Appendix

Utøya island in Lake Tyri, Norway (photograph: Frode Johansen, with permission)

The Utøya area in Southern Norway. Sundvolden hotel was established as the triage and information center. Ringerike Hospital was the local emergency care center (Google Maps)
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Part 1: Trauma team

1.1. Innovation of the BEST training program

The figure below shows the dynamics of the meaning-driven innovations and continual improvement efforts behind the BEST program, developed at a national level and adapted by Ringerike hospital. 10, 11, 12, 60

**Better & Systematic Trauma Care (BEST)**

Purpose: Every acute care hospital should be able to undertake the initial treatment of trauma patients, despite well-developed air ambulance and trauma centers at university hospitals.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 Chance system: Trauma center focus: Huge variations in the trauma treatment between and within hospitals</td>
<td>Knowledge &amp; ED skills: ATLS® (Advanced trauma Life Support)</td>
<td>Multi-professional team training Working together, learning together, training together. In the hospitals own ER</td>
<td>Inter-professional communication &amp; leadership CRM Crew Resource Management training</td>
<td>2006 BEST Training &amp; initial trauma treatment at 49/50 Norwegian ED hospitals</td>
<td>BEST Multi-professional facilitator Courses. &amp; Courses in Hemostatic emergency surgery. The entire team is participating in the course.</td>
</tr>
</tbody>
</table>

1.2. Roles and tasks of the trauma team

Here is a list of the roles and tasks of the trauma teams in the Trauma manual of Vestre Viken Ringerike hospital. Each role has its own tasks which are printed on a laminated “action card”. If a team member thinks it is necessary to intervene in another person’s tasks, they first must ask the team manager for permission to do so, formed as a question without blaming whoever owns the task. It is important that each member of the team always have in mind that performing their own tasks takes priority that nobody else is responsible for their tasks, and fundamental things may be forgotten if they are not focused primarily on their own tasks.
Appendix to “Local emergency medical response after a terrorist attack in Norway – a qualitative study”.

**TRAUMA MANUAL: RINGERIKE HOSPITAL**
(based on the manual of the trauma center at Oslo University, Oslo, Norway)

The acute alarm button in the ER expedition automatically calls in the trauma team.

**Trauma Team:**

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Call phone/Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Leader: Surgical Attending</td>
<td></td>
</tr>
<tr>
<td>Active Examiner: Surgical Resident</td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Surgical Resident</td>
<td></td>
</tr>
<tr>
<td>Surgical Intern</td>
<td></td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td></td>
</tr>
<tr>
<td>ER nurse x 2</td>
<td></td>
</tr>
<tr>
<td>Operating Room Nurse</td>
<td></td>
</tr>
<tr>
<td>Radiology Technician</td>
<td></td>
</tr>
<tr>
<td>Laboratory Technician</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personnel / Responsibility</th>
<th>Acute response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinating Nurse</td>
<td>• Selection of two ER nurses for the Trauma Team</td>
</tr>
<tr>
<td></td>
<td>• Secure proper temperature (28C) in the trauma room</td>
</tr>
<tr>
<td></td>
<td>• Reception of the patients family members</td>
</tr>
<tr>
<td>Paramedic/EMT (Emergency Medical</td>
<td>• Gives the report in the trauma room</td>
</tr>
<tr>
<td>Technicians)</td>
<td>• Transition of responsibility to the trauma team</td>
</tr>
<tr>
<td>Ambulance (air and road)</td>
<td>• Released from the responsibility of patient care by the Trauma Leader</td>
</tr>
</tbody>
</table>
### Trauma Team / All involved
- Meet together outside of the trauma room
- Dress in standard precaution devices: gloves, role-identifying vest; gown, face mask, and eye wear if indicated
- Full attention during the ambulance report
- Stay calm
- Speak clearly, ask questions, make suggestions
- Make sure you can execute your duties
- Clearly relay completed tasks
- All inquiries go directly to the Trauma Leader
- **Prevent hypothermia**

### Trauma Leader: Surgical Attending (tel/page)
**Primary responsibility for patient care**

**Surgical Resident: Active Examiner (tel/page)** Can be the team leader depending upon experience
- Triage when applicable
- Supervise the handover by EMS personnel
- Show clear leadership
- Systematic examination (ABCDE) with continuous communication to the team
- Give clear commands
- Prioritise further exams and treatment
- Call in extra personnel / Relieve personnel of duties
- Decide further treatment and who is responsible for the patient after leaving the trauma room

### Orthopedic Surgical Resident (tel/page)
- Full orientation about the accident details
- Assist the Trauma Leader and Active Examiner
- Reduction of fractures, cast placement
- Act as proxy Trauma Leader in the case of multiple trauma patients

### Anesthesiologist (tel/page)
- Secure the airway, determine the Glasgow Coma Scale
- Evaluate circulation, peripheral venous access
- Eventual arterial line, blood gas, CVK

### Nurse Anesthetist (tel/page)
- Secure the airway, determine Glasgow Coma Scale
- Placement of the SaO2-probe
- Evaluate circulation
- Establish venous access
- Administer pain medication and relay treatment to ER nurses
- Assist the anaesthesiologist
Appendix to “Local emergency medical response after a terrorist attack in Norway – a qualitative study”.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ER Nurse - chosen by the Coordinating Nurse</strong></td>
<td>- Document the Trauma Leader</td>
</tr>
<tr>
<td><strong>ER Nurse 1</strong></td>
<td>- Responsibility for providing handheld ultrasound equipment</td>
</tr>
<tr>
<td></td>
<td>- Write the trauma journal (BEST)</td>
</tr>
<tr>
<td></td>
<td>- Relay relevant patient information</td>
</tr>
<tr>
<td></td>
<td>- Recruit more personnel when instructed</td>
</tr>
<tr>
<td></td>
<td>- Answer telephone calls</td>
</tr>
<tr>
<td></td>
<td>- Order relevant labs (Trauma lab order)</td>
</tr>
<tr>
<td><strong>ER Nurse - chosen by the Coordinating Nurse</strong></td>
<td>- Cut off and remove clothing from the patient</td>
</tr>
<tr>
<td><strong>ER Nurse 2</strong></td>
<td>- Connect monitoring equipment, enter patient identity information</td>
</tr>
<tr>
<td></td>
<td>- Provide warmed blankets</td>
</tr>
<tr>
<td></td>
<td>- Bladder catheterisation when indicated</td>
</tr>
<tr>
<td></td>
<td>- Provide relevant equipment and medications</td>
</tr>
<tr>
<td></td>
<td>- Administrate medications (work with the Nurse Anaesthetist)</td>
</tr>
<tr>
<td><strong>Surgical Intern (tel/page)</strong></td>
<td>- Write the admitting note during the primary survey</td>
</tr>
<tr>
<td></td>
<td>- Assist the Trauma Leader when necessary</td>
</tr>
<tr>
<td></td>
<td>- Order x-rays and trauma CT</td>
</tr>
<tr>
<td><strong>Radiology Technician (tel/page)</strong></td>
<td>- Prepare the CT machine</td>
</tr>
<tr>
<td></td>
<td>- Transport of mobile x-ray machine</td>
</tr>
<tr>
<td></td>
<td>- Prepare the mobile x-ray for use</td>
</tr>
<tr>
<td></td>
<td>- Take the x-ray into the trauma room when instructed</td>
</tr>
<tr>
<td></td>
<td>- Ask the Trauma Leader about other exams (i.e. pelvic x-ray)</td>
</tr>
<tr>
<td></td>
<td>- Contact the radiologist when prompted</td>
</tr>
<tr>
<td><strong>Laboratory Technician (tel/page)</strong></td>
<td>- Phlebotomy, work with the Nurse Anaesthetist</td>
</tr>
<tr>
<td></td>
<td>- Inform the Trauma Team when results are available</td>
</tr>
<tr>
<td><strong>Operating Room Nurse – (tel/page)</strong></td>
<td>- Cut off and remove clothing from the patient</td>
</tr>
<tr>
<td></td>
<td>- Provide warmed blankets</td>
</tr>
<tr>
<td></td>
<td>- Assist in surgical procedures</td>
</tr>
</tbody>
</table>
Primary Survey

A – airway
B – breathing
C – circulation
D – disability
E – exposure

Thorax

* Abdomen/pelvis with bleeding
* Extremities with bleeding
* Caput – Columna
* Abdomen without bleeding
* Extremities without bleeding
  (check the distal pulse in all 4 extremities)

Target:

The primary goal is to stabilise the patient for further testing and diagnostics.

The patient will be well oxygenated with PaO2 over 12kpa. Good peripheral circulation. Systolic blood pressure over 90. Adequate urine production. Prevent hypothermia.
Part 2: Method

2.1. Design

The data collection and analysis in this retrospective, descriptive, exploratory study used a mixture of methodological approaches tailored to the different parts of the research process, as described by Moen & Middelthon:

“In short, qualitative research designs have to be flexible and dynamic in the sense of that they allow – and facilitate – productive working relationships among methods, empirical fields, practicalities, research themes, and theories.”

The research cycle included various data collection approaches, such as key informant interviews, focus group discussions based on the Critical Incident Technique, observations, flip-over notes, observer notes, qualitative interviewing, audio-records, and interview transcripts.

2.2. Ethical considerations

In January 2013, the lead author was talking with the healthcare leadership of Ringerike hospital and Ringerike District Psychiatric Centre about the possibility of inviting the emergency healthcare workers to comment on their successful medical response to the shooting spree that took place at Utøya youth camp on 22 July 2011.

Study participation was voluntary, confidential, and based on informed verbal consent, as well as a written consent with freedom to terminate participation at any time without consequences. Terrorism is a traumatic event. We considered the risk of causing emotional or psychological harm to the study participants, and decided to exclude three groups from the research: (a) survivors and bereaved families; (b) providers who were personally affected by losing a sibling, family friend, or neighbor at Utøya; and (c) providers with health problems who were absent from work because of the terrorist event. Permissions were obtained from the relevant managers before individuals (rescue workers 22-24 July 2011) were approached.

The study was evaluated by the regional ethics committee of South-East Norway and waived from formal approval according to Norwegian law because it did not involve patient interventions. The study was approved by the Data Protection Authority of Oslo University Hospital, as required by Norwegian law. Thus, all necessary approval was in place. The data were stored on the research server of Vestre Viken Health Trust, and the informants’ names were separately encrypted as required by the Data Protection Office of Human Subjects. Permissions were obtained from the relevant managers before individuals were approached. Study participation was voluntary,
confidential, and based on informed verbal consent, as well as a written consent with freedom to terminate participation at any time without consequences.

Participants were also informed (in writing) that a support team by District Psychiatric Services was available in case they should need help after recalling the traumatic events. The lead researcher was unaware if informants sought psychological help after their participation in the study, because this was viewed as a confidential and private matter.

The Norwegian Ministry of Health has established a national coordinating service (provided by the Norwegian National Research Ethics Committee) to protect those affected by the 22 July event in subsequent research. The present study was presented to and discussed by the Committee, and members of our research team participated in the national sessions and seminars that were convened for 22 July researchers.

2.3. Data analysis

Gremler recommended the use of external researchers for analyzing data collected by the Critical Incident Technique. The external research team did not participate in the data collection, nor did they have any substantial work experience with emergency care services. Three of four had records as clinicians and they all had experience as quality improvement advisors in collaboration with diverse disciplines. According to a conventional content analysis (see below), they independently coded the 400 statements before they held a series of meetings (stages 3-9) over eight months.

Research team 1 used the method described by Hsieh & Shannon:

Researchers avoid using preconceived categories, instead allowing the categories and names of categories to flow from the data. Researchers immerse themselves in the data to allow new insights to emerge, also described as inductive category development. Many qualitative methods share this initial approach to study design and analysis. (…)

Data analysis starts with reading all data repeatedly to achieve immersion and obtain a sense of the whole, as one would read a novel. Then, data are read word by word to derive codes by first highlighting the exact words that appear to capture key thoughts and concepts. (…)

Codes are then sorted into categories based on how different codes are related and linked. These emergent categories are used to organize and group codes into meaningful clusters. Ideally, the numbers of clusters are between 10 and 15 to keep clusters broad enough to contain a large number of codes. Depending on the relationship between subcategories, researchers can combine or organize this large number of subcategories into a smaller number of categories.

The purpose of each analysis stage was to read the material repeatedly and to improve their considerations by discussing and reflecting on the patterns that were identified in the material as viewed from the members’ different perspectives. First, they reduced the number of focus group
statements from 400 to 334, because 66 statements did not address the research question. The content analysis ended with a selection of 127 statements underpinning five success domains. Stages 10-12 of the analysis process occurred in dialogue with the emergency service experts (the internal research team). They merged two of the five success domains into one, and increased the selection of statements by 23 to 150 (see Appendix part 4.2), of which 30 comprised the final selection (see Appendix part 4.1), represented by 17 statements in the Results section of the paper.

Moen indicate that the knowledge produced in a qualitative study is a common achievement.42

“(....) The question of who produces knowledge is thematized and theorized to a much lesser extent. In many scientific discourses, it may seem that the implicit idea at work is that the researcher is the (sole) producer of knowledge. In this chapter, we assert that the people we interact with during research need to be recognized both as epistemologically active subjects and as co-producers of knowledge. (...) How we understand the “who” of knowledge production has implications for the entire research process, including how a study is conceived and designed; how fieldwork is conducted; what issues are noticed, accounted for, and critically examined; and how data are analyzed”.

The main researcher has “picked the brains” of outstanding emergency healthcare professionals and leaders and has considered their statements repeatedly in dialogue with some of the leading quality improvement experts in Norwegian healthcare. It has been a rewarding journey. She often thought that the most challenging part of the research process would be to reduce the number of statements to a manageable minimum without losing the empirical support of the findings. However, when reaching this part of the research cycle, the intimate acquaintance with the material made the final selection surprisingly obvious, but still difficult, because some of the key statements had to be excluded as quotations in the Result section for reasons of space (see Appendix part 4.1).

Part 3: Crisis management

The tactical management team at Ringerike hospital has developed this list of challenges and key factors of the crisis management on 22-24 July 2011.

A member of the Tactical management and the internal Research team initially developed the list in 2011 in the wake of the terrorist event. The list had been used in the emergency response planning process at another hospital. The list was presented to the lead author at a research meeting. After discussing the list with other members of Tactical management, who made a few changes to bring the list into accordance with their perspectives on the situation, the “owner” approved the list. Finally, as we translated the list to English, we removed some and anonymized other parts of the sensitive information in the text in dialogue with the “first owner”. A central member of Tactical management (and the professional research team of the present study) has evaluated the triage, diagnosis, and surgical response to the causalities from Utøya.37
3.1. Competence

The hospital was well structured with an appropriate, well-known and readily available (written) emergency preparedness plan, revised by tactical management a few weeks before July 22 2011, and well known by every manager. Good crisis management requires good management skills and medical expertise. The tactical management team must be able to understand the needs of the organization during such an event. The management were confident that the staff was competent and that they were well trained by the BEST-principle. Therefore, they could concentrate entirely on managing the overarching situation.

3.2. Logistics

The logistics revolved around patients, family, personnel, and equipment.

**Personnel Logistics**

The emergency preparedness plan was followed regarding the composition of one team around each patient. The doctors met in reception and other personnel met at their respective departments. Personnel that were needed for transport and/or other treatment tasks were summoned from their respective departments by the disaster coordinator. Each department appointed a coordinator, usually the one that was proposed in the local plan on an action card, or the nurse who had the best knowledge of the departments’ routines. The coordinator distributed tasks within the department and was contactable via the phone number specified in the plan.

Because of the large number of patients, the hospital’s ordinary trauma team was replaced by teams tailored to the trauma of the individual patient, with at least one physician for each team. For example, teams were summoned from the surgical department to attend the most seriously injured patients. Each patient who required surgery, alternatively stabilizing treatment, was followed all the way by a team consisting of a nurse anesthetist, a surgical or an ER nurse, and a physician (when necessary) until the initial treatment was completed. As described by Waage & Poole:

> When the first patients arrived, three of five surgical consultants and one of two surgical residents were available to lead the trauma teams. One of the five consultants performed triage, and one was sent to the scene. The surgical resident on-call was unable to treat any patients owing to the greatly increased organizational duties from the mass casualty incident. Incidentally, there was only one regular acute admission from 15.00 hours until noon the next day. Two orthopedic consultants and four orthopedic residents were present. Of the four anesthetists present, one was sent out to the scene. In addition, there were 11 doctors from the medical department, and gynecologists were also available. Non-surgical personnel took care of the less badly injured patients. Patients with minor injuries were sent to the outpatient department staffed by medical doctors, and moderately to severely injured patients were sent to the emergency department. Owing to a lack of general surgeons, who normally would assess all injured patients, those with apparently isolated extremity injuries were taken care of by an orthopedic surgeon, while patients with head and torso injuries were placed under the care of a general surgeon. (....) Anesthetists were prioritized to the most severely injured patients and to patients requiring immediate surgery.
3.3. Information

The importance of information is under appreciated. Much of the outcome of a crisis management situation depends on how well the information flows, both internally and across the various external stakeholders, such as next of kin and media.

Event log

Documentation was related both to individual patients and to the progression of work during the disaster. The work was documented "real time". This is why the hospital had a comprehensive overview of how the disaster was handled, and find areas for improvement in retrospect. This task was initially taken care of by tactical management and then by a secretary who was fed the information.

Emergency-web and Patient list

Because of the high pace in the emergency entrance, the patients could not be identified at that time and many of the patients were not able to identify themselves. Therefore, patients were registered with continual numbers in the emergency-web that followed the patients through the system. This is how strategic management could monitor patient flow.

In addition, tactical management needed a detailed list of how many patients were in the hospital at any time, the seriousness of the patients’ injuries and other important information about the patient. This was not easy. A patient list was therefore created in Excel where the number from the disaster web was as quickly as possible linked with a verified identity. The list consisted of the patients’ social security number, home municipality, information about their injuries, and other relevant information that was regularly updated.

The patient list was regularly printed out and given to the police liaison and the secretary who answered the external telephone requests. Tactical management were challenged on the legality of this list in terms of confidentiality, but chose to use it in light of the extraordinary situation.

The patient list was also used at a meeting in the intensive ward at midnight, where operating staff, anesthesia staff, and disaster management gathered to plan the night's operations (e.g., who would be sent to other hospitals, etc). The list was systematically checked.

The patient list proved to be particularly useful when it came to identifying all patients with gunshot wounds, also patients who had been sent out of the hospital due to unverified information that the perpetrator may have prepared the projectiles with poison.

The next day, the patient list was used to determine which of the patients came from the same municipality and probably knew each other, so they could stay in the same room. The patients were very happy to be with friends who had been through the same experience.
Family Information

Management placed an emphasis on ensuring quick information to next of kin. None of the patients that were admitted had working cellphones. Employees were constantly reminded that establishing contact with next of kin via the hospital’s telephone was a high priority. Disaster management also established a phone line where next of kin could call for information. Tactical management continually delivered an updated patient list here. The load was much greater than expected because many of those who called were relatives of those who subsequently proved to be among the dead. The number of inquiries was therefore much higher than the number of patients.

3.4. Other success factors

Care processes monitoring

Tactical management had two staff members that circulated, monitoring different processes and giving feedback on bottlenecks which then could be addressed. This helped management feel confident that things were running smoothly and they could concentrate on other things.

Clear management

Tactical management consisted of a tactical leader and a tactical management team. Clear and visible leadership is important in general, but particularly in a crisis. The tactical leaders moved around a lot and talked to people; they encouraged them, listened to what they were concerned about, and gave information.

Psychosocial support to those who are injured

The psychosocial support for next of kin, the uninjured and lightly injured was well attended. It is easy to forget those who are more severely injured and therefore could not receive the same help. They were recently operated upon, perhaps influenced by painkillers, and staff mainly focused on the somatic injuries. Tactical leaders went around to all the patients the day after and caught up with their needs. This mainly revolved around finding out what had happened to those they knew, and establishing contact with surviving friends, and of course next of kin.

Creativity

The disaster plan is an essential tool for the organization to run smoothly and efficiently. Nevertheless, there will always be need for creative ad hoc solutions beyond what can be conveyed in the plan. When creating such solutions it is essential that key personnel are informed so that systems do not work against each other. Information flow and clear management is therefore essential.
Part 4: Selected statements

4.1. The 30 key informant statements

The 17 statements presented in the Method section of the paper are here written in italic.

1. Major incident preparedness and competence

"What is most important about experience is that you have the knowledge and skills you get by training. It makes you able to tolerate extreme situations and make quick decisions. Ringerike hospital has activated the trauma team many times, and with valuable debriefings afterwards. This reinforces the value of experience, making you able to tolerate more”.

"Then we brought out the red emergency preparedness manual and the action cards [a role & task description so that no details were missed], and I was able to repress my own feelings and concentrate on the job”.

"We need a plan anyhow, and action cards to « keep on track». We saw they were clinging to their action cards in a way that some cards were worn out”.

"The same multidisciplinary team followed the same patient thorough the entire care process, from triage to the general or psychiatric ward, and did not let go of the patient before it was justifiable”

"Proximity to the mental healthcare unit and a written emergency cooperation plan was crucial.”

"Knowledge is important, but we need to be trained. If anyone in the team is un-trained, it helps that some have trained and can lead/help the others along”.

"Hole Municipality had a trained crisis team”.

"The police were an important part of the emergency service. They cleared the path for the healthcare workers, and their lifesaving efforts at Utøya were great. They were applying direct pressure to gunshot wounds to stop the bleeding”.

2. Crisis management and leadership

"I would not have been able to lead over 200 persons without good structure as foundation. Neither would I have been able to manage the major incident without enough human resources at hand”.

"We knew we could trust the competence of our trained personnel, thanks to our monthly simulation and team-training system. Knowing this, tactical management was able to concentrate on other issues”.

"Fortunately, an experienced senior manager was available to take the responsibility as ambulance commander”.

"There was progress all the way; good flow, well directed by the (hospital) medical commander, and people did what was expected from them”.

"We endeavored to bring together the right professionals, forming good, multidisciplinary teams”.

"Crisis management must understand the real time needs of the organization and what needs can be expected in the next sequences of events”.

14
“Tactical management went around talking with the health professionals, encouraging and listening to their concerns and stories, and provided information”.

“The information we collected was both related to each patient (patient list), and to the consecutive events (Event log). A successful outcome depended to a large degree on the quality of the information flow, internal to the healthcare leaders, coordinators, and workers and external to the attached families and to the press”.

“The interaction between the police liaison and tactical health care leadership worked perfectly”.

3. Empowerment of the multi-professional networks

“Cooperation, and that we knew each other well, helped us manage the situation. It would have been very difficult to be alone. We needed each other in making the right decisions”.

“Then we spoke to the youngsters for hours. Their stories were heart-breaking, and we knew that we must not lose each other if we [were to] be able to withstand this”.

“When the hospital was blocked by the police due to a terror threat, those who did not have patient contact were scared. We who worked with the patients were not scared”.

"Life-saving that the ambulance/prehospital expertise was that great".

"We knew you were coming, (anesthesiologist arriving at the support center) and were aware of your presence. It was very important to have someone with your expertise among us”.

“The presence of such a versatile expertise was reassuring to me. I would not be able to do my part of the job otherwise”.

4. Ability to improvise based on structure and competence

“Easier to improvise because we have regular training, both as individuals and together with the others in the team. Enough to understand each other and to know where we had to improvise. ”

“The action cards freed up mental capacity to improvise. E.g., when the police closed the road to Oslo, we established a second support center in cooperation with primary care services, taking care of the families being shut out from the main support center. This was useful”.

"We regularly provided updated patient lists to the police through the entire evening. Never felt this could be wrong”.

“The support center at the hotel constituted a solid and comforting environment for providing psychosocial support.”

“Structure and competence makes room for improvisation”.

"Three helicopters landed about the same time with severely injured patients, two landed on the hospital’s helipad (meant for one) and the third in front of the main entrance.”

"Thanks to the updated patient list, tactical management was soon able to identify patients from the same municipality and placed them together in the same room (at the ward). They were pleased to come together with friends sharing the same experiences”.