

EMERGENCY OPERATIONS PLAN IMPLEMENTATION AND DISASTER READINESS OF NURSES IN PROVINCIAL HOSPITALS OF DAVAO ORIENTAL

¹Fermin S. Briones, RN, LPT, MAN(c), ²Wilven Jordan T. Romarate, RN, MAN, PhD, CLSSBB

¹Instructor, ²Professor,

¹Faculty of Nursing and Allied Health Sciences,

¹Davao Oriental State University, Mati City, Philippines

Abstract: This study examined the implementation of hospital Emergency Operations Plans (EOPs) and nurses' disaster readiness in provincial hospitals in Davao Oriental using a quantitative correlational-comparative design with predictive analysis. A total of 139 staff nurses participated, most of whom were young, early-career nurses assigned to high-acuity areas and had prior disaster training. Findings revealed that hospital EOP implementation was "Extensive" (mean = 3.76), while nurses demonstrated a "High" level of disaster readiness (mean = 4.18), indicating generally strong institutional preparedness and nursing response capacity. A significant positive relationship was identified between EOP implementation and disaster readiness ($p < 0.001$), indicating that stronger emergency systems are associated with better-prepared nurses. Differences in EOP implementation were noted based on prior training, while disaster readiness varied by training and specialization. Among the EOP domains, continuity of essential services emerged as the strongest predictor of disaster readiness. Although hospitals demonstrated high preparedness overall, gaps in surge capacity and human resource systems remain, highlighting the need for strengthened simulation-based training, standardized disaster protocols, and continuous institutional support to further improve hospital resilience and nursing preparedness during disasters.

Keywords: *Hospital Preparedness; Emergency Response Coordination; Surge Capacity Management; Disaster Training Programs; Healthcare System Resilience*

I. INTRODUCTION

Disasters continue to increase globally and place major pressure on healthcare systems, disrupting hospital operations and threatening continuity of care [1,2,3]. Hospitals are expected to respond effectively through strong implementation of the Emergency Operations Plan (EOP), which supports coordination, communication, resource management, and the continuity of essential services during emergencies [4,5,6]. As frontline healthcare providers, nurses play a critical role in disaster response; however, studies consistently show gaps in disaster preparedness due to limited training, weak institutional support, and inconsistent exposure to disaster drills and simulations [7,8].

Globally and across Asia, disaster readiness among nurses remains inconsistent, with preparedness often influenced by training, clinical exposure, and organizational support systems [7,8,9,10,11,12,13]. In the Philippines, despite the implementation of disaster risk reduction policies such as Republic Act No. 10121, many nurses remain inadequately prepared for disaster situations, with barriers including poor coordination, insufficient staffing, and limited preparedness programs [14,15,16,17,18].

These challenges became more evident following recent disasters in the country, including earthquakes and typhoons that affected healthcare facilities and disrupted services in several regions, including Davao Oriental [6,19,20]. Although hospitals had existing EOPs, inconsistencies in implementation highlighted gaps in communication, training, command systems, and surge capacity management. Existing studies have commonly focused either on institutional preparedness or on nurses' disaster readiness separately, with limited research examining the relationship between the two within provincial hospital settings [21,22,23].

Thus, this study was conducted to examine the relationship between hospital EOP implementation and nurses' disaster readiness in provincial hospitals of Davao Oriental. The study provides localized evidence emphasizing that disaster readiness is strengthened not only through individual competency but also through effective institutional preparedness, structured training, and resilient healthcare systems.

NEED OF THE STUDY.

The increasing occurrence of disasters continued to challenge healthcare systems, particularly in disaster-prone areas such as the Philippines, where hospitals were expected to maintain continuity of care through effective Emergency Operations Plan (EOP)

implementation. However, gaps in hospital preparedness, disaster training, communication, and surge capacity persisted, while many nurses remained inadequately prepared for disaster response. Although previous studies focused separately on hospital preparedness and nurses' disaster readiness, limited research examined their relationship, differences across demographic characteristics, and predictive factors within provincial hospital settings. Thus, this study was conducted to assess the extent of hospital EOP implementation and nurses' disaster readiness in Davao Oriental, determine their significant relationship and differences, identify predictors of disaster readiness, and provide evidence-based recommendations to strengthen disaster preparedness and healthcare system resilience.

III. RESEARCH METHODOLOGY

The methodology section outlines the plan and methods for conducting the study. This includes the study's universe, the study's sample, the Data and Sources of Data, the study's variables, and the analytical framework. The details are as follows:

3.1 Population and Sample

The study included staff nurses employed in the five provincial government-run hospitals in Davao Oriental. Participants included registered nurses with at least 3 months of hospital experience who were actively involved in direct patient care, while nurses in managerial positions and those with less than 3 months of service were excluded from the study.

Furthermore, the Raosoft Sample Calculator determined the sample size from the total population of 217 staff nurses, yielding 139 respondents, with an additional 20% buffer for potential non-respondents. Stratified random sampling was employed, with each hospital serving as a stratum, and participants were selected proportionally using computer-generated random numbers to ensure fair representation and minimize selection bias.

3.2 Data and Sources of Data

The study gathered data from 139 staff nurses employed in the five provincial government-run hospitals in Davao Oriental who met the inclusion criteria and were invited to participate in the study. Participants were selected through stratified random sampling from a total population of 217 nurses, ensuring proportional representation from each hospital. Data were collected using an adapted World Health Organization (WHO) Hospital Emergency Response Checklist and a researcher-developed questionnaire that included a demographic profile, Hospital Emergency Operations Plan (EOP) implementation, and disaster readiness of nurses. The instruments utilized a five-point Likert scale and underwent expert validation and reliability testing, yielding high internal consistency. Data collection was conducted via an online survey, with ethical approval and institutional permission obtained, and confidentiality, voluntary participation, and informed consent were strictly observed throughout the study.

3.3 Theoretical Framework

The study's variables include dependent and independent variables. The study used a prespecified method for selecting variables. The study used the Level of Disaster Readiness of Nurses as the dependent variable, the Extent of Hospital Emergency Operations Plan Implementation as the independent variable, and the Demographic Characteristics as the moderating variable. The results served as the basis for developing the intervention program.

This study was anchored in Albert Bandura's Self-Efficacy Theory and supported by Patricia Benner's Novice-to-Expert Theory, which, together, explain disaster readiness among nurses as a combination of psychological confidence and clinical competence. Bandura's theory emphasizes that individuals who believe in their ability to perform tasks are more likely to demonstrate motivation, resilience, and effective performance in challenging situations, such as disasters. In this study, self-efficacy explained how nurses' confidence, shaped by experience, training, and exposure, influences their ability to implement Emergency Operations Plan (EOP) domains and respond effectively during emergencies.

Complementarily, Benner's Novice-to-Expert Theory explains that nursing competence develops progressively through experience and education from novice to expert levels. This theory clarified how years of service, specialization, and continuing education enhance nurses' clinical judgment, decision making, and ability to execute disaster related responsibilities effectively.

Together, these theories provided a comprehensive framework showing that disaster readiness is shaped by both confidence (self-efficacy) and competence (clinical experience). They supported the study's assumption that stronger EOP implementation and greater training exposure enhance nurses' disaster readiness by developing both the ability and confidence to respond effectively during disasters.

3.4 Statistical Tools

This section elaborates on the appropriate statistical tools used to advance the study from data to inferences. This study utilized descriptive and inferential statistics to analyze the data. The methodology is described as follows.

3.4.1 Descriptive Statistics

Descriptive statistics were used to summarize and describe the characteristics of the respondents and the main study variables. Frequencies and percentages were used to present the demographic profile of the staff nurses, while the mean and standard

deviation were used to describe the extent of implementation of the hospital Emergency Operations Plan (EOP) and the level of nurses' disaster readiness. These measures provided a clear overview of the data and established the baseline conditions for further inferential analysis.

3.4.2 Inferential Statistics

Inferential statistics were used to draw conclusions and make generalizations about the population based on the sample data. In the correlational analysis, Pearson's *r* was employed to determine the relationship between the extent of hospital Emergency Operations Plan (EOP) implementation and nurses' disaster readiness. For comparative analysis, independent t-tests and ANOVA were used to examine significant differences in EOP implementation and disaster readiness across groups defined by demographic variables such as age, gender, years of experience, area of specialization, continuing education, type of continuing education, and previous disaster response training. Finally, a stepwise multiple linear regression was applied to identify the key EOP domains that best predict nurses' disaster readiness, highlighting the most influential institutional factors in disaster preparedness.

All inferential results were interpreted at a 0.05 level of significance, where p-values less than 0.05 indicated statistically significant relationships, differences, and predictors, while the direction and strength of relationships were determined using *r*-values, *t*-values, *F*-values, and regression coefficients.

IV. RESULTS AND DISCUSSION

4.1 Results of Descriptive Statistics of Study Variables

Table 4.1.1: Demographic Characteristics of the Respondents

Demographic Characteristics		Frequency (f) (n=139)	Percentage (%)
Age	20-29 years old	57	41.0%
	30-39 years old	47	33.8%
	40-49 years old	25	18.0%
	50-59 years old	10	7.2%
	Total	139	100%
Gender	Female	109	78.4%
	Male	30	21.6%
	Total	139	100%
Years of Experience	3 months - 1 year	44	31.7%
	1 year – 4 years	34	24.5%
	5 years – 7 years	22	15.8%
	8 years – 10 years	16	11.5%
	11 years and above	23	16.5%
	Total	139	100%
Area of Specialization	Delivery Room	13	9.4%
	Emergency Room	34	24.5%
	General Ward	10	7.2%
	Intensive Care Unit	3	2.2%
	Medicine Ward	24	17.3%
	Neonatal Intensive Care Unit	3	2.2%
	OB Gyne - Pedia Ward	6	4.3%
	OB and Gyne Ward	15	10.8%
	Operating Room	9	6.5%
	Outpatient Department	3	2.2%
	Pediatric Ward	11	7.9%
	Surgery Ward	8	5.8%
Total	139	100%	
Continuing Education	Bachelor	132	95.0%
	Master	7	5.0%
	Total	139	100%
Type of Continuing Education	Certificates	46	33.1%
	None	75	54.0%
	Units	18	12.9%

	Total	139	100%
Previous Disaster Response Training	No	39	28.1%
	Yes	100	71.9%
	Total	139	100%

As shown in Table 4.1.1, the respondents were predominantly young adults aged 20–29 years (41%) and female (78.4%), with most having 3 months to 1 year of experience (31.7%) and commonly assigned to the Emergency Room (24.5%). Nearly all held a bachelor’s degree (95%), more than half reported no continuing education (54%), and a majority had prior disaster response training (71.9%), reflecting a generally early-career nursing workforce with exposure to emergency care settings.

Overall, the findings suggest that demographic characteristics had limited influence on both disaster readiness and perceptions of EOP implementation, indicating that preparedness is shaped more by institutional systems and structured training than by personal profile [24,25]. However, nurses with prior disaster training and those working in high-acuity units consistently demonstrated higher readiness, emphasizing the importance of exposure and experiential learning in strengthening competence [26,27]. Collectively, these results point to disaster readiness as a function of training opportunities and clinical exposure rather than demographic background, underscoring the need for sustained, equitable capacity-building strategies across all units [28,29].

Table 4.1.2: The Extent of Hospital Emergency Operations Plan Implementation of the Respondents

Domains	Mean	SD	Description
Command and Control	3.87	0.89	Extensive
Communication	3.79	0.94	Extensive
Safety and Security	3.78	0.95	Extensive
Triage	3.83	0.92	Extensive
Surge Capacity	3.71	0.89	Extensive
Continuity of Essential Services	3.91	0.89	Extensive
Human Resources	3.57	1.04	Extensive
Logistics and Supply Management	3.64	0.95	Extensive
Post-Disaster Recovery	3.78	0.94	Extensive
Overall Mean	3.76	0.84	Extensive

Legend: 4.2-5.0 -Very Extensive; 3.40-4.19 – Extensive; 2.60-3.39 - Fairly Extensive; 1.80-2.59 – Rarely Extensive; 1.00-1.79 - Not Extensive.

Meanwhile, Table 4.1.2 shows that the Hospital Emergency Operations Plan (EOP) implementation was generally rated as “Extensive” (M = 3.76, SD = 0.84), indicating that key emergency systems were well established across hospitals. Among the domains, continuity of essential services obtained the highest mean (3.91), while human resources recorded the lowest (3.57), with relatively small standard deviations suggesting consistent responses among participants. Overall, this reflects that core EOP components such as command, communication, triage, logistics, and service continuity were already in place and functioning within routine hospital operations.

While implementation was generally strong, the variation across domains highlights remaining operational gaps. Leadership and coordination functions were more developed than workforce-related components, particularly human resources and surge capacity, suggesting continuing challenges in staffing adequacy, flexibility, and scalability during emergencies [30,31,32]. This pattern aligns with evidence that even well-structured EOPs may experience limitations in workforce expansion and resource mobilization despite strong command systems [10,31,33]. Overall, the findings indicate that EOP implementation is functionally established but requires further strengthening in human resources, surge capacity, and system-wide standardization to achieve a more balanced and resilient disaster response system [34,35].

Table 4.1.3: The Level of Disaster Readiness of the Respondents

Domains	Mean	SD	Description
Mitigation	4.29	0.66	Very High
Preparedness	4.06	0.75	High
Response	4.23	0.71	Very High
Recovery	3.96	0.77	High
Prevention	4.38	0.72	Very High
Overall Mean	4.18	0.65	High

Legend: 4.2-5.0 -Very High; 3.40-4.19 – High; 2.60-3.39 - Moderate; 1.80-2.59 –Low; 1.00-1.79 – Very Low.

Similarly, Table 4.1.3 shows that nurses demonstrated a generally high level of disaster readiness ($M = 4.18$, $SD = 0.65$), with prevention scoring highest (4.38), followed by mitigation and response, while recovery scored lowest (3.96). Overall, this indicates strong preparedness, particularly in immediate response-related competencies, although recovery remains a relative area for improvement.

These findings suggest that nurses are most competent in prevention, mitigation, and triage-related functions, reflecting familiarity with emergency procedures and the positive influence of training and clinical exposure [19,36,37,38]. However, the lower recovery score indicates that longer-term disaster management is less emphasized, consistent with evidence that post-disaster competencies often receive limited reinforcement in training and simulation activities [39,40].

Overall, disaster readiness appears to be driven by structured training, clinical exposure, and institutional support within EOP implementation. Strengthening continuous education and simulation-based programs, particularly in recovery-focused competencies, is necessary to achieve more balanced readiness across all disaster phases [38,41].

4.2 Results of Inferential Statistics of Study Variables

Table 4.2.1: Test of Correlation on the Extent of Hospital Emergency Operations Plan Implementation and the Level of Disaster Readiness of the Respondents

Level of Disaster Readiness	Extent of Hospital EOP Implementation	Pearson Correlation	Sig. (2-tailed)	Decision	Interpretation
Overall Disaster Readiness	Command and Control	0.655	<0.001	Reject Ho1	Significant
	Communication	0.564	<0.001	Reject Ho1	Significant
	Safety and Security	0.599	<0.001	Reject Ho1	Significant
	Triage	0.667	<0.001	Reject Ho1	Significant
	Surge Capacity	0.634	<0.001	Reject Ho1	Significant
	Continuity of Essential Services	0.700	<0.001	Reject Ho1	Significant
	Human Resource	0.636	<0.001	Reject Ho1	Significant
	Logistic and Supply Management	0.645	<0.001	Reject Ho1	Significant
	Post-Disaster Recovery	0.604	<0.001	Reject Ho1	Significant
	Overall Hospital EOP Implementation	0.703	<0.001	Reject Ho1	Significant

Note: Significant at the 0.05 level of significance (2-tailed).

Overall Disaster Readiness (Mitigation, Preparedness, Response, Recovery, and Prevention)

Furthermore, Table 4.2.1 shows a significant positive correlation between Hospital Emergency Operations Plan (EOP) implementation and nurses' disaster readiness ($r = 0.703$, $p < 0.001$), indicating that more structured and functional hospital systems are associated with higher levels of nurses' readiness. Among the domains, continuity of essential services had the strongest relationship ($r = 0.700$), while communication showed the weakest but still significant correlation ($r = 0.564$). Overall, these results suggest that strengthened institutional systems are associated with improved disaster readiness, particularly when core operational functions are well established.

These findings are consistent with studies using WHO-based emergency preparedness tools and hospital disaster frameworks, which consistently report that stronger institutional preparedness is linked to better nursing readiness outcomes [41,42,43]. Further evidence indicates that key EOP components, such as command and control, triage, logistics, and workforce systems, are major determinants of effective disaster response [42,43,44,45,46,47,48]. Although all correlations were statistically significant at the 0.05 level ($p < 0.001$), indicating that the relationships are unlikely to be due to chance, variation in strength suggests that communication and recovery systems remain comparatively underdeveloped, likely due to limited training exposure and operational emphasis [49,50]. Overall, the findings confirm a clear positive relationship, underscoring the need to strengthen continuity planning, workforce capacity, and recovery systems to further enhance nurses' disaster readiness and institutional resilience.

Table 4.2.2: Test of Comparison in the Extent of Hospital Emergency Operations Plan Implementation and the Respondents' Demographic Characteristics

Demographic Characteristics		Mean	F / t-value	p-value (2-tailed)	Decision	Remarks
Age	20-29 years old	3.87	1.02	0.359	Accept Ho2	Not Significant
	30-39 years old	3.59				
	40-49 years old	3.85				
	50-59 years old	3.78				

Gender	Female	3.75	0.0757	0.784	Accept Ho2	Not Significant
	Male	3.80				
Years of Experience	3 months - 1 year	3.89	0.401	0.807	Accept Ho2	Not Significant
	1 year – 4 years	3.65				
	5 years – 7 years	3.71				
	8 years – 10 years	3.73				
	11 years and above	3.76				
Area of Specialization	Delivery Room	4.08	1.53	0.190	Accept Ho2	Not Significant
	Emergency Room	3.71				
	General Ward	3.74				
	Intensive Care Unit	3.51				
	Medicine Ward	3.60				
	Neonatal ICU	3.08				
	OB Gyne - Pedia Ward	4.48				
	OB Gyne Ward	3.61				
	Operating Room	4.00				
	Outpatient Department	3.37				
	Pediatric Ward	3.78				
	Surgery Ward	3.94				
Continuing Education	Bachelor	3.79	1.81	0.225	Accept Ho2	Not Significant
	Master	3.28				
Type of Continuing Education	Certificates	3.83	0.833	0.442	Accept Ho2	Not Significant
	None	3.79				
	Units	3.49				
Previous Disaster Response Training	No	3.40	5.43	0.023	Reject Ho2	Significant
	Yes	3.97				

Note: Significant at the 0.05 level of significance (2-tailed).

Table 4.2.2 shows that most demographic variables, including age, gender, years of experience, area of specialization, continuing education, and type of continuing education, did not yield statistically significant differences in EOP implementation ($p > 0.05$). This suggests a generally uniform level of implementation across nurse groups, indicating that exposure to Emergency Operations Plan protocols is consistently provided regardless of demographic profile. The pattern reflects strong institutional standardization, with EOP implementation embedded as a system-wide practice rather than shaped by individual characteristics, consistent with studies showing minimal demographic influence in well-structured preparedness systems [26,51,52].

In contrast, prior disaster response training demonstrated a significant difference ($p = 0.023$), with trained nurses reporting higher levels of EOP implementation. This indicates that while institutional policies ensure uniform access to EOP frameworks, differences emerge in how deeply they are understood and applied, depending on training exposure. Evidence supports that disaster training enhances preparedness, engagement, and competency across nurse groups, reinforcing its role as a key differentiating factor in implementation outcomes [53,54,55]. Overall, the findings highlight that EOP implementation is largely consistent across demographics due to standardized systems, while prior disaster training remains the primary factor associated with meaningful variation in implementation levels, underscoring the importance of sustained and structured disaster education [26,54,56].

Table 4.2.3: Test of Comparison in the Level of Disaster Readiness and the Respondents' Demographic Characteristics

Demographic Characteristics		Mean	F / t-value	p-value (2-tailed)	Decision	Remarks
Age	20-29 years old	4.24	0.479	0.699	Accept Ho2	Not Significant
	30-39 years old	4.15				
	40-49 years old	4.20				
	50-59 years old	3.97				
Gender	Female	4.16	0.785	0.388	Accept Ho2	Not Significant
	Male	4.27				
Years of Experience	3 months - 1 year	4.22	0.521	0.722	Accept Ho2	Not Significant
	1 year – 4 years	4.23				
	5 years – 7 years	4.26				
	8 years – 10 years	4.07				

	11 years and above	4.05				
Area of Specialization	Delivery Room	4.43	2.66	0.025	Reject Ho2	Significant
	Emergency Room	4.77				
	General Ward	4.26				
	Intensive Care Unit	4.65				
	Medicine Ward	3.94				
	Neonatal Intensive Care Unit	3.39				
	OB Gyne - Pedia Ward	4.06				
	OB Gyne Ward	3.94				
	Operating Room	4.50				
	Outpatient Department	3.93				
	Pediatric Ward	4.14				
	Surgery Ward	4.31				
Continuing Education	Bachelor	4.19	0.497	0.505	Accept Ho2	Not Significant
	Master	4.10				
Type of Continuing Education	Certificates	4.23	0.734	0.486	Accept Ho2	Not Significant
	None	4.20				
	Units	4.00				
Previous Disaster Response Training	No	3.90	4.41	0.039	Reject Ho2	Significant
	Yes	4.40				

Note: Significant at the 0.05 level of significance (2-tailed).

Likewise, Table 4.2.3 shows that disaster readiness did not significantly differ across most demographic variables ($p > 0.05$), indicating a generally uniform level of preparedness among nurses regardless of age, gender, years of experience, or educational background. This suggests that, within the study setting, disaster readiness is consistently developed across groups and is more strongly shaped by institutional systems and standardized exposure than by demographic characteristics, consistent with findings of minimal between-group variation when structured preparedness frameworks are in place [41,57].

Conversely, significant differences were observed in area of specialization ($p = 0.025$) and previous disaster training ($p = 0.039$), with nurses assigned to high-acuity units such as the Emergency Room and Intensive Care Unit, as well as those with prior training, demonstrating higher levels of disaster readiness. This indicates that experiential exposure and targeted training create meaningful differences in preparedness outcomes across groups. Supporting evidence shows that disaster training and repeated clinical exposure enhance competencies in triage, response, and decision-making, making them key determinants of readiness compared to demographic factors [43,53,54,55,58,59]. Overall, the findings emphasize that disaster readiness is primarily differentiated by training and clinical exposure rather than demographic profile, highlighting the need to strengthen equitable training and expand experiential learning opportunities across all nursing units [60,61,62].

Table 4.2.4: Test of Prediction on the Domains of the Hospital Emergency Operations Plan Implementation Best Predicts Disaster Readiness of the Respondents

Predictor	Estimate	SE	T	p-value	Decision	Remarks
Continuity of Essential Services	0.3621	0.1218	2.972	0.004	Reject Ho3	Significant
Logistic and Supply Management	0.1511	0.0858	1.761	0.041	Reject Ho3	Significant
Command and Control	0.1775	0.1047	1.695	0.042	Reject Ho3	Significant
Triage	0.1379	0.0904	1.525	0.049	Reject Ho3	Significant
Human Resource	0.0849	0.0721	1.179	0.241	Accept Ho3	Not Significant
Post-Disaster Recovery	-0.0643	0.0859	-0.748	0.456	Accept Ho3	Not Significant
Communication	-0.0731	0.0828	-0.883	0.379	Accept Ho3	Not Significant
Safety and Security	-0.1090	0.0907	-1.203	0.231	Accept Ho3	Not Significant
Surge Capacity	-0.1226	0.1059	-1.157	0.249	Accept Ho3	Not Significant

Model Test: $R = .741$, $R^2 = .549$, $F = 17.44$, $p < .001$.

Note: Significant at the 0.05 level of significance (2-tailed).

Finally, Table 4.2.4 regression analysis demonstrated that the hospital Emergency Operations Plan (EOP) domains significantly predicted nurses' disaster readiness, accounting for 54.9% of the variance ($R^2 = 0.549$, $F = 17.44$, $p < 0.001$). This indicates that institutional preparedness systems play a substantial role in shaping disaster readiness, with improvements in EOP implementation corresponding to higher levels of nurse readiness. Among the domains, continuity of essential services emerged as the strongest and best predictor ($p = .004$), underscoring the centrality of sustaining healthcare delivery during emergencies to effective disaster response. Command and control ($p = .042$), logistics and supply management ($p = .041$), and triage ($p = .049$) also

significantly contributed, underscoring the importance of leadership structure, resource coordination, and patient prioritization in strengthening readiness outcomes [63,64,65].

On the other hand, communication, safety and security, surge capacity, human resources, and post-disaster recovery were not statistically significant predictors, suggesting that their effects on disaster readiness may be indirect or dependent on the performance of core operational domains. This pattern aligns with evidence that disaster preparedness is shaped by interconnected system functions rather than isolated components, where foundational domains such as continuity planning and command structures often drive overall readiness more strongly than supportive mechanisms [66,67]. Overall, the findings confirm that nurses' disaster readiness is best predicted by core functional elements of the EOP, particularly continuity of essential services, logistics, command and control, and triage, reinforcing the need to prioritize these areas in strengthening hospital disaster preparedness and workforce resilience.

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