No-Notice Disaster Events in the Hospital Setting: Staff Nurses' Actions and Opportunities for Organization Support

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Article

Abstract

Hospitals are not immune to no-notice disaster events such as onsite violence, surges in the number of patients requiring care because of large-scale emergencies, power failures, earthquakes, and wildfires. Such events happen quickly, require immediate action, and come with high consequences. Frontline staff nurses are positioned as a hospital's first line of defense. Registered nurses represent the largest component of the hospital workforce and provide care to patients in departments and units throughout the hospital. Few studies have systematically examined actions or observations of staff nurses during real no-notice disaster. The purpose of this qualitative phenomenological study was to document the actions and observations of hospital-based staff nurses to inform hospital organizational leaders attempting to support their response to no notice disaster events. Nurse executives who supervised nurses during actual no-notice disasters described nurses who needed to respond immediately without guidance from a functional incident command structure. Nurses made and acted on immediate decisions. Their actions included management of the evacuation of an entire hospital; large and sudden surges of wounded or deceased victims from a mass casualty event; and protecting critical and vulnerable patients in the presence of an onsite active shooter. Nurses experienced symptoms of traumatic exposure which required immediate and long-term psychological support. Findings from this study suggest further studies and conversations among nurse leaders about how to best expand disaster preparedness activities to nurses working at the bedside.

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

Mass casualty incidents, onsite violence, power failure, earthquake, and wildfires serve as examples of disaster events that impact a hospital setting and have a potential for high consequence (Adashi et al., 2015; Inabi et al., 2018; Kelen et al., 2012; Nates et al., 2012; Soncrant et al., 2021). The authors define this type of disaster that happens with little or no notice and requires immediate action as no-notice disaster events.

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Representing the largest component of the hospital workforce (U.S. Bureau of Labor Statistics, 2019), registered nurses (RNs) providing constant clinical care in departments throughout the hospital are positioned as the first line of defense to such disaster events. We studied the lived experiences of Nurse Executives (NEs), often referred to as a Chief Nursing Officers, who have supervised nurses during real-life no-notice disasters in the hospital setting. This study then documented the actions and observations of staff nurses to inform hospital organizations on strategies to support nurses' response.

Background

Hospital Preparation for Disaster Response

Hospitals provide disaster preparedness training for employees in alignment with the requirements of federal, state, and local authorities (e.g., Centers for Medicare and Medicaid Services [CMS], Occupational Safety and Health Administration, National Fire Protection Agency). Accreditation organizations such as The Joint Commission (TJC) determine if hospitals are in compliance with standards, such as having an up-to-date Emergency Operations Plan (EOP) based on a unique hazard vulnerability assessment (HVA). Hospital leaders must prove they have the infrastructure to support their EOP by showing documentation of drills, exercises, and emergency preparedness training for staff (CMS, 2021; TJC, 2021). Hospitals are required to identify and train staff consistent with their expected roles as described within the EOP (CMS, 2021). However, they are given flexibility to designate who participates in physical drills and exercises based on their HVA (e.g., staff from Emergency Department [ED]). The requirement to test employees over time usually means that nurses complete annual computer competencies. Essential skills may get evaluated by completion of a range of skill stations every one to two years (Levine & Johnson, 2014).

Emergency Preparedness for Nurses

Academic nursing curricula requirements cover basic components of emergency preparedness. Post-licensure, employers, and nurses share responsibility for life-long-learning and training that is required by each hospital or state licensing board to address unique vulnerabilities. The International Council of Nurses (ICN) Core Competencies in Disaster Nursing 2.0 is among many competencies authored by disaster nursing experts or professional nursing organizations (ICN, 2019).

Prior to the COVID-19 pandemic, very little had been published regarding nurse readiness to manage disasters (Baack & Alfred, 2013). Nurses may not perceive themselves as prepared because they lack real-life disaster experience (Hodge et al., 2017). As an example, fewer than 10% of nurses in rural Texas were confident in their ability to diagnose or treat bioterrorism related conditions, but greater than 69% were interested in training opportunities (Jacobson et al., 2010). Although there is a paucity of literature to describe nurses' response to hospital based disasters, most available information references natural disasters that occur "with notice" and are supported by a supervisory team or intact incident command structure (ICS) (Grochtdreis et al., 2017). This study aimed to address a gap in the literature by documenting nurses' response to no-notice disasters in the hospital setting and strategies to support their response.

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Methods

Human Subjects Protection

This qualitative phenomenological study was approved by the VA Greater Los Angeles Healthcare System Institutional Review Board (IRB) and the IRBs of each study collaborator. Participants provided verbal informed consent prior to the interview. They received no compensation. Participants were guaranteed confidentiality regarding their personal identity and hospital affiliation.

Sample/Recruitment

A convenience purposive sample of NEs (n = 11) was recruited with input from key informants, reports, and public after-action reports. Inclusion criteria were defined as a NE or a NE designee with experience supervising nurses during a major disaster in a hospital (VA and non-VA) within the United States. Consideration was given to represent a wide range of threats by type (e.g., weather, violence, infectious disease, fire), timing (no-notice versus notice), response (e.g., evacuation, shelter in place) and geographical location.

An invitation to participate was sent by email to 32 NEs followed by a telephone call. Of those invited, 11 agreed, 2 refused, 2 provided referrals, and 17 did not respond. Of the 11 who agreed, 5 experienced a disaster occurring with notice and 6 experienced a no-notice disaster. The time between the date of the disaster and the date of the interview ranged from six months to 3.5 years. This article focuses on interviews from the 6 of 11 NEs who experienced a no-notice disaster event.

Data Collection

The interview guide was collectively written by all four authors using open-ended questions to maximize the ability for participants to describe the lived experiences of the NE. All authors have disaster research experience, three are licensed RNs and all have advanced nursing degrees. The interview questions were:

- Describe your observations of the range of roles and responsibilities assumed by the nurses you supervised.
- 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?

- Based on your experience and observations, can you suggest organizational strategies for supporting nursing response during disaster in the hospital setting?

Each NE participated in a telephone interview lasting approximately 30–60-minutes. Interviews were conducted from a private office workspace, audio recorded, professionally transcribed, and checked for accuracy against the transcript. One team member conducted all interviews for consistency and 2-3 team members had the chance to ask follow-up questions. The respondents and research team members had no prior relationships.

Data Analysis

All authors agreed to and participated in an inductive coding process. Each author read every transcript and served as the lead in completing steps (e.g., bracketing, intuiting, analyzing, and describing) for a shared number of interviews to support a phenomenological analysis (Polit & Beck, 2022). The process included the use of an electronic spreadsheet to parcel and tag quote chunks with code names as they emerged (Polit & Beck, 2022). Each lead then presented a summary of findings in memo format to the author group and facilitated a line-by-line discussion through the spreadsheet. Any disagreements were reconciled, and decisions were recorded and provided to the team after each meeting (Boeije, 2002). When the group could not reconcile disagreement, a short 15-minute follow-up telephone call was made to the NE to validate interpretations of the interview data (Braun & Clarke, 2006; Delve & Limpaecher, 2023; Polit & Beck, 2022). Over time, the group collapsed codes that were similar, separated codes because of differences, and identified emerging themes.

Themes and codes were next referenced against the eight ICN (2019) Core Competencies in Disaster Nursing Domains to serve as a framework for dissemination (Patton, 2014). The ICN partnered with the World Health Organization (WHO), and international disaster nursing experts to publish core competencies for the general nurse (Level I) and the executive nurse (Level II) to translate findings from the field to education, practice and policy settings. The eight domains used for reference included: Preparedness and Planning, Communication, Incident Management, Safety and Security, Assessment, Intervention, Recovery and Law and Ethics.

Data for the six no-notice events were abstracted from the data corpus and used for this publication. Demographics for this subset of six interviews included a naming convention for the NEs (NE1-NE6) by type of event, type of response, frequency of staff nurse actions (ICN Level I) and frequency of observations made by the NEs (Level II) within the eight ICN domains (See Table 1).

Table 1. *No-Notice Disaster Demographics*

NE	Disaster Type	Response	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	a o	a o	a o	a o		a	o	a
2	**Weather** Generator Failure	Complete emergent evacuation	a o	a o	a o	a o		a	o	a
3	**Violence** MCI	Critical care surge	o	a o	a o	o		a o	a	a
4	**Violence** MCI	Surgical surge	o	a o	o	o	a	a o	a	
5	**Violence** AS	Run-Hide-Fight	a o	a o	a o	a o	a	a	a	
6	**Violence** AS	Shelter in Place	o	a o	a o	a o	a	a	a	

MCI =Mass Casualty Incident
AS = Active Shooter
a = staff nurse actions
o = observations made by the NEs

Abstracted descriptive phrases provide a detailed account of the nurses' actions and observations for organizational support organized by response: Evacuation, Surge, and Active Shooter (See captured in Supplementary Materials A, B & C).

Supplemental Material A. Emergent Hospital Evacuation

Supplemental Material B. Critical Care Surge and Surgical Surge

Supplemental Material C. Critical Care and Surgical Surge

Results

NEs described how nurses remembered procedures they physically practiced...

Qualitative analysis of interviews with six NE participants who supervised nurses' response to a no-notice disaster event in a hospital setting provides a collection of the actions and observations of nurses with six emerging themes. The following section provides an overview of the themes aligned with the associated ICN domain, and supported by NE quotes. The exact words of the NEs set the scene for each event (See Supplemental Material D).

Supplemental Material D. Setting the Scene

Actions of Nurses

Theme #1 Importance of Drills and Actual Experience; ICN Domain 1: Preparation and Planning. NEs described how nurses remembered procedures they physically practiced (e.g., moving real patients in beds to the hallway and practicing power substitutions) and worked together with other disciplines (e.g., respiratory therapists, transporters, physicians) as they completed vertical evacuation. Although they had never practiced vertical evacuation, they had discussed the steps:

> ...a lot of nurses came to me afterwards to tell me that they remembered, ...[for example,] when I can't move sideways with my patient, I need to start moving down... [A] ...key concept, but basic... [T]here were a lot of independent decisions being made that weren't coming from incident command, because at that point we didn't even have an incident command set up that was very functional. (NE1)

NEs observed how the no-notice events impacted departments throughout the hospital and required interdepartmental collaboration. All NEs endorsed drills that would extend to the unit level and include active, in person drills and discussion. The following quote describes how some observed the shortfall of relying on videos as a substitute for physical practice and discussion:

> ...our excuse in the past was nurses are too busy and nurses themselves would say, I'm too busy to go learn how to use the med sled. I'll just watch the video. ...[W]hat we learned in the moment...[was] the video is not a substitute for actually putting... [the equipment] together and dragging somebody in it down the hallway. In the video, it glides nicely down the hallway and one nurse can pull the 400-pound patient down the hallway, ...[when] in reality, you can't. (NE2)

One NE described a hospital wide quality improvement project involving doctors, nurses, diagnostic technologists, transporters, and administrative assistants from all units to eliminate a habit of holding admitted patients in the ED. The NE believed behaviors learned during the project positively impacted the hospital's ability to manage the large numbers of victims from a mass casualty event, as described in this quote:

> I wouldn't say we drilled on surge, but we relentlessly prepared for surge. …[W]e had a throughput committee where we actually coached our nurses on how long it took them …[to]…discharge [a patient]… We looked at the metrics… from the time when the patient presented to the emergency department to when they either discharged from the ED or they were dispositioned to the floor and then from the time the patient got the discharge order to go home. We focused on, pulling in doctors earlier to discharge patients, holding nurses accountable to how long it took them to disposition a patient on the inpatient units… [and after] …present[ing] to our ED…. [We also looked at] how long it took a provider to see them, …get a CT scan… [and] … [or] x-ray. When your patients enter your facility, if they're not a priority when it's not an emergency, they won't become a priority when it is an emergency. (NE3)

Most NEs observed the need for units caring for the most vulnerable patients (e.g., ICU, OR, Labor and Delivery) to engage in pointed discussions about how they can respond to events of violence and surge (e.g. talking through safest reactions to various scenarios). Both NEs who experienced an onsite active shooter believed workplace violence training should be mandatory for everyone, described in the following quotes:

> …[in] hindsight, we would have drilled every orientee, every resident, … everybody…, what do you do with this workplace violence? We do a great job teaching our staff how to deal with families and patients. We do it a lot [training]. We have a lot of addiction medicine, and we deal with a lot of this stuff but not, but not this. You just aren't prepared. (NE6)
>
> …there have been a number of studies that were done …and all of them pretty much say that the nurses wish that they had more training, and yet, it's easy to look in the rear-view mirror and see where you've come. It's a little harder to look forward about where you're going… the fact that it [happened] rattled people about feeling guilty that they weren't good enough or crisp enough or informed enough about what would happen or what should happen and what their roles would be, but in reality, they did a phenomenal job… (NE2)

Theme #2 Communication Failures; ICN Domain 2: Communication. Faced with the failure of communication systems within and beyond the hospital as well as all chargeable contingencies, NEs described how nurses were able to maintain communication within and beyond the hospital. Nurses utilized their personal cell phones, achieved connection with neighboring cell towers, used previously printed downtime forms and in one scenario utilized rescue workers traveling up and down stairwells to deliver and return spoken messages represented in these various quotes:

…NEs described how nurses were able to maintain communication within and beyond the hospital.

> …Your cell phone was your only means of communication because none of the other systems were working, (NE2)
>
> …[T]here was some texting that was going on. …[O]ne of [the ED charge nurses] was outside, bouncing off a different cellphone tower, and so they could talk to the person at a different cellphone tower, but they couldn't talk to people in their immediate vicinity… (NE3)
>
> …[O]ur phones are connected to the computers, so if [a disaster]… happens…, you need to be prepared… (NE4)

Despite established plans for a naming convention, the number and sudden surge of unidentified victims made it difficult for staff to assign temporary names or document assessments. This NE described how life-saving activities took priority over reconciling plans for documentation:

> I mean we're not talking about people that you had time to [prepare for] … [It was] like being on the side of an interstate or in the middle of a war-torn [area]—that's how they were coming in. (NE3)

All 6 NEs described nurses making and leading others in steps and strategies to safely preserve life.

Theme #3 Command Decisions of Frontline Nurses; ICN Domain 3: Incident Command. Given the sudden nature of the no-notice events, incident command was not set up or functional for any of the events. All 6 NEs described nurses making and leading others in steps and strategies to safely preserve life. In these responses, the NEs described how nurses made the decision to guide the evacuation of an entire hospital destroyed by a tornado, moved vulnerable patients to areas of the hospital with greater emergency electrical outlets, took the initiative to call colleagues at nearby

hospitals who could safely receive and care for specialized patient groups, assigned and directed the steps of doctors and respiratory therapists to safely transfer neonates down dark stairwells, and teamed with doctors to organize a triage methodology:

> …the charge nurse, was directing [incident command]… on their unit. …[S]o, in essence, … we had a lot of incident commanders that evening that directed the evacuation on individual units and individual floors. (NE1)
>
> You know nurses understand the incident command shift, and we get that in an emergency, the mission changes, so nobody's fussing about patients getting a bed bath and that kind of stuff, right? We… know that we're going to maximize lives and we're going to do the things we have to do and prepare what has to be prepared for the next thing [that could occur]… (NE2)
>
> **…**the biggest thing [to]… remember, leadership isn't always available, so you have to have people that are willing to step up and be strong leaders, even in the absence of leadership. (NE4)

Theme #4 Patient Protection & Psychological Trauma; ICN Domain 4: Safety and Security.

Despite the real or perceived dangers of each situation, all six NEs described how nurses illustrated their commitment to maintaining the safety of their patients. Faced with difficult and often austere conditions, nurses evacuated and traveled with their patients to receiving hospitals. In some cases, they did so knowing their own homes were destroyed. During sudden power failure, nurses quickly substituted manual for powered equipment and took responsibility for making sure vulnerable patients were safely relocated. These quotes describe efforts to ensure safety and security:

…nurses quickly substituted manual for powered equipment and took responsibility for making sure vulnerable patients were safely relocated.

> I went up in the dark and told people, prepare to move your sickest baby first…the nurse who was cocooning the baby held the endotracheal tube because she was able to do that and keep it steady and then they went down the stairs calling out step, step, step so that they all moved as one [unit] with a lot of medical students holding flashlights… I think their ability to figure that out was pretty incredible, but I don't know that any leader could have said, well you're going to do it this way. (NE2)
>
> Even when taught to run to save their own life, in the face of an active shooter, some nurses opted to stay and protect the safety of their patients. As [the event] was unfolding and no one knew where the active shooter was, doors were closed, people were hiding, nurses took patients and hid with them, … [O]ne of our nurses hid under a bed with a patient who …was freshly trached. (NE5)
>
> There were people who were barricading themselves in the operating room suites where surgeries were still going on. (NE6)
>
> …there was a lot of shock and horror going on, kind of fear of the unknown. Not to mention that there were ones that literally walked up on what had happened. The place they live every day…this individual that even though he had done some hard-to- understand things, he had been one of [them]… I can't even imagine what they were experiencing with that…(NE6)

In the aftermath of each event, NEs observed symptoms of traumatic exposure.

> ...we were out of the hospital and scattered for 59 days before we came back in... [N]urses really missed being part of their family, their unit, which is where they spend a good portion of their adult life, work[ing] ...with their friends and colleagues ... [Once communication came back up,] we found hotel space..., or diners in the area where nurse managers, ... could email their staff and say, we're going to have a staff meeting in the diner on "location identified" at 10 o'clock this morning for any of you that could come, ...[E]verybody came because they needed that connection, they obviously wanted information, but they also needed to see their colleagues and touch people and hug people ... and have ... that bonding experience because that was hard. We were, our nurses were, ...[in] a diaspora. (NE2)
>
> ...nurses who were on that night came in early... Most nurses just started to come to the hospital.... "Where do you need me?"...the following day where the shooting took place, they came in, but they were distraught. They were distraught that they weren't here for their colleagues who had to go through this. ...[S]ome of [the night nurses] ... came in... and we deployed them to other areas. Some... [nurses] couldn't work. ...The nurses [who were on the units where the shooting took place] came in the following day, I think one of them stayed in the unit. The rest of them just, they left. We had to send them home [because]... they couldn't work. ... Sometimes I can talk about it and nothing, and sometimes I talk about it and I think about the staff afterwards at that leadership where we had this cleansing session with psychiatry and how I could see my [nurse manager] ...she was completely traumatized. (NE5)

All NEs required participation in debriefing opportunities. Nurses received psychological support immediately and long-term, as described here:

> I hired a person from the inpatient psych world and ...she was part of the caregiver team that was in that waiting room. ...[S]he just had an innate sense about how she needed to separate family members and walk with family members out of there when people started to escalate. ...[S]he played a great role in not only managing the family members but also in managing our staff in the days to follow...she knew the nurses that worked in that facility, and she knew most of them well and was able to say yes or no, this person is acting like they usually act which is an issue, right? (NE4)
>
> So very quickly, we started using the words instead of saying get back to normal, we said transition to a new normal for them because it was never going to be the same for anybody that had been at ---(NAME OF FACILITY) or as an employee and probably even if they were off; just because the days that followed were so different. We had lots of crisis intervention support. [W]e did reach out to the VA... [who] are the experts in dealing with ...war time... [and] lots of loss. Would you come into the organization and help us deal with this? And they did and they had counselors onsite... 24/7, day after day after day helping this group of individuals; just listening ... and helping them understand what had happened [which is] ....so beneficial. Our own employment systems, ...were onsite too. We had pet therapy [and offered] ....all of the things that people felt like might help these individuals feel comfortable... Never forget; support them through thick and thin and know that they're going to have good days and bad. ...[L]et them be part of the change. [The employees] ...drove--a lot of the changes... because they lived it. (NE6)

Theme #5 Improvise, Adapt, and Overcome; ICN Domain 6: Intervention. Faced with sudden and lifesaving decisions, NEs described nurses coming up with innovative solutions to unexpected problems. For example, nurses evacuated patients from a destroyed hospital; shifted from powered equipment to manual; called on friends from specialty hospitals to request transfer of their specialty patient groups; directed evacuation teams in total darkness; triaged large numbers of critically wounded victims from a parking lot; resuscitated wounded colleagues; arranged transfer of stable patients to sister hospitals to make room for surge; and managed critical and vulnerable patients in the presence of SWAT and other first responder professionals.

Faced with rapidly changing clinical scenarios, NEs described evidence of prioritizing complex critical steps, teamwork, and efficient actions.

Faced with rapidly changing clinical scenarios, NEs described evidence of prioritizing complex critical steps, teamwork, and efficient actions. For example, nurses used personal cell phones to request supplies and equipment from sister hospitals. They managed the flow of patients through the ICU, diagnostic departments, and the operating room while providing just-in-time training to medical/surgical nurses so they could assist at a higher skill level. They completed 50 open surgical cases in 24 hours, stopped bleeding, started intravenous lines, coordinated surgical teams for wounded victims, and initiated the transfer of 50 patients to sister hospitals in the middle of the night; some of these are described below:

> The labor and delivery … and the postpartum nurses came [in], and you know what they're really good at? They were experts [in] …blood administration. They understand,… were able to do, and …contribut[e]. (NE3)

Nurses stayed with vulnerable patients.

Nurses respectfully managed large numbers of deceased victims while they protected their bodies within a secure makeshift morgue and used identifying features to determine their identity. Nurses chose to risk their own lives to protect vulnerable and critical patients from gun shots. During MCI and AS events, nurses chose to risk their own lives to stay with critical patients and protect vulnerable patients from gun shots. During MCI and AS events, nurses chose to risk their own lives to stay with critical patients and protect vulnerable patients from gun shots.

> …[W]hen I got to the unit and I saw [name], she's … an RN case manager, and I said to her, "Oh my goodness," …[S]he was recently in this role, I guess about a year, and she said, "I'm a nurse first. I'm a nurse first." (NE5)
>
> I had another nurse in my surgical ICU that cared for our patient that probably had the greatest number of surgeries. She was shot in the chest, and she had friable vessels in her chest and in trying to repair one thing, they went through something else that was shredded. …[T]hey were able to fix that and ended up transfusing her [with] …three total body exchanges. The same nurse stayed with her for about 17 hours and refused to hand her over. Until she got to a point—she knew that that girl was going to live. She … had a place in her head she knew she had to get her to before she turned her over. (NE3)

Replacing traumatized nurses with uncommon skills proved to be difficult with short notice:

> …the ER staff had come to the peri-operative suites and were trying to help there and then they were in an area that they weren't familiar… [Y]ou think about your experts in the OR are now not able to even communicate because they're so emotional they can't really kick back into their normal routine. And then the trauma team came in and they were all business trying to get things done. But this is an operating room that they aren't completely familiar with. So, lots and lots of stuff going on for that staff. (NE6)

Theme #6 Difficult Decisions; ICN Domain 8: Law and Ethics. Faced with ethical practice during disaster response, NEs described nurses consulting with each other and physicians to make decisions about how to respond to patients crushed by debris:

> …[T]here were patients that were damaged from the impact of the tornado, …in addition to their already …critical condition. … I know that there were some [triage] decisions made. I can't help this one, but I could help these three… There was some support provided by hospitalists that were in the building. I think it was some group thought process, and then individual actions. (NE1)
>
> …you don't know when you're going to have to face that, and I think that needs to be in the thought process. And the nurse, as they're considering some of these scenarios or drills, or whatever you might be putting them through to help them—you have to educate them, that there are times where you may be faced with making some difficult decisions. … I think [the possibility of making difficult decisions] needs to be part of the discussion [and] …needs to be part of that thought process as you're educating nurses, because in reality, it can certainly affect them all. (NE1)

Discussion

Our data analysis included six hospital based events which happened with little or no notice and came with high consequences. The documentation of nurses' actions and observations made by the NEs begins to address a gap in our understanding of how nurses respond to such occurrences and how hospital organizations can better support the response. Researchers who initiated early studies about critical care nurses have associated factors such as authority of command, sound theoretical or scientific knowledge base, and influence of role models with their ability to make high quality decisions in crisis environments when survival of life is at stake (Baumann & Bourbonnais, 1982; Baumann & Deber, 1989). More recently,

researchers have identified factors such as years of practice, accumulated knowledge, organizational and unit culture, and peer mentorship with their ability to gain confidence, deal with changes in patient condition, and make sudden critical decisions (Maharmeh et al., 2016; Nibbelink & Brewer, 2018).

They showed their ability to innovate in the moment...

NEs described self-directed actions of nurses self-reporting to the disaster scene, assuming responsibilities, collaborating with interdepartmental teams, providing just-in-time training to elevate the skill level of their colleagues, guiding the steps of others, risking their own health to assure the safety of their patients, and respectfully caring for deceased victims. Nurses worked independently as well as collaboratively with colleagues to assure patient safety, provide an elevated level of care, and maintain the quality of continued care. They showed their ability to innovate in the moment as they immediately recognized the seriousness of each crisis and made necessary substitutions for failing infrastructure (e.g., power, medical gases, communication systems, physical structure) and exhausted supplies.

NEs made valuable observations about the reality of no-notice events happening before ICS was established and the need for discussions with nurses in their unit about the possibility of them managing a disaster in the absence of direction. The NEs observed the need for very targeted discussions with nurses who work in vulnerable somewhat isolated units (e.g., ICU, OR, and Labor and Delivery) where patients are most critical and difficult to move or protect. NEs observed the impact of psychological trauma on all nurses, regardless of being on duty during the event. All needed to seek additional organizational resources to satisfy immediate and long-term mental health needs.

Annual hands-on disaster training or simulation may help nurses with critical decisions and confidence

While a small sample of surveyed nurses described a perceived lack of confidence in their ability to respond to a disaster (Hodge et al., 2017), the nurses described in this study seemed nothing short of heroic. This suggests a challenge to consider preparedness efforts that may provide or increase confidence without having to experience a real event. NEs observed how nurses remembered or used what they practiced or executed frequently. Examples of this included moving patients into the hallway and making all equipment substitutions; participating in a daily quality assurance project to address holding ED patients; and regularly transporting neonates throughout the hospital, by land or by air. Annual hands-on disaster training or simulation may help nurses with critical decisions and confidence much like annual CPR certification refreshes skills not used every day.

Differences in hospital HVA priorities lead to varied types and levels of disaster training and when hospitals conduct training, drills, and exercises, they often focus on events that happen with notice and the ED as the most obvious entry point. This study suggests a need for future studies describing the actions and observations of nurses' responses to no-notice events with an expanded look at exercises extending to all departments and contingencies for ICS.

Limitations

The questions for interviews used in this study were not written based on the ICN (2019) Core Competencies in Disaster Nursing. As such, the interview data did not touch on two of the eight domains (i.e., Assessment and Recovery). This was an analysis of six study interviews related to no-notice disaster events. The findings are not generalizable given the methodological approach; however, the in-depth interviews offered within our analysis provides a rich description of the NEs' experiences with feedback from staff nurses about their actions and opportunities that reflected their experiences and challenges.

Conclusion

The observations of NEs arising from actual disasters illustrate the striking reality of no-notice events happening without guidance from nurse leaders or a functional incident command structure. NEs described staff nurses making and acting on immediate decisions. The findings from this study suggest the need for further research and conversations among nurse leaders about how to best expand disaster preparedness activities to all nurses and especially to those who work at the bedside.

Disclosure

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