Overseas Specialist Surgical Association of Australia (OSSAA)

Royal Australasian College of Surgeons (RACS)

Plastic Surgical team visit

HNGV, Dili, Timor Leste

25 May – 1 June 2019

Mark Moore, AM, FRACS

Plastic and Craniofacial Surgeon

Team leader , OSSAA

INTRODUCTION

This visit of the OSSAA plastic surgical team to HNGV, Dili in May-June represents the 20th year that our teams have been performing volunteer surgical missions and teaching in Timor Leste. Following the original agreement signed between Dr John Hargrave, on behalf of ASEA Rehab, and ICRC to provide reconstructive surgical services to the new nation in 2000, our teams have provided an uninterrupted service. On the first clinical mission in June 2000 were the present team leader (MM) and Dr Brian Spain, anaesthetist, so it was pleasing that we could be reunited for this memorable 20th anniversary visit.

Also we were fortunate to be able to work with a number of nurses/ theatre staff who were there back in 2000, as well as Mr Sarmento Correia, RACS in country coordinator, whom we first encountered when he was employed by MSF at Baucau Hospital. Whilst there have been many changes in this young country, some people have remained there for their people throughout the ups and downs of the last 20 years.

TEAM PERSONEL

The OSSAA team for this visit was comprised as follows :

Mr Mark Moore	Plastic and Craniofacial Surgeon Women's and Children's Hospital and Royal Adelaide Hospital, Adelaide.
Dr Brian Spain	Anaesthetist Royal Darwin Hospital, Darwin
Sr Joy Booth	Theatre Nurse / Educator Royal Adelaide Hospital, Adelaide
Sr Sandy Grixti	Anaesthetic / Recovery Nurse Royal Adelaide Hospital
Ms Celina Lai	Speech Pathologist Royal Darwin Hospital, Darwin

The team was once again accompanied by Dr Zameer Gill, a Plastic Surgical registrar, presently working in Launceston, Tasmania. He was able to assist us with photographic documentation of this visit.

PARTICIPATING LOCAL STAFF AND COUNTERPARTS

The team was assisted by our long term counterparts Dr Joao Ximenes (Plastic surgical trainee/ surgeon), HNGV, Mr Sarmento Faus Correia (RACS in country coordinator) and a number of other local medical and nursing staff in the outpatient, operating theatre and surgical ward environment. Dr Cesaltina (Noki) , who is Dr Joao X's junior staff, based at HNGV and at Aileu was present all week and assisted in outpatients and theatre – she is increasing her skills in plastic surgery and looks to be part of the next generation of plastic and reconstructive surgeons .

A number of local anaesthetic staff, nursing and medical worked closely with Dr Spain, and Mr Cornelio M Mok Freitas (Mok) led the theatre nursing staff who worked alongside the team all week.

OVERVIEW

Our OSSAA team visit to HNGV in May – June 2019 is both the 47th volunteer reconstructive surgical team mission to Timor Leste and the 20th anniversary of our first mission there.

The in-country preparation for the team was once again overseen by Mr Sarmento Correia, from the RACS office in Dili. Advertising for the assessment clinic was limited to promotion on local Timorese television, with no regional outreach pre-screening performed. As a consequence we saw patients from virtually all corners of the country – Suai in the south and west to Viqueque in the east. This resulted in 60 patients being assessed in the Saturday clinic, allowing for the production of surgical lists of about 8 cases per day throughout the upcoming week. Whilst a further 18 patients arrived later in the week, a number of whom also required surgery, we did have 4 cases cancelled or deferred because of chest or gastro-intestinal infections, allowing addition of several more to the surgical list. Those extra cleft cases who were from nearby regions and of a degree of severity that Dr Joao felt comfortable to treat were recommended to return and have surgery with him after the team's departure.

The theatre list was in fact largely full having seen 57 patients, but just as we thought this was the finish of the clinic, three young children from the same family, all with severe bilateral cleft lip/ palate appeared accompanied by their 47 year old mother. Having walked for more than three hours to get to Same, they then came about 4hours by bus to arrive in Dili, so that they had to be operated on. In addition to their facial clefting all had hypertelorism (widely spaced eye sockets) and the elder boy hypospadias, making them likely to have the genetically determined form of clefting Opitz G syndrome.

On Sunday afternoon the team took the opportunity to visit with Maria Dias at her PAS clinic in Becora. This was the location where we first undertook our assessment clinics back in 2000. Now this clinic initiated by Dr Terry Yuen functions as a dental /orthodontic clinic, with two dental chairs, staffed by local dental technicians and visiting Australian dentists and orthodontists. We are now referring our age appropriate cleft cases to this clinic for their necessary dental and orthodontic needs. Whilst visiting Maria we were able to meet with a young lady with a repaired unilateral cleft who is presently in orthodontic braces being managed by the visiting orthodontists.

Monday morning saw our team commence the weeks operating. Local counterparts, surgical, anaesthetic and theatre nursing were there to greet and work with us. Surgically we were assisted by and Dr Joao X, Dr Cesaltina (Noki) who is being guided into reconstructive surgery by Dr JX, and also Dr Cesaltino who works with Noki in Aileu. All three local surgeons were present throughout

the week, if not otherwise occupied by other emergency cases, and Dr JX continued to develop his cleft surgical skills. By weeks end he has now completed about 165 cleft repairs since starting with our team.

From an anaesthetic perspective Dr Spain was assisted by a combination of local nurse anaesthetists, anaesthetic registrars in training and consultant anaesthetists that he has been involved in training in the past. There were no specific anaesthetic issues that arose during the week.

The theatre nursing and recovery / anaesthetic nurse activities are summarised in a separate report by Joy Booth and Sandy Grixti. The standout aspect of that interaction was again the consistent involvement of Mr Cornelio M Mok Freitas (Mok) who always anticipates the team visit and ensures he avails himself of every learning opportunity during the week.

In addition to the informal teaching provided in the operating theatre, lectures were given by Dr Spain to the paediatric department, and the Hospital Grand Round was given by Dr Moore – the topic being “Management of Cleft Lip and Palate”. In this a plea was made to establish a regular cleft outpatient clinic for Dr JX and the concept of the cleft team with speech and dental/orthodontic inputs emphasized.

The clinical workload was again focused on cleft lip and palate – on this occasion perhaps a few more palates and less cleft lips – Dr JX is performing more cleft lip repairs when the team is not around. Also a number of significant hand and upper limb burn contractures in children were treated, as to delay these would risk irreversible joint deformity and long term loss of hand function. These cases were mainly skin grafted, due to the size of the defect after release, and splinted, with instruction for ongoing splintage and physiotherapy to maintain and improve the surgical result. The availability of the latter remains uncertain.

We were accompanied by Ms Celina Lai, speech pathologist from Royal Darwin Hospital. She was the inaugural OSSAA / Doug and Terry Omond scholar and was there to further her teaching of the local speech pathologist, and also to assist with advice regarding feeding of cleft infants. A full report of her activities is attached separately.

All organisational and logistic issues were once again managed very efficiently by Mr Sarmento Correia, with the support of Ms Veronica Verghese in the Dili RACS office. There were no issues with customs in regard to the consumables and equipment the team brought with it.

SUMMARY OF CLINICAL ACTIVITIES – PLASTIC SURGERY

TOTAL PATIENT CONSULTATIONS	**78**
CLEFT LIP/PALATE	
BURNS/ CONTRACTURES	

TOTAL SURGICAL PROCEDURES		**41**
CLEFT LIP	**16**	
CLEFT PALATE	**11**	
BURNS/ CONTRACTURES	**7**	
OTHERS	**7**	

Three siblings with bilateral cleft lip and palate and hypertelorism (wide set eye sockets) with their mother who also has a repaired right sided cleft lip. (Above)

Immediate post-operative appearance of all three children (Below)

AF – Female infant with left unilateral cleft lip and palate undergoing cleft lip repair.

AN – 4 year old with bilateral cleft lip and palate after lip repair.

Visiting team with staff and patients outside of operating theatre complex, HNGV

Dr Joao X with young girl with right unilateral cleft lip before and after repair.

Dr Brian Spain and George, a Timorese nurse anaesthetist who first worked together 20 years ago.

Joy and Mark with operating theatre staff, some of whom first worked with the OSSAA teams 20 years ago.

Maria Dias displaying the team shirts for the visiting orthodontic team at her PAS clinic in Dili.

Dr Joao X with Dr Moore planning a surgical procedure

Dr Spain and Sr Grixti assisting local staff with the delivery of anaesthesia

OSSAA Nursing report

5 June 2019

Plastic Surgical team visit to Dili East Timor

Nursing observations and overview:
Joy Booth & Sandy Grixti

Introduction

Following a busy day of consulting at the Hospital Nacional Guido Valadares 41 patients were scheduled for surgery; list planning considerations for the scheduled 5 days of operating were based around ascending age and availability of equipment to be reprocessed. As the team carried a portable pulse oximeter, we could ascertain whether the patient was in an appropriate state of health to undergo the anaesthetic required for the surgery. Their airway and general state of health was also assessed; thankfully, there were no major issues with any patients which may have prevented them from undergoing their planned surgery.

In 2018, OSSAA made the decision to send a second nurse to support education in Recovery, this year Sandy Grixti joined the team.

Nursing counterparts

One again Mr Cornelio M Freitas (Mok**)** liaised with the team pre departure and requested roster changes so he could be allocated to work alongside the team. A second instrument /circulating nurse was allocated to the team each morning/afternoon. Two nursing staff were allocated to Recovery every morning and one in the afternoon, unfortunately apart from Mok there was limited consistency with staffing allocations.

Observations

All patients arrived to the theatres with IV insitu and were checked for fasting and consent prior to be allowed into the waiting area; ward nurses did not leave the patient until this had been undertaken.

Improvements from previous years such as sharps management and counting processes have all been maintained with counts documented on the white board and all sharps removed and contained by the instrument nurse prior to leaving the theatre. Unfortunately previous improvements noted regarding the introduction of the *Surgical Safety Checklist* have not been maintained. Surgical nurses were adamant that the Nurse Anaethetist is responsible for initiating the checklist and this was not a task that they would take any responsibility for. Interestingly when asked what happens when there is no Nurse Anaethetist for a procedure the response indicated that no other team member initiates the checklist.

Stock rotation still remains unresolved: nursing and sterilising staff consistently place and remove sterile stock from the storeroom with no concept of stock rotation practices; repeatedly observed when staff restocked the shelves with gowns and drapes.

As in previous visits concerns with the education of cleaning staff remain unresolved, and there appeared to be a wide variation in what cleaning was undertaken depending on who was allocated to the role. When asked the cleaners were very obliging to scrub sinks and spot clean walls but appeared not to self-initiate cleaning above mopping floors and bin emptying. Equipment trolleys, tables and vents all required cleaning. Cleaning between patients in Recovery appeared to have improved since last year; the oxygen masks were wiped over with alcohol sprayed swabs, however staff needed to be shown again to wipe the monitoring leads after each patient.

Part of the recovery room staff role is the preparing of barouches (patient trolley). Staff were observed to take the recovered patient to the ward, and on return, place a clean sheet over it and another one on top to cover the patient. There was no cleaning of the mattress.
It was pleasing to witness that the practice of gently dabbing ooze from the patient's mouth, as introduced previously had been maintained and when suction was required, it was performed with a soft plastic suction catheter. From what could be ascertained, this was not re-used on another patient. It was noted that there was a supply of plastic Yankeur suckers on the shelfs under the vital signs monitors if required.
There were a few instances where staffing in recovery was problematic. This was evident when there were several emergency caesarean sections, an emergency orthopaedic case and the patients from OT 3. It was at these times that having the parent of the paediatric patient was very beneficial, as it provided comfort for the child as well as an extra set of eyes should the child become restless and or agitated.
There appeared to be no supplies of sampling lines for the end tidal CO2 monitor and despite carrying out calibration of the oxygen cell on the anaesthetic machine, it continued to display a message that it required calibration. Both Sevoflurane and Halothane anaesthetic gases were available on the anaesthetic machine but due to cost implications, Dr. Spain, used predominantly halothane. Oxygen for the post-operative patients was supplied via large oxygen bottles, and not the wall units as per previous year.
Supportive team behaviours continue to be problematic. When nursing staff allocated in OT 1 & OT 2 had no cases they resisted attempts to engage or support their colleagues allocated to OT 3 with the team. It is acknowledged that shift configurations are not supportive of all day surgery.
As per previous year in recovery there was quite a difference in approach to work depending on the individual staff member. Some would disappear. The use of mobile phones in patient care areas remains problematic and staff often required fatigue breaks throughout their shift.
Hospital supplies for surgery are still limited with ECG dots and diathermy plates being reused. While there are 4 Valley lab diathermy machines there is only one Bipolar foot pedal hence when running two theatres this needs to be considered.

Whilst Mok has developed good organisational skills in list management and utilises clear communication processes to accurately exchange information with medical, ward, sterilising and cleaning staff there are gaps in his knowledge regarding basic aseptic principles. This was highlighted when Mok was observed bringing in sterile stock for a case whilst still wearing contaminated gown and gloves from the previous case.

The sterilising team kept pace with surgery although concerns remain with use of the bench top sterilisers. Language barriers made it challenging to discover the reason for a number of wet loads.

Teaching and training

Throughout the week opportunistic education was undertaken, medical jargon and colloquiums were avoided and inclusive language utilised so that nursing and sterilising staff were comfortable and included in all discussions.

Education with Mok was focused on revisiting basic infection control principles and framing this within the local context of practice. Information was broken into manageable chunks and each time the process was repeated information was added moving from simple to more complex information. Focus on aseptic principles included practices issues reinforced on earlier visits such as having a waterproof base under the instruments, keeping gloved hands on top of the trolley, in between case cleaning, stock rotation and hand hygiene. Discussion was revisited with Mok understanding the importance of encouraging nursing staff to oversee and plan the cleaning of the theatre and equipment as part of nursing responsibility to the patient. Opportunistic role modelling was undertaken for cleaning equipment /trolleys whenever possible.

Once again time was spent establishing trust and relationships with local staff; experience has shown that this will often provide the foundation upon which the learning experience will develop.

Recovery education focused on the importance of having accurate observations and included role modelling the assessment of respiratory rate by gently placing the hand over the patient's lower chest and counting out loud, for 60 seconds, and documenting. This was repeated at the next time interval (15 minutes later). Some members of staff appeared to follow this example whilst others would just revert to their old ways when not observed. Assessment and documentation of oxygen saturation, heart rate and blood pressure, when undertaken, was generally performed accurately as staff simply read off the monitors. Discussion surrounding cross contamination and role modelling cleaning were undertaken.

Recommendations

Continue with 2 nurses on all trips and maintain a strategic focus on basic principles such as cleaning, aseptic techniques and sterilising processes.

Continue and maintain improvements with Recovery staff through role modelling and opportunistic teaching.

Explore with Mok potential for another staff member to be allocated to team to learn from him regarding list management techniques.

Liaise with Mok pre departure regarding specific presentations that would benefit staff.

Anaesthetic machine

Recovery room

Recovery room

Team activities

Once again the team stayed at the Hotel California and ate at out each evening at the wide variety of restaurants that Dili has on offer. The team was privileged to be hosted dinner by the family of Celina Lai, our inaugural Doug and Terry Ormond scholarship recipient. The team was also humbled to have the staff provide an evening meal on the last day to celebrate 20 years of OSSAA visits to Timor.

Thankyou

Georgia Cooymans Wellness and Lifestyle Co-ordinator Phillip Kennedy Centre and the PKC knitting group for the teddy bears for children
Royal Adelaide Hospital CSSD for sterilising instruments
Royal Adelaide Hospital Biomedical Engineering Department for checking pulse oximeters
Womens and Childrens Hospital Biomedical Engineering Department for checking End tidal CO2 monitors

Happy mum & baby going home after cleft lip repair

Decontaminating airway equipment

Whilst waiting for surgery nail polish was well utilised

PLASTIC & RECONSTRUCTIVE SURGERY –

TIMOR LESTE SPEECH PATHOLOGY REPORT

25th – 31st May, 2019

Background

I was especially humbled to receive the inaugural Doug and Terri Omond scholarship from OSSAA to join the Plastic and Reconstructive Surgery team on their visit to Timor-Leste, working the week at Dili's national hospital (HNGV), alongside Mr Mark Moore, and his surgical team, Drs Brian Spain, Zameer Gill and Srs Joy Booth and Sandy Grixti.

I have been fortunate to have participated in other cleft missions with OSSAA to Timor over the years. My focus has been to support the local speech pathologist, to strengthen links between the speech pathologist, the Timorese surgical and paediatric teams and to raise awareness of the role of speech pathology as part of cleft management, general communication development and rehabilitation.

I have been a speech pathologist for 20 years, and have worked at Royal Darwin Hospital (RDH) for 14 years. Whilst I work as a generalist speech pathologist, my area of interest is paediatrics, mainly paediatric feeding and cleft lip and palate management. My interest in Timor is a personal one; my parents migrated from East Timor in the 1970s for a new life in Australia. One of the newest independent countries in Asia, East Timor's history is one that has seen its people demonstrate the meaning of resilience. It is a privilege to contribute in a small way to the development of healthcare in this young nation.

Speech Pathology Services

Ms Alotu da Costa Sarmento is an Indonesian trained speech pathologist. She has worked at HNGV for 5 years. Alotu is the sole speech pathologist at HNGV, working with an allied health team of 2 occupational therapists, 9 physiotherapists, 1 acupuncturist, 1 rehabilitation consultant and 1 nurse.

Alotu works with paediatric and adult outpatients presenting with speech and language disorders and delays resulting from varied sequelae including stroke, meningitis and developmental delay. Due to the complexity of swallow assessments, Alotu does not currently assess or manage patients with dysphagia.

Over the years, the number of patients returning for therapy post cleft repairs has been small. The reasons for patients not returning are varied: limited understanding that surgery does not necessarily fix speech production, financial

and time costs of travel to Dili for repeated therapy sessions are some of the projected reasons for children and adults do no return for speech therapy.

Clinic Consultations

Interestingly there were four (4) presentations for tongue tie (no cleft involvement) amongst the patients at consultation clinic on the first day. These children were referred to have tongue ties assessed to determine if that was the cause of speech and language delay. Of the children who were referred, only 1 case was found to be impacting speech production. It was suggested that all children receive regular speech therapy before further consideration for surgical intervention.

The following patients were seen for speech pathology assessment and/or management during the week:

Inpatients

- 8 y.o boy with submucous cleft (having lip repair) for speech assessment
- 16 y.o girl with submucous cleft (for palate repair) for speech assessment pre-surgery
- 3 day old boy with right cleft lip & palate for feeding assessment

Outpatients

- 19 y.o woman with repaired cleft palate (Nov 2018) for speech therapy
- 26 y.o. man post tuberculosis meningitis (April) for speech and language assessment and therapy
- 2 y.o. boy with tongue tie for speech and language assessment
- 20 mths old boy with tongue tie for speech and language assessment
- 17 mths old boy with tongue tie for speech and language assessment
- 2 y.o. boy with Down Syndrome for language and feeding assessment
- 9 y.o. boy with suspected Autism for speech and language assessment
- 10 y.o. boy with suspected speech and language delays for assessment
- 60 y.o. man post left CVA for language therapy
- 50 y.o. man post left CVA for language assessment and therapy
- 2 y.o. boy post dengue encephalitis (joint session with occupational therapist)

The young woman returning post cleft palate repair was very motivated to attend speech therapy. She is currently a medical student and aware that her ability to speak clearly was going to be important part of her studies and career. She attended therapy daily, practiced her prescribed exercises and made good progress in the short time I worked with her.

Networking

I made time to visit with a few colleagues outside of the Rehabilitation
Unit.

These included:

- Jacinta Baretto – a neonatal nurse from RDH who is currently seconded to a nurse education position with St John of God based at HNGV. I brought over

a number of cleft teats and squeeze bottles for HNGV's special care nursery and provided an inservice to Jacinta on how to assess the need and use of this feeding equipment. She will provide onward education to SCN nurses. Breastfeeding is promoted as the preferred way to feed infants and it can be hard to shift mindsets that breastfeeding may not be possible for a baby born with cleft palate or cleft lip & palate. There needs to more education around "breastfeeding via bottle" and supporting new mothers to express, which can be difficult in a country where pumps and bottles are few and of varying availability and quality.

- Paediatric medical officers – still to be recognised as paediatricians, there are a number of Timorese paediatric trainees who have passed in-country exams. They service the paediatric inpatients on 2 paediatric wards and a special care nursery, as well as paediatric outpatients. I provided an inservice on speech and language disorders and feeding issues of infants with cleft lip and palate. The paediatric doctors were very interested in knowing when typical speech sound development occurred and key markers in language development.

- We visited the PAS Dental clinic on the Sunday prior to the working week started and met Mark's friend, Maria Diaz. It was wonderful to see all the work that has occurred at this clinic, resulting in dental and orthodontic care for Timorese people. It will be wonderful to have cleft patients routinely attending dental services as part of their overall cleft management.

Considerations

Alotu will be finishing up at HNGV soon, to do further study in Indonesia for the next few years. This will leave HNGV without a speech pathology service in the foreseeable future and at this stage, the impact is unknown. There is another Timorese speech pathologist at Centro Nacional de Reabilitacao (CNR), a provider of mobility equipment in Timor, however we were unable to meet up during the week. Alotu stated that this speech pathologist will receive external referrals.

I have listed challenges before in other reports, but unfortunately ways to overcome have not progressed as quickly as hoped:

- Limited knowledge in feeding assessment of children with cleft c onditions (breastfeeding still strongly encouraged, mechanics of sucking not understood).
- Limited access to appropriate feeding equipment for children with cleft conditions, education on use and follow up.
- Attendance for speech therapy post-surgical repair (due to distance, costs, lack of understanding that surgery doesn't automatically fix poor articulation).
- Limited understanding of therapy and the role of significant others in progress.

The barriers listed above are not easily overcome at this time in Timor-Leste and continued building of collegial relationships and sharing of knowledge and skills is paramount for long-term support.

Acknowledgement
I am in awe of the work OSSAA does in the Asia-Pacific region, and am grateful to this organisation for the opportunity to work with Mr Moore's surgical team in East Timor.

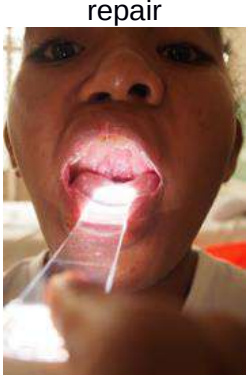
Celina Lai
Speech Pathologist

Speech therapy room

Ana with cleft palate repair

Ana practicing oral airflow

3 day old boy with cleft lip and palate



Patient with submucous cleft

Alotu carrying out speech assessment

Family gathering post lip repair

Meeting with paediatric doctors

Loro monu Areia Branca

Sunset in Areia Branca