

stakeholders, we have been able to build local faculty to ensure sustainability and local ownership.

Results: Thirty-six personnel have been trained across four countries. Thirty-six candidates are now instructors, with a further 36 identified for future development as instructors. The evaluation illustrates the long-term partnerships that have been developed and the ongoing capacity development of key regional partners.

Discussion: The Regional Engagement program demonstrates that prolonged engagement with key regional stakeholders and adequate and sustained mentoring will successfully build local capacity to the level needed to mount a successful response to a disaster. Personnel trained through this program helped guide the response to the Lombok earthquake and in Fiji, a MIMMS Team Member training program was conducted with minimal external support.

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A Registry Software for Road Traffic Injury Patients at Apex Trauma Centre in India: An Innovation

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Introduction: A trauma registry is a disease-specific data collection composed of a file of uniform data elements that describe the injury event, demographics, prehospital information, diagnosis, care, outcomes, and costs of treatment for injured patients.

Aim: To establish a trauma registry system on an electronic platform enabling data capturing through Android phones.

Methods: A software has been developed for the registry data collection for road traffic injury patients arriving at JPNATC, AIIMS, New Delhi. The software has been designed to use in the Emergency Department on Android phones/laptops with internet access.

Result: A detailed registry data set has been prepared to enter prehospital, in-hospital, and post-discharge details of all the admitted patients. This includes demographic data, prehospital data, injury event data, vital signs within 24-hrs of arrival, ED disposition (date and time), operative procedures within 48 hours of arrival, chest x-ray (date and time), CT (date and time), ventilation days, ICU-stay days, hospital disposition (date and time), injury coding data (region, severity level, ISS, AIS, ICD-10) and Others, e.g., first neurosurgical consultation (date and time) and first blood transfusion (date and time). There are two panels for this software; one for user panel and another for the administrative panel. User panel is being used for data collection by the trained data collectors 24/7 at the emergency department on a rotation basis. The administrative panel is accessible to only the investigator or other authorized persons. The administrative panel and user panels are password protected. The entered data is being saved in a spreadsheet in the backend and can be used for periodic data quality check and data analysis.

Discussion: There is no trauma registry in India so far for the road traffic injury patients. Present innovation would lay the foundation of national Trauma Registry in India.

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Required Competencies for Clinical Nurses during the Initial Phase of Disaster Emergence

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Introduction: A learning project was launched to prepare for natural disasters such as earthquakes and floods. Competencies were developed for clinical nurses in the Initial phase of disasters as an indicator to build a bridge between daily training and actions during crises. There are two predominant features of the competencies that differ from other works. First was to concentrate only on “the initial phase” of a crisis outbreak. The second was to associate each competence with services and roles of clinical nurses.

Methods: The development has been conducted in accordance with the ibstpi[®] competency development model. First, 50 outlining competencies from earlier studies were selected, like ICN Framework and Disaster Nursing Core Competency for undergraduates in Japan. Then a web-based questionnaire was carried out with a four-point scale of “able,” “probable,” “impossible,” and “cannot understand meaning” for incumbent nurses in order to gauge their adequacy.

Results: There were 86 responses with an average of 14 years (1–40) of nursing experience. We compared them in three groups; those with a job post (G1), those with experience of longer than five years (G2), and those with experience of fewer than five years (G3). The average competency score (total 150 points) was 96.7 (67–129) in G1, 88.2 (53–145) in G2 and 80.2 (59–114) in G3.

Discussion: The results imply, even in G1, the average score is low at 65/100 points. This may indicate most clinical nurses should make efforts to develop their skills and knowledge of disaster nursing through daily work. Only 32 competencies (G1), 14 (G2), and 5 (G3) were marked as “able” or “probable” by over 80% of responders. Thus with consideration, depending on the result and expert reviews, the competencies determined to be “required” for clinical nurses were finally refined down to 35 items including the premise of ten.

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Rescue Operations in Underground Mines: Caring for Patients in a Challenging Environment

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