

ASSESSING THE RELATIONSHIP BETWEEN CLINICAL COMPETENCIES AND DISASTER PREPAREDNESS OF NURSES AT THE PHILIPPINE NATIONAL POLICE REGIONAL MEDICAL AND DENTAL UNIT 11

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Assessing the Relationship Between Clinical Competencies and Disaster Preparedness of Nurses at the Philippine National Police Regional Medical and Dental Unit 11

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Abstract. Disaster preparedness among nurses is a critical component of effective emergency response, particularly in high-risk and specialized settings such as police medical units. This study assessed the relationship between clinical competencies and disaster preparedness among nurses assigned to the Philippine National Police Regional Medical and Dental Unit 11 (PNP RMDU-11). A quantitative correlational research design was employed, involving a total enumeration of 23 registered nurses. Data were collected using validated self-assessment instruments measuring proficiency in essential clinical skills, such as basic life support, triage, wound care, and intravenous therapy, and levels of disaster preparedness across cognitive, affective, and behavioral domains. Statistical analyses, including descriptive statistics, Pearson's correlation, and regression analysis, were conducted at a 0.05 level of significance. Findings revealed that respondents demonstrated high levels of clinical competence and disaster preparedness. A statistically significant positive relationship was identified between clinical competencies and disaster preparedness, indicating that higher proficiency in essential clinical skills is associated with greater readiness for disaster response. Among the competencies, triage and basic life support emerged as significant predictors of preparedness. The results highlight the importance of competency-based training, simulation exercises, and continuous professional development in strengthening disaster readiness among nurses in law enforcement healthcare settings. This study contributes to the limited body of research on disaster preparedness within police medical units and provides evidence-based insights for the development of targeted training programs, policy enhancements, and institutional strategies aimed at improving emergency response capacity and healthcare system resilience.

Keywords: Clinical competencies, Disaster preparedness, Emergency response, Nursing competence, Police medical units

Introduction

Disasters, whether natural or man-made, cause extensive damage, displacement, and strain on health systems. Beyond physical destruction, they disrupt economies, weaken social cohesion, and threaten public health. Disaster nursing has evolved to address these challenges, expanding the role of nurses to preparedness, triage, crisis management, psychosocial support, and inter-agency coordination.

Nurses are often the first responders, making their competencies critical in reducing mortality and morbidity. However, studies highlight gaps in preparedness, limited training, unclear role definitions, and ethical dilemmas in resource-constrained settings. International frameworks, such as those developed by the International Nursing Coalition for Mass Casualty Education (INCMCE), emphasize disaster nursing competencies, yet inconsistencies in scope and application remain. Effective disaster nursing requires clinical

expertise, critical thinking, communication, and ethical judgment across all phases of disaster management—preparedness, response, recovery, and mitigation.

In the Philippines, geographic vulnerability heightens the need for capable responders. Nurses in the Philippine National Police Regional Medical and Dental Unit-11 (PNP RMDU-11) perform essential emergency functions such as first aid, triage, life support, and rapid assessment under high-stress conditions. Despite this, research on disaster preparedness in police-based nursing units is scarce.

This study addresses this gap by examining the relationship between essential clinical skills and disaster preparedness among PNP RMDU-11 nurses. Findings aim to guide competency-based training, strengthen disaster readiness, and inform policy initiatives to enhance the effectiveness of police medical units in emergency response.

Research Questions

This study aimed to determine the correlation between essential clinical skills and disaster preparedness among police nurses assigned to PNP RMDU-11.

To address this overarching research problem, the study sought to answer the following questions;

1. What is the socio- demographic profile of the respondents?
2. What is the level of proficiency in essential clinical skills among nurses assigned to PNP RMDU-11?
3. What is the extent of disaster preparedness among these nurses?
4. Is there a significant correlation between nurses' proficiency in essential clinical skills and their disaster preparedness?
5. Which specific clinical skills significantly predict disaster preparedness among PNP RMDU-11 nurses?

Scope and Delimitation of the Study

This study examines the relationship between essential clinical skills and disaster preparedness among nurses assigned to the Philippine National Police Regional Medical and Dental Unit-11 (PNP RMDU-11). It focuses on key competencies such as basic life support, wound management, intravenous therapy, and triage, and how these relate to readiness for disaster response. The scope is limited to registered nurses currently assigned to PNP RMDU-11 in Region XI. Civilian nurses, other healthcare personnel, and units outside this setting are excluded. Data reflect clinical skills and preparedness during the current operational year only. The study concentrates on individual-level skills and preparedness using standardized self-assessment tools and validated disaster readiness scales. Other factors such as years of service, prior disaster experience, access to training, or psychological resilience are acknowledged but not analyzed as independent variables. A quantitative correlational design is employed, without qualitative exploration of personal narratives. Since the study is geographically and institutionally bounded, findings may not be generalizable to nurses in other regions, private institutions, or non-police healthcare settings.

Literature Review

Literature Review

Impact of Disasters on Society and Health Systems

Disasters, whether natural (typhoons, earthquakes, floods, pandemics) or human-made (armed conflicts, industrial accidents, terrorism), disrupt societies worldwide. They damage infrastructure, displace populations, and strain governance and healthcare systems. Beyond physical destruction, disasters weaken economies, erode social cohesion, and place heavy burdens on public health. At the individual level, they often result in fatalities, disabilities, psychological distress, and long-term declines in quality of life (Holla et al., 2018; Perry, 2018). These widespread impacts highlight the need for robust disaster management strategies and emphasize the critical role of healthcare professionals—particularly nurses—in mitigating adverse outcomes and supporting community resilience.

Emergence of Disaster Nursing as a Specialty

The growing frequency and complexity of disasters have led to the emergence of disaster nursing as a specialized field. This discipline expands the traditional role of nurses to include broader responsibilities in large-scale emergencies. According to Kalanlar (2018), disaster nursing involves applying professional knowledge, clinical skills, and critical decision-making to reduce health risks and manage life-threatening conditions. In practice, disaster nurses provide direct patient care while also leading in emergency preparedness, rapid triage, crisis management, health education, and psychosocial support. They are trained to function in high-stress, resource-limited environments and to adapt quickly to the unpredictable conditions of disaster settings.

Expanded Roles and Responsibilities of Nurses in Disasters

Modern disaster nursing requires a broad skill set that extends beyond bedside care to coordination within emergency response systems. Nurses often serve as first points of contact for victims, working in hospitals, communities, and field operations. Their responsibilities include mass casualty triage, rescue participation, public health initiatives, and risk communication to reduce panic. They must also uphold ethical decision-making in resource-limited settings and demonstrate cultural competence when serving diverse populations. These expanded roles highlight nurses' critical contribution to reducing mortality and morbidity, reinforcing disaster nursing as a key component of national and global health security. Calls for continuous training, policy development, and integration of disaster preparedness into nursing practice reflect this growing importance.

Interdisciplinary Nature of Disaster Response

Effective disaster response is inherently interdisciplinary, requiring collaboration among nurses, physicians, paramedics, EMTs, and other professionals. International studies show that while each profession has distinct roles, coordinated teamwork and clear communication are essential for optimal outcomes (Brinjee et al., 2021; Mani et al., 2020; Schultz et al., 2012). For nurses, this means their disaster activities often intersect with those of other responders, emphasizing the need for well-defined roles, leadership skills, and competency in collaborative practice during crises.

Challenges in Disaster Preparedness and Nursing Education

Despite the recognized importance of disaster nursing, persistent challenges remain in preparing nurses for effective response. Reviews highlight several systemic and practice-based issues. Many nurses lack hands-on or simulation-based training, resulting in low confidence during actual disasters. Disaster content is often insufficiently integrated into nursing curricula, leaving gaps in knowledge of disaster management principles. Ethical and legal responsibilities, such as triage priorities and resource allocation, are frequently unclear, causing moral distress. In addition, the scope of nursing roles in non-hospital settings is often poorly defined, limiting coordination with other agencies. These challenges, noted in studies such as Hammad et al. (2011), Aliakbari et al. (2014), and Nejadshafiee et al. (2020), show that many nurses feel underprepared for disasters. As a result, healthcare responses may be slower or less effective, potentially worsening the impact on affected populations.

Need for Specialized Competencies and Context-Specific Research

Most studies on disaster preparedness in nursing remain general and lack focus on specific contexts or sub-populations. Scholars emphasize the need for competencies that are both profession-specific and tailored to distinct disaster types and settings. For example, the skills required in pandemics differ from those needed in earthquakes, and rural disaster sites demand different approaches than urban ones. Developing such targeted competencies allows for more precise training, education, and policy formulation (Al Thobaity & Alshammari, 2020; Loke et al., 2021). The COVID-19 pandemic further exposed vulnerabilities in healthcare systems and underscored the importance of adaptive, evidence-based competencies for nurses. Recent studies call for rigorous, context-driven research to build frameworks that are not one-size-fits-all but customized to local realities, disaster types, and healthcare infrastructures. Such tailored approaches can better prepare nurses for the specific challenges they are most likely to encounter.

Efforts to Standardize Disaster Nursing Competencies

Recognizing nurses' critical role in disaster response, several initiatives have sought to professionalize and standardize disaster nursing competencies. In the United States, the International Nursing Coalition for Mass Casualty Education (INCMCE) at Vanderbilt University was an early effort to define nursing roles in mass casualty events. This initiative emphasized leadership, role clarity, and the integration of emergency preparedness into nursing practice, laying the foundation for competency-based frameworks tailored to disaster contexts (Daily & Padjen, 2010). Despite these advances, inconsistencies in terminology, scope, and application remain across institutions. Definitions of "disaster preparedness" and the skills required of a "disaster-competent nurse" vary, creating ambiguity in education and practice. Such disparities hinder the uniform implementation of disaster nursing standards and complicate the evaluation and comparison of nurses' readiness across organizations and countries.

Defining Nursing Competency in Disaster Contexts

Nursing competency refers to the integration of knowledge, technical skills, behaviors, and attitudes required for safe and effective care (Satoh et al., 2018). In disaster settings, this competency extends beyond routine clinical practice to include critical thinking, communication, coordination, and ethical judgment under pressure (Latif et al., 2019). Competent disaster nurses are expected to rapidly assess evolving situations, make sound decisions despite uncertainty, communicate clearly, collaborate with response teams, and uphold ethical standards in chaotic environments. A fundamental aspect of competency is understanding the disaster management cycle—mitigation, preparedness, response, and recovery—where nurses must

demonstrate proficiency across all phases through participation in community programs, emergency drills, and continuous learning (Tzeng & Yin, 2008; Veenema et al., 2016). The International Council of Nurses (ICN) Disaster Nursing Competency Framework (2019) provides global standards by clustering competencies into domains such as emergency preparedness and planning, communication and coordination, ethical and legal principles, and psychological and cultural responsiveness. This framework serves as an international benchmark, guiding policymakers and educators in harmonizing nursing curricula with disaster preparedness needs and ensuring nurses worldwide are equipped with consistent baseline competencies for disaster response.

Training and Simulation to Enhance Disaster Preparedness

Recent studies emphasize that bridging the gap between theory and practice is essential for disaster nursing. Advanced training methods—particularly high-fidelity simulations, disaster drills, and psychological preparedness programs—have been shown to significantly improve nurses' confidence, triage accuracy, teamwork, and decision-making under pressure (Al Thobaity et al., 2017; Horrocks et al., 2019; Said & Chiang, 2020; Choi et al., 2022). These experiential approaches recreate high-stress environments, allowing nurses to develop skills that classroom learning alone cannot provide. However, research also reveals a persistent gap between perceived readiness and actual performance, with nurses often overestimating their competence (Hutton et al., 2016; Aliakbari et al., 2014; Nejadshafiee et al., 2020). To address this, experts recommend continuous assessment using standardized tools, competency checklists, and regular refresher programs to ensure preparedness is accurately measured, sustained, and supported institutionally.

Essential Clinical Skills for Disaster Response

A vital aspect of disaster nursing competency is the mastery of essential clinical skills that directly affect survival in emergencies. These include basic life support, airway management, hemorrhage control, triage, rapid assessment, and wound care with infection control. Benner's (1984) model of skill acquisition explains that nurses progress from novice to expert through experience and reflection, yet even experienced nurses must perform these procedures under extreme time pressure and resource limitations. The ability to execute critical interventions reliably in austere conditions—such as triaging multiple victims or managing airways without advanced equipment—can determine patient outcomes (Watson et al., 2002). For this reason, disaster training programs emphasize repeated practice of these core skills until they become second nature.

Disaster Preparedness in Nursing Practice

Preparedness in nursing extends beyond technical skills to include knowledge of disaster systems, emotional resilience, and willingness to respond under challenging conditions (Veenema et al., 2016). It is framed across the disaster cycle—mitigation, preparedness, response, and recovery—requiring nurses to function effectively in each phase. Prior disaster experience, exposure to drills and simulations, and continuing education significantly enhance readiness (Labrague et al., 2018). Institutional support, such as clear disaster plans, regular exercises, and adequate resources, also strengthens preparedness (Gebbie & Qureshi, 2002; Whetzel et al., 2013). Without such support, even skilled nurses may face systemic barriers that hinder effective response. Preparedness is best assessed through both objective measures, such as performance in drills, and subjective measures, such as self-confidence. Meta-analytic findings show that frequent training, prior disaster experience, and strong organizational programs are associated with higher preparedness levels (Tas & Çakir, 2022). These results highlight that disaster readiness requires both individual commitment to training and organizational initiatives that institutionalize preparedness across healthcare systems.

Core Constructs and Operational Definitions

This study focuses on two core constructs: essential clinical skills and disaster preparedness. Essential clinical skills are defined as nurses' self-reported proficiency in performing emergency procedures directly relevant to disaster response, such as resuscitation, triage, and acute care techniques (Benner, 1984; Spencer & Spencer, 1993). High proficiency indicates the ability to perform these interventions swiftly and effectively under pressure. Disaster preparedness is defined as the degree to which nurses possess the knowledge, practical skills, psychological readiness, and motivation to function effectively in disaster conditions (Veenema et al., 2016; ICN, 2019). Competency in disasters integrates both constructs, encompassing knowledge, judgment, technical skills, and interpersonal abilities to deliver safe and culturally sensitive care during emergencies (Redman et al., 2000; Latif et al., 2019). Clear operational definitions ensure validity and allow meaningful comparison with global studies.

Global Perspectives on Disaster Nursing and Preparedness

Global research underscores the vital role of nurses in disaster and public health emergencies. Gebbie and Qureshi (2002) highlighted early gaps in preparedness, calling for structured emergency training, while Veenema (2018) consolidated best practices through competency frameworks and case

studies that emphasize embedding disaster education in nursing curricula. Evidence from low-resource settings, such as the Philippines (Labrague et al., 2018), shows nurses often demonstrate low to moderate preparedness due to limited training, minimal simulation exposure, and weak institutional support—contrasting with stronger programs in resource-rich countries. Tas and Çakir's (2022) meta-analysis of 24 studies confirmed that experience, recent training, and organizational investment are key predictors of preparedness, with nurses who undergo regular drills and specialized courses consistently demonstrating higher competence.

Key Theoretical Frameworks and Models Informing Disaster Nursing

Several models guide the development and evaluation of disaster nursing competencies. The Competency-Based Education and Training (CBET) model (Spencer & Spencer, 1993) views competencies as measurable clusters of knowledge, skills, and attitudes, supporting structured training in tasks such as CPR and triage. Benner's Novice-to-Expert model (1984) emphasizes experiential learning, showing that proficiency advances through practice and exposure—critical in disaster contexts requiring rapid decision-making. Donabedian's Structure-Process-Outcome framework (1988) offers a holistic lens by linking system attributes, actions, and outcomes in preparedness evaluation. The ICN Disaster Competency Framework (2019) provides internationally validated standards across preparedness, response, recovery, and ethical/cultural domains. Finally, the Competency Outcomes Performance Assessment (COPA) model (Redman et al., 2000) highlights simulation and performance checklists to ensure defined competencies are achieved.

Empirical Studies on Nurses' Disaster Preparedness and Training

Studies show that nurses have both strengths and weaknesses in disaster preparedness. Some nurses report high confidence, but their actual skills may not always match their self-assessment, highlighting the need for objective evaluation (Hutton et al., 2016; Murphy et al., 2021). Research consistently shows that training, especially simulations, prior experience, and regular drills, improves nurses' knowledge, triage skills, teamwork, and confidence (Tas & Çakir, 2022; Brinjee et al., 2021; Mani et al., 2020; Choi et al., 2022). Clinical competencies, including knowledge and skill proficiency, are key factors that influence disaster preparedness (Chegini et al., 2022; Setyawati et al., 2020; Kang et al., 2023). However, challenges such as lack of equipment, unclear protocols, and limited institutional support can reduce nurses' preparedness (Whetzel et al., 2013; Goniewicz & Burkle, 2019; Al Harthi et al., 2020). Studies also show that resilience and organizational support play an important role in improving readiness (Aqtam et al., 2024; Hussain & Khan, 2022). Simulation-based and blended learning approaches are highly effective in enhancing disaster preparedness. These methods improve decision-making, teamwork, and long-term skill retention (Eskici et al., 2025; Martínez Rodríguez et al., 2021; Garcia Pérez et al., 2024). Similar results were found across different countries, where combining theory and practice improved triage accuracy and confidence (Yamamoto et al., 2020; Li & Wong, 2022; Patel et al., 2025). In the Philippine context, nurses generally have adequate theoretical knowledge but lack practical skills in areas such as triage, CPR, and emergency care due to limited training and resources (Reyes & Villafior, 2019; De Jesus & Manzano, 2020; Salvador et al., 2021; Ramirez & del Rosario, 2019). However, training programs, workshops, and simulation-based interventions significantly improve their competence, confidence, and disaster preparedness (Torres & David, 2022; Morales et al., 2023).

Methodology

Research Design

This study utilized a quantitative-correlational design to examine the statistical relationship between nurses' proficiency in essential clinical skills (independent variable) and their level of disaster preparedness (dependent variable) within the Philippine National Police Regional Medical and Dental Unit-11 (PNP RMDU-11). The design was appropriate as it enabled objective measurement of the strength and direction of associations between naturally occurring variables, providing evidence of how clinical competence influences disaster readiness without manipulating environmental or operational conditions.

Sampling Design

The study employed a total enumeration sampling method, including all 23 nurses assigned to PNP RMDU-11 who met the inclusion criteria. This approach was methodologically appropriate given the unit's small, specialized, and mission-specific workforce, characterized by uniform organizational structures, shared training systems, and similar operational exposures. Including the entire population minimized sampling bias and ensured that findings captured the full range of competencies and preparedness levels within the unit. Although the numerical sample size is limited, it represents 100% of the target population, providing a comprehensive and internally valid assessment of disaster preparedness among PNP RMDU-11 nurses. While generalization to other regions or healthcare systems should be cautious, the results are

directly applicable to policy, training, and program development within the PNP Health Service and comparable police medical units.

Research Locale

The study was conducted in Region XI (Davao Region), within the jurisdiction of the Philippine National Police Regional Medical and Dental Unit-11 (PNP RMDU-11). This operational unit provides healthcare services to police personnel and local communities during routine operations and emergencies. The Davao Region is frequently exposed to disasters such as earthquakes, typhoons, floods, armed conflicts, and mass gatherings, making it a strategic setting for assessing disaster preparedness among law enforcement healthcare providers.

Research Participants

The study population comprised all registered nurses assigned to PNP RMDU-11, a specialized group functioning within a law-enforcement health system rather than conventional hospital settings. These nurses deliver routine clinical care while supporting police operations, emergency responses, and disaster deployments across Region XI, requiring adaptability, rapid decision-making, and competence under high-risk conditions. Inclusion criteria required participants to be licensed registered nurses under the PNP Health Service, with at least six months of continuous service at PNP RMDU-11 to ensure operational familiarity, and to have provided informed consent. This ensured contextual relevance and adequate exposure to disaster response functions within the unit.

Research Instrument

Two validated instruments were used for data collection. The first was an Essential Clinical Skills Self-Assessment Checklist, adapted from the Department of Health Emergency Nursing Manual and WHO disaster care protocols. It measured nurses' self-perceived proficiency in core emergency procedures such as Basic Life Support (BLS), hemorrhage control, airway management, triage, intravenous therapy, and wound care, using a 4-point Likert scale (1 = Not proficient to 4 = Highly proficient). The second was an adapted Disaster Preparedness Evaluation Tool (DPET), which assessed preparedness across cognitive, affective, and behavioral domains, including knowledge of disaster protocols, psychological readiness, confidence in role execution, and willingness to respond. Responses were rated on a 5-point Likert scale (1 = Strongly disagree to 5 = Strongly agree). Both instruments underwent expert content validation and pilot testing. Internal consistency was confirmed with a Cronbach's alpha coefficient of ≥ 0.80 , establishing their reliability for measuring clinical competence and disaster preparedness.

Data Gathering Procedure

Data collection was conducted systematically and in compliance with ethical standards. Approval was first secured from the institutional review board and the PNP Health Service. Informed consent was obtained from all participants following a brief orientation, delivered either face-to-face or virtually depending on deployment. Only nurses who provided signed consent were included. Validated instruments were then distributed using both printed copies and secure electronic platforms (e.g., encrypted Google Forms or password-protected email) to ensure accessibility for field-deployed personnel. Clear instructions accompanied the surveys, and the researcher remained available for clarifications. Data collection spanned two weeks, with a possible one-week extension to maximize response rates. Reminders and tracking logs were used to monitor completion. Completed responses were reviewed for accuracy, encoded into a secure digital file, and analyzed using SPSS software. Strict data protection protocols were observed, with access limited to the researcher and adviser, ensuring compliance with institutional and national research ethics policies.

Results and Discussions

Problem 1: What is the socio- demographic profile of the respondents?

Table 1:Frequency Table - Age of the Participants

Age of the Participants	Frequency	Percentage
31–35 years old	5	21.7%
36–40 years old	15	65.2%
41–45 years old	2	8.7%
51 years old and above	1	4.3%
Total	23	100%

Table 1 shows that the majority of respondents were 36–40 years old (65.2%), representing a predominantly mid-career workforce. A smaller proportion belonged to the 31–35 age group (21.7%), while only 13% were above 40. This age distribution indicates that most participants are at the peak of professional efficiency—neither novice nor nearing retirement. Evidence suggests that nurses in this age range typically demonstrate higher disaster self-efficacy, stronger decision-making maturity, and accumulated practical knowledge (Al Thobaity & Alshammari, 2020; Awais et al., 2022). From Benner’s Novice-to-Expert framework, the 36–40 cohort often corresponds to the Proficient or Expert stage, characterized by intuitive judgment, situational awareness, and rapid prioritization—skills essential in disaster triage and emergency coordination (Benner, 2021). This mid-career composition is advantageous for disaster deployment, combining clinical judgment with physical stamina. Younger nurses (31–35) may still require structured mentoring, while succession planning is needed to sustain institutional expertise as the workforce ages.

Table 2: Frequency Table – Sex of the Participants

Sex of the Participants	Frequency	Percentage
Male	14	63.6%
Female	8	36.4%
Total	22	100%

Table 2 shows that the sample is male-dominated (63.6%), though females account for a meaningful 36.4% representation within PNP RMDU-11. This reflects the broader demographic profile of the Philippine National Police while highlighting women’s growing role in medical and dental service functions. International evidence suggests that sex does not significantly predict technical disaster preparedness, though differences may appear in psychological readiness and confidence (Li et al., 2021; Khalid et al., 2023). Importantly, mixed-gender health teams often outperform homogeneous groups, as gender diversity enhances communication, empathy, and collaborative decision-making—qualities essential in crisis response (Wong et al., 2022). Women also contribute critical strengths in psychosocial care, family-centered communication, and community engagement, making them indispensable in disaster recovery operations (Mendoza et al., 2023). From a theoretical lens, Bandura’s Social Cognitive Theory explains that disparities in confidence are shaped more by training exposure and organizational empowerment than by sex itself. Thus, equitable access to training and deployment opportunities is vital. Ensuring gender-equitable rotation and leadership roles prevents clustering of duties, strengthens cross-training, and enhances overall unit resilience. Evidence further shows that female responders perform at levels comparable to males when given equal exposure, while also bringing distinctive strengths in relational leadership, situational sensitivity, and collaborative decision-making (Ortega et al., 2023).

Table 3: Frequency Table – Civil Status of the Participants

Civil Status	Frequency	Percentage
Single	5	21.7%
Married	18	78.3%
Total	23	100%

Table 3 shows that the majority of respondents were married (78.3%), while only 21.7% were single. This distribution highlights that most participants balance professional responsibilities with family commitments, which carries implications for disaster preparedness and deployment readiness. Research indicates that married personnel may face greater work–family conflict and emotional strain during prolonged or high-risk missions, often affecting willingness to accept dangerous assignments (Ramadhan et al., 2022; Ortega et al., 2023). At the same time, marriage can serve as a protective factor, as strong family support has been shown to enhance emotional stability, coping capacity, and resilience under operational stress (Bautista et al., 2021). From the perspective of Role Strain Theory, married nurses juggle multiple roles—spouse, parent, and responder—which can generate stress but also foster motivation and community attachment. In collectivist contexts such as the Philippines, this duality often translates into sustained engagement and prosocial behavior during disaster operations. For PNP RMDU-11, civil status should be considered an operational planning variable. Married personnel may benefit from targeted psychosocial support, structured family communication during deployments, and equitable rotation policies. Such measures can reduce anxiety, strengthen resilience, and ensure readiness for extended disaster missions.

Table 4: Frequency Table – Highest Educational Attainment

Educational Attainment	Frequency	Percentage
Bachelor's Degree	15	65.2%
Master's Degree (Units)	5	21.7%
Master's Degree (Completed)	3	13.0%

Table 4 shows that all respondents hold at least a bachelor's degree, while 34.7% have graduate-level education. This reflects a highly credentialed workforce, with a significant proportion possessing advanced academic training. Evidence indicates that higher educational attainment is associated with stronger critical thinking, better retention of disaster protocols, enhanced leadership readiness, and improved risk assessment and decision-making accuracy (Montemayor et al., 2020; Li et al., 2021; Awais et al., 2022). Graduate-level education further equips nurses with competencies in systems thinking, epidemiology, health policy, and incident command, positioning them for leadership and planning roles in disaster operations. From the perspective of Human Capital Theory, academic attainment represents investment in professional knowledge that yields organizational returns through heightened disaster response efficiency. Personnel with postgraduate qualifications are well-suited for roles such as incident command section chiefs, planners, or safety officers. For PNP RMDU-11, strengthening continuing professional development pathways and integrating academic advancement into the leadership succession pipeline will enhance disaster preparedness and organizational resilience.

Table 5: Frequency Table – Position at Work

Position	Frequency	Percentage
Nurse PNCO	7	30.4%
Nurse PCO	1	4.3%
Nurse Officer	1	4.3%
Administrative/Supervisory	5	21.7%
Nurse I	3	13.0%
Nurse PCO/TL PMDT	1	4.3%
Senior/Head Nurse	3	13.0%
PMDT/Nurse PNCO	1	4.3%
CMDT-RMDU11	1	4.3%
Total	23	100%

Table 5 shows that respondents occupy a range of positions, from frontline roles (e.g., Nurse PNCO, Nurse I) to supervisory and command posts (e.g., Senior Nurse, CMDT-RMDU11). This distribution reflects a structurally diverse workforce, essential for effective disaster response. A multilayered structure ensures that clinical responders, middle managers, and command-level personnel perform interconnected tasks, enabling coordinated operations during emergencies. Recent studies emphasize that disaster readiness is strongest when frontline and leadership roles are aligned under Incident Command System (ICS) principles, ensuring clear task delineation and unified command (Santos & Dizon, 2021). Effective communication across hierarchical levels further enhances reliability, with supervisors providing logistical and technical support that improves frontline performance (Prasetyo et al., 2022; Wong et al., 2022). Frontline nurses contribute critical skills in triage, resuscitation, wound care, and stabilization, while supervisory roles anchor strategic decision-making, surge activation, and coordination with incident management teams. Both tiers are indispensable and mutually reinforcing. To maximize capacity, disaster training should be role-specific: frontliners require intensive clinical and triage training, while supervisors need advanced competencies in coordination, logistics, and ICS operations. Mentorship and competency transfer from experienced personnel will further strengthen organizational resilience. The diversity of positions within PNP RMDU-11 thus provides a strong foundation for comprehensive ICS integration and coherent disaster management operations.

Table 6:Frequency Table – Position at Work

Assignment Area	Frequency	Percentage
Emergency Room/Trauma Unit	9	39.1%
Administrative/Training Office	5	21.7%
Out-Patient Department	4	17.4%
PMDT	3	13%
Community Relations	1	4.3%
Provincial Health Unit	1	4.3%
Total	23	100%

Table 6 shows that respondents were distributed across multiple areas: Emergency Room/Trauma Unit (39.1%), Administrative/Training Office (21.7%), Out-Patient Department (17.4%), PMDT (13%), and smaller proportions in Community Relations (4.3%) and Provincial Health Units (4.3%). This reflects the unit's expanded operational ecosystem, extending beyond hospital-based care into community and administrative functions. Such distribution supports a Whole-of-System approach to disaster management, where acute care, administrative coordination, and community engagement are integrated. ER staff provide critical expertise in trauma management and surge response, administrative personnel strengthen logistics and planning through the Incident Command System (ICS), while community-based staff contribute to risk communication, triage, and public health interventions (Li et al., 2021). This balance of facility-based and community-facing roles ensures that disaster response is not confined to hospitals but reaches vulnerable populations at the community level. To optimize capacity, disaster training should be role-specific: ER staff require intensive clinical and triage training, administrative staff need advanced ICS and logistics competencies, and community personnel should focus on communication and public health strategies. Overall, the distribution of assignments within PNP RMDU-11 demonstrates a well-structured workforce capable of supporting both clinical and public health demands, positioning the unit for comprehensive and coordinated disaster response.

Table 7:Frequency Table – Length of Service

Length of Service	Frequency	Percentage
Less than 1 year	2	8.7%
1–5 years	2	8.7%
6–10 years	5	21.7%
11–15 years	13	56.5%
More than 20 years	1	4.3%
Total	23	100%

Table 7 shows that most respondents had 11–15 years of service (56.5%), followed by 6–10 years (21.7%), while only a small proportion had fewer than five years or more than twenty years of experience. This indicates that the PNP RMDU-11 workforce is composed largely of seasoned personnel with extensive exposure to clinical duties, administrative responsibilities, and field operations. Length of service is widely recognized as a strong predictor of disaster readiness, as longer tenure allows personnel to internalize protocols, refine technical skills, and build resilience under pressure (Awais et al., 2022; Ortega et al., 2023). Experienced responders demonstrate higher self-efficacy, stronger situational awareness, and faster clinical judgment—competencies critical in mass casualty incidents and complex emergencies. Veteran personnel also benefit from cumulative exposure to drills, mobilizations, and inter-agency operations, which enhances intuitive decision-making and adaptive reasoning. Their organizational knowledge and institutional memory strengthen coordination across health, police, military, and local government actors, ensuring operational stability during crises. Kolb's Experiential Learning Theory explains this advantage: longer service provides more "concrete experiences" that foster reflective insights and adaptive expertise, enabling personnel to respond flexibly in dynamic disaster environments. Strategically, senior staff are best suited for command, safety oversight, and triage supervision, while newer personnel should be paired with mentors to accelerate skill acquisition and confidence. Institutionalizing knowledge through after-action reviews and formal debriefings will ensure that lessons from veteran responders are retained and transferred, sustaining organizational learning and preparedness.

Problem 2: What is the level of proficiency in essential clinical skills among nurses assigned to PNP RMDU-11?

Table 8: Essential Clinical Skills Self-Assessment

Emergency Clinical Skill	Mean	Std. Dev.	Verbal Interpretation	Rank
Assessing vital signs under stressful or field conditions	3.26	0.62	Proficient	1
Performing wound cleaning, debridement, and dressing	3.13	0.69	Proficient	2
Managing airways (head tilt–chin lift, jaw thrust, airway adjuncts)	2.96	0.64	Proficient	3
Inserting and managing intravenous (IV) lines	2.96	0.71	Proficient	3
Performing Basic Life Support (BLS) and CPR	2.91	0.67	Basic Proficiency	5
Applying hemorrhage control techniques (direct pressure, tourniquets)	2.91	0.67	Basic Proficiency	5
Conducting rapid primary and secondary patient assessments	2.87	0.55	Basic Proficiency	7
Recognizing and responding to signs of shock and cardiac arrest	2.87	0.55	Basic Proficiency	7
Administering fluids and emergency medications	2.83	0.72	Basic Proficiency	9
Using personal protective equipment (PPE) effectively during disaster or trauma response	2.83	0.65	Basic Proficiency	9
Conducting triage in mass casualty incidents	2.78	0.67	Basic Proficiency	11
Providing spinal motion restriction and fracture immobilization	2.78	0.74	Basic Proficiency	11
Managing infectious or contagious conditions in emergency shelters	2.65	0.65	Basic Proficiency	13
Documenting clinical findings and interventions accurately during emergencies	2.61	0.72	Basic Proficiency	14
Handling patients with burns or chemical exposure	2.43	0.84	Basic Proficiency	15

Table 8 shows that most respondents rated themselves between Basic Proficiency and Proficient across the fifteen core emergency skills. This pattern reflects strong foundational competencies from routine clinical exposure, alongside areas requiring further disaster-specific training. The highest-rated skill was vital signs assessment under stressful conditions (Mean = 3.26, Proficient), underscoring confidence in rapid physiological evaluation—a critical determinant of survival in disaster contexts. Other skills rated Proficient included wound care (Mean = 3.13), airway management (Mean = 2.96), and IV-line insertion (Mean = 2.96), highlighting readiness in trauma-related interventions. Skills rated Basic Proficiency included BLS/CPR, hemorrhage control, patient survey, and recognition of shock/cardiac arrest (Means = 2.87–2.91). These results align with evidence that competencies such as resuscitation and hemorrhage control require frequent practice and simulation to maintain mastery. Moderate ratings were also observed in PPE use, fluid administration, and mass casualty triage (Means = 2.78–2.83), reflecting the need for structured disaster-focused training. Lower ratings were reported for infectious disease management in shelters (Mean = 2.65), emergency documentation (Mean = 2.61), and burn/chemical exposure management (Mean = 2.43). These specialized skills are less frequently practiced and demand targeted simulation, particularly chemical incident management, which remains a global competency gap. Interpreted through Kolb’s Experiential Learning Theory, higher proficiency corresponds to skills frequently encountered in practice, while lower ratings reflect limited experiential exposure. This highlights the importance of simulation-based training, refresher courses, and interdisciplinary drills to strengthen rarely practiced but critical disaster competencies. Overall, the results reveal a competent workforce with strong emergency foundations, but with clear training needs in specialized disaster interventions. Addressing these gaps through structured competency-based programs will enhance RMDU-11’s readiness and align its clinical capabilities with international disaster medicine standards.

Problem 3: What is the extent of disaster preparedness among these nurses?

Table 9: Knowledge of Disaster Protocols

	Statement	Mean	Std. Dev.	Verbal Interpretation
1.	I am familiar with the disaster response protocols of my unit.	4.17	0.58	Agree
2.	I understand the roles and responsibilities of healthcare personnel during disasters.	4.17	0.49	Agree
3.	I can activate appropriate communication channels during emergencies.	4.00	0.60	Agree
4.	I know how to initiate emergency triage systems.	4.00	0.43	Agree
5.	I know where to access emergency supplies and logistics during deployment.	3.96	0.71	Agree
6.	I have been trained on institutional guidelines for mass casualty events.	3.87	0.76	Agree
7.	I am knowledgeable about national and local disaster management agencies.	3.87	0.55	Agree
8.	I can identify the phases of the disaster management cycle.	3.78	0.52	Agree
9.	I am confident in applying the incident command system (ICS) structure.	3.74	0.75	Agree
10.	I can locate and interpret hazard maps and risk reduction plans.	3.70	0.56	Agree
	Average	3.93	0.45	Agree

Table 10 shows that the highest mean score of 3.02 was recorded for challenges in conducting online research and evaluating source credibility, followed by a mean of 2.94 for difficulties navigating online platforms for educational resources. This indicates that students struggle with finding reliable information and using online learning platforms effectively. Observations suggest that students often encounter challenges in assessing source trustworthiness, identifying bias, and efficiently locating educational materials. Research by Pasiczny and Winograd (2017) supports these findings, highlighting that students frequently face difficulties in evaluating online information despite having access to abundant digital resources. Meanwhile, the lowest mean score of 2.66 was recorded for challenges in maintaining online privacy, interpreted as moderately challenged. This suggests that students have difficulties protecting personal information online despite understanding its importance. Observations indicate that students may struggle with creating strong passwords, managing privacy settings, and avoiding risky online behaviors. Studies by Czerniawski and McLaughlin (2017) emphasize that while students are aware of online privacy, they often lack the practical skills needed to safeguard their information effectively. Targeted guidance and education on internet safety practices could help students develop better habits and strengthen their online privacy skills.

Table 10: Psychological Preparedness for Disaster Response

	Statement	Mean	Std. Dev.	Verbal Interpretation
1.	I recognize my psychological limitations and seek help when needed.	4.17	0.58	Agree
2.	I maintain focus and emotional control during high-pressure events.	4.09	0.60	Agree
3.	I have developed mental resilience through training or field experience.	4.04	0.56	Agree
4.	I can manage personal anxiety when exposed to emergency situations.	4.00	0.69	Agree
5.	I can handle graphic injuries or death without emotional breakdown.	4.00	0.60	Agree
6.	I can provide psychological first aid to patients and colleagues.	3.96	0.56	Agree
7.	I am emotionally ready to face mass casualty situations.	3.96	0.56	Agree
8.	I believe I can function well despite personal fear in a disaster.	3.96	0.56	Agree
9.	I can return to duty quickly after emotionally taxing deployments.	3.87	0.63	Agree
10.	I have undergone stress management or coping training.	3.57	0.79	Agree
	Average	3.96	0.49	Agree

Table 10 shows that respondents reported a high level of psychological readiness (Mean = 3.96, Agree), indicating confidence in managing the emotional and cognitive demands of disaster response. The

strongest rating was for recognizing psychological limits and seeking help ($M = 4.17$), reflecting self-awareness and adaptive coping—critical for preventing burnout and sustaining resilience. High scores were also noted for emotional control under pressure ($M = 4.09$) and resilience gained through training or field exposure ($M = 4.04$), consistent with evidence that repeated operational experience enhances crisis decision-making. Moderate-high ratings for managing anxiety, handling traumatic scenes, and readiness for mass casualty events (Means ≈ 4.00) suggest that personnel possess foundational trauma-management skills, though variability indicates some may require additional support. Confidence in providing psychological first aid ($M = 3.96$) further highlights the unit's capacity for psychosocial stabilization alongside clinical care. Lower scores were observed for returning to duty after taxing deployments ($M = 3.87$) and formal stress-management training ($M = 3.57$), pointing to gaps in structured recovery systems. This underscores the need for institutionalized mental health programs, debriefings, and peer-support networks to sustain long-term resilience. Overall, the findings show that RMDU-11 personnel are psychologically prepared for disaster response, but strengthening organizational support and resilience training will be essential to maintain performance in prolonged or high-risk missions.

Table 11: Confidence in Emergency Role Execution

	Statement	Mean	Std. Dev.	Verbal Interpretation
1.	I can communicate effectively with multidisciplinary teams.	4.00	0.52	Agree
2.	I understand my scope of practice during disaster response.	4.00	0.52	Agree
3.	I can manage patients in non-hospital or improvised treatment areas.	4.00	0.52	Agree
4.	I can adapt quickly to dynamic situations in a disaster environment.	3.96	0.47	Agree
5.	I am confident in performing emergency procedures even with limited equipment.	3.96	0.56	Agree
6.	I trust my judgment in prioritizing care during triage.	3.96	0.56	Agree
7.	I can lead or assist in emergency medical interventions confidently.	3.91	0.60	Agree
8.	I feel equipped to manage my assigned duties under pressure.	3.91	0.60	Agree
9.	I am able to make timely clinical decisions during emergencies.	3.87	0.46	Agree
10.	I can supervise others or take initiative if leadership is needed.	3.87	0.63	Agree
	Average	3.94	0.43	Agree

Table 11 shows that respondents reported a high level of confidence (Mean = 3.94, Agree) in performing their emergency roles during disaster operations. This reflects strong professional readiness, adaptability, and capability under pressure. The highest ratings were for effective communication with multidisciplinary teams, clear understanding of scope of practice, and managing patients in improvised treatment areas ($M = 4.00$). These competencies highlight operational versatility and readiness to function in disrupted healthcare environments. Confidence was also strong in adapting to dynamic situations, performing emergency procedures with limited equipment, and prioritizing care during triage (Means ≈ 3.96), underscoring resilience and problem-solving capacity in resource-constrained settings. Moderate-high scores for leading interventions and functioning under pressure ($M = 3.91$) indicate preparedness for both clinical and situational leadership, though slightly lower ratings in timely decision-making and supervisory roles ($M = 3.87$) suggest variability in command confidence. Overall, the findings show that RMDU-11 personnel are confident, adaptable, and capable of executing emergency roles effectively, with training needs focused on ICS-based leadership, rapid decision-making, and structured command simulations to further strengthen disaster response reliability.

Table 12: Willingness to Respond

	Statement	Mean	Std. Dev.	Verbal Interpretation
1.	I accept the possibility of danger when responding to critical incidents.	4.17	0.58	Agree
2.	I will respond to disaster situations as long as I am physically capable.	4.04	0.56	Agree
3.	I am willing to perform roles outside my usual assignment during disaster response.	4.00	0.52	Agree
4.	I feel morally and professionally obligated to respond during disasters.	3.96	0.49	Agree

5.	I would respond to a call even during personal inconvenience.	3.96	0.47	Agree
6.	I am ready to work overtime or under extreme conditions if needed.	3.94	0.43	Agree
7.	I will not hesitate to assist during high-risk deployments.	3.94	0.43	Agree
8.	I am willing to be deployed for disaster response, regardless of location.	3.93	0.45	Agree
9.	I am open to volunteering even when deployment is not mandatory.	3.91	0.60	Agree
10.	I will assist during biological or chemical emergencies if trained.	3.91	0.60	Agree
Average		3.98	0.51	Agree

Table 12 shows that respondents reported a high willingness to respond during disasters (Mean = 3.98, Agree), reflecting strong motivation and commitment to deployment despite risks and challenges. The highest rating was for acceptance of danger in disaster response (M = 4.17), underscoring risk awareness and professional duty. Respondents also expressed readiness to respond as long as physically capable (M = 4.04) and willingness to perform roles outside their usual assignment (M = 4.00), highlighting flexibility and adaptability—key traits in surge capacity and task-shifting during crises. Strong agreement was also noted for moral obligation to respond (M = 3.96) and willingness to assist despite inconvenience or extreme conditions (Means $\approx$ 3.94–3.96), reflecting altruism and professional identity. Respondents further indicated readiness for deployment regardless of location (M = 3.93), supporting national mobilization strategies. Slightly lower but still positive ratings were observed for volunteering when not mandatory and responding to chemical/biological emergencies if trained (M = 3.91), suggesting confidence tempered by the need for specialized training and protective systems in high-risk scenarios. Overall, the findings show that RMDU-11 personnel possess strong behavioral intent to respond, shaped by duty, adaptability, and resilience. To sustain this readiness, targeted programs in CBRN preparedness, family support systems, and structured risk communication are recommended.

Problem 4: Is there a significant correlation between nurses' proficiency in essential clinical skills and their disaster preparedness?

Table 13: Pearson Correlations Between Essential Clinical Skills and Disaster Preparedness Domains

Variables	P2_AveEssential Clinical Skills	P3A_AveKnowledge of Disaster Protocols	P3B_AvePsychological Preparedness	P3C_AveConfidence in Role Execution	P3_AveOverall Disaster Preparedness
P2_Ave Essential Clinical Skills	1.00	.51* (.01)	.50* (.01)	.48* (.02)	.53** (.01)
P3A_Ave Knowledge of Disaster Protocols	.51* (.01)	1.00	.80** (.00)	.77** (.00)	.91** (.00)
P3B_Ave Psychological Preparedness	.50* (.01)	.80** (.00)	1.00	.90** (.00)	.96** (.00)
P3C_Ave Confidence in Role Execution	.48* (.02)	.77** (.00)	.90** (.00)	1.00	.95** (.00)
P3_Ave Overall Disaster Preparedness	.53** (.01)	.91** (.00)	.96** (.00)	.95** (.00)	1.00

The results in Table 13 show that essential clinical skills are significantly and positively correlated with all domains of disaster preparedness, meaning that stronger clinical competency is consistently linked to higher levels of knowledge, psychological readiness, confidence, and overall preparedness. The correlation between clinical skills and overall disaster preparedness was moderately strong ($r = .53$, $p = .01$), suggesting that personnel proficient in trauma care, triage, airway management, and other emergency procedures are more ready to mobilize effectively during disaster operations. Clinical mastery appears to reinforce disaster self-efficacy and operational confidence, consistent with evidence that skilled responders deploy more rapidly and perform more effectively in mass casualty incidents. A similarly strong relationship was observed between clinical skills and knowledge of disaster protocols ($r = .51$, $p = .01$), indicating that routine application of clinical competencies enhances comprehension of unit guidelines, triage pathways, and ICS-based workflows. Clinical proficiency also correlated with psychological preparedness ($r = .50$, $p = .01$), supporting Bandura's Self-Efficacy Theory that mastery experiences reduce anxiety and strengthen emotional resilience. The link between clinical skills and confidence in role execution ($r = .48$, $p = .02$) further underscores that technical competence fosters adaptability, leadership readiness, and decision-making under pressure. The strongest correlations were found among the preparedness domains themselves, with knowledge, psychological preparedness, and confidence all highly associated with overall

disaster readiness ($r = .91-.96$, $p < .001$). These results confirm that cognitive, emotional, and behavioral dimensions of preparedness are deeply interconnected, and that disaster performance depends not only on technical skills but also on psychological resilience and confidence. The findings support the Competency-Based Disaster Preparedness Model, which emphasizes the integration of clinical mastery, disaster knowledge, and psychological stability as foundations for operational reliability. Overall, the results highlight the importance of integrated training approaches that combine clinical skill development, protocol education, resilience-building, and ICS-based leadership simulations. Improvements in any single domain, particularly clinical skills or disaster protocol knowledge, are likely to strengthen others. For RMDU-11, institutionalizing multi-domain training, scenario-based drills, and structured mental health support systems will ensure sustained disaster readiness and enhance performance in complex emergencies.

Ethical Considerations

This study adhered to established ethical standards in nursing and educational research to safeguard the rights and welfare of all participants. Formal permission to conduct the research was obtained from the Philippine National Police Regional Medical and Dental Unit-11, and approval was secured from the appropriate academic authorities of Dr. Carlos S. Lanting College. Informed consent was obtained from all respondents after clearly explaining the study's purpose, procedures, and their right to participate voluntarily or withdraw at any time without penalty. Confidentiality and anonymity were strictly maintained; participants' identities were protected through coding, and no personal information was disclosed in the analysis or reporting of results. All data collected were used solely for academic purposes, stored securely, and handled in compliance with the Data Privacy Act of 2012 (Republic Act No. 10173). Care was taken to ensure that respondents were not exposed to physical, psychological, or emotional harm during the study. Survey instruments were non-intrusive, and data collection was scheduled to avoid disruption of professional duties. Ethical principles of fairness, respect, and academic integrity were upheld throughout the research process, ensuring that the study contributed responsibly to the advancement of disaster nursing knowledge and practice.

Conclusion

The findings of this study lead to several important conclusions. First, nurses in PNP RMDU-11 possess a strong foundation in essential clinical skills, with self-assessed proficiency indicating confidence in managing core emergency interventions. This competency base is critical for health professionals working in disaster environments. Second, overall disaster preparedness among respondents is high, encompassing not only technical knowledge but also psychological resilience and confidence in role execution. Such multidimensional readiness is vital given their dual responsibilities as clinicians and first responders. Third, the study confirms a significant positive relationship between clinical skills and disaster preparedness, supporting the view that technical proficiency enhances adaptability and decision-making under stress. Fourth, triage and basic life support emerged as the strongest predictors of preparedness, consistent with global disaster frameworks that prioritize rapid patient categorization and life-saving interventions. Finally, while general competency levels are strong, gaps remain in specialized skills such as burn management, toxic exposure response, and disaster documentation. Addressing these through targeted, scenario-based training will ensure a more comprehensive preparedness model capable of responding to low-frequency but high-impact events.

Recommendations

Based on the findings, several recommendations are proposed to strengthen the disaster preparedness of PNP RMDU-11 nurses. First, the PNP Health Service should institutionalize a structured, competency-based disaster nursing program that integrates simulation-based training and scenario drills for mass casualty care, hazardous materials, and high-pressure triage. Second, targeted workshops must address identified skill gaps, including chemical exposure management, burn care, infectious disease control in displacement settings, and emergency documentation, using problem-based learning and expert facilitation. Third, the psychological dimension of preparedness should be reinforced through resilience-building interventions such as peer support systems, stress debriefings, and access to mental health services before and after deployments. Fourth, a mentorship program pairing experienced disaster responders with newer nurses should be established to promote knowledge transfer, critical thinking, and practical expertise. Fifth, inter-agency coordination must be strengthened through joint drills with the Department of Health, local government units, the Armed Forces of the Philippines, and relief organizations to ensure operational synergy and alignment with national disaster protocols. Sixth, family preparedness programs should be introduced, including pre-deployment briefings and support networks, to reduce conflict between personal and professional responsibilities and enhance deployment compliance. Finally, disaster preparedness training and evaluation should be embedded into institutional policy, with regular drills, competency assessments, and disaster simulations incorporated into performance appraisals and aligned with national

DRRM frameworks. By addressing skill-specific training, reinforcing psychological resilience, and embedding preparedness protocols into organizational systems, the PNP Health Service can further enhance the capacity of its nurse responders and ensure sustained readiness in future emergencies.

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