



**ASIA PACIFIC EMERGENCY AND DISASTER NURSING NETWORK  
MEETING  
AND CAPACITY BUILDING WORKSHOPS**

**Auckland, New Zealand  
6 to 8 November 2010**

**System-wide Quality Improvement: The Foundation of Emergency and  
Disaster Resilience**

**Manila, Philippines  
June 2011**

**REPORT**

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AND CAPACITY BUILDING WORKSHOPS**

**Convened by:  
WORLD HEALTH ORGANIZATION  
REGIONAL OFFICES FOR THE WESTERN PACIFIC  
AND SOUTH-EAST ASIA  
AND WHO COLLABORATING CENTRE FOR NURSING, MIDWIFERY AND  
HEALTH DEVELOPMENT, UNIVERSITY OF TECHNOLOGY, SYDNEY (UTS)**

**Auckland, New Zealand  
6-8 November 2010**

*Not for sale*

**Printed and distributed by:  
World Health Organization  
Regional Office for the Western Pacific  
Manila, Philippines**

**Sponsorship received from:  
AusAID International Seminar Support Scheme  
Japan Voluntary Contribution  
NZAID Pacific Island Countries Participation Fund  
WHO WPRO  
WHO SEARO  
WHO South Pacific  
WHO Collaborating Centre for Nursing, Midwifery and Health Development, Faculty of  
Nursing, Midwifery and Health, University of Technology, Sydney  
University of Technology, Sydney International Department  
New Zealand Ministry of Health  
Commonwealth Secretariat  
Auckland University of Technology  
James Cook University**

## NOTE

The views expressed in this report are those of the participants in the Asia Pacific Emergency and Disaster Nursing Network Meeting and Capacity Building Workshops and Emergencies and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development at University of Technology Sydney on behalf of the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Western Pacific Region and for those who participated in the Asia Pacific Emergency and Disaster Nursing Network Meeting and Capacity Building Workshops which were held in Auckland, New Zealand, from 6 to 8 November 2010.

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## 1. INTRODUCTION

Recognizing the necessity of coordinated, sustained and maximum response to the growing numbers of emergencies and disasters in the Asia and the Pacific region, the World Health Organization (WHO) Regional Offices for South-East Asia and the Western Pacific Regions, in collaboration with nursing leaders and partners formed the *Asia-Pacific Emergency Disaster Nursing Network (APEDNN)* in 2007, with the aim of providing a network through which emergency and disaster preparedness could be enhanced. Membership is composed of policy-makers, practitioners, researchers, educators, WHO representatives, and invited stakeholders committed to building disaster preparedness, response and recovery capacities. The network's 2008 meeting was held in Jinan, Shandong, China. The 2009 meeting was convened in Cairns, Australia.

The 2010 *Asian Pacific Emergency Disaster Nursing Network (APEDNN)* meeting, convened in Auckland, New Zealand, from 6 to 8 November 2010, was made possible through the support of the World Health Organization (WHO), the Japan Voluntary Contribution; AusAID, NZAID, Commonwealth Secretariat, the New Zealand Ministry of Health and the WHO Collaborating Centre for Nursing, Midwifery and Health Development at the University of Technology, Sydney (WHO CC UTS).

### 1.1 Participants

The APEDNN meeting was attended by over 66 participants from 26 countries. The full list of participants is found in Annex 1.

### 1.2 Meeting aim

The meeting aimed to enable nurses, facilities and communities to improve trauma and disaster systems of care in partnership with other professions, stakeholders and communities, through research, capacity-building and policy development.

### 1.3 Expected outcomes

By the end of the meeting and capacity-building workshops, participants were expected to have:

1. Identified key variables and interventions to improve trauma and disaster care;
2. Discussed and finalized the APEDNN conceptual framework;
3. Identified lessons learned from recent disasters to strengthen national, local, institutional trauma care and disaster preparedness and response;
4. Demonstrated new knowledge and/or skills in selected aspects of participatory learning approaches and technical areas of quality improvement, trauma and disaster systems of care and mental health and disasters;
5. Agreed upon shared methods to promote research around emergency-disaster nursing and quality improvement; and

6. Formulated action plans focused on the 2001-2011 core capacity-building course and accompanying research, monitoring, evaluation and reporting.

The meeting agenda is included as Annex 2.

## 2. PROCEEDINGS

### 2.1 Day One: Saturday, 6 November 2010

#### 2.1.2 Formal Opening and Powhiri

The Powhiri was led by the traditional leader, or in Maori terms, the kaumatua (revered elder).

#### 2.1.3 Opening Session and introductory remarks

Dr Jane O'Malley, Chief Nursing Officer, New Zealand, gave a brief overview of the day's planned proceedings and briefly outlined the areas to be covered at the meeting including quality improvement in the keynote presentation, and country case studies. Meeting participants were then asked to introduce themselves individually to the larger group to facilitate an understanding of people's backgrounds and their expectations of the meeting.

#### 2.1.4 Meeting overview, expected outcomes, working processes

Kathleen Fritsch, Regional Nursing Adviser of the WHO Western Pacific Region thanked the New Zealand colleagues for the Powhiri and Dr O'Malley for the overview and introduction to the meeting. Mrs Fritsch then extended greetings from Dr Shin Young-soo, Regional Director of the WHO Western Pacific Region.

After reviewing the inception of the APEDNN, subsequent meeting outcomes and the theme of quality improvement in emergency and disaster care, Ms Fritsch emphasized the importance of sharing lessons learned in this forum and their potential application to future situations. Case studies of the role of nurses and midwives in emergencies and disasters were solicited.

#### 2.1.5 Keynote presentation: Quality improvement and its applicability to trauma, disasters

Ms Gillian Bohm, Principal Advisor Quality Improvement, Health Quality and Safety Commission, Ministry of Health, New Zealand described how her professional career and current role incorporated quality improvement, including infection control. Her engagement in emergency and disaster planning work came about as a response to the SARS epidemic.

Ms Bohm explained the inter-linkages of the two key areas of her work through theoretical models of quality improvement and emergency and disaster planning. The four step methodology for quality improvement described was the *Plan-Do-Check/Study-Act (PDSA)* or Deming cycle; the current quality management model utilized by the Ministry of Health.

In the planning stage, focal questions are asked: How will we do it? What resources can be used and who will be involved? How to communicate with others? Setting targets or key performance indicators (KPIs) – how to measure how we got there?

As work commences in the *do* stage, it is important to check the appropriateness of people for the work required. Preparatory planning was emphasised, as well as infrastructure and record keeping.

When *checking/studying*, it is necessary to compare what happened against what was planned. Data collection is important when starting to study the system and having KPIs in place assists the process. Analysis commences after the conclusion of the study and checking, to identify what has been learned. Actions are based on what was learned in the check/study step. The cycle links directly back to the planning stage when improvements or refinements can be identified and sustainability evaluated, based on what was or was not successful in the test study.

In an emergency management model of quality improvement, reducing and managing the risk, the reduction stage, would be part of everyday work. The response phase focuses on the emergency or disaster itself and precedes the recovery phase. The recovery phase can be difficult as those responding to the emergency have left the scene and others undertaking recovery remain. Recovery provides a key opportunity for public education and lobbying for government support.

A table top exercise board was demonstrated and some interest was expressed by members of the group in such table top exercises.

## 2.1.6 Country case studies

### 2.1.6.1 Malaysia

Malaysia's experience in disaster preparedness and response was presented by Dato Hj Fatihilah Hj Abd Wahab, Director of Nursing, Registrar of the Nursing Board, and the Secretary of the Midwifery Board, Malaysia and Matron Leela Chellamuthu, Assistant Nursing Director.

The speaker provided a brief overview of Malaysia's geography and demographic profile of its' population of 28 million. An overview of health facilities was provided. The total nursing workforce in Malaysia currently totals 83 802.

In recent decades, Malaysia has experienced a diversity of disasters. These included an air crash in 1977; the collapse of jetty in 1988; a school fire in 1989 and a factory fire in 1991; a bus accident, a landslide, and mudslides in 1996 during a tropical storm in Sabah; an enteroviral outbreak and environmental haze in 1997; Japanese Encephalitis outbreaks in 1999; followed by SARs, Avian Flu in West Malaysia in 2003; a tsunami in 2004, Johor floods in 2006 to 2007 and a landslide in 2008.

The nation's flood alert system was described, along with the role of the Hospital Flood Operations Room and its monitoring function. Examples of disaster management plans inclusive of nursing leadership roles and involvement during the disaster phases were presented. The role of nurses in providing counselling and in facilitating child play therapy was illustrated as was

their role in teaching hand washing and hygiene, carrying out vaccinations and in advising the community.

Dato' Hjh Fatihilah Hj Abd Wahab emphasized the need for continued competency development of nurses in all aspects of emergency and disaster care, strong cross-sectoral coordination and preparedness at all levels of care as nations are faced with recurrent and new disaster threats.

#### 2.1.6.2 Philippines

The Philippines response efforts to Typhoon Ondoy, Pepeng and Santi (OPS) was presented by Dr Sheila Bonito, Associate Professor, University of the Philippines and Dr Josefina Tuazon, Professor and Dean, University of Philippines, College of Nursing.

The disaster resulting from three typhoons in the Philippines was presented, including lessons learned for action planning. The economic impact of the typhoons amounted to USD 4.38 billion in damage and losses and USD 1.7 billion of estimated damage to health care facilities.

The response efforts at national, regional and local levels were coordinated by the National Disaster Coordinating Council. The nursing sector response included the provision of PHC services in evacuation centres and public and private health care facilities. The Philippine Nurses Association, in conjunction with the through Philippine Medical Association, deployed volunteer nurses to provide relief operations and medical missions.

The major problems encountered by the Department of Health (DOH) included information management deficits; poor surveillance, management of volunteers and primary health care (PHC) in evacuation centres; poor logistical reporting at local level and increased numbers of hospital admissions due to some non-functioning health facilities.

Apparent gaps in the health sector response included the under-utilization of the nursing workforce; a lack of definition of roles of nurses in disaster preparedness and response in the Emergency Response Systems, the non-identification of the nursing sector as a distinct member of the health sector response team, and the lack of trained of nurses for an emergency response. Though services provided assistance, in many cases, it was insufficient to cope with heavy demands. The lack of public information regarding the prevention of diseases was evident.

Associate Professor Bonito outlined the quality improvement steps to be taken as a result of the analysis of the disaster:

- Formalising the nursing sector as part of the Health Sector within the DOH system;
- Full implementation of policies to ensure the integration of disaster preparedness in pre-service health professional education;
- Validation of competencies of nurses in emergency and disaster preparedness and response; and

- Maximizing the functions of the Philippine Nurses Association in organizing nurses to prepare for and respond to emergencies and disasters.

#### 2.1.6.3 New Zealand

Ms Mary Gordon, Executive Director of Nursing, Canterbury District Health Board, New Zealand, described the earthquake and aftershocks experienced near Christchurch, New Zealand from 4 to 25 September, 2010, focusing on the local level public health response.

Major public health issues resulting included sewerage running into rivers and flood waters from broken pipes; power outages; food safety issues, and displaced persons. The immediate response system, of hospitals, emergency medical technician members of the Regional Civil Defence (CDEM) control team, medical health officers and District Health Board Control (DHBC) members, was activated at Christchurch Hospital, which established contact with all Canterbury District Health Board (CDHB) hospital sites. Response came from the entire health system - Community and Public Health, Primary Care, Hospitals- all of which were linked to the National Health Control Centre (NHCC).

Emergency back-up systems (e.g. power) functioned and coordination commenced, involving community and public health; medical health and primary care officers and private Hospitals. Initial structural assessments were carried out and hospitals prepared for response. The public were advised about safe drinking water and the use of alternative toilets' connecting with neighbours, and a welfare centre was established for people having to leave their homes. In the early days after the earthquake, the hospital was used as an emergency control centre, with water being brought in from outside the city; possible evacuations prepared for and carried out; and the first health staff responders from outside the Christchurch area were received. Daily briefings were held with the Health Board, coordinating centres and other parties.

On day 4, nurses were deployed to the CDEM, and counsellors were sent to convey key messages to reduce anxiety. The safety of hospitals in the affected areas and water safety were important key messages conveyed, as well as the normalcy of feeling anxious. On day 5, a large aftershock led to the closure of more buildings and the relocation of some emergency services. During the recovery phase some people had left the area, and the community now focused on looking at ways to rebuild and strengthen infrastructure and services.

The Canterbury Health System remained intact and operational. Ms Mary Gordon concluded that the people working through the quake put in an outstanding effort and the plans made for such an event worked. Efforts to address community effects of the disaster will continue through the challenging recovery phase.

#### 2.1.7 Preliminary results of the safety, quality/ trauma survey

Dr Lesley Seaton, of the WHO Collaborating Centre, University of Technology Sydney, provided background information about the quality survey, noting that it was a component of the quality and patient safety work of WHO and Member States in the Western Pacific region. The survey aimed to assess work underway in quality and safety; factors influencing cultures of safety and quality in the Region and concerns, problems and needs related to quality, safety and trauma, disaster care. Preliminary data results from the electronic survey deployed to APEDNN members indicated that:

- Both administrative and nursing personnel were well represented in the group of survey responders.
- The majority of responders felt that quality and safety in their country was acceptable, however the preliminary findings also indicated that personnel worked longer hours than optimal for patient safety.
- Respondents, while reporting that existing procedures and systems were effective most of the time in preventing errors from being made, indicated also that there is still work to do. Many respondents indicated that sometimes there were safety problems in their country or organisation.
- The majority of survey responders stated that safety and quality policies, documents, standards or directives are in use in their country. The majority of responders had had formal training in quality improvement and were actively doing things to improve patient safety.
- Survey responses revealed the absence of trauma registries as well as the monitoring and analysis of sentinel events.

Dr Seaton explained that the initial sample size was small due to time constraints; therefore further data collection is planned and further support envisioned for lesser-resourced countries.

#### 2.1.8 Quality improvement—An introduction

Ms Gillian Bohm introduced the topic of improving quality and the vision that people in the New Zealand receive people-centred, safe and high quality services that continually improve and are culturally competent.

Common barriers to quality improvement (QI) were described: a lack of well-embedded systems approaches to QI; QI activities not always well coordinated or integrated; and a lack of shared purpose, vision and language. Ms Bohm noted that when these barriers are understood, we are able to then move forward in improving quality.

Ms Bohm quoted Don Berwick, CEO of the Institute for Healthcare Improvement - “Every system is perfectly designed to achieve the results it gets” and explained that if you are not achieving what you want, go back and review the system.

The PDCA cycle –Plan, Do, Check, Act was used to illustrate problem analysis and change, in response to the question: “What today is impossible to do in your business, but if it could be done, would it fundamentally change what you do?” Emphasis was placed on a systems thinking approach to system improvement. Various systems improvement concepts discussed included lean thinking, value and waste, constraint theory and flow, and health literacy. Advantages of flow charting organisational processes were discussed, as well as process mapping.

Core elements of the global patient safety challenge were highlighted: safety principles, blood safety, injection practices and immunisation, environmental hygiene and waste

management, clinical procedures and hand hygiene. The *World Alliance for Patient Safety's Global Patient Safety Challenge* report served as a reference for the safety issues discussed.

The *Quality in New Zealand Healthcare* study illustrated that many adverse incidents are highly preventable. The cost of sentinel events was explored, as were the two views of causes or errors. The person approach to adverse event analysis induces a cycle of fear, whereas the system approach aims for a culture of safety and a continuous cycle of improvement.

Leadership in initiating and sustaining change was stressed, as making change can be harder than anything we have ever done. The session concluded with the acknowledgement that change must begin with leadership and that organisations must be receptive to change.

#### 2.1.9 Quality improvement in trauma disaster care

##### 2.1.9.1 New Zealand's response to the Samoa tsunami, Dr Ted Hughes

Dr Ted Hughes, an intensive care physician at Royal North Shore Hospital, provided an overview of the response to the tsunami disaster and lessons learned in the Pacific Region, as head of the New Zealand trauma response mission to Samoa, following the tsunami. Generally, patients injured at the time of the tsunami, if reaching the hospital alive, survived.

In Samoa, the waves had hit just before 7 am, in an area 50 kilometres distant by road from Apia. The hospital staff from Apia going to the disaster area encountered many destroyed roads and downed trees and debris. Department of Health staff and volunteers at the hospital awaited the arrival of casualties. A team of Australian civilian volunteers (4 doctors, 8 nurses) arrived on day two. Their response supported local staff in triage, urgent surgery and wound care. Wound contamination of traumatic injuries was a great concern.

A second ready response force arrived to relieve the first team on days 4 to 5, while the local Samoan health workers continued working. The first New Zealand team of doctors and nurses arrived on day 6. Sufficient preparation time had enabled the response team to be composed of workers familiar with Samoa and its' people. Ward care for infected wounds and fractures major issues addressed.

Dr Hughes reflected on the lessons learned from the Samoan experience; the need to prepare a quick response team for the future and the vital importance of working hand in hand with local health personnel, learning from one another.

##### 2.1.9.2 New Zealand's response to the Samoa tsunami, Ms Jodie Orchard

Ms Jodie Orchard, trauma nurse specialist, Royal North Shore Hospital, outlined her role in preparing for and managing patients brought back to New Zealand after the tsunami. She noted that they had preliminary communications about the patients, which was an advantage and gave the team in Auckland time to prepare for the wounded as well as the influx of family members from New Zealand, and to deploy additional nursing staff.

Eleven patients flown in from Samoa were assessed, and seven were admitted to wards. Ms Orchard noted the importance of taking time to talk with the survivors and listening to their stories, providing support, repatriations and transfers, protection from media and also keeping the media informed. Debriefing, reviewing and evaluation and the use of networking were also seen

as important. Essential patient data and a patient tracking system were vital, as was good and consistent communication.

The need to have a disaster plan with clear levels of activation was apparent, to enable workers to cope with any situation that may happen. The plans should be practiced for emergencies and coordinated incident management response (CIMS) and trauma training implemented in advance. Ms Orchard briefed participants on the disaster nurses network, the use of "Emergo train," a recognized health simulation tool, and the Australasian Trauma Society. She concluded that the main aim is to lessen trauma outcomes and have the right people making the right decisions.

#### 2.1.9.3 Quality improvement lessons learned from the New Zealand earthquake

Ms Gordon delivered the final session of the day, the identification of lessons learned from the New Zealand earthquake.

The major public health issues experienced after the earthquake were:

- Broken sewerage systems
- Sewage in rivers and flood water
- Likely contamination of non-chlorinated water supplies
- Power outages; food safety
- Shelter / welfare centres
- Social disruption, anxiety.

The disaster response from days 1 to 14 following the quake and aftershocks was presented, as well as the effects on and responses by all hospitals, staff, Canterbury District Health Board, the Coordinated Incident Management System (CIMS), Operations Teams and Welfare Centres.

The involvement of the whole of health system in disaster response was highlighted. Continual assessment and reassessment were noted as particularly important for staff reassurance and for safety. The daily briefing system and early morning planning meetings supported continued communications and coordination. The ongoing nature of the disaster and a high level of continued anxiety will continue to impact day to day life.

## 2.2 Day Two: Sunday, 7 November 2010

### 2.2.1 Keynote presentation – emergency disaster planning in rural communities

Ms Leanne Samuel, Chief Nursing and Midwifery Officer, Southern District Health Board (SDHB), New Zealand, welcomed participants to the meeting and gave a brief history and overview of the geography and the unique characteristics of the SDHB catchment area.

Emergency planning assumptions for extreme weather events include emergency service units working closely together and individuals, communities and the region having a degree of self sufficiency. Strategic aims of the SDHB's Emergency Plans include putting into operation reduction, readiness, response and recovery measures; ensuring all health workers are trained in CIMS; and having in place agreed upon modes of communication and backup plans.

The underlying principles of the SDHB emergency plan are:

- **Reduction:** Action to avoid or minimise the adverse health-related impacts of events likely to give rise to an emergency.
- **Readiness:** Includes planning, establishing and maintaining systems and undertaking training for an efficient and effective health sector response to a potential emergency.
- **Response:** Mobilising and deploying health resources immediately prior to, or during an emergency, in collaboration with other services, to ensure as far as practicable, the continuation of essential health services, the relief and treatment of people injured or in distress as a result of the emergency, and the avoidance or reduction of ongoing public or personal health risks to all those affected by the event.

Details of the *Operational Emergency Plans* and the *Coordinated Incident Management Systems* (CIMS) were provided. Many nurses are trained in these plans and standardized processes. The major component functions of CIMS include planning and intelligence, operations, logistics, public information management, safety and liaison and communication. The SDHB Emergency Operation Centre, the facility for centralised coordination, can be set up anywhere. Support Teams are coordinated from Incident Control Points.

The speaker noted the importance of incident debriefing and reflection on where things can be improved. Ms Samuel noted the benefits of adjusting plans as necessary and including things not anticipated. She also emphasized the importance of nursing integration into emergency and disaster plans.

### 2.2.2 Human resource considerations for emergency and disaster operations

Dr Kristine Qureshi of the University of Hawaii at Manoa introduced the key elements for emergency/disaster surge capacity –system, space, supplies and personnel.

The system and its parts were then described, including command (functioning incident command system), control of the infrastructure in which you are operating, communication including the importance of messaging to staff, continuity of operations – identification of essential operations and what may be shut down if necessary, and community infrastructure. The space in which you are working and supplies/equipment including clinical care, staff support, communication, transportation, must also be considered.

Dr Qureshi suggested that personnel should be seen as the most important, and that there is little literature on staffing during disasters. In the USA, as health care costs increase, hospitals operate at 98% capacity leaving no room to quickly expand in the case of emergencies. Extra

staffs are also not available when needed. The definition of personnel is therefore expanding to include nursing students and volunteers.

The three levels of resources identified by Hick et al (2009) were identified. Conventional referred to the usual staffing formulas of an Emergency Department. Contingency staffing occurs when there is an event that disrupts normal operations but existing resources are sufficient. Crisis staffing is more difficult and depends on the nature and extent of disaster, available resources, and the length of event.

Dr Qureshi asked the group to reflect on their experiences in this area, what worked and what did not work.

Dr Jane O'Malley noted that New Zealand had developed an on call personnel system with one person as a first backup, with other staff as further support. It was noted that volunteers can now be credentialed in advance, to assure their appropriateness to work.

In Vanuatu, where volcanic eruptions are common, there can be a need for extra nursing care from other sides or unaffected areas of islands. Vanuatu now deploys nurses from public health programs and community health services to provide facility nursing care and has trained them for this purpose. This plan helps to avert severe reductions of nursing personnel in their original places of work.

### 2.2.3 Evaluation of the WHO *Safe Hospitals Tool*

Ms Gillian Bohm presented New Zealand's Safe Hospital evaluation, as part of the National Health Emergency Plan and work initiated by WHO in 2008 to 2009. WHO had developed the Safe Hospitals Save Lives guidelines and tools for the physical and functional integrity of hospitals and health facilities in emergency conditions.

A safe hospital was defined as “an establishment whose services remain accessible and functional at maximum capacity and within the same infrastructure following a natural health or civil defence emergency” (WHO, 2008-2009). New Zealand, having adopted the safe hospital campaign in 2009, learned a number of important lessons through the process, such as the discovery of vulnerability surrounding water supplies and took subsequent action to change the situation.

The Project set out to ascertain whether the hospital safety index tool developed by the WHO Region of the Americas PAHO and WHO globally, could be useful in helping New Zealand hospitals prepare for health emergencies; and whether the tool could provide useful information for national, local and regional planning. The *Hospital Safety Index Tool* assesses the probability of hospitals being able to remain operational in emergency situations and supports the management and reduction of health sector risk.

Ms Bohm outlined the evaluation process, emphasising the need to engage people at the beginning. The assessment tool assessed hospital capacity within the following categories – location, structural safety, non-structural safety and organisation and management. The *Guide for Evaluators*, the principal training tool is accessible at:

<http://www.paho.org/english/dd/ped/SafeHospitalsChecklist.htm>.

It was suggested that the tool may need further adjustment for use in New Zealand and Australia with additional details and clearer explanations. In general it was found to provide valuable information for emergency planning and management at national, regional and local levels.

In the future, work could focus on reducing the vulnerability of health facilities and identifying other sectors involved in safeguarding health facility from disasters. The findings can them be incorporated into criteria for health investments.

#### 2.2.4 Quality improvement in pre-hospital emergency and disaster response

Professor Arbon, of the Research Centre for Disaster Resilience and Health, Flinders University, South Australia, introduced the topic of pre- hospital care systems, their capabilities, preferred outcomes and other associated issues, the aim to strengthen out of hospital care and how to build other supportive strategies.

Pre-hospital care systems were explained, with data indicating that most people think this takes place within ambulances. However, ambulance services are an expensive resource. Professor Arbon suggested that it is necessary to build better out-of-hospital capacities and community resources.

The need to build on existing research in this area was noted, particularly in relation to the best strategies for different situations.

Professor Arbon questioned the purpose for the service – whether it is to provide primary care or more services. Lessons learned from emergency responses show that a community member is likely to be the first responder to assist. In an emergency/disaster situation, the amount of damage depends on the strength of community, and inevitably the most vulnerable are most affected. Often the number of people affected is related to how well the community works. The dynamic state of evolving events or disasters show that as one thing changes, so do others as they are all connected.

Improving or building out-of-hospital care should focus on:

- Resilience – the ability of organisations or communities to survive through a disruptive event, recover and develop to a better place. The capacity of a community to adapt and change is important, e.g. the opposite of vulnerability.
- Building resilient communities – through risk management, increasing capacities through training, health education; buffering capacity – what is essential that could be sacrificed and what can be done to replace essentials if not working; response capacity- including rescue and relief, and surge capacity.

The development of community resilience was emphasised, through youth education, first aid training, community projects, work with vulnerable members of the community. First aid skills and interventions were seen as invaluable to the community.

Professor Arbon also briefly outlined current projects underway at the Flinders Research Centre for Disaster Resilience and Health and encouraged participants to peruse the *World Association for Disaster and Emergency Medicine website* ([www.wadem.medicine.wisc.edu](http://www.wadem.medicine.wisc.edu)).

#### 2.2.5 Logistical preparedness: Working with communities, partners

Ms Cynthia Vlasich, Director of Education and Leadership, Sigma Theta Tau International delivered greetings to meeting participants from Sharon Stanley, Chief Nurse of the American Red Cross, Esther Lau, State Nurse Liaison in Hawaii, and Lucille James, Disaster Health Service Advisor in Hawaii.

Ms Vlasich stressed the importance of leadership and working with community partners in logistical preparedness and planning. She noted that planning must occur or the response will also be a disaster. All disasters are local therefore local leaders have primary responsibility and must be supported by others. Disasters have a personal impact which is understood more fully in the local context; local persons should therefore have some leadership role.

The question of partnerships – emergent and long-term was raised and it was noted that sometimes compromise is required. Contributions of external others need to be relevant to prioritized needs, especially from organisations such as pharmaceutical companies etc., as supplies received, if excessive and not relevant to the needs at hand, still require inventorying, storage and when not needed, disposal.

Logistical considerations include warehouse and administration; relief and logistics kits and emergency response unit personnel, security equipment, radio and telecommunication, power supply and electrical equipment, tools and hardware, vehicles and consumables, water and sanitation, food, household items, shelter and construction materials, and livelihood materials. Detailed lists of such items are available from the International Federation of Red Cross and Red Crescent Society (IFRCRCS). Drug products and medical disposable supplies and equipment are also considerations, as are basic health care, emergency care and triage, rapid deployment of emergency hospital personnel, referral hospital emergency response units and surgical hospital care.

Ms Vlasich explained the collaborative analysis process undertaken in emergencies and its evaluation categories: entity, responsibility, ability/expertise, proximity, reliability, flexibility and issues. A *PEST* analysis or **p**olitical, **e**conomic, **s**ocial, and **t**echnological analysis looks at the political, environmental, social and technological aspects of a partnership situation to address strategic management. The IFRCRCS and PEST tools, available online free of charge, focus on vulnerability and capacity, global food security, preparedness planning, household water and safe storage.

Many tools for disaster preparedness assessment were outlined and are also available through the IFRCRCS, including: vulnerability and capacity assessment, global food security assessment guidelines, disaster preparedness training programmes, household water treatment and safe storage in emergencies, logistics and humanitarian logistics software.

Meeting participants discussed their experiences of the tsunami (Tonga), looking at strengthening of nursing in countries to prepare for disasters (Fiji) and maintaining a global family of nurses so all can act together.

#### 2.2.6 Samoan tsunami: Lessons learned

Mrs Pelenatete Stowers, Assistant Chief Executive Officer, Performance and Quality Assurance, Nursing and Midwifery, Ministry of Health, Samoa, recalled that during the 2009

APEDNN meeting in Cairns, Australia, she and others received news of the tsunami that had hit Samoa and surrounding areas without warning. Many persons died and much of the coastal area on western side of the island was destroyed, as was the district hospital. Five nurses there lost houses and family members. Samoa's national response and nursing plan in times of disasters /emergencies requires that nursing personnel prepare their family and then report to the nearest health facility.

Immediately after the tsunami, nurses reported to main hospital in Apia and set up a special ward for incoming survivors. By second day further assistance had arrived from Australia and later, New Zealand. It was necessary that volunteers arriving had competencies to help where most needed. Subsequent to the disaster, overseas Samoan nursing personnel have been rotated to Samoa every two weeks from the time of the tsunami until today.

During the recent anniversary of the tsunami, the national government of Samoa devoted a day of reflection focused on the 2009 disaster. The Ministry of Health made a strong effort to include all people involved in the tsunami response. As a result, an important lesson was learned about the need to reflect, to talk about individual experiences and to share emotions, ideally closer to the time of the disaster, rather than one year later. The ongoing need for psychosocial support was underestimated.

Some gaps were identified in terms of nursing staff capacities in coping with such emergency situations, for example, on-site resuscitation. Plans have been made to work with the University of Technology WHO Collaborating Centre and its' faculty in addressing capacity-building needs.

Recurring disasters and emergencies were discussed, in the context of initial as well as ongoing credentialing of emergency and nurses' emergency and disaster competencies.

#### 2.2.7 Quality improvement in psychosocial health and disasters

Prof Kim Usher of James Cook University, Australia, presented the draft course materials of the psychosocial health and disaster course, to be disseminated to countries represented at the meeting for use as a training tool. Course developers, Dr Margaret Grigg and Professor Kim Usher requested feedback on the documentation presented, with the aim of ensuring course relevance and appropriateness.

Professor Usher, while presenting the course aims and its' six course modules, stressed the importance of looking after the helpers in disaster situations. The complete course and its' teaching and learning methods will include online workbooks, with links to PowerPoint presentations, videos, and podcasts by experts and health responders. CDs will be made available to overcome internet access barriers. It was explained that assessments for formal certification will be possible and a person completing the course may qualify for accreditation of one subject at postgraduate level. The training course can be used for self-learning, group learning and/or flexible learning in a face to face or distance format.

A technical evaluation feedback form as well as a system for gathering further evaluation data at later dates was suggested by Dr Qureshi. The course developers do plan on developing a course evaluation and/or pre- and post-test. The authors requested inputs such as narratives of disaster experiences, photos, stories for case studies, as well as suggestions on how to present the

material in ways that are most culturally appropriate, recognizing that each culture deals with situations differently.

Professor Usher and her team were congratulated on the important work undertaken.

#### 2.2.8 Infection control

Ms Leela Chellamuthu, Principal Assistant Nursing Director, Ministry of Health Malaysia, outlined the infection control (IC) infrastructure and policies in Malaysia at national, state and hospital levels and their recent review, using the regional infection control assessment tool.

Some funds are available for procurement of consumables for IC and are allocated to the hospitals through the state health department according to hospital size and number of beds. All state hospitals have isolation wards and rooms available. In epidemic situations state hospitals coordinate and control outbreaks.

The National Influenza Pandemic Preparedness Plan (NIPPP) is followed during epidemic situations and all hospitals have plans for outbreaks or epidemics. These plans include expansion of triaging areas, staff deployment, traffic flow and personal protective equipment (PPE) use in Accident and Emergency Departments. Hospitals have a responsibility for clinical management and tracking of cases according to the Standard Operating Procedures for a particular disease.

Surveillance of health care associated infections is monitored by each hospital and data reported to state and national bodies. All hospitals follow a standard disease surveillance protocol. Supplies and PPE are accessible 24 hrs each day and the isolation of infectious patients takes place when and where necessary. Negative pressure isolation rooms are available in state hospitals and some hospitals with specialists, in accordance with requirements of the national 2010 IC policies and procedures. All chief nursing officers have undertaken IC training and IC committees are established, with the appointment of link nurses for IC in all hospitals and health centres.

#### 2.2.9 Infection Control in the Asia Pacific region

Dr Eric Chan, Coordinator, Health Professions, Nursing and Midwifery, Acting Chief Scientist for Nursing and Midwifery, World Health Organization Headquarters, reviewed the assessment tool presented earlier, noting that it had been developed for use in the region and for wider application. He explained that the next step was to review the frequency and outcomes of its use. He noted the need to look at groups of hospitals or clusters, with an aim of working together to carry out surveillance. The infection control training toolkit introduced to the network in 2009 was reviewed, with Dr Chan noting that an IC training for nurses and other health personnel in the Asia Pacific region will be piloted in Hong Kong this month, based on the toolkit.

As well as IC capacity-building and curricular integration of IC, there is a great need to look at how IC is managed overall. It was noted that organisations need leaders in clinical infection control which requires substantial education. Dr Chan went on to describe a link person as someone working in clinical unit who has responsibility to understand current IC practices, to serve as a resource person; and to do clinical work. The link person, a fundamental component of IC management, help to monitor, train and connect IC services.

#### 2.2.10 Alternate Care Sites – Planning and Operations in the State of Hawaii, USA

Dr Qureshi explained that the USA experience of Hurricane Katrina, highlighted many problems of healthcare systems in dealing with disasters, such as issues with complex medications and maintaining such regimes for patients through disasters and their aftermath. Consequently, the US government established the *Alternate Care Sites System* (ACS).

At times when hospitals are already at capacity, there are people who will be directed to the Disaster Alternate Care Site (ACS). The ACS is defined as a temporary, scalable operation that aims to provide low acuity care for individuals with special health needs during a large scale public health emergency and who have no one else to care for them. The number of persons living in communities with serious chronic illnesses requiring complex management has risen markedly. An ACS provides triage and basic ADL care and chronic disease management.

The timeframe for establishing an ACS was discussed along with the importance of setting up the sites before a system is overwhelmed. Specific information was given about the types of care provided within an ACS including activity of daily living care, health maintenance care, influenza care and simple wound care.

Dr Qureshi outlined who would work in alternative care sites and how they are organised. All types of workers will be needed and the site will operate using the Incident Command System. Staff will be direct patient care providers, not nurses, working in teams and pods, with perhaps one professional nurse per 100 patients. It was noted that safety of the ACS workers will be the first priority. Data collected at alternative care sites will be confidential, and care will be client centred.

Dr Qureshi noted the serious problems caused by disasters and the need of public health systems for assistance in providing care. Non traditional personnel can assist at these times and enlisting and training them beforehand will enhance response capacity.

Mrs Pelenatete Stowers explained that during the H1N1 epidemic in Samoa, community centres were set up in each village, and village people were trained by the government nurses to take care of patients that should avoid going to the main hospital. Their families provided bedding and kept the person isolated and cared for. Ms Hillia Langrine added in her country there is a group called *Women Preparing for Health* who are active in health care and help in disasters. In Tonga some churches have trainings to assist the nurse practitioners as part of a back to basics intervention. Ms Sunshine Chan presented an example after the China earthquake, in which some students, studying away from their homes, were mobilized to translate, and interpret for those affected by the disaster.

#### 2.2.11 APEDNN vision, mission and objectives

Dr Kristine Qureshi and Assistant Professor Sheila Bonito, University of the Philippines, introduced the final session for the day, recalling that the APEDNN mission — to advance a professional network to promote nursing's ability to reduce the impact of emergencies and disasters on the health of communities - has remained the same, with the addition of network members and partners from around the world. The APEDNN vision, mission and objectives are found in Annex 3.

Some minor adjustments were made to the objectives to reflect the intention of the group to address QI. The revised strategic objectives (subject to endorsement by all APEDNN members) aim to:

- (1) Establish a system for ongoing interaction among members to strengthen collaboration and capacity building;
- (2) Identify and validate emergency and disaster nursing competencies;
- (3) Develop and share tools, materials and training programmes in emergency and disaster nursing education, services and research;
- (4) Identify best practice standards and evidence-based guidelines and interventions using a quality improvement process;
- (5) Collaborate with others in establishing the research agenda for emergency and disaster nursing;
- (6) Implement mechanisms for timely and effective sharing of information and other resources on an ongoing basis, including times of crisis; and
- (7) Disseminate information on the work of the network to inform and influence the development of emergency and disaster management policy and resource allocation.

The APEDNN *Capacity-building Framework*, developed after the initial APEDNN needs assessment and its' 2007 inaugural meeting was briefly explained by Ms Fritsch, noting that it is based on the needs assessment, the disaster management continuum and an analysis of emergency and disaster competency sets undertaken by Ms Lisa Conlon and Dr Sheila Bonito (see Annex 4). The framework identifies core capacity-building courses linked to sequential phases of the disaster management continuum. The presenters suggested that the framework serve as a living plan and be flexible to suggestions and revisions. The global disaster nursing competencies<sup>1</sup> are undergoing validation in selected countries.

The *APEDNN Conceptual Framework*, (see Annex 5), developed by Dr Beth Marks, was presented by Dr Kim Usher, noting that some changes had been made to facilitate understanding of its purpose and application.

The APEDNN conceptual model or framework illustrates an ecological guiding approach to the work of the network. It is meant to show community, nursing and country interpersonal, socio-cultural, policy, environmental and other contextual factors influencing and guiding the work of APEDNN, its aim, strategic objectives, activities and desired network outcomes and impact.

Contextual ecological factors or characteristics are listed in the first or left hand column. The boxes in column one contain factors denoting characteristics of nurses and other health

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<sup>1</sup> ICN and WHO Western Pacific Region. *ICN framework of disaster nursing competencies*. Manila, World Health Organization, 2009.

workers, as well as environmental and country contextual factors underlying and influencing the work of APEDNN. Strategic interventions are listed in column two, accompanied by the expected short-to medium term outcomes in column three. The impact of the work of the APEDNN, in relation to its' aim and strategic objectives is described in the final, fourth column of the framework.

Within this conceptual model or approach, participation, inclusiveness and collaboration are emphasized, aimed at achieving outcomes which mitigate the impact of disasters, through enhanced capacities and responses, community empowerment and resilience.

Associate Professor Yuli Zang, Shandong University, agreed to make arrangements to have the foundational APEDNN documents and meeting reports posted on the APEDNN website. The site enables the inputting of comments from users. There was general agreement that the network vision, mission, objectives and conceptual framework be reviewed at the next APEDNN meeting, to serve as a foundational context underlying the ongoing work of the network. Participants were encouraged to post comments on the website for integration into the revised conceptual model.

### 2.3 Day Three: Monday, 8 November, 2010 — Asia Pacific Emergency and Disaster Nursing Network (APEDNN) and South Pacific Chief Nursing and Midwifery Officers Alliance (SPCNMOA) Combined Meetings

The meetings commenced with a Powhiri Ceremony and morning tea in conjunction with the South Pacific Nurses Forum.

#### 2.3.1 Welcome address and opening remarks

Introductions were delivered by Ms Kathleen Fritsch, Regional Adviser in Nursing, WHO Western Pacific Region, who stated that the meetings had been combined to permit the sharing of experiences and plenary presentations by keynote speakers and to enable delegates to join the South Pacific Nursing Forum Powhiri. The meetings ran concurrent sessions in the afternoon to support the WHO South Pacific, Pacific Human Resources for Health Alliance (PHRHA) AusAID funded project consultation, Enhancing Standards for Pacific Nursing, coordinated by James Cook University and Auckland University of Technology.

#### 2.3.2 Keynote presentation: Total care requirements of burn patients – implications for a disaster management planning

Dr Richard Wong She, plastic surgeon and Clinical Leader for Burns, National Burn Centre, New Zealand, described the reasons why burn injuries create special care and system needs. He presented case study examples and statistical data showing that as surgeon takes on more patients, increased nursing hours are concomitantly required. The statistics presented enable the forecasting of nursing, surgical and operating theatre hours based on the type and degree of burn. For a possible mass casualty scenario the degree of injury makes all the difference to the length of care and resources required.

Dr Wong She stated that health professional education and practice must include evidence-based pathways to help to standardize care. He concluded that a focus on systems analysis and quality improvement make us aware of our limitations, which enables preparation for what happens tomorrow.

### 2.3.3 Partner and research updates

#### 2.3.3.1 APEDNN web platform

The aims of the APEDNN web platform and the results of a stakeholder analysis of APEDNN web users and potential sponsors or partners were presented by Dr Amy Zang, Shandong University, China. Dr Zang also explained how the web platform contributes to the achievement of APEDNN objectives through:

- The sharing of information and resources;
- The development of multi-disciplinary networking activities;
- The dissemination of tools, materials, training courses and evidence, research to improve emergency and disaster education and practice; and
- Increasing interactions, quality of work processes and productivity.

The session concluded with agreement that improving the web-based service to meet users' needs is the highest priority for the developer of the APEDNN web platform. The need to secure resources to sustain the development and maintenance of web platform was highlighted.

#### 2.3.3.2 International Council of Nurses (ICN) — Ms Rosemary Bryant

Ms Rosemary Bryant, International Council of Nursing representative and Chief Nurse and Midwifery Officer, Department of Health and Ageing (Mental Health and Workforce Division), Australia, stressed the need for using evidence and promoting nurses contributions to healthcare. Ms Bryant extended an open invitation to the upcoming ICN 2011 Congress in Malta, which will be focused on driving access to quality care. She explained that the ICN continues working in many areas, including emergency and disaster related work. ICN is working with Haiti to reduce the number of local nurses being out of work secondary to a large number of aid organisations with nurses in-country who are favoured over local nurses.

#### 2.3.3.3 Sigma Theta Tau International

Ms Cynthia Vlasich, of Sigma Theta Tau International, encouraged delegates to use the internet to find the Sigma Theta Tau International (STTI) organisation's web site if they have not yet done so. She explained it is the honour society of the nursing profession, composed of members who have distinguished themselves through nursing. The STTI has recently begun working in partnership with the ICN and WHO on various projects. Meeting members were invited to apply to join the honour society.

#### 2.3.3.4 World Association of Disaster Emergency Medicine (WADEM)

Professor Arbon, of Flinders University, referred delegates to the World Association of Disaster Emergency Medicine's (WADEM) website ([www.wadem.medicine.wisc.edu](http://www.wadem.medicine.wisc.edu)) and explained that the organization is multidisciplinary and nurses are seen as a key part of it. He advised the group that the 17<sup>th</sup> World Congress on Disaster and Emergency Medicine will be held in Beijing, China next year with 11 consecutive sessions, with topics from land mines to nursing and infection control. Professor Arbon also briefly described WADEM's work to

develop best standards of practice through committees and taskforces, and encouraged delegates to view the website and consider joining.

#### 2.3.3.5 Health Professions Networks, Nursing and Midwifery in WHO

Dr Eric Chan, Acting Coordinator, Health Professions and Chief Scientist for Nursing and Midwifery, World Health Organisation Headquarters, reported on the work over the past few months in the WHO Headquarters within the Health Systems Strengthening and Services Cluster. The work in the Human Resources for Health Department of the Cluster is seen as very important in relation to MDG issues and the major shortage of health professional worldwide. The social determinants of health were discussed, including general socio-economic, cultural and environmental conditions, social and community networks, and individual lifestyle factors.

Dr Chan presented some key recent WHO publications:

- Global standards on the initial education of professional nurses and midwives – 2009;
- A compendium of primary care case studies – 2009;
- Framework for action on Inter-professional Education & Collaborative Practice – 2010;
- A Global Survey Monitoring Progress in Nursing and Midwifery – 2010; and
- Global policy recommendations: Increasing access to health workers in remote and rural areas through improved retention -2010.

#### 2.3.3.6 Health Professions Networks, Nursing and Midwifery

The concurrent session of the WHO South Pacific PHRHA AusAID funded project on enhancing academic standards in the Pacific was co-facilitated by Professor Kim Usher, James Cook University and Ms Mary MacManus Auckland University of Technology. This session, targeted towards South Pacific nurse educators and leaders, was recorded by the project team with the expectation of a report being issued in due course.

#### 2.3.3.7 Korean Armed Forces Nursing Academy Disaster Education Update

Lieutenant Colonel Yoo Myoungan, Chief of the Department of Nursing Science of the Armed Forces Nursing Academy, South Korea, focused her presentation on the increasing number and scale of disaster victims and the corresponding increased need for healthcare providers. The responsibilities of nurses were outlined in accordance with the Korean Nurses' Code of ethics. She introduced the Armed Forces Nursing Academy and its training role to improve nurses' competency to respond in emergency situations through its Comprehensive Disaster Nursing courses (CDNC), and International Disaster Nursing Conference. Special education methods include problem based learning, skills practice, simulation based learning and actual drill based learning. These methods aim to improve critical thinking abilities, practical competencies and management and control capacities. Course evaluations to date have had positive results with high levels of competency reported. Future plans include the development of web-based educational materials and integrated training with other disciplines.

#### 2.3.3.8 Australian Trauma Society

Ms Jodi Orchard, Trauma Clinical Nurse Specialist, introduced participants to the Australian Trauma Society (ATS), a vital source of multi-disciplinary professional collaboration and expertise. The ATS can be accessed via its' website ([www.traumasociety.com.au](http://www.traumasociety.com.au)). In her role at North Shore Hospital, as a secondary level provider and case manager for major trauma cases, responsible for the assessment of all trauma cases coming to the hospital, she reported that her involvement with the trauma nurses interest group of the ATS has been very beneficial. The ATS currently has 200 members; its' membership fee of \$100+ allows access to online journals, networking online, peer support and review, email contacts and invitation to its' annual meeting.

#### 2.3.3.9 Disaster Nursing Nomenclature

Dr Lidia Mayner, Flinders University Research Program for Disaster Nursing, introduced the International Council of Nursing's (ICN) International Classification for Nursing Practice (ICNP) unified disaster language system. The ICNP, a database of compositional terminology for nursing practice facilitates the development of and the cross-mapping among local terms and existing terminologies. It is currently a work in progress employing systematic glossary and bibliometric analysis techniques and can be used to build a nursing practice plan for disaster nursing based on scientific research and evidence.

#### 2.3.3.10 Medical Reserve Corps

Dr Qureshi presented the mission of the Medical Reserve Corp (MRC), which represents a team of local volunteers who are prepared to contribute their skills and expertise during times of public health emergencies, and for medical and public health service throughout the year. The MRC is comprised of local volunteers prepared to assist during a disaster through public health surge capacity. Dr Qureshi stressed that the MRC fills in gaps but does not duplicate efforts of other organisations. The MRC functions in a variety of venues (such as community settings, volunteer organisations, hospitals, pre-hospital settings) and works in collaboration with other organizations and services.

Medical reserve Corps volunteers are expected to be able to:

- (1) Describe communication roles(s) and processes with response partners, media, the general public and others;
- (2) describe procedures and steps necessary to protect the health, safety and overall well being of themselves, their families, the team and the community;
- (3) Document a personal and family emergency plan;
- (4) Describe the chain of command;
- (5) describe the role of the MRC unit in public health and /or emergency response;
- (6) describe the impact of an event on the mental health of the MRC members, responders and others;

- (7) Demonstrate ability to follow procedures for assignment, activation, reporting and deactivation; and
- (8) Identify limits to own skills, knowledge, and abilities as they pertain to MRC roles.

The role of MRC Volunteers in disaster response was outlined and includes functions that support the maintenance of essential services and emergency response. Dr Qureshi explained that MRC members will be able to make a significant contribution to fulfilling disaster surge capacity and public health needs of the community.

#### 2.3.4 APEDNN 2010 Summative Action Planning, Evaluation and Closure

Ms Kathleen Fritsch, Regional Adviser in Nursing, WHO Western Pacific explained that the 2011 APEDNN meeting will be held in Seoul, South Korea in October or November. The focus for this meeting will be how to continue move forward, guided by the APEDNN mission, conceptual framework and strategic objectives, including the integration of quality improvement into the APEDNN objectives.

Quality improvement capacity-building is also closely linked with the work of the SPCNMOA, in building leadership and strategic planning capacities and continuously evaluating the contributions of nursing and midwifery to health system performance. The Institute for Health Systems Research, Ministry of Health, Malaysia, a WHO Collaborating Centre for Health Systems Research and Quality Improvement, has been instrumental in facilitating in various quality improvement training programs in the Pacific Islands as well as in the Asia Region.

An invitation was extended to those members who have not yet participated in the Safety, Quality, Trauma survey in the hope that it can be used to better plan for people's needs and more effective capacity building in the Pacific sub-region. Ms Fritsch suggested that surveys from clusters would provide broader baseline data, to build on the preliminary data analysis undertaken to date. She also suggested that results could be fed back for subsequent planning through the use of Elluminate.

The upcoming intensive bi-regional infection control training course being convened in Hong Kong was described as a key step in building nursing and midwifery capacities for quality and safety improvements through the application of IC principles and practices. Northern Pacific Island nurses will also move forward in moving forward with the QI and IC training, focused on improving hand hygiene practices. It is hoped that the outcomes of these training programs will be presented in the 2012 APEDNN meeting.

Ms Fritsch thanked the day's keynote speaker, Dr Richard Wong and emphasised the importance of planning ahead through continuous quality improvement. She emphasized that APEDNN has an obligation, through its' mission statement, to support local communities to stay healthy and resilient to prepare for and respond to disasters. Better and increased ways of partnering can support communities in becoming more resilient.

Dr Josefina Tuazon suggested looking at more efficient ways of organizing the network and volunteered to examine what is needed for more active involvement in the foundational work of the network. The James Cook University WHO Collaborating Centre had also agreed to serve as the secretariat, on a rotational two-yearly basis. The core working groups for course development and information dissemination through the network were acknowledged and

Associate Professor Amy Zang was thanked for her work in developing and maintaining the web site and server. Ms Fritsch agreed to liaise with other WHO staff in regard to administrative structures used by other groups and networks.

Dr Qureshi reflected that the APEDNN group started in a small way and may now have outgrown some processes. She suggested that Elluminate could be used monthly for working group communication. It was generally agreed that this would encourage greater input from more people, would be easy to do, and should be implemented. Dr Qureshi addressed the issue of the meeting evaluation and what is done with the information during the course of the year. She suggested that it could be used as guide to ascertain what worked and what was less successful. It was agreed that people do like interaction in presentations – and in the future perhaps only 15 or fewer slides in a presentation are necessary for use as talking points.

Upon the return of South Pacific colleagues from the concurrent session, Ms Fritsch discussed with the entire group how APEDNN would move forward, and ways to structure the network to be more efficient.

Dr Jane O'Malley reflected on the big journey this meeting had been and that this meeting had been a gift to New Zealand. She thanked delegate for their contribution.

Next year's meeting in Korea October - November 2011 was flagged. Delegates were encouraged to start fundraising immediately and the large team of partners, supporters and donors was thanked for their contributions to this meeting to enable delegates to share lessons learned and build quality improvement capacities in disaster preparedness and response. The next step is to go back and report on the meeting's accomplishments at national level and work towards the next steps, including the uptake and capacity-building through use of the APEDNN Psychosocial Health and Disaster Course in 2011.

The APEDNN meeting was closed with a song in the Pacific way.

LIST OF PARTICIPANTS: APEDNN 2010 MEETING AND CAPACITY-BUILDING WORKSHOPS  
AUCKLAND, NEW ZEALAND, 6-8 NOVEMBER 2010

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
1.	Ms	Rosemary	Bryant	Australia	Chief Nursing and Midwifery Officer Department of Health and Ageing Mental Health and Workforce Division	<a href="mailto:rosemary.bryant@health.gov.au">rosemary.bryant@health.gov.au</a>
2.	Prof	Kim	Usher	Australia	Director of Research; Associate Dean of Research Studies James Cook University School of Nursing, Midwifery & Nutrition	<a href="mailto:kim.usher@jcu.edu.au">kim.usher@jcu.edu.au</a>
3.	Ms	Michele	Rumsey	Australia	Director of Operations and Development Faculty of Nursing, Midwifery & Health, University of Technology, Sydney (UTS) WHO Collaborating Centre for Nursing, Midwifery and Health Development	<a href="mailto:michele.rumsey@uts.edu.au">michele.rumsey@uts.edu.au</a>
4.	Prof	Denise	Dignam	Australia	Associate Dean (Teaching and Learning) University of Technology, Sydney Faculty of Nursing Midwifery and Health	<a href="mailto:Denise.Dignam@uts.edu.au">Denise.Dignam@uts.edu.au</a>
5.	Prof	Paul	Arbon, AM	Australia	Dean Flinders University School of Nursing and Midwifery, Faculty of Health Sciences	<a href="mailto:paul.arbon@flinders.edu.au">paul.arbon@flinders.edu.au</a>
6.	Dr	Lidia	Mayner	Australia	Senior Lecturer & Inaugural Director , FURP for Disaster Nursing, ICN Accredited Centre for (ICNP®) R&D Flinders University	<a href="mailto:lidia.mayner@flinders.edu.au">lidia.mayner@flinders.edu.au</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
					School of Nursing and Midwifery, Faculty of Health Sciences	
7.	Ms	Anne	Christie	Australia	Volunteer University of Technology, Sydney FNMH	
8.	Ms	Amanda	Neill	Australia	Project Manager University of Technology, Sydney FNMH	
9.	Mr	Tyson	Sofo	Australia	Senior Analyst University of Technology, Sydney	
10.	Dr	Renee	Henry	Australia	James Cook University	
11.	Ms	Caryn	West	Australia	James Cook University	
12.	Dr	Marcia	Petrini	China	Wuhan University	<a href="mailto:mapetrini@yahoo.com">mapetrini@yahoo.com</a>
13.	Dr	Yuli 'Amy'	Zang	China	Associate Professor Shandong University School of Nursing	<a href="mailto:yulizh@sdu.edu.au">yulizh@sdu.edu.au</a> / <a href="mailto:zylpear2005hk@hotmail.com">zylpear2005hk@hotmail.com</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
14.	Ms	Sunshine	Chan	China	Nurse Consultant The Hong Kong Polytechnic University School of Nursing	<a href="mailto:hschan@inet.polyu.edu.hk">hschan@inet.polyu.edu.hk</a>
15.	Mr	Kevin	Leung	China	Clinical Associate The Hong Kong Polytechnic University School of Nursing	<a href="mailto:hslk@inet.polyu.edu.hk">hslk@inet.polyu.edu.hk</a>
16.	Mr	Sijian	Li	China	Lecturer The Hong Kong Polytechnic University, School of Nursing	<a href="mailto:hssjli@inet.polyu.edu.hk">hssjli@inet.polyu.edu.hk</a>
17.	Mr	Timothy	Lai	China	Advanced Practice Nurse The Hong Kong Polytechnic University School of Nursing	<a href="mailto:hskhlai@inet.polyu.edu.hk">hskhlai@inet.polyu.edu.hk</a> ,
18.	Ms	Iokopeta	Ngari	Cook Islands	Director of Nursing Cook Islands Ministry of Health	<a href="mailto:i.ngari@health.gov.ck">i.ngari@health.gov.ck</a>
19.	Mrs	Ngakiri	Teaea	Cook Islands	Charge Nurse Medical Ward / Lecturer Cook Islands Nursing School	<a href="mailto:n.teaea@health.gov.ck">n.teaea@health.gov.ck</a>
20.	Sr	Unaisi	Sikivou	Fiji		
21.	Mr	Albert	McLaren	Fiji	Director, Fiji School of Nursing	
22.	Dr	Maureen	Shannon	Hawaii, USA	Associate Professor University of Hawaii at Manoa School of Nursing and Dental Hygiene	<a href="mailto:mshannon8387@yahoo.com">mshannon8387@yahoo.com</a>
23.	Dr	Eric	Chan	Switzerland	Coordinator Health Professions, Chief Scientist	<a href="mailto:chane@who.int">chane@who.int</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
					Nursing and Midwifery World Health Organisation Department of Human Resources for Health	
24.	Prof	Aiko	Yamamoto	Japan	Professor and Executive Director University of Hyogo Research Institute of Nursing Care for People and Community	<a href="mailto:a_yamamoto@cnas.u-hyogo.ac.jp">a_yamamoto@cnas.u-hyogo.ac.jp</a>
25.	Ms	Maaka	Rui	Kiribati	Dy Director of Nursing Ministry of Health and Medical Services Tungaru Central Hospital	<a href="mailto:maakarui@yahoo.com/mr.teiwaki@gmail.com">maakarui@yahoo.com/mr.teiwaki@gmail.com</a>
26.	YH Dato'Hjh. (Mrs)	Fathilah	Hj. Abd. Wahab	Malaysia	Director of Nursing, Malaysia / Registrar of Nursing Board, Malaysia Ministry of Health Nursing Division	<a href="mailto:fathilah_ab@moh.gov.my">fathilah_ab@moh.gov.my</a>
27.	Matron	Leela	Chellamuthu	Malaysia	Assistant Director of Nursing Ministry of Health Nursing Division	<a href="mailto:leela@moh.gov.my">leela@moh.gov.my</a>
28.	Ms	Hillia	Langrine	Marshall Islands	Deputy Chief Nurse Public Health Majuro Public Health	<a href="mailto:hkonou@yahoo.com">hkonou@yahoo.com</a>
29.	Ms	Rensely Philip	Alik	Marshall Islands	Vice President College of the Marshall Islands American Pacific Nursing Leaders Council	<a href="mailto:renalik04@gmail.com">renalik04@gmail.com</a>
30.	Ms	Gano	Mwareow	Nauru	Director of Nursing Republic of Nauru Hospital	

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
31.	Ms	Leanne	Samuel	New Zealand	Chief Nursing and Midwifery Officer Southern DHB	<a href="mailto:Leanne.Samuel@southerndhb.govt.nz">Leanne.Samuel@southerndhb.govt.nz</a>
32.	Ms	Jocelyn	Peach	New Zealand	Director of Nursing & Midwifery, Emergency Systems Planner Waitemata District Health Board	<a href="mailto:Jocelyn.Peach@waitematadhb.govt.nz">Jocelyn.Peach@waitematadhb.govt.nz</a>
33.	Ms	Gillian	Bohm	New Zealand	Principal Advisor Quality Improvement Ministry of Health Health Quality and Safety Commission, Sector Capability and Implementation Directorate	<a href="mailto:Gillian_Bohm@moh.govt.nz">Gillian_Bohm@moh.govt.nz</a>
34.	Ms	Mary	Gordon	New Zealand	Executive Director of Nursing Canterbury District Health Board The Princess Margaret Hospital	<a href="mailto:Mary.Gordon@cdhb.govt.nz">Mary.Gordon@cdhb.govt.nz</a>
35.	Dr	Richard	Wong Shee	New Zealand	Consultant Plastic and Reconstructive Surgeon, Department of Plastic & Reconstructive Surgery and Clinical Leader for Burns, National Burn Centre, Middlemore Hospital	<a href="mailto:Richard.WongShee@cmdhb.org.nz">Richard.WongShee@cmdhb.org.nz</a>
36.	Dr	Jane	O'Malley	New Zealand	Chief Nurse Ministry of Health Sector Capability and Implementation Directorate	<a href="mailto:Jane.O'Malley@moh.govt.nz">Jane.O'Malley@moh.govt.nz</a>
37.	Dr	Lesley	Seaton	New Zealand	WHO CC UTS (New Zealand)	

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
38.	Ms	Jodie	Orchard	New Zealand	Waitemata DHB, North Shore Hospital	
39.	Dr	Josefina	Tuazon	Philippines	Professor and Dean University of Philippines College of Nursing	<a href="mailto:josefina_tuazon@yahoo.com">josefina_tuazon@yahoo.com</a>
40.	Ms	Kathleen	Fritsch	Philippines	Regional Adviser in Nursing WHO WPRO	<a href="mailto:fritschk@wpro.who.int">fritschk@wpro.who.int</a>
41.	Ms	Monica	Fong	Philippines	Technical Officer WHO South Pacific Office Human Resources and Health Systems Research	<a href="mailto:fongm@wpro.who.int">fongm@wpro.who.int</a>
42.	Ms	Sheila	Bonito	Phillippines	Assistant Professor University of Philippines	<a href="mailto:bonito_s@hotmail.com">bonito_s@hotmail.com</a>
43.	Mrs	Pelenatete	Stowers	Samoa	A/CEO Ministry of Health Health Services Performance, QA	<a href="mailto:pelenatetes@health.gov.ws">pelenatetes@health.gov.ws</a>
44.	Mrs	Fulisia	Aiavao	Samoa	Dean National University of Samoa	<a href="mailto:f.aiavao@nus.edu.ws">f.aiavao@nus.edu.ws</a>
45.	Ms	Maatasesa	Mathes	Samoa	Observer National Health Services	
46.	Mr	William	Same	Solomon Islands	President Solomon Islands Nurses Association	<a href="mailto:wsame@moh.gov.sb">wsame@moh.gov.sb</a>
47.	Mr	Michael	Larui	Solomon Islands	National Director of Nursing Solomon Islands Government	<a href="mailto:mlarui@moh.gov.sb">mlarui@moh.gov.sb</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
					Ministry of Health and Medical Services	
48.	Ms	Verzilyn	Isom	Solomon Islands	Head of School Solomon Islands College of Higher Education School of Nursing and Health Studies	<a href="mailto:snhs@siche.edu.sb">snhs@siche.edu.sb</a>
49.	Mr	George	Pego	Solomon Islands	National Deputy Head of Nursing National Deputy Head of Nursing Development	
50.	Prof	Il Young	Yoo	South Korea	Yonsei University College of Nursing	<a href="mailto:iyoo@yuhs.ac">iyoo@yuhs.ac</a>
51.	Major	Joe	SeunYoung	South Korea	Professor of Community Health Nursing Armed Forces Nursing Academy	<a href="mailto:afna4551@mnd.go.kr">afna4551@mnd.go.kr</a>
52.	LTC	MyoungRan	Yoo	South Korea	Director Armed Forces Nursing Academy Department of Nursing Science, Disaster Nursing Education Center	<a href="mailto:7179ymr@hanmail.net">7179ymr@hanmail.net</a>
53.	Ms	Liza	Kelekolio	Tokelau	Health Manager / Acting Nurse Advisor & Cervical Screening Coordinator Tokelau National Health Department Health training Coordinator	<a href="mailto:liza.kelekolio@lesamoa.net">liza.kelekolio@lesamoa.net</a>
54.	Ms	Faimanifo	Peseta	Tokelau	EPI and HIV Coordinator Tokelau National Health Department	<a href="mailto:fmpeseta@lesamoa.net">fmpeseta@lesamoa.net</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
					Tokelau Apia Liaison Office	
55.	Mrs	Seilini	Soakai	Tonga	Senior Nursing Sister/ Sister In-charge of the National Centre for Diabetes and Cardiovascular Diseases Tonga Nurses Association	<a href="mailto:ssoakai@health.gov.to">ssoakai@health.gov.to</a> / <a href="mailto:seilinisokaikai@yahoo.com">seilinisokaikai@yahoo.com</a>
56.	Mrs	Fatafehi	Atalua Tei	Tonga	Nursing Sister, Supervising Public Health Sister Ministry of Health	<a href="mailto:fehitei@yahoo.com">fehitei@yahoo.com</a>
57.	Ms	Sela	Passi	Tonga	Chief Executive Officer Ministry of Health	<a href="mailto:spaasi@health.gov.to">spaasi@health.gov.to</a>
58.	Ms	Amelia Latu	Afuhaamango Tu'ipulotu	Tonga	Senior Lecturer Queen Salote School of Nursing	<a href="mailto:amyafuhaamango@hotmail.com">amyafuhaamango@hotmail.com</a>
59.	Mrs	Eline	Soloseni	Tuvalu	Hospital Sister Princess Margaret Hospital	<a href="mailto:tagialofa@yahoo.com">tagialofa@yahoo.com</a>
60.	Ms	Cynthia	Vlasich	USA	Director Sigma Theta Tau International Education and Leadership	<a href="mailto:Cynthia@stti.iupui.edu">Cynthia@stti.iupui.edu</a>
61.	Dr	Kristine	Qureshi	USA	Associate Professor University of Hawaii at Manoa School of Nursing and Dental Hygiene	<a href="mailto:kqureshi@hawaii.edu">kqureshi@hawaii.edu</a>
62.	Mr	John	Tasserei	Vanuatu	Chairman Vanuatu Nursing Council	<a href="mailto:jtasserei@vanuatu.gov.vu">jtasserei@vanuatu.gov.vu</a>
63.	Mr	Viran	Tovu	Vanuatu	Acting Senior Health Planner	<a href="mailto:vtovu@vanuatu.gov.vu">vtovu@vanuatu.gov.vu</a>

No	Title	First Name	Last Name	Country	Position Organisation Unit	Email contact
					Ministry of Health Planning Office	
64.	Mrs	Rosari	Maurice	Vanuatu	Clinical Tutor Vanuatu College for Nursing Education	<a href="mailto:mrosaria@vanuatu.gov.au">mrosaria@vanuatu.gov.au</a>
65.	Mrs	Leipakoa	Matariki	Vanuatu	Hospital Manager Vila Central Hospital	
66.	Ms	Bich Luu	Nguyen	Vietnam	Chief of Nursing Office Ministry of Health Administration for Medical Service	<a href="mailto:luu1705@gmail.com">luu1705@gmail.com</a>



MEETING AGENDA: APEDNN 2010 MEETING, AIMS AND OUTCOMES  
AUCKLAND, NEW ZEALAND, 6-8 NOVEMBER 2010<sup>2</sup>

**SYSTEM-WIDE QUALITY IMPROVEMENT: THE FOUNDATION OF EMERGENCY AND  
DISASTER RESILIENCE**

**Meeting Aim:**

Enable nurses, facilities and communities to improve trauma and disaster systems of care in partnership with other professions, stakeholders and communities, through research, capacity-building and policy development.

**Expected Outcomes:**

By the end of the meeting and capacity-building workshops, participants will have:

1. Identified key variables and interventions to improve trauma and disaster care;
2. Discussed and finalized the APEDNN conceptual framework;
3. Identified lessons learned from recent disasters to strengthen national, local, institutional trauma care and disaster preparedness and response;
4. Demonstrated new knowledge and/or skills in selected aspects of participatory learning approaches and technical areas of quality improvement, trauma and disaster systems of care and mental health and disasters;
5. Agreed upon shared methods to promote research around emergency-disaster nursing and quality improvement; and
6. Formulated action plans focused on the 2001-2011 core capacity-building course and accompanying research, monitoring, evaluation and reporting.

**Venue**

Aotea Center, Auckland

*Note: Concurrent scheduling of sessions with SPCNMOA on DAY 3 of APEDNN meeting.*

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<sup>2</sup> *Note: Core working group members to arrive 4<sup>th</sup> November, for preparatory meetings on 5<sup>th</sup> November, for final logistical, administrative, technical planning discussion*

**APEDNN 2010 PROGRAMME: DAY 1, Saturday 6<sup>th</sup> November 2010**  
**SYSTEM-WIDE QUALITY IMPROVEMENT: THE FOUNDATION OF**  
**EMERGENCY AND DISASTER RESILIENCE**

<b>Time</b>	<b>Session</b>	<b>Expected Outcomes</b>	<b>Outcomes achieved</b>
0800	Registration: <b>Upper NZI Room 4, Aotea Center, Auckland</b>		
0900-1030 1030-1045 1045-1130 1130-1230	<p>Powhiri; Opening Ceremony Remarks; Morning Tea</p> <p><b>Session 1.1</b> Meeting Overview, expected outcomes, working processes— Kathleen Fritsch, WHO</p> <p>• Participant Introductions</p> <p><b>Session 1.2</b> Keynote Presentation: Quality Improvement and Its Applicability to Trauma, Disasters—Gillian Bohm, Principal Advisor Quality Improvement, Health Quality and Safety Commission, Ministry of Health, New Zealand</p> <p><b>Session 1.3</b> Country case studies/lessons learned from quality and primary health care perspectives</p> <ul style="list-style-type: none"> <li>○ <b>Malaysia</b>—Dato' Hjh. Fathilah Hj. Abd. Wahab; Matron Leela Chellamuthu, Assistant Nursing Director</li> <li>○ <b>Philippines</b>—Sheila Bonito, Josefina Tuazon</li> <li>○ <b>New Zealand</b>—Mary Gordon, Executive Director of Nursing position, Canterbury District Health Board</li> </ul>	<b>1, 4</b>          <b>3</b>	<b>Met</b>          <b>Met</b>
<b>Lunch</b>			
1330-1415	<p><b>Meeting Overview</b>—Michelle Rumsey</p> <p><b>Session 1.4</b> Safety, Quality/Trauma Survey, Contextual Analysis— Preliminary Results—Lesley Seaton</p>	<b>1, 4</b>	<b>Met</b>
1415-1515	<p><b>Session 1.5</b> Introduction to Quality Improvement—Gillian Bohm</p>	<b>1, 4</b>	<b>Met</b>
1515-1530	<b>Afternoon Tea</b>		
1530-1630	<p><b>Session 1.6</b> QI in Trauma, Disaster Care: Essentials that Make a Difference in Outcomes, Dr Ted Hughes; Intensivist; and Jodie Orchard, Trauma Clinical Nurse Specialist, North Shore Hospital</p>	<b>1,3, 4</b>	<b>Met</b>
1630-1700	<p><b>Session 1.7</b> Day 1 Summary: Emergency Operations Centre Applying QI Lessons Learned from the New Zealand Earthquake: Mary Gordon</p>	<b>1, 3, 4</b>	<b>Met</b>
1700-1800	<b>WPRO / UTS Reception Upper NZI Room, Number 4,</b>		

**APEDNN 2010 PROGRAMME: DAY 2, Sunday 7<sup>th</sup> November 2010**  
*Quality Improvement In Trauma and Disaster Care---A Systems Perspective*

<b>Time</b>	<b>Session</b>	<b>Expected Outcomes</b>	<b>Outcomes achieved</b>
0830-0930	<b>Session 2.1</b> Keynote Presentation—Disaster Systems of Care, Leanne Samuel, New Zealand Southern District Health Board	<b>4</b>	<b>Met</b>
0930-1000	<b>Session 2.2</b> HRH Staffing for Emergency Rooms During Times of Disasters, Kristine Qureshi	<b>4</b>	<b>Met</b>
10:00-1030	<b>Session 2.3</b> Evaluation of the WHO Safe Hospitals Tool----Gillian Bohm	<b>3</b>	<b>Met</b>
1030-1045	<b>Morning Tea</b>		
1045-1115	<b>Session 2.4</b> Pre-Hospital Quality Improvement, Paul Arbon, WADEM	<b>3,4</b>	<b>Met</b>
1115-1200	<b>Session 2.5</b> Logistical Preparedness: Working with Communities, Partners, Cynthia Vlasich, Director, Education and Leadership Sigma Theta Tau International	<b>3,4</b>	<b>Met</b>
1200-1230	<b>Session 2.6</b> Alternate Care Sites---Planning & Operations, Kristine Qureshi	<b>3,4</b>	<b>Met</b>
<b>Lunch</b>			
1330-1500	<b>Session 2.7</b> Quality Improvement in Psychosocial Health and Disaster Care---APEDNN Psychosocial Health and Disaster Course. Prof Kim Usher, James Cook University	<b>1,3, 4</b>	<b>Met</b>
<b>Afternoon Tea</b>			
1530-1545	<b>Session 2.8</b> Feedback Regional Infection Control Assessment Tool – Malaysia Ms Leela Chellamuthu, Principal Assistant Nursing Director, Ministry of Health Malaysia	<b>1,4</b>	<b>Met</b>
1545-1700	<b>Session 2.9</b> Overview of Infection Control in the region Dr Eric Chan, World Health Organisation	<b>4</b>	<b>Met</b>
	<b>Session 2.10</b> An overview of Alternate Care Sites – Planning and Operations in the State of Hawaii, USA, Dr Kristine Qureshi, University of Hawaii at Manoa	<b>1,3,4</b>	<b>Met</b>
	<b>Session 2.11</b> Review of APEDNN Vision, Mission and Objectives, Dr Kristine Qureshi, University of Hawaii at Manoa, and Assistant Professor Sheila Bonito, University of The Philippines	<b>2,3,4,5,6</b>	<b>Met</b>

**APEDNN 2010 PROGRAMME: DAY 3**  
**and SPCNMOA 2010 PROGRAMME: DAY 1, Monday 8<sup>th</sup> November, 2010**

<b>Time</b>	<b>Session</b>	<b>Expected Outcomes</b>	<b>Outcomes achieved</b>
	<b>Quality Improvement In Trauma and Disaster Care---A Systems Perspective</b>		
0900-1100	Powhiri Opening Ceremony and Morning Tea <i>BNZ Foyer, Aotea Center</i>		
1130-1215	<b>Session 3.1</b> Keynote Presentation: Total Care Requirements of Burn Patients—Implications for A Disaster Management Plan. Delivered by: Richard Wong She, Plastic Surgeon, Middlemore Hospital, Clinical Leader for Burns. National Burn Centre.  Upper NZI Room 4, Aotea Center	<b>3,4</b>	<b>Met</b>
<b>Lunch</b>			
1315-1415	<b>Session 3.2</b> Global Partner Updates: APEDNN Web Site, Amy Zang, Shandong University International Council of Nurses---Rosemary Bryant Sigma Theta Tau International, Cynthia Vlasich World Association of Disaster Emergency Medicine, Paul Arbon World Health Organization, Eric Chan	<b>1, 4</b>	<b>Met</b>

**CONCURRENT SESSIONS: APEDNN and SPCNMOA**

1415-1500	<b>Session 3.3 [APEDNN]</b> <b>Research and Partner Updates</b> <ul style="list-style-type: none"> <li>• Korean Armed Forces Nursing Academy, Disaster Education Update—LTC Yoo</li> <li>• AUSTRALASIAN Trauma Society; Jodie Orchard</li> <li>• ICNP Disaster Nursing Centre, Disaster Nomenclature, Lidia Mayner</li> <li>• Kristine Qureshi:-Medical Reserve Corps (MRC), Kristine Qureshi</li> </ul>	<b>1, 4</b>	<b>Met</b>
1500-1530	<b>Afternoon Tea</b>		
1530-1630	<b>Session 3.4</b> Summative Action Planning Evaluation and Closure	<b>5</b>	<b>Met</b>
Evening 1830	Official SPNF Dinner Hosted By Te Runanga O Aotearoa Venue: <b>BNZ Foyer</b>		

## APEDNN VISION, MISSION, OBJECTIVES, CAPACITY BUILDING FRAMEWORK

**Vision:** A leader in the Asia Pacific region for emergency and disaster nursing for safer and resilient communities.

**Mission:** Advance a professional network of nurses and partners to support communities for prevention, mitigation, response, and recovery related to emergencies and disasters.

**Objectives:**

1. Establish a system for ongoing interaction among members to strengthen collaboration and capacity building.
2. Identify and validate emergency and disaster nursing competencies.
3. Develop and share tools, materials and training programmes in emergency and disaster nursing education, services and research.
4. Identify best practice standards and evidence-based guidelines and interventions using a quality improvement process.
5. Collaborate with others in establishing the research agenda for emergency and disaster nursing.
6. Implement mechanism for timely and effective sharing of information and other resources on an ongoing basis, including times of crisis
7. Disseminate information on the work of the network to inform and influence the development of emergency and disaster management policy and resource allocation.



APEDNN CAPACITY BUILDING FRAMEWORK

**DISASTER MANAGEMENT CONTINUUM GLOBAL COMPETENCIES**



CORE CURRICULAR DOMAINS





