Observations and Actions of Nurse Executives During No-Notice Disaster Events in the Hospital Setting

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Article

Abstract

Hospital-based nurses are on the frontline of no-notice disaster events. They are supervised by a nurse executive (NE) who is responsible for the constant delivery of safe and competent nursing care, including during times of disaster. As a member of the hospital administrative team and Hospital Incident Command System, the NE is well positioned to maximize nurses' safety and readiness. Specific actions by NEs during no-notice events are largely absent from the scientific literature. This non-experimental, descriptive, qualitative study aimed to describe the observations and actions of NEs (*n* = 6) who experienced at least one no notice disaster event. Domains from The International Council of Nurses Core Competencies in Disaster Nursing served as a framework for analysis. A collaborative thematic analysis then considered the real-life experience of NEs who supervised nurses' response to a major no-notice disaster. NEs were amongst the first administrators to respond onsite. Communication was often most effective using personal cell phones. Nurses needed to make immediate life-saving decisions despite the absence of a formalized incident command structure. Many suffered from traumatic exposure and NEs facilitated immediate and long-term mental health support. This article describes our study methods and the seven themes that emerged from our analysis, along with implications for research and practice.

Key Words: Incident, mass casualty, violence, tornadoes, nurse administrators, mass casualty incidents, disaster victims, workplace violence, gun violence, triage, equipment and supplies, hospitals, emergencies

As the largest employee group in the hospital setting, nurses are on the frontline of no-notice disaster events. They are supervised by a nurse executive (NE), sometimes referred to as the Chief Nursing Officer, who is responsible for the constant delivery of safe and competent nursing care, including during times of disaster. As a member of the hospital administrative team and Hospital Incident Command System, the NE is well positioned to maximize nurses' safety and readiness. Specific actions of NEs during no-notice events are largely absent from the scientific literature; therefore, in this article we aim to describe the activities of the NE and any observations which would support nurses' response.

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"No-notice events," as defined here, happen with little or no warning and require immediate action, such as a tornado or an active shooter. In contrast, "notice events" are defined here as those that happen with the notice of several hours or days, such as a hurricane or pandemic. Although hospitals may be less likely to experience a disaster without notice, the unpredictability of such events can present significant security challenges for facilities who prove to be uniquely vulnerable over time (Kelen et al., 2012; Nates, 2004; Soncrant et al., 2021).

Review of Literature

The Role of the Nurse Executive

Nurse executives are ultimately responsible for the delivery of disaster training for every nurse at the time of hiring and on an annual basis thereafter. As such, the NE has influence on organizational strategies to support response by nurses to a

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disaster. As the leader of the nursing staff and member of the hospital administrative team, the NE is an active participant in the establishment of the Emergency Operations Plan ([EOP]; California Emergency Medical Services Authority, 2016; Kaye et al., 2021) and compliance with emergency management standards required by organizations such as the Centers for Medicare & Medicaid Services ([CMS], 2016). The NE is a member of the Hospital Incident Command System (HICS) and would be assigned a role during a disaster event.

The Role of Nurses During Disaster

Most of the extant literature about nurses and their role during a disaster references natural disasters that occur with notice and the presence of an intact HICS (Grochtdreis et al., 2017). Apart from the published literature, hospital after-action reports are a potential source of information, but such documents are typically not intended for a larger public audience. Occasionally, event timelines during notable disasters can be found (Nadworny et al., 2014), but methodical studies of the NEs actions during no-notice events is largely absent from the scientific literature. The goal of this study was to understand the actions of NEs in response to a no-notice event in the hospital. Analysis of their observations and perspectives on strategies can be useful to support nurses' response to no-notice events.

Methods

Design, Sample, and Setting

This non-experimental, descriptive, qualitative study was reviewed and approved by the VA Greater Los Angeles Healthcare System Institutional Review Board (IRB) and the IRBs of each study collaborator. We considered key informants, news reports, and public after-action reports to inform our effort to collect a convenience sample. Inclusion criteria consisted of a NE or a NE designee who supervised nursing staff during a major disaster in a hospital setting (both Veterans Administration [VA] and non-VA).

To encompass the wide range of potential threats that hospitals face, we attempted to identify multiple disasters examined by type (e.g., weather, violence, infectious disease, fire), responses (e.g., evacuation versus shelter in place), timing (notice versus no-notice), and geographic location within the United States. Of 32 NEs who received an email invitation and follow-up phone call, 11 agreed to participate, 2 refused without a stated reason, 2 provided referrals, and 17 did not respond.

Eleven NEs who agreed to participate experienced disasters caused by weather, violence, and infectious disease between 2014 and 2020. The time between the disaster and interview date ranged from six months to 3.5 years. Five experienced a disaster with notice and six experienced a disaster with no-notice. This article focuses on the analysis of experiences of the NEs (n = 6) who experienced no-notice events.

Data Collection

The research team developed an interview guide with the open-ended questions listed below to learn about the actions of NEs during the disaster, factors that prepared them for their response, and organizational strategies that would best support their response.

1. Describe your observations of the range of roles and responsibilities assumed by the nurses you supervised.
2. In recalling the knowledge, skills, and abilities required of nurses during the disaster you supervised, can you describe what you think are the educational needs of post-licensure nurses to best prepare them for disaster response in the hospital setting?
3. Based on your experience and observations, can you suggest organizational strategies for supporting nursing response during disaster in the hospital setting?

All team members have disaster research experience and three have active registered nurse (RN) licenses and hospital work experience. A 30 to 60 minute telephone interview was conducted from a private office workspace. Confidentiality of personal & hospital identity was guaranteed. Interviews were led by the same person for consistency and other research team members had the opportunity to ask follow-up questions. All interviews were recorded, professionally transcribed, and checked for quality against the transcript.

Data Analysis

A collaborative thematic analysis was used to describe the real-life experience of the NEs and form assumptions about their experiences (Braun & Clarke, 2006). All authors participated in analysis through group coding. First, the research team agreed to an inductive coding process. Interview transcripts were read by all team members, and each served as the lead coder for a portion of transcripts. The lead coder identified and coded quote "chunks" to grasp broad ideas as they appeared (Polit &

Beck, 2022). Then, the respective lead reviewers' findings were presented to the rest of the research team and compared for consistency in interpretation. Additions, disagreements, or decisions were reconciled, recorded, and disseminated back to the team in writing (Boeije, 2002).

Over time, themes were collapsed or separated, based on their similarities or differences. When necessary to assure accuracy, a follow-up phone call was arranged to address outstanding questions posed by the research team and to provide the respondent with an opportunity to validate team interpretations (Braun & Clarke, 2006; Delve & Limpaecher, 2023). This process was completed using a spreadsheet, without the use of computer-assisted qualitative data analysis software.

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In an effort to integrate theory with practice (Patton, 2014), domains described by the International Council of Nurses Core Competencies in Disaster Nursing ([ICN], 2019) were referenced as a framework for analysis. The ICN and World Health Organization (WHO) collaborated with an international group of disaster nursing experts to publish core competencies for general (Level I) and executive nurses (Level II) with the aim of "building the capacities of nurses at all levels to safeguard populations, limit injuries and deaths, and maintain health system functioning and community well-being in the midst of continued health threats and disasters" and providing a "framework for educational programs and study" (ICN, 2019, p. 5). The ICN Disaster Nursing Core Competencies are organized by eight domains:

1. Preparedness and Planning
2. Communication
3. Incident Management
4. Safety and Security
5. Assessment
6. Intervention
7. Recovery
8. Law and Ethics

The domains were designed to complement the format of emergency management planning and provide the opportunity to translate research from the field to education, practice, and policy settings (ICN, 2019). Only pertinent ICN domains (1, 2, 3, 4, 7, and 8) were referenced in our analysis.

Quotations were summarized into short descriptive phrases and organized by ICN domain categories and type of response...

Quotation chunks from the eleven notice and no-notice events were first identified and coded by the authors. Only quotation chunks for the six no-notice events were identified from the data corpus and analyzed for this discussion. Quotations were summarized into short descriptive phrases and organized by ICN domain categories and type of response (e.g., evacuation, surge, run-hide-fight/shelter in place) to facilitate practical application (See Supplemental Materials A-C). Themes were extrapolated from the data analysis by group consensus.

The six no-notice disaster events referenced in this discussion include one EF5 tornado, one sudden generator failure, two mass casualty incidents (MCI) and two active shooter (AS) incidents.

Supplemental Materials A-C

No-notice disaster demographics, including a naming convention for the six NEs (NE1-NE6), an overview of each type of event, response, and frequency of NE actions and/or observations within the 8 ICN domains are provided in Table 1.

Table 1. No-Notice Disaster Demographics

NE	Disaster Type	Response	Actions/Observations within ICN Domain Categories							
			Domain 1 Preparedness and Planning	Domain 2 Communication	Domain 3 Incident Management	Domain 4 Safety & Security	Domain 5 Assessment	Domain 6 Intervention	Domain 7 Recovery	Domain 8 Law & Ethics

1	Weather EF5 Tornado	Complete emergent evacuation	*	*	*	*		*	*
2	Weather Generator Failure	Complete emergent evacuation	*	*	*	*	*	*	
3	Violence MCI	Critical care surge	*	*	*			*	*
4	Violence MCI	Surgical surge	*	*	*			*	*
5	Violence AS	Run-Hide-Fight	*	*	*	*		*	
6	Violence AS	Shelter in Place	*	*	*	*		*	

Results

Seven themes emerged from our data analysis. Themes 1-5 reflected observations of the NEs; theme 6 reflected actions taken by the NEs. Theme 7 considers both NE observations and actions. An overview of these themes, supported by quotes from the NE participants, are described below and aligned with the appropriate ICN domain. The NEs set the scene for the six events. Their exact words illustrate the lack of notice and immediate need for life saving action (Supplemental Material D).

Supplemental Material D

Nurse Executive Observations

Theme #1: Extending Drills to Unit Level; ICN Domain 1: Preparedness and Planning. All six NEs found benefit of extending drills and exercises to nurses at the unit level, involving physical practice and discussions about contingencies, and response in the absence of guidance. Physically moving real patients from their room with equipment contingencies during a drill gave nurses confidence to conduct a vertical evacuation.

All six NEs observed the benefit of extending drills and exercises to nurses at the unit level.

> NE1: ...people remember much better what they've actually done or participated in, rather than what they read. And they reminded me that those times when I said yes, I want you to move the patients in the hallway as you would if this were an actual event. While they grumbled if we had to do that when we were doing a drill, that evening [in response of a EF5 tornado and emergent evacuation] they said, thank you, because I knew exactly what to do.
>
> NE5 spoke about preparing nurses for the realities of SWAT response and difficultly moving or leaving patients who are in active labor, critical care units or surgery.
>
> NE5: The nurse managers were off the floors and downstairs for a bed huddle [when the active shooter event occurred] ...they were all escorted out of the building. They did not get up until we brought them back in after the shooter was down...But, I think... [the staff] need to be prepared... [to respond without their immediate supervisor],... [staff also] need to be told, when [SWAT] comes in... it's... their hospital. It's no longer your hospital. Guns get pointed at people, and that's education that we learned by experiencing it, and anybody I've spoken to, I say, "You have got to prepare your people for this."

All six NEs described damaged or overloaded community phone systems...

Theme #2: Communication Failure and Contingencies; ICN Domain 2: Communication. The NEs observed failures in predetermined communication contingencies and noted the reliance on personal cell phones as the primary source of communication. All six NEs described damaged

or overloaded community phone systems which impacted hospital phone and computer systems, overhead paging, and printing capabilities. Backup communication devices failed or could not be accessed or charged. Personal cell phones filled the gap for communication failures.

> NE1: [When the EF5 tornado hit our]...a nine-story [hospital]...we couldn't move throughout and make any announcement of here's what we're doing now, nor could we make an overhead announcement, because the overhead,... phones,... [and] paging system[s were not] ...working.
>
> NE2: ...the biggest problem was communication [when the generator failed, and we had to evacuate the hospital]. The satellite phones ...we use for emergencies, we only have a few of them. They were in the [dark] command centers, but the satellite phones weren't working because the system that runs the satellite phones in the city had gotten knocked out...It was around eight o'clock at night. People were coming in. People were getting ready to go. Some people had turned in their walkie talkies and those needed to be charged...the main way to communicate was by cell phone and eventually those fell apart, so the main way we communicated was by humans. I would say, ask your policeman to find a nurse manager and see if the nurse manager needs to tell us anything, because right now you're the only way we can communicate, so it was running up and down the stairs in the dark...

Plans for an alphabetical naming nomenclature for unnamed victims proved to be unrealistic when providing care superseded efforts to keep up with the flow of hundreds of unnamed victims. Numerous 911 calls from personal cell phones triggered SWAT response and numerous 911 calls coming from inside and beyond the hospital grounds triggered response from two different police municipalities.

Theme #3: Clinical Contributions to Emergency Management Activities; ICN Domain 3: Incident Management. The NEs observed the importance of contributing a clinical perspective to the planning process for no-notice incident management. NE3 spoke about the reality of the administrator on call not being a clinician and the collective efforts of emergency department (ED) and anesthesia physicians with ED and intensive care unit (ICU) charge nurses to establish a plan in real time for triage and transport of critical patients directly from the parking lot to pertinent specialty ICUs for stabilization prior to surgery. Anesthesia teamed with NE4 to coordinate available surgery teams for prioritized patients.

NEs observed the unique and vulnerable aspects of specialty units.

NEs observed the unique and vulnerable aspects of specialty units. NE4 detailed numerous departments within the perioperative department and challenged operating room (OR) nurses to be ready to serve as the leader for a large-scale surgical surge event. NE6 observed how difficult it was to find staff with the familiarity of the perioperative space and skill set to relieve traumatized OR staff in the moment.

During a prior evacuation experience, NE2 observed gaps in transfer mechanisms, especially for specialty patients (e.g., organ, heart, oncology, etc.). NE2 subsequently worked the city and community coalition alongside the nurse leadership team and served as clinical advisors to assure safe and seamless transfer of patients and workforce during emergent hospital evacuation; transfer arrangements to provide continuity of specialty care, a streamlined credentialing process, and mechanisms for accessing medical records. NE2 observed gaps in transfer mechanisms.

> NE2: ...the city was not prepared at all to help with ... finding... [receiving] hospitals [when the generator failed and we had to evacuate], so what I affectionately refer to as the nursing mafia... [which included the] chief nurses in [name of city] ... called me... [asking] do you need any beds, ...I had an army of my directors sitting in a room with landlines and cell phones calling [them back]... the fact that we are the people who are at the bedside of patients 24/7 and therefore, we know things that nobody else does...so [it is] better to bring.. [nursing] along to have the conversation, even to sit in the background and coach you, but you're going to make a better system if you have... [nursing] there as part of the discussion... defining care needs of patients by the type of bed is not a good way to do this because... I might have... a [patient in a] quote-unquote regular room [who] might be an ICU patient in a community hospital... [so] we added criteria about the needs of the patient. ...is [it] a patient with a ventilator which is an unstable patient with an endotracheal tube, or [is it] a patient who's at home with a trach on a home ventilator, right[?], those are two different patients, and they need two different types of care, and it can't be defined by the bed that they're occupying.

NE2 used this prior experience to engage with the city hospital association and local emergency management teams to facilitate formal arrangements, and establish a streamlined credentialing process, financial reimbursement approach, and access to medical records systems for a safe and seamless transfer of patients and workforce. Those actions facilitated the

prompt evacuation of this no-notice event.

The NEs observed patient safety issues and clinical implications of no-notice events.

Theme #4: Culture of Safety; ICN Domain 4: Safety and Security. The NEs observed patient safety issues and clinical implications of no-notice events. NE5 and NE6 both observed the importance of mandating active shooter training and discussion for all employees and shared special concern for "stuck units" such as intensive care, labor and delivery and operating room where patients are most critical and difficult to move. Both NE5 and NE6 observed the value of establishing a culture of safety.

> NE6: Even things down to what would make you feel safe at work. We walked, we rounded, administration rounded, we rounded night after night [after the active shooter event] …and just said, you know, tell us what you're feeling and thinking. And they were very open. They appreciated us being there. We still have an "ask leadership email" where you can go in and send an email and it can be anonymous or it can be from you. And it gets cleared, announced, and resourced to the right person.

NE2 spoke about the evening the generator power turned on and not knowing the critical generator power outlet pathways. Amid searching for active outlets and moving the sickest patients to newer parts of the hospital, the generator completely failed. The entire hospital was dark.

Theme #5: Crisis Care; ICN Domain 8: Law and Ethics. The NEs observed nurses needing to make decisions about how and who they could help first and how organizations can best prepare nurses for that moment.

> NE1: I think it's difficult to say with a lot of certainty here's exactly what you do, and the steps you take, … because if you're really in a crisis situation [when your hospital is directly hit by an EF5 tornado], very seldom do those things all line up the way you might present them. And that it does have to be in the thought process of how would I respond and what would I do, and what are some things I would consider?

Nurse Executive Actions

Theme #6: NEs First Incident Command Responders; ICN Domain 3: Incident Management. NEs were the first reporting members of the incident command team. All six events occurred without notice over a weekend or during an evening shift. Nurses had to make immediate and life-saving decisions. Five NEs were the first of the incident command team to arrive on the scene, two were accompanied by their physician counterpart.

Nurses had to make immediate and life-saving decisions.

> NE5: …the chief medical officer and I… went upstairs with armed guards and the dogs…It was a total team approach [in response to an active shooter]. So you had your contingent downstairs which was the director of nursing and the VP of operations. And so as we were on units and figuring things out, we were calling down to them. It was a mini command center.

NEs managed surgical surge in the perioperative department. NE4 essentially served as incident commander for the perioperative department, a contained department within the hospital, consisting of 23 operating rooms, pre- and post-anesthesia care units, sterile processing, central supply, environmental services, pharmacy, and anesthesia.

> NE4: ...you need a huge checklist [in response to MCI/Surgical Surge event], EVS [environmental services]..., central supply..., sterilization [processing department (SPD)] needs to be.... [called in]...how many chest tubes,... and how much blood do you have? We needed blood runners because the nurses in the rooms couldn't run for blood...Everybody needed blood... SPD was amazing...They were immediately turning over the trays...I said to our supply people you have got to get me chest tubes, .. putting two and three in a person at a time...we had EVS ... in the hallway, so as soon as they took a patient out, they were in there cleaning up...to turn the rooms over ...even though we have 23 operating rooms, we don't [utilize] all.... [at] same time, ... suddenly, we've got all these ...rooms working, and do we have the staff, ...nurses, ... surg techs, and ...doctors? ... The PACU and the pre-op departments coordinated together... taking care of all those patients that had been brought over from the emergency room. We had people in our waiting rooms, everywhere, so people who are non-ancillary came in and they start working our waiting room for the families. And remember, I was only one person.

The NEs observed the need to expand usual mental health services in real time.

Theme #7: Expansion of Mental Health Services; ICN Domain 7: Recovery. The NEs facilitated the expansion of immediate and long-term mental health services. All six NEs recognized the traumatic exposure for both the nurses who were present and those who were not on duty to help their colleagues. The NEs observed the need to expand usual mental health services in real time.

> NE6: ...they [the OR nurses] were truly kind of that first victim [during the active shooter event] if you think of it. They've got a [critically injured] co-worker that... [cannot be moved and may not] survive. They've got another [injured] co-worker that by this time, we moved to our other organization, the Trauma Team has come in and are trying to work [on the co-worker who is critically injured] in the space of the [OR team] trying to help this individual that we didn't feel should be moved.

In all cases, hospitals needed to expand their usual mental health services, and some relied on extra support from psychiatry clinicians and the VA.

> NE3: The VA was our friend during this time too...they set a van out in our parking lot immediately post-[the critical care surge]event, within 36 hours, ...[Also] there are lots of people who don't want the stigma associated with talking to someone even about a trauma like this...But they didn't want to talk to [us] we had 24/7 counselors in our building for 30 days, and then we provided appointment counseling up to 45 days post-event, but the VA had... a group of people that... nobody in our hospital knew, and you could go into the van, you could identify... [or] not identify yourself, and they stayed with us a couple of weeks in our parking lot and talked to people who didn't feel comfortable talking in a group setting.

All of the NEs provided immediate and long-term mental health services by expanding their usual mental health services and relying on extra support from psychiatry clinicians and the VA. Except for displaced nurses after evacuation, all NEs provided debriefing sessions.

> NE5: The roles and responsibilities of leaders change immensely [during an active shooter event]. You need a strong nursing team. The person in charge has to be able to make decisions. People are dazed and confused. They can't believe this is even happening. People are kind of in a shell. They're just acting. They're just moving. And you need to direct them. And you need to care for them. And you've got to be assessing who needs this help right away [be]cause you can see people are just completely dazed and confused.... Others are right back into the swing of it. There's a piece that you don't realize you have to care for.... the psychiatry people were very keyed into this, and they were part of us for a long time, and we kept checking back with those that we knew...[were most traumatized].

Discussion

The actions of NEs during these real-life disaster events provide an understanding of specific actions and responsibilities of the NE during no-notice events. Moreover, their observations offer valuable knowledge to inform strategies that may support the nursing workforce during a no-notice event.

As the clinical leader who takes responsibility for 24-hour nursing care, it is not surprising to observe that the NEs were amongst the first of the incident command team to physically respond. This is also consistent with the efforts of nursing leadership during the Cold War to prepare nurses for their potential role in the aftermath of a nuclear attack (Leifer & Glass, 2008; Phelps, 1968).

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Perhaps the largest take-home message for organizational leaders to consider as they strategize their support for nurses would be that no-notice events can happen at any time and nurses may need to make life-saving decisions despite the absence of a formalized incident command structure. Accordingly, each NE observed the benefit of extending drills beyond the ED to all nursing units and including physical learning experiences and discussions that support their response under duress, and prompt the recollection of important concepts. Preparing perioperative nurses for mass casualty surge, in addition to those nurses in the ED, supports an optimal response for these situations (Gabbe et al., 2022).

Much like the psychological burden experienced by firefighters and police (Jitnarin et al., 2022; Velazquez & Hernandez, 2019), all six NEs observed the impact of psychological trauma. Comparing the experience to war, each of them facilitated the expansion of baseline services and some embraced the help of the VA, a response consistent with the fourth mission of the VA to support community response to disasters (Dobalian et al., 2015; Wyte-Lake et al., 2021). All six NEs observed the need to harden vulnerable units such as ICU, OR, and Labor and Delivery. Their concerns are consistent with other reports (Inaba et al., 2018; Jacobs & Burns, 2017).

...all six NEs observed the impact of psychological trauma.

The six scenarios described by participants provide interesting observations regarding the failures of power and communication contingencies. Understanding emergency generator power pathways, especially within aging hospitals, is a valuable lesson and consistent concern (Hart et al., 2018; Vugrin et al., 2015; Waxman et al., 2017). Future research is warranted to examine these topics that are beyond the scope of this discussion.

Strengths and Limitation

The findings from our study begin to fill a gap in knowledge regarding the actions of the NE and organizational strategies to support nurses' response during no-notice events. Our findings are not generalizable given our methodological approach; however, the in-depth interviews offer a rich description of the NEs' experiences and their challenges. Additional research is required to augment and verify these findings. Because the interview guide was not written to match the ICN disaster nursing competency domain headings, each domain may not be fully represented.

Summary and Conclusion

The nurse executives who we interviewed were amongst the first administrators to respond to the no-notice events. Nurses suffered from traumatic exposure and NEs facilitated immediate and long-term mental health support. NEs described nurses who needed to make immediate life-saving decisions despite the absence of a formalized incident command structure. Personal cell phones were the primary source of communication after communication contingencies failed. NEs observed the benefit of drills and exercises that extend to the unit level and include discussion and physical practice. NEs who experienced active shooter events observed the benefit of mandatory active shooter training for all staff as well as discussions and mitigating actions to protect unique units such as the OR, ICU and Labor and Delivery where patients are most critical and difficult to move.

Personal cell phones were the primary source of communication after communication contingencies failed.

Contribution to Practice

This work represents continuation of a Veterans Emergency Management Evaluation Center (VEMEC) initiative to support a 2014 Disaster Nursing Call to Action (Veenema et al., 2016; Veenema et al., 2017; Langan et al., 2019). A disaster preparedness research center within the Department of Veterans Affairs, the VEMEC leaders collaborated with disaster nursing experts in 2012 to "develop a vision for the future of disaster nursing, identify barriers and facilitators to achieving the vision, and develop recommendations for nursing practice, education, policy and research" (Veenema et al. 2016, p. 11). As the largest group of hospital employees positioned throughout the hospital (U.S. Bureau of Labor Statistics, 2019), nurses are naturally on the frontline of a no-notice event. This study supports the assertion that the NE is well positioned to respond directly and promote strategies that will support their response.

Disclosure

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