Research, Professional Role, Interprofessional Relations, Patient-Centered Care

Introduction

Emergency Departments (EDs) serve as pivotal entry points in the healthcare system, managing a broad spectrum of clinical conditions and providing timely diagnostic, therapeutic, and stabilization services. In Italy, the ED is mandated to perform not only urgent diagnostic and therapeutic interventions but also the initial clinical, instrumental, and laboratory assessments, stabilization of the patient, and the protected transport (Presidenza della Repubblica Italiana, 1992). EDs represent a crucial component of the Italian National Health Service, ensuring immediate access to acute care. However, in recent years, EDs have faced growing pressure due to a substantial increase in patient visits, many of which are classified as non-urgent. In 2023, Italian EDs managed approximately 18.27 million visits, 68% of which were classified as white or green codes, indicating non-urgent or low-acuity conditions (AGENAS, 2022). This

high volume of predominantly low-acuity presentations contributes to overcrowding, with potential consequences including prolonged waiting times, increased clinical risk, and elevated stress among healthcare professionals.

The inappropriate use of EDs is a globally recognized challenge (Kim et al., 2024), prompting national and regional authorities to seek organizational innovations to streamline patient flow and safeguard quality of care. Several studies have highlighted the effectiveness of nurse-led interventions and early care pathways in improving patient flow, reducing waiting times, and enhancing clinical outcomes (Burgess et al., 2021; Considine et al., 2019; Varndell et al., 2018). In response, models such as the Fast Track pathway have been developed, targeting patients with low clinical complexity to reduce unnecessary delays (AGENAS, 2022).

Within this evolving landscape, the Early Care Pathway (ECP) model has emerged as a promising solution. Unlike traditional workflows, the ECP enables selected patients, following triage, to begin clinical-care protocols initiated by triage nurses or specially trained personnel, without waiting for a physician's assessment (Douma et al., 2016). These nurse-led protocols typically include early diagnostic testing and analgesic administration, particularly in cases involving trauma or acute pain (Burgess et al., 2021; Considine et al., 2019; Varndell et al., 2018). When implemented effectively, ECPs can mitigate the consequences of ED overcrowding by accelerating the care process and enhancing patient safety (Borghetti et al., 2021). Empirical evidence underscores the clinical benefits of ECP protocols. For instance, Douma et al. (2016) found that nurse-initiated pathways reduced the time to analgesic administration by 186 minutes, the time to diagnostic testing for chest pain by 79 minutes, and the length of stay for hip fractures by 224 minutes (Douma et al., 2016). These data support the efficiency and safety of early nursing interventions within emergency workflows.

Beyond organizational aspects, the implementation of the ECP model can also be interpreted through theoretical perspectives related to nursing professional identity, autonomy, and relational care. Professional identity in nursing is considered a dynamic construct shaped by clinical practice, responsibility, and interprofessional interactions (Chenou et al., 2025; Gawthorne et al., 2025). Models that expand nurses' decision-making capacity, such as the ECP, may contribute to strengthening this identity. In addition, nursing autonomy is closely linked to the ability to exercise clinical judgment and act independently within defined protocols (Gawthorne et al., 2025). The introduction of nurse-led pathways challenges traditional hierarchical models and supports more collaborative approaches to care. Finally, relational care frameworks emphasize the importance of communication, empathy, and the nurse–patient relationship (Santana et al., 2018; Walsh et al., 2022). In emergency settings, these dimensions are often constrained by time pressures, and the ECP model may reshape how relational care is delivered.

In Italy, these models are increasingly supported by national and regional regulations aimed at strengthening organizational pathways and expanding nursing competencies in emergency care. These reforms reflect a broader effort to enhance the role of nurses in acute care delivery and improve the efficiency of EDs. Several EDs in Lombardy have drawn inspiration from the Triage Nurse Ordering model, leveraging nurse-led ECPs to transform passive waiting into active clinical intervention (Rowe et al., 2011). This approach not only optimizes patient flow but also improves satisfaction and clinical outcomes.

Despite the promising outcomes reported in quantitative research, little is known about how nurses subjectively experience and make sense of implementing ECP protocols in everyday emergency care. Understanding these experiences is important for the sustainable adoption of nurse-led pathways, particularly because ECP implementation may reshape professional identity, relational care, clinical autonomy, and interprofessional dynamics. Therefore, this study adopted an interpretative phenomenological approach to explore how ED nurses in Northern Italy make sense of their lived experiences with the ECP model, with particular attention to meaning-making processes related to professional identity, relational care, and organizational change.

Methods

Study design

This study was conducted and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ)

guidelines (Tong et al., 2007), which is provided in supplementary material.

This study utilized a qualitative design based on Interpretative Phenomenological Analysis (IPA), a method well-suited for capturing rich, in-depth perspectives and the meanings participants attach to their experiences (Smith & Fieldsend, 2021). IPA enables researchers to explore the subjective world of participants, focusing on how they make sense of their experiences (Smith & Fieldsend, 2021). This approach aligns closely with the study's aim of providing a nuanced understanding of how ED nurses adapt to the innovative ECP model (Smith, 2011). IPA's dynamic and interactive nature allows consideration of both participants' viewpoints and researchers' interpretative analyses, capturing the complex interplay between experience and meaning (Smith et al., 2021; Smith & Fieldsend, 2021). This approach guided both data collection and analysis, with a focus on understanding participants' subjective meaning-making and the interpretative role of the researchers.

Setting and participants

The study was conducted in a high-volume Emergency Department located in Milan, Northern Italy, where the ECP model had been recently implemented. The department manages approximately 60,000 patient admissions per year and represents a key access point for acute care within the regional healthcare system. Participants were recruited using a combination of purposive and convenience sampling. Purposive sampling was employed to identify nurses with direct experience of the ECP model, in line with the study aim. Convenience sampling was used to facilitate recruitment within the clinical setting, allowing access to participants available during the data collection period. This combined approach ensured both the relevance of participants' experiences and the feasibility of recruitment (Sasso et al., 2025). Participants were approached face-to-face within the clinical setting and provided with information about the study before consenting to participate. No participants refused to participate or withdrew from the study.

The sample size was not defined a priori but was guided by the concept of information power, consistent with the focused and idiographic orientation of the study. Given the specificity of the sample, the narrow study aim, participants' direct experience of the ECP model, and the richness of the interview accounts, recruitment continued until the dataset provided sufficient depth and experiential variation to support a nuanced exploration of the phenomenon. Inclusion criteria were: a) registered nurses with current licensure in Italy; b) at least three months of experience working in an ED with the ECP model; c) formal training in triage and ECP protocols; d) willingness to participate and provide informed consent. Exclusion criteria were: a) nurses without formal triage training; b) nurses lacking direct experience with the ECP model; c) nurses with less than three months of ED experience; d) nurses who declined to provide informed consent. A total of 17 nurses participated in the study.

Data collection

Data were collected between July and August 2024 through in-depth, semi-structured interviews (Sasso et al., 2025), selected for their capacity to elicit rich and nuanced accounts of how participants experienced and interpreted the ECP model. No repeat interviews were conducted. Field notes were recorded during and immediately after each interview to capture contextual observations and support interpretation of participants' accounts. Interviews were conducted in private, quiet locations within the hospital to ensure confidentiality and participant comfort. Each interview lasted between 20 and 40 minutes and concluded when participants felt they had fully expressed their thoughts. All participants provided written informed consent prior to the interviews, which were audio-recorded and transcribed verbatim to guarantee accuracy. To deepen the exploration, follow-up prompts encouraged participants to elaborate on their responses. The interview guide, presented in Table 1, consisted of open-ended questions designed to investigate nurses' perceptions, challenges, and perceived benefits of the ECP model.

Table 1. Interview Guide.

Section 1: Introduction
"Thank you for agreeing to participate in this interview. The aim of this conversation is to explore your experiences and perspectives related to the implementation of the Emergency Care Practitioner (ECP) model in your department. There are no right or wrong answers. Please feel free to share your thoughts openly. Everything you say will be kept confidential and used only for research purposes."
Section 2: Opening Questions
1. ***Can you briefly describe your professional background and current role in the emergency department?***
2. ***When and how did you first become involved with the ECP model?***
Section 3: Core Questions
3. ***Can you describe your professional experience with the introduction of the ECP model?*** *Follow-up: What were your initial expectations or concerns?*
4. ***Have you observed any emotional or psychological impact on your professional practice following the implementation of the ECP model?*** *Follow-up: How did it affect your motivation, stress levels, or job satisfaction?*
5. ***In your opinion, how has the ECP model influenced the quality of care provided to patients in the emergency department?*** *Follow-up: Could you provide any specific examples?*
6. ***How do you believe the ECP model has affected relationships and collaboration between you and other members of the emergency team?*** *Follow-up: Have there been changes in communication, decision-making, or team dynamics?*
7. ***What were the main obstacles or challenges you encountered during the implementation of the ECP model?*** *Follow-up: How were these challenges addressed, if at all?*
8. ***From your perspective, what benefits or advantages have you observed since the introduction of the ECP model?*** *Follow-up: Were any of these unexpected?*
9. ***Which improvements or modifications would you suggest for the future implementation and refinement of the ECP model?*** *Follow-up: What advice would you give to another department planning to adopt it?*
Section 4: Closing Questions
10. ***Is there anything else you would like to add or think is important for us to understand about your experience with the ECP model?***
11. ***Would you be open to a follow-up conversation if further clarification is needed?***

Data Analysis

All audio recordings were meticulously transcribed verbatim by one author (SH). The translation process from Italian to English was carefully conducted to preserve the original meaning and interpretative depth of participants' narratives. The initial translation was performed by one researcher (SH) and subsequently independently reviewed by a second researcher (LG) to ensure semantic accuracy and consistency. This process involved researcher triangulation, whereby both researchers compared the translated texts with the original transcripts to verify fidelity to participants' meanings. Any discrepancies or ambiguities were discussed and resolved collaboratively, ensuring that the final version accurately reflected the nuances of the original data while maintaining interpretative coherence.

Data analysis was conducted by two researchers (SH and LG), who independently engaged with the transcripts and subsequently discussed emerging interpretations to reach a shared understanding. Themes were inductively derived from the data. No qualitative data analysis software was used. Data were analyzed following the principles of IPA as outlined by Smith et al. (2021) (Smith et al., 2021). The analytic process was iterative, inductive, and idiographic, with a focus on understanding how individual participants made sense of their lived experiences with the ECP model. Each transcript was first analyzed independently to preserve the idiographic commitment of IPA. This involved repeated close reading and detailed exploratory commenting, including descriptive, linguistic, and conceptual notes. Particular attention was paid to the meanings participants attributed to their experiences, as well as to the emotional and relational dimensions embedded in their narratives. Emergent themes were then developed for each individual case, capturing both explicit statements and underlying meanings. This phase involved a double hermeneutic process, whereby the researchers engaged in interpreting how participants themselves interpreted their experiences.

Subsequently, patterns across cases were

examined, identifying convergences and divergences while maintaining sensitivity to individual nuances. Themes were organized into superordinate themes and related sub-themes, reflecting both shared experiential structures and individual meaning-making processes.

Throughout the analysis, discussions among the research team supported the interpretative process, ensuring that findings remained grounded in the data while acknowledging the researchers' active role in meaning construction.

Rigour and reflexivity

To strengthen the rigor and trustworthiness of the analysis, multiple strategies were implemented. Bracketing was employed to consciously acknowledge and set aside researchers' preconceptions, ensuring interpretations remained grounded in participants' lived experiences. Audit trails were meticulously maintained to transparently document every phase of the analytic process, enhancing reproducibility and clarity. Additionally, thick descriptions were provided, offering rich, contextually detailed accounts that deepen the understanding and transferability of the findings within the participants' environment. The researchers' backgrounds and positioning were considered throughout the study in line with IPA principles. The research team consisted of nurse researchers with experience in emergency care and qualitative research. This professional background facilitated access to the field and a deep understanding of the clinical context, while also requiring careful reflexive awareness. To address this, reflexivity was actively practiced throughout the research process. Researchers engaged in bracketing to critically reflect on their assumptions, and regular team discussions were conducted to examine alternative interpretations and ensure that findings remained grounded in participants' accounts.

In addition, this study adhered to Lincoln and Guba's (1988) established criteria for qualitative rigor: credibility, transferability, dependability, and confirmability (12). Credibility was ensured through prolonged engagement with the data, allowing a comprehensive understanding of participants' perspectives, member checking, and methodological triangulation. Member checking was conducted after the preliminary analysis phase by sharing initial interpretations and emerging themes with a subset of participants. Participants were asked to review whether the interpretations accurately reflected their experiences and meanings. Feedback received was used to refine and confirm the analysis, ensuring that the findings remained grounded in participants' perspectives. Triangulation was achieved by cross-referencing diverse data sources, such as interview transcripts and field notes, to strengthen the robustness and accuracy of the analysis. Feedback received was incorporated into the final analysis. Triangulation was achieved by cross-referencing diverse data sources, such as interview transcripts and field notes, to strengthen the robustness and accuracy of the analysis. Transferability was addressed by offering detailed contextual descriptions of the study setting, participant profiles, and key results, enabling readers to evaluate the applicability of findings to other contexts. Dependability was supported through thorough audit trails that recorded every step of data collection, analysis, and interpretation, guaranteeing transparency and methodological consistency. Confirmability was enhanced through ongoing reflexivity and the use of bracketing, whereby researchers actively minimized personal biases, thereby preserving the objectivity of the study and ensuring that the results accurately reflect the participants' narratives.

Ethical considerations

The study complied with the Declaration of Helsinki (2013), including Regulation (EU) 2016/679 (General Data Protection Regulation – GDPR) and the Italian Privacy Code (Legislative Decree No. 196/2003, amended by Law No. 56/2024). Participants were fully informed about the study's aims, procedures, possible risks, and their right to withdraw at any time without penalty. All data were anonymized, and confidentiality was rigorously maintained throughout. Ethical approval was obtained from the appropriate institutional review board.

Results

The sample included 17 nurses (12 females, 5 males) aged 24 to 55 years (mean 46), with diverse professional backgrounds ranging from recent graduates to veterans with over 30 years of experience. Educational levels varied from

diploma holders to nurses with bachelor's degrees and postgraduate qualifications, including master's degrees (see Table 2 for details).

Table 2. Population description.

Nurses	Age, Sex	Work	Educational Qualification
1	55 years, female	27 years	Diploma, Master's degree
2	53 years, female	33 years	Diploma
3	50 years, female	27 years	Diploma
4	53 years, female	27 years	Diploma
5	29 years, female	5 years	Bachelor's degree
6	29 years, female	4 years	Bachelor's degree
7	30 years, female	5 years	Bachelor's degree, Master's degree
8	24 years, female	2 years	Bachelor's degree
9	27 years, female	4 years	Bachelor's degree
10	27 years, female	4 years	Bachelor's degree
11	30 years, female	5 years	Bachelor's degree
12	33 years, male	8 years	Bachelor's degree
13	28 years, male	4 years	Bachelor's degree
14	33 years, male	8 years	Bachelor's degree
15	32 years, male	8 years	Bachelor's degree
16	52 years, male	31 years	Diploma
17	40 years, female	16 years	Bachelor's degree

Thematic analysis revealed five core themes capturing the multifaceted impact of the ECP model on nursing practice, patient care, and interprofessional dynamics:

1. Deepening the nurse-patient connection
2. Empowerment and professional identity growth
3. Streamlining care through organizational innovation
4. Fostering communication and team synergy
5. Navigating challenges and overcoming barriers

Although themes represent shared patterns across participants, the analysis remained grounded in individual accounts, with attention to how each nurse made sense of their experience within the ECP model, in line with IPA principles. Each theme, which is divided into two subthemes (see Figure 1), provides key insights supported by participants' direct quotes, illustrating authentic voices and experiences.

Deepening the nurse-patient connection

This theme captures how participants experienced a transformation in the relational dimension of care, moving beyond task-oriented interactions toward more meaningful engagement. Two sub-themes were identified, reflecting both the structural conditions enabling connection and the emotional processes through which care is interpreted.

Experiencing relational depth in care encounters

For several participants, the ECP model was experienced as enabling a shift from fragmented, task-oriented interactions toward more relational and person-centered encounters. This

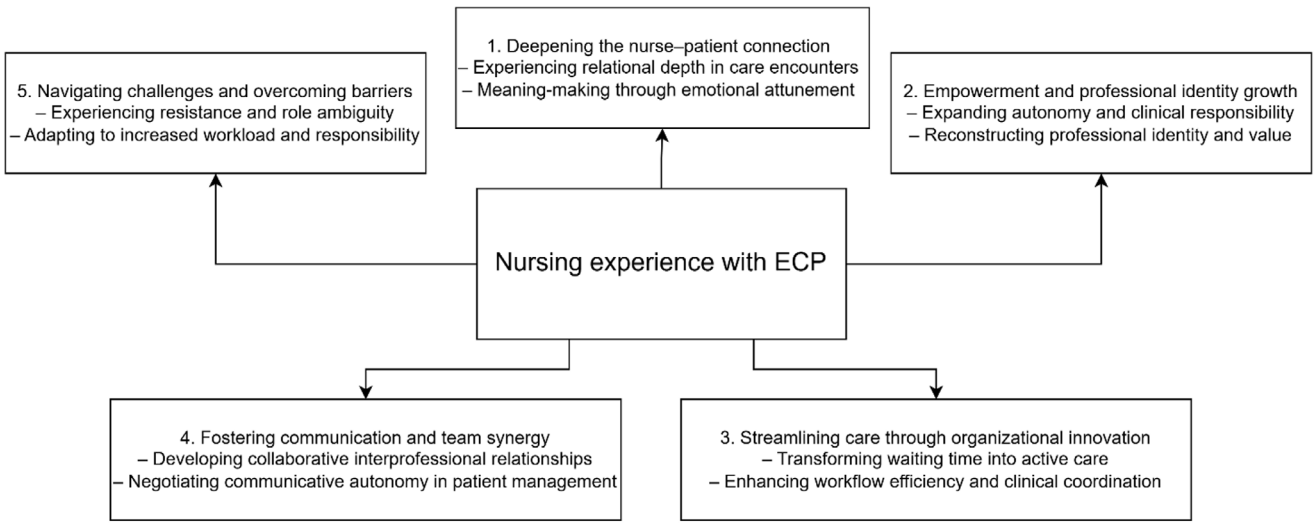

Figure 1. Themes and sub-themes.

transformation was closely tied to the availability of uninterrupted time, which allowed nurses to engage more meaningfully with patients and reframe care as a shared relational process. One participant emphasized how *"applying the ECP means spending meaningful time with the patient, explaining the care pathway, and responding to their needs. This fundamentally increases the patient's feeling of being truly cared for"* (Interview 15), highlighting how time becomes a vehicle for connection rather than merely a logistical resource. Similarly, another nurse reflected that *"having dedicated time and space ensures privacy and genuine care"* (Interview 9), suggesting a reorientation from efficiency-driven care toward relational presence. Through these accounts, care is interpreted not simply as intervention but as a co-constructed relational experience grounded in attention, communication, and mutual recognition. While this experience was shared across participants, the intensity and meaning attributed to relational engagement varied, reflecting individual ways of interpreting care encounters.

Meaning-making through emotional attunement

Beyond the structural availability of time, participants described a deeper emotional engagement with patients, interpreting this as central to their professional role. Emotional attunement emerged as a process through which nurses actively made sense of patients' experiences and responded in a sensitive and individualized manner. As one participant explained, *"listening deeply helps me step into the patient's shoes, understand their emotions, and respond sensitively"* (Interview 16), illustrating how empathy is enacted as an interpretative practice. This was reinforced by another nurse who noted that *"you understand how important it is for the patient to be heard, even in the emergency context. This model allows that"* (Interview 1), emphasizing the value of recognition and voice. Patients' reactions further shaped this meaning-making process, as nurses observed that *"patients seem more composed and more willing to accept waiting times, knowing they are being cared for"* (Interview 10). In this sense, emotional attunement becomes a reciprocal process, through which nurses construct care as both affective and relationally responsive. However, the degree to which autonomy was embraced differed among participants, with some expressing confidence and others highlighting initial uncertainty.

Empowerment and professional identity growth

This theme reflects how the ECP model influenced participants' sense of autonomy, responsibility, and professional self-perception. The analysis revealed two interconnected sub-themes, highlighting both the expansion of clinical agency and the reconstruction of professional identity.

Expanding autonomy and clinical responsibility

Participants consistently interpreted the ECP model as fostering greater autonomy and clinical responsibility, fundamentally reshaping their engagement with care processes. The ability to initiate interventions and make decisions independently was experienced as both empowering and transformative. One nurse described how the model *"boosts self-esteem and awareness of our contribution… it challenges us to be true protagonists in health promotion"* (Interview 3), suggesting that autonomy is internalized as a core dimension of professional identity. This shift was also reflected in interprofessional dynamics, as participants noted that *"communication with physicians improved, and we gained more autonomy in care decisions"* (Interview 15), indicating a redistribution of decision-making authority. Moreover, acting directly on clinical protocols reinforced this sense of agency, as another nurse explained that *"if a patient fits the analgesia protocol, I can administer pain relief immediately"* (Interview 11), highlighting the immediacy of decision-making. *"You feel you are no longer just executing orders, but actively contributing to patient outcomes"* (Interview 6). These experiences highlight how autonomy is not merely granted but actively enacted and embodied in practice, contributing to a sense of professional empowerment. Nevertheless, participants varied in their comfort with this increased autonomy, with some embracing it as empowering and others experiencing it as a source of initial uncertainty.

Reconstructing professional identity and value

Alongside increased autonomy, participants described a broader process of reconfiguring their professional identity, shaped by recognition, responsibility, and visibility within the healthcare team. Nurses interpreted the ECP model as legitimizing their competencies and redefining their role beyond traditional expectations. This was evident in reflections such as *"after implementing the model, we felt our profession finally acknowledged and valued"* (Interview 13), which point to a shift in perceived professional worth. Similarly, the recognition of expanded competencies led one participant to observe that *"nursing is achieving decision-making autonomy previously unrecognized"* (Interview 10), indicating a redefinition of role boundaries. This transformation was also experienced at a personal level, as another nurse noted, *"I feel more competent and responsible, and this model has given me the tools to express my skills more fully"* (Interview 4). Through these accounts, professional identity emerges as fluid and continuously reconstructed, shaped by evolving practices and relational validation. These shifts in professional identity were not experienced uniformly, as participants differed in the extent to which they internalized recognition and redefined their role within the team.

Streamlining care through organizational innovation

This theme explores how participants interpreted changes in workflow and care delivery following the implementation of the ECP model. Two sub-themes were identified, capturing the transformation of time into an active resource and the reorganization of clinical processes.

Transforming waiting time into active care

Participants described a significant shift in how waiting time was experienced within the emergency department, interpreting it no longer as passive delay but as an opportunity for proactive intervention. The ECP model enabled nurses to reframe waiting as *"active waiting",* where care begins earlier and patients are no longer left unattended. This transformation was captured in the observation that *"the ED experience is more efficient; waiting becomes productive care time"* (Interview 3), emphasizing the operational and experiential shift. Participants also highlighted the relational implications of this change, noting that *"patients seem more composed and more willing to accept waiting times, knowing they are being cared for"* (Interview 10). The value of early intervention was further reflected in statements such as *"it's rewarding when a patient comes back just to thank you for relieving their pain promptly"* (Interview 5), indicating the tangible impact on patient experience. *"Even if they wait, they feel something is being done for them"* (Interview 9). In this sense, waiting time is reinterpreted as clinically and relationally meaningful time. Despite this shared perception, participants attributed different meanings to this transformation, with some focusing on efficiency and others emphasizing its impact on patient reassurance and relational care.

Enhancing workflow efficiency and clinical coordination

Participants also emphasized improvements in workflow efficiency and coordination, interpreting the ECP model as enabling a more structured and coherent organization of care. The introduction of dedicated spaces and protocols facilitated concentration and reduced fragmentation, as reflected in the statement *"finally, we have a space to concentrate on reassessment without distractions"* (Interview 15). Early initiation of care was perceived as improving overall flow, with one participant noting that *"starting care earlier saves time and confusion – it's a real game-changer"* (Interview 14). These changes were also experienced as enhancing clarity and predictability in clinical processes. *"Everything is more organized, and you know what to do sooner"* (Interview 2). *"It reduces the chaos that usually characterizes the emergency department"* (Interview 6). These experiences suggest that organizational innovation not only improves efficiency but also reshapes how nurses perceive and manage clinical complexity. However, the perceived benefits of organizational changes varied among participants, reflecting individual ways of adapting to and making sense of new workflows.

Fostering communication and team synergy

This theme illustrates how the ECP model reshaped communication practices and interprofessional relationships within the emergency department. The analysis identified two sub-themes, reflecting both the development of collaborative dynamics and the emergence of communicative autonomy.

Developing collaborative interprofessional relationships

Participants described a shift toward more collaborative relationships with physicians, interpreting this as a move toward greater professional integration. Communication was experienced as more open and reciprocal, enabling nurses to participate more actively in care decisions. One nurse reflected that *"There's more dialogue now; physicians listen and truly work with us to manage care"* (Interview 2), illustrating a change in relational dynamics. This collaborative approach was also linked to patient safety, as another participant emphasized that *"Communication among us is key to maintaining patient safety"* (Interview 7). *"We are more aligned as a team, and this improves how we work together"* (Interview 12). These accounts suggest a reconfiguration of professional relationships, grounded in mutual respect and shared responsibility. At the same time, participants differed in how they experienced these changes, with some describing strong collaboration and others highlighting ongoing tensions within the team.

Negotiating communicative autonomy in patient management

In parallel, participants described increased autonomy in communicating with patients and managing initial care decisions. This shift allowed nurses to take a more proactive role in guiding patients through their care pathway. As one participant stated, *"We answer patient questions and decide independently, without always referring to physicians"* (Interview 6), highlighting reduced dependency on physicians. The model also enabled greater involvement in patient education, expanding the communicative dimension of care. *"Now I explain the process directly to the patient, and they rely on me"* (Interview 8). *"We also have more time to provide information, which patients really appreciate"* (Interview 5). Communication thus becomes a space of autonomy and responsibility, reinforcing the expanded scope of nursing practice. This increased communicative autonomy was interpreted differently across participants, depending on their confidence, experience, and prior role expectations.

Navigating challenges and overcoming barriers

This theme addresses the difficulties and tensions encountered during the implementation of the ECP model. Two sub-themes were identified, highlighting both the experience of resistance and ambiguity, and the process of adaptation to increased demands.

Experiencing resistance and role ambiguity

Despite the positive aspects of the ECP model, participants described challenges related to resistance from physicians and unclear role boundaries. These tensions were interpreted as part of a broader process of change, where established roles were being renegotiated. One nurse expressed frustration, stating that *"sometimes I have to push physicians to take over patients I initially saw, which can be frustrating"* (Interview 3), highlighting difficulties in interprofessional collaboration. Uncertainty about roles was also evident, as participants described ambiguity in responsibilities. *"At the beginning, it wasn't clear where our role ended and the physician's began"* (Interview 14). *"Some colleagues were skeptical and didn't trust the model at first"* (Interview 12). These experiences reflect the complexity and tension inherent in organizational transformation. The experience of resistance was not uniform, as some participants perceived it as a significant barrier, while others interpreted it as part of a natural process of organizational change.

Adapting to increased workload and responsibility

Participants also described the increased workload and responsibility associated with the ECP model, particularly during its initial implementation. Managing new protocols

alongside existing duties was experienced as demanding, as one nurse explained that *"learning new protocols while managing existing duties was demanding"* (Interview 7). Initial hesitation and concern were also present, as reflected in the statement *"I hesitated, worried it would interfere with my core tasks"* (Interview 17). However, over time, participants described a process of adaptation and growing confidence. *"At first it felt overwhelming, but then it became part of the routine"* (Interview 8). *"Now I feel more confident, even if the responsibility is greater"* (Interview 4). These accounts illustrate how challenges are integrated into a process of professional development and adaptation, rather than remaining purely as obstacles. Over time, participants made sense of these challenges in different ways, with some integrating them into professional growth and others continuing to perceive them as ongoing strain.

Discussion

From an interpretative phenomenological perspective, these findings suggest that the ECP model is not merely an organizational innovation but represents a transformative experiential shift in how nurses understand and enact their professional role. Participants' accounts indicate a reconfiguration of meaning across relational, professional, and organizational dimensions, highlighting the dynamic interplay between autonomy, responsibility, and identity construction. From a phenomenological perspective, these findings can be understood as reflecting a process of meaning-making in which nurses actively reinterpret their role within a changing clinical environment. The ECP model appears not only to modify organizational practices but also to reshape how nurses experience their professional identity and relational engagement with patients.

This study provides an important and timely contribution to the growing body of literature on innovative nursing care models in emergency settings, focusing particularly on the Italian healthcare system. Utilizing an IPA approach, the research offers an in-depth exploration of the lived experiences of nurses engaged in the implementation of the ECP model. The rich qualitative data not only illuminate clinical and organizational changes but also highlight the emotional, relational, and professional impacts on nursing practice. By centering the perspectives of emergency nurses – often underrepresented in healthcare policy and system reform discussions – this study elucidates the complex interactions between advanced nursing roles, care delivery processes, and interdisciplinary collaboration.

The findings reveal that the ECP model significantly contributes to nurse empowerment and professional development. Participants consistently reported increased autonomy, expanded clinical responsibilities, and enhanced visibility within multidisciplinary teams. This evolving professional identity was characterized by greater self-esteem, reinforced clinical authority, and a stronger sense of ownership in patient care decisions. The ability to initiate protocols and administer medications independently led many nurses to view themselves as "protagonists of health and prevention". These results align with contemporary research on Advanced Practice Nurses (APNs), which shows that autonomous application of evidence-based protocols enhances nurse engagement, motivation, and professional satisfaction (Lenza et al., 2023). However, empowerment was not uniformly experienced. Some participants identified barriers including role ambiguity, skepticism, and hesitation to assume new responsibilities, underscoring the necessity for ongoing organizational support, clear role definitions, and tailored training programs. Empowerment should thus be understood as a dynamic and context-dependent process rather than a fixed state (Gawthorne et al., 2025). These findings can be interpreted as a process of professional identity reconstruction, in which autonomy and responsibility are not merely functional changes but are integrated into nurses' self-understanding. From this perspective, the ECP model contributes to redefining nursing as an active, decision-making profession, rather than a task-oriented role.

From an organizational perspective, the ECP model contributed to the restructuring of traditional hierarchies, fostering greater collaboration and parity between nurses and physicians. Participants described a shift toward shared decision-making and a more horizontal model of care delivery. This interdisciplinary synergy is critical in high-acuity environments, where effective communication and mutual trust enhance both team cohesion and patient

safety (Mota et al., 2024). At a broader level, these changes can be interpreted as a shift toward more collaborative and less hierarchical models of care, in which professional boundaries become more fluid. This transformation reflects an ongoing reconfiguration of interprofessional roles, where meaning is negotiated through interaction and shared clinical responsibility.

Additionally, the introduction of early care protocols improved workflow efficiency by transforming waiting times into periods of active intervention. Early analgesia administration and timely reassessment reduced delays and facilitated faster access to diagnostic pathways (Interview 11), consistent with studies on nurse-led fast-track protocols demonstrating improved patient throughput and reduced ED length of stay (Curtis et al., 2023; Fournier et al., 2026). The establishment of dedicated reassessment areas further optimized resource utilization and reinforced continuity of care, promoting interdisciplinary coordination (Benjamin, 2025). Nurses also reported a more positive work environment characterized by improved communication and mutual respect with physicians, indicating that such models not only enhance patient flow but also reshape team dynamics toward shared responsibility and collaborative problem-solving (Mota et al., 2024; Ruiz, 2020).

Participants consistently emphasized that the ECP model enabled more authentic and individualized patient care by providing dedicated time and clinical autonomy. This enhanced the nurse-patient relationship through increased trust, active listening, and emotionally attuned care. Nurses described this experience as enabling "true care" (O'Hagan et al., 2014), which aligns with patient-centered care literature highlighting the importance of quality communication and relational continuity in reducing patient anxiety, improving adherence, and enhancing health outcomes (Walsh et al., 2022). Nurses also observed greater patient calmness and satisfaction when preliminary nursing care preceded physician evaluation (MacIsaac & Peter, 2025). Such relational benefits are particularly valuable in overcrowded and high-stress emergency settings, where emotional reassurance and clear information significantly influence patient perceptions of care quality (MacIsaac & Peter, 2025). From a phenomenological perspective, the enhanced nurse–patient relationship described by participants can be understood as a re-centering of care on the lived experience of the patient. This suggests that relational care is not an additional component of practice but a fundamental dimension through which clinical work acquires meaning.

Despite these positive effects, the implementation of the ECP model faced challenges. Some participants expressed initial resistance due to skepticism, uncertainty regarding evolving roles, and discomfort with increased responsibilities. These barriers highlight the importance of sustained leadership engagement, continuous professional development, and clear communication to facilitate role clarity and acceptance. Without such supports, the relational and organizational benefits may be unevenly distributed and difficult to maintain over time (Gawthorne et al., 2025). These challenges can be interpreted not only as organizational barriers but also as moments of tension within the process of professional transformation. Resistance, uncertainty, and adaptation reflect the complexity of integrating new meanings into established practices.

Overall, the findings suggest that the implementation of the ECP model represents not only a structural innovation but a transformation in how nurses interpret, experience, and give meaning to their role within emergency care. Beyond its contextual relevance, this study offers a conceptual contribution by illuminating how nurses interpret and give meaning to organizational innovation within emergency care. The findings suggest that the implementation of the ECP model is not only a structural change but also a process of professional and relational transformation, in which autonomy, identity, and care practices are actively redefined. This study contributes to the existing literature by extending current understandings of nurse-led models beyond efficiency outcomes, highlighting the experiential and meaning-making dimensions of practice. In this sense, the findings offer insights that may be transferable to other healthcare contexts where similar organizational innovations aim to expand nursing roles and enhance patient-centered care.

This study presents several limitations that must be considered when interpreting the findings. First, the sample was limited to 17 nurses from a single ED in Northern Italy. While appropriate for an IPA approach, this narrow

scope may have constrained the diversity of perspectives and limited the transferability of the results to other healthcare contexts, including within the Italian setting where healthcare organization may vary across regions. Moreover, despite efforts to recruit a heterogeneous sample, differences in age, education, and professional experience among participants may have influenced their perceptions. The implementation of the ECP model also faced organizational challenges, including resistance to change, unclear procedural guidelines, and inconsistent adherence to protocols, which may have impacted its overall effectiveness (Interview 3, 7, 12). Importantly, the study did not include the viewpoints of other key stakeholders such as physicians, administrators, or patients. The absence of these perspectives limits the comprehensiveness of the analysis and understanding of the model's systemic impact.

In addition, as with all qualitative interpretative research, the findings are inevitably shaped by the researchers' role in the analytic process. Although reflexive strategies were employed, including bracketing and team discussions, the interpretation of participants' experiences is influenced by the researchers' perspectives and professional backgrounds. Furthermore, the translation of data from Italian to English represents a potential limitation. Although careful procedures were followed to preserve semantic accuracy, nuances of meaning embedded in the original language may not be fully transferable. As meaning in qualitative research is closely tied to language, this process may have influenced the interpretation of participants' narratives.

Implications for Practice

The findings demonstrate that nurse-led protocols embedded in the ECP model have the potential to enhance the quality, timeliness, and continuity of emergency care by strengthening nurses' autonomy, clinical reasoning, and decision-making capabilities. Clinically, the model supports optimizing patient flow while fostering the relational aspects of care, such as trust and emotional support, which are often compromised in crowded ED settings. Organizationally, the study highlights the importance of revising workflows and professional roles to encourage interdisciplinary collaboration and shared responsibility. However, successful implementation requires strong leadership, ongoing professional development, and inclusive change management to overcome resistance, role ambiguity, and uneven training.

Future Perspectives

Future research should adopt a multi-stakeholder approach to better capture the diverse experiences of nurses, physicians, administrators, and patients, thereby providing a more comprehensive evaluation of the ECP model's feasibility and impact. Incorporating patient perspectives would deepen understanding of the emotional and relational dimensions of early care, while mixed-methods studies could quantify clinical outcomes such as ED length of stay, time to analgesia, patient satisfaction, and continuity of care post-discharge. Moreover, the development and validation of tools to measure constructs like perceived nurse autonomy, therapeutic alliance, and emotional climate would enable systematic assessment of the model's effects on care delivery, professional satisfaction, and organizational efficiency. Given the ongoing challenge of ED overcrowding, refining and scaling nurse-led protocols such as the ECP represents a strategic priority to improve patient outcomes and system efficiency.

Conclusion

This study contributes valuable insights into the implementation and impact of the ECP model within a high-pressure ED context. By focusing on nurses' experiences, the research highlights the critical role of nurse-led protocols in enhancing clinical autonomy, decision-making, and relational care. The findings emphasize how empowering nurses through structured, evidence-based frameworks can improve patient flow, reduce delays, and foster a more patient-centered approach, even in overcrowded and resource-constrained settings.

However, the study also underscores the complexity of integrating such innovations into real-world clinical practice. Organizational barriers, including resistance to change, unclear

guidelines, and variable adherence, can hinder effective implementation. Overcoming these challenges requires strong leadership, targeted training, and inclusive strategies that promote interdisciplinary collaboration and shared responsibility. Recognizing nurses as both technical experts and relational professionals is essential for advancing emergency care quality and sustainability.

Looking ahead, this research lays the groundwork for further exploration of nurse-led models across diverse healthcare environments. Future studies incorporating multi-stakeholder perspectives and mixed methods will be crucial to validate and scale the ECP approach. Ultimately, fostering professional transformation and system innovation through nurse empowerment represents a promising path to meet the evolving demands of emergency healthcare and improve patient outcomes. By providing an interpretative account of nurses' lived experiences, this study advances current knowledge on the role of meaning-making in the successful implementation of innovative care models.

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