

Australian Civilian Hospital Nurses' Lived Experience of the Out-of-hospital Environment Following a Disaster

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For those nurses who have, and those nurses who will, unconditionally put aside their lives to assist people affected by the adversity of disasters; particularly for civilian hospital nurses in the out-of-hospital environment following a disaster.

Abstract

Disasters disrupt the normal functioning of communities. From a health perspective, disasters may place an increased demand on health services within affected communities. When a disaster occurs, Australian nurses may respond as part of a government or non-government disaster medical assistance team. There is an increasing international literature base of nurses' personal experiences and descriptions of single disastrous events. However, Australian civilian hospital nurses' lived experience of the out-of-hospital environment following a disaster has not yet been explored.

Phenomenology is concerned with the essence of things as they are appearing in the conscious awareness of the first person. This phenomenological study uncovered what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. Hermeneutics and phenomenology formed the theoretical framework for this study. While there is no one way to do phenomenology and get back to the things themselves as they are appearing in themselves, for this study, an epoché and reduction were the key methods of phenomenology in guiding a way.

To get to the essence of the phenomenon being uncovered, narrative was obtained from eight participants, using semi-structured interviews at two points in time. Participants were Australian civilian hospital nurses who had worked in the out-of-hospital disaster environment as part of a disaster medical assistance team. From the participant narratives, descriptive moments formed a lived-experience description as an anecdote of what it may be like *being* a nurse in an out-of-hospital environment following a disaster. The uncovered moments in this study included 'on the way to a disaster', 'prior to starting work', 'working a shift in a disaster', 'end of a shift' and 'returning home'. Phenomenological reflections of the existentials of spatiality, corporeality, communality and temporality overlaid the moments of

the lived-experience description. Commentary on the phenomenological reflections provided further depth to the insights of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster.

A nurse's experience following a disaster, from a spatial perspective, was described in this study as *lived-space as shrinking then opening too-wide*, and *disaster health lived-space as occupying, sharing and giving back*. From a corporeal perspective, their experience was described as a *nurse's lived-body, for nursing following a disaster*, and a *nurse's lived-body, for patients following a disaster*. From a communal perspective, their experience was described as *with colleagues, being relationally close; with patients and their families, being an insider; and being with self*. From a temporal perspective, their experience was described as *kairos time speeding up and condensing* and *kairos time slowing down and stretching*.

Chronos time emerged as a featured backdrop to the life-world of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. In particular, chronos time was described as intersecting between the uncovered moments and the phenomenological existentials as a way to gain greater insights of a possible experience. These insights, in turn, informed possibilities for future practice, future education and professional development, and future research related to the experience of an Australian civilian hospital nurse in the out-of-hospital disaster environment as part of a disaster medical assistance team following a disaster.

Statement of Authorship

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Candidates' signature:

A handwritten signature in black ink, appearing to read 'Anse', written in a cursive style.

Date: 31 August 2017

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Abbreviations and Acronyms

ABC	Australian Broadcasting Corporation
ADF	Australian Defence Force
AusMAT	Australian Medical Assistance Team
ED	Emergency Department
ICN	International Council of Nurses
ICU	Intensive Care Unit
IV	Intravenous
UN	United Nations
UNISDR	United Nations Office for Disaster Risk Reduction
WHO	World Health Organization

Prelude

The following anecdote is a moment from my lived experience of *being* a nurse in an out-of-hospital environment following a disaster. I remember this moment as if it occurred yesterday.

Canberra Bushfire 2003¹

A large bushfire was burning on the outskirts of Canberra, Australia, an inland metropolitan city with a population of approximately 350,000 people. On Saturday 18 January 2003, the fire extended through the city's western suburbs. Four people died and over 500 homes were destroyed by the fire. Hundreds of people were injured or became ill. Thousands of people were displaced. Many people found shelter at one of four evacuation centres established throughout the city at the request of the local government.

At the time of the bushfire, I had been a registered nurse for five months, working on the orthopaedic trauma ward at the Canberra Hospital. I was not rostered to work at the hospital on the day of the bushfire. I had been a volunteer with St John Ambulance Australia for 10 years. Upon hearing about the bushfire, I volunteered with St John at the nearest evacuation centre. At the evacuation centre, I was tasked with establishing a health service and providing health care to the people who were displaced.

At the evacuation centre, people not affected by the bushfire were streaming in with blankets, pillows, toys and other random items for donation. People who now had no home because of the bushfire were constantly arriving. They looked stunned and shocked by the surprise arrival of the bushfire that had led them to be in the evacuation centre.

¹ Bushfire in Canberra, Australian Capital Territory (ACT), Australia, 18 January 2003.

I remember being called by a member of the evacuation centre staff to see an elderly man who was complaining of a headache. While he was elderly, he was not frail. He looked well presented. He was sitting on the floor leaning against a wall. He was surrounded by others, strangers who had fled the destruction of the bushfire. I knelt beside the elderly man to commence my conversation with him, at eye level. We were in a wide-open space. There was no privacy. He whispered to me, telling me about his health history. I whispered back, trying to solve his problem among the organised chaos of the evacuation centre.

Our conversation was specific about his life. He lived alone and cared for himself adequately. He specifically mentioned his upbringing, family, work life and extended circle of loved ones (past and present). His three children had moved interstate. His wife had passed away some years ago. He focused on his home, which was under threat by fire. His home was his life and held over 60 years of memories.

As we whispered, a stranger passed by. The stranger said that the homes in the elderly man's street had all burned to the ground. The elderly man looked at me. 'I have lost my home,' he whispered. Our conversation quickly turned to plans for the future. He said he wanted to 'give up' as it was 'too hard to start again'.

Abruptly, I was called to assist another evacuee who was complaining of shortness of breath. I left the elderly man to sit among strangers. When I had an opportunity to go back to see the elderly man, he had gone.

I still wonder what happened to this elderly man. I wonder how I could have been better prepared to care for him. How could I better prepare to help in future disasters? I wonder what the experience of other nurses who work in the hospital environment may be like, when they

are in the out-of-hospital environment following a disaster? How could I help other nurses prepare for disasters?

The above wondering and questioning led me to undertake this study exploring what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. This questioning led me to other research and scholarship activities related to nursing, disasters and emergency health care. The research and scholarship activities completed during my doctoral candidature are listed in Appendix A: Research and scholarship.

Chapter 1: Introduction

There are varying definitions for what constitutes a disaster. Al-Madhari and Keller (1997) stated, ‘it must be accepted that because of different professional requirements, it is not feasible to formulate a universal definition [of disaster] that will satisfy all practitioners’ (p. 19). For the purpose of this study, a disaster has been defined as ‘a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources’ (United Nations Office for Disaster Risk Reduction [UNISDR], 2009, p. 9). Further, the definition of a disaster for this study has adopted the definitions of disaster from Birnbaum, Daily, O’Rourke and Loretto (2014) and Ransie and Lenson (2012). Birnbaum et al. (2014) and Ransie and Lenson (2012) both added to the UNISDR (2009) definition of disaster, stating that from a health perspective, a disaster overwhelms the normal operating capacity of a health service, where an outside health response is required to restore and maintain the normal day-to-day health services and standards of care for the disaster-affected community.

Guha-Sapir, Hoyois and Below (2015) reported that internationally, on average, there were 384 disasters annually for the decade 2004–2013, affecting 199.2 million people and resulting in 99,820 deaths. During this decade, three disasters led to deaths well above the annual average: the Indian Ocean tsunami² (226,408 deaths), Cyclone Nargis³ (138,366 deaths) and the Haiti earthquake⁴ (225,570 deaths). In addition to a human cost, disasters have an economic cost. Since the 1980s, there has been an increasing economic loss from disasters. During the period 1980–2012, the World Bank (2013) reported an estimated US\$3.8 trillion

2 Tsunami from the Indian Ocean, affecting various countries, 26 December 2004.

3 Cyclone in Myanmar, Burma, 2 May 2008.

4 Earthquake in Haiti, 12 January 2010.

loss related to disasters. These disasters were primarily (74%) related to extreme weather events (World Bank, 2013). Guha-Sapir et al. (2015) reported that the economic consequences of disasters for the decade 2004–2013 are estimated at US\$162.5 billion per annum.

Disasters have long-term social and health consequences. In an integrative review of the psychosocial impact from various natural disasters, Warsini, West, Mills and Usher (2014) stated that post-traumatic stress disorder, depression, anxiety and stress are observed frequently after a disaster. Following the Christchurch earthquake,⁵ it has been reported that the incidences of nicotine dependence increased, as did mental health disorders such as major depression, post-traumatic stress disorder and anxiety disorders (Fergusson et al., 2014). Additionally, crimes such as family violence increased (New Zealand Government, 2014). Since 9/11 in the United States,⁶ there has been a reported increased incidence of cognitive impairment and possible dementia among the first responders to the disaster (Clouston et al., 2016).

Given the significant impact that disasters have on an international scale, in 2005 the United Nations (UN) hosted a World Conference on disaster risk reduction in Kobe, Hyogo, Japan. An outcome of this conference was the *Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters* (International Strategy for Disaster Reduction, 2007). In 2015, the UN General Assembly endorsed the *Sendai Framework for Disaster Risk Reduction 2015–2030*, replacing the Hyogo Framework. The Sendai Framework was a call to action over a 15-year period, with an expected outcome of having a ‘substantial reduction of disaster risk and losses in lives, livelihoods and health and in the

5 Earthquake in Canterbury region, New Zealand, 22 February 2011.

6 Terrorist attacks and World Trade Center collapse, United States, 11 September 2001.

economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries' (p. 12). To achieve this, the framework aimed to:

Prevent new and reduce existing disaster risk through the implementation of integrated and inclusive economic, structural, legal, social, health, cultural, educational, environmental, technological, political and institutional measures that prevent and reduce hazard exposure and vulnerability to disaster, increase preparedness for response and recovery, and thus strengthen resilience (UNISDR, 2015, p. 12).

1.1 Australian Disaster Medical Assistance Arrangements

Australia has disaster medical assistance arrangements to assist in increasing the preparedness for, and response to, disasters. These arrangements include the deployment of disaster medical assistance teams to disaster-affected communities, nationally and internationally. Disaster medical assistance teams are multidisciplinary health teams with staff including, but not limited to, doctors, nurses, paramedics and pharmacists (Aitken, Canyon, Hodge, Leggat, & Speare, 2006; Key, 1994). Disaster medical assistance teams aim to provide a coordinated health response in an attempt to restore or maintain the health capacity of a disaster-affected community, without placing a burden on the communities' already stretched resources and infrastructure (Van Hoving, Wallis, Docrat, & Vries, 2010). Therefore, disaster medical assistance teams are often self-sufficient in terms of health resources and other amenities of daily living such as food, water, accommodation and sanitation. In Australia, disaster medical assistance teams may comprise either civilian government Australian Medical Assistance Teams (AusMATs), non-government organisations, the Australian Defence Force (ADF), or a combination of these.

When a disaster occurs in South Asia, South-eastern Asia and Oceania, the Australian Government may be approached by the government of the disaster-affected country, requesting disaster medical assistance. If agreed, the Australian Government may form an AusMAT contingent consisting of civilian nurses, together with other health professionals,

from State- and/or Territory-based disaster medical assistance teams. According to Norton and Trewin (2011), AusMATs have been deployed on a number of occasions such as ‘the Javanese Earthquake,⁷ the Samoan Tsunami⁸ and the Christchurch earthquake . . . [and] the Pakistan floods’ (p. 9).

Disaster medical assistance teams are well established in Australian non-government organisations such as the Australian Red Cross and St John Ambulance Australia. These disaster medical assistance teams are deployed interstate following disasters in Australia. For example, St John Ambulance Australia has deployed nursing members to disasters such as the Black Saturday and Victorian bushfires⁹ (Ranse & Lenson, 2012; Ranse, Lenson, & Aimers, 2010) and Queensland extreme weather events.¹⁰

Nurses are engaged by the ADF in both career and reservist capacities to provide health support activities to the Australian Army, the Royal Australian Navy and the Royal Australian Air Force. In the past, ADF nursing reservists have assisted in disasters such as the Aitape tsunami¹¹ (Pearn, 1998; Taylor, Emonson, & Schlimmer, 1998), Bali I bombing¹² (Hampson, Cook, & Frederiksen, 2002), and the Indian Ocean tsunami (Chambers, Campion, Courtenay, Crozier, & New, 2006). More recently, the ADF has provided logistical support to AusMAT civilian government contingents, rather than deploying ADF health-specific disaster medical assistance teams.

7 Earthquake in Yogyakarta, Indonesia, 27 May 2006.

8 Earthquake and Tsunami, Samoa, 29 September 2009.

9 Bushfires in Victoria, Australia, February 2009.

10 Flooding and extreme weather events, Queensland, Australia, December 2010 and January 2011.

11 Tsunami in Aitape, Papua New Guinea, 17 July 1998.

12 Bombing in Kuta, Island of Bali, Indonesia, 12 October 2002.

Some of the historically notable disasters in Australia requiring medical assistance have included Cyclone Tracy¹³ (Gurd, Bromwich, & Quinn, 1975; Mahajani, 1975), the Granville rail disaster¹⁴ (Christopher & Selig, 1977), the Ash Wednesday bushfires¹⁵ (Bacon, 1983; Cox, 1997) and the Thredbo landslide¹⁶ (Harris, 1997). More recently, there have been a number of examples, both internationally (see Table 1.1) and nationally (see Table 1.2), in which Australian disaster medical assistance teams have been deployed.

Table 1.1. Examples of Disaster Medical Assistance Internationally

Disaster	Year
Fiji Tropical Cyclone Winston	2016
Vanuatu Tropical Cyclone Pam	2015
Philippines Typhoon Haiyan	2014
Christchurch earthquake	2011
Pakistan floods	2010
Pacific tsunami	2009
Java earthquake	2006
Bali bombings II	2005
Indian Ocean tsunami	2004

Adapted from the Australian Government Department of Health (2011).

13 Cyclone in Darwin, Northern Territory, Australia, 24 December 1974.

14 Train accident in Granville, NSW, Australia, 18 January 1977.

15 Bushfires in South-eastern Australia, 16 February 1983.

16 Landslide in Thredbo, NSW, Australia, 30 July 1997.

Table 1.2. Examples of Disaster Medical Assistance Nationally

Disaster	Year
Tropical Cyclone Yasi	2011
Queensland and Victorian Floods	2011
SIEV sinking near Christmas Island	2010
SIEV explosion near Ashmore Reef	2009
Victorian bushfires	2009

Adapted from the Australian Government Department of Health (2011).

1.2 Australian Nurses in the Out-of-hospital Environment Following a Disaster

Tables 1.1 and 1.2 note the instances of deployment of Australian civilian nurses as part of disaster medical assistance teams in the out-of-hospital environment following a disaster. Despite multiple deployments of nurses in disaster medical assistance teams, the literature pertaining to Australian civilian nurses in the out-of-hospital environment is scant, both nationally and internationally. The literature that does exist concentrates superficially on nurses' roles in single disastrous events. For example, following Cyclone Tracy, nurses were described as assisting in evacuation centres (O'Shea, 1975) and establishing community first aid posts (Gurd et al., 1975). Following the Ash Wednesday bushfires, nurses were described as being members of the resuscitation teams (Bacon, 1983) and providing first aid in the community (Cox, 1997). Following the Indian Ocean tsunami, nurses were described as staffing the operating theatre and being responsible for the sterilisation and packaging of equipment (Bridgewater et al., 2006).

The literature includes personal reflective descriptive accounts from nurses. In an account of the Katherine Floods,¹⁷ Serghis (1998) stated that nurses assisted in evacuation camps that were established with the assistance of the ADF following the evacuation of the local hospital. In the evacuation camps, nurses participated in wound care and implemented strategies to mitigate the spread of infectious diseases. In a self-reflective editorial on assisting as part of a disaster medical assistance team following the Victorian bushfires, Martin (2009) focused on the implication of being a nurse practitioner and the need to explore the role of nurse practitioners in disaster medical assistance teams. In a statement to the 2009 Victorian Bushfire Royal Commission, registered nurse Ms Katherine Harland stated that she:

joined other volunteer nurses who had set up a first aid station, sought assistance on local radio for medical support and medical supplies, and liaised with the CFA [Country Fire Authority of Victoria] and Victoria State Emergency Service to identify first aid response needs and locations. (Parliament of Victoria, 2010, p. 327).

Other literature is descriptive of single events. In a survey of nurses who assisted in the out-of-hospital environment during the Black Saturday and Victorian bushfires, the nursing role was reported as including clinical activities, command roles and administration (Ranse et al., 2010). In a follow-up to that research, 11 nurses were interviewed about their role in the Black Saturday and Victorian bushfires (Ranse & Lenson, 2012). These nurses described their roles as being providers of clinical care, a psychosocial supporter of both relief workers and the disaster-affected community, coordinators of care and problem solvers.

1.3 Problem Statement

Disasters occur internationally with significant short- and long-term human and economic costs. Nurses who respond as part of a military humanitarian response may have a different experience to Australian general Registered Nurses (Division 1), who primarily work as

¹⁷ Floods in Katherine, Northern Territory, Australia, January 1998.

clinicians in a hospital and have deployed following a disastrous event as part of a non-military organisation, association or group or health disaster medical assistance team.

Therefore, this study focused on civilian nurses rather than military nurses.

The Australian literature relating to nurses' experiences of the out-of-hospital environment following a disaster has been mostly simply descriptive, personal reflections and based on single disastrous events. To enhance the preparedness for the response and recovery in disaster-affected communities, an in-depth understanding of Australian civilian nurses' experiences of the disaster context is required. Until now, there has been no exploration in the Australian disaster nursing literature of the nurses' experiences from a phenomenological perspective, particularly by phenomenological reflection using the preparatory epoché-reduction and reduction proper overlaying the phenomenological existentials of 'lived-space', 'lived-body', 'lived-relations' and 'lived-time'. Such an approach would provide insight into understanding an experience of what it may be like *being* a civilian hospital nurse in the out-of-hospital environment following a disaster. This understanding could inform future practice, future education and professional development and future research. This would be aligned with the goal of the Sendai Framework to 'reduce existing disaster risk through . . . increase[d] preparedness for response and recovery, and thus strengthen resilience' (UNISDR, 2015, p. 12).

The research question for this study was 'what may it be like *being* an Australian civilian hospital nurse as part of a disaster medical assistance team in the out-of-hospital environment following a disaster'?

1.4 Structure of this Thesis

The prelude to this study presented a first-person anecdote of my experience of *being* a nurse in an out-of-hospital environment following the Canberra Bushfire. This anecdote focused on a specific moment in the disaster response that led to my programme of research and scholarship relating to emergency health care and ultimately, to this study of Australian civilian hospital nurses' lived experience of the out-of-hospital environment following a disaster.

This introduction chapter has outlined the international impact of disasters from a human and economic perspective. Historical and current Australian disaster medical arrangements have been discussed, noting that although Australian nurses respond as part of disaster medical assistance teams in the out-of-hospital environment following a disaster, the literature regarding their experiences has been based on personal reflective accounts and simple descriptions from single disastrous events. The purpose of this study has been identified and the research question underpinning the study has been presented.

The literature review in Chapter 2 presents what is known about the experience of nurses in the out-of-hospital environment following a disaster, from an international perspective. This chapter identifies that there is a great deal known about nursing following a disaster.

However, the literature does not include the experience of Australian civilian hospital nurses in the out-of-hospital environment following a disaster, from a phenomenological perspective of lived-space, lived-body, lived-relationships and lived-time, from multiple disasters.

Chapter 3 describes a variety of phenomenological theoretical perspectives. This is approached from the perspective of phenomenology being concerned with the essence of

things as they are appearing in the conscious awareness of the first person. The relationship between phenomenology and hermeneutics are discussed.

In Chapter 4, the previously presented phenomenologies and associated theoretical underpinnings are applied to this study as a method. This chapter outlines a practical way of ‘doing phenomenology’ as it is applied to the research question for this study, particularly the preparatory epoché-reduction and reduction proper as a key method.

Chapter 5 integrates the participant narratives with descriptive moments in an experience for nurses in the out-of-hospital environment following a disaster. The identification of moments of what it may be like *being* a nurse in an out-of-hospital environment following a disaster is supported by exemplars of participant narrative. The narrative is placed against summary anecdotes using the phenomenological *I*. The summary anecdotes lead to a ‘lived-experience description’ in Chapter 6.

Following the lived-experience description in Chapter 6, a series of reflections are presented in Chapters 7, 8, 9 and 10 overlaying the phenomenological existentials with the uncovered moments of the lived-experience description. These reflections go beyond the physical, touchable life-world of a nurse and delve into what it may be like for a nurse existentially. The focus of these reflections is on *being* a civilian hospital nurse in the out-of-hospital environment following a disaster, from a lived-space (Chapter 7), lived-body (Chapter 8), lived-relationships (Chapter 9) and lived-time (Chapter 10) perspective. A preparatory epoché-reduction and reduction proper guide these reflections on *being* a nurse in an out-of-hospital environment following a disaster from the previously presented lived-experience description. The commentary provides a discussion about these observations from an eidetic position.

Chronos time emerges as a strong backdrop to the life-world of a nurse in Chapter 11.

Chronos time intersects with the previously presented uncovered moments in Chapter 5, the lived-experience description in Chapter 6 and phenomenological existential reflections in Chapter 7, 8, 9 and 10. As chronos time emerges in Chapter 11, the experience of nurses is further uncovered as an experience that is about time.

Finally, Chapter 12 presents the implications, questions and final commentary, outlining the key implications and questions for this study relating to future practice, future education and professional development, and further research. The importance of this study is discussed, in particular highlighting its uniqueness and the contribution it makes in enhancing the future experience of Australian hospital nurses as part of a disaster medical assistance team in the out-of-hospital environment.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides a review and critical appraisal of the literature pertaining to the experience of nurses in the out-of-hospital environment following a disaster. The question guiding this literature review was ‘what is known from the literature about hospital nurses experiences of the out-of-hospital environment following a disaster?’ This review was undertaken systematically at the commencement of this study. Databases and search engines for this review were OvidSP (Ovid Technologies; New York, New York USA; MEDLINE [Medline Industries, Inc.; Mundelein, Illinois USA), PsycINFO (American Psychological Association; Washington DC, USA), and DARE (Rutgers University Libraries; New Brunswick, New Jersey USA), CINAHL (EBSCO Information Services; Ipswich, Massachusetts USA), Pubmed (National Center for Biotechnology Information; Bethesda, Maryland USA), and Scopus (Elsevier; Amsterdam, Netherlands) and Google Scholar. The search strategy included different combinations of keywords and Medical Subject Headings terms that were relevant to the research question, such as ‘disasters’, ‘emergencies’, ‘emergency medicine’, ‘emergency shelter’, ‘experience’, ‘life experiences’, ‘mass casualty incidents’, ‘nurse’, ‘nurses’, ‘nursing’, ‘out-of-hospital’, ‘relief work’ and ‘rescue work’. No date restrictions were placed on this search.

In addition to undertaking this review at the beginning of this study, this literature review was undertaken iteratively throughout the study using citation alerts to identify contemporary works. Further, this review used manuscript reference lists in a snowballing manner to identify possible literature for inclusion. This review included literature about real-world disaster events that included nurses as participants, where nurses were in the out-of-hospital environment following a disaster. It excluded literature relating to the experience of nurses in

the hospital environment following a disaster (rather than the out-of-hospital environment), such as literature from the Nepal earthquake¹⁸ (World Health Organization [WHO], 2015), the Christchurch earthquake (Lyneham & Byrne, 2011) and Cyclone Yasi¹⁹ (Hayes, 2011; Little et al., 2012; McArdle, 2011). Additionally, this literature review focused on papers on real-world events, rather than on discussion or theoretical papers about possible or hypothetical disasters that had not occurred.

The literature included in this review has been divided, using a heuristic approach, into categories such as nurses' clinical experience, nurses' disaster medical assistance team affiliations, nursing practice, nurses as leaders and team members, and the psychosocial well-being of nurses and communities.

2.2 Nurses' Clinical Experience

Nurses who have responded following a disaster have had varied hospital clinical experience. In a descriptive study of nurses who formed a disaster medical assistance team in the out-of-hospital environment following the Wenchuan earthquake,²⁰ the most frequently reported hospital clinical background of nurses was from the operating theatre environment ($n = 8$, 33.3%) (Yin et al., 2012). All nurse ($n = 10$, 100%) in another study following the Wenchuan earthquake had clinical experience in either emergency or perioperative environments (Yang, Xiao, Cheng, Zhu, & Arbon, 2010). In describing the clinical experience of nurses from research regarding a Swedish tram and train disaster,²¹ Suserud and Haljamae (1997) reported that the majority of nurses ($n = 11$, 68.8%) had an intensive care or emergency nursing background.

18 Earthquake in Nepal, April–May 2015.

19 Tropical Cyclone in Queensland, Australia, 3 February 2011.

20 Earthquake in Wenchuan County, China, 12 May 2008.

21 Tram and train disaster, Sweden, date unknown.

In addition to nurses having predominantly clinical experience in emergency, intensive care or perioperative environments, nurses responding to some disasters had predominantly medical or surgical clinical experience. Following the Jiji earthquake,²² the nurses that assisted in the disaster response were medical ($n = 14$, 30%), followed by surgical ($n = 9$, 20%), intensive care ($n = 9$, 20%) and emergency ($n = 8$, 17%) nurses (Shih, Liao, Chan, Duh, & Gau, 2002). Similarly, in a survey of nurses who assisted in the Black Saturday and Victorian bushfires, Ranse et al. (2010) reported that the clinical experience of nurses included the acute medical ($n = 9$, 37.5%) and surgical ($n = 8$, 33.3%) environments. A smaller number were from the emergency department (ED) ($n = 4$, 16.7%), perioperative ($n = 1$, 4.2%) and intensive care ($n = 1$, 4.2%) environments.

The previous disaster experience of nurses varied from assisting in multiple previous disasters as part of a disaster medical assistance team to having no prior disasters experience. Nursing members of St John Ambulance Australia who responded following the Black Saturday and Victorian bushfires answered a survey indicating that they all ($n = 24$, 100%) had previous out-of-hospital clinical experience, with most ($n = 16$, 67%) reporting that they had previous disaster experience as a nurse (Ranse et al., 2010). On average, nurses in this research had assisted in two previous disasters (Ranse et al., 2010). In a study of nurses who assisted following the Sweden tram and train disaster, most ($n = 10$, 62.5%) had out-of-hospital nursing experience, particularly at other disasters and emergencies (Suserud & Haljamae, 1997). Conversely, all nurses ($n = 13$, 100%) in a qualitative study relating to the Bam earthquake²³ had no previous disaster experience (Nasrabadi, Naji, Mirzabeigi, & Dadbakhs, 2007). Dickerson et al. (2002) observed that nurses with previous disaster experience prior to

22 Earthquake in Nantou County, Taiwan, 21 September 1999.

23 Earthquake in Bam Province, Iran, 26 December 2003.

assisting in the events following 9/11 experienced less frustration and anxiety than those who were having their first disaster experience.

2.3 Nurses' Disaster Medical Assistance Team Affiliation

As established in the introduction, nurses respond following disasters as members of disaster medical assistance teams. These teams may be government civilian, non-government organisations or defence force disaster medical assistance teams. Nurses who respond following a disaster as part of a disaster medical assistance team have a sense of being prepared and supported. Ketchie and Breuilly (2010) observed that nurses in a national disaster medical assistance team following the Haiti earthquake had a sense of feeling prepared for their work. Similarly, following 9/11, Dickerson et al.'s (2002) hermeneutic phenomenological study observed that nurses who were affiliated with a disaster medical assistance team were supported with access to formal organisational leadership and role delineation. This would be expected because disaster medical assistance teams provide a governance structure. Conversely, nurses deploying without disaster medical assistance team affiliation expressed frustration in their inability to assist to their perceived full potential (Dickerson et al., 2002).

Nurses may decide to respond following a disaster independent of an established disaster medical assistance team, without an official call or invitation for their assistance. Following the Christchurch earthquake, nurses who were in the city attending a conference made themselves available at first aid posts (Chiarella, 2011). Learning of the devastation in New York City immediately following the events of 9/11 via television broadcasts, Gatto (2002) self-presented to offer her assistance. Similarly, following the Puerto Rico floods,²⁴ after the

²⁴ Floods in Puerto Rico, 29 September 1985 onwards.

media announced to the community that an evacuation centre had been established, nurses and nursing students self-presented to assist (Rivera, 1986).

As nurses live and work within the general population in disaster-affected communities, it is reasonable to expect them to decide to assist without an official invitation and to do so independently of any disaster medical assistance team affiliation. However, the experience of nurses who respond following independently from an established disaster medical assistance team may be different from nurses who are affiliated with a disaster medical assistance team.

2.4 Nursing Practice

Nursing practice following a disaster can be varied, based on the type of disaster, a nurse's country of origin and a nurse's scope of practice. This literature review notes that following a disaster, nursing practice included assessing and managing various injuries and illnesses, aspects of public health nursing, psychosocial care and other nursing practices. However, there is a lack of complexity in the published literature because it has originated from single events and the authors, commonly reflecting on their own experience of being in the disaster, have provided a superficial account of their nursing practice.

Following a disaster, nurses are required to use their clinical decision making and rely less on well-developed protocols or guidelines to guide their nursing practice. For example, Gatto (2002) stated that following 9/11:

There was no policy, no procedure, no one to report to, or get report[s] from. There was no routine, no schedule . . . it was nursing knowledge and skill—the true nursing instinct you find when you're faced with a totally unknown experience (p. 5).

This was similar to the experience of nurses following the Bam earthquake, who described the out-of-hospital disaster environment to be different from the hospital environment, lacking

guidelines or protocols to assist in their decision making (Nasrabadi et al., 2007). Practising without policies and procedures may be normal in a disaster because the situation of practising in a disaster would be unfamiliar to most nurses.

2.5 Injury and Illness Assessment and Management

Nurses provide care to patients with minor injuries following disasters. Following the Black Saturday and Victorian bushfires, nurses described primarily treating minor injuries and wounds (Ranse & Lenson, 2012). Similarly, when comparing the two real-life disasters in the Sweden tram and train disasters, nursing practice primarily involved the care of patients with minor injuries ($n = 126$, 66.3%) rather than severe injuries ($n = 42$, 22.1%) or deceased patients ($n = 22$, 11.5%) (Suserud & Haljamae, 1997). Managing cuts, bruises and wounds were activities undertaken by nurses following the Katherine floods (Serghis, 1998). First aid was suggested as an essential component of care by nurses following the Puerto Rico floods (Rivera, 1986). Likewise, minor injuries requiring band-aids were required following Hurricane Katrina²⁵ (Weeks, 2007). Following the Texas tornado, Brown (1989) recalled undertaking minor wound assessment and management. Managing minor injuries may be predominant following a disaster because people who are impacted directly by the disaster may either die or have minor injuries.

Nurses following a disaster undertake the management of chronic conditions such as hypertension and diabetes. Following the Black Saturday and Victorian bushfires, monitoring chronic conditions such as hypertension was part of a nurse's role (Ranse & Lenson, 2012). Similarly, following the Puerto Rico flood and Jiji earthquake, nurses managed cases of chronic illnesses such as hypertension and diabetes, stating that this aspect of nursing was an

²⁵ Tropical cyclone, south-east United States, August 2005.

important activity (Rivera, 1986; Shih et al., 2002). In addition, nurses participate in individual patient medication management for chronic conditions. They problem solve with patients to determine the type of medications a patient normally takes, and the dose and frequency, and determine avenues to access medications for patients. Following the Black Saturday and Victorian bushfires, nurses worked with patients to determine their medication requirements and how they could access those medications (Ranse & Lenson, 2012). Nurses who assisted after the Texas tornado reported that patients presented with a lack of health supplies such as medications (Brown, 1989). Managing chronic health conditions following a disaster would be expected because many people in any given population have chronic health conditions. However, beyond describing the literature regarding injury and illness assessment and management, the literature lacks any in-depth understanding of what it may be like *being* a nurse in an out-of-hospital environment following a disaster in caring for people who have injuries and illnesses.

2.6 Public Health Nursing

Following a disaster, nurses undertake public health roles such as communicable disease management and providing opportunistic vaccinations. Nurses were involved in the management of infectious diseases (e.g., gastroenteritis) that occurred after the Puerto Rico floods (Rivera, 1986) and Katherine floods (Serghis, 1998). This was particularly evident when evacuation centres were in venues with compromised water supplies, failed sewerage systems and minimal toilet facilities (Rivera, 1986). Following the Great Eastern earthquake and tsunami,²⁶ nurses undertook public health surveillance activities in evacuation centres in Japan (Kako, Ranse, Yamamoto, & Arbon, 2014). Additionally, at evacuation centres during

²⁶ Earthquake and tsunami in Japan, 11 March 2011.

the Puerto Rico floods, nurses provided opportunistic vaccinations for infectious diseases (Rivera, 1986).

2.7 Psychosocial Care

Nurses provide psychosocial assessments and care to people in disaster-affected communities. Disasters are a known cause for mental illness, such as various forms of depression, post-traumatic stress disorders and elevated suicide risk (Warsini, Mills, & Usher, 2014). Evacuees from Hurricane Katrina were assessed by nurses for both their physical and psychosocial well-being (Weeks, 2007). Similarly, following the Puerto Rico floods, a psychological assessment was carried out by nurses on all people presenting to evacuation centres and found ‘depression, anxiety, loneliness, insecurity and above all the concept of loss’ (Rivera, 1986, p. 141).

People in a disaster-affected community discuss their thoughts, feelings and emotions related to being in a disaster openly with nurses. In researching both nurses and those affected by the Ash Wednesday bushfire, Cox (1997) suggested that those affected by the disaster disclosed things to nurses that they would not normally disclose to a stranger. Nurses who lived and worked external to the disaster-affected community were accepted in the community as ‘insiders’ rather than being seen as ‘outsiders’. Nurses provided psychosocial caring to people affected by the tram and train disaster in Sweden (Suserud & Haljamae, 1997), as well as following the Queensland extreme weather events (Hasleton, Allan, Hegner, Kerley, & Stevens, 2013). Similarly, following the Black Saturday and Victorian bushfires, nurses stated that patients presented for clinical assessment and management of minor ailments and during these consultations patients wanted to talk about their experiences of being in the disaster (Ranse & Lenson, 2012).

2.8 Other Practice

Nurses refer patients to other health services. For example, following the Texas tornado, some patients were without their dentures and hearing aids and nurses were able to link patients with services to obtain such adjuncts (Brown, 1989). Similarly, in identifying a psychosocial referral need for some patients following the Puerto Rico floods and Ash Wednesday bushfire, nurses linked patients with local mental health services (Cox, 1997; Rivera, 1986). Some infrequent nursing practice reported following a disaster includes delivering babies, performing cardiopulmonary resuscitation, tracheal intubation and thoracic drainage. The delivery of babies was reported following the Haiti earthquake (Ketchie & Breuilly, 2010) and participating in cardiopulmonary resuscitation of an evacuee in an evacuation centre was reported following Hurricane Katrina (Weeks, 2007). Additionally, Yin et al. (2012) reported that tracheal intubation ($n = 4$, 16.7%) and thoracic drainage ($n = 1$, 4.2%) were performed occasionally by nurses.

It is evident that the scope of practice for nurses differs between countries. For example, Australian nurses are unlikely to perform tracheal intubation or thoracic drainage. Because of this variation in nursing scope of practice between various countries, it was reasonable in this research to first study the experience of one nursing population, to better understand the experience of *being* a nurse in an out-of-hospital environment following a disaster, before exploring a multinational experience.

2.9 Nurses as Leaders and Team Members

Nurses are leaders of health teams following a disaster. Some nurses ($n = 16$, 66.7%) who assisted following the Black Saturday and Victorian bushfires undertook a leadership role in the Emergency Operations Centre, such as commander ($n = 4$, 16.7%), liaison with other organisations ($n = 2$, 8.3%) or organising logistics ($n = 2$, 8.3%) (Ranse & Lenson, 2012).

Nurses with an intensive care or emergency nursing background are more likely to undertake a clinical leadership role than are other nurses. For example, during the Sweden tram and train disaster, half of the intensive care and emergency nurses ($n = 8/16$, 50%) undertook a clinical leadership role, while no other nurses undertook a leadership role at these events ($n = 0/16$, 0%) (Suserud & Haljamae, 1997). However, following some disasters, nurses experience a sense of poor leadership from a health perspective, which results in nurses adopting an unplanned or spontaneous leadership role. For example, a lack of leadership was noted at evacuation centres following 9/11 (Gatto, 2002). Similarly, a lack of leadership was noted on arrival to evacuation centres following the Puerto Rico floods (Rivera, 1986). Weeks (2007) stated that in Texas following Hurricane Katrina, although she did not think she was necessarily the best person to be in a leadership role, she undertook it because someone needed to take charge.

Following a disaster, working in teams enhances collegiality. Disasters result in a 'coming togetherness', a mateship between nurses that did not necessarily exist prior to the disaster (Dickerson et al., 2002). Shih et al., (2002) reported that building stronger collegial relationships and getting to know colleagues better, in a way that would not have occurred if they were not deployed together, was a positive attribute of being in a disaster. However, being in a team is not always a positive experience for nurses, with a lack of teamwork and poor organisation resulting in a negative experience. Nurses from the Bam earthquake suggested that there was an overall lack of teamwork, particularly during the early stages of the disaster. This lack of teamwork was made more noticeable when disaster medical assistance teams from other countries arrived, with a lack of coordination in the disaster assistance efforts (Nasrabadi et al., 2007). Similarly, poor organisation resulted in a negative experience for some nurses ($n = 3$, 18.8%) involved in the Sweden tram and train disaster (Suserud & Haljamae, 1997).

Teamwork and cooperation occurs between disaster medical assistance teams, resulting in nurses sharing equipment. For example, following the Wenchuan earthquake, nurses shared their equipment among different disaster medical assistance teams, as damaged transport infrastructure prevented all the desired equipment being available at the disaster site (Yang, Xiao, et al., 2010). Similarly, following Hurricane Katrina, the evacuation centres that were established in nearby cities lacked items such as first aid supplies, beds and linen. The sharing of equipment between nurses at the evacuation centre and local hospitals resulted in low-acuity patients being able to remain at the evacuation centre, rather than being transported to hospital (Weeks, 2007) However, a lack of corporation between organisations can result in nurses improvising in providing care for patients. In the Wenchuan earthquake, nurses in a disaster medical assistance team from outside Wenchuan County had to learn about the local health system, vulnerable community members and food and water resources in the region because agencies were unwilling to coordinate (Yang, Xiao et al., 2010). In addition, the nurses were required to improvise to provide adequate care for patients, such as using intravenous set lines as urinary catheters to manage patients with urinary retention.

2.10 Psychosocial Well-being of Nurses and Communities

Disaster work is physical. This was exemplified by nurses following the Wenchuan earthquake, who recalled the requirement to walk more than nine hours to the disaster area carrying a backpack weighing 30 kg (Yang, Xiao et al., 2010). This was a necessity due to damaged transport infrastructure that did not permit the movement of vehicles to transport either human or material resources. The nurses from this disaster expressed having a sense of physical unpreparedness for disaster work in the out-of-hospital environment. In addition to the need to be physically prepared to carry heavy items over long distances, nurses who assist following disasters may become physically exhausted as they may work more hours in a day when compared to the day-to-day non-disaster hospital environment. Nurses in disaster

responses following the Ash Wednesday bushfires and the Izmit earthquake²⁷ stated that they worked more hours per day than their usual hospital working hours (Cox, 1997; Margalit et al., 2002).

Nurses who assist following a disaster need to be prepared psychosocially. Nurses involved in the response to the Wenchuan earthquake said they felt unprepared psychosocially (Yang, Xiao et al., 2010). Nurses involved in the response to the Ash Wednesday bushfires said they were ill-prepared from a psychosocial perspective and described being overwhelmed (Cox, 1997).

Nurses' experiences in a disaster from the perspective of caring for a deceased or dying patient is different to an experience of death and dying in the hospital environment, as death in a disaster is on a large scale. One nurse recalled seeing numerous bodies lying on the ground, with family members leaning over them, crying for long periods (Shih et al., 2002). Following the Wenchuan earthquake, nurses experienced the sight of many people dying and seeing large numbers of corpses (Yang, Xiao et al., 2010). Yang, Xiao et al. (2010) recounted a story from a nurse who held the hand of a young girl who died while being rescued from a collapsed building. This nurse could not sleep for long periods once her deployment ended.

Images in the media do not emphasise the overwhelming emotional devastation witnessed by nurses following a disaster. While assisting following the 9/11 disaster, nurses witnessed the emotions of the disaster-affected community members and relief workers (Dickerson et al., 2002). Brown (1989) noted that while images on television give some insight into the disaster environment (e.g., the Texas tornado), it does not prepare a person for the first-hand experience of witnessing the overwhelming sense of devastation and grief of those affected by

27 Earthquake in the Marmara Region, Turkey, 19 October 1999.

the disaster. Similarly, Ketchie and Breuilly (2010), who responded following the Haiti earthquake, stated that the devastation seen on television and in the media did not capture the destruction and large numbers of displaced people resulting from the disaster.

The emotional effects of assisting in a disaster are not always negative. Serghis (1998) reported that the Clinical Nurse Consultant of Katherine Hospital noticed that some staff were not coping with the events of the Katherine floods, whereas others seemed to be fine and continued to work. Some nurses may experience personal and professional growth from being in a disaster and have a sense of joyfulness, meaningfulness and privilege for caring for people. For example, some nurses who assisted following the Bam earthquake reported a sense of joyfulness because of their experience (Nasrabadi et al., 2007). Similarly, Rivera (1986), in a personal account of the Puerto Rico floods, described a sense of personal and professional growth because of their experience. Both personal and professional growth was described by nurses following the Wenchuan earthquake, with caring for others providing a sense of meaning (Yang, Xiao et al., 2010), as nurses felt privileged to be able to assist those affected by the disaster (Shih et al., 2002).

Nurses engage in humour to cope in a disaster. After the Christchurch earthquake, humour was apparent among survivors and nurses (Chiarella, 2011). It was important that nurses did not lose their humour, as it was a technique for remaining focused on providing clinical care (Serghis, 1998). However, following Ash Wednesday, humour was kept within nursing and not shared with the wider community, as it was considered to be 'black humour', which seemed to be acceptable internally for coping with the disaster but would be unacceptable externally (Cox, 1997).

2.11 Summary

This literature review has highlighted that the experience of nurses in the out-of-hospital disaster environment following a disaster mostly consists of descriptive accounts from single disastrous events. Single descriptive accounts lack the depth to provide a deeper understanding of what it may be like *being* a nurse in an out-of-hospital environment following a disaster. The perspectives of this experience from various disaster types could provide broader insights into the singularities of disasters. A phenomenological perspective that uncovers a possible or likely experience from multiple disasters, from an existential perspective, is absent from the literature. Further, the literature review has demonstrated that the Australian literature pertaining to the real-life experience of nurses assisting in out-of-hospital disasters is scant. It is important to understand the lived experience of Australian civilian nurses following a disaster in the out-of-hospital environment as part of a disaster medical assistance team because it may differ experientially from an international nursing experience. To explore what it may be like *being* an Australian civilian nurses in the out-of-hospital environment following a disaster as part of a disaster medical assistance team, a phenomenological approach would be appropriate. The next chapter provides an exploration of phenomenologies from a theoretical perspective, to form the basis of this study.

Chapter 3: Phenomenologies

3.1 Introduction

Phenomenology is concerned with the way a person experiences things within the world (Heidegger, 1953/2010; Husserl, 1900/2001; Merleau-Ponty, 1945/2002). Phenomenology is not concerned with finding answers to the life-world experiences. Rather, phenomenology may raise more questions and give new insights and understandings about an experience that is being explored. Phenomenology is steeped in an attitude of wonder, to give insight into what it may be like to have a particular experience (van Manen, 2013). In the case of this study, what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. Therefore, phenomenology is concerned with the essence of things as they are appearing in the conscious awareness of the first person.

Four key aspects of phenomenology are explored in this chapter: things, conscious awareness, first person and appearing. Additionally, hermeneutics and its overlapping relationship phenomenology are discussed.

3.2 Things

Things in the world have properties. Physical or material things are objects with concrete properties. Things often have meaning and purpose. For example, if a piece of plastic joined to metal is placed on a desk, it might be observed to be a piece of plastic joined to metal. However, if this plastic has a particular shape, such as cylindrical Y-shaped tubing, it might be more than ‘just’ a piece of plastic joined to metal. If the bottom of the Y-shaped plastic is round, double-sided and metallic in nature and the top of the Y-shaped tubing has two small, soft pieces of plastic on either side, it might resemble a recognisable thing. It might be recognised that this thing is a stethoscope. If someone picks up the stethoscope from the desk,

they can note other properties, such as the length of the tubing or weight of the stethoscope, that may not have been known until the person holds the stethoscope in their hand or they place the stethoscope around their neck. The tubing might be long, short or just right for the purpose for which they wish to use it.

It is the uniqueness or singularity of the properties of a thing that gives the thing its 'thingness', the what its 'whatness' or *being* its '*beingness*'. These unique properties are referred to as the essence of a thing (van Manen, 2014b). If the essence of a thing is removed, the thing can no longer be recognised as that thing, but instead is something else. Therefore, the essences are the uniqueness or singularity of a thing. As a simple example, if the Y-shaped tubing from a stethoscope is removed and only the round, double-sided metallic piece remains, it may not be recognisable as a stethoscope.

3.2.1 A stethoscope, a patient and me.

Ranse (2015) described the phenomenological aspect of a stethoscope as follows:

The anecdote below provides an insight into the phenomenological natural attitude of the stethoscope and what it may be like to experience a stethoscope as a nurse or as a patient. A stethoscope is a thing that has concrete properties, purpose and meaning. The stethoscope holds purpose and meaning for me as nurse.

I walk into the hospital and place my stethoscope around my neck. The stethoscope turns me from a layperson into a nurse, with tools ready-at-hand. My stethoscope is ready to be used for a particular purpose, auscultation. When I use my stethoscope I am interested in the patient as a whole, but I am concentrating on the sound that is reverberating through the tubing of the stethoscope. I am concentrating on the intricacies of the sound that is being listened to, such as the lub-dub of a heartbeat. Whilst the stethoscope amplifies a sound of interest, I find it difficult to hear the conversations of those nearby or the sound of monitors alarming in the distance. External sounds are reduced to a muffle. I need to concentrate, I need to listen. The stethoscope allows for the unheard to be heard. The unheard provides insight into the patient's condition. I hear what the patient themselves do not hear; I know what the patient themselves do not know. My auditory insight provides knowledge about the patient's condition for the sake of planning and evaluating care.

The patient's experience of the stethoscope as a thing may be somewhat different from that of a nurse. Perhaps patients have an expectation of a nurse with a stethoscope around their neck? That a nurse has a certain level of clinical knowledge? The stethoscope partners a nurse and patient in a collaboration of care.

As a patient, I willingly lift my shirt for a nurse to use their stethoscope. I may not always be willing; on occasions, I am hesitant to lift my shirt. The stethoscope may be cold. The stethoscope reminds me of my previous illness. The illness of a loved one. It may evoke a stressful moment in life. I cannot hear my own heartbeat; it is only heard by a nurse that uses the stethoscope.

The young child or confused elderly may not want the stethoscope near them. They may use their hand to brush away the stethoscope. Fighting against the stethoscope. Not realising that this tool is being used with the intent to assist, not hinder. For the unconscious patient or deceased, they have no choice. A nurse just uses the stethoscope without their willing or knowing.

The stethoscope is an example of a thing that is tangible, visible and physically touchable; it is a concrete life-world object. However, things do not always present like this. Non-physical, immaterial moments are 'non-material things'. Like concrete life-world things, these moments, too, have properties. However these properties are not touchable; instead, these properties are often related to the meaningfulness of a moment or situation in which someone finds themselves, such as *being* in a hotel room (Van Lennep, 1987), sharing a secret (Langeveld, 1944) or *being* at home sick (Van Den Berg, 1972).

3.2.2 On a Background of the World

The life-world extends beyond the physical space to the spaces in reference to the world within which one lives (Heidegger, 1953/2010). The life-world does not refer to a person's nearest surroundings, such as the domestic surroundings of the home or workplace. Things are experienced in the world. Things only make sense when they are considered within a certain aspect in the world, against a background of totality or completeness, which Heidegger called the background (Heidegger, 1953/2010). For example, a stethoscope 'makes sense' if it is used by a nurse with a patient, a veterinarian with an animal or in situations such as children playing 'doctors and nurses'.

3.2.3 Epoché

Phenomenology is concerned with the relationship between subjects and objects, or people and things, within the lived-world (Husserl, 1954/1970). Husserl (1900/2001) suggested that it is possible to remove the minds' content or abstain from judgement regarding a thing for the purpose of determining its true nature. This is called 'bracketing'. When bracketing, an individual suspends, as much as possible, all opinion, beliefs and presuppositions concerning the thing in question. This is done to allow things to show themselves as they are in themselves. Husserl (1900/2001) suggested that it is possible for an individual to remove the awareness of what a stethoscope is and then when uncovering an experience of using a stethoscope, finding out what it is like as if it is the first time the thing has been experienced. Importantly, when exploring an experience, bracketing does not aim to 'forget' a thing, such as what an experience of a stethoscope is for a nurse, or what it may be like *being* a nurse in an out-of-hospital environment following a disaster. Instead, bracketing aims to bring into light the essence of a thing, an ability to describe the thing as it is in itself.

In contrast, Heidegger (1953/2010) argued that it is not possible to bracket things. Bracketing in a true sense is difficult to achieve, particularly if an experience or thing is something with which you have been actively engaged for some time or is a moment, such as an experience of *being* a nurse in an out-of-hospital environment following a disaster. In fact, Heidegger (1953/2010) stated that the world is more than just subjects contemplating things. Rather, the idea of having subjects and things separate from one another is preposterous, as a broader world exists. Therefore, the exploration of experience should start with the world itself. The existence of an external world does not need proof; it just needs to be taken as if it exists and exploration is not required to know this (Heidegger, 1989/2012).

Heidegger (1953/2010) maintained that in fact, *being* in the world is being an active participant in the world, interacting and responding to the world. It is not as if an individual is suspended in the world and can only observe it through a pane of glass. Sartre (1943/2003) suggested moving away from the notion of *subjects* and *objects* to use the notions of *I* and *world*, as it would be impossible to imagine a lived-world without *I*. This lived-world can be accessed from an experience of the first person's conscious awareness.

3.3 Conscious Awareness

Things have properties and these things make sense when viewed against a particular aspect of the subject's mental content, on a backdrop of the world. As such, an individual's intentionality has a number of assumptions, beliefs or presuppositions, and ideas and thoughts about that thing.

3.3.1 Intentionality.

It is suggested that conscious awareness, or at least the content of the mind, is always directed towards something (Husserl, 1931/2012; Husserl, 1954/1970). This is the base premise of phenomenology, in which subjects contemplate things. Husserl used this notion as a foundational building block to develop his understanding of the world. He gave this the term intentionality, meaning the 'directedness' or 'towardness' towards something (Husserl, 1931/2012). This intentionality is about neither the intention of the subject nor the intention of the thing. Instead, it is a term coined to define the mental consciousness of thought towards a thing. Following Husserl's (1900/2001) philosophical stance, if a nurse was using the stethoscope to hear a patient's heartbeat, their intentionality is directed towards the stethoscope when undertaking an activity, such as auscultating.

In contrast, Heidegger's (1953/2010) philosophical stance suggested that a nurse is not directing their mental content towards the stethoscope or even the heartbeat. A nurse does not necessarily think about auscultating a patient's chest; a nurse just does it. A nurse may hold the stethoscope in one hand against the patient's chest, listening intently, because they have been taught to do it this way or they have taught themselves to do it. While undertaking the activity of auscultating, a nurse may have been able to think about other patients and their needs, think about the priorities of care for other patients, recall previous conversations or actions, or observe the patient's domineer or skin colour. That is, the nurse would not have been directing all of their mental content towards their stethoscope or the activity of auscultating. Therefore, the activity of auscultating is not necessarily in the conscious awareness of a nurse. A nurse may observe the thing to be a stethoscope because the thing looks like a stethoscope, but when using it on a day-to-day basis, a nurse may not necessarily have a memory of using it in every occasion on every day, as their actions have passed through their transparent consciousness (Heidegger, 1953/2000). Instead, what a nurse knows is that on the completion of their shift, or when the patient is discharged home, a nurse must have used a stethoscope.

When something goes wrong in the activity of auscultating, such as the nurse no longer hearing the heartbeat of a conscious patient, then the nurse becomes consciously aware of the activity of auscultating. It may be that the stethoscope does not have appropriate contact with the patient's skin, or that the tubing is kinked, impeding the movement of sound, or that the bell is open rather than the diaphragm. It is then that a nurse becomes consciously aware of this activity and directs their mental content to the activity of auscultating with a stethoscope. For a nurse who experiences an activity such as auscultating every day, it is a somewhat unconscious activity until an alteration, interruption or problem is encountered. Then the subject becomes consciously aware of the thing within this activity (Heidegger, 1953/2000).

3.4 First Person

3.4.1 *Being.*

The term *being* is widely used throughout phenomenology. This term has German origins from the words *da* meaning *here*, and *sein* meaning *being*. The word *dasein* means being here or existence (Olafson, 1994). *Dasein* refers to the existence of a human being in the world, behaving or interacting with the world in a certain manner, rather than in reference to a human being as a subject (Heidegger, 1953/2000; Heidegger, 1953/2010). *Dasein* itself at times could be described as a way of existing for a human being. As such, *dasein* can be described as the activity of *being* in the world, or *being* within a particular moment, situation or event. This is an important notion, as this study is exploring the *beingness* of *being* an Australian civilian hospital nurse as part of a disaster medical assistance team in the out-of-hospital disaster environment following a disaster.

Dasein has the basic characteristics of what Heidegger calls disposition (Heidegger, 1989/2012). For example, mood is a disposition of *dasein*. It is important to note that a human being in the world exists in a particular mood. However, this mood does not necessarily arise from having no mood at all. Instead, things matter to *dasein* and these things that matter are of importance. This importance can influence mood. Additionally, *dasein* is a rationale of *being* and is a coping with regard to *being* (Olafson, 1994). That is, individuals do what they do to be understood and acknowledged within the world in which they exist. For example, if a nurse uses a stethoscope to auscultate a patient's chest to hear a heartbeat, but instead cannot hear a heartbeat, the nurse has the ability to cope. That is, the nurse will identify the problem and set out to fix this problem, which may be originating from the stethoscope. As such, a nurse may twist the end of the stethoscope to open the diaphragm instead of the bell, take and use another stethoscope, or seek assistance from a colleague. These options may provide a

way to achieve the desired outcome of auscultating. The nurse is now consciously aware of the stethoscope.

3.4.2 Perception.

In phenomenology, the notion of the purpose of the body was not at the fore until Merleau-Ponty (1945/2002) focused on the way the body interacts with the world, or the way the body is embodied within the world, to make meaning of the world. This is termed 'corporality' and refers to the lived-body within the lived-world. The notions of corporality or lived-body are existential notions of the position of body in the lived-world through which the phenomena is lived through as we actually live through it (Merleau-Ponty, 1945/2002).

The world is perceived through the relationship one has with the world. This is particularly true in terms of the proximity of the subject to the world. This proximity could be considered as the relationship of a person or subject to a thing. A person can only experience something from where they stand. In particular, an individual experiences a thing from the angle or view from where they stand (Merleau-Ponty, 1945/2002). For example, the closer a nurse is to the patient, the more detail they can see of the patient. If a nurse holds a patient's hand, looking directly at the patients' hand, the nurse would see the patient's hand in exquisite detail, noting all the perfection and imperfection of the hand. When looking at the hand itself, it does not mean that the nurse is disregarding that a patient exists holistically; it is simply that the patient as a whole is not at the fore; the hand is.

When a nurse moves back from the hand, an arm can be seen and further back from the arm, a person or patient can be seen. If a nurse moves further away from the patients' bedside and further down the ward, the nurse can not only see the patient, but now a patient in a ward. This may have meaning for *dasein*, as a ward has particular characteristics. For example, a

nurse could tell if the patient was in an ED, intensive care unit (ICU), general surgical ward or aged-care facility. At this position on the ward, the nurse can no longer see the intricate details of the single patient's hand. Instead, the nurse has an overview of many patients.

At various points in time throughout a shift, nurses position themselves to have an optimal view of the thing that they wish to experience. At times, this may be a hand of the patient and at other times, it might be an overview of a number of patients on a ward. Regardless of where a nurse stands, a nurse will never be in a position to see multiple patients in their totality and in exquisite detail at the same time, as a nurse cannot see all sides of all patients at once. The body of *dasein* is important in understanding an experience, as the body is drawn to a position in which the perception of *dasein* is best viewed with an optimal position of the lived-world (Merleau-Ponty, 1945/2002).

A person cannot experience a thing from where another person stands. Seemingly, the same situation may not be experienced exactly the same way by individuals because the individuals' views, opinions and beliefs differ. Individuals do not perceive and experience the world in the same way. If this was not the case and all individuals experienced the world in the same way, the world would be harmonious, homogeneous and monotonous. For example, if two nurses stand side-by-side at the end of a patient's bed, looking at the patient, their perceptions of the patient are not the same. Further, if these two nurses stand face-to-face conversing about a patient, they do not experience the same thing. Each nurse is able to see beyond the other nurse to the background, but each nurse cannot experience their own background. The background may be important. If the patient is in the background of one of the nurses, this nurse may discuss the patient in a different manner when compared to the nurse that does not see the patient. The nurse that sees the patient in the background while conversing about the patient may include the patients' current condition in the conversation,

as this is seen. Both of these nurses are at the same place at the same time, but their experience of the situation is different.

3.5 Appearing

Things do not just appear to be for the first person; things evolve over time, appearing through meaning, understanding, truth and the person's interactions with things in the lived-world. It is over time that a phenomenon shows itself, in and as itself. This evolution of appearing over time can be plotted against time (Gadamer, 1960/2013; Heidegger, 1953/2010; Merleau-Ponty, 1945/2002). This plotted time can be demonstrated within a framework of the past (retention), the now and the future (pretention). This structure of time is termed 'temporality' (Heidegger, 1953/2010) and is interested in how time is lived. More importantly, how time is lived in 'kairos' terms. Kairos time relates to lived or felt time. For example, I may recall a moment from my first involvement in a disaster. In fact, I may provide detailed anecdotes of the details of my experience as if this experience occurred yesterday.

3.5.1 Past (retention).

In the intentional structure of time, the past disappears. This passing of time is termed 'retention' (Husserl, 1931/2012). The past, or the history, is the historical horizon of *dasein*. The historical horizon includes perceptions of the world, memories, recall and the influence of culture. This includes the conscious experiences with the lived-world. For example, if a nurse who experiences a disaster returns home and subsequently undertakes further education pertaining to assisting following disasters or assists with other disasters, their recall and memory of the first experience of assisting in their first disaster may be different to their recall and memory of an experience the day after the event. As such, the passage of time from an experience may be influenced by things in life that influence the experience of the

phenomena. In contrast, given time, *dasein* may have a different understanding of an experience as things are uncovered over time. Therefore, an historical horizon is individually unique to *dasein* and in addition, the subsequent effect of time passing from an experience is individualistic.

3.5.2 Now.

The present or 'now' exists in the conscious awareness of the first person. However, the now can never be reached. When an individual thinks about the now, the now has already gone and has become the past (Heidegger, 1953/2010).

3.5.3 Future (pretention).

The future exists in the imagination of *dasein*; this future is termed 'pretention' by Husserl (1931/2012). This is to say that *dasein* can only imagine what the future may be like, based on expectations and assumptions of the lived-world. For example, a nurse can use a stethoscope to plan and evaluate care in the future, as noted earlier in the quotation from Ranse (2015):

The stethoscope allows for the unheard to be heard. The unheard provides insight into the patient's condition. . . . My auditory insight [gained by using my stethoscope] provides knowledge about the patient's condition for the sake of planning and evaluating care.

The premise of temporality or pretention in the structure of time is that *dasein* is always orientated towards the future, doing something in the now for the sake of doing something in the future. In fact, *dasein* is already ahead of itself, pressing into the future (Heidegger, 1953/2010).

3.6 Hermeneutics in Phenomenology

Hermeneutics has been in existence from early Greek times, with the original derivative of the word coming from a Greek word meaning 'to interpret'. The earliest Greek origins relate to a

mythological being called Hermes, who was said to be the interpreter, communicator and messenger between the gods and humankind (Bulhof, 1980). Since early Greek times, hermeneutics has been used in a number of disciplines, predominantly to undertake an interpretation of text, symbols and art.

On a day-to-day basis, individuals do not concern themselves greatly with how to do hermeneutics or how to interpret something. Hermeneutics only becomes important when individuals want to make an interpretation of a particular situation in which they find themselves, such as when looking at art, watching the news or reading research participant narratives. However, meaning is not always important. It is possible to take things as they are, without needing to have meaningful sense of what they are (Heidegger, 1953/2000). To some degree, this is a description of phenomenology, which provides a lived-experience description of a particular experience. Individual only need to interpret things when they have meaning or they want to make meaning from them. For example, a participant narrative in the form of a lived-experience description about *being* a nurse in an out-of-hospital environment following a disaster is important and therefore requires some interpretation. This interpretation may aim to understand an experience better, to improve future practice, future education and professional development and/or future research directions. Ultimately, a better understanding of an experience from this perspective may lead to better patient outcomes for those affected by a disaster.

3.6.1 Text.

Biblical scripture is the most widely viewed international text that is subject to hermeneutics. Biblical scripture is made up of a series of letters and poems from various authors. To understand the scriptures, readers approach the interpretation of these genres in different ways (Fee & Stuart, 2011). For example, reading a poem would not be undertaken in the same

manner as reading a letter. Further, a 16th-century document does not have the same meaning as text that is written for a reader today. An interpretation of text requires consideration of a number of key aspects, including the historical and political situation or the context of the time during which the text was written, the studied text credentials or references, and the interpretation or hermeneutics of the interpreter (Gooder, 2008). Gooder suggested that these aspects form a triangle of considerations known as the 'hermeneutic triangle'. These principles can be applied to the interpretation of historical texts, with the reference and context of text presupposed to the effects of time. The lessons observed from biblical hermeneutics can be applied to other forms of hermeneutics, such as philosophical hermeneutics (Gadamer, 1976/2008). However, hermeneutics in philosophy is less perceptive than this. Rather than being a 'how to do hermeneutics', philosophical hermeneutics is a way of interpretation.

Hermeneutics was first introduced into philosophy by Aristotle in his work *On Interpretation* (Thomas & de Vio Cajetan, 1962). This suggests that the marriage between philosophy and hermeneutics is longstanding. However, the marriage between phenomenology and hermeneutics is much more recent, particularly promoted by the work of Dilthey (1976/1979), Gadamer (1960/2013) and Heidegger (1953/2010).

3.6.2 Hermeneutic circle.

When interpreting text, the reader is engaged in a circle of self-discourse through the 'hermeneutic circle'. The hermeneutic circle is a circular argument of the interpreter allowing for the fundamental ontological situation to be clarified (Heidegger, 1953/2010). The hermeneutic circle highlights hermeneutics as a relationship and method of interpreting; in being non-prescriptive, it is a way of interpreting. This relational process involves the reader moving from part of the text to the whole of the text and back to the part again, continually

building on prejudices from the part read and readjusting the horizon on which an understanding, meaning and truth of the text is formed. This back-and-forth relational process is the key element that defines the hermeneutic circle, by which to understand the whole, first it is necessary to understand the detail of the parts in terms of the whole (Gadamer, 1960/2013). The hermeneutic circle is not a prescription for interpretation, but rather a way of understanding (Heidegger, 1953/2010). The circular structure of understanding from the hermeneutics circle can be demonstrated from the readers' temporality of *dasein* (Heidegger, 1953/2010). As such, hermeneutics and the hermeneutic circle build on aspects of the concept of an experience appearing in the phenomenological sense to include the interpreter and interviewer actively as participants in the research process. That is, it takes into consideration the interpreter's past, now and future.

Hermeneutics is used to consciously bridge the distance that separates the interpreter (reader) from the text (of the author) (Gadamer, 1960/2013). Hermeneutics becomes a questioning of things. As when describing a thing such as a stethoscope, the interpreter needs to be consciously aware of and reserved about their presuppositions and historical horizon, so that the narrative presents itself as it is in itself and not as a misunderstanding. As such, this requires a methodological consciousness of the text being read (Heidegger, 1953/2010).

The reader projects their meaning from the part of the text to the meaning of the whole of the text, as the text emerges (Heidegger, 1953/2010). The reader has expectations of what is to appear, similar to the future in the appearance of the phenomenon whereby *dasein* imagines what the future of an experience may be like. The reader starts to project some meaning as a whole soon after the initial text emerges (Gadamer, 1960/2013). However, this meaning is revisited in the now as the reader continues to read more and more of the text. As the reader progresses through the text, the assumptions built by their imagination of what is being read

are either met or shattered, the latter requiring the reader to reassess their expectations and assumptions regarding the part and then the whole of the text.

It is acknowledged that as the reader progresses through the text, some prejudice is applied to their interpretation. It is important to note that prejudice is not negative; rather, prejudice refers to making a judgement before all elements of a text or experience have been explored (Gadamer, 1960/2013). The prejudice of the reader includes their historical horizon and imagination. However, the hermeneutic circle is not a vicious circle, as the hermeneutic circle is dissolved when the interpreter has explored the text in its fullest (Heidegger, 1953/2010)..

3.6.3 Historical horizons.

Text transcribed from a participant narrative during interviews creates a textual medium between the author (interviewee) and interpreter (interviewer) that may be interpreted eventually. This highlights the relationship between the interviewer and the interviewee. This relationship may extend beyond the interview to the text produced from the narrative of the interview. Once the text is produced, the interviewer or researcher may engage in a relational way with the text more so than with the interviewee themselves. Hermeneutics is a way of co-creation between the researcher and a text, in which the meaning occurs through a circle of reading and reflection from parts to the whole (Gadamer, 1960/2013).

Koch (1995) stated, 'Hermeneutics invites participants into an ongoing conversation, but does not provide a set methodology. Understanding occurs through a fusion of horizons, which is a dialectic between the pre-understandings of the research process, the interpretive framework and the sources of information' (p. 835). Hermeneutics brings together the historical horizons of the reader and the text to a fusion of the horizons, resulting in a co-authored and co-understanding of a possible experience. Ultimately, this way of interpretation is an active

process between the researcher and participant text, uncovering a co-created understanding of an experience.

3.7 Summary

This chapter has presented various phenomenologies, with a focus on phenomenology being concerned with the essence of things as they are appearing in the conscious awareness of the first person. Additionally, the relationship between phenomenology and hermeneutics in phenomenologies has been discussed. Phenomenologies and hermeneutics have been explored from a theoretical standpoint, rather than as a practical method or way of doing phenomenology and hermeneutics. Thus, this chapter has presented the theoretical underpinnings that guide the phenomenologies and hermeneutics for this study of Australian civilian hospital nurses in the out-of-hospital environment following a disaster. The next chapter builds on these theoretical underpinnings and presents a method or way of doing phenomenology and hermeneutics, as it is applied to this study.

Chapter 4: Doing Phenomenology

4.1 Introduction

Phenomenology is a way of exploring the lived experience of a thing, by getting get back to the ‘thingness’ of that thing as the thing shows itself. There is no one way to achieve this, as the activities of doing phenomenology are predicated on the impulse of insight and these insights do not occur in a linear manner. Doing phenomenology is by nature overlapping, twisted and unfolding in a non-linear way. These activities continually move from the whole of the narrative to the parts of the narrative and back to the whole again, in a hermeneutic manner. This chapter outlines a phenomenological method as it is applied to this study, as a way of getting back to the ‘thingness’ of what it may be like *being* an Australian civilian hospital nurse as part of a disaster medical assistance team in the out-of-hospital environment following a disaster.

4.2 Individuals Who Have Had Experience(s)

Phenomenological research seeks to provide insight into a likely or possible experience. Having experienced the phenomena being uncovered is of utmost importance when determining the appropriateness of individuals in phenomenological research. This research explored the experience of Australian general Registered Nurses (Division 1) who worked primarily as clinicians in a hospital; had been deployed following a disastrous event as part of a non-military organisation, association, group or health disaster medical assistance team; had worked primarily in the out-of-hospital environment following that disaster; and had been involved in a disastrous event that had occurred in the five years prior to the collection of data (between 2008 and 2012).

4.2.1 Finding individuals.

Finding individuals who had real-life experience as a nurse in the out-of-hospital environment following a disaster commenced with a personalised email. These emails were distributed to 58 adjuncts, associates and members of the Flinders University Disaster Research Centre, now the Torrens Resilience Institute. This email contained an invitation and information sheet that outlined the research (see Appendix B: Invitation and Information). This invitation and information sheet provided a general overview of the research, the research aim, what participation would involve and information about the researcher and research ethics. The email recipients were encouraged to disseminate the invitation and information sheet to their own personal and professional contacts.

There were no controls put over the various avenues that the email recipients would use to disseminate the invitation and information sheet. Postings seeking research participants were observed on social media sites such as Facebook, Twitter and LinkedIn. Some participants received the invitation and information sheet from professional associations and organisations, such as the Australian College of Nursing and World Association for Disaster and Emergency Medicine.

In total, nine potential participants made contact with the researcher, expressing a desire to be included. Of these, eight were eligible to participate in the study. One nurse was not eligible, as they had not experienced being part of a disaster medical assistance team in the out-of-hospital environment following a disaster. Instead, this nurse had assisted with storm damage as a layperson in their local State Emergency Service unit.

4.3 Obtaining Narrative

Participant narrative was obtained from individual face-to-face interviews that were conducted in September and October 2012. Each participant in this study was interviewed individually at two distinct points in time, exactly one week apart. Interviews were held at a mutually agreed location and time in the residing town of the research participant. The venues varied according to the preferences of each individual interviewee. For example, interviews were held in private offices, local universities or cafés.

All discussions between the researcher and participants commenced with a general conversation, including topics such as work, life, recent news events and the previous research of the researcher that had led to the undertaking of this study. This interaction between the researcher and participant prior to each interview was not recorded, as it did not constitute part of the research narrative pertaining to the research question. However, these conversations prior to each interview provided an opportunity for commencing a discourse and building rapport between the researcher and research participants. The interview schedules that guided the interview are presented in Appendix C: Participant interview schedules.

All interviews were recorded using a Livescribe™ Echo® Smartpen digital device to capture the dialogue of the researcher and participant. Where participant narrative is presented in this document, a number of notations may be evident. A key to reading the narratives is provided below:

- [] means the researcher has added narrative to make the context and/or meaning more clear

- ... means that words, phrases or sentences of the interview have been deleted to make the context and/or meaning more clear
- () after each original participant narrative indicates that participant's numerical pseudonym, serving as a reference to an original narrative. For example, (7.2:13) represents the seventh participant, second interview, narrative on page 13 of the transcription.

4.3.1 First interview.

The activities related to obtaining narrative from participants in their first interview are outlined in Table 4.1. The first interview for each participant was semi-structured in nature, commencing with a broad question that encouraged storytelling, such as:

Can you tell me a little bit about what happened? I'm after, I guess, a bit of a story about where you started or how you heard about [the disaster] and how you ended up. (researcher; 7.1:3)

Participants were encouraged to engage in storytelling as a means of eliciting experiential anecdotes. As the participants were retelling their experiences, the researcher was reserved, quiet and listening, allowing the participant to have an active and dominant role in the conversation.

Table 4.1. Obtaining Narrative: First Interview

Activity	Rationale
Conduct first interview	Phenomenological in nature, to obtain experiential accounts of what it is like <i>being</i> a nurse in an out-of-hospital environment following a disaster, based on first-hand lived experience of real-world events
Transcribe recorded audio of first interview	Provides textual narrative of the participant's lived experience
Read first interview transcribed textual narrative and listen concurrently to the audio narrative	Provides a holistic perspective of the participant narrative, providing a greater understanding of the essence of an experience being portrayed by the participant

Further depth to the participants' anecdotes was obtained throughout the interview when the researcher prompted them to elaborate on their experiences with details of a specific situation, time or moment. For example:

So in the morning, for example, on a day-to-day basis, you'd leave your accommodation, congregate. Then what happened? (researcher; 3.1:8)

van Manen (2014b) suggested that it can be difficult to keep interview participants orientated to the required phenomenon while they relate an experiential account of their experience. To overcome this issue, if participant descriptions started to diverge from the experience of *being* a nurse in an out-of-hospital environment following a disaster, the researcher used questions that re-orientated the participant to the phenomenon, such as:

Just going back a little bit, so you had your brief . . . what happened after that? (researcher; 7.1:6)

Immediately following the interview, the interview audio was transcribed to textual narrative (see the example in Appendix D: Example of transcribed participant narrative [3.1:2–3]).

Textual narratives were read a number of times. While reading the textual narrative, the researcher listened concurrently to the audio narrative captured during the interview. This approach was used to provide a holistic perspective of the narrative, providing the researcher with a greater understanding of the essence of what was being portrayed by the participant.

4.3.2 Second interview.

The activities related to obtaining narrative from participants in their second interview are outlined in Table 4.2. The second interview allowed participants to add or build on anecdotes that may have been omitted from the first interview. To begin this interview, the researcher asked a question, such as:

Since our last time [the first interview], did you have anything else that you thought about, that you might want to add? (researcher; 1.2:1)

Table 4.2. Obtaining Narrative: Second Interview

Activity	Rationale
Conduct second interview one week after the first interview	Phenomenological in nature, introduces hermeneutics in-action, coming to a co-authored understanding of a lived experience
Transcribe recorded audio of interviews from second interview	Provides a textual narrative of conversations from which the phenomenological epoché-reduction can be applied
Read second interview transcribed textual narrative and listen concurrently to the audio narrative	Provides a holistic perspective of the participant narrative, providing a greater understanding of the essence of an experience being portrayed by the participant

While the second interview was phenomenological in nature, this interview applied the theoretical underpinnings of hermeneutics and the hermeneutic circle in-action during the interview, rather than in retrospect. This interview technique was a way of leading to a co-authored understanding of the experiential anecdotes being discussed with the participant (van Manen, 2013). This co-authored understanding provides clarity on what the participant is meaning to say, as the meaning of experiential anecdotes is not always apparent to the participants who produce them, but meaning can be made from the narratives produced by them (Ranse & Arbon, 2008).

Applying hermeneutics in-action in a second interview does not leave the openness and retrospective application of hermeneutics to interpretation from the researcher alone, reliant only on the textual narrative and audio recording. Instead, this allows for a mutual understanding of what is being said in-action and reduces misunderstandings at a later point (van Manen, 2013). Questions relating to the understanding of the content from the first

interview were asked in a semi-structured manner, becoming more unstructured as the interview progressed. For example:

As we go, I've made a few notes of what you said last time [during the first interview] . . . I've just got a couple of notes on things that I just wanted to clarify to make sure I understood what you were saying about what it was like [*being* a nurse in an out-of-hospital environment following a disaster]. (researcher; 1.2:1)

As with the first interview, immediately following the second interview, participant audio narrative was transcribed to a textual narrative. Once textual narrative was produced in the form of transcripts, this textual narrative with participant anecdotes acted as a reservoir for phenomenological reflection, allowing for a deeper understanding of the phenomenon of what it may be like *being* a nurse in an out-of-hospital environment following a disaster.

4.4 From Individual Narrative to a Lived-experience Description

For this phenomenological study, 'doing phenomenology' was a way of reflecting on a participant narrative leading to a lived-experience description of what it may be like *being* a nurse in an out-of-hospital environment following a disaster. This method included the following activities: identification of moments (see Table 4.3); identifying exemplars of these moments (see Table 4.4); and presenting an anecdote as a lived-experience description of these moments-based exemplars from the participant narrative (see Table 4.5).

4.4.1 Moments.

van Manen (2014a) stated that 'a moment is really the key for phenomenological analysis, because phenomenology is always reflecting on moments' (p. 1). As such, the identification of moments of an experience of what it may be like *being* a nurse in an out-of-hospital environment following a disaster is an important place to start when seeking to uncover the phenomenon. The moments resulting from these activities of doing phenomenology are provided in more detail in Chapter 5. The rationale for this method is presented in Table 4.3.

Table 4.3. A Way of Doing Phenomenology: Moments

	Activity	Rationale
Moments	Read all transcribed textual narrative, and listen concurrently to the verbal narrative	Provides a holistic perspective of the collected data, providing a greater understanding of the essence of an experience being portrayed by the participant
	Give titles to the moments of the lived experience	Moments of an experience are identified that exemplify the phenomenon
	Read the transcribed textual narrative and listen concurrently to the verbal narrative while asking, 'Does this title of the moment of an experience exemplify the moment of the phenomenon being explored?'	Confirms the moments of an experience. Titles may be removed or added as the uncovering of moments of the phenomena evolves

4.4.2 Exemplars.

Once the moments were identified, exemplars of those moments from the participant narrative were identified. These exemplars later formed part of the lived-experience description of the moments of what it may be like *being* a nurse in an out-of-hospital environment following a disaster. A method for identifying these exemplars is outlined in Table 4.4.

Table 4.4. A Way of Doing Phenomenology: Exemplars

	Activity	Rationale
Exemplars of moments	Identify exemplars of each moment within the narrative	Enhances the distinction between exemplars that do or do not exemplify the phenomenon
	Read transcribed textual narrative and listen concurrently to the verbal narrative while asking, 'Does this exemplar represent the moment of the phenomenon being explored?'	Enhances the rationality of the data analysis process, ensuring that identified exemplars represent the phenomenon
	Group the identified exemplars under moments	Grouping of specific exemplars under moments assists in uncovering the phenomenon

4.4.3 A lived-experience description.

A lived-experience description is a recognisable anecdote of the singularity or uniqueness of an experience being uncovered. According to van Manen (2013), the ‘lived-experience description as an anecdote is grounded in experience, not leading to abstraction and theorising’ (p. 39). The way of uncovering the lived-experience description in this study is outlined in Table 4.5. The lived-experience description, as an anecdote, is not necessarily representative of a particular individual that was interviewed and therefore may not be the exact experience that was expressed by any one individual. Instead, the lived-experience description is representative of what a specific moment of an experience may be like for an individual civilian hospital nurse in the out-of-hospital environment following a disaster. A lived-experience description represents aspects of the singularity and uniqueness of an experience; that is, what makes the experience unique and different from other experiences. For example, what differentiates *being* a nurse in an out-of-hospital environment following a disaster from *being* a nurse in a different context?

Table 4.5. A Way of Doing Phenomenology: Lived-experience Description

	Activity	Rationale
Lived-experience description	Outline a lived-experience description from each moment, using participant narrative exemplars	Provides narrative that is singular of a moment, which is recognisable as the essence of a moment of the phenomenological experience
	Read specific parts of the narrative, with a focus on the moments	Enhances the distinction between exemplars that do or do not exemplify the phenomenon of each moment
	Finalise an anecdote of the participant’s narrative in a lived-experience description that is orientated to the phenomenon	Provides an anecdote of what an experience being uncovered may be like

4.5 Epoché-reduction

There is no single way of ‘doing phenomenology’ and getting back to the things themselves as they are appearing in themselves. Epoché and reduction are the key methods of used for this process (Husserl, 1931/2012). Epoché has been discussed earlier in Chapter 3 and can be summarised as a way of opening to the world, free from presuppositions, with an aim to bring into light the essence of a thing. Reduction can be described as a ‘way to the phenomena [that] give[s] and show[s] [them] in their uniqueness’ (van Manen, 2014b, p. 220), to get back to the things’ singularity. In this study, the epoché-reduction was undertaken in two parts, first as the preparatory epoché-reduction and second, the reduction proper.

4.5.1 Preparatory epoché-reduction.

In this study, the heuristic, hermeneutic, experiential and methodological preparatory epoché-reductions were dominant in uncovering the experience of what it may be like *being* a nurse in an out-of-hospital environment following a disaster. These preparatory epoché-reductions led to a lived-experience description as an anecdote of the moments of an experience. The preparatory epoché-reduction approaches used in this study is summarised in Table 4.6.

Table 4.6. Preparatory Epoché-reduction Approaches Used

	Epoché-reduction	Description
Preparatory	Heuristic epoché-reduction: Wonder	Seeks to bracket all taken-for-grantedness as an attitude or disposition of wonder
	Hermeneutic epoché-reduction: Openness	Seeks to bracket all interpretation to have a genuine openness through phenomenological reflection
	Experiential epoché-reduction: Concreteness	Seeks to bracket all theoretical meaning, generalisation and abstractions to have a concrete experience
	Methodological epoché-reduction: Approach	Seeks to bracket all conventional techniques and to invent a method, acknowledging the doing of phenomenology as a ‘no method’ method

¹ Adapted from van Manen (2014a; 2014b).

4.5.2 Reduction proper.

From the lived-experience description of the moments, the reduction proper can be applied to provide a deeper phenomenological experiential account of what it may be like *being* a nurse in an out-of-hospital environment in a disaster. The product is a larger lived-experience description as a holistic anecdote of an experience, which gets back to the thingness of the phenomenon as it shows itself. In this study, the reduction proper led to the lived-experience description from which the phenomenological existentials could be overlaid. The dominant reduction proper approaches used in this study are outlined in Table 4.7.

Table 4.7. Reduction Proper Approaches Used

	Reduction	Description
Proper	The eidetic reduction: Whatness	To get back to the whatness or thingness through making the world appear in its uniqueness or singularity of the phenomenon
	Ontological reduction: Ways of <i>being</i>	The mode of <i>being</i> in the world. The ontological mode of <i>being</i> a being experiencing a phenomenon. To think, reflect and inquire
	Radical reduction: Self-givenness	What shows itself first, gives itself as it is, not constituted by consciousness

Adapted from van Manen (2014a; 2014b).

4.6 Phenomenological Appraisal

This study used a phenomenological validation criterion, in an iterative manner. This ensured that the phenomenological texts produced were in-depth, orientated to the phenomenon and were a recognisable anecdote of the singularity of an experience. van Manen (2014b) recommended that phenomenological texts, such as a lived-experience description, could be critically appraised using criteria for phenomenological work. van Manen (2014b) stated that ‘One must evaluate it [a phenomenological text] by meeting with it, going through it, encountering it, suffering it, consuming it, and, as well, being consumed by it’ (p. 355). When

exploring the lived experience leading to the lived-experience description in this study, the criteria outlined in Table 4.8 were applied. This iterative application of the phenomenological validation criteria resulted in a strengthening of the nature of the lived-experience description as an anecdote of what it may be like *being* a nurse in an out-of-hospital environment following a disaster.

Table 4.8. Validation Appraisal for Phenomenological Works

Question	Purpose
Is the study based on a valid phenomenological question?	To ask, ‘What is this human experience like?’ ‘How is this or that phenomenon or event experienced?’
Is the analysis performed on experientially descriptive accounts, transcripts?	To ensure the analysis avoids empirical material that consists mostly of perceptions, opinions, beliefs or views
Is the study properly rooted in primary and scholarly phenomenological literature?	Ensures the validity of the sources, rather than relying on questionable secondary and tertiary sources
Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other (non-phenomenological) methodologies?	To set aside non-phenomenological validation criteria, such as trustworthiness

Adopted from van Manen (2014b, pp. 350–351).

4.7 Protection of Human Participants

Ethical approval to conduct this research was received from the Flinders University and Southern Adelaide Local Health Network, Social and Behavioural Research Ethics Committee on 10 October 2011 (see Appendix E: Ethical approval to conduct research).

Participation in this study was voluntary and there was no financial remuneration for participants. Voluntary participation in this study was evident, as participation relied on participants contacting the researcher, rather than the researcher contacting participants. Prior

to participating in this study, the participants signed a consent form (see Appendix F: Participant consent form).

Throughout the research process, a number of strategies were used to ensure the anonymity of participants. For example, the lived-experience description was generic and not specific to any individual. Additionally, the exemplars of participant narrative that were used in this research were not linked to anyone in an identifying manner, such as participant demographics. As explained earlier, numerical notations have been used after each participant exemplar, as a pseudonym and reference point to the original transcription. Finally, any specific narrative excerpts from a participant that is presented in this research can only be known to a reader if that specific participant has disclosed that excerpt previously to another person, such as a colleague or friend.

Participants could withdraw from this study at any time, prior to the interview, during an interview or following an interview. However, no participants who participated in this study withdrew at any stage.

During the interviews, participants reflected on their experiences of responding following a disaster. Such recollection of events could have resulted in a degree of emotional distress for participants. However, while the participants discussed and recalled emotive moments following a disaster, there was no evidence from them of any adverse emotional responses resulting from being interviewed. This is consistent with the researcher's experiences in interviews regarding nurses' experiences and roles in disasters, such as nurses who have assisted in bushfires (Ranse & Lenson, 2012). Additionally, the researcher has had previous research experience of interviewing nurses who have had emotive life events, such as graduate nurses participating in resuscitation in non-critical care environments (Ranse &

Arbon, 2008) and student nurses participating in end-of-life care for the first time (Ranse, Ranse, & Pelkowitz 2017). Further, the researcher has a professional background in emergency nursing, providing a basis for determining an appropriate level of assessment and referral for participants if a negative emotional response was observed during the interviews.

4.8 Summary

This chapter has presented a way of doing phenomenology from the phenomenologies theoretical underpinnings as applied to this study. In particular, doing phenomenology has been discussed as a way of getting back to the thingness of the phenomenon of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. Doing phenomenology in this study commenced with the identification of appropriate participants and interviewing these participants on two occasions. Following this, as outlined in the next two chapters, uncovered moments were identified from the participant narrative, along with exemplars of these moments, which led to the creation of a lived-experience description. This was achieved with an overlay of preparatory epoché-reduction and reduction proper throughout these activities.

Chapter 5: Uncovered Moments

5.1 Introduction

The phenomenon of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster could be described in parts of the whole, with each part of the phenomenon being a moment with uniqueness and singularity. Moments provide an entry and insight into the life-world of the study participants and begin to describe what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment following a disaster. There were five moments identified in this study: ‘on the way to a disaster’; ‘prior to starting work’; ‘working a shift in a disaster’; ‘end of a shift’; and ‘returning home’. An overview of the moments identified in this study is outlined in in Table 5.1.

Table 5.1. Moments of an Experience

Moment	Overview
On the way to a disaster	An experience of learning about a disaster and arriving in a disaster-affected community
Prior to starting work	An experience of <i>being</i> in a disaster-affected community, prior to commencing clinical work
Working a shift in a disaster	An experience of working a clinical shift in a disaster
End of a shift	An experience of <i>being</i> in a disaster-affected community, on deployment, when not working a clinical shift
Returning home	An experience of leaving a disaster-affected community and returning home

In the disaster-affected community

5.2 On the Way to a Disaster

I saw the devastation of the disaster on social media and on the television. I got a lot of awareness about the unfolding disaster situation from the media:

[I found] out about these disasters through the media or through Twitter or through alerting from the organisation, but mostly looking at the news really. I pretty much know when there's going to be an opportunity to be deployed just by turning on the TV. (8.1:4)

I actually saw it on the television . . . saw the [disaster] and realised that it was very, very serious for that region. I think it went by my mind and I thought, 'Gee, I wonder would we respond to that'. (5.1:3)

It was at the end of [the year] when the weather pattern started [to change] and we'd heard about [the disaster] in the news, that there were issues in [the disaster-affected area], so I was aware of [the disaster] in a broad sense. (7.1:3)

watching the media and could see different things that were happening and were thinking, 'Oh my god, these poor people'. You see the devastation on the TV. . . . You're keen to get up there and do what you could. (4.2:1)

from the media because we didn't have first-hand feedback from people on the ground, as such, until we got to the briefing . . . from the media and what I would expect to see in a [disaster]. We did listen to radio interviews. (7.2:3)

Soon after becoming aware of the disaster, I received a text message to my mobile telephone notifying me that a disaster response was required. The text message came from my local health service. The text message requested a reply ascertaining whether I would be able to assist in the disaster. Soon after receiving the text message, I received a phone call. The health service wanted to know if I could assist in the disaster and if I could 'be on standby':

[Initially I received a] text message and then . . . I had a phone call from my ADON [Associate Director of Nursing] just saying, 'Be on standby'. (2.1:8)

I got a [phone] call from the . . . [disaster] coordinator here, just sounding me out as to whether I would be interested and available [to assist] and I said 'potentially'. . . . I put my hand up very early. (5.1:4)

Then it came through phone calls [asking], ‘Are you ready to go if anything happens? There’s a possibility it could be this day.’ (4.1:2)

It was a Sunday when I got a text message and a phone call . . . and I was told that there was a very tight turnaround and they needed to know whether I could deploy . . . and they needed to know that afternoon. (7.1:3)

They had put a [phone] call out to see who was interested in going and I put my hand up to say I was interested. . . . I was told to go out to [the state disaster coordination centre] the following day. (2.1:2)

I was willing to assist in the disaster, as I knew I had the skills to help:

I feel like I’ve obviously got skills that can be helpful to them. So you want to go and do what you can do. (1.2:12)

a desire to want to help people and I suppose when you see people in particularly vulnerable situations and disasters, it hits home a little bit more. But also, I’m willing because I’ve got the skills, the skill set to be able to go and do it. (2.2:1)

I had completed a number of disaster-related courses previously. My training has included nationally recognised courses:

I’ve done all these courses; this is a way to see whether I can actually do those things. (3.2:1)

MIMMS, done the commander course . . . [and the] Team Member AusMAT [course]. (1.1:21)

[The AusMAT specific training] gave me a really good global overview of what was going on at the higher level and government level and that sort of thing. I don’t know that they actually prepared me so much [for] the nursing side of things as to what would be going on. (2.1:15)

I’d done a lot of disaster training, but it was really more about managing a disaster in terms of triaging, setting up of, you know, it was very process orientated rather than emotional support and dealing with the things that you see; there was not a focus on that at all. (8.1:17)

My local health service has provided me with some disaster-specific training:

[Our local area health service] had trained us. We've had several training sessions. You know, what to expect. . . . How to set up in the centre. How to set yourself up. Items you should take. (4.1:12)

Before agreeing to assist in the disaster, I made sure my family was content with me being away from home:

My children are all grown up and I've got a really supportive husband, so there were no issues for me. (3.1:4)

I rang up [my husband] and said, 'Look, are you happy for me to go . . . are you fine? You know, the kids, you've got the three young kids, are you right?' He goes, 'No, it's fine'. I rang my sister, 'Can you look after [the family]?' (3.1:18)

So when [my teenage children] were happy and my husband was happy with me going, then I was happy that I could go and just leave them for a while. (5.2:1)

Leaving home is never the issue for me. Yeah, it's often hard saying goodbye to family but I don't struggle with that. . . . There's a bit of adrenaline going, there's a bit of excitement because you're being deployed. (8.2:4)

Once I agreed to assist, I waited to find out what day and time I might be required to deploy. I was told that I would be advised by the health service when I needed to go, and I needed to be ready to leave at short notice:

I had probably only about 18 hours to get . . . up and running, so it was done fairly quickly. (3.1:3)

We did have some sort of notice that we might be required, but when we were actually given the go-ahead, it was one or maybe two days. (4.2:1)

It was a day or two afterwards [being notified that I departed], so they gave you a couple of days to get everything sorted. (7.1:3)

I was excited to be going. However, I recognised that I was going to a disaster where many people have lost their lives, suffered:

There was quite a bit of adrenaline and excitement. . . . Because it's the unknown. (3.2:1)

But it's weird to be excited because it's a disaster. (1.2:1)

I really was excited to go and as an emergency nurse. Sometimes it can seem a little bit strange, but we get excited about traumas and things that come in and I try to explain it to people that aren't in that setting that it's not that we're celebrating or that we're happy that someone's been injured or hurt. This is what we've dedicated ourselves professionally to and so we know that bad things are going to happen to people who get maimed and there are going to be terrible things that are going to happen, but we've focused our professional energy and we've worked bloody hard for a long period of time to prepare for it. So that's why, professionally, there's a fulfilment in being there at the right time to do your job. So it's not a morbid fascination with other people suffering, by any means, it's the opposite. (7.2:2)

I was waiting for confirmation of my expected departure date, time and initial meeting location. During this time, I commenced packing the items I was planning on taking to the disaster. I packed my uniforms and two sets of clothes. These clothes were neutral, non-offensive clothing, with no logos or words on them:

If you're going to come and be deployed, [wear clothing that is neutral], whether it's plain white or plain blue. Nothing on it. Because what you might think is a simple word could be really offensive to somebody, you know. So you don't even understand how that impacts upon them at all and stuff like that. (3.1:13)

[I] just took scrubs and pyjamas. You know, if I have to get up in the morning I'm in scrubs and I'll leave the scrubs with the people because they can use them afterwards. (3.1:24)

We were only allowed to take very minimal personal supplies, so basically we had one or two sets of change of clothes, which is our personal clothes to put on after hours, but the rest was, nothing else, basically. (6.1:8)

They wanted us to bring uniform items that we had and they'd try to supplement what we didn't have, as well as our personal gear, just a small bag for it that would just sustain us for a few days. (7.1:4)

As I was conscious that I needed to stay well, so that I could care for other people, I packed sturdy boots and purchased insect repellent prior to departing:

You know, we're so conscious of providing for other people but really, to be able to do that, you need to be able to take with you the stuff to care for yourself as well. So if you're not caring for yourself, you can't do anything for anyone anyway. (8.2:1)

We had our [uniforms] and we purchased our own t-shirts, white t-shirts that we wore and sturdy shoes and underclothing of course. We were advised to take insect repellent, which we had the opportunity to obtain prior to going and just basic essentials. We didn't take too much more. We took some civilian clothing but not a great amount. (4.1:3)

We were told about faeces in the street, you had to have certain boots. . . . The insects and certain mosquito repellent . . . I'd already pre-purchased that. Some people hadn't. (4.2:1)

I packed some items that would provide comfort while I slept. This included a sleeping bag and a bedroll:

I'd packed a bit of food. I'd packed a sleeping bag. I packed all the little things, almost like you're going camping, because you don't know what you're going to have. But they really didn't tell us what to take in that respect. (1.1:10)

I still probably wouldn't think about taking a tent or whatever else, because . . . you'd think if you're going in a group and it's an organised group that they would have something figured out in that respect. (1.1:11)

I had a sleeping bag and stuff; some people didn't, because we didn't go prepared to look after ourselves. (1.1:9)

I'd taken a sleeping bag with me and uniforms and that sort of thing, but we had no idea where we were going to be staying or what we were going to need. (2.1:3)

I kind of made sure I had a bedroll and a sleeping bag and towel and all that sort of stuff and enough food to keep me going for the first 24 hours. But in saying that, I had heard before we left that we were going to be based at the hospital and that there'd be food and that sort of thing there, so I knew a little bit more about what we were going to as well. (2.1:11)

I packed this all into a small bag:

[We] all just had one bag each with our uniforms and our boots and some warm gear and some wet gear and whatever you had that you thought was a good idea to take, you only had that one bag, so we were all packing a bit light. (7.1:4)

I did not pack any medical or health supplies for patients. These supplies were being forwarded to the disaster area by the health service:

We weren't asked to bring any of our own first aid kits or supplies. (7.1:4)

[Medical supplies] all went over [before us] . . . we didn't have to take as much of our own supplies. (6.1:8)

[The] WHO actually gave us all our medications. They had already been organised by the time we got over there. (6.1:8)

In preparing to go to the disaster, I started to read about the country, the climate, culture, religion, poverty levels and the existing health infrastructure. I tried to get a general overview of the country's socio-economic-health status prior to the disaster occurring:

I started reading up a bit about the culture. . . . I was printing out about the population of [the country] and bits and pieces about some of their traditions and things like that and about the religion aspects. . . . Well you are prepared in some ways, but I think you go with the attitude that you're not there as a great white saviour, you're there to support them and complement them. So I wasn't completely aware of how much impact religion was in that society and I wasn't, even though you talk about it—the matriarchal—you didn't really realise the impact that it actually has on that culture. (3.1:12)

I do as much background reading as I can into the disaster and get as much information on the pre-existing state of that country as well just because it has a huge influence on how you approach the mission. So I do a lot of things like research the climate, the socio-economic aspects of that country, the poverty levels, all that kind of thing, what their biggest issues were before the [disaster] hit, just so I have an understanding of what I'm facing. (8.1:5)

I was now packed and ready to be deployed. I received a phone call to go to the central congregation point. I was about to go, then I received a phone call and was told, 'Don't go

yet, it might be another seven hours before you go'. Approximately seven hours had passed when I received another phone call stating, 'It may be another couple of hours before you go'. It was now late in the night. I received another phone call to say, 'You will not be going until the early morning'. During the night, I got a phone call to meet at the central congregation point, with a very tight time frame:

Originally, they were going to send us [at] sort of eight or nine o'clock that night and then we got stood back for a little bit. Then we got messages saying it might be two o'clock in the morning and then eventually, I think, four o'clock in the morning they said, 'You won't be going until later in the day, so turn up to the [disaster] headquarters there . . . at 11 o'clock in the morning'. (1.1:8)

Yes we're going, no we may not, yes we are, not we're not, yes we're going . . . one minute we were going, the next minute we weren't, we were, we weren't. So I was quite unsure of whether we were or weren't going. Still got ourselves organised anyway, in the event that we were going. (6.1:7)

We're going, we're not going, we are going, we're not going. So that's unsettling. Are we or aren't we? Do I get excited, do I not? Do I get nervous? (6.2:1)

We've just got to hurry up and wait because we just didn't know what was happening and they kept saying we're just going to be flexible. (1.2:2)

It was a 'hurry up and wait' game. You know . . . we had changing information all the time. (5.1:4)

[For me, it was] about two weeks of uncertainty with dates changing all the time. (5.1:4)

When the [disaster] hit and I was alerted to the fact that we may be deploying within 24 hours of the [disaster] happening and put on standby . . . I was ready within 24 hours but, you know, once they got all the visas and everything sorted, it was a couple of weeks after the [disaster]. (8.1:3)

about five days', at a guess, notice but [the state health service] had been asked to send up a team so whether I was going to be on the team or not, I don't think it was decided then. (4.1:2)

I met other team members at a central congregation point near the health service disaster coordinator centre. At this location, I was provided with a detailed brief of the disaster by one of the health service leaders:

The following morning we were given our [uniforms] before we went to [the headquarters]. We met down there the morning we were to fly out. We were briefed by the head person. (4.1:3)

Our small groups congregated at the hospital. (3.1:4)

[I was] transported to [the disaster coordination centre] . . . at one of the old hospitals. So we all met down there prior to the day of flying out of [the city]. We stayed there in . . . the old nurses' accommodation, that night. (4.1:3)

The brief went for a number of hours:

We had several hours of induction briefs. (7.1:4)

The briefings were, I think, really effective. They were concise and they were what we needed to know. There was no waffle, there was no sense of the normal death by PowerPoint. They were relevant and they were appropriate, so I was really glad with that. (7.1:5)

The brief covered aspects of the area affected by the disaster:

It was such a huge area that had been affected and from the media coverage, if you don't know [the country], it was hard to sort of visualise what towns were affected, what catchment areas. So [the briefing leaders] kind of gave us a bit of an overview of what we were dealing with. (7.1:5)

The briefing extended to include awareness of potential security concerns:

Just listening to a lot of security stuff, it really hit home a lot more. Oh my gosh, there is a lot more security than we needed to worry about. (6.1:7)

[The day prior to departure] we went through all the hostage scenarios and negotiation strategies and things. They just tried, I guess, to get us prepared as much as they could for worst cases. (5.1:4)

There was a couple of confronting things . . . we had to have proper photos taken by the Forces and we were told that these photos would identify us if we were captured

and taken hostage . . . we had to answer questions that only we would know the answer to, so if troops had to come and rescue us they'd know that they had us and we had to write a letter to our family saying goodbye sort of thing, and so that brought it home. (5.1:5)

During the briefing, I was instructed to decrease the amount of luggage I was taking with me:

were asked to decant from their large bag into a set sized bag. (3.1:5)

They said to us, 'You need to minimise the weight'. . . . They said, 'Less than 20 kilos in your bag and just pack clothes.' (1.1:10)

During the briefing, a number of rules were outlined that we needed to abide by. These included rules relating to where we could eat and abstinence from the consumption of alcohol:

[We had a camp meeting] and got introduced to the camp and we were given camp rules in what we were to do and what we weren't to do. (6.1:9)

no alcohol whatsoever and that didn't concern us at all really. Didn't even think about it at the time. (3.1:15)

And we had one person who went in the evening and had a meal . . . got diarrhoea, so they weren't a member in that team for three days because we said, 'You can't go out, you've got diarrhoea'. (5.1:16)

Following the briefing, I had an opportunity to meet members of the disaster medical assistance team who would be deployed with me. The contingent had nurses from a number of different clinical backgrounds. This included emergency and intensive care nurses:

There were three from ED here and two from ICU and then there was a couple of ICU nurses from [a city] and an ED nurse and then a couple of ED nurses from [another city] and then the consultants came from [various different cities]. (2.1:6)

Within the contingent, there were varying disciplines. In addition to nursing, the disciplines included medicine, paramedicine, social work, government disaster relief planning, environmental health and allied health:

We had one that I know was a paramedic, we had three or four RNs [Registered Nurses] . . . we had a social worker, we had people who worked in local government disaster relief and planning . . . we had one enrolled nurse as well . . . we had one doctor as well. (7.1:4)

There would be an ED or senior retrieval person and . . . two paediatric doctors . . . a nurse practitioner . . . a junior doctor. (3.1:8)

So when we first got there, the medical facilities was only just being set up by [the local] Ambulance [service] . . . they very much took over the logistic side of it, and they had equipment. (1.1:4)

There were people like environmental health and different allied health people available to us as well, so it wasn't all nursing or all medical. It was a real team effort. (5.1:4)

The contingent consisted of people from nearly all states and territories in Australia:

I think there was [*sic*] probably 17 from [my state] in the end and we took over a team of about 24. (5.1:4)

There were people from Perth, Queensland, I should say WA [Western Australia], Queensland, NT [Northern Territory], and one from NSW [New South Wales], I think. (6.1:6)

When I met the contingent for the first time, I recognised a number of people that I had previously worked with:

It was good to see familiar faces, so there were two people from emergency when I went to [a previous disaster] that I knew, which was great, but then everybody else in the room I didn't know. (1.2:1)

I think we all kind of stuck to just talking to the people we knew, because it was all very business-like at that first point. (1.2:2)

While some people in the contingent were familiar to me, some people were not, so I tried to get to know these members:

You know, you do a trauma call and you've got unfamiliar doctors and specialists that you wouldn't normally work with and they're all in your space and it's crowded, and everybody, students and registrars, and everyone wants to get their hand in the mix and there's a bit of crowd control going on. I suppose it was the same, because I was being deployed and I didn't know the team that I was working with. (7.2:4)

I asked others who had been to a previous disaster, 'What did you take?'

[A colleague gave me] an idea about what we might need for that first 24 hours, but no, we sort of went in a bit blind there, really. (2.1:12)

Regardless of what profession or what role in the team, we all talked to each other as if we were equal. Many of the people in the team had been to previous disasters. I asked questions such as, 'What do you think it will be like? What do you think we will see?':

Even though you're not even actually on site, or you're not even on the [aero]plane, it's about trying to build up good dynamics. So the professional part about it, finding facts, that was just automatic I think, but the other things I had to consciously think, 'Now what do I want to know? Who could I ask?' It was more about the cultural things, about the scene, people's previous experiences. (3.2:4)

I asked the people who were above me that were on the plane, like the incident control and things like that, 'What's going to be expected? What do you think we'll find?' So just trying to get as much information in my head to try and work out some of the scenarios, the things that I might be dealing with. (3.2:3)

I guess we had a bit of an idea about that [what to expect] because a lot of our team had been to [disasters] in the past and so we talked about this at the airport before we left. (2.1:17)

We're waiting at the airport . . . [asking around the team], 'Has anyone been to [this country]? Oh, I go there on holidays.' . . . What's the weather like?' So everyone's giving, imparting bits and pieces of information. 'What sort of injuries do you think they're going to have?' (3.2:3)

I was asking myself questions such as, ‘I wonder what it will be like?’:

I did think through ‘Okay, what can I expect to see?’, ‘What am I going to have to do?’, ‘What am I going to need to be able to work with?’ (7.2:3)

[I am thinking to myself], ‘Will I have the education and ability to carry out what I need to do? What do I have to do? How far have people progressed?’ . . . In the training, you’re taught to expect the unexpected. So you start to think, ‘Well heck, what is the unexpected? What am I going to be looking at?’ (4.2:1)

While I was waiting to depart for the disaster-affected area, the plans about transport kept on changing. I was going to fly on either an Air Force or a commercial flight:

[The coordinators were] trying to organise transport to get us over there . . . they were organising Air Force planes . . . [these were not available] so they organised a commercial flight for us. (1.1:8)

I ended up flying on an Air Force aircraft. It was a C-130J Hercules. This was unlike a commercial aircraft I had been on for holidays or business trips. There was less legroom, a small number of comfortable seats and it was noisy:

going in a Hercules. . . . We sit with our legs touching each other. We wore earplugs. (3.1:5)

We made friends with a couple of military guys at [the Air Force base] who told us what to expect on the plane . . . about 10 seats up the front and we all proceeded to grab them and then our colleagues were sort of down the side, you know. I ended up actually going down the side because you could lie down and I slept through most of the way to [the disaster]. (5.1:6)

It was good for the first couple of hours, because you could walk around and have a look around and see what was on board and look out the window. Then towards the end of [the flight], it became, ‘Can we get there, can we get there, can we get there?’ It was long . . . no TV. (6.1:7)

I tried to entertain myself on the aeroplane, mainly by talking to others or trying to sleep:

[On the plane] we talked to each other. . . . tried [to] sleep. (6.1:7)

The flight was seven hours. I actually was the only person who slept. I can sleep anywhere. I rolled up into a very small ball and I actually slept for four and a half hours of that flight. (3.1:6)

5.3 Prior to Starting Work

The aeroplane landed. I walked with the contingent off the plane and into the airport terminal. I collected my baggage. I then congregated with the contingent to wait for the local officials to meet us. I saw many people sleeping in the terminal. I continued to wait. There was no one to meet us:

So [on] the aeroplane flight, we're thinking, 'Ok, somebody was supposed to meet us at the airport. Will they be there, are they organised enough to be there? What are we going to? What's our accommodation like?' (4.2:1)

[We] arrived with our team leaders as well and there was nobody to meet us at the airport and the understanding was that [Australian government agency officials] were going to meet us there. (1.1:8)

When we arrived, [the local government official] didn't know that we were actually coming at that particular time so we arrived to no one to greet us at the airport. (2.1:2)

So we got to the airport. The Emergency Management guys weren't there and we couldn't contact them. So we all kind of bedded down for the night [in the airport], thinking that's where we were going to sleep . . . in the airport there were a lot of people sleeping. (1.1:9)

Eventually, our contingent was met by local government officials:

We were met at the airport by the [local official] and a scattering of other officers who welcomed us and said, 'Thanks for coming. We've asked for help from you guys and it's great that you're here'. (7.1:4)

So we had a night in [a nearby city] where we were met by some of the locals, the local [disaster relief organisation] people that were stationed there permanently. (8.1:4)

The officials drove us from the airport, through the disaster-affected community, to our accommodation and health precinct. On the way, the driver pointed out the structures and roads that had existed prior to the disaster and we discussed the general impact of the disaster

in the area. I could see the impact of the disaster, including the destruction of roads, destruction of homes and evidence of an elevated water line, such as boats being up in trees:

So we are met at the airport . . . we split up into the vehicles and they drove us to [the disaster area] . . . on the way, it was pointed out to us in various places where the water level was . . . when you see boats in trees and things like that, you do start to wonder, and you wonder what ramifications it had [for] the other people. (4.2:1)

There was only one road so the [local] government cleared the [remaining] roads quite quickly. There was still a lot of debris and still people wandering around, but they had kind of cleared the road. Lots of small fires where they were starting to burn debris and that, to try and get rid of it and things like that, but we were able to get to the places we wanted to. When we were going up into the actual more remote areas, we did have a four-wheel drive. (3.1:9)

I've got friends in [this town]. I've been there socially and have friends and relatives, and so when I wasn't actually out there in the mud getting [my] hands dirty. . . . I went to his place one evening when I had some down time. (7.1:7)

When I arrived in the disaster-affected community, what I had seen in the media and on the television was different to what was actually occurring in the communities. At points, parts of the region seemed unaffected and they were functioning as normal. At other places, the impact on the regions was devastating:

Your expectations develop out of the pre-reading you do, the information that you get on TV, the conversations that you have with people before your deployment. Your expectations kind of evolve out of that anyway. (8.2:3)

We were there, you know, 24, 36 hours after the initial footage was being shown on tele[vision], so a lot saw terrible doom and gloom on the tele[vision] because they were only showing the worst parts of things. But when you get there, life and the rest of the town is actually quite normal and especially a lot of parts of [the disaster-affected-community] had been completely unaffected. I mean, a lot of [people] were terribly affected, but you know, two-thirds of the city was still functioning and fine. (2.1:15)

You read about the different injuries and what devastation you're going to see. You may read about it and we all listen to the news when it happens, and when you actually see it, it's still like, oh wow [this is devastating]. (3.1:23)

You can certainly gain information and then you can find out a little bit about what it's like, either from the media or from the people who are on the ground already when

you're getting your reports back before you go. But I think until you actually get there, it's really hard to know. . . . I mean, the information that you're getting is sometimes not accurate, so I think being flexible and adaptable is really, really important if you're going into a disaster as a nurse. (2.1:16)

It didn't look the same as a lot of the media coverage we've had and different needs, and even though some suburbs were devastated, other parts of the city started functioning normally quite quickly again. (7.2:3)

I arrived at my place of accommodation. I took it for granted that I would have

accommodation and that this would have been prearranged for me:

About four o'clock in the morning, all of us [were driven on a bus] to this [non-used community building] and we basically just got there and pushed the tables and chairs out of the way . . . and basically bunked down for the night. (1.1:9)

I think we took it for granted that we . . . just expected to have the accommodation there and everything sorted, and when we arrived, you know, you suddenly realised that you were one very small team among hundreds and hundreds and hundreds of volunteers and people and army people that are helping and there was literally no accommodation. (8.2:1)

I was told where I would be sleeping:

We were put in groups and told which tent we were actually to sleep in, so instead of having individual tents, we had bigger tents throughout the whole camp and basically, we had five in our tent and yes, they tell you where you've got to sleep. . . . We borrowed some stretchers . . . and that was . . . home for the next four or five weeks. (6.1:9)

I was sharing a tent with a number of other health professionals from within my contingent:

First of all the tent was on the ground and then we had a little camp stretcher each and then we were in a mozzie dome over that. (5.1:8)

So we had one end [of the camp] with all the delegates' facilities, so we had individual delegate tents where we ended up sharing each tent with another person . . . our shower and toilet facilities and then a mess hall. (8.1:6)

A camp stretcher was my bed:

So one nurse would stay overnight at the facility on one of the stretcher beds. . . . The doctors were in the other accommodation and the ambulance paramedics were in another accommodation. (1.1:4)

There was a period during which it seemed that there was no specific plan for me and I was unsure of what I was going to be doing. During this period of waiting for a specific plan, I saw members of the community digging mud and cleaning streets. I was doing nothing for the community:

At that point [prior to starting work], we didn't even know what our role would really be . . . we knew that we were clinicians and that we were going to help, but it's an unknown quantity. (7.1:6)

The most nerve-wracking or the most frustrating part was when we felt like we didn't have a plan. Not so much the accommodation because we knew we could just figure that out, but certainly the work side of things. (1.2:2)

So half of that day, we were doing nothing. We were waiting and seeing what was happening, and that was really hard. . . . [I thought] 'If you need us to go and, you know, dig dirt out of people's houses, we'll go and do that. Let's go and do something.' I needed to be doing something. (1.1:27)

Then that initial 24 hours when we actually arrived was frustrating because we wanted to get in there and get going and get helping and we had to wait for some powers to be to tell us what they wanted us to do and that was really pretty frustrating. (2.2:2)

There was a big clean-up in a public space, a park, and [I was] feeling like we weren't contributing enough because I didn't have a shovel and I wasn't digging mud, but we were told that our role is [*sic*] to stay clean and to be there. (7.2:1)

We actually saw people who were, like, shovelling and cleaning up mud and trying to return areas of space back into . . . functional, and get rid of this thick mud . . . we weren't allowed to help because we needed to stay clean and we weren't allowed to get in there, because it was really hot and people were shovelling mud and they were working up sweats and were dripping with sweat. (7.1:12)

Eventually, I was tasked to work in the local hospital, supporting the local nursing staff. I was going to work in areas such as in the ED, on the trauma ward and in the mental health ward:

It was put to us that we'd assist with shifts in the general hospital to fill vacancies in Accident and Emergency. It's been a lot of years since I've done my general training . . . the [disaster] centre said nothing much is occurring and we were not required at all to do that. (4.2:3)

We imagined we'd be out among the people. But then we thought, well, the people are spread quite near and far. On our way up there, we were thinking well, would we be working in a mental health unit, [then we were told we would be an evacuation centre]. We thought it'll be a daily drop-in service, for outpatients and things like that. And that didn't occur either. (4.2:4)

However, this plan to work in the hospital did not eventuate. Again, I had no plan. Soon after, I was directed to return to the main camp and health precinct, where I would provide a health service from our temporary health facility:

So we all thought that we were going to be going working in ED at [the local city] hospital and supporting them with the trauma . . . [but] all the trauma had been and gone . . . they didn't need us to work in the hospital. (2.1:2)

The temporary health service was established on a local sports field:

It was a [sports] field, which was an ideal location . . . a flat space, so it was an absolute miracle that we found this [sports] field. (8.1:6)

It was a huge [sports] field with a stadium and everything and the stadium lights used to come on in the middle of the night and you'd be sleeping at one o'clock in the morning and the stadium lights would come on. (8.1:6)

The majority of the infrastructure for the camp and health facility was established by the ambulance service and defence force:

The [ambulance service] was bringing their facility over to their tent hospital. When they knew that, they decided that they would task our team to go and work out of that facility . . . put us into an area where it wasn't so much your acute cases, but it was about patients who couldn't get from their suburb, from their home, to the hospital or

to their doctor, as the road access was horrendous to the hospital, and a lot of them didn't have vehicles that they could use, and things like that. (1.1:14)

So they ended up getting it to the oval and between all of us and the army, we set up. (1.1:14)

[The ambulance service personnel] didn't actually work through patients when we were there. There were probably enough of us to do that. But they just made sure that we had everything that we needed. (1.1:15)

[The ambulance service] supplied the tent and there were six paramedics with us who came over to help put the tent up and manage the tent. They weren't doing any clinical stuff. (2.1:4)

[The ambulance service] had the tent and we set up like a big community health centre to support the local population while the GPs and pharmacies were all closed down. (2.1:3)

I assisted in the establishment of some of the infrastructure. Additionally, I assisted with some of the logistics in establishing the camp:

But that first day was really all about getting the [health facility] set up, so a lot of it was logistical-type stuff that we were just helping with and working out what we needed. (2.2:2)

The final temporary health facility was a combination of a number of individual tents, which together provided a space to provide a variety of health services:

It was more a tent that provided certain services to the local community. I mean, we had the capacity to do field hospital things, but it was definitely not a field hospital . . . it was more like a community-based centre. (8.1:21)

5.4 Working a Shift in a Disaster

Once we had established our health facility, we opened it for assessment and management of patients. People found out about our services by word of mouth:

[The people affected by the disaster] didn't even have radio to be able to put it out there that we were there. So it really did happen word of mouth, and it really happened quite quickly. (1.1:16)

people to come and see [the health facility]. So the village people, by word of mouth would come and bring their relatives that had wounds and things like that. (3.1:9)

[People came by] word of mouth. (5.1:10)

So [the people affected by the disaster] would have known that we were there and obviously the local community, word of mouth. (2.1:8)

Some people travelled for many hours to receive care. On some occasions people walked for days to access our service:

It's amazing how quickly the reputation spreads in a disaster setting. Yeah, people literally come from everywhere and come to get help. (8.1:8)

Some days we'd get people that had walked for five, six hours in this heat just to come to us to get their treatment. . . . We couldn't offer them any transport back or whatever else. (6.1:15)

I had women walking for five days from the rural areas to come and have their babies at the hospital because it was free and because they'd heard that the service being provided was international and of a great standard. (8.1:8)

During the early stages of our establishment, I remember people lining up to access the health services we were providing:

[On] day one, we were probably excited, which is a bit wrong, but we were excited to be getting in there and actually working and seeing people. When we got there the first day there were people lining up outside, so they'd found out we were there, they'd found out what was happening and yeah, it was good to just get in there and actually start doing something. (1.2:4)

Because you had over 300 people and every time you looked, there'd be more and more people lined up. Everyone wanted to come in and you knew that you wouldn't be able to see absolutely everyone. (6.2:1)

At times, we were busy and overwhelmed by the number of presenting patients. Initially, patients were pushing each other out of the way to access our service. Soon after witnessing this, I assisted in establishing a triage system at the entrance to our facility:

People were pushing in front of others and running in the camp . . . and getting all confused, so in the end we just went well, we need a triage system, so we ended up having a nurse out there triaging. (6.1:14)

So once we finally got our triage system, we were able to explain to them that we were going to start working the priorities down. That everyone would be seen and everyone would be treated; but we just needed to work out who was the sickest out of all. They kind of sat back and took that on, so it made it a bit easier. (6.2:2)

We actually had to get a sign made up. They thought we were a hospital. They thought that we would be able to tell them what the sex of their baby was going to be, when they were going to have their baby, whether we could take gall bladders out, whether we can do appendectomies. Some guy asked if we could treat his . . . he needed a new [cardiac] stent, and whether we had any spare that we could throw in for him. (6.1:13)

We had a triage system to ensure there was an appropriate order and priority of patients being seen. I worked in the triage area of our health service:

working out who needs to be seen first, triaging . . . paperwork and documentation . . . dealing with families and psychological support and especially in these instances . . . it seems to be a lot of coordination . . . you're basically coordinating the service and that could be a number of different things. (2.1:13)

Like we sort of have had a bit of an order as to when people were being seen and not, because we were run off our feet. (1.1:19)

I approached each patient in a systematic way, applying what I would do in my usual practice as a nurse to individual patients in the disaster context:

As an emergency nurse or a trauma nurse . . . you're working through . . . airway, breathing, circulation, which is very basic life support, but then there's the added elements in advanced life support, and stuff like that. So you're just applying that in every scenario. (1.1:23)

With minimal equipment, my clinical activities relied on an assessment using my hands and my stethoscope. I was very 'hands on':

I'm actually palpating a pulse and, you know, hands-on assessment skills. I don't have the monitors and I don't have a 12-lead ECG [electrocardiography] right now. I can do a postural BP if I'm that worried, but all I can do is these first base lines. I've got a stethoscope in my hand. (7.1:15)

It was going back to your basics, going back to your assessment skills, going back to all of that sort of primary stuff that you learned and dealing with whatever came through the door in that way. (1.1:22)

There were no x-ray facilities, pathology for blood tests or electrocardiography machines. I was looking at my patient without the technology. At times, I was relying on my knowing how to recognise the sick patient from non-sick patient:

you know, look at the patient and not just what they've presented with, but for what could be behind that, and not relying on the resources that you have seen in a tertiary facility. So you can deal with not having x-ray, you deal with not having blood tests and things like that. (1.1:22)

We didn't have ECG machines or anything like that. (1.2:7)

It was really back to basics with your gear and the equipment and the resources, but that was okay. I'm a real proponent, in nursing, [of] telling nurses to look at the patient, so it didn't worry me that we didn't have all the flash machinery around. It really went back to basic nursing assessments and that was really good, actually. (5.2:2)

just your everyday skills as an emergency nurse. You know, knowing how to recognise the sick from the non-sick and to quickly act on that and to be able to prioritise. (5.1:19)

It was a really tough environment to work in and it had a lot of very, very unwell people with very limited resources. (8.1:5)

The care that I provided to patients was nurse-led. I initially met the patient, undertook assessment and discharged patients:

You still need to do your general nursing. You still need to know roughly what's going on . . . you worked very solo, like you've got set guidelines, set criteria and because we knew the main patients would be cholera or malaria, we had, 'This is what you do, this is what you don't do', basically bang, bang, bang, bang. So [each patient] had the same [assessment and management] and at the end of the day, you're doing it in your sleep. . . . They'd come in, you treated them and out the door they'd go. (6.1:17)

You've got to be able to stand on your own. You've got to be able to go, all right, this is what I've got to follow, but you've got to use your common sense as well. And if you can do that you're fine. . . . If I had to be supervised every single step, well then we wouldn't have been as successful as what we were. (6.1:17)

What you have to be doing is connecting with people immediately on a human level. So level headed, calm, don't panic and able to chat to anybody in a respectful way and gain rapport quickly. (7.1:18)

That element of [talking with people, autonomously] interests me particularly because you weren't necessarily out there with other health care teams. (4.1:7)

You needed your [clinical] skills; you needed to work independently a lot. You still had your doctors there, and you need to have, I guess, a senior knowledge and skill level to be able to do that. I think definitely the [clinical skills] definitely helped. (6.2:4)

We [nurses] had to see patients. We were basically doing a nurse practitioner model of care there without a doubt. Probably, I think I added up, because I was ticking them off for my Masters [degree] as well, I think I saw about 600 patients myself. Probably 80% you'd try and fast track. (5.1:18)

I'd describe it as the same as what you know but in a context that's unfamiliar. So you're still a nurse, and what you know and what you can do is still valuable, but you need to let go of some of your control and some of your rigidity and your expectations—so self-expectation management, managing your sense of entitlement and managing what you demand, and being willing to improvise and go with things and realise that resources are already strained. (7.2:5)

For unfamiliar areas of practice, such as managing patients with tropical diseases, my decision making was made against clinical guidelines from the WHO:

There was just a constant sharing and teaching. Each day I still learned all the time . . . World Health [Organization] stuff that I really didn't know much about [prior to the deployment] was terrific. (5.1:18)

Getting to know the WHO protocols just took a little while as far as the work aspect goes. But just getting to know what protocols we were operating within and standard medication doses and things, so obviously it was a lot of malarial drugs, stuff that I hadn't used in that volume ever. So that took quite a while to just make sure we were doing the right things there, but even then, that became routine pretty quickly. (5.2:2)

On occasions, when patients were unwell I would meet the patient, undertake an assessment and refer them to someone in the medical team:

getting a bit of a basic assessment done before we referred them on to the consultant, and sometimes it was just things like a dressing and they wouldn't even need to see [the medical staff]. (2.1:6)

I would sometimes discharge people from our service to nowhere. Some patients had no home left, no food, no water and had no family. Their family was killed in the disaster:

I found that discharging people to nowhere with nothing. . . . It was just so foreign to what we do, you know, and you just had to harden up and just do that I guess. (5.1:13)

They had no homes. They had no food and they had no water, and that was the hardest thing discharging people. You know, you'd do your little bits and pieces and then you'd say 'off you go' and people would start to cry and tell you that they had nowhere to go, you know. I had an 80-year-old lady whose husband was killed in the [disaster] and she was basically relying on the help of neighbours and they'd been married for 60 years. So dealing with that sort emotion, the trauma that these really stoic people were going through, that was tough too. (5.1:11)

The patient population that I saw varied in age. Many unwell children presented for assessment and management:

We did see babies and young kids. (2.1:7)

We had some very, very sick children, particularly in the first week I would say that we were there, we probably saw the sickest amount and there was [*sic*] probably about five peri-arrests. Sicker than many I've ever seen. (5.1:12)

It was quite a traumatic experience the first time around, mainly because of the stories that we were hearing and the people that we were seeing and, you know, there were a lot of children that were affected. (8.1:16)

There were also some absolutely tragic cases [involving children] that would come in that were absolutely beyond help. There were children with a lot of genetic issues. . . . Massive amount of failure to thrive. (5.1:11)

A lot of children. A lot of failure to thrive. (6.1:13)

Additionally, there were many elderly patients:

There was [*sic*] a lot of older people. I think [they] just wanted a little bit of support. They just didn't really know what to do with themselves. You know, they were digging their own toilets in the backyard and stuff like that. (1.1:17)

In addition to caring for people within the general population that was affected by the disaster,

I spent my time caring for other health care relief workers:

met the head of the centre who was a health worker and we were talking with her and she broke down while we were talking with her. (4.1:5)

One of the doctor's we had—she was [from the disaster-affected community]—she had lost five of her family members . . . her house was completely destroyed, so she said, 'I can't find five of my [family] members. They may have gone from there but I'm not quite sure where they are'. (3.1:11)

We could see the interactions between the different teams and people in the teams. One would hope it wasn't normal . . . in talking to them, not only did they have their own personal crises, loss of house, trying to support other family members and everything, they still had to work. (4.2:2)

So we went [to a small town] and we were in the office talking to the mental health worker who, in talking to us, she started to break down crying. Because she started to talk about her loss and her husband's loss of business and things like that. And it just became obvious to us, everybody we saw was basically not coping. Not coping at all. (4.2:2)

When mental health workers are talking to you about the loss of their home, the businesses that their partners were running, and things like that, they're crying. . . . It

does make [it], at times, difficult to cope with your own emotions. You are in a bit of a turmoil. (4.2:4)

I also cared for other non-health professional relief workers that were assisting in the aftermath of the disaster:

So then we were talking to other people in the centre that were volunteers and they were all breaking down as well, and we thought, 'They're just not coping'. (4.1:5)

working alongside people that were going home to their cars to live because their houses were destroyed . . . they were sleeping on the street, yet they were coming to work every day and putting on their best face to help their own people . . . they'd lost family members, they'd lost children, they'd lost people close to them and were suffering themselves. (8.1:12)

I saw people present with disaster-related injuries. These were mostly minor injuries such as cuts, abrasions and bruises. However, they did not have the basic items, such as clean water, to care for themselves:

Initially, definitely, there were so many [disaster] related [injuries]. (5.1:11)

But it was really like category four and five [triage]-type patients, a lot of cuts and abrasions and a couple of broken bones. (2.1:4)

cuts and abrasions . . . possible infected by grotty water in their cuts . . . but nothing major really . . . primary health stuff. (2.1:11)

Lots of primary health, lots and lots of primary health . . . lots of cuts and bruises and things that they . . . would normally have managed themselves but they didn't have any clean water or anything to manage even just a simple cut. (1.1:17)

Mostly it was sort of just basic primary health care really. (2.1:4)

But it really was the primary health care stuff that we were doing. (1.1:18)

Aside from minor injuries, some patients presented with wounds that required surgical debridement:

coming with quite bad wounds and some of them we had to send up for debridement . . . we had heads that had been sutured up and they had sand still in their scalps. (3.1:10)

I saw patients who had delayed seeking assessment and management of their injury because they were too busy after the disaster finding shelter, food and water:

We had patients who were coming in with injuries [that] may have happened during the [disaster], but they were too busy tending to what they needed to tend, to actually do anything about it, and also some who had started to clean up. (1.1:14)

I saw many patients who had injured themselves secondary to the disaster. This was primarily during the clean-up activities following the disaster, such as broken limbs from falling off walls and burns, cuts and abrasions from people attempting to repair their own homes:

broken limbs [for people] who'd fallen off walls when they were trying to fix things. (1.1:17)

I kind of visualised that there'd be a lot of contaminated cuts and scrapes because we were in the week after the [disaster] . . . so I thought it would be clean-up. So non-tradespeople trying to repair their own homes and clean up their own debris. There'd be cuts and scrapes, and people under pressure, not taking care of them . . . that was consistent with what we got in our briefing and it's consistent with what we saw. (7.1:6)

There was a lot of people with musculoskeletal stuff, so you were basically going back and trying to figure out if there was an injury or if it was kind of related to the fact that they were stressed and hadn't slept and things like that. (1.2:6)

somebody who actually had a terrible burn from trying to fix up one of the buildings . . . lot of lacerations, because the locals would just wear thongs or bare feet . . . nails in their feet, lacs [lacerations], burns and things like that. So we started having this second wave where we were actually now providing acute care for these people, for secondary injuries or things like that. (3.1:20)

Many people presented with non-disaster-related injuries:

a lot of broken bones. We had a young girl, it was actually the day of the [disaster], she was hit by a truck, so pedestrian versus truck. She had a fractured open-book pelvis and a fractured femur, and she was 11. (8.1:9)

the directly affected but also the indirectly affected. . . . I mean, you may get more of the directly affected in the beginning but it really doesn't last long. You know, sometimes within a few days, sometimes within a few weeks, you start to see the ones that are indirectly affected. (8.1:9)

I remember one boy who presented with a pre-existing injury to his leg. His leg was swollen and pustulating. He could not explain what had happened and I could not understand him because of my inability to communicate in his language. I was unsure whether this injury had occurred in the disaster. It turned out that the local hospital knew him and it was a pre-existing condition:

We had to see a boy one time . . . he had a really swollen leg and pus was coming out . . . I thought that he must have got [that] from the incident, and he couldn't explain it to us and his family, and we were really worried about him and there was no medical records. We spent about half an hour trying to sort out this—was it old or was it new, was it always with pus like that? When we got him to the hospital in [the local village], they knew him. (3.1:14)

I saw people with pre-existing illnesses. I remember one man who presented with a carcinoma of his trachea. He wanted a surgeon to operate to alleviate the pressure from his trachea:

patients that were non-[disaster] patients . . . they would like us to do, you know—there was a patient who had a carcinoma that was pressing against the windpipe—they wanted the surgeon to do a little bit of an operation on them. (3.1:7)

Patients presenting with acute illness was a mainstay of my daily work. I saw lots of patients with acute gastroenteritis illnesses:

was just huge amounts of vomiting and diarrhoea, lots of cholera . . . contaminated water had caused it, plus the fact that they had got cuts and grazes and wounds and things which had then got infected due to the contaminated water. (6.1:13)

Basically, nasogastrics were our mainstay. We didn't do a lot of [IV therapy] really. It was just putting in nasogastrics and refilling people up with [oral rehydration fluids] . . . often there was just packages of Panadol going out. Everyone was getting multi-vitamins . . . covering patients for iron deficiency . . . lots and lots of oral antibiotics and water. Just trying to give them the basic stuff really. (5.1:12)

I saw patients present with varying respiratory illnesses, such as chest infections, asthma and pneumonia exacerbated by saltwater inhalation or smoke inhalation:

chest infections, so young children with chest infections, respiratory infections. (8.1:9)

Respiratory. There was a lot of asthma and pneumonia. (5.1:12)

some respiratory problems because they'd actually inhaled some of the salt or because of the burn-off, there were some issues. (3.1:10)

I had patients present with varying tropical diseases and heat-related illnesses:

So lots of very febrile people, initially septic, malaria, typhoid, cholera. We had a lot of scabies. Lots of things that you see in the top end [of Australia] really, with the tropical stuff. (5.1:11)

heat stress or heat-related illness. (7.1:13)

I saw many patients with chronic health diseases, such as diabetes, hypertension and renal failure:

Even a minor injury had a lot of complications for [the patient population of this country] because they have a high instance of diabetes . . . a large portion have hypertension and renal failure. (3.1:10)

One lady that comes to mind came out to me saying that she needed her blood pressure checked and I checked it and it was really high. She had known hypertension. (7.1:11)

what I'd normally do in ED with an assessment of what's going on—her systolic was like 210 or something, and with her body type, she looked like she had multiple cardiovascular risk factors—but she was very, very anxious and under a lot of stress and not coping, she also hadn't been taking her antihypertensive. (7.1:12)

A part of the reason many people presented with an exacerbation of their chronic illness was related to their inability to access their normal means of self-managing their illness:

people that couldn't access their usual methods of managing their chronic health condition, [such as accessing medications], needing to come and get them, so a lot of diabetic patients . . . a lot of people with a lot of complications, a lot of renal disease. (8.1:9)

dealing with a lot of chronic ailments, so people that couldn't access their usual health services [came] to get their scripts. (8.1:22)

The local pharmacies and general practitioners were closed longer than anticipated. So people could not access their prescription medications via their normal means:

people who just had run out of medications or didn't have their prescriptions because the pharmacies were closed, GPs were closed. (2.1:4)

people who had lost their medications, there was no pharmacy to get scripts filled. (7.1:7)

mostly dealing with the patients who couldn't get to their GPs and who needed minor sort of stuff and lots of medication. (1.1:14)

I saw patients who did not have their medication and could not remember the name of it. They could only provide small amounts of information about their medication, such as 'it is a small round blue tablet':

But the problem, too, is that a lot of [patients], because they are upset, can [only] remember it was a blue tablet, you know, and then you'd have to ask. And some of the older people didn't speak English. They spoke their dialect, so they'd describe it to their son or to the small child and you know, 'What blue tablet? What's it for?' And so you hopefully pick the right blue tablet. (3.1:13)

They didn't have their medications. They couldn't remember their medications so they didn't have their [hyperglycaemic]. They hadn't taken their blood pressure tablets for a while. They were on antibiotics but they weren't taking their antibiotics and things like that, so we had that second wave of people. (3.1:10)

People presented and did not have a large enough supply of medication to last them for the duration of the disaster. People said, 'I thought I was only going to be displaced for a couple of days'. I spent a lot of my time trying to find medications for people:

We spent most of our time trying to find medications . . . it was amazing how people don't have a lot and their medications will last them for a period [of] time. 'I thought I was only going to be here two days and I only brought two tablets'. (3.1:14)

I saw women who were pregnant and wanting maternal health checks:

Lots of maternal child health. There were certainly pregnant ladies who came and got checks done. (1.1:17)

lots and lots of maternity. (6.1:14)

[The local community] hadn't seen much Western influence at all and they were really isolated as far as technology [goes] . . . we had ultrasound, for example. We would get all these pregnant women coming in, [saying], 'I want to see my baby' and we had a lot of antenatal care. (5.1:11)

I saw death and people dying. This was different to what I see in an Australian hospital. I remember seeing people whom we could not help. We had intubating equipment, but no ventilators:

I think we definitely made a difference and the hard thing to get around is we definitely saved lives, but lives were lost. [If a person was dying], we'd try and get them straight back out of our [health facility] to go home with their family, or if they wanted to they could go to the hospital. (6.1:14)

But there were quite a lot of sick people that you did send either to the hospital or home, so that was sad. (6.2:2)

dealing with death and dying and dealing with traumatised people. I think that's always the biggest challenge working in a disaster setting because not only are you dealing with patients that are traumatised, you're working alongside staff that are also traumatised. (8.1:11)

We had intubating equipment but we had no ventilators so, you know, you could intubate properly and then stand by their bed and hand bag them, but how long can you do that for? You know, we did that once for a lady who was septic, she was post-

partum, she had retained products probably three days after delivery, so she was septic, multi-organ failure, really unwell, had a massive bleed as well. So this lady was absolutely unwell. We tubed her but there was nothing we could do other than support her and try and get those antibiotics in, but she died. (8.1:10)

I saw multiple children die. In the Australian hospital, this was not common for me. I remember one seven-year-old girl who was bleeding from everywhere. The cause was unknown. We tried absolutely everything to save her. She died. I cannot get her picture out of my head:

People were going to die regardless of whether or not you had intervention and some of those were children. (6.1:14)

I had some pretty traumatic deaths of people that were just . . . I remember a seven-year-old girl that died . . . she just bled out and she was bleeding from the mouth and just haemorrhaged out of her mouth. . . . We just couldn't pinpoint what was wrong with her . . . we tried absolutely everything, yet she died. I can't get that picture of her out of my head . . . whereas, when you're in a context that's stressful anyway, and you're in the middle of a disaster, I don't know whether that lowers your sensitivity too. I don't know. It's kind of hard. It just feels different to dealing with trauma here. (8.1:16)

But we had a tent set up as a mortuary and tried to carry this girl, this seven-year-old girl, to the mortuary and lay her out. It's a huge process, you know, it really is. You know, you're the mortuary person, you're the counsellor, you're the nurse, you're absolutely everything. (8.1:17)

On death's door children and we'd have to say 'Well, this is it'. (5.1:19)

I sent people either back to their homes, if their homes were not affected by the disaster, or to hospital. Either way, these people would die. I remember sending a couple to die at home:

We had the very, very sick and we had to send a couple home to die at home because there was nothing else we could do. We'd done everything that we could. (5.1:19)

When I saw people in the disaster-affected area, I didn't know if the person's home was destroyed, if they had lost loved ones or if they were directly affected by the disaster in some other way. I would often just say, 'Hello' or 'How are you going'? Commonly, people would then start to talk about their disaster experience:

You didn't know whose family, whose homes, whose loved ones had been affected, so we found out during the course of the week. There was one RN that I was working with who had been directly involved in [the disaster], had tried to save an elderly woman who'd died in front of her . . . [people] hadn't been sleeping, they'd been working long days, long hours. (7.1:5)

Our specific job was often just saying, 'Hello' . . . they'd come out into the street and they'd want to ask some question about, 'Oh, I've got some elbow pain' or 'I've got this little scratch', but really when you got to the bottom of it, they just needed to talk to somebody. (7.1:11)

We actually learned to say to them, 'How are you going'. If you ignored the fact that the [disaster] happened, that seemed to be more damaging. They wanted you to ask and we learned that we had to ask. We had to say, 'How are things going? Was your place damaged?' That sort of thing. (1.2:8)

Most patients who presented for care of their physical injuries and illness displayed some level of psychosocial need:

[Patients] came in with other complaints but a lot of the time, they also needed a lot of emotional support as well and their complaints may have been that they needed a script or perhaps . . . they had a minor abrasion or a laceration that needed suturing and a bit of a dressing. There was never anything particularly major, but once you got talking to them, you'd just sense that there were certainly a lot of other psychosocial issues going on as well. (2.2:3)

In the beginning, there was a lot of traumatised people, health and psychosocially traumatised people. (8.1:9)

In comparison to what I would see in an Australian hospital, there was much more psychosocial need in the disaster environment. It was needed for every person:

The patients that we were looking after had physical injuries or physical problems but then every single one of them had the psychosocial stuff going on, . . . which is not

what we deal with every day [in an Australian hospital]. You deal with it on a very surface level, probably, in most cases. (1.2:5)

Sometimes this need was obvious, as people were obviously angry or physically sick:

A lot of very angry people and people suffering grief, so all different affects we came across. It didn't require anything clinical, such as medical treatment. It was all mental health. (4.1:6)

[Emotional disturbance was] very widespread. Whole communities . . . [at a town meeting] the audience, different people that were hostile with one another and saying things to one another. (4.1:6)

And the big surprise to us was when we got people together to deal with their depression and anger and things like that, the amount of anger there was. (4.1:7)

I remember one lady that would vomit every time there was an aftershock:

Every patient who came in had mental stuff going on, because they were all traumatised by what had happened. But it was significant, people who hadn't slept for three or four days. There were people who every time there was an aftershock—I remember one lady would just vomit. She just had this—she was so anxious and she hadn't slept for days. (1.1:17)

I identified people who were not coping with the stress after the disaster. I referred them to additional help when it was available:

identifying mental health issues, people who were not coping with the stresses. I personally identified people who were suicidal and had to try and refer them on to get help, to protect them during that crisis. (7.1:6)

My assumption was that I'm going to a [disaster] relief, there are going to be people that are injured or have first aid problems or health problems, but the majority of it ended up being emotional support, mental health first aid, and triaging based on, 'Are they at risk right now or are they coping?' (7.1:15)

The community as a whole, because they have that religious base, that was their mental health support. I think the working mental health nurses were a bit closer but they were very much focusing on getting back into church and things like that, you know, and so they were all focused and I think . . . their medication basically, you know, was religion. (3.1:27)

[One person said], ‘There’s no way out of this for me. This is it, I’m done’, and you could tell they had no sense of survival, had no sense that this is going to be okay. So I’m like, ‘Red flag’. (7.1:14)

One [person] in particular, I couldn’t leave the suburb where we were until I knew that someone knew about him and were following up, because from my ED experience, I’ve dealt with suicidal people before and we have systems in place, but you’re out there in the community in front of what’s left of his house, and he’s telling you stuff and you’re reading between the lines and realising this guy’s hugely at risk. I was really concerned and I had to find someone that could look after him. (7.1:6)

Sometimes I did not need to refer patients to other services. I did not have a concern that they were at risk of self-harm; they just wanted to talk to someone:

It was just a matter of being able to talk to somebody rather than needing actual counselling. (2.1:13)

People just wanted to discuss their experience:

mental health trauma and that sort of thing as well . . . people just sort of wanting to come in and have a chat. (2.1:4)

So . . . you’re there in a uniform and it’s a trusted organisation and I had a big tabard that says ‘Nurse’—it’s a trusted profession. I then had to be prepared to hear the sad stories and have no answer. (7.1:10)

We’re going in and we’re getting first-hand accounts from people that are living it. (7.1:10)

People wanted to share their stories with me because I was not personally involved in the disaster:

We weren’t people who had been through it so they could offload to us without feeling like they were burdening us, I think, and that’s what we realised down the track. (1.2:8)

Because we’d come from Australia and none of us had been personally involved in the [disaster] . . . I think people felt comfortable talking to us about their concerns because they knew that we weren’t directly involved. (2.1:13)

I heard stories from people who had lost their children. One woman recounted her disaster experience, which involved her two young children. The disaster had been imminent and she was holding her two children, one in each arm. As the disaster struck, she needed to hold onto a tree so all three of them would not be swept away. She held onto the tree with one arm and held her oldest child in her other arm. She had to let go of her youngest child to save herself and the oldest child. The youngest child had not been found:

A mother said, you know, ‘I had two children and the wave came and I grabbed a tree and I let go of my six-month-old’ . . . and so people just wanted to talk about it. (3.1:10)

On another occasion, one mother and father were discussing their five-year-old child with me. Their child was swept away in the water during the disaster and was missing. After a number of hours, the child had been found safe and well. However, the child had not spoken a single word since the disaster:

[A mother and father were discussing] their five-year-old child [who] hadn’t spoken one word since they were dragged off in the water, but was saved. Just not spoken one word. And there were lots and lots of scenarios [like this] . . . I think the child thing and the devastation that the different children went through was the most emotionally provoking process that I experienced up there. (4.2:5)

One middle-aged woman recounted her experience of being on the roof of her house with her two elderly parents. The floodwaters were rising and lapping the roofline. Luckily, a helicopter came past to rescue them. However, when the crew were winched down to the roof, they informed the family of three that there was only enough space in the helicopter for one person. The elderly parents decided that the daughter should be rescued. The daughter was winched into the helicopter and taken to an area near our health facility. She had the impression that her parents were going to die:

One lady, well we were talking to her and she was on the roof of her house and with her parents . . . she said she was picked up by a helicopter but the helicopter only had

room for one. And they pulled her up and she said, ‘No you can’t go, you can’t go. You’ve got take my parents’. And she was told from the team in the helicopter, they just said, ‘Lady, they’re going to die’. And they flew off . . . Well, it turns out they didn’t die. They were saved by another helicopter. (4.2:5)

I heard many stories from the elderly relating to how they coped in the disaster and what they had lost. I spoke with one man who had lived in this roof space for a week. He was too afraid to come out of his roof space because he thought that the damage from the disaster was too extensive. He was waiting for people to find him:

One elderly man, . . . to escape the waters and the mud, went up into his attic so he was up on higher ground, and he put a sign out the front of his house saying he was up there, like, ‘Help me’, and it had just fallen down, so no one knew he was there. He was up there with tins and whatever rations he had, and he was elderly and he lived alone, . . . it was a week after the clean-up had started before some St John volunteers found him and he’s like, ‘I didn’t know how bad it was out there and I was just waiting for someone to come, and I thought it must be really bad if you haven’t been and it’s been a week’. (7.1:10)

Another elderly couple were staying in their home with no electricity or water, cooking on a fire in their backyard and using a hole in their backyard as their toilet. When he came to us, the man was very unwell, with an exacerbation of his chronic respiratory disease:

I remember this old couple—they were 80 odd—who’d been sitting in their home. They had no electricity, no running water. They’d been cooking their food over a fire in the backyard and they’d dug a hole in the yard to use as a toilet. They were 80 and they had severe COPD [Chronic Obstructive Pulmonary Disease], both of them. By the time they got to us, he was sick, he could not breathe and they didn’t want to bother anyone, but they were so traumatised. They felt like they had to guard the . . . entire street because the street had left; everyone had just up and left their homes. (8.1:22)

Another elderly man recalled a story of how he became separated from his family in the disaster. When a bus arrived to assist in the evacuation of people from the disaster area, he was told to get on the bus and he lost contact with his entire family. He later learned that he had lost all of his possessions in the disaster, his wife had died and other members of his family were missing:

One gentleman . . . he's lost his whole house. . . . His wife was dead, some of his children were missing, plus his mother-in-law [was missing] . . . so he was trying to find them and was in a situation on his own . . . a bus turned up and told him he had to get on. . . . You have to get on it now, you've got to leave everything and get on now . . . he came into us and they'd put [him] in [his] own little accommodation and by the time he got to me, he was an absolute mess. He was really stressed about himself, plus his family. He didn't get to help them, he didn't know where they were . . . [they had] lost complete contact with each other, so [he] didn't know where they were or what was going on. They had no transport. (6.1:15)

I was listening to the stories of people who had been in the disaster and I was trying to support these people to the best of my ability. In the Australian hospital environment, I would have many other nurses to share this emotional load. Additionally, I would be able to refer patients to other support services and mental health teams. This is not the case in the disaster environment:

[In your normal workplace] . . . you've got people to share the emotional load. Whereas when you're working in these settings, there's no one really to share the emotional workload with and, as delegates, you often rely on each other just to support each other and debrief with each other. (8.1:12)

So it was more the psychosocial aspect of the people that were affected that was the challenge for me, not so much the work; the work was run of the mill for me. It's more listening to the stories and trying to support them in the best way that we could. (8.1:21)

They did talk to us about peoples' responses to stress and losing everything and losing family members, losing assets, losing their homes, but very much a big part of our role . . . was psychological care. (7.1:6)

talked a lot among the team . . . I felt quite emotional. We weren't seeing anything particularly horrendous, you know, it was [that] these people [had] been through a really shitty time and that was it. (2.2:6)

As an emergency nurse I've seen a lot, you know, and I've dealt with a lot of very tragic circumstances . . . the difference is, I guess, that people have more emotional support here [in Australia] and we have more resources to help with that. (8.1:12)

I spent a lot of my time providing health education to people who presented for care. I

provided education to patients regarding coping strategies and the normal grief process:

We went back and we set up a presentation on teaching them how to cope, what they can do, they're not at fault, they're not guilty. So we were just doing this on the run. (4.1:5)

I spent a lot of my time providing health education to people who presented for care.

A lot of education, just educating them. We found education was one of the biggest things that we spent doing, besides supplying them with their medical treatment. (6.2:2)

I provided education about general hygiene, such as how to wash your hands and how to handle food:

patient education . . . whether it be antenatal stuff or just your basic hygiene measures and things. (5.1:13)

educating them about their food, about their hygiene, about, you know, simple things, washing their hands before eating, the way they prepare their meals now that . . . all the water was contaminated, where were they going to get fresh water from. Just basically explaining to them about the malaria treatment, when is the most appropriate time to take it, or when do they have to tell the kids to take it and making sure the children do take it. Fluids; encouraging fluids. (6.2:2)

[Patients and their families] were under the impression to fix this child/any family member that was unwell, suffering from vomiting or having just diarrhoea, would be to stop the fluid and diet intake, which is one of the normal things. So trying to undo that and trying to educate them that that was actually the wrong thing and to re-educate them on the right, took . . . a lot of time. (6.2:2)

I also provided education regarding wound care:

I educated one man in re-dressing a wound on his lower leg . . . someone from one other agency had already given him some wound supplies, but it just needed to be reviewed and I thought there was a high risk of infection. (7.1:13)

Education was provided regarding vaccinations:

blood pressure checks and I'd go through and do what I'd normally do for an assessment, and giving general health advice as well. I had people that were asking about tetanus boosters and whether or not they needed a new one and I'd ask them when they had their last one and if they weren't sure, then we'd flag that and refer that on to the council who was coordinating those, to my knowledge . . . people were asking about all sorts of health issues. . . . I would ask the question, 'So who's providing vaccinations for this area?' or 'Is there a local hospital or doctor that people are going to see if they need it?' (7.1:12)

Early in the deployment, I did not have all the resources I needed, such as forms for documenting patient progress and the equipment and health resources that I used were of a basic standard and in short supply:

Day one we were pretty much setting it up, making sure we had everything we thought we'd need; making sure we had documentation, and things like that, because we actually didn't have any forms [for documenting patient progress]. We had to kind of create what we needed, or use what the [local] hospital had [given us]. (1.1:4)

In the medical tents themselves . . . we didn't have a lot of supplies. A lot of it was medication that we had or a few things with some dressings. Then, of course, the pregnancy stuff. They had their own kind of equipment, but we were very basic.

I had only one oxygen concentrator. I remember one time when three patients required oxygen. The three patients were equally unwell. I ended up sharing the oxygen between the three patients, giving each of them small amounts at any one time:

one oxygen concentrator . . . we had to triage who was going to receive oxygen and who wasn't. (8.1:5)

I had three patients needing oxygen one day and they were equally as unwell as each other and, you know, we had an elderly patient that had had a stroke and was severely

hypoxic and looked blue. He was 80 and, you know, we did what we could but we had a neonate that was also hypoxic and [had] a chest infection; and then we had a fitting, eclamptic woman that needed oxygen as well. So, I mean, you're talking about three equally needing, or equally deserving, people for that same treatment, but we literally had to give it to one for a little while and share it with another one for a little while and that's always hard. (8.1:10)

During the deployment I ran out of a number of clinical items, such as IV giving sets:

At one stage, we were lucky to have IV giving sets. You know, we were running out of resources. (8.1:5)

We didn't use pumps for fluids, we just used gravity lines. I think we had pumps if we needed them but we didn't really use them. (1.2:7)

Each day I would look at what clinical equipment we had used and what was remaining. I would compare this to what injuries and illnesses we had been seeing and make a judgement about the required resources for the following day. I would then organise to get equipment from somewhere if possible. On some occasions, I got equipment from the local hospital:

We just looked at what supplies we had and what sort of things we were treating and you know, like oral antibiotics and topical antibiotics and that sort of thing, dressings, and we could get them from [the local hospital] as we needed to. (2.1:5)

figure out exactly what [the other health services] had and what we thought we would need, in which case then we had to source them from the hospital and liaise with the hospital to get that. (1.1:4)

On another occasion, I would visit the local medical supplies depot, which was a big warehouse, to obtain some supplies:

Every morning, at the start of every shift and the end of every shift, we'd go through the Virginia depot where there'd be staff . . . basically it's a big warehouse and they would just have stores and you would be told the types of thing you'd be doing. (7.1:8)

We got a whole lot of supplies from a hospital. (1.1:15)

The equipment I used was sometimes unfamiliar to me:

using equipment that perhaps you don't normally use in your own department, but once you got used to it was fine. (2.1:5)

Obviously, the documentation was different. (2.1:5)

I was very busy. As a team we were seeing hundreds of people each day:

Initially when we first got there, everyone seemed to be a priority one or two, they were just that sick. Like there was no one I could say, you have to sit here [and wait] . . . everyone needs to come in now. (6.1:15)

There were times when . . . you had to be very quick with your assessments because we saw about 12,000 patients, so we were seeing 300 a day while we were there and then that did taper off. I think the first day we saw about 450. It's pretty massive work. I was stunned at what we were able to do. (5.1:14)

We were seeing up to 300 a day, if not more. It was a lot. (6.1:13)

I was busy, I was flat out. . . . I was working in the intensive care area and because I was a midwife as well, I always seem to find that there's a big demand in midwifery skills and also basic nursing skills. (8.1:5)

I mean, we had bed block issues anyway, but you just squeeze an extra bed in or top and tail people; we had four babies to a bed sometimes. So there was none of this, you know, one patient per space . . . we seriously had issues with the amount of patients we had, literally four babies to a bed; it was crazy. (8.1:11)

I worked every day of the deployment:

We went out every day. I was there for a week. (7.1:7)

We worked every day . . . didn't have a day off, so [work] was every day for five weeks. (8.1:7)

The hours that I worked each day varied. Initially I was working long hours, many more than I would work in the hospital. As the deployment progressed, the hours I worked each day reduced:

The longest that we were probably awake and having no real break would have been from five to seven or eight [hours] I suppose. You wouldn't have any more than, say, 14 hours of work. (7.1:8)

We were having breakfast at, like, six in the morning, so we were always up by five in the morning and we generally wouldn't have been back until dinnertime, so they were full days. (7.1:8)

tried to keep it similar to what you do in a civilian shift job, just you're getting up early and getting to bed late. (7.1:8)

8.00 am and we went until probably about 8.00 pm. So then we had a really good look at our hours and we started to tailor them back a bit. In the end, it worked out from about 8.00 am to 6.00 pm every day. (5.1:9)

For the first couple of days a lot of the morning staff stayed on and did a 12-hour day . . . as the days went on, so most people would do a morning or an afternoon . . . last couple of days we were closing earlier and earlier. (2.1:7)

We worked anything between eight to 12 hours depending on what was going on at the time. I remember one night, we had a young girl who was very unwell, so I specialised her pretty much while the other nurse, was supporting the rest of the patients . . . it was mostly about supporting the local staff to do the work really . . . the second time that I was there. . . . It was more about educating [local staff], supporting them. I mean, it's all about sustainability, I think. (8.1:7)

Eventually, the clinical shift became very slow and not busy at all:

It started off quite busy, and then as we got to the end . . . it petered off. (1.1:16)

It was pretty slow. We actually weren't as busy as they thought we would be . . . [the disaster control centre] basically set us up based on the usual amount of transfers that they would have. (1.1:5)

We weren't seeing the volume of patients that I would normally see, so it was a slower pace, it was at the clean-up phase, we were all about peoples' state of mind and emotions and minor treatment was our role. (7.1:17)

So everything that I dealt with, I'd seen before or I understood what was going on and I felt confident and because they weren't a huge volume of cases, we were able to deal with each one really well. (7.1:18)

As our clinical activities slowed in our health facility, I participated in a health outreach service that patrolled the nearby community, identifying people who required health assistance. I would provide care to these patients in the community or refer them to our health service or local hospital, as the normal health clinics were not open to receive patients. However, patrolling the area and providing a health outreach service were not required for very long:

We were slowing down, so that's when we thought we needed to get outreach involved. So they attempted an outreach which wasn't successful, as in it was just a bit too dangerous outside the boundary, the compound. (6.1:15)

tried very hard to do outreach work and I think there was only ever two teams that went out. (5.1:10)

During the immediate aftermath of the disaster, normal health clinics were not open to receive patients. Local health care professionals from the closed health clinics assisted us throughout the deployment. I remember working with a local community health nurses, a maternal child health nurse and some local general practitioners. These health professionals had knowledge of the area and links to community health services:

We had some of the community health nurses coming in to work with us as well, which was really handy, because they knew all the systems and most of them were fantastic to work with and people were very keen to come and help us. Physiotherapists turned up who couldn't work because their clinics were closed down. (2.1:10)

There were people who started to hear that we had a facility there and they had services that they could help with, but didn't have anywhere to do it from. The dental van arrived and parked outside and they saw patients, and we did have the maternal child health nurse who'd come and work from the centre, and then we also had some of the local GPs. (1.1:16)

[The local health professionals assisted in linking with local health] things, with prescription pads, pharmacy, where we could refer to. There were still some x-ray facilities working around the place and so they sort of helped us out to know who was working and how we could get in touch with them, and we then started to refer people to those places. (1.1:16)

As local health services recommenced their normal functioning, I increased the referral of patients to various services. There was a list that was updated each day, outlining the local services that were becoming operational:

If there were other clinics or other areas and we knew who was functioning, we referred them to those as well. So we were still able to refer them to some of those places. (1.1:18)

Once the GP clinic started opening and we knew that, we started referring people back to the clinic. So we had a list every day that was updated with which clinics were open, where they were coming from if not from their normal place. (1.1:16)

We'd done what we could and most of the patients were going back to their GPs, which was great. That's what we wanted. That was the outcome that we aimed for. (1.1:28)

worked hard to work out what the resources were for the local community, so we had people to refer to and we had services that we could tap into to kind of follow these people up. (8.1:22)

One of the major things was to get the information to the people as well; who they could go [to] for assistance. So in one way, we were doing a lot of triage and redirecting people to the appropriate services for more appropriate assistance. (4.2:5)

As the local health services were re-established, we started to hand over our services to the local health care professionals as a strategy to withdraw our services from the region:

We finished at lunchtime on the last day that we were there because there was just no one coming through. And at [that] stage we had GPs that had come in to take over . . . we scaled it right back. (2.1:7)

So initially in the first couple of days we were seeing quite a few people and then as the time went on, towards the last few days we were sort of just trickling along and we weren't doing much at all . . . we handed over to the GPs and the people who would normally be doing the sort of work that we were doing, the community health nurses. (2.1:9)

The more that the government brought in, in their resources in the locals, you know, the less and less that we do. . . . Sometimes we'd go out and it may not be a lot of clinical [work]. (3.1:20)

5.5 End of a Shift

Once a day I participated in an operational debriefing. During the debriefing, I sometimes shared stories from my day with the other contingent members and other team members shared their stories. The focus was on what went well and what could be done differently the next day:

debriefed every day as a team. (4.1:15)

Yeah, [the debrief] was just a good time to kind of do a handover because . . . we'd break into the two shifts each day, so we'd all come together and kind of compare stories and things like that. (1.2:4)

We always had a debrief [at the end of the day], talked about [the disaster]. . . . And then we'd talk about what we were going to do the next day. We'd go and we'd look at all our stock, pack it all back up again, see what we might need for tomorrow, maybe re-stock things to take out the next day, talk about the staff and how they're going. (3.1:15)

As a team we would meet every afternoon or evening. It just depended on when we actually got back. . . . But every evening we got together, we debriefed. (4.1:9)

Every night we'd get together and they'd give us a summary of what they were doing and what conversations they were having and that transparency was really valuable and I think it kept the team together. (8.1:21)

But at the end of the day, we would meet and sort of debrief ourselves to help our own emotional feelings. (4.2:3)

We were again made aware of any security concerns for the team. This particularly related to violence that was occurring in the disaster-affected community:

We had briefings every day, if not twice a day. We had twice a day, one in the morning and one at night . . . they were more operational on what's going on . . . they would get security warnings or alerts. . . . They tried to keep everything very honest and open and actually warn us about [the security risks and the health needs of the community]. (6.1:12)

In that same sports field there was like a big basketball stadium . . . a recovery centre had been set up . . . about Day 2 or 3 of us being there, they had to close that down . . . because it was not sanitary . . . [and] there was some kind of gang violence happening, and we had security at our tent 24/7. (1.1:15)

In the first few weeks following the earthquake, security was an issue, so we weren't allowed to go out of the boundaries of that football field . . . you start really feeling like you're trapped and you really lose sense of where you are as well. (8.1:7)

Security was never good at the camp to start with . . . basically unprotected and so it was always in the back of your mind that we could be a target. But I think we were just so busy with work that you kind of just forgot about it and kept going. (5.1:7)

Emotional support for me in the disaster environment took on many forms. I found support in both individual and group contexts. There was a psychologist and padre that I could easily access if I wanted to talk to someone outside the health team:

There was a . . . psychologist embedded with us but he was actually there for staff, which was a good thing because definitely a lot of staff really needed him through the time. (5.1:13)

There was a padre embedded. You know, an army padre, and he was terrific and very good for well-being and he would run interdenominational church services for people . . . I went to one of those once. (5.1:16)

I spent time alone reading and listening to music. I would think about the people I had seen during the day:

I'm the kind of person that needs a bit of downtime and a bit of space from people, so I need to download and just have my own time, particularly after having an intense day . . . you'd try and find a quiet spot in a corner of the mess tent and try to read or listen to music or whatever. (8.1:13)

[Death and dying] does have an effect on you, but there's nothing else you can do, you just get on with it. Look, I cried after [the death of a child], that was really an intense moment. . . . So for me, it's going back to my tent and just thinking about what I'm doing and letting it out. (8.1:17)

Early in the deployment, I was not having enough rest time. As the deployment progressed, I made sure I got enough rest and took the time to have breaks. I became very tired:

Because there were so many of us, we tried to be really good at not overworking people, so we organised shifts, we tried to make it fair in terms of people getting rest time. (8.1:7)

[Early in the deployment] we weren't having our breaks; and, you know, by the time it gets to the late afternoon you're hungry and you can't think and therefore you're getting a bit more on edge than what you normally would. So we worked out that, and they were very strict, I must say. Our commander was extremely strict on us eating [at regular intervals]. (6.2:5)

We all had little naps, not much, to cope with the tiredness. I think, you know, your adrenaline and excitement overrules it and every day is different. It wasn't until probably about, oh gosh, the third or fourth day of being there that we all started to get extremely tired. It was good because that's when we had a bit of shift work; so you were either on the morning or the late . . . you still had to get up for your morning frees, but you could still have a bit of downtime, just to, you know, read a book or relax for a bit before you went some days . . . it was too hot to sleep overnight, so everyone was extremely tired. (6.2:3)

Just so tired, really tired at times, just from the heat, I think, more than anything. (5.2:3)

Aside from spending time alone to reflect and rest, I found support from other contingent members and discussed my day, thoughts and feelings with them. Social activities provided a good opportunity for this discussion:

the communal camp where you could go occasionally and they'd have fun activities or you could have a lay down near the fan or whatever else on that day. (6.1:9)

Look, everyone used to just sit around and talk, or we'd play. There'd be a game, like we'd have football or touch football and they'd play a bit of cricket, or then we had a cooking competition to see who could cook the best thing out of rat[ion]-packs and they had trivia nights. So they'd have camp fun things that you could go and do if you wanted to and everyone tended to go and do them because there was nothing else to do. (6.1:16)

The group that we went with was extremely close and I think that we did a lot of debriefing chatting, general conversation among ourselves and I just think everyone got on well. (6.1:12)

Talking to different people, I found, was a coping mechanism. So you're working in the [temporary health facility] with the same people all day, or it's the same rough group of people. I found that come my own time, around teatime, I'd try and go and sit with someone else and eat. Or I'd introduce myself to someone a few tents up, or a group of people that were playing cards. They did the same; so I think just talking to different people. (6.2:6)

We did probably rely on each other a little bit [in the disaster when compared to the hospital environment] and talking through things with each other. (1.2:5)

You certainly build a strong rapport with, and attachment with, the team that you're with, and that builds very quickly, which is, I think, very important. You do learn to look out and become caring for the rest of your team. (4.2:6)

When I was having a meal, over breakfast, lunch or dinner, I would talk to other people about my day:

I must admit we had a lot of camaraderie-ship sort of thing, a lot of discussions and we did go out a lot and people were funny and we had breakfast and things like that together. (3.1:26)

It would be an informal sort of debrief over dinner. You know, we would catch up. There was a little smokers' corner. A lot of people started . . . smoking or even doubled it and so that was a real meeting place for the [support services personnel] and the medical crew. (5.1:16)

I congregated with people who had a similar sense of humour to me. We shared many laughs and it was sometimes very black humour:

Like, there was so much, so many laughs, particularly, I guess, when we weren't working. (5.2:5)

I do have a fairly humorous personality. A bit naughty. You know, a typical black-humoured ED nurse and I think that stability to be able to just work one hell of a shift and not get bogged down with crap and just keep going, you know. (5.1:19)

I really gravitated I think towards [a particular group of people] because we had the same sense of humour and . . . I made some really good friends. (8.1:13)

At the end of a shift, I would call home. I had access to a communal phone. However, I was restricted in the length of calls and I had to be careful about what I said:

They had four phones and you could go and ring your family whenever you wanted. There was a time limit of, I think it was five minutes per call and then you had to get off and let someone else have a go. You could go back and ring again later if you wanted to, so that was comforting to know. (6.1:11)

Very, very strict on what you could say, repeated . . . over and over again that if you say something inappropriate on the phone or anything that you're not meant to say, your phone will be cut off. (6.1:11)

We had to be strict on email [in terms of the written communication and sensitive nature of the deployment], which is fair enough. So basically, a lot of us didn't email, we spoke on the phone. (6.1:11)

The health service at home kept in touch with my family via phone and email:

We could call home whenever we wanted but our Head of Disaster Deployment in [the state] Health rang our families every second or third day to see how they were going. (4.1:14)

[A liaison for the health service] would send a sit-rep [situation report] every day back to [the health service], and people here in [disaster headquarters] would then send our families a bit of a summary email and even send photos to our family. So our families knew more of what was going on. (1.1:13)

They did ring up my family every day to tell them what was happening. . . . I knew that my family would feel fine about it and that was fine. (3.1:26)

Our family was contacted via email really regularly, to let them know what we were up to. (2.1:8)

The team . . . [were] fantastic at keeping my mum up to date with what was happening and what the challenges were and what we were up to, and she really appreciated that. (8.1:20)

When I was not working clinically, I kept myself very busy by assisting with other camp activities. I was always assisting with jobs to maintain the functioning of the camp. At times, this included building a water drainage system around the camp, cleaning tents and the communal areas, and gathering items for meals. There were no days off:

You may have to help build a water drainage system for the camp, which we did have to do, because the camp flooded and the tents were floating away. . . . In the middle of the night, we had to move a whole tent of patients into another tent. We had to help clean the tents every day. You know, there were jobs that needed to be done that surprised me that people weren't willing to do. (8.1:14)

You've got to keep yourself busy, so if you were on in the morning then you'd be home in the afternoon, or if you're on the afternoon shift you'd have the morning off. But by the time you washed your clothes and got yourself organised, it was pretty much time to go to work. (6.1:16)

You also had camp duty all the time, so there was [*sic*] a lot of extra things where you were collecting rations, cooking, cleaning. . . . There were always jobs. (5.1:9)

I did not have any days off work during the deployment. If I was not on shift working clinically, I was assisting in the activities to maintain the camp . . . there wasn't days off, you know. (5.1:17)

Camp life was busy. At times, it seemed busier working in the camp than working a clinical shift. Maybe this was because I was familiar with the work in the clinical environment or maybe because the clinical facilities were more comfortable in terms of the climate:

The camp life was very unnatural. It was very challenging to be suddenly embedded with [other services] in the middle of [a foreign country] in the middle of a [disaster] and with extreme climate around us. So that was where I think probably the emotional and physical challenges lay. (5.2:2)

Work was almost a reprieve [when compared to the camp life] because you were there for a purpose and . . . your hours would just fly [at work]. (5.2:2)

Doing lots of camp work . . . was hard. It was hot, hotter than the 35 degrees in the tent, and it was just not as relaxed, not as easy as it was working, you know? (5.2:2)

For longer deployments, I was given ration packs for some meals, which were the same packs as you would expect defence personnel to be consuming on their deployments:

The food itself was ration packs and for people like myself that had never lived on ration packs for large amount of time, took at least three to four days to be able to go all right, I'm absolutely starving, I have no choice, I have to eat it. (6.1:10)

I adjusted to a different diet when on deployment. The food was different to what I would normally eat at home:

Your diet's out of whack [and with that] comes all the other issues that you have until your body can get back into that whole role of things. (6.1:10)

I think the second week, people had learned that they needed to increase their fluid and they needed to eat and slow it down. (6.1:10)

I shared some of the food from my rations with other team members:

Well we'd share our food that we had, so when we ate we'd open up our packs and say, 'Well, do you want some?', and we had extra packs. (3.1:21)

Water suitable for consumption was scarce. I ran out of drinkable water at one point. I consumed large amounts of water:

That morning we had actually ran out of . . . water . . . so we hadn't had much to drink at all and we were just hanging [out] to get there so we could all have a drink of water. (6.1:9)

I counted the next day . . . I had [consumed] 17 litres [of water] that day. I couldn't keep up with the thirst or the sweat. (5.1:7)

Initially we had no showering facilities. Instead, I was given a small number of bottles of water and I used these to shower. As the deployment progressed, a showering area was established in a cordoned-off area of the camp:

not having any shower facilities at all; that was really hard going. But you were just grateful . . . I guess, you lowered your thresholds lots, and you were grateful to get the bottles of water to wash yourself. (5.2:2)

There were no showers initially to start with and . . . I think we were allocated four bottles of water and we were to shower in a little cordoned-off area with our four bottles and we shared that with four other women just on a rubber mat. (5.1:8)

When we got there, we had nothing, so we were using water bottles to birdbath. They had one big tent set up for females and one for males and to start off with, you'd just go in there and pour the water over [yourself] and have a bath that way. (6.1:10)

They set up these cardboard showers and we had these porta loos eventually . . . that was probably set up within a couple of weeks of me arriving. (8.1:13)

Initially there were no flushing toilets and I was using pit-drop toilets:

not even having a flushing toilet. Just trying to make sure that that was going to be safe for us; that we weren't going to get sick. (5.2:2)

Our toilets were drop toilets, so basically it was a tin. (6.1:10)

We started off with pit latrines . . . when you know you're only there for five weeks, you can pretty much do anything. (8.1:13)

The toilets needed emptying and cleaning a couple of times each day. At times, I was responsible for emptying the toilets:

We had to empty those toilets . . . for about the first three weeks, we were on 'shitter duty' and took on the pan room . . . of course it was the bloody nurses that ended up with [the job of emptying the toilets]. We did our 'shitter duty' every day, morning and night. There was a roster of shared duties. (5.1:9)

A couple of times a day there'd be certain groups, and everyone has to have a go, and everyone will do it over their time, and we had to empty [the toilets] into another big pit. (6.1:10)

5.6 Returning Home

At the end of the deployment, I did not want to leave because there was much more work to be done to assist the disaster-affected community. I was close to the other contingent members and did not want to leave them either:

But it was hard to leave, because we didn't want to leave, because we knew that they were nowhere close to being sorted, you know. (1.1:28)

bizarre actually leaving, because it had been such an overwhelming kind of experience and you'd suddenly got close to these people [in the contingent] that two weeks ago you'd never even met and it was kind of that camp thing where you feel like, 'Oh, I'm sad to go.' I'm sad to actually leave all these people, even though you were also looking forward to going home. (1.2:5)

then you up and leave and I think leaving is actually one of the hardest things to do; number one, because you're leaving people behind in a situation that's less than ideal. Often you've hardly even put a band-aid on the situation. (8.2:4)

I stepped off the aeroplane, walked down the air bridge and my feet touched the tarmac. I was home. I have never been so tired. I was so tired that it took a number of days to recuperate:

After five weeks of being in the field, you're emotionally exhausted, you're physically exhausted. (8.1:15)

I reckon it took me a week [to recuperate]. But even lying down in bed I'd feel nauseated, I'd have to sit up. (6.1:19)

I slept probably for two days straight. Once I got home, I think you just let that guard down. (5.1:17)

I've never been so tired in my life when we got home, because we had basically been on the go for five weeks day and night and there wasn't a lot of rest time . . . so I was really excited to get home . . . you've been away for so long, just needed to have a break. (6.2:7)

Colleagues, friends and family wanted to hear about my experience:

[They would say] . . . 'Tell us your experience, tell us, tell us, tell us.' . . . We did a bit of an in-service to the ED and showed them photos and they were just like, 'Wow'. So for a few weeks you get people going, 'Oh tell us more'. (6.1:21)

After a while, I needed some time alone:

for my adjustment, it took me probably a week. I found that I just needed to be by myself for a bit, I needed some 'me time'. (6.2:8)

When I returned to work in the hospital, patient and staff concerns relating to the Australian health system seemed insignificant. Patients presenting to the ED were complaining about extended waiting times for what seemed to be trivial ailments. Patients seemed to have a complete disregard for those affected by the disaster on the other side of the world:

Your everyday work suddenly seems so trivial and that's how I felt when I came back here. You'd hear people whinging [about waiting times and] about things and you'd just think, 'You've got no idea of what's going on over on the other side of the world'. Just the minutia that was suddenly so important to our colleagues, unless you'd been in [the disaster]. . . . You would just think, 'What are they talking about?' (5.1:17)

When you see people suffering so much and then you come back into an environment where you really physically can't see anyone suffering, it just takes a while to get your head back into this space. (8.1:19)

At times, there were too many people around me:

I felt, like, overwhelmed if there was 10 or more people around me. Everyone wanted to hear your story, [and] you wanted to tell everyone your story as well, but you know you just needed that bit of down time. (6.2:8)

Driving your car down the road, it's really hard to make people understand how opulent that feels and how, I don't know, but when you've been walking everywhere [in the disaster] and you haven't seen a car. (8.1:19)

I walked into the supermarket and there was a large variety of food on the shelves. The options were extensive:

the variety in the supermarket. You've gone from having no access to food or variety to every choice under the sun and it's overwhelming for you. (8.1:19)

I know probably for the first week I felt very overwhelmed going into supermarkets and things. Just seeing the plethora of stuff and people and noise and it was all really different. Life felt very simple and easy back there and suddenly we were just so spoilt

for food and choice and commercialism. It really helped put things into perspective and that's why I said it was life altering. (5.1:17)

You really need down time to, number one, process what you've done; number two, to get used to being back home. You know, simple things like driving your car down the road and going to the local supermarket are a challenge and, you know, the first time you experience having difficulty with those things. (8.1:18)

I now think back to my time in the disaster and ask myself a number of questions: 'Should I still be there helping?' 'Did I do all that I could have done?' 'Did I really make a difference?':

Have we made a difference, did we do all we could do, should we still be here doing it? So you're sort of leaving that behind as well. (1.2:5)

I look back and say, 'Maybe I should have done this a bit better', or 'I should have made sure that I checked that'. You know, the things that you can in hindsight? Yeah, you think about it. (3.2:2)

I implicitly knew that what I was doing was invaluable and making a difference to the disaster-affected community. I know that there was never a day where I did not try my best. Surrounding me there was such a large need for assistance; however, the best I could do was to help one person at a time:

a lot of apprehension with what we did. [Was] this the best way that our time could be utilised while we were there? And after we very quickly came to assess what was going on with all the workers as well as other people in the area, and assessing in our debriefing what we were doing after one or two days, we knew that it was invaluable what we were doing. (4.2:4)

But the whole thing was enjoyable. Like, the work was very gratifying; you felt like you were making a huge difference to an area that was . . . just hit so hard. It was life-threatening illnesses that were suddenly being treated—malaria I'm predominantly thinking about—and you knew that suddenly, without their medication, they would be just dying. (5.2:5)

Making a difference each day or feeling like you made a difference each day, I think was what got you through. . . . I'm sure out of all those people you see, there is definitely a person that you have made a big difference to. We felt that we made a difference by treating, just by talking. (6.2:2)

There was never a day where I went, 'We didn't try our best'. (8.1:11)

I learned in [this deployment] that it had to be enough just helping one person at a time, it had to be enough. You know, I couldn't help everyone. (8.2:6)

Now I am home, I think about particular patients and their situations, their family and their community. There are stories that I heard and situations that I have seen that will stay with me:

Then you'd have other, you know, people come in that had sad stories. So you'd go home thinking about these poor kids, or this little girl that had been knocked off a motorbike and had horrendous injuries. You know, how she would cope with those open wounds and infection and whether she would survive; or what would happen to her. (6.2:2)

There are certain stories that stay with you, and things that you see stay with you. . . . I said about the mother who said, 'Why did I let go of my six-month-old?' and I think, 'Well I've got three children and what if I let go of one of mine?' I've seen containers with 250 bodies in the hot sun, the smell. (3.2:2)

When comparing my situation to those left behind in the disaster, I had many things; they had nothing:

You've developed quite close relationships with the people that you're working with . . . you're living and breathing each other; you're treating people; you're experiencing peoples' circumstances. It's really hard to just lay all that down in a split second and go back to your nice life where you have a roof over your head, you have a car, you have a supermarket down the road, you have a job that pays really well, you have job security, you have family that are alive and well; you have things that these people just don't have. (8.2:5)

The feeling I had when I got home—but it wasn't only when I got home, it was when we were up there, and going out into the Valley and that and seeing the devastation and driving down the streets seeing all these shells of houses, nobody living in them, people living in tents in the shell of their house and things like that, and we would go back to the motel and have a meal . . . and then when you come home you think and ponder about all that. Here you are at home and you've got all this and those people up there are still experiencing the devastation and the loss. (4.1:15)

The opportunity to debrief when I returned home varied. At times, this was very operationally focused:

We got this presentation, what went well, what didn't happen, the improvement, talked all about the cache, the team, what some of the issues were. (3.1:27)

never a lot where they said, 'Well, why don't we sit down and have a long discussion about your mental health well-being?', you know. And for me, I mean I think about [the disaster] . . . I never got [a debrief]. (3.1:26)

A discussion about my well-being occurred months after returning home:

We came back to [our home state]—it was supposed to be organised to go to the [disaster coordination centre] for a debrief there and with the other team. That didn't happen until several months after. (4.1:15)

On another occasion, I had one-on-one sessions with a psychologist soon after arriving home.

This was followed up by more sessions over the next six months:

I think it was probably about two weeks after we were back . . . we had one-on-one sessions here with a psychologist as well. Then I think we had one at six months if I remember as well, just touching base again. (5.1:17)

one-on-one briefings about how we felt with the psychologist that they had there and he would come and touch base or he would look around and kind of get a feel for it and, you know, how you're going. (6.1:12)

We had a hot debrief where, before we were released to our families, we went back to headquarters in [the disaster centre] and they had a structured debrief for us where we all went around, everyone got a say, to give feedback; everyone could voice concerns, everyone could talk about the positives . . . make contact with you a week, a couple of weeks, and if necessary, they'll keep being in contact with you as you readjust post-deployment . . . I felt personally I was well equipped, and everything that happened was within my comfort zone. When they rang me and asked me, I told them that and I said, 'Look, I don't know if it's because of my professional background, but everything that happened, I took in my stride and there's been no negative consequences; in fact I felt quite comfortable while I was there'. (7.1:20)

I received a welcome and recognition from my family and friends when I arrived in the airport terminal. They were all clapping and cheering:

[When] we got off the plane they took us into a special room with all our family and everyone was cheering and clapping. (3.2:2)

A number of months after returning home from assisting in the disaster, I received further recognition in the form of awards and medals. This included an Australia Day award from the local health service and a humanitarian medal or something. I was just doing my job. I did not know why the spotlight was on me:

We've received Australia Day awards here at the hospital and we've been nominated for a humanitarian award. (2.2:7)

We got the Humanitarian Overseas Assistance Medal, or something. (1.1:28)

A year later [after my deployment], I actually received a citation and I accepted it and said, 'Thank you', because you have to do that when you're part of an organisation. . . . As an individual, I thought, 'I was only doing my job and it was the least I could do' . . . I didn't have it that bad [in the disaster] . . . [you] feel guilty being acknowledged when you didn't have it that bad. (7.1:17)

I learned a lot from being in the disaster. However, I realised that I still had such a knowledge deficit in the area of disaster health. I wanted to learn more, so I have started to do more courses and training to assist specifically with a deployment if I am called to assist in a disaster again:

It was really interesting; everyone was trying to do more courses. They suddenly realised what their deficits were and so I've started doing more courses and other people said, 'Look, I'm doing that course now'. (3.2:7)

[Returning home from the disaster, I thought] I need to know more about all of this. . . . [I went and did] AusMAT courses. (6.1:17)

There's more training now than there's ever been, but certainly not when I started. So from my perspective, it's been learning by doing and learning how to do it well and how not to do it, but it's a bit of trial and error. (8.1:17)

I don't really know that I have done much by way of disaster training at all before that . . . certainly no real disaster training. I've certainly done a lot more since. (1.1:20)

I think there's a lot of room even just for the awareness about what to expect when you're going somewhere different, if that makes sense. Our nurses are going to another hospital. It's not in a disaster scenario, but that's what we're preparing them for . . . it's a general awareness [of a disaster and the nurse's role that is needed]. (1.1:25)

Education is fantastic and I think that you can probably never do too many courses to get you prepared for disaster response. . . . I'm sure that education clearly does prepare you for certain things, but I don't know that it ever completely prepares you. (2.2:4)

5.7 Summary

This chapter has provided an exploration of uncovered moments of a disaster as identified in this study. The voices of participants have been quoted in this chapter as exemplars of parts of the uncovered moments. Summary anecdotes of the participant narrative have been presented from a phenomenological *I* perspective. The uncovered moments can be displayed diagrammatically, as outlined in Figure 5.1. The next chapter overlays these summary anecdotes as a lived-experience description of what it may be like *being* an Australian hospital civilian nurse in the out-of-hospital environment following a disaster.

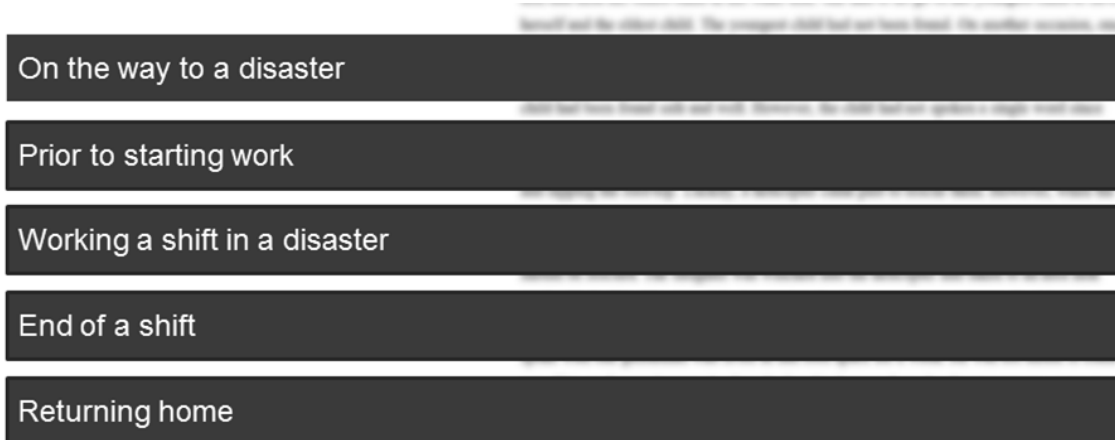


Figure 5.1. Diagrammatic representation of moments.

Chapter 6: Lived-experience Description

6.1 Introduction

This chapter provides a consolidation of the summary anecdotes from the previous chapter in the form of a lived-experience description. The lived-experience description below is an anecdote of what it may be like *being* an Australian civilian hospital nurses in the out-of-hospital disaster environment following a disaster as part of a disaster medical assistance team.

6.2 On the Way to a Disaster

I saw the devastation of the disaster on social media and on the television. I got a lot of awareness about the unfolding disaster situation from the media. Soon after becoming aware of the disaster, I received a text message to my mobile telephone notifying me that a disaster response was required. The text message came from my local health service. The text message requested a reply ascertaining whether I would be able to assist in the disaster. Soon after receiving the text message, I received a phone call. The health service wanted to know if I could assist in the disaster and if I could 'be on standby'. I was willing to assist in the disaster, as I knew I had the skills to help. I had completed a number of disaster-related courses previously. My training has included nationally recognised courses. My local health service has provided me with some disaster-specific training. Before agreeing to assist in the disaster, I made sure my family was content with me being away from home.

Once I agreed to assist, I waited to find out what day and time I might be required to deploy. I was told that I would be advised by the health service when I needed to go, and I needed to be ready to leave at short notice. I was excited to be going. However, I recognised that I was going to a disaster where many people have lost their lives, suffered.

I was waiting for confirmation of my expected departure date, time and initial meeting location. During this time, I commenced packing the items I was planning on taking to the disaster. I packed my uniforms and two sets of clothes. These clothes were neutral, non-offensive clothing, with no logos or words on them. As I was conscious that I needed to stay well, so that I could care for other people, I packed sturdy boots and purchased insect repellent prior to departing. I packed some items that would provide comfort while I slept. This included a sleeping bag and a bedroll. I packed this all into a small bag. I did not pack any medical or health supplies for patients. These supplies were being forwarded to the disaster area by the health service.

In preparing to go to the disaster, I started to read about the country, the climate, culture, religion, poverty levels and the existing health infrastructure. I tried to get a general overview of the country's socio-economic-health status prior to the disaster occurring.

I was now packed and ready to be deployed. I received a phone call to go to the central congregation point. I was about to go, then I received a phone call and was told, 'Don't go yet, it might be another seven hours before you go'. Approximately seven hours had passed when I received another phone call stating, 'It may be another couple of hours before you go'. It was now late in the night. I received another phone call to say, 'You will not be going until the early morning'. During the night, I got a phone call to meet at the central congregation point, with a very tight time frame.

I met other team members at a central congregation point near the health service disaster coordinator centre. At this location, I was provided with a detailed brief of the disaster by one of the health service leaders. The brief went on for a number of hours. The brief covered aspects of the area affected by the disaster. The briefing extended to include awareness of

potential security concerns. During the briefing, I was instructed to decrease the amount of luggage I was taking with me. During the briefing, a number of rules were outlined that we needed to abide by. These included rules relating to where we could eat and abstinence from the consumption of alcohol.

Following the briefing, I had an opportunity to meet members of the disaster medical assistance team who would be deployed with me. The contingent had nurses from a number of different clinical backgrounds. This included emergency and intensive care nurses. Within the contingent, there were varying disciplines. In addition to nursing, the disciplines included medicine, paramedicine, social work, government disaster relief planning, environmental health and allied health. The contingent consisted of people from nearly all states and territories in Australia. When I met the contingent for the first time, I recognised a number of people that I had previously worked with. While some people in the contingent were familiar to me, some people were not, so I tried to get to know these members.

I asked others who had been to a previous disaster, 'What did you take?' Regardless of what profession or what role in the team, we all talked to each other as if we were equal. Many of the people in the team had been to previous disasters. I asked questions such as, 'What do you think it will be like? What do you think we will see?' I was asking myself questions such as, 'I wonder what it will be like?'

While I was waiting to depart for the disaster-affected area, the plans about transport kept on changing. I was going to fly on either an Air Force or a commercial flight. I ended up flying on an Air Force aircraft. It was a C-130J Hercules. This was unlike a commercial aircraft I had been on for holidays or business trips. There was less legroom, a small number of

comfortable seats and it was noisy. I tried to entertain myself on the aeroplane, mainly by talking to others or trying to sleep.

6.3 Prior to Starting Work

The aeroplane landed. I walked with the contingent off the plane and into the airport terminal. I collected my baggage. I then congregated with the contingent to wait for the local officials to meet us. I saw many people sleeping in the terminal. I continued to wait. There was no one to meet us. Eventually, our contingent was met by local government officials.

The officials drove us from the airport, through the disaster-affected community, to our accommodation and health precinct. On the way, the driver pointed out the structures and roads that had existed prior to the disaster and we discussed the general impact of the disaster in the area. I could see the impact of the disaster, including the destruction of roads, destruction of homes and evidence of an elevated water line, such as boats being up in trees.

When I arrived in the disaster-affected community, what I had seen in the media and on the television was different to what was actually occurring in the communities. At points, parts of the region seemed unaffected and they were functioning as normal. At other places, the impact on the regions was devastating.

I arrived at my place of accommodation. I took it for granted that I would have accommodation and that this would have been prearranged for me. I was told where I would be sleeping. I was sharing a tent with a number of other health professionals from within my contingent. A camp stretcher was my bed.

There was a period during which it seemed that there was no specific plan for me and I was unsure of what I was going to be doing. During this period of waiting for a specific plan, I

saw members of the community digging mud and cleaning streets. I was doing nothing for the community. Eventually, I was tasked to work in the local hospital, supporting the local nursing staff. I was going to work in areas such as in the ED, on the trauma ward and in the mental health ward. However, this plan to work in the hospital did not eventuate. Again, I had no plan. Soon after, I was directed to return to the main camp and health precinct, where I would provide a health service from our temporary health facility.

The temporary health service was established on a local sports field. The majority of the infrastructure for the camp and health facility was established by the ambulance service and defence force. I assisted in the establishment of some of the infrastructure. Additionally, I assisted with some of the logistics in establishing the camp. The final temporary health facility was a combination of a number of individual tents, which together provided a space to provide a variety of health services.

6.4 Working a Shift in a Disaster

Once we had established our health facility, we opened it for assessment and management of patients. People found out about our services by word of mouth. Some people travelled for many hours to receive care. On some occasions people walked for days to access our service. During the early stages of our establishment, I remember people lining up to access the health services we were providing.

At times, we were busy and overwhelmed by the number of presenting patients. Initially, patients were pushing each other out of the way to access our service. Soon after witnessing this, I assisted in establishing a triage system at the entrance to our facility. We had a triage system to ensure there was an appropriate order and priority of patients being seen. I worked in the triage area of our health service.

I approached each patient in a systematic way, applying what I would do in my usual practice as a nurse to individual patients in the disaster context. With minimal equipment, my clinical activities relied on an assessment using my hands and my stethoscope. I was very 'hands on'. There were no x-ray facilities, pathology for blood tests or electrocardiography machines. I was looking at my patient without the technology. At times, I was relying on my knowing how to recognise the sick patient from non-sick patient.

The care that I provided to patients was nurse-led. I initially met the patient, undertook assessment and discharged patients. For unfamiliar areas of practice, such as managing patients with tropical diseases, my decision making was made against clinical guidelines from the WHO. On occasions, when patients were unwell I would meet the patient, undertake an assessment and refer them to someone in the medical team. I would sometimes discharge people from our service to nowhere. Some patients had no home left, no food, no water and had no family. Their family was killed in the disaster.

The patient population that I saw varied in age. Many unwell children presented for assessment and management. Additionally, there were many elderly patients. In addition to caring for people within the general population that was affected by the disaster, I spent my time caring for other health care relief workers. I also cared for other non-health professional relief workers that were assisting in the aftermath of the disaster.

I saw people present with disaster-related injuries. These were mostly minor injuries such as cuts, abrasions and bruises. However, they did not have the basic items, such as clean water, to care for themselves. Aside from minor injuries, some patients presented with wounds that required surgical debridement. I saw patients who had delayed seeking assessment and management of their injury because they were too busy after the disaster finding shelter, food

and water. I saw many patients who had injured themselves secondary to the disaster. This was primarily during the clean-up activities following the disaster, such as broken limbs from falling off walls and burns, cuts and abrasions from people attempting to repair their own homes. Many people presented with non-disaster-related injuries. I remember one boy who presented with a pre-existing injury to his leg. His leg was swollen and pustulating. He could not explain what had happened and I could not understand him because of my inability to communicate in his language. I was unsure whether this injury had occurred in the disaster. It turned out that the local hospital knew him and it was a pre-existing condition.

I saw people with pre-existing illnesses. I remember one man who presented with a carcinoma of his trachea. He wanted a surgeon to operate to alleviate the pressure from his trachea.

Patients presenting with acute illness was a mainstay of my daily work. I saw lots of patients with acute gastroenteritis illnesses. I saw patients present with varying respiratory illnesses, such as chest infections, asthma and pneumonia exacerbated by saltwater inhalation or smoke inhalation. I had patients present with varying tropical diseases and heat-related illnesses.

I saw many patients with chronic health diseases, such as diabetes, hypertension and renal failure. A part of the reason many people presented with an exacerbation of their chronic illness was related to their inability to access their normal means of self-managing their illness. The local pharmacies and general practitioners were closed longer than anticipated. So people could not access their prescription medications via their normal means. I saw patients who did not have their medication and could not remember the name of it. They could only provide small amounts of information about their medication, such as 'it is a small round blue tablet'. People presented and did not have a large enough supply of medication to last them for the duration of the disaster. People said, 'I thought I was only going to be displaced for a couple of days'. I spent a lot of my time trying to find medications for people:

I saw women who were pregnant and wanting maternal health checks.

I saw death and people dying. This was different to what I see in an Australian hospital. I remember seeing people whom we could not help. We had intubating equipment, but no ventilators. I saw multiple children die. In the Australian hospital, this was not common for me. I remember one seven-year-old girl who was bleeding from everywhere. The cause was unknown. We tried absolutely everything to save her. She died. I cannot get her picture out of my head. I sent people either back to their homes, if their homes were not affected by the disaster, or to hospital. Either way, these people would die. I remember sending a couple to die at home.

When I saw people in the disaster-affected area, I didn't know if the person's home was destroyed, if they had lost loved ones or if they were directly affected by the disaster in some other way. I would often just say, 'Hello' or 'How are you going'? Commonly, people would then start to talk about their disaster experience. Most patients who presented for care of their physical injuries and illness displayed some level of psychosocial need. In comparison to what I would see in an Australian hospital, there was much more psychosocial need in the disaster environment. It was needed for every person. Sometimes this need was obvious, as people were obviously angry or physically sick. I remember one lady that would vomit every time there was an aftershock. I identified people who were not coping with the stress after the disaster. I referred them to additional help when it was available. Sometimes I did not need to refer patients to other services. I did not have a concern that they were at risk of self-harm; they just wanted to talk to someone. People just wanted to discuss their experience. People wanted to share their stories with me because I was not personally involved in the disaster.

I heard stories from people who had lost their children. One woman recounted her disaster experience, which involved her two young children. The disaster had been imminent and she was holding her two children, one in each arm. As the disaster struck, she needed to hold onto a tree so all three of them would not be swept away. She held onto the tree with one arm and held her oldest child in her other arm. She had to let go of her youngest child to save herself and the oldest child. The youngest child had not been found. On another occasion, one mother and father were discussing their five-year-old child with me. Their child was swept away in the water during the disaster and was missing. After a number of hours, the child had been found safe and well. However, the child had not spoken a single word since the disaster.

One middle-aged woman recounted her experience of being on the roof of her house with her two elderly parents. The floodwaters were rising and lapping the roofline. Luckily, a helicopter came past to rescue them. However, when the crew were winched down to the roof, they informed the family of three that there was only enough space in the helicopter for one person. The elderly parents decided that the daughter should be rescued. The daughter was winched into the helicopter and taken to an area near our health facility. She had the impression that her parents were going to die.

I heard many stories from the elderly relating to how they coped in the disaster and what they had lost. I spoke with one man who had lived in this roof space for a week. He was too afraid to come out of his roof space because he thought that the damage from the disaster was too extensive. He was waiting for people to find him. Another elderly couple were staying in their home with no electricity or water, cooking on a fire in their backyard and using a hole in their backyard as their toilet. When he came to us, the man was very unwell, with an exacerbation of his chronic respiratory disease. Another elderly man recalled a story of how he became separated from his family in the disaster. When a bus arrived to assist in the evacuation of

people from the disaster area, he was told to get on the bus and he lost contact with his entire family. He later learned that he had lost all of his possessions in the disaster, his wife had died and other members of his family were missing.

I was listening to the stories of people who had been in the disaster and I was trying to support these people to the best of my ability. In the Australian hospital environment, I would have many other nurses to share this emotional load. Additionally, I would be able to refer patients to other support services and mental health teams. This is not the case in the disaster environment.

I spent a lot of my time providing health education to people who presented for care. I provided education to patients regarding coping strategies and the normal grief process. I provided education about general hygiene, such as how to wash your hands and how to handle food. I also provided education regarding wound care. Education was provided regarding vaccinations.

Early in the deployment, I did not have all the resources I needed, such as forms for documenting patient progress and the equipment and health resources that I used were of a basic standard and in short supply. I had only one oxygen concentrator. I remember one time when three patients required oxygen. The three patients were equally unwell. I ended up sharing the oxygen between the three patients, giving each of them small amounts at any one time. During the deployment I ran out of a number of clinical items, such as IV giving sets.

Each day I would look at what clinical equipment we had used and what was remaining. I would compare this to what injuries and illnesses we had been seeing and make a judgement about the required resources for the following day. I would then organise to get equipment from somewhere if possible. On some occasions, I got equipment from the local hospital. On

another occasion, I would visit the local medical supplies depot, which was a big warehouse, to obtain some supplies. The equipment I used was sometimes unfamiliar to me.

I was very busy. As a team we were seeing hundreds of people each day. I worked every day of the deployment. The hours that I worked each day varied. Initially I was working long hours, many more than I would work in the hospital. As the deployment progressed, the hours I worked each day reduced. Eventually, the clinical shift became very slow and not busy at all.

As our clinical activities slowed in our health facility, I participated in a health outreach service that patrolled the nearby community, identifying people who required health assistance. I would provide care to these patients in the community or refer them to our health service or local hospital, as the normal health clinics were not open to receive patients. However, patrolling the area and providing a health outreach service were not required for very long. During the immediate aftermath of the disaster, normal health clinics were not open to receive patients. Local health care professionals from the closed health clinics assisted us throughout the deployment. I remember working with a local community health nurses, a maternal child health nurse and some local general practitioners. These health professionals had knowledge of the area and links to community health services. As local health services recommenced their normal functioning, I increased the referral of patients to various services. There was a list that was updated each day, outlining the local services that were becoming operational. As the local health services were re-established, we started to hand over our services to the local health care professionals, as a strategy to withdraw our services from the region.

6.5 End of a Shift

Once a day I participated in an operational debriefing. During the debriefing, I sometimes shared stories from my day with the other contingent members and other team members shared their stories. The focus was on what went well and what could be done differently the next day. We were again made aware of any security concerns for the team. This particularly related to violence that was occurring in the disaster-affected community.

Emotional support for me in the disaster environment took on many forms. I found support in both individual and group contexts. There was a psychologist and padre that I could easily access if I wanted to talk to someone outside the health team. I spent time alone reading and listening to music. I would think about the people I had seen during the day. Early in the deployment, I was not having enough rest time. As the deployment progressed, I made sure I got enough rest and took the time to have breaks. I became very tired. Aside from spending time alone to reflect and rest, I found support from other contingent members and discussed my day, thoughts and feelings with them. Social activities provided a good opportunity for this discussion. When I was having a meal, over breakfast, lunch or dinner, I would talk to other people about my day. I congregated with people who had a similar sense of humour to me. We shared many laughs and it was sometimes very black humour.

At the end of a shift, I would call home. I had access to a communal phone. However, I was restricted in the length of calls and I had to be careful about what I said. The health service at home kept in touch with my family via phone and email.

When I was not working clinically, I kept myself very busy by assisting with other camp activities. I was always assisting with jobs to maintain the functioning of the camp. At times, this included building a water drainage system around the camp, cleaning tents and the

communal areas, and gathering items for meals. There were no days off. Camp life was busy. At times, it seemed busier working in the camp than working a clinical shift. Maybe this was because I was familiar with the work in the clinical environment or maybe because the clinical facilities were more comfortable in terms of the climate.

For longer deployments, I was given ration packs for some meals, which were the same packs as you would expect defence personnel to be consuming on their deployments. I adjusted to a different diet when on deployment. The food was different to what I would normally eat at home. I shared some of the food from my rations with other team members. Water suitable for consumption was scarce. I ran out of drinkable water at one point. I consumed large amounts of water.

Initially we had no showering facilities. Instead, I was given a small number of bottles of water and I used these to shower. As the deployment progressed, a showering area was established in a cordoned-off area of the camp. Initially, there were no flushing toilets and I was using pit-drop toilets. The toilets needed emptying and cleaning a couple of times each day. At times, I was responsible for emptying the toilets.

6.6 Returning Home

At the end of the deployment, I did not want to leave because there was much more work to be done to assist the disaster-affected community. I was close to the other contingent members and did not want to leave them either.

I stepped off the aeroplane, walked down the air bridge and my feet touched the tarmac. I was home. I have never been so tired. I was so tired that it took a number of days to recuperate. Colleagues, friends and family wanted to hear about my experience. After a while, I needed some time alone. When I returned to work in the hospital, patient and staff concerns relating

to the Australian health system seemed insignificant. Patients presenting to the ED were complaining about extended waiting times for what seemed to be trivial ailments. Patients seemed to have a complete disregard for those affected by the disaster on the other side of the world. At times, there were too many people around me. I walked into the supermarket and there was a large variety of food on the shelves. The options were extensive.

I now think back to my time in the disaster and ask myself a number of questions: 'Should I still be there helping?' 'Did I do all that I could have done?' 'Did I really make a difference?' I implicitly knew that what I was doing was invaluable and making a difference to the disaster-affected community. I know that there was never a day where I did not try my best. Surrounding me there was such a large need for assistance; however, the best I could do was to help one person at a time. Now I am home, I think about particular patients and their situations, their family and their community. There are stories that I heard and situations that I have seen that will stay with me. When comparing my situation to those left behind in the disaster, I had many things; they had nothing.

The opportunity to debrief when I returned home varied. At times, this was very operationally focused. A discussion about my well-being occurred months after returning home. On another occasion, I had one-on-one sessions with a psychologist soon after arriving home. This was followed up by more sessions over the next six months.

I received a welcome and recognition from my family and friends when I arrived in the airport terminal. They were all clapping and cheering. A number of months after returning home from assisting in the disaster, I received further recognition in the form of awards and medals. This included an Australia Day award from the local health service and a

humanitarian medal or something. I was just doing my job. I did not know why the spotlight was on me.

I learned a lot from being in the disaster. However, I realised that I still had such a knowledge deficit in the area of disaster health. I wanted to learn more, so I have started to do more courses and training to assist specifically with a deployment if I am called to assist in a disaster again.

6.7 Summary

This chapter has consolidated the summary anecdotes from the previous chapter of uncovered moments. This consolidation of anecdotes is presented as a lived-experience description of what it may be like *being* an Australian hospital civilian nurse in the out-of-hospital environment following a disaster. Phenomenologically, this lived-experience anecdote is descriptive in nature. The lived experience description can be displayed diagrammatically, as outlined in Figure 6.1. The following four chapters provide an existential overlay of lived-space, lived-body, lived-relationships and lived-time against the uncovered moments presented in this lived-experience description.

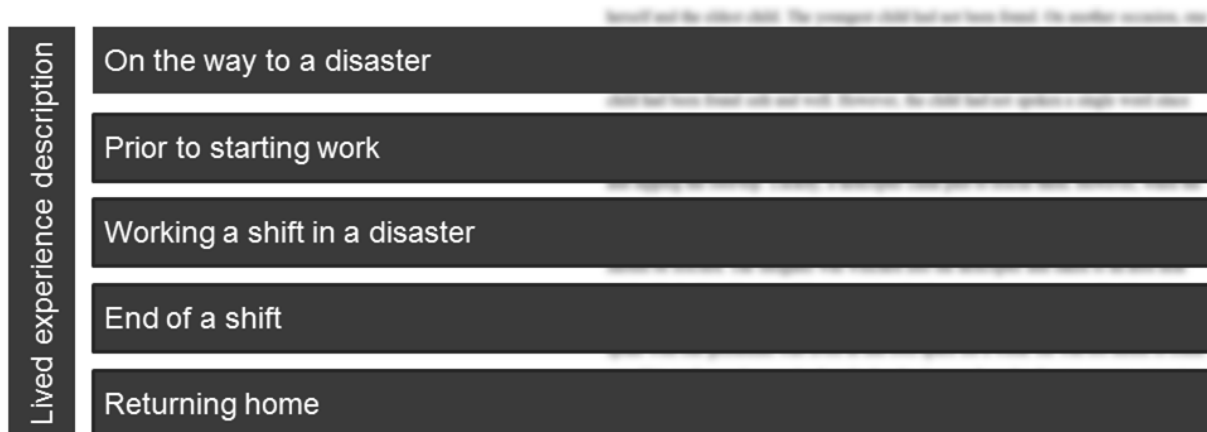


Figure 6.1. Diagrammatic representation of the lived experience description

Chapter 7: A Spatial Reflection on a Lived-experience Description of *Being* a Nurse Following a Disaster

7.1 Introduction

In the minutes following a disaster, reports from the media commonly focus on the impact of the disaster on an affected population. In particular, the focus is on the numerical and measurable impact; for example, the magnitude of an earthquake, the number of hectares burnt by a bushfire, the number of homes destroyed in a cyclone or the number of lives lost in a tsunami. A recent example of the numerical focus from the media relating to Cyclone Winston²⁸ is shown in Figure 7.1.

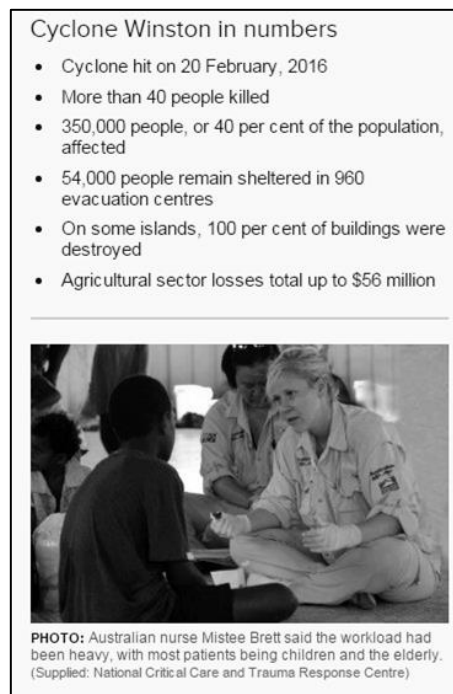


Figure 7.1. Media report focusing on numerical aspects of a disaster.

(Image from Zillman, 2016, Australian Broadcasting Corporation (ABC) News Online)

²⁸ Cyclone in Fiji, 20 February 2016.

The numerical and measurable information may be useful in providing situational awareness of the extent of a disaster. In particular, this may be true when considering a health response to a disaster, the possible health impact and implications for the population affected by the disaster. However, these numerical measures do not provide insight into the spatiality of a disaster. Spatiality goes behind the physical, visible and touchable spaces. Spatial reflection is concerned with felt space; that is, the way in which we find ourselves in the lived-world through the spaces of our day-to-day *dasein* (van Manen, 1990). The lived-space resulting from a disaster is experienced differently by different populations. For example, those who normally live in an area now affected by the disaster experience spatiality differently from those who are visiting the area, or from those who arrive to assist as part of a disaster medical assistance team, having never been in the area before.

Being a nurse in an out-of-hospital environment following a disaster is not a normal day-to-day experience for most hospital nurses. The focus of this reflection is on *being* a civilian hospital nurse in an out-of-hospital environment following a disaster from a spatial, or lived-space, perspective. A preparatory epoché-reduction and reduction proper was used to guide this reflection on the spatiality of *being* a nurse in an out-of-hospital environment following a disaster, from the previously presented lived-experience description.

7.2 Lived-space as *Shrinking Then Opening Too-wide*

The lived-space of a nurse is mostly constant, uniformed and somewhat predictable. This is a nurses' normal state of *being* in a taken-for-granted lived-space. However, as news breaks relating to a disaster, a nurse may become interested in the evolving disaster situation. A nurse may be more attentive than normal to sources of information pertaining to the disaster, such as social media and news on the television:

I saw the devastation of the disaster on social media and on the television. I got a lot of awareness about the unfolding disaster situation from the media.

Attentiveness towards the disaster may be useful for a nurse who wishes to gain insight into the health needs of the disaster-affected community. A nurse may be attentive if they have been involved in previous disaster assistance efforts. A nurse may have lived or visited the disaster-affected region. A nurse may be a member of a disaster medical assistance team and knows that there is a possibility of being called to respond to the disaster that is reported in the media. This attentiveness to the unfolding disaster situation starts to orientate a nurse to *being* in the disaster.

7.2.1 Intentionality, drawing-in and shrinking.

Being attentive to the disaster may start to consume the lived-space of a nurse. This is different to being attentive for holiday planning, as the preparation for a holiday may be dispersed over a comparatively longer period. Upon committing to assist in the disaster, for a nurse, the disaster becomes more at the fore. As the intentionality and subsequent activities of a nurse become nearer to the disaster, a nurse's lived-space starts to collapse, constrict and shrink.

As a nurse prepares to deploy to the disaster-affected area, their activities and commitments that are not related to preparing to be in the disaster become a background to the nurse's life-world. These previous commitments still matter, but they do not seem to matter as they had done previously. The nurse does not forget about their 'normal' lived-space, but it is now in the background.

A nurse may seek opportunities to understand better what it may be like to be in the disaster-affected area. This may include reading, listening to others and conversing with others. For

example, a nurse may read about the existing socio-economic and health status of the disaster-affected area:

In preparing to go to the disaster, I started to read about the country, the climate, culture, religion, poverty levels and the existing health infrastructure. I tried to get a general overview of the country's socio-economic-health status prior to the disaster occurring.

Being around others that are focused on being in the disaster-affected area reinforces the focus on the disaster lived-space. As a foreign experience, a nurse may seek glimpses into the disaster lived-space through the experience of others:

I asked others who had been to a previous disaster, 'What did you take?' . . . 'What do you think it will be like?', 'What do you think we will see?'

Reading about the socio-economic health status of the disaster-affected area and talking with others who will be assisting in the disaster allow insights into the possible lived-space of the disaster. In these instances, a nurse is initiating these activities and seeking information actively for the sake of having a better understanding of what it may be like to be a nurse in the disaster.

While activities such as reading and conversing with others require a nurse to initiate them, other activities, such as attending briefings, provide a further preview into the likely lived-space of the disaster and further orientate a nurse to the disaster. Therefore, these activities result in a further drawing-in of a nurse to *being* in the disaster and result in the shrinking lived-space.

7.2.2 Drawn in, looking out.

A few days earlier, a nurse would not have been expecting to be travelling on an aircraft to a disaster-affected area. Then a nurse finds themselves confined to a noisy aircraft with

personnel and equipment travelling to assist following the disaster. The world of the nurse has become very small, the size of an aircraft, with people and equipment on board for the purpose of assisting in the disaster. This is very different to an aircraft that may be used to transport holidaymakers, business people or people travelling home. The physical space, the activities within it and the purpose of the aircraft draws in a nurse to the lived-space of the disaster.

A nurse would normally commute to work in a car, on a motorbike or via public transport. These transport options allow choice regarding when to leave home and the route to take. However, because of the disaster, the nurse is flying to work on a chartered flight, with no input into their itinerary or route. Once at work, the nurse does not need to travel again until they fly back to their home:

I ended up flying on an Air Force aircraft. It was a C-130J Hercules. This was unlike a commercial aircraft I had been on for holidays or business trips. There was less legroom, a small number of comfortable seats and it was noisy.

Prior to the disaster, a sports field or oval, as a physical space, would have been used for the purpose of recreation and sporting activities. However, following the disaster, this physical space may be reconstructed into a temporary community with numerous tents of varying sizes and purposes, such as housing medical equipment and personnel to provide a health service, and for providing living quarters for recreation, rejuvenation and rest for nurses and other staff:

The temporary health service was established on a local sports field. . . . The final temporary health facility was a combination of a number of individual tents, which together provided a space to provide a variety of health services.

In the disaster-affected area, a nurse's physical space shrinks to the nurse's place of work and place of residence. Both of these may be a tent. In contrast to their normal home, a nurse is told where to sleep and who will share this physical space:

I arrived at my place of accommodation. I took it for granted that I would have accommodation and that this would have been prearranged for me. I was told where I would be sleeping. I was sharing a tent with a number of other health professionals from within my contingent. A camp stretcher was my bed.

Because of the physically encapsulated nature of the disaster workplace and residence, the disaster itself and the tasks-at-hand resulting from the disaster become a nurses' new lived-space. The nurses' lived-space has shrunk to the immediate physical space in which they find themselves in the disaster, regardless of whether this physical space is the size of a sports oval, a neighbourhood or a city.

This condensed lived-space keeps a nurse orientated to *being* in the disaster and the nurse has been drawn in to the lived-space of *being* in the disaster. The nurse does not forget about the lived-space outside of *being* in the disaster, but the lived-space beyond the disaster is distant.

Before arriving in the disaster-affected area, the nurse was seeking glimpses into the lived-space of the disaster. Now in the disaster-affected area, the nurse is seeking glimpses out of the disaster lived-space. These glimpses into the wider worldly lived-space outside their disaster lived-space occur haphazardly via phone calls and emails connecting with family and friends at home. However, phone calls home need to be brief:

At the end of a shift, I would call home. I had access to a communal phone. However, I was restricted in the length of calls and I had to be careful about what I said.

An overlapping of lived-spaces, such as the disaster lived-space and the lived-space at home, provides an opportunity for outside connectedness and grounding in the normal lived-space:

I spent time alone reading and listening to music.

Further to connectedness to a previous lived-space, through media such as telephone conversations, allow a nurse to look out of the disaster lived-space and escape to a fantasised lived-space, such as escaping into the lived-space of a book or music.

7.2.3 Wide-open, crowded.

When a nurse moves from being in the disaster to being back at home again, the nurse transitions from the encapsulated and shrunken lived-space of *being* in a disaster to the world being wide-open again. Upon arriving home from the disaster, the world of the nurse returns to being their normal physical space, opening to include their home, place of work and home community. This transition orientates a nurse to returning to their normal state of *being*. However, the nurse's previous state of *being* cannot be reached immediately because the nurse has experienced an event, the disaster, which has influenced their *being* for the future.

Normally, many everyday events are too trivial to be noticed from a lived-space perspective, such as driving a car or shopping at the local supermarket. While the nurse has been away assisting in the disaster, their normal public physical space has not changed. However, on returning home, the lived-space has become a crowded space for the nurse, such as when visiting the supermarket or attending their workplace. Even though the supermarkets have not added additional line items to their supermarket inventory, the nurse may feel that there is too much choice:

I walked into the supermarket and there was a large variety of food on the shelves. The options were extensive.

When a nurse returns to the normal workplace, colleagues often ask questions about the experience of being in the disaster. This continual sharing of the experience contributes to the feeling of a crowded lived-space in the workplace:

Colleagues, friends and family wanted to hear about my experience. After a while, I needed some time alone.

7.3 Disaster Health Lived-space as *Occupying, Sharing and Giving Back*

In a disaster, the constructed space in the disaster-affected community is deconstructed, torn apart and broken. The normal health system that is part of the constructed space becomes deconstructed and people cannot access the previously existing health system and health system structures. For example, in the aftermath of a disaster, general practitioners may close their practices temporarily, stopping seeing their normal patients and not seeing new patients that may be affected by the disaster. Additionally, pharmacies may be closed for extended periods. Combined, this limits the options for people who wish to seek health care following a disaster:

During the immediate aftermath of the disaster, normal health clinics were not open to receive patients. . . . The local pharmacies and general practitioners were closed longer than anticipated. So people could not access their prescription medications via their normal means.

How the individual nurse may experience the disaster health lived-space orientates a nurse to the lived-space from a disaster health perspective. An experience of *being* a nurse from a disaster health lived-space perspective could be described as *occupying, sharing and giving back*, as described in the next sections.

7.3.1 Occupying.

To overcome a gap in the health space and to continue meeting the needs of people in the disaster-affected community, there is a need for health assistance from outside the disaster-

affected community. This need is implied in the definition of ‘disaster’, meaning that additional resources are required for the affected community to maintain a normal functioning capacity. Commonly, disaster medical assistance teams are established by governments to assist in maintaining the functioning capacity of the community.

As a necessity to maintain an adequate level of health care for a disaster-affected community, foreign disaster medical assistance teams are invited to the disaster-affected region for the purpose of providing a health service. Thus, the foreign disaster medical assistance teams start to occupy the disaster health lived-space. Members of the disaster medical assistance team see patients that would have presented to their general practitioner or local pharmacy previously.

A nurse comes into an area that is affected by a disaster as part of a disaster medical assistance team and commences care of patients from that community. A nurse as part of a team takes over from where the general practitioners and pharmacists ceased to practise, temporarily filling the disaster health lived-space of the health professionals affected by the disaster. This may be a relief for the health care professionals affected by the disaster, because the health care professional can now focus on more pressing needs, such as the care of their family, home or neighbourhood. These health professionals may be focused on reconstructing their space.

7.3.2 Sharing.

A nurse shares their disaster health lived-space with the health care providers of the disaster-affected region. As time progresses, nurses from the local area affected by the disaster may present to the disaster medical assistance team to offer assistance. When welcomed into the disaster medical assistance team, these nurses assist in delivering the health services offered by the disaster medical assistance team. This results in a sharing and blending of the disaster

health lived-space of a nurse in the disaster medical assistance team and a nurse from the local area affected by the disaster:

Local health care professionals from the closed health clinics assisted us throughout the deployment. I remember working with a local community health nurses, a maternal child health nurse and some local general practitioners. These health professionals had knowledge of the area and links to community health services.

The sharing of the disaster lived-space stretches beyond the professional spaces of individual disciplines to include the sharing of patients or clients of those disciplines. The sharing of the disaster health lived-space results in a greater connectedness between the foreign disaster medical assistance team and the local community health services. A shared disaster health lived-space provides a stepping-stone for giving back the disaster health lived-space to its original space.

7.3.3 Giving back.

A nurse passively occupies and fills the disaster health lived-space by being a member of the disaster medical assistance team. This does not require the conscious awareness of the nurse but occurs by virtue of the situation. Similarly, the nurse sharing the disaster health lived-space with local nurses, as they self-present to assist, is passive. However, giving back the disaster health lived-space may require a deliberate action to come to the fore. When a general practitioner, pharmacist and other community-based health services providers recommence their services, disaster medical assistance team nurses may start to give back the disaster health lived-space to the local health care providers:

As the local health services were re-established, we started to hand over our services to the local health care professionals as a strategy to withdraw our services from the region.

7.4 Commentary

The above spatial reflection on a lived-experience description of *being* a nurse in an out-of-hospital environment following a disaster has uncovered a number of key insights. These insights included that it seemed easier for nurses to assimilate from the open lived-space of home to the shrunken lived-space of the disaster, when compared to their difficulties in returning from the shrunken lived-space of the disaster to the previously open lived-space of home. Further, change to the physical space because of a disaster resulted in changes to the way that space was used. The following commentary discusses the key insights uncovered from the spatiality existential reflection in relation to *lived-space as shrinking then opening too-wide*, and the *disaster health lived-space as occupying, sharing and giving back*.

7.4.1 Lived-space as shrinking then opening too-wide.

Why does it seem easier for a nurse to move from the normal open lived-space to the shrunken lived-space of a disaster than the reverse process? Perhaps this is because a nurse is provided with enough information to fill their desire to understand what it may be like to be in the disaster through the structures of briefing and getting to know the others who will be there. Perhaps not knowing what to expect in the disaster means the nurse has no solid expectations and assumptions. Perhaps it is because the emphasis is on what it may be like in the disaster, because the disaster is an unknown, whereas the nurse knows what it will be like to be home.

7.4.2 Disaster health lived-space as occupying, sharing and giving back.

Lived-space occurs within structured spaces. When exploring the phenomenological existential of lived-space, the structure of non-lived-space is uncovered inadvertently. This is important, as the non-lived-space influences space as it is lived. Lefebvre (1992) suggests that

physical spaces have a triad of history, rules and purpose, which affect how space is lived. That is, if there is a change in one of the triad factors, the other factors will be influenced.

Changing the history of the space, such as moving from a structured environment to a deconstructed environment, which is then reconstructed, results in a changing of the rules for that physical space. In the disaster, this change occurs based on necessity; that is, to provide a health service to a community affected by the disaster. A change to the physical space results in a change to the way the space is used. As such, the way this physical space has changed results in the way the space is now lived.

7.5 Summary

This reflection has focuses on what is may be like *being* a civilian hospital nurse in the out-of-hospital environment following a disaster from a spatial, or lived-space, perspective. This reflection has highlighted a possible existential experience as the *lived-space as shrinking then opening too-wide*, and the *disaster health lived-space as occupying, sharing and giving back*. The commentary on the spatial reflection has provided further insight into an experience from a spatial perspective. The spatial reflection can be displayed diagrammatically, overlaying the uncovered moments, as outlined in Figure 7.2.



Figure 7.2. Diagrammatic representation of the spatial reflection.

Chapter 8: A Corporeal Reflection on a Lived-experience

Description of *Being* a Nurse Following a Disaster

8.1 Introduction

Following a disaster, photos and television images emerge showing destruction and devastation, often including images of people, especially those affected by the disaster. These images show people standing among the destruction caused by a bushfire or flood, people trapped or being rescued from the rubble of a collapsed building following an earthquake, health care workers rendering aid, or deceased people lined up along the beach following a tsunami. These images of people are images of bodies as bare flesh.

From a phenomenological perspective, corporeality, or lived-body, goes beyond the flesh of the physical, visible and touchable body. Merleau-Ponty (1945/2002) suggested that people position themselves in the world in a way that will help them to get an optimal grip on the world. Corporeal reflection is concerned with corporeality and the way in which *dasein* is embodied in the world (van Manen, 2014b). Further, the lived-body is not only concerned with the experience of one's body but also one's experience of the other's body (van Manen, 1998), as the lived-body 'for me' and 'for others' co-exist (Merleau-Ponty, 1945/2002, pp. 121–122).

In this phenomenological study, corporeality in a disaster was concerned with the experience of a nurse's lived-body and the way a nurse experiences the lived-body of others, particularly patients. The focus of this reflection was on *being* a civilian hospital nurse in an out-of-hospital disaster, from a corporeal, or lived-body, perspective. A preparatory epoché-reduction and reduction proper was used to guide this reflection on the corporeality of *being* a nurse in this situation from the previously presented lived-experience description.

8.2 Nurses' Lived-body, *When Nursing Following a Disaster*

When caring for a patient in the hospital environment, a nurse's body may move around the patient, the patient's bed, among other health professionals, hospital staff and possibly around family members who are standing or sitting near the patient. A nurse's hands may move to touch the patient or grasp equipment. These movements are undertaken for the sake of caring for the patient and possibly for the patient's family. A nurse does not necessarily need to think about their movements; a nurse's body just moves. A nurse moves in a skilled and masterful way because that is what a nurse does to be understood as a nurse. The experience of *being* a nurse from a *nurse's lived-body, when nursing following a disaster*, could be described as *being* without technology and resources, as well as *being* autonomous.

8.2.1 Without technology and resources.

In the everyday practice of the Australian hospital nurse, the workplace is technology-driven, to inform clinical decision making and practice. The modern hospital environment has enhanced medical-imaging capacity, with images available on computers, improved pathology services with point-of-care testing, abundant electrocardiography machines and integrated devices for general vital sign observation and monitoring. Further, other technology, such as IV fluid pumps that calculate drip rates for drug additives within safe parameters and electronic patient records, are becoming the norm.

These technologies are the ready-at-hand tools that become the taken-for-granted background to the life-world of a hospital nurse. A nurse 'sees' the patient through technology; that is, the technologies become a way of seeing the patient from the angle of a technological device, rather than seeing the patient in the first person. Technology, such as a vital signs observation machine, speaks to a nurse about the patient's physiological condition, such as their heart rate

and their saturated haemoglobin oxygen levels. On occasions, some nurses may become reliant on this technology to tell them about the patient.

A nurse that is deployed in a disaster may be without the aid of technology to make decisions about patient care:

With minimal equipment, my clinical activities relied on an assessment using my hands and my stethoscope. I was very 'hands on'. There were no x-ray facilities, pathology for blood tests or electrocardiography machines.

If a nurse no longer has the technological background to their life-world, as in a disaster, the lived-body of a nurse is positioned in the world to *being* in a disaster, to get an optimal grip on the situation. A nurse may notice the corporeal when the taken-for-granted is no longer present. The corporeal life-world of a nurse that is deployed following a disaster may be noticeable for a nurse as they are displaced from their usual taken-for-granted life-world. This orientates a nurse to *being* in a disaster, as they rediscover their lived-body.

A nurse who normally works in the hospital environment usually has access to the required health resources, such as an IV giving set. In the disaster environment, having access to an everyday resource may be limited:

Early in the deployment, I did not have all the resources I needed, such as forms for documenting patient progress and the equipment and health resources that I used were of a basic standard and in short supply. I had only one oxygen concentrator. . . .
During the deployment I ran out of a number of clinical items, such as IV giving sets.

In a disaster situation, a nurse is positioned to make do with whatever resources are available. The life-world of a nurse is now positioned to *being* without technology and without resources. This positions a nurse to get back to nursing as *being* 'hands on' and without a reliance on resources.

8.2.2 *Being autonomous.*

An Australian nurse knows that their professional practice is bound by regulatory frameworks such as legislation, codes of conduct and professional standards for practice. The hospital nurse practises within these regulatory frameworks, aligned with a particular scope of practice for their practice context. The lived-body of a nurse moves within this scope of practice. On a daily basis in the hospital environment, a nurse may care for patients as part of the multidisciplinary health care team. Within this team, a nurse as a practitioner makes autonomous decisions relating to the care of patients and caring for patients without direct supervision from others and perhaps with little conscious thought about the boundaries to their practice. For example, if a nurse identifies a patient as being unwell and requiring a higher level of health assessment and intervention, a nurse knows that they can ask other health professionals to assist.

Positioned in a disaster, a hospital nurse relies less on technology and resources and may rely more on nursing observation and knowledge to inform decision making:

I was looking at my patient without the technology. At times, I was relying on my knowing how to recognise the sick patient from non-sick patient. . . . when patients were unwell I would meet the patient, undertake an assessment and refer them to someone in the medical team.

Decision making regarding the discharge of patients from a hospital environment is not within the scope of practice of most nurses, as this requires a decision from the in-patient's medical team. However, there are some hospital nursing roles, such as in the ED, in which a nurse assesses, manages and discharges patients independently from any medical team. In the ED, a nurse in an advanced nursing practice role may have additional training to assess, manage and discharge patients within a particular scope of practice, possibly defined within standing

operating procedures. Patients seen by ED nurses in an advanced nursing practice role commonly include high-frequency, low-acuity patients.

In the disaster environment, many patients present as low-acuity patients:

The care that I provided to patients was nurse-led. I initially met the patient, undertook assessment and discharged patients.

In the disaster situation, a nurse may be positioned to take on an advanced nursing practice role, with a broader scope of practice than they practised in the hospital environment.

Although the nurse's scope of practice has changed to include a higher level of decision making relating to the complex care needs of patients within a different context, the nurse still needs to be mindful of working within their knowledge and skill and that country's regulations. In positioning to *being* in a disaster, a nurse's role may be more autonomous in the care of patients, including assessing, managing and discharging patients without input from other health professionals.

8.3 Nurses' *Lived-body, For Patients Following a Disaster*

In the hospital environment, a nurse has access to a defined patient population and to individual patients within this population. In the hospital environment, when a nurse meets a patient, a nurse is meeting the patient within a nurse–patient relationship. The patient's body reveals something to a nurse. A nurse can 'see' whether the patient is ill or injured, exposed or dependent. This is the patient's lived-body, which is somewhat known to a nurse.

In the disaster situation, the lived-body of the patient occurs independently from the nurse; that is, the nurse has little to do with the person who is involved in the disaster, arriving at the health facility following a disaster, or requesting health assistance from nurses in the disaster medical assistance team. People just happen to be among the disaster, require health

assistance and attend the health facility within which the nurse is deployed. From a *nurse's lived-body, for patients following a disaster*, the patient just happens to be there. An experience of *being* a nurse, from a nurse's lived-body, for patients following a disaster could be described as *being* with endless lived-bodies, injured and ill lived-bodies, death, psychosocial well-being, and returning to the lived-body of a hospital patient.

8.3.1 Endless lived-bodies.

The Australian health system has ways of coping with the complex daily demands of patients presenting for health assessment and management. In the ED, systems of triage are established to ensure people receive timely access to health care according to their needs. In operating theatres, waiting lists prioritise people for surgical procedures. Similarly, ICUs have admission criteria to ensure that intensive care beds are reserved for those people who need them most. These systems are well established and recognised to ensure that individual patients receive an appropriate level of timely care based on their current health status. These systems are designed on the principle of doing the greatest good for the greatest number of people.

In the disaster environment, there may be large numbers of people presenting to a disaster medical assistance team for assessment and management:

During the early stages of our establishment, I remember people lining up to access the health services we were providing. At times, we were busy and overwhelmed by the number of presenting patients. Initially, patients were pushing each other out of the way to access our service. . . . As a team we were seeing hundreds of people each day. . . . Some people travelled for many hours to receive care. On some occasions people walked for days to access our service.

Due to the large numbers of people presenting for assessment and management in the disaster environment, a nurse's lived-body may be positioned to cope, by replicating what the nurse knows works in the hospital environment in the situation with increased patient presentations:

I assisted in establishing a triage system at the entrance to our facility. We had a triage system to ensure there was an appropriate order and priority of patients being seen. I worked in the triage area of our health service.

By establishing a system of triage, the nurse may be getting back to what they do and know for the lived-body of the patient in the hospital environment. The nurse is now positioned to *being* in the disaster environment as they were in the hospital environment.

Following a disaster, the people affected by the disaster are doing what they need to do to position themselves to survive and to seek help if needed. The lived-body of a patient following a disaster may be more exposed and more susceptible to the life-world of the situation than those who are not patients in the situation. A nurse, as part of the disaster medical assistance team, is positioned in the disaster to help patients. This position has been made by choice, for the sake of helping those affected by the disaster.

In this situation, the nurse's lived-body just happens to move in a manner that is positioned to help people. Where the historical horizon of the patient and nurse meet, the nurse encounters endless bodies. The fusing of this horizon would not have happened unless the disaster had occurred and resulted in the meeting of individuals with differing circumstances: one who has possibly lost everything and is positioned to survive, the other who still has everything positioned to care:

When comparing my situation to those left behind in the disaster, I had many things; they had nothing.

For a nurse, the endless bodies come to an end when the nurse gives back the 'disaster health lived-space' to another nurse or health care professional or when they return home to the wide-open, crowded lived-space of their normal life-world, leaving the disaster behind.

8.3.2 Injured and ill lived-bodies.

In the hospital environment, a nurse in a clinical role is among patients on a daily basis. Their patient population is somewhat known to the nurse. Increasingly, hospital nurses within metropolitan hospitals work in speciality wards and units with a narrowed patient type with specific injuries and illnesses.

In the disaster situation, a nurse is positioned to *being* among patients with a range of injuries and illnesses that may not be common for hospital nurses who have worked in speciality wards and units:

[In the disaster there was] mostly minor injuries such as cuts, abrasions and bruises . . . some patients presented with wounds which required surgical debridement. . . . I saw many patients who had injured themselves secondary to the disaster . . . [such as] broken limbs . . . burns. . . . I remember one man who presented with a carcinoma of his trachea. He wanted a surgeon to operate to alleviate the pressure from his trachea. Patients presenting with acute illness was a mainstay of my daily work . . . acute gastroenteritis illnesses . . . chest infections, asthma and pneumonia exacerbated by saltwater inhalation or smoke inhalation . . . varying tropical diseases and heat-related illnesses . . . chronic health diseases, such as diabetes, hypertension and renal failure. . . . I saw women who were pregnant and wanting maternal health checks.

When discharging patients from the hospital environment, the patients' social circumstance and living conditions are usually taken into account. Patients may be discharged to their homes, discharged to other social support services, or to a combination of these.

Following a disaster, a nurse may have to discharge patients to 'nowhere', as the patient's home and neighbouring homes may have been destroyed in the disaster:

I would sometimes discharge people from our service to nowhere. Some patients had no home left, no food, no water and had no family. Their family was killed in the disaster.

In the disaster context, a nurse may discharge patients from their health service to their homes, knowing that the patient is likely to die. Discharging patients to nowhere or

discharging patients from the disaster medical assistance team, knowing that the patient is likely to die, positions a nurse to *being* in the disaster.

8.3.3 Death.

In the Australian hospital context, an experience of *being* with someone as they die or *being* with someone soon after death is infrequent. The hospital nurse may go to work and not experience a patient death that day, that month or that year.

For a nurse, seeing images of people in a disaster gives a glimpse into the life-world of a disaster. The images give a glimpse of people who do not know they are being looked at. These images are a snapshot in time, not necessarily reflective of how the body was lived in a disaster.

For the person who had experienced a disaster, their lived-body was positioned to survive. A possible outcome for a person faced with or following a disaster is that they may die because of the event; the lived-body of the patient is now one that is (de)ceased. In the disaster, death and dying may be expected:

I saw death and people dying. This was different to what I see in an Australian hospital. I remember seeing people whom we could not help. We had intubating equipment, but no ventilators. I saw multiple children die. In the Australian hospital, this was not common for me.

In the disaster situation, a nurse is positioned to *being* with patients that cannot be helped and may be exposed to death and dying to an extent not normally experienced in the hospital environment.

8.3.4 Psychosocial well-being.

For patients in a medical, surgical or speciality hospital unit or ward, the patients' primary presenting complaint is at the fore. While a patient on these wards or unit may have an underlying mental health condition, this condition is in the background, as is any other chronic health condition that has the possibility of coming to the fore if factors result in the condition becoming exacerbated. This may be the situation for most wards or units, except in a hospital mental health unit, in which the patient's mental health condition is at the fore.

Following a disaster, a patient may present to a disaster medical assistance team for assessment and management of their physical injury or illness. However, the care in the disaster environment may focus on more than the primary presenting complaint that is at the fore, such as a minor abrasion. A nurse may consider the psychosocial well-being of all of the patients.

Having the psychosocial well-being of all patients at the fore positions a nurse to *being* in the disaster:

Most patients who presented for care of their physical injuries and illness displayed some level of psychosocial need.

For the patient, their response is a normal response to an abnormal situation. The nurses are witnessing lived-bodies with a normal response to an abnormal situation. This response is not like a response a nurse may see normally in their hospital experience. That is, not every patient who presents to the hospital will have an emotional response to an experience that has resulted in the person seeking health assistance. However, in the disaster environment, psychosocial issues are widespread. Not only people with pre-existing mental health conditions exhibit some psychosocial post-disaster stress but so, too, do those with no pre-existing mental health concerns:

I recognised that I was going to a disaster where many people have lost their lives, suffered. . . . In comparison to what I would see in an Australian hospital, there was much more psychosocial need in the disaster environment. It was needed for every person.

The widespread nature of the psychosocial need in the disaster-affected community positions a nurse to *being* in a disaster.

8.3.5 Returning to the lived-body of a hospital patient.

The lived-body of patients in the wide-open, crowded lived-space of the Australian hospital does not change while a nurse is on deployment. However, the experience of the patient's lived-body in the disaster may have influenced the way a nurse experiences the lived-body of patients in the hospital environment:

When I returned to work in the hospital, patient and staff concerns relating to the Australian health system seemed insignificant. Patients presenting to the ED were complaining about extended waiting times for what seemed to be trivial ailments. Patients seemed to have a complete disregard for those affected by the disaster on the other side of the world.

A nurse now sees the lived-body of the patient from a different position. Instead of seeing a patient in an ED waiting for the assessment and management of their injury, a nurse now sees a patient with trivial ailments showing disregard for the events in the disaster-affected community, in which the nurse was embodied.

8.4 Commentary

The above corporeal reflection on a lived-experience description of *being* a nurse in an out-of-hospital environment following a disaster uncovered a number of key insights. These insights included that a change in a taken-for-granted life-world results in a change of nursing practice that may go 'back to basics', be 'hands on' and adopt an alternative scope of practice. Further, a nurse's scope of practice may be different as a member of a disaster medical assistance team

when compared to the nurse's hospital scope of practice. Additionally, a nurse following a disaster is positioned to be less access to technology and resources, instead being more nurse-led. The following commentary discusses the above key insights uncovered from the corporeality existential reflection in relation to *nurses' lived-body, when nursing following a disaster*, and *nurses' lived-body, for patients following a disaster*.

8.4.1 Nurses' lived-body, when nursing following a disaster

The international literature pertaining to nursing and disasters over the last two decades has been saturated with conversations and recommendations relating to nurses' competencies (Daily, Padjen, & Birnbaum, 2010; Gebbie & Qureshi, 2002; Gebbie, Hutton, & Plummer, 2012; International Council of Nurses (ICN)/WHO, 2009; Silenas, Akins, Parrish, & Edwards, 2008; Walsh et al., 2012). However, these various competencies have not been evaluated in the disaster context. Additionally, a set of competencies may imply that a nurse comes to the disaster with competencies ready at hand. This may not be the case, as nurses may just find themselves as part of a disaster medical assistance team, among the disaster.

A nurse's scope of practice may change as a member of a disaster medical assistance team when compared to their hospital scope of practice. This change in scope of practice may derive from the necessity to do the greatest good for the greatest number of people; that is, to collectively assess, manage and discharge the most possible patients who present for care. As part of the multidisciplinary team, a nurse may ensure that patients are seen by the right member of the multidisciplinary team at the right time. In particular, a nurse may need to know when to refer patients to a higher level of care, similar to the situation in the hospital environment. Additionally, a nurse may need to know when not to refer patients to a higher level of care and instead, discharge patients from the disaster medical assistance team's health service.

The lived-body of a nurse in the disaster is positioned to be without technology and resources, instead being more nurse-led and changing the nurse's scope of practice. I wonder whether this would change the standards of care for patients. Perhaps the standards of care delivered in the disaster environment may be less than what would be expected in the Australian context. Perhaps this is reasonable. Perhaps the standards of care delivered in the disaster environment may be higher than what would be expected in the international context in a disaster. Maybe the disaster medical assistance team should adopt the standards of care of the country in which they are providing assistance. Perhaps the standards of care should not change, but what a nurse is able to do within the disaster context with the given resources will determine the care that is delivered.

8.4.2 Nurses' lived-body, for patients following a disaster

A nurse working in the Australian hospital health system is working in a system with well-established processes, such as triage and waiting lists. The lived-body of an Australian hospital patient moves within this system. The Australian hospital patient's lived-body is a privileged body in this system, as it moves mostly effortlessly. Following a disaster, the lived-body of the patient moves within a disrupted health system. In some circumstances, there may be no systems at all. A nurse's lived-body, for patients in a disaster, is orientated doing the greatest good for the greatest number. For a nurse, there are these lived-bodies in a disaster and sorting through the bodies as flesh to determine who should be seen first, second and third is required in a manner that will help the most number of people. Perhaps this is achieved by reverting to the system a nurse knows will help the greatest number of people. Perhaps this is the right approach, as the system is known to a nurse; however, the system may not be known to the patient. Perhaps a nurse should adopt a system known to the patient, whatever this is. An experience of not being able to help everyone who is affected by the disaster may not be a familiar experience for a hospital nurse.

Regardless of a nurse's hospital life-world, the lived-body of a nurse is positioned to care for an abundance of broken bodies. These bodies have varying types of injuries and illnesses, some related to the disaster, some secondary to the disaster and some pre-existing prior to the disaster. The lived-body of a nurse is positioned to care for these patients. I wonder what 'group' of nurses may be best positioned to provide care to this range of patient presentations. I wonder whether all nurses could provide this care in a timely and effective manner, or whether there is a group of nurses that would be most suitable for this work. Ransie (2013) suggested that 'community, public health, general practice and/or mental health nurses are an appropriate group to assist in disasters alongside those from the critical care environments . . . to ensure the health needs of the community are met during and following a disaster' (p. 2). Perhaps it is not so much the 'group' of nurses from a speciality or sub-speciality of nursing, but instead, a personality or experience base from which all nurses in all specialities or sub-speciality could be working within these 'groups'.

The lived-body of the person in a disaster is positioned to survive; however, it would be expected in a disaster that some deaths would occur and on occasions, there may be an extremely high proportion of deaths. This could be expected purely by the definition of a disaster, as a situation in which the health requirements of the population are overwhelmed. Lawler (2006) suggested that for the Australian hospital nurse, the problem with death and dying is that it is 'privatised' and 'secret', with the process of death and the care of the dead occurring away from the 'public view' (p. 193). However, a nurse's lived-body, for patients in the disaster, cannot hide, privatise or secretly obscure the fact that death has occurred. Instead, death is evident and emphasised in the media, to describe the magnitude of a disaster.

The lived-body of a nurse, for patients in a disaster, needs to have the psychosocial well-being of those affected by the disaster at the fore, regardless of the physical injury or illness of an

individual. How does it become the common way of *being* for the hospital nurse to shift from possibly having a primary presenting condition of a patient at the fore, to now in a disaster having the psychosocial well-being of all at the fore? Can this be addressed with additional education and professional development beyond that of the undergraduate? Does a nurse need a list of prompting questions to assist in eliciting from people a response that would give a cursory indication of the level of psychosocial well-being? Perhaps the inherent characteristic of a nurse shifts effortlessly through their transparent consciousness to having the psychological well-being of others at the fore.

Returning to the lived-body of a hospital patient, a nurse may see patients with what the nurse now considers minor ailments. However, the patient population and presenting conditions at the nurse's hospital have not changed dramatically during the nurse's deployment.

8.5 Summary

This reflection has focused on what it may be like *being* a civilian hospital nurse in the out-of-hospital environment following a disaster, from a corporeal, or lived-body, perspective.

This reflection has highlighted a possible existential experience of lived-body for a nurse as *being a nurse's lived-body, for nursing following a disaster* and as *a nurse's lived-body, for patients following a disaster*. The commentary on the corporeal reflection has provided further insight into the experience from a corporeal perspective. The corporeal reflection can be displayed diagrammatically, overlaying the uncovered moments, as outlined in Figure 8.1.



Figure 8.1. Diagrammatic representation of the corporeal reflection.

Chapter 9: A Communal Reflection on a Lived-experience

Description of *Being* a Nurse Following a Disaster

9.1 Introduction

Following a disaster, physical relationships between people may change as the individuals change. Individuals may change physically if they have become disfigured following a bushfire or they have lost a limb following an earthquake. People may die or go missing following a disaster. These changes of a physical nature may change an individual's lived-relationships with others.

Communality, or lived-relationships, from a phenomenological perspective, goes beyond a physical or touchable relationship. Communality includes relationships as they are lived. It is common to hear people 'proclaiming, almost instantaneously following a disaster, how wonderful it is that the community is pulling together, [and] how the disaster has brought the community closer' (Hobfoll & De Vries, 2013, p. 116). This is evidence of a relational narrowing between people in a community following a disaster.

In this phenomenological study, communality in a disaster is concerned with an experience of a nurse's lived-relationships with colleagues, patients and self. The focus of this reflection is on *being* a civilian hospital nurse in the out-of-hospital environment following a disaster, from a communality, or lived-relationships, perspective. A preparatory epoché-reduction and reduction proper was used to guide this reflection on the communality of *being* a nurse in an out-of-hospital environment following a disaster, from the previously presented lived-experience description.

9.2 With Colleagues, *Being* Relationally Close

For a hospital nurse, the nursing and multidisciplinary team change on a shift-by-shift basis. On a month-by-month basis, students and graduate nurses come and go, as do other members of the nursing and multidisciplinary team. This constantly changing team forms the taken-for-granted background to the life-world of a hospital nurse's lived-relationships with colleagues.

For a nurse deployed as part of a disaster medical assistance team, the team does not change. An experience of *being* a nurse in an out-of-hospital environment following a disaster, from a nurse's lived-relationships perspective, *with colleagues being relationally close*, can be described in terms of starting relationships, relational closeness as work becomes home and home becomes work, and relational widening, as detailed in the next sections.

9.2.1 Starting relationships.

As a shift begins in the hospital environment, nursing staff gather to obtain a handover of the care provided to patients and to gain situational awareness of the activities of the ward or unit. This activity takes place between nursing staff that are mostly familiar with one another because they have an existing relationship, working with each other on a daily or weekly basis.

Following a disaster, nurses may meet each other for the first time during a pre-departure briefing session or at the airport:

Following the briefing, I had an opportunity to meet members of the disaster medical assistance team who would be deployed with me. . . . When I met the contingent for the first time, I recognised a number of people that I had previously worked with. While some people in the contingent were familiar to me, some people were not, so I tried to get to know these members.

Meeting people from the disaster medical assistance team for the first time at a pre-departure briefing or in an airport starts a lived-relationship with others. This relationship starts because individuals have congregated on neutral ground, for the same reason: to help those in a disaster-affected community.

9.2.2 Relational closeness as work becomes home and home becomes work.

The background to the normal life-world of a hospital nurse consists of their work and their home. Work and home may have distinctly different characteristics from both a structural and a phenomenological perspective. In the hospital environment, a nurse may work with the same team of people, but on a shift-by-shift basis, a nurse may work with different groups of people from within the team. A nurse may be relationally close to some people in this team and not others. A nurse may work a rotating roster with designated time off, going from work to home, then back to work the following day, perhaps followed by two or three days off work, and then going back to work again. A nurse may share their home with others, perhaps family or friends. A nurse in the hospital environment may be relationally closer to their family and friends than with work colleagues.

In the disaster environment, a nurse works with the same group of people on a daily basis, seven days a week for the duration of the deployment. When the clinical shift ends, a nurse may return to camp, where the same group of people congregates and camp work begins:

There were no days off. Camp life was busy. At times, it seemed busier working in the camp than working a clinical shift. . . . When I was not working clinically, I kept myself very busy by assisting with other camp activities.

In the camp environment, a nurse may live with the same people with whom they have worked a clinical shift. A nurse may not have a choice about who they share sleeping arrangements with or where they sleep:

I was sharing a tent with a number of other health professionals from within my contingent.

The physical closeness of the interpersonal space working, living and sleeping among people from the disaster medical assistance team, orientates a nurse to *being* relationally close with colleagues. The relational closeness orientates a nurse to *being* in a disaster.

9.2.3 Relational widening.

In the hospital environment, a nurse leaves the workplace at the end of a shift. They have access to a roster of their shifts and therefore may know when they will likely return to work and see their work colleagues again.

During the disaster deployment, a nurse may have become relationally close to the people in the disaster medical assistance team. At the end of the deployment, a nurse may wish to maintain a relational closeness with people in the disaster medical assistance team:

At the end of the deployment, I did not want to leave. . . . I was close to the other contingent members and did not want to leave them either.

Being relationally close to people in the disaster medical assistance team may not continue after nurse returns to the normal life-world of their home and work. Instead, the relationality of the nurse and the other people in the disaster medical assistance team will become widened, as the nurse's interpersonal space is no longer shared between working, living and sleeping.

9.3 With Patients and Their Families, *Being* an Insider

Nurses in the Australian hospital environment may have a professional relationship with the patients that they are caring for. Depending on the hospital clinical context, this relationship may have distinct dynamics and characteristics. The relational closeness between a nurse and

a patient in the ED may be different to that in the ICU, which may be different to that in a respiratory ward, and which may be different to that in an oncology ward. Patient length of stay may influence the relationality of a nurse and a patient. A patient in the ICU may have a length of stay that is much shorter when compared to a patient's length of stay on a ward that manages chronic illness, such as a respiratory ward. Further, the ability of a patient to interact and engage with a nurse may influence relationality. In the ICU, the ability of the patient to engage with staff may be decreased due to the nature of their injury or illness, which may require endotracheal intubation and ventilation. The likelihood of seeing a patient again may influence relationality between a nurse and a patient. It may be that the ED or ICU nurse will not see a patient again, as their moments of care are ad hoc. However, on a ward that manages chronic illness, the patient may return frequently and this may affect the relationality of a nurse and patient.

All of these variations in relationality between nurses and patients form the taken-for-granted background to the life-world of nurses' lived-relationships with patients. A nurse's lived-relationship with patients and their families *being* an insider can be described as orientating to *being* an insider, and *being* an insider and people disclosing things, as detailed in the next sections.

9.3.1 Orientating to *being* an insider.

In the hospital environment, nurses may wear a specific uniform that identifies them as a nurse. For a nurse in a perioperative or similar environment, a nurse may wear their civilian clothes to work and change into scrubs once they arrive. Wearing a nursing uniform transforms a layperson into a nurse.

A nurse who is deployed to the disaster environment may not wear their normal nursing uniform. They may wear a uniform of the disaster medical assistance team with which they are deployed and may be conscious of what they are wearing. In this conscious aware state, a nurse may consider clothing items that may be culturally and contextually appropriate:

I packed my uniforms and two sets of clothes. These clothes were neutral, non-offensive clothing, with no logos or words on them.

What a nurse wears portrays them as a nurse. Wearing clothing that is culturally and contextually appropriate starts to orientate a nurse to *being* in a disaster. This may assist a nurse to become relationally closer to people in the disaster-affected community.

9.3.2 *Being an insider and people disclosing things.*

In the hospital environment, people may disclose things to a nurse *because* they are a nurse. They may disclose things that they would not normally disclose to a stranger, such as a shop assistant or neighbour.

Following a disaster, this can be similar. People may talk more openly to nurses who are part of a disaster medical assistance team:

When I saw people in the disaster-affected area, I didn't know if the person's home was destroyed, if they had lost loved ones or if they were directly affected by the disaster in some other way. I would often just say, 'Hello' or 'How are you going'? Commonly, people would then start to talk about their disaster experience. Most patients who presented for care of their physical injuries and illness displayed some level of psychosocial need.

People openly seek an opportunity to talk about their experience of being in a disaster with nurses, particularly because the nurses were not affected by the disaster directly:

[People from the disaster-affected community] just wanted to talk to someone. People just wanted to discuss their experience. People wanted to share their stories with me because I was not personally involved in the disaster.

Prior to the disaster, a nurse as part of the disaster medical assistance team would have no jurisdiction to undertake an assessment or management of a patient in the now disaster-affected community. It is by virtue of the disaster that a nurse has access to these patients and this may result in a closing of the relationality between a nurse and people in the disaster-affected community. This orientates a nurse to *being* in a disaster.

9.4 *Being With Self*

Following a shift in the hospital environment, a nurse may have well-developed ways to cope with the shift. The way(s) in which a nurse may cope with *being* a nurse in the hospital environment form the taken-for-granted background to the life-world of a hospital nurse.

Following a disaster, the way(s) a nurse cope may change, as a nurse may not be able to access the same strategies as at home. An experience of *being* a nurse in an out-of-hospital environment following a disaster, from a nurse's lived-relationships, *being* with self perspective, could be described as *being* by (my)self, carrying an emotional burden and questioning the effort, as explained in the next sections.

9.4.1 By (my)self.

In the hospital environment, if a nurse is unwell and unable to attend work, their workplace will call casual or agency staff to ensure an appropriate staffing of the clinical ward, unit or department.

In a disaster environment, calling on casual or agency staff is not possible, as they are not readily available. Therefore, there is a reliance on staff to be well enough to be active members of the disaster medical assistance team:

I was conscious that I needed to stay well, so that I could care for other people, I packed sturdy boots and purchased insect repellent prior to departing. I packed some items that would provide comfort while I slept. This included a sleeping bag and a bedroll.

A nurse is orientated to *being* in the disaster to care for those affected by the disaster. In *being* orientated to care, a nurse is aware of the need to remain well, for the sake of caring for others. Nurses care for themselves from a physical perspective, ensuring they have appropriate personal protective equipment, such as sturdy boots and insect repellent. In addition to their physical well-being, nurses may consider their psychosocial well-being as important for the well-being of others. They may spend time by themselves reading, listening to music and resting. During this time, they may be thinking about the people they had cared for during the day:

I spent time alone reading and listening to music. I would think about the people I had seen during the day. Early in the deployment, I was not having enough rest time. As the deployment progressed, I made sure I got enough rest and took the time to have breaks. I became very tired.

Being aware of the need to remain physically well and psychosocially well forms a background to a nurse's life-world of *being* with self in a disaster.

9.4.2 Carrying an emotional burden.

In the hospital environment, patients present with varying injuries and illnesses. Some patients may present to hospital following an uncommon or stressful event, which may include being involved in an event that results in the death of a family member or the death of a child. When a patient presents to hospital following an uncommon or stressful event, a nurse

would be aware of this event. A patient may discuss this event with a nurse and other members of the multidisciplinary team. An event such as this would not be an everyday occurrence for an Australian hospital nurse. If this event did occur, the emotional burden of this event may be shared with other members of the hospital health care team.

In the disaster environment, events that may be considered uncommon in the hospital environment become common. A nurse may hear multiple stories of uncommon or stressful events from different people, daily, for the duration of their deployment:

I heard stories from people who had lost their children. One woman recounted her disaster experience, which involved her two young children. . . . She had to let go of her youngest child to save herself and the oldest child. . . . On another occasion, one mother and father were discussing their five-year-old child with me. Their child was swept away in the water during the disaster . . . the child had not spoken a single word since the disaster. One middle-aged woman recounted her experience of being on the roof of her house with her two elderly parents. . . . a helicopter came past to rescue them. . . there was only enough space in the helicopter for one person. . . . She had the impression that her parents were going to die. I spoke with one man who had lived in this roof space for a week. . . . Another elderly couple were staying in their home with no electricity or water, cooking on a fire in their backyard and using a hole in their backyard as their toilet. When he came to us, the man was very unwell. . . . Another elderly man recalled a story of how he became separated from his family in the disaster. . . . he was told to get on the bus . . . his wife had died and other members of his family were missing.

In the disaster environment, a nurse may hear stories from patients regarding various stressful events. The frequency of the uncommon and stressful stories is greater than what they would experience in the Australian hospital environment:

I was listening to the stories of people who had been in the disaster and I was trying to support these people to the best of my ability. In the Australian hospital environment, I would have many other nurses to share this emotional load. Additionally, I would be able to refer patients to other support services and mental health teams. This is not the case in the disaster environment.

At the end of a shift, a hospital nurse may have strategies to cope with the emotional labour of experiencing a patient following an uncommon or stressful event. A nurse may attend a

formal debriefing session. A nurse may return home and discuss the event with family, or spend time alone.

Following deployment in a disaster, a nurse may have opportunities to be involved in formal programmes of debriefing:

The opportunity to debrief when I returned home varied. At times, this was very operationally focused. A discussion about my well-being occurred months after returning home. On another occasion, I had one-on-one sessions with a psychologist soon after arriving home. This was followed up by more sessions over the next six months.

During and following a disaster, a nurse may not have access to the same strategies for coping with stressful events as does a hospital nurse and this may change the way a nurse copes. Carrying an emotional burden and not having access to normal ways of coping orientates a nurse to *being* in a disaster.

9.4.3 Questioning the effort.

A hospital nurse may not necessarily think much about the day-to-day activities that have occurred in the workplace. A nurse may account for much of their day as a 'normal' day. In the hospital environment, nurses may recount and question extraneous events, such as a resuscitation on their ward or unit, the death of a child, or the death of a patient. They may question the decision making during these situations or question the systems that resulted in a patient being in the position they were in.

Upon returning home from a disaster, a nurse may question their effort in a disaster. *Being* with self, a nurse questions the efforts that they had individually contributed to the disaster medical assistance team. A nurse may question the level of impact they had in making a difference in the disaster-affected community. A nurse may think about some of the patients they saw and the patient situations.

When thinking of patients following a disaster, nurses may compare their own situation to the situation of those affected by the disaster:

I now think back to my time in the disaster and ask myself a number of questions: ‘Should I still be there helping?’ ‘Did I do all that I could have done?’ ‘Did I really make a difference?’ I implicitly knew that what I was doing was invaluable and making a difference to the disaster-affected community. I know that there was never a day where I did not try my best. Surrounding me there was such a large need for assistance; however, the best I could do was to help one person at a time. Now I am home, I think about particular patients and their situations, their family and their community. There are stories that I heard and situations that I have seen that will stay with me. When comparing my situation to those left behind in the disaster, I had many things; they had nothing.

This is a questioning of self and a nurse’s relationality with self as *being* with self.

Questioning the effort orientates a nurse to *being* following a disaster.

9.5 Commentary

The above communality reflection on a lived-experience description of *being* a nurse in an out-of-hospital environment following a disaster uncovered a number of key insights. It showed that nurses who wish to assist in the out-of-hospital disaster environment should be prepared for camp-like living conditions from a relational perspective. A relational closeness between nurses and the other health professionals occurs because of the closeness in interpersonal space combined with the speed with which the team is established and is required to work together. Further, a nurse is consciously aware of the clothing they will be wearing, as this portrays them as a nurse and as an insider closing the relationality between a nurse and a patient. Additionally, people from the disaster-affected community may speak more openly with nurses who have a geographical separation from the disaster-affected community. The following commentary discusses the above key insights uncovered from the communality existential reflection in relation to lived-relationships as *with colleagues, being relationally close, with patients and their families being an insider, and being with self*.

9.5.1 With colleagues, *being* relationally close

Being relationally close with colleagues indicated a shift in focus on the relationship of a nurse from previously *being* with their family in a maternal or paternal sense, to now *being* a family member among health professionals. As a family member among health professionals, a nurse works and lives with their colleagues.

A nurse may have spent much less time with people from the disaster medical assistance team when compared to their colleagues in the hospital environment, with whom they may have spent months or years. However, the interpersonal closeness of the lived-relationship with a nurse in a disaster orientates a nurse to *being* in a disaster. This may have occurred due to the interpersonal closeness of a nurse to other colleagues and due to the speed in which the relationship between a nurse and other colleagues has developed. A nurse may not have experienced this extent of professional relationality before.

On deployment in a disaster environment, there may be closeness in relationality between a nurse and other members of the team. This may be similar to the experience of *being* involved in an attempt to resuscitate a patient in the hospital environment, in which staff from various departments or units in the hospital come together for a common purpose: to resuscitate a patient or to formalise the ceasing of treatment. This can result in a closeness for all those involved, particularly for graduate nurses in the hospital non-critical care environments (Ranse & Arbon, 2008).

In a disaster environment, the closeness in lived-relations may be similar to those experienced by children on their school camp, who often would like to remain on camp for a longer period. Although the children would have spent many hours and days with the same people at school, living with people on camp results in closeness from a lived-relationship perspective.

Nurses who wish to assist in the out-of-hospital disaster environment should be prepared for camp-like living conditions from a relational perspective; that is, living and working with the same people for a long period. Getting to know people quickly makes it harder to leave them.

9.5.2 With patients and their families, *being an insider*

Lawler (2006) identified a number of ‘contextors’ that she described as contributing ‘to the structuring of the situations of nursing practice. Two of these [contextors] centre on the persona of the nurse (‘the uniform’ and ‘the manner’)’ (p. 151). When deployed to an area affected by a disaster, nurses may consider what uniform they will take and what other clothing they will wear. They may want to be seen as insiders to the disaster-affected community, as this may facilitate their ability to care for people. This would support Lawler’s (2006) notion that a nurse’s uniform is one contextor for situating nursing practice.

In addition to a uniform, Lawler (2006) stated that the nursing manner is an important contextor. The ‘manner [is] a particular style of personal presence that is variously described as “being professional”, “being clinical”, “being matter-of-fact”, “appearing as though you know what you’re doing”, “being in control”, “appearing as though you have done this a million times before”’ (p. 153). This was not expressed by participants of this study.

Nurses who assisted in the out-of-hospital environment following a disaster had a sense that people from the disaster-affected community wanted to talk to them because a nurse in the disaster medical assistance team comes from outside the disaster-affected community.

Perhaps a person in the disaster-affected community would be more willing to discuss the disaster with a nurse from a different jurisdiction than with a nurse in the disaster-affected community. This was seen in the experiences of nurses following the Ash Wednesday bushfires, when nurses established relationships with local community nurses, general

practitioners and existing community groups and hospitals to refer patients (Berah, Jones, & Valent, 1984; Cox, 1997). Mental health nurses actively reached out to the people of the disaster-affected community, who wanted to talk to nurses from outside of the disaster-affected community regarding their loss, grief and healing (Cox, 1997).

Perhaps all nurses are insiders by virtue of the fact that they are a nurse. That is, nurses as part of a disaster medical assistance team have a particular uniform that identifies them as nurses, as well as the distance from the disaster that gives people a sense of ability to discuss the disaster with them.

9.5.3 *Being with self*

Lived-relations with self and *being* with self as a nurse in the out-of-hospital environment following a disaster provide insights into the ways in which nurses may cope following a disaster. This phenomenological study did not seek to find answers to any psychological expression from nurses following a disaster, such as whether the disaster experience was a ‘good’ or a ‘bad’ experience. However, this study has provided insight into the psychosocial life-world of a nurse.

There is an abundance of published literature and case studies relating to the psychosocial effect of disasters on people within disaster-affected communities. Such literature now spans at least five decades. A commonality across the various decades is the discourse regarding post-traumatic and post-disaster stress-related conditions (Raphael & Middleton, 1987; Cao, McFarlane, & Klimidis, 2003; Madakasira & O’Brien, 1987; Srivastava, Goel, Semwal, Gupta, & Dhyani, 2015). Recent examples of literature highlighting the increased occurrence of psychological disorders among people within disaster-affected communities includes

research from Hurricane Katrina (McLaughlin et al., 2011), the Joplin Tornado²⁹ (Houston et al., 2015) and the Christchurch earthquakes (Fergusson et al., 2014).

Nurses have provided psychosocial care to people in disaster-affected communities following the Victorian bushfires (Ranse et al., 2010), the Ash Wednesday bushfires (Cox, 1997) and Queensland extreme weather events (Hasleton et al., 2013). Additionally, this current phenomenological study has provided insights into the psychosocial care provided by Australian civilian nurses as part of a disaster medical assistance team following a disaster. In particular, this study has revealed that nurses take on an emotional burden from their experience of *being* following a disaster. This manifests primarily in relation to listening to accounts of the disaster from multiple people affected by the disaster. Additionally, on returning home, nurses question their effort in the disaster.

Pulido (2007) suggested that social workers who responded following 9/11 demonstrated signs of secondary traumatic stress, related primarily to listening to the stories of people affected by the disaster. From a nursing perspective there is scant literature regarding the psychosocial effects for nurses following a disaster. One study specifically explored nurses' psychosocial responses following the Wenchuan earthquake, highlighting a higher level of psychological distress in nurses following a disaster when compared to nurses who did not assist in a disaster (Zhen et al., 2012). Following the Christchurch earthquakes, it was identified that the effect of the disaster had a significant emotional impact on nurses, both personally and professionally (Johal & Mounsey, 2016).

²⁹ Tornado in Joplin, Missouri, United States of America, 22 May 2011.

9.6 Summary

This reflection has focused on what it may be like *being* a civilian hospital nurse in the out-of-hospital environment following a disaster from a communality, or lived-relationships perspective. This reflection has highlighted a possible existential experience of lived-relationships as *with colleagues, being relationally close; with patients and their families, being an insider; and being with self*. The commentary on the communal reflection has provided further insights into an experience from a communal perspective. The communal reflection can be displayed diagrammatically, overlaying the uncovered moments, as outlined in Figure 9.1.



Figure 9.1. Diagrammatic representation of the communal reflection.

Chapter 10: A Temporal Reflection on a Lived-experience

Description of *Being* a Nurse Following a Disaster

10.1 Introduction

Time can be measured in seconds, minutes, hours, days, weeks and so on. For a nurse, this measurable time is embedded in the daily activities of nursing. This was noted in Ranse (2014), suggesting that ‘nursing . . . has time embedded in it. For example: medication time, theatre time, time for a break, length of stay—measured in time, rules of time—such as the four-hour target for decision making in the [Australian] emergency department’ (p. 591). This time is measurable time, or *chronos* time. Daily activities that surround *chronos* time form the background to a nurse’s normal state of *being* in a taken-for-granted hospital life-world.

Following a disaster, *chronos* time and timing may be a focus for the people affected by the disaster. Some people may be concerned with the time it will take before infrastructure can be restored, such as power, water, sewerage, telecommunications and/or transport. Some people may be concerned with the time it will take before health services can be restored or until further health assistance will arrive from another jurisdiction. Nurses may be concerned with the time since the onset of the disaster or the time until they will arrive in a disaster-affected community as part of a disaster medical assistance team.

Temporality, or lived-time, from a phenomenological perspective goes beyond the measurable *chronos* time, to felt time—*kairos* time. Things or moments of significance seem to either speed up or slow down in *kairos* time. *Kairos* time that speeds up portrays a sense of time passing quickly, whereas *kairos* time that slows down portrays a sense of time passing slowly (van Manen, 2014a). The temporal reflection in this chapter is concerned with *kairos* time; that is, the way we find ourselves in the lived-time of *being* in the world (van Manen, 1990).

In this phenomenological study, temporality following a disaster is concerned with an experience of a nurse's lived-time *speeding up and condensing* or *slowing down and stretching*. The focus of this reflection is on *being* a civilian hospital nurse in an out-of-hospital environment following a disaster, from a temporal or lived-time perspective. A preparatory epoché-reduction and reduction proper was used to guide this reflection on the temporality of *being* a nurse in an out-of-hospital environment following a disaster from the previously presented lived-experience description.

10.2 Kairos Time *Speeding Up and Condensing*

On occasions, nurses in the hospital environment may proclaim to each another that the shift 'went fast' when compared to previous shifts, as 'there was a lot to do'. van Manen (1990) suggested that kairos time speeds up when someone is busy, engaged and enjoying themselves. An experience of *being* a nurse in an out-of-hospital environment following a disaster, from a nurse's lived-time, *kairos time speeding up and condensing* perspective could be described as *being* rushed, *being* busy and finding time.

10.2.1 *Being* rushed.

Normally, hospital nurses have advance notice of when they will be working, receiving their rosters weeks to months in advance of their actual shifts. Usually, nurses do not need to make rushed decisions to plan their working rosters and the activities that form a background to their life-worlds. However, there may be some instances in which a nurse needs to make a rushed decision to commit to working in the hospital environment, such as when receiving a phone call or text message from a health service manager requesting them to work an extra shift due to low staffing numbers. This message may be received with short notice prior to the commencement of being required to work, such as hours rather than days, weeks or months in

advance. Perhaps these phone calls and text messages asking nurses to fill staff shortages are the normal way of registering an interest in extra work for a hospital nurse.

Following a disaster, there seemed to be a need to make a rushed decision to either accept or reject the opportunity to assist as part of a disaster medical assistance team, as members of the team needed to be confirmed and logistics organised to ensure they arrived in the disaster-affected community in a timely manner. The initial contact with a nurse may occur via a mobile phone text message, followed soon after by a phone call from a health service representative:

Soon after becoming aware of the disaster, I received a text message to my mobile telephone notifying me that a disaster response was required. The text message came from my local health service. The text message requested a reply ascertaining whether I would be able to assist in the disaster. Soon after receiving the text message, I received a phone call. The health service wanted to know if I could assist in the disaster and if I could 'be on standby'.

The decision to accept or reject the opportunity to be part of a disaster medical assistance team following a disaster has potentially large ramifications that may disrupt a nurse's normal life-world for weeks or months, possibly extending to years.

Making a rushed decision and *being* rushed to commit to respond as part of a disaster medical assistance team following a disaster may result in a sense of *kairos time speeding up and condensing*. *Kairos time speeding up and condensing* results in a nurse *being* rushed. *Being* rushed orientates a nurse to *being* in a disaster medical assistance team following a disaster.

10.2.2 *Being* busy.

A hospital nurse may experience periods of busyness. For example, when an unconscious patient presents to the ED by ambulance, the care of this patient may have many nurses, doctors and other members of the health care team *being* busy. This is busyness around one

patient. On a surgical ward, when multiple patients return from theatre, there may be busyness for nurses around a small group of patients. When a staff member goes home sick, leaving the ward understaffed, the remaining nurses may be busy around an entire ward, unit or department. These periods of busyness may not be everyday occurrences for the hospital nurse.

For a nurse early in a deployment with a disaster medical assistance team to a disaster-affected community, many people need their injuries and illnesses to be assessed and managed. *Being* busy when working a shift in a disaster may engender a sense of kairos time *speeding up and condensing*:

As a team, we were seeing hundreds of people each day. I was working long hours, many more than I would work in the hospital. . . . I remember people lining up to access the health services we were providing. . . . At times, we were busy and overwhelmed by the number of presenting patients. Initially, patients were pushing each other out of the way to access our service.

After a busy shift, a hospital nurse may leave the hospital and return to their home, where they may cook and clean or choose to order a meal that is delivered to their home. The busyness of their hospital work does not necessarily continue at home.

A nurse in the disaster-affected community as part of a disaster medical assistance team needs to contribute to camp activities such as cooking and cleaning. The camp activities are everyday activities for a nurse as part of a disaster medical assistance team. At times, these camp activities at the end of a shift may seem busier than the activities of working a shift:

When I was not working clinically, I kept myself very busy by assisting with other camp activities. I was always assisting with jobs to maintain the functioning of the camp. At times, this included building a water drainage system around the camp, cleaning tents and the communal areas, and gathering items for meals. There were no days off. Camp life was busy. At times, it seemed busier working in the camp than working a clinical shift.

Being busy in both the clinical and camp environment as part of a disaster medical assistance team following a disaster portrays a sense of *kairos time speeding up and condensing*. *Being* busy and *kairos time speeding up and condensing* orientates a nurse to *being* in disaster medical assistance team following a disaster.

10.2.3 Finding time.

When lived-time passes quickly in the life-world of a nurse on deployment to a disaster area, a nurse may try to find additional time. Early in the deployment, a nurse may be *being* rushed and *being* busy. Therefore, a nurse may not have time, as time is speeding and condensed.

When a nurse does get moments of additional time, outside the clinical and camp demands, this time may be spent resting or being alone. When resting, a nurse may find time to read a book or listen to music:

Early in the deployment, I was not having enough rest time. . . . I spent time alone reading and listening to music. . . . As the deployment progressed, I made sure I got enough rest and took the time to have breaks. I became very tired.

Being rushed, *being* busy and finding time as part of a disaster medical assistance team following a disaster portrays a sense of *kairos time as speeding up and condensing*. *Kairos time as speeding up and condensing* orientates a nurse to *being* in a disaster medical assistance team after a disaster.

10.3 Kairos Time *Slowing Down and Stretching*

A hospital nurse may have a patient requiring theatre at a certain time in their shift; however, it may seem to ‘take forever’ for the patient to be transferred to the operating theatre. Hospital nurses on their shift may proclaim to each another that the shift ‘went slowly’ when compared to previous shifts, as there ‘was little to do’ or they spent much of their shift waiting for others. van Manen (1990) suggested that *kairos time* slows down when someone is bored or

anxious, which can be unsettling. An experience of *being* a nurse in an out-of-hospital environment following a disaster, from a nurse's *kairos time*, *slowing down and stretching* perspective, could be described as *being* unsure and filling in time.

10.3.1 *Being* unsure.

A hospital nurse may have some idea about what their shift may be like and may know who they are likely to encounter on a daily basis. A nurse knows that they have a certain patient population for which they will care and that they will work with other members of the multidisciplinary team, such as other nurses, doctors or allied health professionals. For a hospital nurse, time is usually planned and this may provide a window to an imagined future. When time is not planned, an experience may be unsettling and portray a sense of *being* unsure for a nurse. A hospital nurse, depending on the ward, unit or department in which they work, may complete a medication round at approximately 0800 hours. Patients may ask to have a shower in the morning and the shift may finish at 1530 hours, at which time a nurse may have handed over to another nurse to continue the care of the patients. For the above to occur, a nurse may have an understanding of what a shift may be like and therefore may have a plan of what their shift may be like.

For a nurse deployed following a disaster, there may be no specific plan, particularly in the early stages of the deployment. If a plan does exist, this plan may change continually. This continually changing plan in the early stages of deployment may engender a sense of *being* unsure. Some moments following a disaster that may exemplify the experience for a nurse as *being* unsure may include waiting for information after receiving a phone call to assist with a disaster medical assistance team, *being* unsure of who will meet disaster medical assistance team in the disaster-affected community and *being* unsure about the working environment.

Waiting for information and *being* unsure of a plan starts from the moment of receiving a phone call or text message inviting the nurse to be deployed.

Once the decision is made to assist following a disaster, a nurse may experience a period of *being* unsure, waiting for the exact details of their deployment to be known:

Once I agreed to assist, I waited to find out what day and time I might be required to deploy. I was told that I would be advised by the health service when I needed to go, and I needed to be ready to leave at short notice. . . I received a phone call to go to the central congregation point. I was about to go, then I received a phone call and was told, 'Don't go yet, it might be another seven hours before you go'. Approximately seven hours had passed when I received another phone call stating, 'It may be another couple of hours before you go'. It was now late in the night. I received another phone call to say, 'You will not be going until the early morning'. During the night, I got a phone call to meet at the central congregation point, with a very tight time frame.

The need to make a hurried decision, followed by a period of waiting until details are known, may engender a sense of *kairos* time passing slowly. *Being* unsure of a plan and having time to wait to respond as part of a disaster medical assistance team following a disaster may engender a sense of *kairos time slowing down and stretching*. Prior to leaving for the disaster-affected community, communications may have occurred between the governments or health services of the disaster-affected community and the community from which the disaster medical assistance team is being deployed. However, this plan may change once a nurse arrives as part of a disaster medical assistance team in the disaster-affected community. The original plan to meet a local official may not come to fruition. Instead, there may be no one to meet the disaster medical assistance team members:

The aeroplane landed. . . . I then congregated with the contingent to wait for the local officials to meet us. I saw many people sleeping in the terminal. I continued to wait. There was no one to meet us.

Being unsure of who will meet the disaster medical assistance team in the disaster-affected community and the changing plans may engender a sense of *being* unsure. *Being* unsure of a

plan and plans changing continually may engender a sense of *kairos time slowing down and stretching*. *Kairos time slowing down and stretching* orientates a nurse to *being* in a disaster medical assistance team following a disaster.

A hospital nurse has a plan of care for the patients in their care and this engenders a sense of control. They may have a plan for one patient in the ICU or a plan for numerous patients on a ward.

A nurse deployed following a disaster may be unsure of where they will be working, whether in a hospital providing support to local staff or in the out-of-hospital environment. This plan is out of the control of a nurse. For a period, there may be no specific plan and this may engender a sense of *kairos time passing slowly*:

There was a period during which it seemed that there was no specific plan for me and I was unsure of what I was going to be doing. During this period of waiting for a specific plan, I saw members of the community digging mud and cleaning streets. I was doing nothing for the community. Eventually, I was tasked to work in the local hospital, supporting the local nursing staff. I was going to work in areas such as in the ED, on the trauma ward and in the mental health ward. However, this plan to work in the hospital did not eventuate. Again, I had no plan. Soon after, I was directed to return to the main camp and health precinct, where I would provide a health service from our temporary health facility.

Being unsure of a plan and having plans change continually forms the background to the life-world of a nurse following a disaster, waiting for information after receiving a phone call to assist with a disaster medical assistance team, *being* unsure of who will meet the disaster medical assistance team in the disaster-affected community and *being* unsure of the working environment. Not being in control of a plan and not having a plan at all may be unsettling. Having a sense of being unsettled may engender a sense of *being* unsure. *Being* unsure portrays a sense of *kairos time slowing down and stretching*. *Being* a nurse in an out-of-

hospital environment following a disaster with time *slowing down and stretching* orientates a nurse to *being* in a disaster medical assistance team following a disaster.

10.3.2 Filling in time.

As previously described, when kairos time passes quickly, a nurse may try to find time for the purpose of resting or being alone. Conversely, when time passes slowly and stretches the life-world of a nurse, the nurse may seek to fill in the time, perhaps by finding things to do, such as packing clothing and other items to take to the disaster. Additionally, a nurse may use this time to gain a better understanding of the disaster-affected community:

I was waiting for confirmation of my expected departure date, time and initial meeting location. During this time, I commenced packing the items I was planning on taking to the disaster. . . . In preparing to go to the disaster, I started to read about the country, the climate, culture, religion, poverty levels and the existing health infrastructure. I tried to get a general overview of the country's socio-economic-health status prior to the disaster occurring.

Being unsure of a plan and filling in time at various moments of the disaster response, such as having no plans regarding transport and clinical activities; and experiencing changes in existing plans can lead to a sense of uncertainty. This uncertainty portrays a sense of *kairos time slowing down and stretching*. *Being* unsure of a plan and time passing slowly orientates a nurse to *being* in a disaster medical assistance team following a disaster.

10.4 Commentary

The above temporal reflection on a lived-experience description of *being* a nurse in an out-of-hospital environment following a disaster has uncovered a number of key insights. These insights included that when engaged in clinical and camp work, it can seem that time passes quickly but when *being* unsure of the plan for working in a disaster, time passes slowly. The following commentary discusses these key insights uncovered from the temporal existential

reflection in relation to lived-time as *kairos time speeding up and condensing* and *kairos time slowing down and stretching*.

10.4.1 Kairos time speeding up and condensing

For nurses who are busy, time passes quickly. Nurses in this study had a sense of *being* rushed to make a decision to commit to deploying with a disaster medical assistance team following a disaster. When exploring the phenomenological existential of lived-time, the structure of non-lived-time is uncovered inadvertently. When nurses were *being* rushed to hurry up and decide to deploy to a disaster, *being* rushed engendered a sense of time passing quickly but waiting for further information engendered a sense of *kairos time slowing down and stretching*. Anecdotally, ADF personnel who assist with humanitarian aid have the same experience. From a disaster nursing perspective, there is scant literature relating to this experience of ‘hurry up and wait’. Delehanty (1996) discussed the role of American civilian disaster medical assistance teams, such as those associated with the American Red Cross, stating, ‘The government’s standard practice of ‘hurry up and wait’ might work in military circles where personnel have no other job, but when mobilizing volunteers, who have a life in their community, considerations need to be made’ (pp. 188–189). Perhaps consideration is required for Australian civilian hospital nurses who have commitments to their workplace, family or community.

10.4.2 Kairos time slowing down and stretching

Being unsure of a plan to deploy to disaster, which engendered a sense of time passing slowly, related to the communication between health services and individual nurses. Perhaps, to improve the experience of *being* unsure of a plan and moving to *being* sure of a plan, communication between health services and individual nurses could be improved, drawing from the experience of other disciplines or services in relation to preparation for deployment

from an individual's experience of temporality. In particular, experience may be drawn in relation to communication within and between government, health services and individual nurses.

10.5 Summary

This reflection has focused on what it may be like *being* a civilian hospital nurse in the out-of-hospital environment following a disaster, from a temporal, or lived-time, perspective. This reflection has highlighted a possible existential experience as lived-time as *being* slow and stretching as well as *being* fast and condensing. The commentary on the temporal reflection has provided further insight into an experience from a temporal perspective. The temporal reflection can be displayed diagrammatically, overlaying the uncovered moments, as outlined in Figure 10.1.



Figure 10.1. Diagrammatic representation of the temporal reflection.

Chapter 11: *Being About Time*

This study uncovered the following moments of a possible experience of *being* a nurse in an out-of-hospital environment following a disaster: ‘on the way to a disaster’, ‘prior to starting work’, ‘working a shift in a disaster’, ‘end of a shift’ and ‘returning home’. These moments led to an anecdote, presented as a lived-experience description, of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital environment as part of a disaster medical assistance team following a disaster. This lived-experience description was presented in chronos time. That is, the moment of being ‘on the way to a disaster’ occurred prior to, and for the sake of, the moment ‘prior to starting work’. The moment ‘prior to starting work’ occurred prior to, and for the sake of, the moment of ‘working a shift in a disaster’. The moment ‘working a shift in a disaster’ occurred prior to, and for the sake of, the moment ‘end of a shift’. Finally, the moment ‘end of a shift’ occurred prior to, and for the sake of, the moment ‘returning home’.

As one moment occurs for the sake of the next moment, the experience of these moments orientates a nurse to *being* in the future. The phenomenological existential reflections then overlay the uncovered moments. By virtue of overlaying the phenomenological existentials with the uncovered moments, the phenomenological existentials implicitly form a chronos time background to an experience. As chronos time appears throughout an experience, it forms the taken-for-granted background to a nurse’s life-world of *being* in the out-of-hospital environment as part of a disaster medical assistance team following a disaster. The following examples describe this overlay and intersection of time, the uncovered moments and phenomenological existentials: time, uncovered moments and lived-space; time, uncovered moments and lived-body; time, uncovered moments and lived-relationships; and time, uncovered moments and lived-time. A two-dimensional, simple diagrammatic representation

of the complex intersection between time, the uncovered moments and phenomenological existentials is represented in Figure 11.1.

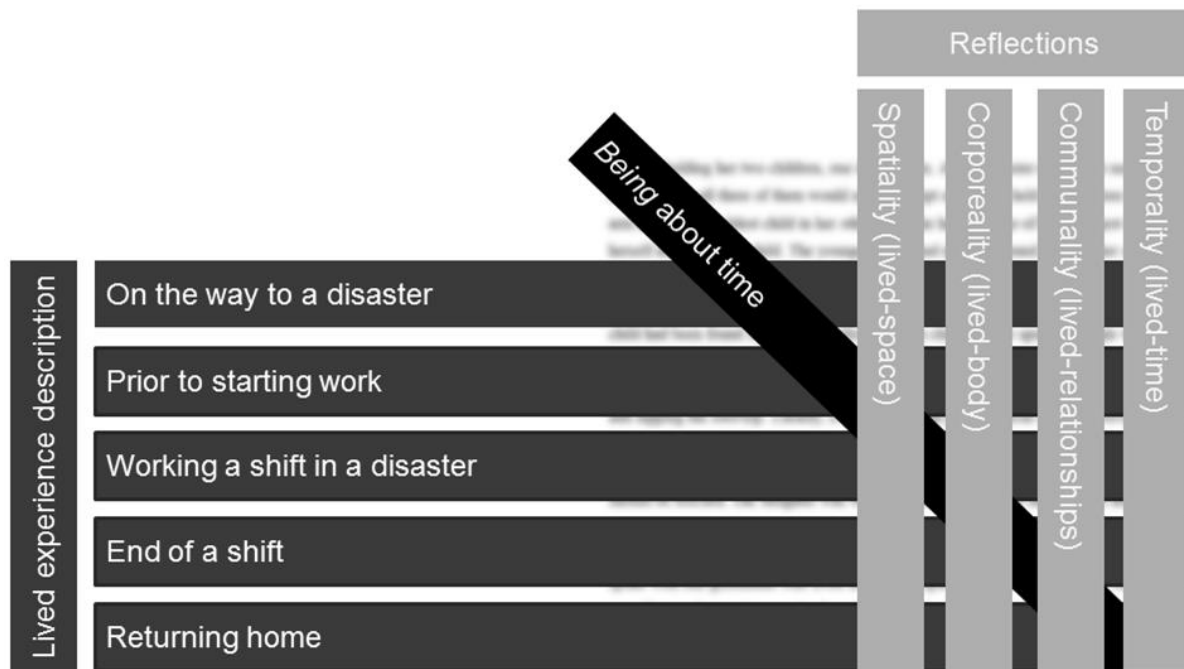


Figure 11.1. Diagrammatic representation of chronos time across moments and existentials.

The phenomenon of what it may be like *being* a nurse in an out-of-hospital environment following a disaster may appear differently over time for an individual who has experienced nursing in a disaster. Such experience may be plotted against the structures of time, being the past [retention], now and future [pretention]. A nurse cannot experience what they experience unless they experience things appearing over time. It is over time that things start to make sense. Things make sense in totality as parts of an experience show themselves. Such an understanding of an experience as parts of a whole is undertaken in the manner of a hermeneutic circle. As such, the experience of what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital disaster environment as part of a disaster medical assistance team is formed on the predicate of time, pushing to the future. Ranse (2014) stated, ‘Delving into the past allows for the building of a trajectory of a plausible evolution, giving

insights into the imagined future' (p. 590). As such, in this chapter the overlay and intersections of the time itself, uncovered moments and existentials are viewed as intrinsically linking to an experience of *being* a nurse as part of a disaster medical assistance team.

Lived-space changes over time. The timing of changes relating to space may be influenced by factors such as the onset of the disaster, the duration of the nurse's deployment and the timing of the nurse's return home. Lived-space changes as *intentionality, drawn in and shrinking* when a nurse is in the moment of 'on the way to a disaster'. Additionally, this is exemplified in an experience of *being drawn-in, looking out* and in the moments of 'prior to starting work', 'working a shift in a disaster' and 'end of a shift'. Further, this may be exemplified in the *wide-open, crowded* lived-space when 'returning home'. Time intersects with the uncovered moments of a possible experience following a disaster together with the phenomenological existential of spatiality.

A nurse's *lived-body, for patients following a disaster* appears differently over time and therefore the experience of lived-body changes over time for a nurse. *Lived-body for patients following a disaster* is primarily situated in the moment of 'working a shift in a disaster', purely by virtue of the fact that nurses are with patients during a shift. This includes the experience of *endless lived-bodies, injured and ill lived-bodies, death and psychosocial well-being*. The experience of *returning to the lived-body of a hospital patient* is experienced in the moment of 'returning home'. Time intersects with the uncovered moments of a possible experience following a disaster together with the phenomenological existential of corporeality.

Lived-relationships are formed over time. A nurse may spend one minute with someone and form an instant relationship, or spend a lifetime with someone else and never have a

relationship. The timing of lived-relationships following a disaster may be influenced by when the relationship started, when the relationship finished, whether the relationship was ongoing and the intensity of the relationship. *With colleagues being relationally close*, relationships are formed over time as *starting relationships* when nurses first meet ‘on the way to a disaster’. *Relational closeness as work becomes home and home becomes work* occurs in the moments of ‘prior to starting work’, ‘working a shift in a disaster’ and ‘end of a shift’. *Relational widening* occurs when ‘returning home’. Thus, time intersects with the uncovered moments of a possible experience following a disaster together with the phenomenological existential of communality.

Lived-time, as temporality, may be influenced by time. An experience of *being unsure* intersects during the moments of ‘on the way to a disaster’ and ‘prior to starting work’, as is the experience of *filling in time*. As the uncovered moments progressed chronologically to ‘working a shift in a disaster’ and ‘end of a shift’, this was experienced as *kairos time speeding up and condensing*. Time intersects with moments of an experience and lived-time as an existential of an experience. An experience in totality is formed on the background predicate of time. That is, things as moments of an experience are orientated towards time and things change over time. Time intersects with the uncovered moments of a possible experience following a disaster together with the phenomenological existential of temporality.

11.1 Summary

Each of the phenomenological existentials is in its own manner a way to uncover the thingness of a thing. However, it is not as if an experience is made up of one existential, exclusive from one another, as the phenomenological existentials are not mutually exclusive. *Being* a nurse in an out-of-hospital environment following a disaster sees an overlying and intersecting of the existentials and the influence of one existential on another. Chronos time

intersects the uncovered moments and the existentials. As such, time emerges strongly as part of the experience of *being* an Australian civilian nurse as part of a disaster medical assistance team following a disaster.

Chapter 12: Implications, Questions and Final Commentary

12.1 Introduction

This phenomenological study has provided insights and new knowledge into a possible experience of what it may be like *being* an Australian civilian nurse in the out-of-hospital environment as part of a disaster medical assistance team following a disaster. This chapter explores various implications and questions relating to the experience of *being* a nurse in a disaster medical assistance team following a disaster, outlining the key implications from this study and including many questions arising from the insights into the experience that may require further exploration. These implications and questions emerged throughout this study, based on the uncovered moments, existential reflections and phenomenological insights. These implications and questions may be of interest to clinicians, managers, leaders, policy developers, educators and researchers. The implications and questions explored in this chapter appear in no particular order of importance in the areas of future practice, future education and professional development, and future research.

12.2 Future Practice

This section provides implications and questions for future practice that may be of interest to clinicians, managers, leaders, policy developers, educators and researchers. These implications and questions are related to the phenomenological existentials of lived-space, lived-body, lived-relationships and lived-time. Additionally, the implications and questions relating to future practice are considered with respect to '*being about time*'.

From a spatial perspective, this study revealed the experience of nurses in a disaster medical assistance team following a disaster as *lived-space shrinking then opening too-wide*. The briefings in the uncovered moment of 'on the way to a disaster' in preparation for deployment

were forward looking, concerned with the realities of what it may be like in the disaster environment. These briefings were based on intelligence, situational awareness and information forwarded to the disaster medical assistance team. Conversely, debriefings in the uncovered moment at the 'end of a shift' were looking back at what had occurred, particularly from an operational perspective. Perhaps debriefings also need to be forward looking and include what to expect for a nurse in the moment 'returning home' from a disaster. This may be important, as the *wide-open, crowded* lived-space when a nurse was 'returning home' seemed to be an unsettling experience.

In their experience of the *wide-open, crowded* lived-space as *shrinking then opening too-wide*, it was evident that nurses wanted to share their stories of *being* in a disaster. Additionally, there were requests from family, friends and work colleagues to hear stories about a nurse's experience. Perhaps the preparation for nurses 'returning home' to the *wide-open, crowded* lived-space could include some strategies to help a nurse reassimilate and reassemble their previous lived-space, such as providing them with structures for ways of sharing their experience with family, friends and colleagues. Perhaps, through the use of technology, this could be achieved in a contemporaneous manner throughout all moments following a disaster and be used as a diary or reference point upon returning home.

This study revealed a *nurse's lived-body, when nursing following a disaster as being autonomous*. As such, a nurse may need to know when not to refer patients to a higher level of care and when not to discharge patients from a disaster health service. This may be abnormal practice for the hospital nurse who normally does not make decisions about discharging patients from their service. Perhaps hospital nurses wishing to assist in a disaster medical assistance team following a disaster could have experience in areas of nursing that may have more autonomous role, such as community nurses and/or public health nurses.

Previously, Ranse (2013) has considered what 'group' of nurses should assist following a disaster. Rokkas, Cornell and Steenkamp (2014) argued that public health nurses have a unique set of skills that could be valued following a disaster, such as care *being* nurse-led and autonomous. Similarly, Ranse, Hutton, Wilson and Usher (2015) suggested that mental health nurses could make a contribution following a disaster, particularly from a mental health perspective.

With regard to a *nurse's lived-body, for nursing following a disaster as being autonomous*, a nurse may have a different scope to what they practice normally in the hospital environment. Further exploration relating to a nurse's scope of practice and standards of care within the out-of-hospital disaster environment is needed. Within the Australian context, Cusack and Gebbie (2015) suggested that this conversation needs to occur among 'professional nursing organisations, Chief Nurses, unions, and regulation authorities' (p. 6). Perhaps this conversation should commence with the principles of ethical standards of care in the disaster environment. It may be that the standards of care delivered in a disaster influence patient outcomes, rather than the actual or perceived competencies of nurses.

With colleagues, being relationally close explored an experience of living and working with each other. This formed a *relational closeness as work becomes home and home becomes work*, between nurses who would otherwise likely be strangers and may have never worked or lived together. Perhaps lessons may be able to be drawn from other disciplines or services in relation to relationality and closeness of people on deployment. For example, organisations such as the ADF have been deploying people on humanitarian missions for many years and their practices with personnel in relational closeness situations may provide insight and strategies for Australian civilian nurses in deployment following a disaster. Further, perhaps education of nurses should include issues beyond the clinical shift, such as the realities of

being at the 'end of a shift' when on deployment. Perhaps activities that involve nurses camping together would assist in simulating this experience.

From a *with patients and their family, being an insider and being an insider and people disclosing things* perspective, people disclosed issues to nurses because they were identified as nurses. The commentary on this topic suggests that this may be related to the uniform and manner of nurses, as contextors of nursing. Perhaps nurses, as part of a disaster medical assistance team, should be required to wear a uniform that identifies them as a nurse. This may encourage people affected by disasters to discuss their psychosocial situation with nurses.

From a lived-relationship, *being with self* perspective, engaging in activities such as reading and listening to music were strategies used by nurses in this study in *filling in time* when *kairos time was slowing down and stretching*. Additionally, nurses' experiences of listening to music were *lived-space shrinking then opening too-wide when drawn in, looking out*. Such experiences of music occurred in the uncovered moment the 'end of a shift'. Areni and Grantham's (2009) research demonstrated that disliked music versus liked music influences an experience of kairos time. When music is disliked, time passes slowly, whereas when music is liked, time passes quickly. Perhaps this is why music therapy is being used increasingly in health, as a way of patients passing time more quickly during moments of kairos time slowing down. Perhaps nurses following a disaster who listened to liked music experienced a speeding of kairos time and that is why they listened to music. Perhaps a variety of musical genres should be available to nurses in a disaster to facilitate the *filling in time*.

12.3 Future education and professional development.

There is little undergraduate (Usher & Mayner, 2011) or postgraduate education (Ranse, Shaban et al., 2013) for Australian nurses pertaining to disaster preparedness. Ranse, Hammad et al. (2013) suggested that currently, the responsibility for the educational development of nurses preparing for a disaster lies with the individual nurse's employers or the individual nurses themselves. This section makes recommendations for education and professional development and poses questions for clinicians, managers, leaders, policy developers, educators and researchers. In particular, the recommendations and questions in this section relate to enhancing nurses' understandings of the realities of *being* a nurse as part of a disaster medical assistance team following a disaster. This section presents the implications and questions related to the phenomenological existentials of lived-space, lived-body, lived-relationships and lived-time. Additionally, the implications and questions relating to future education and professional development are considered with respect to '*being about time*'.

As part of a disaster medical assistance team following a disaster, nurses may experience the *disaster health lived-space as occupying, sharing and giving back*. Nurses should be aware of the changing physical space in a disaster and the resulting changing disaster health lived-space. Perhaps awareness of the changing lived-space could be achieved via educational activities. An enhanced understanding of the disaster health lived-space may result in an early sharing of this space with health professionals in the disaster-affected community, thus enhancing the transition of patient care and responsibility to the community's usual health providers. Educational emphasis could be on working with health care professionals from within the disaster-affected community whose practices have been disrupted due to the disaster.

In this study, *nurse's lived-body, for nursing following a disaster was without technology and resources, being hands-on and nurse-led*. The educational development of nurses should have an element of working in low-resource environments, promoting a workforce that can provide nursing care without a reliance on technology. That is, perhaps the education of nurses at an undergraduate and postgraduate level needs to include care without technology. This could be replicated in hospital education sessions.

Perhaps a decreased reliance on technology needs to have a presence within the initial and ongoing education of nurses at all levels. This may have a two-fold benefit. First, it could provide insight into the realities of what it may be like to be a nurse in a disaster without technology and resources. Second, it could provide insight into the continuity of care from a business perspective, such as how a nurse in a hospital experiences the lived-body with diminished technology and resources during events such as bushfires, flood or power outages.

Following a disaster, a nurse may be exposed to death and dying to an extent not experienced normally in the hospital environment. Additionally, from a *nurse's lived-body, for patients following a disaster*, death and dying is public in comparison to a death in a hospital. Perhaps education can prepare nurses for the reality of caring for death and dying publicly, particularly when the extent of death and dying is unlike what a nurse may have experienced previously in the hospital environment.

A just-in-time approach to delivering education to nurses could take place when nurses experience kairos time as *slowing down and stretching*. This may facilitate nurses who are *filling in time* at various moments following a disaster. Just-in-time disaster education strategies have been successfully implemented in China (Yang, Chen et al., 2010) and the United States of America (Littleton-Kearney & Slepski, 2008). Similar suggestions have been

made previously for nurses in Australia (Ranse, Hammad et al., 2013). Veenema (2016) developed a smartphone application for disaster nursing education for all nurses. A more specific application for nursing as part of a disaster medical assistance team could be explored. Just-in-time education on a device could take many forms. For example, education could be developed for nurses about the culture, religion and current health situation of the disaster-affected county. Further, a just-in-time education application on a device could give nurses updates on the best available evidence for practice, such as the various possible injuries and illnesses that may be encountered when working in a disaster. Just-in-time education may be useful for nurses who are not familiar with the various WHO treatment guidelines and fact sheets related to communicable and tropical diseases. Just-in-time education could elaborate on standards of care for a nurse ‘on the way to a disaster’, serve as a communication tool ‘on the way to a disaster’ for briefings and situation updates, or as a diary for use at the ‘end of a shift’.

Australian civilian hospital nurses who assist in the out-of-hospital environment following a disaster may require education and professional development to enhance their experience and prepare them better to enhance patient outcomes. The timing of these education and professional development activities should be carefully considered.

12.4 Future research.

International disaster nursing research priorities were identified by Ranse, Hutton, Jeeawody and Wilson (2014) through a Delphi process. The top-ranking research statements from this Delphi study included aspects of education and curriculum (n = 2, 20%), clinical practice (n = 2, 20%) and relationships and networking (n = 1, 10%). Of particular note was the high ranking of multiple psychosocial research statements (n = 5, 50%). Ranse et al. (2014) stated the ‘future disaster nursing research should focus on the area of psychosocial aspects of

disaster nursing, in particular, both the psychosocial needs of a disaster-affected community and the psychosocial well-being of nurses who assist in disaster health activities' (p. 448).

Research could be conducted from a lived-relationship perspective in which nurses experience *being with self*. This study revealed the experience of a nurse of *being with self* as *carrying an emotional burden*. This emotional burden may be greater than the emotional burden of hospital nurses. Debriefing following a disaster, from a *being with self* perspective, varied for nurses. The effectiveness of debriefing and other critical incident stress management strategies have been debated in the literature regarding their place and value (Bledsoe, 2003; Smith & Roberts, 2003). Following a systematic review of studies relating to single-session psychological debriefing, Rose, Bisson, Churchill and Wessely (2002) concluded that there is insufficient evidence that individual psychological debriefing is of value in preventing post-traumatic stress disorder. Further, Roberts, Kitchiner, Kenardy and Bisson's (2009) systematic review identified that multiple sessions within the first three months following a stressful event did not prevent post-traumatic stress disorder. Both Rose et al. (2002) and Roberts et al. (2009) suggested that compulsory debriefing sessions should no longer take place. However, these systematic reviews focused specifically on post-traumatic stress disorder and disregarded other distress-related episodes from exposure to stressful circumstances such as disasters. Further research should explore ways to support nurses returning home from a disaster. Research questions could explore questions such as:

- 'What is the effect of nurses *carrying an emotional burden* during and following a disaster?'
- 'What is the effect of *questioning the effort* following the disaster for a nurse in the short or long term?'

- ‘What is the prevalence of post-traumatic stress disorder in nurses following a disaster?’
- ‘What strategies does an individual employ to keep themselves well from a psychosocial perspective?’
- ‘What approach to psychosocial support should exist to determine ongoing levels of support for nurses?’
- ‘What does a nurse expect from the disaster medical assistance team health service in terms of psychosocial support?’
- ‘How are nurses supported following a disaster from a psychosocial perspective?’
- ‘What support strategies should exist to support nurses ‘returning home’ following a disaster?’
- ‘What is the place and value of operational versus psychosocial debriefing?’

Such research questions may help to develop an evidenced-based approach to supporting nurses following future disasters.

From a *kairos time slowing down and stretching* perspective, nurses may have a sense of *being unsure*. On occasions, *being unsure* may relate to the minimal communication that occurs between the initial contact of asking a nurse to assist following a disaster and communication once a plan is known. Research could answer questions such as:

- ‘What is the essential information that nurses require following a disaster?’
- ‘What are the facilitators and barriers to communication ‘on the way to a disaster’?’
- ‘What are the best strategies to improve communication between health services and nurses ‘on the way to a disaster’?’
- ‘How can technology assist in improving communications between health services and nurses?’

The ethics of beneficence and non-maleficence should be considered when undertaking research with nurses and others in the disaster-affected community following a disaster (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004; Powell, Fitzgerald, Taylor, & Graham, 2012). When research is being considered regarding the experience of nurse in the out-of-hospital environment following a disaster, consideration should be given to it *being about time* against the uncovered moments of a possible experience. This consideration of timing may be dependent on the research aim and design. For example, research that involves reflective journaling may be appropriate to undertake following a disaster contemporaneously, whereas other research may be better suited to the situation when a nurse has ‘returned home from a disaster’.

12.5 Final Commentary

Hundreds of disasters occur annually, affecting the lives of millions of people across the globe. Australian civilian hospital nurses may respond to a disaster as part of government or non-government disaster medical assistance team in the out-of-hospital environment. This study has provided new insights into what it may be like *being* an Australian civilian hospital nurse in the out-of-hospital disaster environment as part of a disaster medical assistance team following a disaster.

The uncovered moments from the participant narrative in this study included ‘on the way to a disaster’, ‘prior to starting work’, ‘working a shift in a disaster’, ‘end of a shift’ and ‘returning home’. The exemplars from the uncovered moments were summarised in an anecdote as a lived-experience description of what it may be like *being* a civilian hospital nurse in the out-of-hospital environment as part of a disaster medical assistance team following a disaster. This study is unique, as the phenomenological epoché-reduction and reduction proper were used with a lived-experience description to overlay reflections of the phenomenological

existentials of spatiality, corporeality, communality and temporality. This overlay of the uncovered moments and the phenomenological existentials provided further insights and a deeper understanding into the possible experience being explored.

Time emerged strongly in this study. In the totality of an experience of what it may be like *being* a nurse in a disaster medical assistance team following a disaster, time itself intersected with both the uncovered moments and the phenomenological existentials. As such, time formed a backdrop to the taken-for-granted life-world of a nurse following a disaster. This taken-for-granted backdrop of time orientated a nurse to the future, always doing something in the present for the sake of future moments.

The insights from this research have various implications and questions relating to future practice, future education and professional development, and future research. Such implications and questions form a trajectory of a possible experience towards enhancing the experiences of Australian civilian hospital nurses as part of a disaster medical assistance team following a disaster. The implications and questions resulting from this study keep alive the experiences of nurses who participated in this research for the sake of enhancing an experience for nurses following a future disaster.

References

- Aitken, P., Canyon, D., Hodge, J., Leggat, P., & Speare, R. (2006). *Disaster Medical Assistance Teams: A literature review*. Western Australian Department of Health; Disaster Preparedness and Management; Health Protection Group. Retrieved from <http://www.public.health.wa.gov.au/cproot/347/2/disaster%20medical%20assistance%20teams%20literature%20review%202006.pdf>
- Al-Madhari, A., & Keller, A. (1997). Review of disaster definitions. *Prehospital and Disaster Medicine, 12*(01), 17–21.
- Areni, C. & Grantham, N. (2009). Time flies when the tune flows: Music influences affective responses to waiting by changing the subjective experience of passing time. *Advances in Consumer Research, 36*, 449–455.
- Australian Government Department of Health. (2011). *National incident room*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-bio-factsht_inc_room.htm
- Bacon, A. (1983). Medical aspects of the ‘Ash Wednesday bushfires’. *Australian Family Physician, 12*(12), 838–839.
- Berah, E., Jones, H., & Valent, P. (1984). The experience of a mental health team involved in the early phase of a disaster. *Australian and New Zealand Journal of Psychiatry, 18*(4), 354–358.
- Birnbaum, M. L., Daily, E. K., O’Rourke, A. P., & Loretta, A. (2014). Disaster research/evaluation frameworks, Part 1: An overview. *Prehospital and Disaster Medicine, 29*(2), 1–12.
- Bledsoe, B. E. (2003). Critical incident stress management (CISM): Benefit or risk for emergency services? *Prehospital Emergency Care, 7*(2), 272–279.

- Bridgewater, F. H., Aspinall, E. T., Booth, J. P., Capps, R. A., Grantham, H. J., Pearce, A. P., & Ritchie, B. K. (2006). Team Echo: Observations and lessons learned in the recovery phase of the 2004 Asian tsunami. *Prehospital and Disaster Medicine, 21*(S1), S20–S25.
- Brown, B. J. (1989). Headed for disaster: A Red Cross nurse's first experience. *Journal of Christian Nursing, 6*(4), 18–22.
- Bulhof, I. N. (1980). *Wilhelm Dilthey: A hermeneutic approach to the study of history and culture* (Vol. 2). Netherlands: Martinus Nijhoff Publishers.
- Cao, H., McFarlane, A. C., & Klimidis, S. (2003). Prevalence of psychiatric disorder following the 1988 Yun Nan (China) earthquake. *Social Psychiatry and Psychiatric Epidemiology, 38*(4), 204–212.
- Chambers, A. J., Champion, M. J., Courtenay, B. G., Crozier, J. A., & New, C. H. (2006). Operation Sumatra Assist: Surgery for survivors of the tsunami disaster in Indonesia. *Australian and New Zealand Journal of Surgery, 76*(1-2), 39–42.
- Chiarella, M. (2011). Nurses in the park: A personal account of the Christchurch earthquake. *Australian Nursing Journal, 18*(9), 20–21.
- Christopher, P. & Selig, M. (1977). Medical aspects of the Granville rail disaster. *Medical Journal of Australia, 17*(12), 383–386.
- Clouston, S. A., Kotov, R., Pietrzak, R., Luft, B. J., Gonzalez, A., Richards, M. . . . Bromet, E. (2016). Cognitive impairment among World Trade Center responders: Long-term implications of re-experiencing the 9/11 terrorist attacks. *Alzheimer's & Dementia: Diagnosis, Assessment & Disease Monitoring, 1–8*(4), 67–75.
- Collogan, L. K., Tuma, F., Dolan-Sewell, R., Borja, S., & Fleischman, A. R. (2004). Ethical issues pertaining to research in the aftermath of disaster. *Journal of Traumatic Stress, 17*(5), 363–372.

- Cox, H. M. (1997). Disaster relief work: Nurses and others in bushfire territory. *International Journal of Nursing Practice*, 3(4), 218–223.
- Cusack, L. & Gebbie, K. (2015). Call for national dialogue: Adapting standards of care in extreme events. We are not ready. *Collegian*, 24(1), 93–100.
- Daily, E., Padjen, P., & Birnbaum, M. (2010). A review of competencies developed for disaster healthcare providers: Limitations of current processes and applicability. *Prehospital and Disaster Medicine*, 25(5), 387–395.
- Delehanty, R. A. (1996). The emergency nurse and disaster medical assistance teams. *Journal of Emergency Nursing*, 22(3), 184–189.
- Dickerson, S. S., Jezewski, M. A., Nelson-Tuttle, C., Shipkey, N., Wilk, N., & Crandall, B. (2002). Nursing at ground zero: Experiences during and after September 11 World Trade Center attack. *Journal of New York State Nurses Association*, 33(1), 27.
- Dilthey, W. (1976/1979). *Dilthey: Selected writings* (H. Rickman, Trans.). London: Cambridge University Press.
- Fee, G. D. & Stuart, D. K. (2011). *How to read the Bible for all it's worth* (3rd ed.). Michigan: Zondervan.
- Fergusson, D. M., Horwood, L. J., Boden, J. M., & Mulder, R. T. (2014). Impact of a major disaster on the mental health of a well-studied cohort. *Journal of the American Medical Association - Psychiatry*, 71(9), 1025–1031.
- Gadamer, H.-G. (1960/2013). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans., 4th ed.). London: Bloomsbury.
- Gadamer, H.-G. (1976/2008). *Philosophical hermeneutics* (D. E. Linge, Trans.). Berkley: University of California Press.
- Gatto, M. (2002). Nursing at ground zero: A life-changing experience. *Journal of New York State Nurses Association*, 33(1), 4–8.

- Gebbie, K. M., Hutton, A., & Plummer, V. (2012). Update on competencies and education. *Annual Review of Nursing Research, 30*(1), 169–192.
- Gebbie, K. M. & Qureshi, K. (2002). Emergency and disaster preparedness: Core competencies for nurses: What every nurse should but may not know. *The American Journal of Nursing, 102*(1), 46–51.
- Gooder, P. (2008). *Searching for meaning: An introduction to interpreting the New Testament*. Louisville: Westminster John Knox Press.
- Guha-Sapir, D., Hoyois, P., & Below, R. (2015). *Annual disaster statistical review 2014: The numbers and trends*. Retrieved from http://www.cred.be/sites/default/files/ADSR_2012.pdf
- Gurd, C. H., Bromwich, A., & Quinn, J. V. (1975). The health management of Cyclone Tracy. *Medical Journal of Australia, 1*, 641–644.
- Hampson, G. V., Cook, S. P., & Frederiksen, S. R. (2002). Operation Bali Assist. *Medical Journal of Australia, 177*(11-12), 620–623.
- Harris, R. D. (1997). Medical log: Forward command Thredbo. *Medical Journal of Australia, 167*(11), 627–629.
- Hasleton, K., Allan, J., Hegner, R., Kerley, D., & Stevens, G. (2013). Mental health deployment to the 2011 Queensland floods: Lessons learned. *Australian Journal of Emergency Management, 28*(3), 35.
- Hayes, B. (2011). Renal dialysis service and patient evacuation during the Queensland Cyclone Yasi disaster. *Renal Society of Australasia Journal, 7*(2), 72–75.
- Heidegger, M. (1953/2000). *Introduction to metaphysics* (G. Fried & R. Polt, Trans.). London: Yale University Press.
- Heidegger, M. (1953/2010). *Being and time* (J. Stambaugh, Trans.). Albany: State University of New York Press.

- Heidegger, M. (1989/2012). *Contributions to philosophy (of the event)* (R. Rojcewicz & D. Veallega-Neu, Trans.). Bloomington, Indiana: Indiana University Press.
- Hobfoll, S. E. & De Vries, M. W. (2013). *Extreme stress and communities: Impact and intervention* (Vol. 80). Dordrecht: Springer Netherlands..
- Houston, J. B., Spialek, M. L., Stevens, J., First, J., Mieseler, V. L., & Pfefferbaum, B. (2015). 2011 Joplin, Missouri tornado experience, mental health reactions, and service utilization: Cross-sectional assessments at approximately 6 months and 2.5 years post-event. *Public Library of Science*.
- Husserl, E. (1900/2001). *Logical investigations* (J. Findlay, Trans., Vol. 1). London and New York: Routledge.
- Husserl, E. (1931/2012). *Ideas: General introduction to pure phenomenology* (W. R. B. Gibson, Trans.). London and New York: Routledge.
- Husserl, E. (1954/1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy* (D. Carr, Trans.). Evanston, Illinois : Northwestern University Press.
- International Council of Nurses (ICN)/World Health Organization (WHO). (2009). *ICN framework of disaster nursing competencies*. Retrieved from http://www.icn.ch/images/stories/documents/networks/DisasterPreparednessNetwork/Disaster_Nursing_Compencies_lite.pdf
- International Strategy for Disaster Reduction. (2007). *Hyogo Framework for Action 2005–2015: Building the resilience of nations and communities to disasters*. (UN/ISDR-07-2007-Geneva). Geneva: United Nations.
- Johal, S. S. & Mounsey, Z. R. (2016). Recovering from disaster: Comparing the experiences of nurses and general practitioners after the Canterbury, New Zealand earthquake sequence 2010–2011. *Nursing & Health Sciences*, 19(1), 29–34.

- Kako, M., Ranse, J., Yamamoto, A., & Arbon, P. (2014). What was the role of nurses during the 2011 Great East Earthquake of Japan? An integrative review of the Japanese literature. *Prehospital and Disaster Medicine, 29*(3), 275–279.
- Ketchie, K. & Breuilly, E. (2010). Our experience in earthquake-ravaged Haiti: Two nurses deployed with a disaster medical assistance team. *Journal of Emergency Nursing, 36*(5), 492–496.
- Key, G. (1994). Disaster medical assistance teams. *Bogotá, Colombia: Dirección Nacional para la Prevención y Atención de Desastres. mar. 1994.*
- Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21*(5), 827–836.
- Langeveld, M. J. (1944). The stillness of the secret place. *Phenomenology and Pedagogy, 1*(1), 11–17.
- Lawler, J. (2006). *Behind the screens: Nursing, somology, and the problem of the body.* Sydney: Sydney University Press.
- Lefebvre, H. (1992). *The Production of Space.* (D Nicholson-Smith, Trans.). Brisbane: Wiley-Blackwell.
- Little, M., Stone, T., Stone, R., Burns, J., Reeves, J., Cullen, P. . . . Gillard, N. (2012). The evacuation of Cairns Hospitals due to severe Tropical Cyclone Yasi. *Academic Emergency Medicine, 19*(9), E1088–E1098.
- Littleton-Kearney, M. T. & Slepski, L. A. (2008). Directions for disaster nursing education in the United States. *Critical Care Nursing Clinics of North America, 20*(1), 103–109.
- Lyneham, J. & Byrne, H. (2011). Nurses' experience of what helped and hindered during the Christchurch earthquake. *Kai Tiaki Nursing Research, 2*(1), 17–20.
- Madakasira, S. & O'Brien, K. F. (1987). Acute posttraumatic stress disorder in victims of a natural disaster. *The Journal of Nervous and Mental Disease, 175*(5), 286–290.

- Mahajani, A. G. (1975). Darwin and Cyclone Tracy: Christmas 1974. *Annals of the Royal College of Surgeons England*, 57(5), 274–275.
- Margalit, G., Rosen, Y., Tekes-Manova, D., Golan, M., Benedek, P., Levy, Y. . . . Bar-Dayana, Y. (2002). Recommendations for nursing requirements at a field hospital, based on the Israel Defense Forces field hospital at the earthquake disaster in Turkey: August 1999. *Accident and Emergency Nursing*, 10(4), 217–220.
- Martin, R. (2009). Black Saturday and the Victorian bushfires: Implications for advanced nursing practice roles. *Australasian Emergency Nursing Journal*, 12(2), 30–31.
- McArdle, J. (2011). Cyclone Yasi: Dialysis mission impossible. *Renal Society of Australasia Journal*, 7(3), 76–78.
- McLaughlin, K. A., Berglund, P., Gruber, M. J., Kessler, R. C., Sampson, N. A., & Zaslavsky, A. M. (2011). Recovery from PTSD following Hurricane Katrina. *Depression and Anxiety*, 28(6), 439–446.
- Merleau-Ponty, M. (1945/2002). *Phenomenology of perception* (C. Smith, Trans.). London and New York: Routledge.
- Nasrabadi, A. N., Naji, H., Mirzabeigi, G., & Dadbakhs, M. (2007). Earthquake relief: Iranian nurses' responses in Bam, 2003, and lessons learned. *International Nursing Review*, 54(1), 13–18.
- New Zealand Government. (2014). *Current issues for the 51st Parliament: Social effects of the Canterbury earthquakes*. New Zealand: New Zealand Government.
- Norton, I. & Trewin, A. (2011). *Australian Medical Assistance Team Training* (3rd ed.). Darwin: The National Critical Care and Trauma Response Centre.
- O'Shea, R. F. (1975). The Darwin cyclone disaster: Experience of the Queensland medical relief team. *The Medical journal of Australia*, 1(21), 649–650.

- Olafson, F. A. (1994). Heidegger à la Wittgenstein or ‘coping’ with Professor Dreyfus. *Inquiry*, 37(1), 45–64.
- Parliament of Victoria. (2010). Relief and recovery. In *2009 Victorian Bushfires Royal Commission: Final report* (Vol. 2, Ch. 8). Victoria: Parliament of Victoria.
- Pearn, J. (1998). Medical response to disasters: Doctoring at its best. *Medical Journal of Australia*, 169(11-12), 601–601.
- Powell, M. A., Fitzgerald, R. M., Taylor, N., & Graham, A. (2012). *International literature review: Ethical issues in undertaking research with children and young people*. (Literature review for the Childwatch International Research Network). Lismore: Southern Cross University, Centre for Children and Young People / Dunedin: University of Otago, Centre for Research on Children and Families.
- Pulido, M. L. (2007). In their words: Secondary traumatic stress in social workers responding to the 9/11 terrorist attacks in New York City. *Social Work*, 52(3), 279–281.
- Ranse, J. (2013). The role of Australian nurses in disasters: What ‘group’ of nurse should assist? *The Hive* - Australian College of Nursing. Winter edition.
- Ranse, J. (2014). Review: The mental health imaginary vis-à-vis its nurses and Australian environs: An essay. *Journal of Research in Nursing*, 19(7-8), 590–591.
- Ranse, J. (2015). *The stethoscope, a patient and me*. Retrieved from <http://journalofadvancednursing.blogspot.com.au/2015/09/the-stethoscope-patient-and-me.html>
- Ranse, J. & Arbon, P. (2008). Graduate nurses’ lived experience of in-hospital resuscitation: A hermeneutic phenomenological approach. *Australian Critical Care*, 21(1), 38–47.
- Ranse, J. & Lenson, S. (2012). Beyond a clinical role: Nurses were psychosocial supporters, coordinators and problem solvers in the Black Saturday and Victorian bushfires in 2009. *Australasian Emergency Nursing Journal*, 15(3), 156–163.

- Ranse, K., Ranse, J., & Pelkowitz, M. (2017). A palliative approach to caring for the dying: the experience of third year nursing students. *Contemporary Nurse*. [accepted].
- Ranse, J., Hammad, K., & Ranse, K. (2013). Future considerations for Australian nurses and their disaster educational preparedness: A discussion. *Australian Journal of Emergency Management*, 28(4), 49–53.
- Ranse, J., Lenson, S., & Aimers, B. (2010). Black Saturday and the Victorian Bushfires of February 2009: A descriptive survey of nurses who assisted in the pre-hospital setting. *Collegian*, 17(4), 153–159.
- Ranse, J., Hutton, A., Jeeawody, B., & Wilson, R. (2014). What are the research needs for the field of disaster nursing? An international delphi study. *Prehospital and Disaster Medicine*, 1–7.
- Ranse, J., Hutton, A., Wilson, R., & Usher, K. (2015). Leadership opportunities for mental health nurses in the field of disaster preparation, response and recovery. *Issues in Mental Health Nursing*, 391–394.
- Ranse, J., Shaban, R. Z., Considine, J., Hammad, K., Arbon, P., Mitchell, B., & Lenson, S. (2013). Disaster content in Australian tertiary postgraduate emergency nursing courses: A survey. *Australasian Emergency Nursing Journal*, 16(2), 58–63.
- Raphael, B. & Middleton, W. (1987). Mental health responses in a decade of disasters: Australia, 1974–1983. *Psychiatric Services*, 38(12), 1331–1337.
- Rivera, A. (1986). Nursing intervention in a disaster. *International Nursing Review*, 33(5), 140–142.
- Roberts, N. P., Kitchiner, N. J., Kenardy, J., & Bisson, J. I. (2009). Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. *The Cochrane Library*.

- Rokkas, P., Cornell, V., & Steenkamp, M. (2014). Disaster preparedness and response: Challenges for Australian public health nurses: A literature review. *Nursing & Health Sciences, 16*(1), 60–66.
- Rose, S. C., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews, (2)*, CD000560.
- Sartre, J.-P. (1943/2003). *Being and nothingness: An essay on phenomenological ontology* (H. E. Barnes, Trans.). London and New York: Routledge.
- Serghis, D. (1998). After the flood. *Australian Nursing Journal, 5*(9), 16–19.
- Shih, F.-J., Liao, Y.-C., Chan, S.-M., Duh, B.-R., & Gau, M.-L. (2002). The impact of the 9-21 earthquake experiences of Taiwanese nurses as rescuers. *Social Science and Medicine, 55*(4), 659–672.
- Silenas, R., Akins, R., Parrish, A. R., & Edwards, J. C. (2008). Developing disaster preparedness competence: An experiential learning exercise for multiprofessional education. *Teaching & Learning in Medicine, 20*(1), 62–68.
- Smith, A. & Roberts, K. (2003). Interventions for post-traumatic stress disorder and psychological distress in emergency ambulance personnel: a review of the literature. *Emergency Medicine Journal, 20*(1), 75–78.
- Srivastava, M., Goel, D., Semwal, J., Gupta, R., & Dhyani, M. (2015). Posttraumatic stress disorder symptoms in the population of Uttarkashi, Tehri, and Pauri Garhwal India in reference to Uttarakhand flood—June 2013. *International Journal of Health System and Disaster Management, 3*(5), 37–43.
- Suserud, B. & Haljamae, H. (1997). Acting at a disaster site: Experiences expressed by Swedish nurses. *Journal of Advanced Nursing, 25*(1), 155–162.

- Taylor, P., Emonson, D., & Schlimmer, J. (1998). Operation Shaddock: The Australian Defence Force response to the tsunami disaster in Papua New Guinea. *The Medical Journal of Australia*, 169(11-12), 602–606.
- Thomas, S. & de Vio Cajetan, T. (1962). *Aristotle On interpretation: Commentary by St. Thomas and Cajetan*. Milwaukee, WIS: Marquette University Press.
- United Nations Office for Disaster Risk Reduction (UNISDR). (2009). *UNISDR terminology on disaster risk reduction*. (UNISDR-20-2009). Geneva.
- United Nations Office for Disaster Risk Reduction (UNISDR). (2015). *Sendai Framework for Disaster Risk Reduction 2015–2030*. (UNISDR/GE/2015 - ICLUX EN5000). Geneva.
- Usher, K. & Mayner, L. (2011). Disaster nursing: A descriptive survey of Australian undergraduate nursing curricula. *Australasian Emergency Nursing Journal*, 14(2), 75–80.
- Van Den Berg, J. H. (1972). *The psychology of the sickbed*. Pittsburgh: Duquesne University Press.
- Van Hoving, D., Wallis, L., Docrat, F., & Vries, S. (2010). Haiti disaster tourism: A medical shame. *Prehospital and Disaster Medicine*, 25(03), 201–202.
- Van Lennep, D. (1987). The hotel room. *Phenomenological Psychology* (Vol. 103, pp. 209–215). Dordrecht: Springer Netherlands.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. New York: State University of New York Press.
- van Manen, M. (1998). Modalities of body experience in illness and health. *Qualitative Health Research*, 8(1), 7–24.
- van Manen, M. (2013). *Phenomenology of practice and the tradition of the Utrecht School*. Paper presented at the Utrecht Summer School, Utrecht, Netherlands.

- van Manen, M. (2014a, 1 October). *Phenomenology of practice [workshop]*, Newcastle City Hall, Newcastle, NSW.
- van Manen, M. (2014b). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Walnut Creek: Left Coast Press.
- Veenema, T. G. (2016). *Disaster nursing app for iPhone android as tool for real time learning transfer*. Paper presented at the Sigma Theta Tau International / National League of Nursing, Nursing Education Research Conference, Washington.
- Walsh, L., Subbarao, I., Gebbie, K., Schor, K. W., Lyznicki, J., Strauss-Riggs, K. . . . James, J. J. (2012). Core competencies for disaster medicine and public health. *Disaster Medicine and Public Health Preparedness*, 6(1), 44.
- Warsini, S., Mills, J., & Usher, K. (2014). Solastalgia: Living with the environmental damage caused by natural disasters. *Prehospital and Disaster Medicine*, 1–4.
- Warsini, S., West, C., Mills, J., & Usher, K. (2014). The psychosocial impact of natural disasters among adult survivors: An integrative review. *Issues in Mental Health Nursing*, 35(6), 420–436.
- Weeks, S. M. (2007). Mobilization of a nursing community after a disaster. *Perspectives in Psychiatric Care*, 43(1), 22–29.
- World Bank. (2013). *Building resilience: Integrating climate and disaster risk into development: Lessons from World Bank Group experience*. Washington, DC: The World Bank.
- World Health Organization (WHO). (2015). *Nurses' reflection post-Nepal earthquake*. New Delhi: Regional Office for South-east Asia, World Health Organization.
- Yang, Y. N., Xiao, L. D., Cheng, H. Y., Zhu, J. C., & Arbon, P. (2010). Chinese nurses' experience in the Wenchuan earthquake relief. *International Nursing Review*, 57(2), 217–223.

- Yang, Y., Chen, Y., Chotani, R. A., LaPorte, R. E., Ardalan, A., Shubnikov, E. . . . Huang, J. (2010). Chinese disasters and just-in-time education. *Prehospital and Disaster Medicine, 25*(5), 477–481.
- Yin, H., He, H., Arbon, P., Zhu, J., Tan, J., & Zhang, L. (2012). Optimal qualifications, staffing and scope of practice for first responder nurses in disaster. *Journal of Clinical Nursing, 21*(1/2), 264–271.
- Zhen, Y., Huang, Z. Q., Jin, J., Deng, X. Y., Zhang, L. P., & Wang, J. G. (2012). Posttraumatic stress disorder of Red Cross nurses in the aftermath of the 2008 Wenchuan China Earthquake. *Archives of Psychiatric Nursing, 26*(1), 63–70.
- Zillman, S. (2016). Cyclone Winston: Australian nurse and doctor reflect on recovery as they prepare to return home. *ABC (Australian Broadcasting Corporation) News Online*. Retrieved from <http://www.abc.net.au/news/2016-03-08/australian-nurse-and-doctor-reflect-on-cyclone-winston-recovery/7229802>

Appendices

Appendix A: Research and Scholarship

This appendix outlines examples of my research and scholarship, focusing on the activities and outputs during my candidature.

Grants and scholarships.

Cannon, M. & **Ranse, J.** (2014). Development of an Australian Mass Gathering Triage Scale.

Competitive Research Grant: St John Ambulance Australia. \$9,000.

Luther, M., **Ranse, J.**, & Ranse, K. (2014). Understanding the effect of an evidence-based

pathway versus clinician dependent management for Salmonella-like-symptoms. *ACT*

Health Practice Development Scholarship. \$9,062.

Ranse, K. & **Ranse, J.** (2014). A palliative approach to caring for the dying: Experience of

third-year nursing students. *Margaret Corden Scholarship: Palliative Care ACT.*

\$5,000.

Ranse, J., Hutton, A., Lenson, S., Keene, T., Burke, B., & Luther, M. (2013), Patient

characteristic to onsite health providers, ambulance paramedics and hospitals from a

mass gathering: A case study. *Competitive Research Grant: St John Ambulance*

Australia. \$5,000.

Aimers, B., Hutton, A., Arbon, P., & **Ranse, J.** (2012). The role of St John Ambulance

Australia in facilitating hospital avoidance during a mass gathering event. *Competitive*

Research Grant: St John Ambulance Australia. \$12,500.

Mann-Farrar, J., Moutia, D., Cannon, M., & **Ranse, J.** (2012). Nursing practices in the

prehospital care context: The perception of Registered Nurses on their scope of

practice. *Competitive Research Grant: St John Ambulance Australia.* \$7,843.

Lenson, S. & **Ranse, J.** (2011). The experience of nurses who participated in the Queensland extreme weather events of 2011. *Ben Morely Scholarship: College of Emergency Nursing Australasia*. \$2,000.

Ranse, J. (2011). Australian civilian hospital nurses' lived experience of the out-of-hospital environment following a disaster (PhD). *Annie M Sage Memorial Scholarship: Australian College of Nursing*. \$10,000.

Ranse J., Arbon P., & McAslan, A. (2011). Emergency management volunteers' research: A literature review and future research priorities. *Australian Emergency Management Institute*. \$34,270.

Book chapters.

Ranse, J., Mateer, J., & Cusack, L. (2015). Pandemics and environmental emergencies. In K. Curtis & C. Ramsden (Eds), *Emergency and trauma care: For nurses and paramedics* (2nd ed., Chap. 28). Chatswood, Australia: Elsevier Australia.

Taylor, J. & **Ranse, J.** (2014). Data collection: Quantitative research. In S. Jirojwong, M. Johnson, & A. Welch (Eds), *Understanding nursing research: Methods for evidence-based practice* (2nd ed., Chap. 10). South Melbourne, Australia: Oxford University Press.

Mateer., J, Cusack., L, & **Ranse, J.** (2011). Pandemics and environmental emergencies. In K. Curtis, C. Ramsden, & B. Lord (Eds), *Emergency and trauma care: For nurses and paramedics* (pp 673–694). Chatswood, Australia: Elsevier Australia.

Taylor, J, & **Ranse, J.** (2011). Data collection: Quantitative research. In S. Jirojwong, M. Johnson, & A. Welch (Eds), *Understanding nursing research: Methods for evidence-based practice* (pp. 235–260). South Melbourne, Australia: Oxford University Press.

Refereed articles in scholarly journals.

- Ranse, K., **Ranse, J.**, & Pelkowitz, M. (2017). A palliative approach to caring for the dying: the experience of third year nursing students. *Contemporary Nurse*. [accepted].
- Hutton, A., **Ranse, J.**, & Munn, B. (2017). Developing public health initiatives through understanding motivations of the audience at mass gathering events. *Prehospital and Disaster Medicine*. [accepted].
- Cannon, M., Roitman, R., **Ranse, J.**, & Morphet, J. (2017). Development of a mass-gathering triage tool: An Australian perspective. *Prehospital and Disaster Medicine* 32(1), 101–105.
- Ranse, J.**, Hutton, A., Keene, T., Lenson, S., Luther, M., Bost, N. . . . Burke, B. (2017). Health service impact from mass-gatherings: A systematic literature review. *Prehospital and Disaster Medicine* 32(1), 71–77.
- Ranse, J.**, Luther, M., & Ranse, K. (2016). Impact of a pilot pathway for the management of gastroenteritis-like symptoms in an emergency department: A case study following a Salmonella outbreak. *Emergency Medicine Australasia* 28(1), 34–38.
- Steenkamp, M., Hutton, A., **Ranse, J.**, Lund, A., Turriss, S., Bowles, R. . . . Arbon, P. (2016). Exploring international views on key concepts for mass gathering health through a Delphi process. *Prehospital and Disaster Medicine* 31(4), 445–453.
- Turriss, S., Steenkamp, M., Lund, A., Hutton, A., **Ranse, J.**, Bowles, R. . . . Arbon, P. (2016). International consensus on key concepts and data definitions for mass gathering health: Process and progress. *Prehospital and Disaster Medicine* 31(2), 220–224.
- Hutton, A., Savage, C., **Ranse, J.**, Finnell, D., Kub, J. (2015). The use of Haddon’s matrix to plan for injury and illness prevention at outdoor music festivals. *Prehospital and Disaster Medicine* 30(2), 175–183.

- Ranse, J.,** Hutton, A., Wilson R., & Usher, K. (2015). Leadership opportunities for mental health nurses in the field of disaster preparation, response and recovery. *Issues in Mental Health Nursing* 36(5), 391–394.
- Hutton, A., **Ranse, J.,** Verdonk, N., Ullah, S., Arbon, P. (2014). Understanding the characteristics of patient presentations of young people at outdoor music festivals. *Prehospital and Disaster Medicine* 29(2), 1–7
- Kako, M., **Ranse, J.,** Yamamoto, A., & Arbon, P. (2014). What was the role of nurses during the 2011 Great East Earthquake of Japan? An integrative review of the Japanese literature. *Prehospital Disaster Medicine* 29(3), 1–5.
- Lenson, S., **Ranse, J.,** & Cusack, L. (2014). National consistency in industrial awards for disaster release for Australian nurses: An integrative review of enterprise arrangements. *Asia Pacific Journal of Health Management* 9(2), 53–58.
- Lund, A., Turriss, S., Bowles, R., Steenkamp, M., Hutton, A., **Ranse, J.,** & Arbon, P. (2014). Mass gathering health research foundational theory: Part 1 Population models for mass gatherings. *Prehospital and Disaster Medicine* 29(6), 648–654.
- Moutia, D., **Ranse, J.,** & Banu-Lawrence, H. (2014). Operational aspects of health delivery at World Youth Day 2008: Lessons learnt by an emergency management organisation. *Australasian Journal of Paramedicine* 11(3), 1–9.
- Ranse, J.,** Hutton, A., Jeeawody, B., & Wilson, R. (2014). What are the research needs for the field of disaster nursing in the next five years? An international Delphi study. *Prehospital Disaster Medicine*, 29(5), 1–7.
- Ranse, J.,** Hutton, A., Turriss, S., & Lund, A. (2014). Enhancing the minimum data set for mass gathering research and evaluation: An integrative literature review. *Prehospital and Disaster Medicine* 29(3), 280–289.

- Turriss, S., Lund, A., Hutton, A., Bowles, R., Ellerson, E., Steenkamp, M., **Ranse, J.**, & Arbon, P. (2014). Mass gathering health research foundational theory: Part 2 Event modelling for mass gatherings. *Prehospital and Disaster Medicine* 29(6), 655–663.
- Wilson, R.L., **Ranse, J.**, Cashin, A., & McNamara, P. (2014). Nurses and Twitter: The good, the bad, and the reluctant. *Collegian* 21(2), 111–119.
- Arbon, P., Cusack, L., **Ranse, J.**, Shaban, R., Considine, J., Kako, M. . . . Hammad, K. (2013). Exploring staff willingness to attend work during a disaster: A study of nurses employed in four Australian emergency departments. *Australasian Emergency Nursing Journal* 16(3), 103–109
- Arbon, P., **Ranse, J.**, Cusack, L., Considine, J., Shaban, R., Woodman, R. . . . Mitchell, B. (2013). Australasian emergency nurses' willingness to attend work in a disaster: A survey. *Australasian Emergency Nursing Journal* 16(2), 52–57.
- Bail, K., **Ranse, J.**, Clarke, R., & Rattray, B. (2013). Open access to nursing journals: An audit of the 2010 ERA journal list. *Australian Journal of Advanced Nursing* 30(4), 5–11.
- Filmer, L., & **Ranse, J.** (2013) Who is my leader? Lessons from a hospital disaster drill in a less developed country. *Australasian Emergency Nursing Journal* 16(4), 170–174.
- Ranse, J.**, Hammad, K., & Ranse, K. (2013). Future considerations for Australian nurses and their disaster educational preparedness: A discussion. *Australian Journal of Emergency Management* 28(4), 49–53.
- Ranse, J.**, Shaban, R., Considine, J., Hammad, K., Arbon, P., Mitchell, B., & Lenson, S. (2013). Disaster content in Australian tertiary postgraduate emergency nursing courses: A survey. *Australasian Emergency Nursing Journal* 16(2), 58–63.
- Rattray, B., Cooke, J., Bail, K., & **Ranse, J.** (2013). A comparison of open access in exercise science journals: 2010 to 2012. *The Open Sports Science Journal* 6, 1–7.

Ranse, J., & Hutton, A. (2012). Minimum data set for mass gathering health research and evaluation: A discussion paper. *Prehospital and Disaster Medicine* 27(6), 543–550.

Editorials, letters and notes.

Ranse, J. (2015). A stethoscope, a patient and me. *Journal of Advanced Nursing Interactive*. Available from <http://journalofadvancednursing.blogspot.com.au/2015/09/the-stethoscope-patient-and-me.html>

Ranse, J. (2014). Review: The mental health imaginary vis-à-vis its nurses and Australian environs: An essay. *Journal of Research in Nursing* 19(7-8), 590–591.

Ranse, J., & Hutton, A. (2013). Minimum data set for mass-gatherings health research and evaluation: The beginning of an international dialogue. *Prehospital and Disaster Medicine* [author reply] 28(2), 3.

Ranse, J. & Lenson, S. (2013). Author response—Letter to the editor: Beyond a clinical role: Nurses were psychosocial supporters, coordinators and problem solvers in the Black Saturday and Victorian bushfires in 2009. *Australasian Emergency Nursing Journal* 16(3), 1.

Extract from papers.

Cannon, M., Roitman, R., **Ranse, J.**, & Morphet, J. (2017). Development of a mass gathering triage tool: An Australian Perspective. *Prehospital and Disaster Medicine* [abstract—poster presentation] 32(s1), s140.

Ranse, J., Arbon, P., Cusack, L., & Shaban, R. (2017). Australian civilian hospital nurses' lived experience of the out-of-hospital environment following a disaster: A lived-space perspective. *Prehospital and Disaster Medicine* [abstract—paper presentation] 32(s1), s146.

- Ranse, J.**, Hutton, A., Keene, T., Lenson, S., Luther, M., Bost, N. . . . Burke, B. (2017). Health service impact from mass-gatherings: A systematic literature review. *Prehospital and Disaster Medicine* [abstract—paper presentation] 32(s1), s138.
- Steenkamp, M., Turriss, S., Lund, A., Hutton, A., **Ranse, J.**, & Arbon, P. (2017). A proposed minimum data set for mass gathering health: Updates and moving forward. *Prehospital and Disaster Medicine* [abstract—paper presentation] 32(s1), s133.
- Arbon, P., Steenkamp, M., Lund, A., Turriss, S., **Ranse, J.**, Hutton, A. . . . Ramsey, I. (2015). Describing an international Delphi project on mass gathering health data collection. *Prehospital and Disaster Medicine* [abstract—paper presentation] 30(s1), s20–21.
- Hutton, A., **Ranse, J.**, & Wilson, R. (2015). What are the research needs for the field of disaster nursing? An international Delphi study. *Prehospital and Disaster Medicine* [abstract—paper presentation] 30(s1), s20–21.
- Steenkamp, M., Ramsey, I., **Ranse, J.**, Hutton, A., Lund, A., Turriss, S. . . . Arbuthnott, K. (2015). Data for mass gathering health: What is on your shopping list? *Prehospital and Disaster Medicine* [abstract—poster presentation] 30(s1), s67.
- Steenkamp, M., **Ranse, J.**, Hutton, A., Lund, A., Turriss, S., Arbon, P. . . . Anikeeva, O. (2015). Findings from Phase 1 of an international Delphi project to establish a minimum data set for mass gathering health. *Prehospital and Disaster Medicine* [abstract—paper presentation] 30(s1), s54–55.
- Hutton, A., **Ranse, J.**, & Arbon, P. (2013). The characteristics of patient presentations from Australian outdoor music festivals. *Prehospital and Disaster Medicine* [abstract—paper presentation] 28(s1), s15–16.
- Lund, A., Turriss, S., Bowles, R., Gutman, S., Hutton, A., **Ranse, J.**, & Arbon, P. (2013). Progressing towards an international consensus on data modeling for mass gathering

- and mass participation events. *Prehospital and Disaster Medicine* [abstract—paper presentation] 28(s1), s113–114.
- Lenson, S. & **Ranse, J.** (2013). Industrial considerations for Australian nurses responding to disaster. *Prehospital and Disaster Medicine* [abstract—paper presentation] 28(s1), s155.
- Ranse, J.** & Hutton, A. (2013). Biomedical data collection for mass gathering research and evaluation: A review of the literature. *Prehospital and Disaster Medicine* [abstract—paper presentation] 28(s1), s72.
- Ranse, J.** & Lenson, S. (2013). Disaster and emergency medicine on-line research repository: A retrospective review. *Prehospital and Disaster Medicine* [abstract—paper presentation] 28(s1), s69.
- Arbon, P., Cusack, L., **Ranse, J.**, Shaban, R., Considine, J., Mitchell, B. . . . Woodman, R. (2011). To work or not to work: An analysis of the willingness of Australian emergency nurses to respond to a disaster. *Australasian Emergency Nursing Journal* [abstract—paper presentation] 14(s1), s31.
- Lenson, S. & **Ranse, J.** (2011). Exploring the role of nurses during the ‘Black Saturday’ and Victorian bushfires of 2009 in Australia. *Australasian Emergency Nursing Journal* [abstract—paper presentation] 14(s1), s16.
- Lenson, S., **Ranse, J.**, & Cusack, L. (2011). Industrial considerations for nurses responding to disasters. *Australasian Emergency Nursing Journal* [abstract—paper presentation] 14(s1), s28.
- Ranse, J.**, Arbon, P., Cusack, L., Shaban, R., Considine, J., Mitchell, B. . . . Bahnisch, L. (2011). Understanding the willingness of Australian emergency nurses to respond to a health care disaster. *Prehospital and Disaster Medicine* [abstract—paper presentation] 26(s1), s159.

Ranse, J., Arbon, P., Shaban, R., Considine, J., Mitchell, B., & Lenson, S. (2011). Disaster content varies in Australian postgraduate tertiary emergency nursing courses: Implications for educational preparedness. *Prehospital and Disaster Medicine* [abstract—paper presentation] 26(s1), s15.

Ranse, J. & Lenson, S. (2011). Role, resources, and clinical and educational backgrounds of nurses who participated in the 2009 Bushfires in Victoria, Australia. *Prehospital and Disaster Medicine* [abstract—paper presentation] 26(s1), s33–s34.

Other articles.

Ranse, J. (2013). The role of Australian nurses in disasters: What ‘group’ of nurses should assist? *The Hive* [Australian College of Nursing—newsletter publication] 4, 24–25.

Ranse, J. (2012). Be prepared: Thinking of your health during natural disasters. *The Conversation*. Available from <https://theconversation.edu.au/be-prepared-thinking-of-your-health-during-natural-disasters-5160>

Ranse, J. (2012). In the wake of disaster: Treat physical and mental injuries. *Nursing Review* [Australian College of Nursing—newsletter publication], September.

Ranse, J. (2011). Understanding the willingness of Australian emergency nurses to respond to a disaster. *Connections* [Australian College of Nursing—newsletter publication] 14(4), 6–7.

Presentations.

Keynote speaker.

Ranse, J. (2017, July 27). *Caring during catastrophe: How nurses can make a difference*; invited speaker for Disaster Nursing - Not If, But When... Melbourne, Vic.

Ranse, J. (2014, October 8). *The realities of being in a disaster: Issues for nurses and nurse leaders*. Keynote speaker at the Association of Queensland Nurse Leaders Conference, Gold Coast, QLD.

Ranse, J. (2011, November 26). *Rural health issues in disasters*. Keynote speaker at the Royal College of Nursing Australasia, Acute Care Conference, Wagga Wagga, NSW.

Ranse, J. (2011, August 8). *Disasters happen: Practice implications and issues for nurses*.

Keynote speaker at the 4th Passionate about Practice Conference, Brisbane, QLD.

Invited/guest speaker.

Ranse J. (2017, March 16). *Trends in mass gathering health*. Presentation and guest panel member to volunteer members of the St John Ambulance, South Australia, Adelaide, SA.

Ranse, J. (2016, August 22). *Disaster nursing*. Presentation to the University of Canberra Nursing Society, Canberra, ACT.

Ranse, J. (2015, June 3). *The realities of assisting in a disaster: An Australian perspective*.

Presentation to students and faculty staff of the University of Santo Tomas, Philippines, Canberra, ACT.

Ranse, J. (2015, May 12). *Disaster health: What emergency nursing students need to know*.

Presentation to the Canberra Emergency Nursing Student Society, Canberra, ACT.

Ranse, J. (2014, June 5). *Disasters happen: The realities of being in a disaster*. Presentation to the Faculty of Nursing at the University of New England, Armidale, NSW.

Ranse, J. (2014, April 29). *Understanding patient presentations among young people at mass*

gatherings. Presentation to the Paramedics Australasia, Paramedics Australasia Student Association and St John Ambulance (ACT), Canberra, ACT.

Ranse, J. (2013, October 23). *Health considerations at major events (mass gatherings)*.

Presentation to students of the University of Canberra—Bachelor of Sports Studies, in the unit Sport as Entertainment, Canberra, ACT.

- Ranse, J.** (2013, October 14). *Australian nurses and disaster mental health*. Paper presented to students of the University of Canberra—Mental Health for Practice Undergraduate Nursing, Canberra, ACT.
- Ranse, J.** (2013, September 14). *Injury patterns and crowd behaviour at mass gathering events*. Speaker at the Sex, Drugs, and Rock and Roll—St John Ambulance Australia (ACT) conference, Canberra, ACT.
- Ranse, J.** (2013, August 22). *Social media: Friend or foe*. Debate panel member at the Princess Alexandra Hospital Health Symposium, Brisbane, QLD.
- Ranse, J.** (2013, June 3). *Disaster health: An Australian perspective*. Presentation to the Department of Nursing, Naresuan University, Thailand.
- Ranse, J.** (2013, February 24). *Phenomenology*. Paper presented to students of the University of Canberra—Professional Doctorate in Nurse Practitioner (Research), Canberra, ACT.
- Ranse, J.** (2013, January 31). *Developing a professional presence online: Using Google Blogger*. Workshop presented to Higher Degree Research (HDR) students of the University of Canberra, Canberra, ACT.
- Ranse, J.** (2012, October 15). *Disaster health: An Australian nursing perspective*. Paper presented to delegates of the Naresuan University Thailand, Canberra, ACT.
- Ranse, J.** (2012, September 17). *Role of mental health nurses in disasters*. Presentation to students of the University of Canberra—Postgraduate Mental Health Nursing, Canberra, ACT.
- Ranse, J.** (2012, September 11). *Role of critical care nurses in disasters*. Presentation to students of the University of Canberra—Postgraduate Critical Care Nursing, Canberra, ACT.
- Ranse, J.** (2012, September 28). *Organisations who work with vulnerable people in the community: Are your clients 'health prepared' for a disaster?* Presentation to

participants of an Australian Red Cross, ACT and Southern NSW emergency services workshop—Nurturing Client Resilience with Emergency Preparedness Strategies, Canberra, ACT.

Ranse, J. (2012, August 22). *Health considerations at major events (mass gatherings)*.

Presentation to students of the University of Canberra—Bachelor of Sports Studies, in the unit Sport as Entertainment, Canberra, ACT.

Ranse, J. (2011, October 21). *Disaster health: An Australian nursing perspective*. Paper presented to delegates of the Mahidol University Thailand, University of Canberra, ACT.

Ranse, J. (2011, October 19). *The role of new graduate nurses in disasters*. Workshop presented to new graduate nurses at Calvary Health Care ACT, Canberra, ACT.

Ranse, J. (2011, September 28). *Health considerations at major events (mass gatherings)*.

Presentation to students of the University of Canberra—Bachelor of Sports Studies, in the unit Sport as Entertainment, Canberra, ACT.

Ranse, J. (2011, August 30). *Role of intensive care and emergency nurses in disasters*.

Presentation to students of the University of Canberra—Postgraduate Critical Care Nursing, Canberra, ACT.

Ranse, J. (2011, August 10). *Issues in disasters for health professionals*. Guest speaker at the

Princess Alexandra Hospital, Brisbane, QLD.

Refereed conferences.

Ranse, J., Hutton, A., Keene, T., Lenson, S., Luther, M., Bost, N. . . . Burke, B. (2017, April

29). *Health service impact from mass-gatherings: A systematic literature review*.

Paper presented at the 21st World Congress on Disaster and Emergency Medicine, Toronto, Canada.

- Steenkamp, M., Turriss, S., Lund, A., Hutton, A., **Ranse, J.**, & Arbon, P. (2017, April 29). *A proposed minimum data set for mass gathering health: Updates and moving forward*. Paper presented at the 21st World Congress on Disaster and Emergency Medicine, Toronto, Canada.
- Ranse, J.**, Arbon, P., Cusack, L., & Shaban, R. (2017, April 25). *Australian civilian hospital nurses' lived experience of the out-of-hospital environment following a disaster: A lived-space perspective*. Paper presented at the 21st World Congress on Disaster and Emergency Medicine, Toronto, Canada.
- Cannon, M., Roitman, R., **Ranse, J.**, & Morphet, J. (2017, April 25). *Development of a mass gathering triage tool: An Australian Perspective*. Poster presented at the 21st World Congress on Disaster and Emergency Medicine, Toronto, Canada.
- Steenkamp, M., Ramsey, I., **Ranse, J.**, Hutton, A., Lund, A., Turriss, S. . . . Arbuthnott, K. (2015, April 24). *Data for mass gathering health: What is on your shopping list?* Paper presented at the 19th World Congress for Disaster and Emergency Medicine, Cape Town, South Africa.
- Steenkamp, M., **Ranse, J.**, Hutton, A., Lund, A., Turriss, S., Arbon, P. . . . Anikeeva, O. (2015, April 23). *Findings from Phase 1 of an international Delphi project to establish a minimum data set for mass gathering health*. Paper presented at the 19th World Congress for Disaster and Emergency Medicine, Cape Town, South Africa.
- Hutton, A., **Ranse, J.**, & Wilson, R. (2015, April 21). *What are the research needs for the field of disaster nursing? An international Delphi study*. Paper presented at the 19th World Congress for Disaster and Emergency Medicine, Cape Town, South Africa.
- Arbon, P., Steenkamp, M., Lund, A., Turriss, S., **Ranse, J.**, Hutton, A. . . . Ramsey, I. (2015, April 21) *Describing an international Delphi project on mass gathering health data*

collection. Paper presented at the 19th World Congress for Disaster and Emergency Medicine, Cape Town, South Africa.

Ranse, J., Luther, M., & Ranse, K. (2014, October 9). *Understanding the effect of clinician dependent versus evidence-based pathway for the management of Salmonella-like symptoms in an emergency department*. Paper presented at the 12th International Conference for Emergency Nurses, Perth, WA.

Ranse, J., Lenson, S., Keene, T., Luther, M., Burke, B., & Hutton, A. (2014, October 9). *Patient presentations to onsite health providers, ambulance paramedics and hospital emergency departments from a mass gathering: A case study*. Paper presented at the 12th International Conference for Emergency Nurses, Perth, WA.

Ranse, J., Lenson, S., Keene, T., Luther, M., Burke, B., & Hutton, A. (2014, September 18–20). *Patient presentations to onsite health providers, ambulance paramedics and hospital emergency departments from a mass gathering: A case study*. Poster presented at the Paramedics Australasia International Conference 2014, Gold Coast, QLD.

Hutton, A., **Ranse, J.**, Arbon, P., & Ullah, S. (2013, May 30). *The characteristics of patient presentations from Australian outdoor music festivals*. Paper presented at the 18th World Congress on Disaster and Emergency Medicine, Manchester, UK.

Ranse, J. & Hutton, A. (2013, May 30). *Biomedical data collection for mass gathering research and evaluation: A review of the literature*. Paper presented at the 18th World Congress on Disaster and Emergency Medicine, Manchester, UK.

Lund, A., Turris, S., Bowles, R., Gutman, S., Hutton, A., **Ranse, J.**, Arbon, P. (2013, May 30). *Progressing towards an international consensus on data modelling for mass gathering and mass participation events*. Paper presented at the 18th World Congress on Disaster and Emergency Medicine, Manchester, UK.

- Lenson, S., **Ranse, J.**, & Cusack, L. (2013, May 29). *Industrial considerations for Australian nurses responding to disasters*. Paper presented at the 18th World Congress on Disaster and Emergency Medicine, Manchester, UK.
- Ranse, J.** & Lenson, S. (2013, May 29). *Disaster and emergency medicine on-line research repository: A retrospective review*. Paper presented at the 18th World Congress on Disaster and Emergency Medicine, Manchester, UK.
- Ranse, J.** & Lenson, S. (2012, October 11). *Beyond a clinical role*. Paper presented at the 2nd Australian Capital Region Nursing and Midwifery Research Conference, Canberra, ACT.
- Hutton, A., **Ranse, J.**, & Arbon, P. (2012, May 19). *Understanding and identifying potential risks for participants at music festivals*. Paper presented at the St John Ambulance Australia Member Convention, Sydney, NSW.
- Bahnisch, L., Arbon, P., Cusack, L., **Ranse, J.**, Shaban, R., Hammad, K. . . . Mitchell, B. (2011, September 30). *To work or not to work: An analysis of the willingness of Australian emergency nurses to respond to a disaster*. Paper presented at the 9th International Conference for Emergency Nurses, Adelaide, SA.
- Lenson, S., **Ranse, J.**, & Cusack, L. (2011, September 30). *Industrial considerations for nurses responding to disasters*. Paper presented at the 9th International Conference for Emergency Nurses, Adelaide, SA.
- Lenson, S., **Ranse, J.** (2011, September 29). *Exploring the role of nurses during the 'Black Saturday' and Victorian bushfires of 2009 in Australia*. Paper presented at the 9th International Conference for Emergency Nurses, Adelaide, SA.

- Ranse, J.** & Lenson, S. (2011, June 1). *Role, response and clinical and educational backgrounds of nurses who participated in the pre-hospital response to the 2009 bushfires in Victoria, Australia*. Paper presented at the 17th World Congress on Disaster and Emergency Medicine, Beijing, China.
- Ranse, J.**, Arbon, P., Shaban, R., Considine, J., Mitchell, B., & Lenson, S. (2011, May 31). *Disaster content varies in Australian postgraduate emergency nursing courses: Implications for educational preparedness* Paper presented at the 17th World Congress on Disaster and Emergency Medicine, Beijing, China.
- Arbon, P., Cusack, L., **Ranse, J.**, Shaban, R., Considine, J., Mitchell, B. . . Bahnisch, L. (2011, May 31–June 3). *Understanding the willingness of Australian emergency nurses to respond to a health care disaster*. Poster presented at the 17th World Congress on Disaster and Emergency Medicine, Beijing, China.
- Lenson, S. & **Ranse, J.** (2011, May 6). *Exploring the role of nurses during the 'Black Saturday' and Victorian bushfires of 2009 in Australia*. Paper presented at the International Council of Nurses Conference, La Valeta, Malta.

Appendix B: Invitation and Information

Invitation and Information



AUSTRALIAN CIVILIAN NURSES LIVED EXPERIENCE OF WORKING IN THE OUT-OF-HOSPITAL DISASTER ENVIRONMENT

INVITATION AND INFORMATION

- Are you a nurse who primarily works as a clinician in a hospital?
- Have you participated in the health response and/or recovery to a disaster, in the last five years?
- Did you respond with a civilian (non-military) organisation, association, group or health service?
- Did your response involve you working in the out-of-hospital environment?

If you have answered **yes** to all of the above, you are invited to participate in this research project that will explore your experience of working in the out-of-hospital environment during disasters.

Overview

Historically, Australian nurses have been active participants in the response and recovery to health related disasters, both nationally and internationally. However, the experience of Australian nurses who participate in disasters remains poorly understood. Having a better understanding of the experience of Australian nurses in disasters, may assist in the further development of curriculum, policy and resources to support nurses.

Aim

This project aims to explore the lived experience of Australian civilian registered general nurses (division 1), who have worked in the out-of-hospital disaster environment. In particular, this project will explore the transferability of nurses' experience between the in-hospital and out-of-hospital disaster environment.

Your participation

Participation in this research will involve two face-to-face interviews with the researcher at a mutually agreeable time, at a mutually agreeable location. Each interview will:

- Take place in your city of residence,
- Last approximately 60 – 90 minutes per interview, and
- Be digitally recorded.

It is anticipated that the two interviews will take place within the same week. Participation in this research is voluntary. During the interviews you do not have to answer any question/s that you do not wish to answer, and you may withdraw any comments from the research at any point in time.

About the researcher

Jamie Ranse is a PhD student at the Flinders University Disaster Research Centre. He is a Registered Nurse with a background in Emergency and Intensive Care nursing. Jamie has an interest in disaster health, from a nursing perspective. Jamie's PhD research is being supervised by Professor Paul Arbon, Dr Lynette Cusack and Associate Professor Ramon Shaban.

If at any time you have queries about this project, you may contact either:

Mr Jamie Ranse (PhD candidate / researcher): jamie.ranse@flinders.edu.au or +61 2 6201 5380

Professor Paul Arbon (supervisor): paul.arbon@flinders.edu.au or +61 8 8201 3558

Emotional wellbeing

Prior to, during and/or following your interview with the researcher, you may experience an emotional response relating to your experience. You are encouraged to seek the support of your General Practitioner or your hospital / health service employee assistance program if this occurs.

Results

Following completion of this research project, the findings will be submitted in thesis format, as part of the requirements of the researchers PhD. Additionally, the results may be published in a journal and presented at a conference. Any publications and/or presentations will not individually identify you. All publications and presentations relating to this project can be found at: <http://bit.ly/JamiesPhD>

Ethics

Approval to undertake this research has been obtained from the Flinders University Social and Behavioural Research Ethics Committee (project number: 5423). Should you have any problems or queries about the way in which the research is being conducted, and you do not feel comfortable contacting the research staff, you may contact:

Executive Officer, Research Services Office

E-mail: human.researchethics@flinders.edu.au

Phone: +61 8 8201 3116

Fax: +61 8 8201 2035

Indicate your interest to participation in this research

If you wish to participate in this research, please contact:

Mr Jamie Ranse

PhD Candidate

E-mail: jamie.ranse@flinders.edu.au

Phone: +61 2 6201 5380

Please circulate this invitation and information sheet to your colleagues and associates that may be interested in participating in this research.

Appendix C: Participant Interview Schedules

Interview Schedules



THE LIVED EXPERIENCE OF AUSTRALIAN CIVILIAN NURSES WORKING IN THE OUT-OF-HOSPITAL DISASTER ENVIRONMENT

Interview one: semi-structured

This interview will focus on obtaining information about the participant's broad experience in disaster health, and aim at building rapport with the participant.

Time	Activity
0 – 10 mins	<ul style="list-style-type: none"> • Introduction of research student and supervisory team • Reiterate information on 'invitation and information sheet' and 'consent form' • Ensure consent form has been signed
10 – 85 mins	<p>Ice breaker questions:</p> <ul style="list-style-type: none"> • How long have you been nursing? • What is your nursing background? <p>Previous nursing experience questions:</p> <ul style="list-style-type: none"> • What areas / specialties within nursing have you associated with? • What roles have you undertaken in these areas? <p>Disaster nursing experience questions:</p> <ul style="list-style-type: none"> • Tell me about your experience of working in a disaster? <p>Prompting questions relating to disaster nursing experience:</p> <ul style="list-style-type: none"> • How many disaster events have you been involved with? • Can you tell me about the disaster event/s you have been involved in the last five years? • What was your role/s during these disasters? • Who did you work with? • Did your training adequately prepare you for your role/s? • What have you gained from your in-hospital nursing experience, which contributed to making your disaster involvement a success? • What factors could have enhanced your involvement? <ul style="list-style-type: none"> • Is there anything that you would like to add?
85 – 90 mins	Conclusion and thank you

Key phrases

Exploring – Can you tell me more about ... ?

Validating – So, is what you are saying ... ?

Interview two: unstructured

The aim of this interview is to explore in more detail the personal experiences of the participant.

Time	Activity
0 – 5 mins	<ul style="list-style-type: none"> • Introduction to interview two • Reiterate information on 'invitation and information sheet' and 'consent form' • Discuss any emotional response that the participant may have experienced since the previous interview
5 – 55 mins	Unstructured questioning, with an aim to: <ul style="list-style-type: none"> • Clarifying previous statements from interview one • Exploring and expanding on statements from interview one • Allow participant to provide additional statements that were not previously explored in interview one
55 – 60 mins	Conclusion and thank-you

Key phrases

Exploring – Can you tell me more about ... ?

Validating – So, is what you are saying ... ?

Appendix D: Example of Transcribed Participant Narrative (3.1:2–3)

<p>Interviewee: I do Interpath. I work for Interpath and I go to Philippines for the Cleft Lip and Palette Program down in Mindanao which is a southern island of the Philippines. It's an interesting island in that it's got a large population of Muslims that have a sort of conflict within the government so that it can be considered sometimes as an unstable environment whenever they have a problem - and when I was in my youth I did actually work on patrol boats for the Catholic Church in Manila Bay Province.</p> <p>Facilitator: Oh wow. That would have been very interesting.</p> <p>Interviewee: Interesting. Other than that, that's probably what I've done in disasters - and I went to Samoa in 2009. I deployed as the Field Operation Manager for the Samoa Islands.</p> <p>Facilitator: Yes, so the stuff that you've done predominantly around here seems to be a lot around the logistics and resources - human and physical type resources to ensure they meet the needs of people in the area. Can you tell me any more about the Sussex Inlet stuff - so you went down?</p> <p>Interviewee: Went down there. We were the second team to be released. The first team was actually based in Nowra and what happened is they needed - we were the second team when the decisions were made that they needed to have a medical team to support Sussex Inlet community rather than evacuating that in case something happened. So we were transported to the Sussex Inlet, we were housed in the local club and we actually ran basically a clinic and observed people, checked their asthma, made some visits in the evening to patients that were concerned about their breathing or if they had a child that may have asthma. So it was actually just supporting that community rather than moving them out - and looking at ways in case we had to evacuate - ways that we would evacuate those particular people out.</p> <p>Facilitator: Yes, okay, great. The Samoa is the one that interests me most I guess, because that's really about the group of people that I'm really wanting to know more about. So can you tell me about that experience of Samoa - like, how did that start and...</p> <p>Interviewee: Well the thing is that, because of my role that I am currently in, there was a request from the Australian Government to New South Wales Health to find a team, a health response team, to be sent to Samoa - and we had probably only about 18 hours to get that team up and running, so it was done fairly quickly. Each of the health areas within Sydney were asked to find particular sorts of people to go, so for instance, an area at - not my area - were looking at paediatric staff because a large population of Samoans are under a particular age. My role was to find two ED people, two ICU, an anaesthetist and a surgeon. That was my role and that was now going as part of the</p>	<p>larger 38 team members, and so that's what I had to do. In saying that, the hospital and the area, because of my ED background, said they would like me to go to support those other people that we had chosen. Because they didn't have a lot of experience and because I teach in disasters and I'd been on some before and I had an understanding of the processes, they made me the person to look after that particular section of the staff. So that's how I got to go.</p> <p>Facilitator: Okay, excellent. So the team you got in 18 hours - what kinds of things happened in 18 hours?</p> <p>Interviewee: Well the problem was that it happened fairly quickly in the afternoon and for me I had to try and find... I actually had to find an ED doctor as well - that's the other thing I did and we had to find an ED doctor. I found the other staff quite easily. I found the other ED nurse - I found a head of the nurse practitioner, had really good skills, had done the courses that I'd actually run. The two people that I got from ICU, they were really keen and they had a good understanding - one had done a particular course. The surgeon and anaesthetist - I'd used the anaesthetist on previous ones. I'd deployed him to Indonesia - they were easy to find. The surgeon took a little bit longer but I must admit they found one within a reasonable six hours which was really good. The interesting one I found was trying to find an ED doctor to go - which I thought had been the easiest component - but a lot of the doctors said, oh, it's school holidays and it's too short and how long are we going to be away - and it was all this sort of argy-bargy. But I ended up finding an ED doctor who was actually working at Port Macquarie, who was seconded from our area to Port Macquarie. Somebody had rung him up that couldn't go and said, look you would love to go because you've got all those experiences, you're finishing your seconded position tonight - so he got on a plane at 11 o'clock at night and arrived the next day because they had to be moved that day to Samoa. So finding the team - most of the team was easy to find - trying to find ones that actually had done a whole lot of courses to cover sort of the OH&S and also that they'd have a bit of an understanding, that they weren't going in to an environment that they didn't know, was a little bit difficult. And the anaesthetist I picked, as I say, had done two previous ones for me so he was really good, so between him and I we actually had some experience out in the field of dealing with people from other cultural areas and things like that, so that was fine.</p>
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Appendix E: Ethical Approval to Conduct Research

Flinders University and Southern Adelaide Local Health Network
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

Research Services Office, Union Building, Flinders University
 GPO Box 2100, ADELAIDE SA 5001
 Phone: (08) 8201 3116
 Email: human.researchethics@flinders.edu.au

APPROVAL NOTICE

Principal Researcher:	Mr Jamie Ranse		
Email:	jamie.ranse@flinders.edu.au		
Address:	School of Nursing and Midwifery		
Project Title:	The lived experience of Australian civilian nurses' working in the out-of-hospital disaster environment		
Project No.:	5423	Approval Date:	10 October 2011
		Approval Expiry Date:	31 December 2015

The above proposed project has been **approved** on the basis of the information contained in the application and its attachments.

Please ensure that any permission letters (item D8) that are required by the Committee are forwarded as soon as possible. Additionally, for projects where approval has also been sought from another Human Research Ethics Committee (item G1), please be reminded that a copy of the ethics approval notice will need to be sent to the Committee on receipt.

In accordance with the undertaking you provided in your application for ethics approval for the project, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

You are also required to report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol (modifications);
- any changes to the research team; and
- unforeseen events that might affect continued ethical acceptability of the project.

To modify/amend a previously approved project please either mail or email a completed copy of the Modification Request Form to the Executive Officer, which is available for download from <http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-and-behavioural-research-ethics-committee/notification-of-committee-decision.cfm>. Please ensure that any new or amended participant documents are attached to the modification request.

In order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress and/or final report must be submitted. A copy of the pro forma is available from <http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm>.

Your first report is due on **10 October 2012** or on completion of the project, whichever is the earliest. *Please retain this notice for reference when completing annual progress or final reports.* If an extension of time is required, please email a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date.

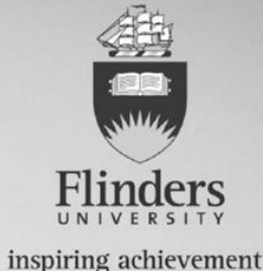


Andrea Mather
Executive Officer
Social and Behavioural Research Ethics Committee
18 October 2011

Cc: Prof Paul Arbon, paul.arbon@flinders.edu.au
Dr Lynette Cusack, lynette.cusack@flinders.edu.au

Appendix F: Participant Consent Form

Consent Form



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THE LIVED EXPERIENCE OF AUSTRALIAN CIVILIAN NURSES WORKING IN THE OUT-OF-HOSPITAL DISASTER ENVIRONMENT

I _____ have read the research project **invitation and information sheet**, and hereby consent to participate in this research. I am aware that:

- Participation in this project will involve two face-to-face interviews of approximately 1 ½ hours each, in my home city.
- The data will be digitally recorded, de-identified and securely stored throughout and upon completion of the project.
- Participation in this project is voluntary, I may withdraw at any stage and I do not have to answer any question I do not wish to answer.
- The results of the project will be submitted for publication in a journal, presented at a conference and submitted to Flinders University as part of the requirement for the researcher PhD candidature.
- I may not directly benefit from taking part in this research.
- If at any time I have queries about this project, I may contact either:
Mr Jamie Ranse (PhD student / principal researcher): jamie.ranse@flinders.edu.au or 02 6201 5380
Professor Paul Arbon (supervisor): paul.arbon@flinders.edu.au or 08 8201 3558
- Approval to undertake this research project has been obtained from the 'Flinders University Social and Behavioural Research Ethics Committee'. Should I have any problems or queries about the way in which the research was conducted, and I do not feel comfortable contacting the research staff, I am aware that I may contact:

Executive Officer, Research Services Office
E-mail: human.researchethics@flinders.edu.au
Phone: 08 8201 3116

By signing this consent form, I agree to participate in this research project. I have read and understood the information provided and I have had the opportunity to ask any questions.

<i>Signature Participant</i>	<i>Print Name</i>	<i>Date</i>
<i>Researcher</i>	<i>Print Name</i>	<i>Date</i>