Overseas Specialist Surgical Association of Australia (OSSAA)

Royal Australasian College of Surgeons (RACS)

Plastic Surgical team visit

HNGV, Dili, Timor Leste

18 – 25 November 2022

Mark Moore, AM, FRACS

Plastic and Craniofacial Surgeon

Team Leader , OSSAA

INTRODUCTION

The OSSAA Plastic and Reconstructive surgical team to HNGV in Dili, Timor Leste was the first visiting surgical team to return to this region following the three year hiatus enforced by the Covid pandemic. Almost exactly three years to the day since our last visit, with well organised pre-visit planning by our local long-term counterparts our team completed a highly successful 49th volunteer surgical mission in Timor Leste since our beginnings in 2000. Central to the large turn out of patients was the advance planning undertaken by Mr Sarmento Correia (the RACS in country coordinator), Dr Joao Ximenes , our counterpart Cleft and Burn surgeon, Mr Cornelio Mok Freitas, our local Theatre nurse colleague and the medical and administrative executive of HNGV.

Having spent the last 20 years performing cleft surgery in Timor Leste and over the last 10-15 years training local staff, the intervention of Covid has created once again a backlog of cases, which will take some time to manage and return us to where we were at in 2019 – having achieved reduction in age of cleft repair, some building of speech and orthodontic interventions and management of cleft patients, amounting to an embryonic cleft team.

TEAM PERSONEL

The OSSAA team for this visit was comprised as follows :

Dr Mark Moore	Plastic and Craniofacial Surgeon Women's and Children's Hospital and Royal Adelaide Hospital, Adelaide
Dr Vani Atluri	Plastic and Craniofacial Surgeon Women's and Children's Hospital and Royal Adelaide Hospital, Adelaide
Dr Todd Maddock	Anaesthetist Women's and Children's Hospital, Adelaide
Sr Joy Booth	Theatre nurse Royal Adelaide Hospital, Adelaide
Sr Mary Martinaitis	Anaesthetic/ Recovery nurse Royal Adelaide Hospital

PARTICIPATING LOCAL STAFF AND COUNTERPARTS

Prior planning meant the team was well supported and assisted both in the outpatients, operating theatre and wards by local administrative, medical/surgical and nursing staff.

In particular Mr Sarmento Correia (the RACS in-country coordinator) had liaised with the HNGV administration/ Dr Joao Ximenes and Dr Colom to reduce surgical activity and provide ward space for our patients, as well as communicate with the government authorities and various media outlets and the churches to advertise the impending return of our team.

Dr Joao Ximenes, our long term counterpart cleft surgeon was ably assisted by Dr Quely Toledino (Maria) a junior surgical trainee.

Dr Colom(bianos) the head anaesthetist and director of theatres worked with us throughout the week to ensure the availability of a second overflow theatre. He was assisted by Dr Mena an anaestheic trainee with other junior doctors and the anaesthetic nurse team also actively involved.

The theatre nurse team was very ably led by Mr Cornelio M Mok Freitas (Mok), who directed his scrub/scout team very expertly under the guidance of his mentor Sr Joy. This included the CSSD sterilising team who manfully kept our instrument trays appropriately ready for use.

OVERVIEW

Our much awaited return to HNGV, Dili, followed pre-visit preparations and communication with Dr Joao Ximenes and Mr Sarmento Correia. Having identified an appropriate timeframe where the hospital was settled and the Covid situation under some sort of control, meetings were held at HNGV between hospital executive, surgeons, anaesthetists and theatre staff. A local agreement was achieved whereby theatre and ward activity at HNGV was reduced to create space and staff for the OSSAA team to use two operating theatres daily, with sufficient ward space to house our pre- and post-operative patients. Dr Colom, the local head of anaesthesia was available to work with our team in the second theatre, as were a number of theatre nurses- thus maximising the available operative time for this our 49th surgical visit to Timor Leste. CSSD staff were involved in the process, in recognition of their important role in theatre activity/ case turnover.

Mr Sarmento, as he did pre-Covid oversaw the administrative issues and organised permissions and customs clearances for the team and our equipment.

Changes in flight scheduling from Darwin to Dili, meant the team arrived a day earlier, on Friday afternoon, in preparation for pre-screening consulting on Saturday. Communication of the team's visit had been organised through radio, television and the churches, as for our previous visits. The success of this, together with the 3 year Covid delay meant that upwards of 300 patients were registered to be seen at our clinic !!

Dr Joao Ximenes, our local counterpart surgeon had been able to perform 36 unilateral cleft repairs over the last 3 years, but by the time of our team's arrival had largely exhausted his supply of appropriate sutures.

Arriving to commence outpatient consultations, we were met by a large crowd of patients and families registering for review. Between 0830hr and 1700hr the team assessed more than 135 patients. Among this were 100 cleft lip and palate patients, ranging from infants through to a small number of adults. Included also were a small number of cases whose cleft lip repair occurred in 2019, and were returning for cleft palate repair, albeit delayed three years by Covid.

Large numbers of bilateral cleft lip and palate were seen, reflecting Dr Joao's excellent work in continuing to repair unilateral cleft lip patients

during the Covid interlude. Similarly, many patients in need of cleft palate repair were assessed, including slightly more isolated cleft palate cases than we usually see – perhaps a consequence of improved education/ understanding and feeding of cleft palates infants. Interestingly one of the new cleft patients was the son of a Timorese interpreter/ volunteer who worked with Dr Mark and Dr Joao on the US navy Mercy ship when it visited Dili in 2012- the father still had a photo taken with Dr Mark from that time.

After seeing 70 patients in clinic we had filled all available theatre spots for this visit, and at that point could only waitlist patients for future visits in 2023, or where Dr Joao was comfortable to repair, he created a similar list for surgery in upcoming months.

In addition to the many cleft patients there were a significant number of burn contractures in need of revisionary surgery. Some of these will be managed by Dr Joao, but a persisting issue is the absence of physiotherapy and splinting services which limits the outcome of surgical correction short and long term. Another young woman aged 26 years was seen more than six years after an extensive burn of her lower leg and ankle region, which had never healed and had now undergone malignant transformation to a large squamous cell carcinoma (Marjolin's ulcer). This unfortunate outcome again demonstrates the natural history of untreated disease in a region where access to plastic and reconstructive surgical services are limited and often much delayed.

Surgery commenced on Sunday morning, with staff available for two operating theatres. This setup continued for all 5 days, with 9-10 cases operated each day. Nursing and sterilising staff were able to maintain continuity of instruments for cases under the guidance and supervision of Sr Joy and Mr Mok, meaning no real delays occurred What couldn't be controlled so well were the occasional power outages which occurred through the week mainly relating to the heavy tropical storms around. Fortunately being in the middle of a cleft palate repair and being plunged into darkness only occurred a couple of times, and were short-lived in their duration.

Dr Todd was ably assisted through the week by local anaesthetic trainees, whilst in the second theatre Dr Colom provided anaesthesia for a smaller number of cases, with some assistance from Dr Todd. At weeks end Dr Colom, whose anaesthetic training was in Fiji, noted that the week's experience had been like undergoing another fellowship, such was the amount of experience he had gained. Similarly the

anaesthetic trainees working with Dr Todd had the opportunity to intubate about 30 + cleft patients, which will stand them in good stead as important contributors to the cleft operative team assembled by Dr Joao.

During the week almost all cases were discharged from hospital within 1-2 days post-operation, this being overseen by Dr Joao. One case was cancelled prior to surgery because of a fever, and was operated later in the week by local general surgeons to drain a large buttock abscess – the cause of his fever. Another cleft lip case was successfully operated on, but in recovery noted to have poor oxygen saturations – subsequent referral to local paediatricians identified congenital heart disease, probably a ventricular septal defect. This baby settled on diuretic therapy and will continue to managed by local paediatric services.

Having produced a lengthy surgical waitlist from the outpatient consulting session, this was further added to by the fact that of the 34 patient who had cleft lip repairs, about 26 will need cleft palate repair in the future.

Interestingly there were more male than female cleft patients assessed in the clinic with a ratio of about 2:1. On the surgical list the difference was even greater, almost 3:1. The majority of patients having their cleft repairs were in the age bracket of 2-5 years, with more than half in this grouping. Only 6 cases were less than a year of age, being a comparable time of repair as would occur in Australia. One can only assume this shift to later age relates to delays imposed by the Covid pandemic.

By weeks end we had almost exhausted all our suture/ consumable supplies, given the heavy workload. Despite this we were able to leave behind some suture supplies and skin graft blades for Dr Joao to continue his surgery of cleft lips/ burns. It is also planned to arrange transport of further supplies/ consumables to him over the next month or two utilising the resources of the Babcock Helicopter company, as we did during Covid.

Dr Joao continues to carry a heavy clinical load as effectively the only reconstructive surgeon resident in Timor Leste. His expertise in unilateral cleft lip repair is of the highest level and he needs opportunities to grow his confidence with more severe clefts. His junior colleague Dr Ceseltina who worked with our team in 2019, is presently away in Fiji completing her general surgical training before returning in

the next year or two. During the week we had Dr Maria/ Quely Toledino assisting us, and she is another of the younger generation of surgeons.

Two patients with craniofacial deformities, of a nature that treatment can not be performed in Timor Leste were assessed, and will be proposed for treatment in Adelaide, sponsored by ROMAC. These cases were a 2year old with a syndromic craniosynostosis and cleft lip and palate, and a 12 year old with a combination of rare Tessier craniofacial clefts who requires a complex nasal reconstruction.

The team on this occasion stayed at the Plaza Hotel, which was closer to the hospital, than on previous visits and very suitable for the week. The choice of vehicle provided on this visit was not really ideal, being too small, and expensive compared to previous visits. This was noted with Mr Sarmento and Mok, and for future visits an alternative option may be more ideal.

The team was farewelled on Thursday night with a formal dinner hosted by the HNGV clinical and medical directors at the La Clu Bar restaurant along the waterfront. The team and all the theatre staff who worked with us were welcomed to a very generous, delicious dinner – a very fitting finish to wonderful return visit to our friends at HNGV.

The team departed Dili on Friday afternoon, overnighting in Darwin due to the lateness of the flight, before returning to Adelaide on Saturday afternoon.

RECOMMENDATIONS

1. The Covid hiatus has caused a large backlog of cases, and the need for increased visits starting in early 2023. This may include a two team visit with one based in Dili and the other in Baucau as we have done in the past.
2. Increased teaching opportunities will flow if the workload is not so intense as on this visit – this applies across surgery, anaesthesia and nursing.
3. Discussion re ongoing supply of sutures/ consumables so that Dr Joao and his colleagues can maintain a continuous service.
4. Discussion with HNGV admin/ executive and Mr Sarmento/ RACS re accommodation / travel/ vehicles for the team whilst in Timor Leste.

ACKNOWLEDGEMENTS

The OSSAA team would like to express its gratitude to the whole HNGV team for once again welcoming us back, and supporting us in our shared endeavours, which resulted in such a successful visit.

To Mr Sarmento Correia for resuming his skilful negotiation of our return visit, arranging customs clearances, communication with health ministry, accommodation and vehicle transfers.

Ethicon / Johnson and Johnson for their generous donation of sutures which have facilitated the large number of cleft cases.

The various public and private hospitals in Adelaide which support our team / team members.

SUMMARY OF CLINICAL ACTIVITIES – PLASTIC SURGERY

TOTAL PATIENT CONSULTATIONS 142

Cleft lip/ palate 102

Burns/ contractures 18

TOTAL SURGICAL PROCEDURES 49
(1 unilateral cleft patient had both lip and palate repair)

Cleft lip- unilateral 19

- **Bilateral 15**

Cleft palate 14

Skin lesion/ graft 1

GENDER :

Male 34

Female 13

AGE RANGE :

<1 year 6

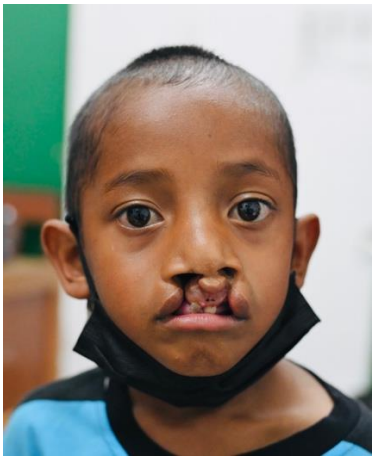
1-2 year 7

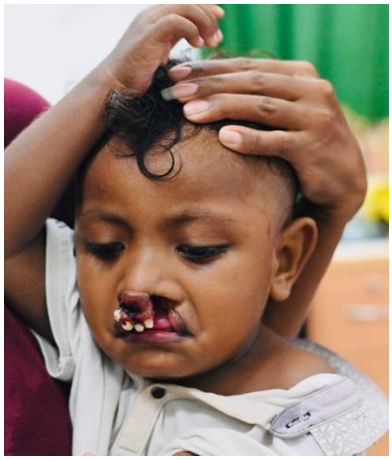
2-5 year 25

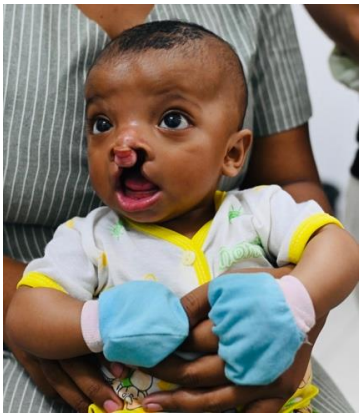
5-10 year 6

>10 year 4

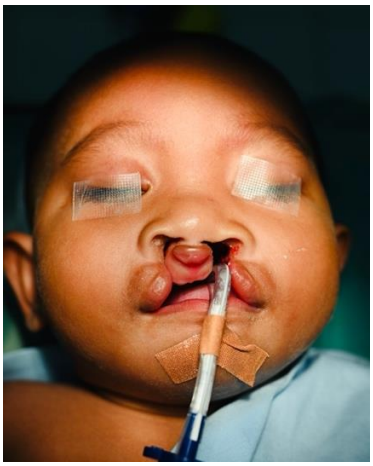
The front of the queue, the first of the more than 140 patients assessed on the first consulting day.

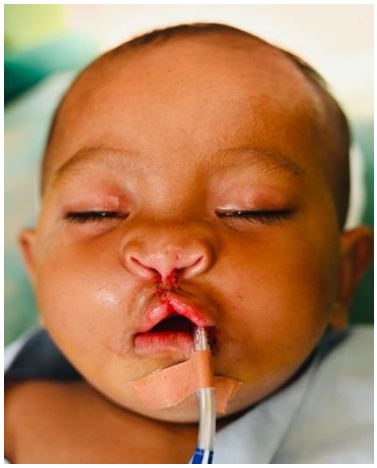




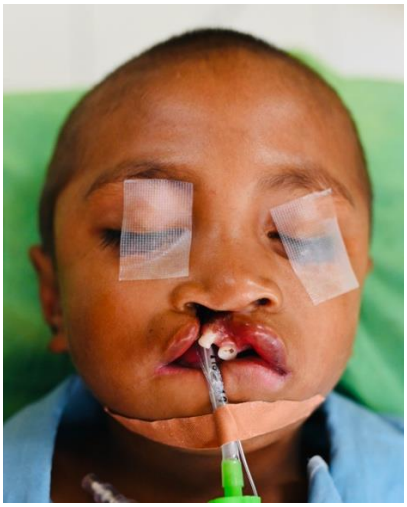


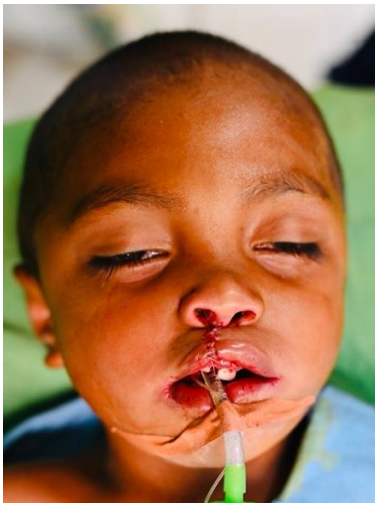
Bilateral cleft lip patients assessed for surgery



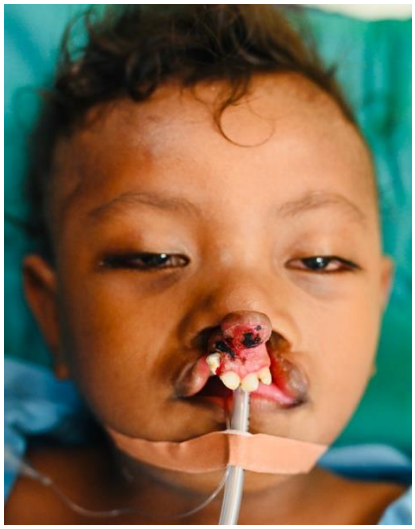


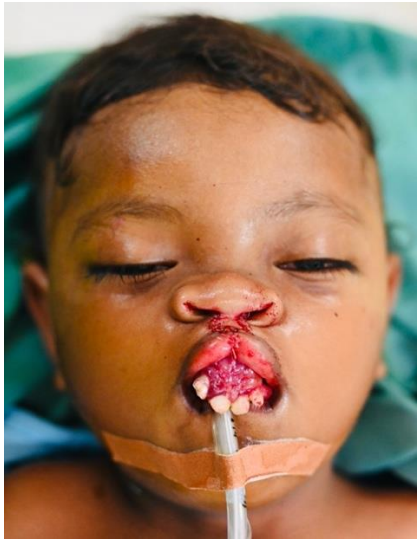
Bilateral complete cleft lip – pre- and post-operative





Right unilateral cleft lip – pre- and post-operative





Bilateral complete cleft lip with protruding premaxilla
- **Pre and post-operative**

Sr Joy Booth with cleft patient and father pre-op

Mr Mok leading the daily team huddle at start of day in operating theatre

Sr Joy Booth, Mr Mok, Sr Mary Martinaitis leading the operating theatre nursing team

Dr Todd and Dr Colom (right of picture) and anaesthetic team

Dr Joao and Mr Mok (right of picture) and surgical team

NURSING TEAM REPORT

JOY BOOTH AND MARY MARTINAITIS

Introduction

It was exciting to be back in Dili after the Covid hiatus and the team were warmly welcomed back. Following a very busy day of consulting the team saw 135 patients at the Hospital Nacional Guido Valadares and 48 patients were scheduled for surgery; list planning considerations for the scheduled 5 days of operating were based around ascending age and availability of surgical trays to be reprocessed.

Nursing counterparts

Once 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 new initiative was undertaken this year where nursing staff volunteered to be allocated to the team to undertake the role of instrument /circulating nurses. This allowed for greater staffing consistency than in previous visits and cemented ongoing relationships.

Observations operating theatres

For the first time two operating theatres were allocated for the team to use for the week. It was pleasant to see that there had been some sustained improvements maintained during the team's three-year absence; this included sharps management and surgical counting processes.

For the duration of the team visit Mok was undertaking the role of acting charge nurse. This is the second time that Mok has had the opportunity to undertake an acting role in a leadership position. 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 leadership and delegation.

Surgical safety checklists were undertaken for all cases, the team were advised that this is now a hospital audited process and copies of the checklist are placed in the patient's notes.

All patients came with a consent documented and this was checked by nursing staff on entrance into the theatre suite. Nursing handover was witnessed from ward staff to theatre staff for all cases. This appeared more structured than previous visits with fasting times included in handover.

Sterile stock rotation remains unresolved: nursing and sterilising staff consistently place and remove sterile stock from the storeroom with sub optimal stock rotation practices; this was repeatedly observed when staff restocked the shelves with gowns and drapes.

Cleaning of operating theatres has not improved since the last visit, theatres noted to have general untidiness and suboptimal cleanliness. End of day cleaning still requires significant

support; the cleaning team manage the end of day cleaning with the same process for in between case cleaning. There appears to be no structure or guidance for cleaning staff to follow; the cleaning team appeared keen to follow instructions, however it is unlikely that the small gains developed over the week will be sustained without nursing staff taking ownership for guiding the cleaning team. As noted in previous visits operating table mattresses are not regularly removed and cleaned allowing a significant build up dried fluids between the tabletop and mattress, walls are splashed with betadine and dust on flat surfaces. Equipment trolleys, tables and vents all required cleaning. Discussion was revisited with Mok re 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.
The sterilising department led by Mr Calisto managed the demands of 2 operating theatres and an unstable power supply. Gowns and drape bundles were sterilised overnight in the large autoclave with instrument trays being processed in small bench top sterilisers. Despite the challenges of power outages there were no delays waiting for instruments. Mr Calisto and his team are acknowledged as a major contributor to surgical list efficiency; the sterilising department had no air conditioning and despite the elevated temperatures generated by the sterilisers the team efficiently reprocessed trays. It was pleasing to note that instrument trays were never released from the steriliser until the correct time had been met.

Operating Theatre teaching and training

Following discussion with Mok it was suggested that as part of his leadership development he could introduce and lead a daily pre surgical list huddle prior to surgery commencing each day .Mok was keen embrace this initiative and after following a script for the first day he confidently led the huddle for the remainder of the week. Mok recognised that the huddle is a significant safety initiative and ensured that the team introduced themselves and that all member of the team including the sterilising staff were provided with an opportunity to highlight concerns or issues for the day. Issues such as changing oxygen cylinders and management of instruments were raised and actioned .It is anticipated that this initiative will be continued.
It is acknowledged that running two operating theatres simultaneously decreased opportunities for teaching, however, 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.
Teaching was focused on developing and embedding leadership skills for Mok, centring on delegation and team management. Mok acknowledged that delegation of work to other staff was an issue he struggles with.

The majority of the nursing team had worked with the team before so a gentle approach to reinforcing aseptic principles from previous visits was undertaken, this included having a waterproof base under the instruments, keeping gloved hands-on top of the trolley, and hand hygiene. Once again time was spent establishing trust and relationships with local staff; experience has shown that this provides the foundation upon which the learning experience will develop.

Recovery observations

The recovery unit was reasonably staffed during the short time that we were there. A lot more males than females but it was the females that took initiative in recovery.

Mobile phones are very popular amongst the staff and often take priority over a patient or patient's airway. There was no situational awareness from staff.
The cleaning and preparing of barouches (patient trolley) seem to be an instilled practice taught from previous visits. After taking a patient to the ward whether on the barouche or in the arms of their parents, staff would often return and clean the barouche with soapy water before laying a new sheet and preparing it for the next patient.
Recovery staff continue to reuse oxygen masks and suction, staff would dip into a canister of tap water to clean the suction out. We tried a different method this time, where the suction plastic yanker or long Y-suction catheter was soaked in Milton's for fifteen minutes before being left to dry and be used again. We did this, rotating between different suction catheters to maintain some level of safety for each patient since a lot of blood was being suctioned from patient's mouths. Their supply of suction catheters was not ample.
The practice of gentle dabbing of ooze from the patient's mouth, as previously introduced, continues. There were several new recovery nurses that were shown how to suction gently to the side of the mouth as not to injure the patient's freshly formed palate. This required reinforcement and by the end of the week became common practice.
It was observed that oxygen masks were wiped clean with alcohol soaked gauzed between patients.
Equipment difficulties in recovery was that the barouches had no brakes or insufficient brakes (one brake on one wheel). This made it very difficult to do adequate jaw support and maintain a patient's airway adequately and safely. If the patient struggled or rolled it was difficult to keep them on the barouche without brakes.

Recovery teaching and training

Education about jaw support and the importance of maintaining a patient's airway through role modelling and practice-based learning was the focus. Staff would often walk away from a patient's airway to chat or to be on their phones. Focused teaching was given to those that appeared to want to learn and were observed to tell others *"How to"* also. Unfortunately, it was the same two staff members that also did most of the work. Education on how to do jaw support correctly on a child over an adult will require more reinforcement. The importance of staying with your patient until they were safe to breathe on their own will also require more time.

Nursing Recommendations

- Support Mok with information on pre surgical list huddles
- Source and provide Mok with leadership articles re delegation
- Provide information and checklist examples re end of list cleaning. Be realistic and comment strategically with a focus on what is sustainable
- Encourage Mok to monitor mobile phone use for staff undertaking patient care

Team activities

Team members had a quick trip to the Tais market on the day of departure to look at the traditional Tais weavings and handicrafts. It was fascinating to see the Tais cloth created by the women of East Timor which is an essential part of the nation's cultural heritage.
On the last day of operating the team was taken out to dinner by hospital executives and the local team, this was a very special evening with the OSSAA team being presented Tais. Tais are traditionally given as a sign of respect and appreciation, so the team felt very honoured to be presented with one each.

Thankyou

Johnson & Johnson representative Sarah Wyndham for organising a donation of much needed sutures to the value of $53,000
Cardinal Health representative Jo Wallace for providing disposable suction
Beryl Gear from the Hand Knitters Guild of SA for a large assortment of knitted toys
Beth Tugwell from Port Wakefield for knitted bears.
Sterilising Department Royal Adelaide Hospital for assorted sundries

Photos

Mary in recovery

Happy patient going home

The team on the last day

Local nurse providing airway support