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Simulated Disaster Day: Benefit from Lessons Learned Through Years of Transformation from Silos to Interprofessional Education

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Summary Statement

Disaster Day is a simulation event that began in the College of Nursing and has increased exponentially in size and popularity over the last eight years. The evolution has been the direct result of reflective practice and dedicated leadership in the form of students, faculty, and administration. Its development and expansion into a robust interprofessional education activity is noteworthy as it gives healthcare professions students an opportunity to work in teams to provide care in a disaster setting. The “authentic” learning situation has enhanced student knowledge of roles and responsibilities and appears to increase collaborative efforts with other disciplines. The lessons learned and modifications made in our Disaster Day planning, implementation, and evaluation processes are shared in an effort to facilitate best practices for other institutions interested in a similar activity.

When disaster strikes, a predictable cycle of response, reconstruction, and mitigation ensues.¹ The success of the response cycle depends heavily on the level of preparedness that

exists prior to the disaster. Following the terrorist attacks of September 11, 2001, a series of Homeland Security Presidential Directives (HSPD) were launched in an effort to mitigate future disasters on U.S. soil and prepare communities nationwide for rapid and effective response.² HSPD-21 identified the four most critical components of public health and medical preparedness in a disaster situation, one of which was mass casualty care, and established guidelines regarding education and training.³ In 2008, the College of Nursing (CON) at A&M instituted a large-scale disaster simulation for students dubbed “Disaster Day” in an effort to meet new accreditation mandates that nurses should be educated regarding mass casualty disasters.⁴ This event grew from 35 nursing students and faculty into an interprofessional education (IPE) event involving 300 students from seven disciplines, 500 volunteers, and multiple community organizations. The significance of this evolution lies in the premise that IPE, defined as a pedagogical approach for preparing health professions students to provide patient care in a collaborative team environment,⁵ provides the best environment for teaching students to work within a health care team. Disaster Day allows students to sharpen their collaborative communication, assessment, intervention, and evaluation skills. They interact with students, faculty, and professionals from other health care disciplines in a controlled, chaotic patient care setting requiring critical thinking skills and reliance on each other to succeed. Disaster preparedness is an emerging issue in environmental health and the Federal Emergency Management Agency (FEMA) promotes trainings like Disaster Day that promote disaster-resilient communities and increase public awareness of community impact.^{6,7} Hundreds of volunteers benefit from observing how multidisciplinary teams respond to both natural and man-made disasters in their communities through this exercise.

Background

Disaster Day consists of four phases: Planning, Team Building, Disaster Simulation, and Group Debriefing. Faculty and multidisciplinary student planning committees work for 10 months each year to organize the event. On simulation day, preselected health care teams consisting of students from all participating disciplines meet for team building sessions during which they establish a strategic plan for patient care. Licensed professionals from every profession represented in the student population are on site observing and guiding students during the simulation. Students are responsible for patient care but can seek professional guidance if needed. These professionals also record what they observe for use in the debriefing session following the simulation. Because all students get a plethora of hours observing licensed professionals performing patient care in clinical rotations, we purposefully designed this simulation to provide students the experience of being fully responsible for patient care; a position in which they can only be placed in a simulated environment for safety reasons.

This design offers students a glimpse into the critical decisions they must make as health professionals in practice. Based on feedback from students, this experience is both humbling and empowering. Faculty appreciate the opportunity to observe and evaluate students’ integration of technical skills and critical thinking, especially in a stressful environment. Each year, the event presents new challenges requiring adaptation and modification that contribute to the ongoing evolution. The planning committee determines what aspects of this

simulation to replicate, abandon and/or replace based on feedback from previous years. Table 1 represents the evolution of Disaster Day from 2008 to 2015. As more health care professions colleges respond to the mandate for disaster preparedness and interprofessional education initiatives from accrediting bodies, many of the lessons learned by the Texas A&M Health Science Center (TAMHSC) over the last nine years may be valuable to those considering implementation of a similar training.

Lesson #1: Build it and They Will Come

Although our current Disaster Day simulation is a massive IPE undertaking that requires ten months and close to 100 planning committee members across seven health care disciplines, it certainly did not start that way. If the end goal is a complex IPE simulation, we suggest starting considerably smaller with the expressed intent of expanding purposefully and strategically. When Disaster Day began, the intent was to better prepare nursing students to understand their role in a disaster situation, and hone their emergency medical skills. Faculty evaluation confirmed that the exercise met these objectives; however, student feedback emphasized a desire to include other health care disciplines to increase realism. Furthermore, many community organizations were required to conduct similar exercises and desired to merge with our existing event. The planning committee elected to make it an IPE event and encourage more community participation.

Incorporating other academic disciplines and community partners was not as simple as first supposed. Not only did it require clearing academic and clinical calendars for students and faculty, it became clear that an event designed for nursing students did not necessarily fit other disciplines. Additionally, groups were requesting to be included sometimes within only weeks of the simulation, requiring last minute changes to the event that often caused confusion and frustration. Addition of community organizations sometimes resulted in campaigns to alter the exercise in such a way that specific learning objectives would be superseded and/or dwarfed by more global, community-focused objectives. Retaining the original scope and purpose of the exercise, while ensuring that community involvement was relevant and constructive, required a delicate balance of open communication and flexibility. To foster this, a new planning strategy was employed.

Three important protocols resulted from near failed attempts to incorporate additional academic disciplines and community partners into Disaster Day. First, any academic department wishing to participate must first send at least one faculty and one (non-senior) student representative to observe Disaster Day to gain a thorough understanding of the purpose, objectives, and scope of the simulation. Following this, a proposal must be submitted outlining how the department would like to be involved the following year including: number of proposed students; students' role in the simulation; and supplies needed to accommodate their inclusion. Second, each academic discipline participating in Disaster Day must have a minimum of at least one faculty member and two students on the planning committee. Third, community partners wishing to join the event must follow a similar procedure proposing their involvement, providing a representative at planning meetings, and fully facilitating their involvement in the event. This protocol has allowed for strategically controlled growth, and educationally meaningful additions to the simulation.

Lesson #2: Let Students Lead

By year three, the creative leadership potential of students was recognized and the majority of planning decisions for Disaster Day were purposefully shifted from faculty to student committees. This subtle shift from students assisting faculty to faculty assisting students is arguably the most significant contributory factor to the continued momentum and sustained success of this event. Virtually every modification in the scope and design of Disaster Day is the result of student feedback, brainstorming, and desire to create the most meaningful learning opportunity possible for themselves and their peers. As student involvement grew, the organizational structure evolved to include underclassmen that shadow team leaders in preparation for the following year, as well as subcommittees within the planning committee, to more efficiently divide the plethora of responsibilities in an event of this magnitude. Participation on the planning committee empowers students to synthesize their knowledge and apply organizational and leadership skills that build their self-confidence and provide them with attributes sought after by future employers. Trusting students with this level of autonomy and responsibility requires exceptional faculty leadership. The level of faculty control and contribution in a similar exercise will vary greatly depending on the location, the institution, and the students involved. Because students share the responsibility for planning, execution, and outcomes of Disaster Day at TAMHSC, its success continues year after year. Comments such as: “best clinical experience,” and “really gives us the opportunity to think on our feet and use our assessment skills” exemplify the fact that Disaster Day enhances the vital skills of critical thinking, organization, and advanced problem solving in these future health care professionals.

Lesson #3: Bigger Doesn't Necessarily Mean Better

In the beginning, CON faculty determined learning objectives for nursing students and developed tools to evaluate them. As other academic departments joined the event, it was important to establish standards for each phase to maintain quality control of planning, implementation, and debriefing. Quality can easily be sacrificed in lieu of quantity. To avoid this, each department was asked to define discipline-specific objectives and evaluative processes for their students. Assistance with IPE objectives and evaluation was sought and obtained from an existing NIH grant.⁸ To maintain quality control in planning, all decisions made by student committees require approval by a faculty liaison assigned to each committee. All committees and faculty liaisons meet monthly, both individually and as a whole, to carefully monitor the process. In the last month before implementation, meetings are held weekly.

Quality control of the implementation and debriefing process is a feat of coordination and organization. Multidisciplinary faculty teams oversee implementation alongside student Incident Commanders and committee chairs. These teams also facilitate the student debriefing sessions. This requires recruitment and training of additional faculty for simulation day, and some departments make faculty attendance and participation mandatory. All faculty are invited to a post-event meeting where ideas are shared for quality improvement for the future.

The NIH grant involvement enables us to evaluate interprofessional teamwork more formally, provides essential feedback for modifications, and helps financially. Creating and implementing IPE evaluation tools, which require IRB approval, was worth the extra time and effort. IPE objectives of each phase of the activity: planning, team building, the simulation, and debriefing (Table 2) have been evaluated and results submitted for publication.⁹ Participants' comments from the evaluative surveys are grouped into categories and shared with the planning committee. For example, participants identified a "need for additional training for [volunteer] patients," "better defined roles and expectations [for student participants]," and "more variation with case scenarios." This information is utilized to inform planning and practice for the next Disaster Day.

Important evaluative measures that are currently missing from our process include the perceived benefits and efficacy of the experience as it relates to current clinical practice of past participants, and the translational effects on patient care, disaster response, and the community that simulation-based medical education such as this is known to produce.¹⁰ Further research in both areas is needed.

Lesson #4: Obstacles Need Not Derail Your Efforts

Many barriers to a large scale multidisciplinary simulation can be avoided with advanced planning. Some of the obstacles that threaten derailment of these events include expense, faculty/administrative buy-in, finding enough volunteers, and limiting liability. Expense is often cited as the primary barrier to an event like Disaster Day. However, there are many ways to minimize expenses. First, strive never to pay for the venue. If space on campus is not ideal, large church or school gymnasiums can often be utilized free of charge, but must be booked up to a year in advance. Many counties have federally mandated mobile hospitals that must be deployed to full operating capacity as a disaster preparedness exercise. Pairing this with another training event is often free of charge. Check with your local county officials to see if this is possible in your area. Second, seek donations from local businesses for consumable supplies, food and drinks, and other expenses. Disaster Day donors are recognized on a t-shirt designed for the event and provided to all participants through the student-led Fundraising Committee. When considering limited financial resources for supplies and implementation, consider planned "supply shortages" written into the overall scenario as a realistic possibility in any disaster response situation. Finally, seek outside funding. Grant support is important to consider since millions of dollars in grant money go un-awarded each year in the U.S. because no one applies for the grant.¹¹

Regardless of how valuable a simulated IPE disaster exercise may be, unless there is support from top administrators, it will be virtually impossible to create a meaningful and sustainable product. Disaster Day at TAMHSC began as a nursing simulation. As popularity grew through word of mouth, both students and faculty from other disciplines clamored to be included. However, this enthusiasm often missed the attention of departmental administration. Subsequently, faculty found themselves without the resources to participate, and students could not get excused from other academic obligations to attend. In order for a large scale simulation to meet the objectives of disaster preparedness and IPE, the administration of each college must be briefed on the importance and value of the event, and

enthusiastic faculty must be identified and provided adequate time to dedicate to the event. The event must become not only compulsory, but provide some measurable benefit to students if they are to take it seriously. Most TAMHSC students participating in Disaster Day receive either clinical hours, course credit, and/or a grade for their efforts. None of this could happen until the deans of each participating college recognized the simulation as a worthy endeavor for their students; only then were time and resources made available.

Finding enough volunteers to make a large simulation realistic can seem daunting. There will never be a shortage of volunteers of all ages willing to play the role of patients if you look in the right places. Groups that repeatedly provide volunteers to Disaster Day include high school drama clubs and health care track students, homeschool groups, local non-profit service organizations, off-duty first responders and health care providers, and college student organizations such as ROTC, sororities, and fraternities that require community service hours for their members. Feedback provided by volunteers has provided valuable insight to the patient perspective of interprofessional health care teamwork during a disaster. Much of the patient feedback focused on communication such as: needing the team members to identify themselves, and having them explain more to the patient. Furthermore, volunteer patients asked that they be given “more information about what to do and expect” and “more guidance as to what their roles were.”

With an event of this magnitude, limiting liability is essential for sustainability. Identifying anyone with a cosmetic or latex allergy prior to applying stage makeup, taping down electrical cords, and making the simulation “needle-free” are just some of the strategies we employ to maximize safety and minimize potential hazards. Additionally, all volunteers must sign a liability waiver; no minors under age 15 may participate without a parent or guardian present; and parents must sign a minor release and liability waiver for any minor 15 or older participating without a parent or guardian. Perhaps the most comforting safety measure implemented, and one that has proven its value on multiple occasions, is a code word taught to all participants that identifies a true medical emergency. In an event where up to 500 people are portraying symptoms from minor injuries to serious medical conditions, it is imperative there be some way to determine if someone is no longer acting, but in need of medical attention.

Conclusion

The lessons learned from the evolution of Disaster Day at TAMHSC can benefit anyone wishing to create a similar event. To minimize roadblocks in the creation of an interprofessional education simulation, identification of committed faculty and buy-in from administration is paramount to get from concept to reality. The National Council of State Boards of Nursing recently concluded that traditional clinical experience can be effectively replaced with simulation up to a ratio of 50/50 when an adequate number of formally trained simulation faculty use equipment and supplies to create a realistic environment and use theory-based debriefing techniques by content experts.¹² An event like Disaster Day provides a plethora of opportunities for faculty development and student credit.

The importance of starting small and controlling growth cannot be overstated. Rapid growth without adequate quality control, support, and careful planning contributes to a poorly organized experience that lacks focus and direction. Gathering and responding to participant feedback is essential so that organizational, instructional, and other needs can be identified, clarified, and addressed. Bringing students from multiple health care professions together in a single simulation requires a substantial time commitment from everyone involved and a great deal of coordination and collaboration.

One of the most valuable lessons learned in the evolution of Disaster Day is the efficacy of empowering students to lead the planning and execution of the event. Without exception, when participants are asked what makes TAMHSC Disaster Day so successful, the magnitude and depth of student involvement tops the list of important contributing factors. However, for institutions interested in providing a more interactive experience between students and practicing professionals, a hybrid of this model is also a viable option for consideration. Established professionals joining the experience and taking a more active role in patient care alongside students could provide learners first-hand awareness of how a real disaster relief situation is managed by professionals in their field of study and may simultaneously satisfy mandated training of health care professionals. TAMHSC administration have expressed their appreciation for the current model and its perceived impact on the campus and community in terms of better understanding the roles and responsibilities of health care providers in a disaster situation.

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Table 1

Year	2008	2009	2010	2011	2012	2013	2014	2015
Simulation Scenario	Hurricane; Care of displaced nursing home patients	Hurricane; Care of displaced nursing home patients	Chemical fire evacuation; 20 scripts including injuries, chronic conditions, birth, CODE	Hurricane; 30 scripts varied as in previous year	Wildfire; 45 scripts varied as in previous year(s)	Explosion; 65 scripts varied as in previous year(s)	Hurricane/Tornado; 16 repeating scripts varied as in previous year(s)	Wildfire; 20 repeating scripts varied as in previous year(s)
Planning Committee	Nursing faculty	Nursing faculty assisted by four nursing students	Nursing faculty assisted by ten nursing students (two assigned as Incident Commanders [ICs])	Two nursing student ICs; two nursing student Deputy ICs; 20 nursing students guided by nursing faculty	Two nursing student ICs; two nursing student DTCs; 40 students from all disciplines Six sub-committees: Case Study Volunteer Supply Food T-shirt Moulage Guided by faculty from all disciplines	Two nursing student ICs; two nursing student DTCs; 70 students from all disciplines Six sub-committees Guided by faculty from all disciplines	Two nursing student ICs; two nursing student DTCs; 75 students from all disciplines Six sub-committees Guided by faculty from all disciplines	Two nursing student ICs; two nursing student DTCs; 80 students from all disciplines Five sub-committees; Food and T-shirt combined into Fundraising Guided by faculty from all disciplines
Faculty Oversight and Evaluation at Simulation	Nursing faculty; Direct observation Informal satisfaction survey of students	Same as 2008	Same as 2009	Same as 2010	Nursing, Medicine, and Pharmacy faculty; Direct observation Informal satisfaction survey of students, faculty, and volunteers	Faculty from all disciplines; Direct observation Informal satisfaction survey of students, faculty, and volunteers	Faculty from all disciplines; Direct observation Three formal IPE evaluation surveys of students, faculty, and volunteers	Same as 2014
Number of Participants: Students Standardized Patients and Volunteers	Students: Nursing: 35	Students: Nursing: 78 SPs: 8	Students: Nursing: 101 SPs: 20 Volunteers: 60	Students: Nursing: 123 Medicine: 8 SPs: 30 Volunteers: 70	Students: Nursing: 151 Medicine: 12 Pharmacy: 4 SPs: 50 Volunteers: 100	Students: Nursing: 146 Medicine: 22 Pharmacy: 8 Allied Health Nursing (AND): 24 Radiology Tech: 32 EMS: 33 SPs: 60 Volunteers: 200 Student Pts: 50	Students: Nursing: 170 Medicine: 57 Pharmacy: 8 AND: 60 RadTech: 30 EMS: 28 Physical Therapy (PT): 22 SPs: 80 Local RNs: 4 Volunteers: 300+ Student Pts: 50	Students: Nursing: 175 Medicine: 40 Pharmacy: 24 AND: 64 RadTech: 24 EMS: 28 PT: 36 Residents: 16 Local RNs: 4 Vet Med: 10 SPs: 0 Volunteers: 450+ Student Pts: 50

Year	2008	2009	2010	2011	2012	2013	2014	2015
Estimated Cost	\$200 – \$300 Most supplies recycled	\$700–\$900 SPs paid Some supplies consumed	\$1300 – \$1500 SPs paid Some supplies consumed	\$3500 – \$3700 SPs paid Some supplies consumed	\$7500 – \$8000 SPs paid All participants fed Some Supplies consumed	\$12,500 – \$13,000 SPs paid All participants fed Some Supplies consumed	\$16,500 – \$17,000 SPs paid All participants fed Some Supplies consumed	\$10,000 All participants fed Some Supplies consumed
Community Organizations	Fire Dept; Red Cross	Fire Dept; Red Cross; EMS Services	Same as 2009	Same as 2010	Same as 2011	Fire Dept; Red Cross; EMS Services; Regional Advisory Council (RAC)	Same as 2013	Fire Dept; Red Cross; EMS Services; RAC; Salvation Army
Schedule AM	Nursing Skills Review: First aid Vital Signs Activities of Daily Living PPE	Same as 2008	Same as 2009	Nursing Skills Review: First aid Vital Signs Activities of Daily Living PPE AM Simulation Debriefing in large group	Interprofessional ISBARR practice Interprofessional teambuilding and role identification session Simulation Debriefing in large group Feedback	Interprofessional teambuilding and role identification session Simulation Debriefing in large group Feedback	Interprofessional teambuilding and role identification session Simulation Debriefing by teams in small groups Feedback	Same as 2014
Schedule PM	Simulation Debriefing Q&A Feedback	Same as 2008	Same as 2009	PM Simulation Debriefing Q&A Feedback	Same as AM 2012	Same as AM 2013	Same as AM 2014	Same as AM 2015
Feedback and Survey Results	Positive response; Will continue Disaster Day simulation	Lack of authenticity and realism; Positive feedback on the use of SPs; More active faculty role during simulation; Begin planning earlier	Too many students for one simulation; Need student evaluation tool; Include other disciplines; Omit skills stations; Need structured guidance of media coverage	Appreciation of interprofessional teamwork; Good organization; Great patient performances; First semester nursing students felt overwhelmed	Appreciation of interprofessional teamwork; Some volunteer performances poor; First semester nursing students overwhelmed; Desire to include other Allied Health program students	Addition of other disciplines highly praised; Post-simulation debriefing too large; Too many cases; Other disciplines desire involvement in planning	Overwhelmingly positive response from participants; Not enough variety in cases; Greater involvement of other disciplines in planning	Overwhelmingly positive response from participants; Not enough variety in cases; Teambuilding sessions need more structure and stronger faculty presence/ involvement

Table 2

PHASE	TAMHSC DISASTER DAY IPE OBJECTIVES
Planning	<p>VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team</p> <p>VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.</p> <p>CC2. Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.</p> <p>CC4. Listen actively, and encourage ideas and opinions of other team members.</p> <p>RR7. Forge interdependent relationships with other professions to improve care and advance learning.</p> <p>TT1. Describe the process of team development and the roles and practices of effective teams.</p> <p>TT5. Apply leadership practices that support collaborative practice and team effectiveness.</p>
Team Building	<p>CC7. Recognize how one's own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships.</p> <p>RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.</p> <p>RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.</p>
Disaster Simulation	<p>VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.</p> <p>RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.</p> <p>TT4. Integrate the knowledge and experience of other professions appropriate to the specific care situation to inform care decisions, while respecting patient and community values and priorities/ preferences for care.</p> <p>CC3. Express one's knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.</p>
Group Debriefing	<p>CC5. Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.</p> <p>TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.</p> <p>TT9. Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care</p>

Adopted from: Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative