

PeriOperative Mission Nursing Guide; Personal and Professional Preparation to Practice

by

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B.Sc.N. University of Victoria 2007

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Abstract

Perioperative mission nursing in developing countries can be a challenging yet rewarding experience. This project draws on personal and professional experience to assist the prospective perioperative mission nurse in critical thinking when faced with practice challenges in operating rooms worldwide. This guide encompasses tools and tips to safely care for patients across the globe. The journey to practicing abroad begins at home in the pre-mission phase with procuring and packing supplies. The journey continues during the mission trip in the developing country outlining practice standards and obstacles and how to best tack them. The journey ends performing post mission work back in North America.

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PeriOperative Mission Nursing; Personal and Professional Preparation to Practice

As I reflected back on my fourteen years as a perioperative registered nurse and mission volunteer, I took notice of the lack of information and education perioperative nurses received as they travelled to developing countries. From my first few mission trips I have since acknowledged my previous feelings of being overwhelmed, confused, nervous, and intimidated, and have gone on to recognize that I have experience and information to make a change. I have also gained education, confidence and competence in my own practice as a mission nurse to impart that knowledge to other prospective mission nurses. I want to assist in making a change so potential perioperative mission nurses can embrace an incredible opportunity with a sense of comfort and confidence.

I acknowledge that it is impossible to prepare and educate a perioperative nurse to every possible scenario they would encounter while practicing abroad in sometimes austere conditions. However, the importance of informing and educating perioperative nurse colleagues can assist in building a foundation which can lead to a positive experience for not only the nurse volunteer but also for the team and ultimately the patients that are cared for.

The intent of this project is to bridge the identified gap in knowledge and create a guide book that will help develop and prepare perioperative nurses so that you feel informed, educated, and well prepared personally and professionally to practice in developing countries throughout the world. Further, the focus of the project is on assisting the perioperative nurse in understanding how to take the recommended standards and practices of North America and critically apply them in the operating room environment in a developing country.

This guide will begin by giving you information about the mission group I volunteer with and guide you through thoughtful reflection of what it means to be a volunteer. General

information will be provided to you about developing countries in general. The guide will have you self-reflect on your current level of perioperative nursing practice and assist you in developing an understanding of what level you may be practicing at on the mission trip. As you embrace a new practice arena abroad; an understanding of caring and cultural awareness will help guide your practice. This guide will also give you information pre, intra, and post mission trip about expectations, previous experiences encountered, and how to apply perioperative standards and policies from North America to operating rooms abroad. In order to have a successful mission trip it is important to not only prepare professionally but personally as well; personal preparedness is also outlined. The appendices will give you tools for you to use prior to and during the mission trip.

It is my goal to teach all that I know so that your journey to perioperative medical mission nursing in developing countries is a positive and rewarding experience that will spark a fire of passion within you for the people of the world that keeps you coming back and volunteering again.

Background

Life Enhancement Association for People (LEAP) was founded in 1991 by Dr. Craig Hobar, a Dallas, Texas plastic/craniofacial surgeon.

“LEAP is dedicated to enhancing and enriching the lives of people around the world by providing specialized medical and surgical services in the love of Christ” (LEAP, 2012 website).

LEAP is dedicated to changing lives throughout the world. Although the primary focus transforms the lives of both children and adults with craniofacial deformities through surgical

intervention, LEAP also provides other services such as; ophthalmic, urological, hand, orthodontic, and otolaryngological surgeries.

LEAP currently averages six medical mission trips per year. LEAP's journey has led teams throughout the world to countries such as the Dominican Republic, Belize, Guatemala, Ecuador, India, Laos, Zimbabwe, and Haiti.

LEAP (2012) is devoted to the local communities of the countries it serves. Post-surgical intervention, LEAP partners with host facilities to provide support and education to assist patients and families transition back into their home village and community. This builds relationships and serves to cement LEAP's commitment and dedication to the people and communities it serves.

LEAP (2012) is also dedicated to education and training. LEAP partners with local hospitals to provide training and education resources to ensure each patient and their family have the right information to care for their loved one from treatment to home. LEAP works, partners, and collaborates with local physicians, surgeons, dentists, nurses, and allied health support personnel to bring an understanding to our methods. We educate on techniques used pre, intra, and post-surgical intervention in all disciplines.

Another facet of LEAP (2012) is caring for challenging patients that are too complex to handle surgical intervention in their respective developing country. LEAP has a special fund that assists with bringing those critical patients to the United States to undergo surgical intervention in a controlled environment with state of the art equipment and resources to best support a positive outcome.

LEAP was founded as a faith-based organization and is dedicated to serving the people of the world through Christ. Keeping that in mind, LEAP provides free medical care to all those in

need despite religious, political, or cultural affiliation. Similarly, LEAP welcomes and accepts volunteers from all religious, political, or cultural affiliations with the only requirement being that, “Christian principles that define LEAP are respected and followed in serving others” (LEAP, 2012).

LEAP is relatively small when compared to other similar non-profit organizations such as Operation Smile and Doctors without Borders. LEAP operates with a primary group of dedicated leaders that work to ensure each mission trip provides top quality care and service specific to the needs of the community it serves. It is with a dedicated small team that LEAP is able to travel to remote villages in some of the far reaches of the world to provide their services.

I am dedicated to LEAP, its mission and vision, and embrace the opportunity and challenge for each mission trip. An opportunity I noted with LEAP is that we focus on providing care throughout the world to those in need but often neglect the needs of the teams we empower to transport that vision to the people of the world.

Search for Written Material

In search of written material specific to perioperative nursing abroad in developing countries, I was shocked at the lack of information available. It seems no repository exists to guide perioperative nurses while practicing abroad. However, there was a plethora of information on nursing in a developing country with regards to primary health, women’s health, and cultural care to name a few. A specific literature review and search in the Association of periOperative Registered Nurse (AORN) journal and on their website revealed only human interest and personal experience articles. These articles provide great insight into perioperative nursing abroad but do not guide perioperative nurses in taking their current practice from a North

America perspective, where there is an environment of abundant resources, and applying them to an environment where many clinical practice challenges are encountered.

With the amount of organizations such as LEAP, Doctors without Borders, Operation Smile, and Smile Train, I would have expected to discover vast source of educational material available to guide practitioners abroad.

In speaking with nurses who have traveled with LEAP and other organizations about their mission preparation, it was surprising to hear that they received information specific to perioperative nursing from word of mouth, from one volunteer to another. Perioperative nurses expressed that a lack of information about the role of mission nurses increased their stress level as they were not prepared for situations that they would encounter and how to trouble shoot to get through them. This gap in knowledge was significant and led to the foundation of this guide.

There are several books available to perioperative nurses that are a generic in nature that serve to guide nurses on how to practice in their controlled environment of North America. Perioperative nurses in the United States and Canada have the means to practice to these standards in a controlled environment with the conventional means of running water, electricity, heat, air-conditioning, instrumentation, and supplies available.

I equate the necessity for a perioperative mission nurse guide book to that of a hospital orientation manual in North America. For example, an institution or organization would not allow a nurse to enter a hospital and practice her profession without a proper clinical orientation to the environment, patient population, policies, and procedures. When a practice question arises in a developed country setting, there are resources readily available to perioperative nurses from nursing leadership, nursing educators, policies and procedures.

Why volunteer to practice your profession in a developing country? Is it on your proverbial ‘bucket list?’ Does the thought of traveling to a foreign country sound like fun? Does the idea of mission work seem like an adventure? Or on the other hand do you want to volunteer because you feel a sense of duty? Do you feel the need to give back to society?

‘Clinical tourism’ is a term that has been coined from the auspices of ‘medical tourism.’ Medical tourism refers to people travelling to countries outside North America on a holiday only to have a surgical procedure done in a country for a lesser cost. While on the other hand clinical tourism is described in the medical field as doctors from medically advanced countries taking a holiday and practicing one’s profession while on that holiday (Levi, 2009). This can relate to the nursing profession as well so we must ask what our true motives for volunteering for mission work really are.

Giving the gift of money to support a charity is seemingly a relatively easy thing to do, but try spending your hard earned vacation time to travel to a developing country to work under trying circumstances and pay for it out of your own pocket; this is the gift of giving (Spry, 2009). This is a volunteer.

Kant’s moral philosophy relates to that of a good act that arises from a sense of duty (Day, 2007). Day then relates if one acts purely from a sense of duty and one is not concerned with their own personal needs, happiness, or desires, it must be that these good intentions then produce good actions. The American Nursing Association Code of Ethics for Nurses (2011) guide nurses in their practice. The code of nursing is a foundation that leads nurses to frame their practice, whether it is in the United States or in a developing country. However Levi (2009) posits that the code of ethics that governs the nursing profession does not address the

needs within a social or cultural context and nursing behaviors that are acceptable in the United States may not be welcomed in another culture.

To define nursing, it is relatively safe to say, that a nurse is a nurse no matter where you call home to your practice. However, the word nurse, internationally, has no defined standard of meaning as it relates to one's practice. Nursing can be defined by how you practice, the field of your practice, the conditions you practice under, the training you receive(d) and what the expectation of you as a nurse are, vary from country to country (Clark, 2006). Experienced perioperative nurses of North America can bring to the patients of the world a unique set of skills having been trained in an environment that offers a wealth of knowledge with the latest technologies and resources. In Parse's Theory of Human Becoming, the first principle, structuring is followed by three concepts; imaging, valuing, and languaging (Mitchell as cited in Allgood and Tomey, 2006). It is through imaging that that nurses explore their own view of meaning and can develop an appreciation for other nurses as explore theirs. Another concept is transforming within the principle of contrascending. Transforming surfaces when nurses make new discoveries and shift their understanding and worldviews based on the unfamiliar (Mitchell, 2006). Mission nurses must evaluate their own worldviews and look to integrate the familiar with the unfamiliar as they embark on a journey outside their comfort zone into that of a culture of a developing country.

Defining a Developing Country

Developing countries, formerly known as 'Third World Countries' referenced by the United Nations as 'Least Developed Countries' (LDC) fit within prescribed criteria. The definition that designates a country as 'least developed' is defined as "low-income countries suffering from structural impediments to sustainable development. These handicaps are

manifested in a low level of human resource development and a high level of structural economic vulnerability” (United Nations, 2011 website). The United Nations has composed a list of the identified least developed countries available on the United Nations website. On the same website there is also a defined standard which developing countries must meet to graduate and advance off the list and move to the status of a ‘developed’ country. It was interesting for me to discover that even though India, a country LEAP travels to annually, has advanced off that LD Country list. Further investigation revealed that the criteria establishing the least developed country designation looks at: gross national index per capita, human assets index, economic vulnerability, and population size (United Nations).

What is of interesting note is that India, Belize, and Zimbabwe, countries that LEAP travels to annually, are not considered LDCs. However, when looking at those countries from a mission nurse perspective; the conditions and need for medical intervention is real. LEAP does not use the UN defined criteria for LD Countries but rather what set the countries LEAP visits apart is the people’s inability to access any form of healthcare. Many of the people LEAP has come to know in the host countries relate that in their own communities, there are families that do not have a steady source of income to pay for healthcare and there is no government assistance for those poor people to access healthcare. It has been told to me from members of the communities LEAP serves that their people of low socioeconomic status focus on the basics to sustain their existence; food and water. Shelter is also highly sought after in most countries to protect the people from either the extreme hot and rainy conditions.

The ‘Health for All’ concept as reflected in the Alma-Ata Declaration of 1978 still remains an indescribable seemingly unattainable goal. The declaration urged all health workers to promote health of and for the people of the world. The program, “Health for All by the Year

2000” began in 1978 with the ambition of bringing basic health to people of the world (WHO, 1978). Similarly, the “Brussels Declaration” from the United Nations General Assembly on Least Developed Countries also proclaimed to free women, men, and children from dehumanizing conditions associated with conditions of extreme poverty (United Nations, 2001). It was with good intention that statements like these are made, but in reality we are far from reaching those goals. Gaps between countries and within social classes within these countries still exist. The World Health Organization (WHO) reports that there is an enormous variation that countries spend per capita on health care and suggest that, on average, a country would need a minimum of \$44 (United States (US)) to ensure essential health services focusing on HIV, tuberculosis, malaria, and child health. Current reported spending per capita from public and private sources shows that in the Southeast Asia region the expenditure ranges from US\$48 to \$3187 and in regions in the Americas from US\$25 in low income countries to US\$4692 in high income countries (WHO, 2012).

LEAP works with known local hospitals in the developing countries it serves to identify the needs of the community. Each country LEAP travels to offers its own set of logistical, political, and governmental challenges. LEAP has worked hard to build the foundation in which we are recognized and trusted to provide the highest level of care to the people of their respective country. Because LEAP is a comparatively small organization in relationship to others and primarily travels with a core group of leaders, LEAP has forged positive working relationships in many levels of the country that assist the team. These relationships assist with the transition of the teams in and out of the country in a smooth non-confrontational manner.

For example, in Belize, LEAP coordinates mission efforts with the Orange Walk Chapter of the Rotary Club International. The Rotarians, many who hold key leadership positions in the

community, assist with the logistics in their country. They work with the local hospital to advertise and identify the medical and surgical needs of the community. The Rotarians work to arrange travel within Belize as well as the meals and accommodations for the team. Belize is situated close to North America which lends itself to a vast number of mission teams rotating in and out of the country to assist the country with medical needs. Orange Walk Town is the location in which LEAP serves. The community is located an hour North from the airport in Belize City and easily accessible by vehicle on a paved road. LEAP coordinates operating room time with the local hospital personnel. The ability for LEAP to provide a variety of surgical services is greater when the traveling distance to the developing country is shorter.

Conversely in India, LEAP works with the Central India Christian Mission (CICM) organization. The LEAP team arrives in New Delhi and takes a twelve hour train ride to the remote village of Damoh. CICM works to support the mission team by providing coordinating transportation, accommodations, and meals. While in India, we stay on the CICM secure compound about thirty minutes from the CICM hospital in Damoh. In the remote village of Damoh, rarely visited by other mission teams due to the extensive travel and logistics, the surgical population is primarily craniofacial cleft lip and palate surgeries.

While every country LEAP visits offer its own different and unique challenges, LEAP strives to serve the people of the world who have no means to seek medical or surgical care at their own expense.

The Education Process

LEAP is an organization that takes perioperative nurses out of the comfort of their current working environment and transports them into unknown and often challenging working conditions. While LEAP welcomes perioperative nurses with varying levels of experiences; it is

the competent perioperative nurse who seems to transition and meet the challenge of mission nursing with a greater aptitude. When volunteering for mission nursing, consider the following when reflecting on your own current clinical practice.

LEAP is looking for clinically competent perioperative nurses who have the ability to scrub and circulate with specific experience in pediatric craniofacial surgery. Defining clinically competent nurses has drawn much discussion. So what does it mean to be clinically competent? Competency as described by Stobinski (2008) is what a nurse is capable of performing that can be measured through actions and behaviors. Benner (1982) drew from Dreyfus Model of Skill Acquisition to describe how five levels of proficiency can be developed in health care, with one of the levels being the ‘competent’ nurse. From novice to expert describes the learner as they pass through five different levels of proficiency; novice, advanced beginner, competent, proficient, and expert. The novice nurse is described as having no experience in the operating room and requires education to guide them in their practice. In perioperative nurse settings the novice nurses are those nurses who require an internship program prior to practicing in a certain field of nursing. The advanced beginner can demonstrate the basic foundation of perioperative nursing and act with guidelines to direct their practice. Benner relates that this level of proficiency still requires guidance and/or a mentor to insure the nurse is operating within safe guidelines and important patient care needs do not go unmet. Novices and advanced beginners can take in little of the situation – it is too new, too strange” (Benner, p. 404). The third level is the competent practitioner. Benner relates the competent practitioner to have at least two to three years of experience. At this level, the nurse can see how her action plan has a long term effect of patient care. The nurse at the competent level acts with the feeling of mastery and begins to see the overall picture of patient care with organization and efficiency

in his/her care. The proficient perioperative nurse at level four performs and sees the whole picture and recognizes when things are out of the norm. This nurse does not contemplate decision making but rather prioritizes and acts with sound knowledge. “Experience teaches the proficient nurse what typical events to expect in a given situation and how to modify plans in response to these events” (Benner, p. 405). At the fifth and final level, level five, the expert emerges. The expert has the knowledge and experience to proficiently and accurately provide the highest level of care to the patient; they see the big picture and anticipate the needs of the patient and/or the surgical team even before they know they need it.

Knowles (1973) in his classic work on education identified four assumptions of learning in his androgical model:

- a. *Self-concept* assumes the learner has moved from a ‘being told to’ form of instruction to a more self-directed role.
- b. The role of *experience* focuses on the learner’s experience as providing a broad foundation for new learning to grow from.
- c. The learner’s *readiness to learn* relates to the evolution from being taught what you need to know to seeking out the information you desire to learn when you are ready to learn it.
- d. *Orientation to learning* can be seen as one’s motivation to learn and coming from within the individual. The need for development often drives the adult learner to achieve their goal (Daloisio & Firestone, 1983).

As a nurse matures through the four assumptions of learning it is recognized that he/she is starting at a dependent role, growing and learning through experience and training and then moving into the independent role. Much like the novice perioperative mission nurse; confident

in their current practice, ready to learn and challenge their practice through motivation and readiness to begin an orientation for development into mission nursing.

It is also important to discuss the way learners absorb information and how to best understand how we learn. Exploring the Cognitive Learning Theory brings to light the definition of cognition and how it relates to nursing practice. Braungart and Braungart (2003) correlate learning theories in relation to healthcare practice. They postulate that there is no need for reward to maintain interest in learning; it is the act of learning that is the reward. My experience in mission nursing supports this concept as many volunteer nurses are interested in the challenge and experience practicing in a developing country and the satisfaction of helping the people of developing countries is the reward.

Cognitive domain. The cognitive domain often referred to as the domain of thinking, involves the learner's abilities to acquire information and then process the same information. Bastable (2003) relates that cognitive knowledge is a prerequisite for the learner to participate in other educational activities. As a mission nurse, it is important to recognize and process information in a timely fashion and then to be able to put that knowledge immediately into practice.

Affective domain. The affective domain is known for how the nurse will respond emotionally to tasks. Affective learning is important when nurses are faced with often challenging ethical issues and value conflicts (Bastable, 2003). It is important on mission trips to be able to have an open positive relationship with your team to support a positive working environment. Another important concept to understand as a mission nurse is the conditions that patient and families present with. For example, in India, I was presented with something I never thought I would hear. A mother with a baby with a severe cleft lip and palate presented for

evaluation. The mother's desire for surgery was incredible as she feared that if her baby daughter did not get the corrective surgery she would be killed. When I looked at the baby it looked like the mother had a son and I was misunderstanding her. However, what I did not understand is that she dressed her baby up as a boy because a baby boy would have a decreased chance of being killed than a baby daughter. I was taken aback by this story and had to quickly gather my thoughts to continue forward in the evaluation process as I knew her daughter was at the borderline age for the surgery and it was in the hands of the physicians for her to be evaluated.

Psychomotor domain. The psychomotor domain is the field that perioperative nurses can relate to and excel the most at; it has to do with skills and coordination. As a mission nurse, some of the structure in how we perform perioperative tasks differs from that in the United States. It is important to recognize how you are able to adapt and overcome these changes that will make you a proficient practitioner abroad.

It is important to understand that LEAP's ultimate goal is to provide perioperative nurses who can practice their profession in sometimes austere working conditions on each mission team. Dissecting down the levels of proficiency and how they relate to the perioperative nurse as they pursue a mission nurse role is very important to the success of the mission trip. Doane and Varcoe (2005) encourage cultivating a process of reflexivity to gain a clearer view on how we perceive knowing. It is imperative that you are aware of your strengths and weaknesses as a perioperative nurse at home and communicate your limitations. Keep in mind that although you may place yourself as a competent perioperative nurse in your current position, consideration must be taken to realize that practicing abroad may have you as an advanced beginner as you become accustomed to perioperative mission nursing in a developing country. After discussing

the various ways perioperative nurses practice and identifying that nurses may practice at different levels, it is encouraged to be true to yourself and acknowledge where you fall on the scale of your perioperative practice.

Caring and Cultural Awareness

The purpose of this perioperative mission nurse manual is to guide perioperative nurses as they journey into mission work in developing countries. As caring and nursing are linked so closely, theorists such as Watson and Leininger have woven caring intricately into frameworks that guide nursing practice. Watson's Model of Caring guides nurses to explore basic 'core' processes of nursing and not the 'trim' (Watson, 1985). Watson challenges nurses to look at the nurse/patient process and not the specialized task oriented actions of techniques and terminology. Leininger's Culture Care Theory focuses on both culture and care as she saw them as missing phenomena when most theorists focused on the metaparadigm concepts of person, environment, health, and nursing (Leininger, 2006). Leininger found that to care for diverse cultures of the world, a foundation of culture and care knowledge was essential to maintain the nursing profession. Both Watson and Leininger provide a foundation of 'caring' which nurses can draw from and adapt into their practice. As worlds collide and west meets east as mission nursing continues to grow, there is an important piece of nursing that needs to be brought to the forefront of care for the diverse patient populations of the world. I was unable to decide in the end on one caring theory to guide this manual as both wove an integral part into mission nursing.

Philosophy and Science of Caring

Watson (1985) bases her Model of Caring through ten carative factors. Each of these factors carries an importance to the overall dynamic to the theory. As I reflect on my experience as a mission nurse, I can align my nursing practice within those carative factors. For the purpose

of this manual, I will explore the first, second, third, and fourth carative factors as they relate to mission nursing in developing countries.

The first carative factor is that of the formation of humanistic altruistic system of values. Watson (1985) grounds this carative factor starting early in one's life and maturing over time. Such acts of this factor include kindness and concern. A quote that I find fitting for mission nurses is that Watson states, "A humanistic-altruistic value system is the commitment to and satisfaction of receiving through giving. It involves the capacity to view humanity with love and to appreciate diversity and individuality" (Watson, 1985, p.11). Watson further explains that to be able to contribute back to society, one must raise self-awareness in one's own personal and professional identity to make the most of one's contributions. As I relate this to perioperative mission nursing, I am linked back to my grass roots in a small rural community. My parents and neighbors were always helping each other through good times and bad from natural disasters to Mother Nature to family emergencies. I saw compassion through the eyes of my elders and they guided me as a child down the path of caring and giving. I find that giving of myself brings a sense of personal and professional satisfaction that fulfills my person and my contribution to society. This carative factor is often cemented as people, patients, and families of those served through LEAP reciprocate with acts of kindness. An example was in Guatemala, a small street vendor had his child in for a corrective cleft lip surgery. During the postoperative visit he brought back leather key chains from Guatemala as a token of thanks.

The second carative factor of exploration is that of the instillation of faith-hope. This factor grows on the first one by taking the goodness of oneself and promoting it into nursing care for others. This carative factor takes the science out of the nurse patient relationship and provides hope that something can be done. Watson (1985) reminds nurses that to care for the

patient in a holistic manner is not to overlook the power of faith-hope as it contributes to and influences the lives of people. In mission nursing personal experience will bring you to solidify this carative statement. While craniofacial deformities of cleft lip and palate are seen in abundance in the remote reaches of India, it is often said that these people see no hope in helping their children, you are their hope. In Belize, a grandmother walked six hours through the jungle carrying a grandbaby with a severe cleft lip and palate deformity; it was hope that saw her through that journey. Hope that there was a chance for corrective surgery. It is with faith that these people seek LEAP's expertise in correcting their child's deformity in the hope that they can live a 'normal' life within their village and within society.

The third carative factor is that of the ability to cultivate a sense of sensitivity to self and others. Watson (1985) challenges nurse's to look into oneself, however hard it may be, to understand your own feelings and potential biases to in turn be able to begin to help others. Watson discusses that honesty to your own self promotes authenticity and sensitivity to others. Mission trips challenge the opportunity to build relationships over time. As a mission nurse, it is important to be able to recognize your own feelings prior to the mission trip to assist in building relationships quickly, efficiently, and more important, genuinely. Relationships forged are built with patients, families, and host volunteers. These relationships last the test of time. Dr. Hobar performed corrective surgery on a young lady in the Dominican Republic. She married and had four children with cleft lip and palates. That lady brought her children back to Dr. Hobar and LEAP for over the past fifteen years. Now if LEAP is in the Dominican Republic, the family stops by to visit and they continue to express their appreciation of LEAP. From social, political, religious, and cultural perspectives, it is important to acknowledge and identify your thoughts,

feelings, and biases prior to embarking on a mission trip so internal personal conflict does not hinder your care abroad.

The fourth carative factor is the development of a helping-trust relationship. Perioperative nurses routinely build these types of relationships relatively quickly during the preoperative visit with patients and their families. However proficient you as the nurse is in your own social/culture context; as a mission nurse, you must remove that feeling of comfort. It is important that you as the nurse realize that in practicing out of one's social comfort zone and walking into a culture that may not have seen anyone from another country, stressors occur. One hindrance of this carative factor is that of verbal and non-verbal communication. In developing countries, you may not speak or understand the language so verbal and non-verbal cues play an important role in building that trusting relationship. A trusting relationship is built on congruency, empathy, warmth, and communication in its entirety (Neil & Tomey, 2006). How you relay these qualities is through your thoughts and actions. An example of building a helping-trust relationship occurred while I was in India where the language barrier is real; I could not understand a hint of what was being said but I could read a mother's non-verbal signs and know that she was concerned for her child. I sought out one of our identified translators and asked him to help me with this mother. I would say the question in English and he would in turn convey the message to the woman in their native language. It was by his tone of voice and non-verbal signs that I could tell that I was not reaching the mother. I asked if he was saying exactly what I asked and he confirmed that he indeed conveyed what I had asked. In self-reflection I realized that in their culture, women are not seen as equals and he was asking harshly questions I meant to come across as concerning an empathetic. I then retrieved a female translator, used touch in my message and received affirmation that I reached the mother through a nod and smile;

however it was not until I followed through on my actions that I felt that the trust was truly gained.

As I explored Watson's Model of Caring, I would like to share that the carative factors extend past the nurse-patient relationship and cross into that of the nurse educator to nurse orientee realm. In the carative factor of interpersonal teaching-learning, I recognized that one of the primary concepts of the factor is to allow the patient to be informed and allow the opportunity for personal growth (Neil & Tomey, 2006). This can then be transposed into the nurse as an educator not only for the patient but for colleagues as well. Watson (1985) relates that information may reduce stress as an emotional response to stressful stimuli such as a painful procedure. One of my objectives of this manual is to help prepare mission nurses to practice abroad; they too can have an emotional response to stressful situations of the unknown.

Culture Care

When I first looked at the concept of cultural care, I wondered what tools I could provide to the perioperative mission nurses to assist them in their practice of providing culturally competent care while in developing countries; I felt that I was on the right track to assist in their professional development. However, what I need to discuss first is whether the expectation is for the perioperative mission nurse to; practice cultural humility or culturally competent care? Exploring the concept of 'culture care' I found a vast amount of information that helped me explore and understand varying definitions about culture care in healthcare settings. It was important for me to gain insight into these definitions to better guide expectations for mission nurses.

Defining the word culture found the literature saturated with varied meanings as they related to many people and many groups. Leininger relates culture as to the "...learned, shared,

and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally” (Leininger, 1991a/b; 1997a as cited in Leininger, 2006, p. 13). Campinha-Bacote (2003) sets forth another example of the definition for culture that dates back to the late 1800s from the works of Tylor stating that culture “...includes knowledge, belief, art, morals, law, custom, any other capabilities and habits acquired by man as a member of society” (p.1).

What then is cultural awareness? Cultural awareness is the one’s own self-reflection and in-depth knowledge of one’s own background. Campinha-Bacote (2003) relates the process of cultural awareness as involving one’s own ability to recognize one’s own biases, prejudices, and assumptions about how one perceives others who are different. Cultural awareness can then be applied to both one’s personal and professional lives. Clinton (1996) describes being culturally aware is when individuals are conscious of their differences from one another primarily based on cultural backgrounds.

Cultural knowledge is the practice of seeking to establish an educational baseline about diverse groups of people (Campinha-Bacote, 2002). Cultural sensitivity on the other hand is an affective function where individuals respond to different cultural situations with respect and thoughtfulness (Hardy & Laszloffy, 1995). Cultural desire is another term that was discovered that describes the desires of the nurse to become more knowledgeable and culturally aware rather than having to engage in the process of becoming culturally aware (Campinha-Bacote). Cultural safety recognizes effective nursing of a patient and family by a nurse of another culture who had taken a process of self-reflection on one’s own cultural identity thus recognizing the impact of one’s culture on their nursing practice (Nursing Council of New Zealand as cited in Papps & Ramsden, 1996). The practice of cultural humility is a life-long process which has no end point

but engages in an active process of ongoing education and change (Dreher & MacNaughton, 2002). Finally, cultural competence is defined by a developed conscious process of an ongoing awareness that is adapted to care in a manner that is consistent with the patient's culture (Purnell, 2002).

It is not surprising to say that with the global movement of people across the continents, that culture care is at the forefront of many scholars' minds. Different perspectives on definitions, concepts, and theories leave a lot to be interpreted by the individual nurse. I chose the Leininger Culture Care Theory to link perioperative mission nursing to.

The Theory of Culture Care Diversity and Universality which is based on the idea that that people from different cultures can be used to assist in the development of professionals to assist in guiding nurses to receive the kind of care they desire to obtain (McFarland, 2006). Leininger's theory is very dynamic so I chose to focus on a couple major concepts central to Culture Care adapted from the Sunrise Enabler which is used as a way to examine the tenants of the theory (McFarland, 2006). With the ultimate goal of providing culturally congruent care for the health, wellbeing or dying, Leininger draws on influencers to assist in shaping the care nurses give.

Worldview. Major concepts draw on one to establish his/her way of looking and understanding the world around them. Worldview can guide actions and decisions through your own understanding of life, people and groups (Leininger, 2006). This overview of the world has direct influence on how you look through, act, and react to your own situations in your environment and immediate surroundings. It was interesting to discover on one of my trips to India there was a woman and a young boy who came right up close to me and looked me straight in the eye. I felt a little uneasy and when I asked them, through the help of a translator, what I

could do for them I did not expect the response I was given. The translator related that they were curious as to my hair color of brown and blonde to the color of my blue eyes. It was not apparent in my own worldview that such a curiosity would arise in that fashion due to the fact that in North America we have all ethnicities that bear various skin tones and eye colors.

Yet another example of worldview pertains to a group of individuals that have a unique set of skills that embrace a perspective on and towards the health of the people of the world; that group is perioperative mission nurses. From the grass roots of basic nursing care to the highly specialized perioperative care that only perioperative nurses can provide; we can take our knowledge and skill to populations all over the globe. As nurses, we are guided by a code of ethics that represents our professional practice; this code in itself is a worldview that speaks, reflects, and guides our nursing practice. For example, in The Code of Ethics, Provision 1.1 states that, “A fundamental principle that underlines all nursing practice is respect for the inherent worth, dignity, and human rights of every individual...” (ANA, 2010). Provision 1.2 relates that in our relationship with patients, nursing care is “universal and transcends all individual differences” (ANA). As a perioperative mission nurse volunteer you have chosen to take your professional practice outside the boundaries of North America and represent not only yourself to the patients of the world but you also exemplify the nursing profession and specialized perioperative nursing care.

Environmental Context, Language, and Ethnohistory. After you have gained an understanding from the worldview perspective, you can then focus on the patient and the influencers around that patient to understand how to provide the kind of care needed. In this area of the Sunrise Enabler many factors can influence the way you shape your way of looking at things. As a nurse, you must reflect on the religious and philosophical, kinship and social,

political and legal, cultural values and beliefs, and education factors of the patients you are working with, just to name a few. For example on one of the mission trips I was challenged to think of women as subservient to their husbands. I was speaking with the parents of a child coming for surgery and having them sign the consent form for surgery. I handed the pen to the woman so she could make her mark and she immediately handed the pen to her husband. In my world of perioperative nursing in a pediatric setting in the United States, often both parents sign the consent form for surgery; it was not until this incident that I further understood that only the father makes the decision for the child to have surgery within the context of the Indian culture.

Leininger and Watson's theories intersect in an existential realm where culture and philosophy meet. Leininger relates that culture can relate to one's values and beliefs. This can transcend into Watson's caring science as an element of an ontological perspective in which there is a philosophical existential aura. Leininger's work is theory within nursing and Watson's work can be classified as a philosophical theory of nursing.

Leininger and Watson's theories connect through the Sunrise Enablers and the Carative Factors. Both theories unite through care and caring; however they have a profound connectivity as explored further. Leininger's concepts are delineated out through an anthropological perspective which can be viewed either individually or collectively from a cultural group standpoint (Cohen, 1991). Watson's concepts, from the field of psychology and philosophy explain her theory from a transpersonal interaction viewpoint (Cohen). Watson's Philosophy of Science and Caring blends into Leininger's Culture Care Theory of Diversity and Universality in that the aspect of providing culturally congruent care is event in both theories. Similarly to Watson's assumptions, Leininger too has major assumptions that support her theory. The link between Watson and Leininger is that they both refer to care as being central to nursing (Neil,

2005). Watson's third carative factor has a central point of having a cultivation of sensitivity to self and others which can align into Leininger's concept of being aware of one's cultural values and beliefs in the Sunrise Enabler. Another similarity is Leininger's description of how religious and philosophical factors influence care and health patterns while Watson's tenth carative factor can be explained as allowing one to have existential spiritual forces.

In conclusion both care and culture play an important role in providing perioperative nursing care throughout the world and here at home in North America. LEAP travels to many countries all over the world and for you as a perioperative mission nurse to become culturally competent in all the cultures and sub-cultures he/she encounters on mission trips abroad is unreasonable. The purpose of the exploration of care and culture is to bring both a knowledge and awareness to you, the mission nurse, so that you may have the tools and resources available to help guide you to understand nursing judgments, decisions, and actions when caring for patients with diverse backgrounds.

Pre-Mission Planning

The Mission Team.

Surgery is a multifaceted area of practice that requires a co-ordinated team approach to provide optimal patient care. The mission team is made up of healthcare professionals from across the United States. The mission team, depending on the country of destination and the identified patient population, can be as few as ten or as large as twenty five. The mission teams are decided upon several months in advance based on the expertise and experience of the individual in their specialized role. On average LEAP runs at least two operating rooms per trip; the team would then consist of:

- a. Surgeons x 2 (on occasion a resident or fellow will accompany the team)

- b. Anesthesia Provider x 2 or 3 (depending on the mix of anesthesiologist and/or Certified Registered Nurse Anesthetist (CRNA))
- c. Scrub Personnel x 2 (may be Surgical Technologists or Registered Nurses)
- d. Circulating Nurse x 2
- e. Respiratory Therapist or Anesthesia Technician x 1
- f. Perianesthesia nurses x 3
- g. Mission Director
- h. Ancillary support personnel x 1 or 2

The role and number of the team depends on the length of the trip, the projected population, and number of operating rooms that need to be staffed. When LEAP ventures across continents, consideration is taken to increase the number of staff in each role to accommodate the increased need to operate more efficiently and often longer in the day during the week long surgical schedule. For example, when LEAP travels to India there is one anesthesia provider per operating room with an extra to offer breaks and assistance to the other providers. Similarly, surgeons will often take craniofacial surgical fellows to augment more in-depth cases or to spell surgeons for breaks.

Communication and teamwork. Patient safety in the operating room requires a culture that fosters open communication and teamwork. It is important for all team members to understand that the focus is on safety at all times. A culture of patient safety survey at one Pennsylvania hospital revealed that their perioperative division felt that their environment lacked a patient centered focus, teamwork and communication (Johnson & Kimsey, 2012). Johnson and Kimsey disclosed that team communication was hindered by obstacles such as hierarchical and situational barriers. An observational study that looked at interruptions and miscommunications

during surgery showed that 30.9% of miscommunications arose from a lack of experience (Gillespie, Chaboyer & Fairweather, 2012). It was also discussed that teams that routinely work together have an increased opportunity to build a relationship where communication is more effective. Another study references the operating room team's ability to function in an emergency situation or crisis as being predisposed to error due to poor communication (Undre, Sevdalis, Healey, Darzi & Vincent, 2006). This study also revealed that the perception of the structure and roles of the team varied amongst participants; some found the team overlapped in roles and some felt the team was hierarchical. Yet another study that was conducted in operating room setting revealed different perceptions on teamwork depended on the personnel surveyed. For example, the quality of collaboration and communication as viewed by surgeons rating operating room nurse was 87% favorable whereas operating room nurses rated the surgeon as collaborative was only 48% favorable (Makary et al, 2006). Makery et al. similarly found the anesthesiologists perceptions on a collaborative relationship was 89% positive and the operating room nurses perception of that relationship in reciprocate was only 63% positive. Interestingly, the surgeons found their collaboration and communication with the anesthesiologist to be 84% favorable whereas the anesthesiologists viewed their relationship as only 70% collaborative.

These studies bring to light the opportunity for improvement in communication and teamwork in operating rooms where environmental conditions are controllable and the stressors limited; now consider those opportunities and factor in the environment in a developing country where supplies and resources are limited. Also factor in the stress of travel, not sleeping in your own bed, no air conditioning in a hot and humid environment, and how that in turn impacts each team member. It is important to reflect on the opportunities you are aware of in your own

practice environment and consider how you may act or react when different stressors come into play.

An example where teamwork and communication played an important role in the outcome of a patient was when a surgeon was trying to add on a patient that was in definite need of surgery. Anesthesia could not support the patient and neither could nursing. There were not enough resources and supplies available to properly and safely care for this child. It was important for both parties to speak with the surgeon honestly and openly. The surgeon expressed frustration but understood that safety came first; the patient was postponed until the next LEAP team came carrying the necessary equipment and supplies to properly care for this patient. Fast turnover time and efficiency are important in North American operating rooms. In developing countries where instrumentation is limited, turnover time is increased as sets are used back to back and must be properly decontaminated and re-sterilized between surgeries. Surgeons often try to push for the turnover they are accustomed to having. As operating room nurses, it is your job to inform the anesthesiologist and surgeon when to bring the next patient back to the operating room; even if that means delaying the surgical case a few minutes while the instrumentation sterilization process is completed.

Poor communication and teamwork can be detrimental to patient safety. Non collaborative teams between physician and nurses can adversely affect surgical outcomes and patient care. LEAP empowers each team member to communicate in a positive and open manner for the benefit of not only the patient but the team as well.

Perioperative pre-mission planning.

Prior to the actual departure of the mission, there is an immense amount of preparation that takes place. From procurement of supplies, sterilization of supplies, pulling of supplies and

packing supplies, the mission trip starts months before the actual mission trip departure date. LEAP stores all the supplies out of a warehouse; that is where all of the surgical mission preparation takes place. There are two nurses who are Co-Directors of Supply and Nursing who assist with all of the operating room preparation for the mission trips. They will coordinate the procurement and sterilization of supplies, as well as arrange pulling and packing dates and sealing and labeling dates for the trunks for travel.

Procurement of supplies. LEAP obtains surgical supplies primarily through donation. Donations come in the form of money or supplies. The donation of supplies also comes in two fashions; sterile and unsterile. While sterile supplies are preferred, LEAP graciously accepts unsterile supplies as well. The Co-Directors of Supply and Nursing work throughout the year to maintain a base stock of the surgical supplies; which includes procuring the supplies and if necessary having the supplies sterilized at local hospitals. There are also coordinated work days throughout the year to involve all perioperative nurse volunteers in sorting supplies and packaging supplies for sterilization. It is encouraged, if possible, that you attend these work days to gain an understanding of the behind the scenes preparation that goes into one mission trip.

Packing. The packing process begins approximately six weeks prior to the trip and is completed one to two weeks prior to the actual departure date. Packing is an involved process and attendance is a highly encouraged expectation if you live in the Dallas area. Several dates will be organized and emails will be sent out with the date and time of packing. At the first packing session of the designated trip, a packing list will be supplied. The packing list contains items such as instrumentation, equipment, sterile supplies, unsterile supplies, and medications. Each packing list that is supplied is mission specific; it has been developed based on the country of destination, patient population, specialty of the surgeons, and length of stay. The packing lists

also take into consideration the availability of supplies and medications in the host country and are modified accordingly. For example, in Haiti LEAP has to pack sterile gowns and drapes, whereas in India, the host hospital is able to supply these items for us. An example of a packing list is found in Appendix B.

The packing process has three stages; first is the pulling of supplies, second is the packing of supplies in the trunks, and third is weighing, sealing, and labeling the trunks.

The first part of the packing process is pulling instruments, supplies, and equipment from the storage bins and racks and placing them onto the supply tables. As the supplies are pulled the nurse pulling that particular supply will check off the packing list that the supply was pulled. All supplies as they are pulled are placed in clear drawstring bags for ease of identification. When pulling equipment such as suction or electrosurgical machines; each piece of equipment is plugged in and turned on to insure that is in working order. Each piece of equipment is then wrapped in bubble wrap for protection prior to being placed on the supply table. Filling the suture list is the most time consuming task of pulling. Packing sutures takes into consideration the surgeons, patient population expected (cleft lip, cleft palate, rhinoplasty, ear reconstruction, etc.) and the best estimate to the volume of the each of these surgeries. Surgeon's preference cards are used to guide in the suture pulling process (Appendix C).

Once all the supplies are pulled, the second step is to pack all the supplies into trunks that will house the supplies as they are transported to the final destination. The amount of luggage/trunk/duffel bags we are able to take with us depend on the country of destination, airline of travel, and the number of team members traveling. Each mission volunteer is allowed two pieces of luggage according to the airlines; however, LEAP allows each volunteer to only pack one personal bag for check in and uses the second allowed check in bag for the mission

supplies. There is an art to packing that has been refined by the two Co-Directors of Supply and Nursing. This is based on years of mission trip packing through trial and error. Consideration to packing depends on the mission destination and anticipated modes of transportation on the trip. It is important that you follow the tips below in order to effectively and efficiently assist in the packing process:

- a. Line all trunks, boxes, and duffels, with heavy duty trash bags to protect supplies from dust and water during travel.
- b. Label all trunks with the appropriate preliminary identify label. For example, trunks are label with a simple number, 1, 2, 3..., if duffel bags are used they are labeled D1, D2, and D3..., and if boxes are used they are labeled with B1, B2, B3...
- c. As supplies are place into trunks, boxes, or duffel bags they must be recorded on the packing sheet. Distribute the heavier items, instrumentation and electrosurgical units, throughout the trunks first and then pack the lighter supplies around them.
- d. All supplies are separated out amongst the different trunks. For example, do not put all the same gloves in one trunk, in the event a trunk is stolen, lost, or damaged we have similar supplies in other trunks that will cover until the missing trunk until located.

Packing can be a lengthy process as items are placed strategically into their trunk, duffel, or box. This itemized way of packing is detailed specifically for custom purposes. Each country of destination has varying requirements during immigration and customs and it varies trip to trip and year to year. This also serves to identify if a trunk gets lost or stolen. If LEAP is missing a trunk it can be easily identified as to which supplies, instrumentation, and equipment will be missing. This will also guide the perioperative nurses in our set-up and surgery scheduling until the trunk has been located. During the packing process, you as a perioperative nurse volunteer

must take into account the importance of maintaining the safety and integrity of sterile supplies during travel.

The final step is the weighing, sealing, and labeling, of the trunks. The goal is to keep the weights of the trunks to around forty-five pounds. Once all the supplies, equipment, and instrumentation are packed the trunks and duffels are weighed. All weights are recorded (see appendix D). If any trunk is over the standard weight limit of fifty pounds, supplies must be moved to distribute the weight accordingly. Keep in mind as you move supplies, equipment or instrumentation you must change the packing sheet to reflect that change. Performing this step assists in insuring that the weight limit of the supplies at the time of airport check-in is not exceeded. LEAP has had instances where recorded trunk weights of forty-eight pounds at the warehouse differed from the airline scale that reflected fifty-two pounds, so we had to shuffle supplies at the airport during international check-in. You will be assisting in the sealing of the trunks and duffel bags which is as simple as using a plastic zip-tie to lock the zipper or to seal the lid to the base of the trunk. Labeling involves labeling the trunks with large numbers on four sides of the trunk and reinforcing the self-sticking number with additional packing tape. The trunks are also labeled with destination stickers as well as LEAP identification labels.

The purpose of the excessive labeling is to insure through all modes of transportation LEAP mission supplies are easily identifiable. To minimize the potential for loss, the perioperative nurse team lead performs trunk/duffel counts at various stages of the trip. For example, counts are performed at:

- a. The warehouse at the end of packing
- b. As trunks/duffels are loaded into the trucks for transport to the airport
- c. Prior to check-in

- d. During check-in as each team member is assigned a trunk or duffel
- e. During baggage claim at the host country
- f. After passing through customs
- g. As the trunks/duffels are being loaded on trucks/buses for transport in the host country
- h. During any stopover where the trunks/duffels are off-loaded
- i. At our final destination prior to storage in the hospital.

The person performing the count is primarily the operating room nurse team lead for the trip; however, once the routine is established more team members begin to take ownership and assist in the counting process.

Mission Work

The medical mission typically begins the following day after your arrival. Travelling to your mission country destination can be exhausting. It is important that once you arrive to your place of accommodation you get settled in quickly so that you may rest comfortably. By discussing morning routines with your roommates you will have a better understanding of the time it will take for you to get ready in each day. For example, if you shower in the morning and if your roommate(s) showers in the morning as well you will need to adjust your wakeup time accordingly. Insuring a good night's rest on your first night, as well as each following night, will carry you through the long hours of the long surgical days ahead.

After your first night of rest, the next day is a long and busy day. The typical schedule for the first mission day is for the team to perform patient evaluations and operating room set-up. The surgical days will then follow, finishing with a cleanup and re-packing day.

Evaluation day and operating room set-up day. Depending on the developing country of your mission trip and length of stay, your evaluation and operating room set-up day may be as

short as four hours or as long as eight. The team is divided up into two groups; evaluation and operating room set-up.

Evaluation team. The evaluation team is responsible for identifying patients, screening patients, and scheduling patients for surgery. The surgeons, anesthesia providers, mission director, perianesthesia nurses, and general volunteers support the patient evaluations. Each host country has a different way of assisting LEAP. For example in India, patients are identified ahead of LEAP's arrival, pre-screened by local physicians, given numbers and then housed in tents on the hospital grounds awaiting the mission teams arrival. LEAP works closely with the mission hospital and requests that infants and children are selected first for screening. The evaluation day is set up in a rotation. The hospital staff assists LEAP by calling out the number of the each patient and guiding them into the clinic area. LEAP utilizes translators to assist in communicating with the local patient and families. The translators have been organized in advanced so there is no delay in moving the evaluation process along. The translators are often nurses and physicians from local hospitals. For example, in India, the nursing students from the local Christian Mission where we stay provide translation services for us.

The first station initiates the patient's chart for LEAP's medical record purposes. It is at this station that the surgical evaluation of the patient is performed by the surgeons. Once the determination has been made that surgery is in fact needed and/or recommended they are sent onto the next evaluation station for screening.

The second station is managed by the anesthesia providers. At this station the anesthesia providers conduct a thorough history and physical to see if the patient is fit for surgery. The patient's age, if known, and weight are recorded and a hemoglobin and hematocrit (H&H) is

ordered. If the anesthesia providers clear the patient for surgery they move to the next station where they are scheduled for surgery.

At the third station, one of the operating room nurses will schedule the patients for surgery. The decision on the day and time of a patient's surgery depend on the following:

- a. Age of the patient
- b. Health status of the patient
- c. Type of surgery
- d. Length of surgery, and
- e. Availability of surgical resources

For example, babies are scheduled first in the day due to fasting overnight and the ability to keep their hydration status closely monitored. Older children can understand the concept of not eating or drinking prior to surgery and can be distracted if needed, thus they are scheduled later in the day. If a patient has mild asthma for example, they are scheduled early in the day so the team medical team can watch them closely after surgery. Cleft palate patients are also scheduled early in the day so the surgeon and anesthesia can closely monitor their airway status throughout the day. Major surgeries such as oral maxillary work are done early in the day and early in the week so the LEAP team can closely monitor their daily progress. Minor surgeries that are typically less than one hour and are superficial are scheduled towards the end of the day. The other consideration is that LEAP travels with limited supplies, instrumentation, equipment, and resources to care for the patient population; however, for example, if the team needs to perform nasal corrective surgery on multiple patients, LEAP only has one nasal set, thus two nasal surgeries cannot be performed at the same time and the scheduling of these patients is carefully staggered on the schedule accordingly. Once the patient is assigned a date and time for surgery

they are also given a sheet of paper with fasting guidelines. They are instructed to follow this guideline closely or their surgery may be cancelled for safety reasons. This station also assists with the patient and family signing a LEAP consent form for surgery. Most of the host hospitals have the patient and family sign their hospital's own consent as well.

The last station is the station in which each patient gets their picture taken for LEAP records. LEAP takes before and after pictures for ongoing mission education as well as patient and family education. One Indian teenage patient with a severe cleft lip and palate came to see LEAP while we were in India. Her father related to us that his daughter had no prospect of marriage because he could not afford the dowry due to her facial deformities. LEAP took a before picture and proceeded to perform corrective cleft lip surgery. This young lady came back the next year for her cleft palate surgery. She showed us her before picture and was very appreciative of how her appearance changed and how she looked now. She and her father were so excited to tell us that due to her previous surgery, he was now able to afford her dowry and she was engaged to be married.

Once the surgical schedule has been filled, the LEAP team continues to see the rest of the patients that have been pre-screened and have been waiting to see the team. From the rest of the patients, LEAP builds a waiting list based on the patients that did not make the surgical schedule. The waiting list consists of approximately ten patients that fast each day in the event the schedule ends early and there is opportunity at the end of the day to add them on or in the event a patient is sick and surgery cannot be performed. Those patients seen that did not make the schedule or the waiting list are put on another list and are given priority the following year when LEAP returns.

Operating room set-up. The surgical technologists, circulating registered nurses, respiratory therapist, and anesthesia technician set up the operating rooms while the patient evaluations are being performed. The operating room set-up can be a lengthy process depending on the country LEAP is in, if the operating rooms are currently in use, and how the operating rooms are laid out. The primary focus of the operating room set up is to insure patient and staff safety throughout the mission trip. There are certain primary steps that the operating room team lead considers upon entering the operating room area:

- a. The patient flow from the preoperative phase to the intraoperative phase to the postoperative phase is important. Depending on how the host hospital utilizes their current space, LEAP often changes things to accommodate flow for safety and efficiency. For example, our perianesthesia nurses function in both the preoperative and postoperative phases of surgery so having these areas in close proximity is important to insure nursing availability to support each area. Another example is considering the traffic of the patient during all phase of the perioperative experience in insuring traffic patterns do not congest hallways in case of an emergency.
- b. The operating room layout is important. The host hospitals allow LEAP to use the operating rooms for the duration of the trip. They give us the opportunity to remove some of their furniture, supplies, and equipment to better accommodate what LEAP brings. For example, in one country their operating room is full of orthopedic equipment and furniture which LEAP would not use during any of their procedures so the host hospital allowed us to move those items out into a storage area which made room for our supplies and equipment. LEAP brings their own anesthesia machines so there is no need for the host country anesthesia machine so those are removed to

- storage. LEAP takes into consideration the ease of patient transport in and out of the operating room. LEAP insures stretchers and staff can easily access all areas of the room without any difficulty. Another consideration for the room layout is for the ability of the team to keep the sterile field away from the traffic of the staff and patient to insure sterility is maintained.
- c. Environmental safety is also important. The circulating nurse team lead walks through the perioperative area to identify any potential hazards that might compromise patient and staff safety. Items of specific consideration are:
- i. Electrical hazards
 - ii. Fire hazards
 - iii. Chemical hazards
 - iv. Location of fire extinguisher if available
 - v. Stability and working ability of the operating rooms overhead lights
 - vi. Room equipment (back table, prep stand, and mayo stand)
 - vii. Hospital generator checks, and
 - viii. Working abilities of the operating room tables

The importance of these specific checks has been substantiated by close calls and near misses that LEAP has been challenged with throughout the years. For example, on one of our first mission trips to India, we had to use their electrical converters since their electricity is different from ours. To use the converter, we plugged our equipment into the converter and then the converter is plugged into the plug in the wall. During one of the surgical cases sparks started to fly and the converter caught on fire. One of the operating room employees from the host hospital quickly unplugged the converter and pulled it, flames and all, out the operating room

door past the anesthesia machine in the adjacent room, down the hall and through the door to the outside. Everything happened so quickly that by the time it was over we realized what a close call that really was and how it jeopardized patient and mission team safety. Based on this event, we had the hospital purchase new converters for us to use, and perform a fire safety sweep at each host facility looking for any potential hazards, as well as locating fire extinguishers and the closest water source. Another example was in the Dominican Republic; with surgical cases under way, the power went out for about five minutes. We were fortunate, all the patients were safe and we used flashlights and headlights to see until the power came back on. We soon found out that at ten o'clock every morning the hospital scheduled generator and power checks. From this information we were better prepared the next time this happened and scheduled surgery accordingly. We continue to communicate with host hospitals to see and anticipate similar events in different countries. Yet another example of a near miss was assuming an operating room table worked. It was when we were to use an old crank handle operating room table. The patient was under general anesthesia, the nurse prepped the patient and the surgeons had just draped the patient when he wanted the patient in the head down position. I went and put the crank in the head down position and went to turn the handle. It did not move. The anesthesiologist gave it a try and could not get it to work. The crank was rusted frozen in the flat position and we could not accommodate the surgeons request for head down. We had to improvise and adjust the patient's body position to accommodate the needs of the surgeon. After the surgical procedure we were able to unfreeze the bed crank for the rest of the surgeries. It was often through unfortunate near misses and trial and error that our safety list was developed. As we reflect, it was often things that were taken for granted in our own practice environment in North America that led us to be naive in developing countries.

Once these determinations have been made, the set-up team begins to unpack and coordinate the room set-up of all the equipment and supplies for the surgeries. Some basic set-up tips for your consideration are:

- a. Unpack the equipment and supplies.
- b. Sort supplies in the trunks into like categories then label each trunk. For example, put all the gloves together in one trunk; put all the dressing supplies in another and the entire suture in another and so forth. This makes it easier to pull supplies for the surgical cases.
- c. Test all equipment, electrocautery units, headlights, and suction to insure they did not get damaged during transport.
- d. When unpacking the instrumentation; inspect that the set are not damaged and note if they are still sterile as customs will often open the instrument sets and render them unsterile. If they are contaminated they will need to be processed prior to use.
- e. Assign each surgeon to an operating room. Some suture and supplies are specific to particular doctors and it makes supply management easier.
- f. Place a base stock of the common surgical supplies and suture in the room for each surgical team:
 - a. Suture
 - b. Gloves
 - c. Dressings
 - d. Sponges
 - e. Syringe and needles
 - f. Prep trays

- g. Electrosurgical grounding pads
 - h. Positioning supplies
 - i. Gowns and drapes
 - j. Blades, and
 - k. Instrumentation
- g. Place one electrosurgical unit, headlight, and suction in each room; plug each one in to insure they and the electrical outlets are working.
- h. The decontamination of surgical instrumentation area needs to be established. In a normal sterile processing department this is performed by trained sterile processing technicians. It is important that as a scrub or circulating nurse, you understand this process. It is key to have a decontamination area close in proximity to the operating room to decrease the chance of exposure of contaminated items to unnecessary personnel as the used instrumentation is transported from the operating room to the decontamination room. In a developing country, there is not the luxury of covered case cart systems so improvising adds risk of exposure to others as we often carry dirty instrument sets openly to the decontamination area. As each surgical case is finishing the circulating nurse will provide the scrub personnel with a basin filled with an enzymatic solution for immediate softening and breakdown of blood and debris (Phillips, 2007). Manual cleaning then follows in the decontamination area where manual cleaning is used to remove any residual debris from the instrumentation prior to terminal sterilization (Phillips). It is important to wear personal protective equipment while washing instrumentation to avoid possible spray. LEAP provides gloves, eyewear, and masks for the decontamination area. After the instrumentation

- has been properly decontaminated the circulating nurse will then take it to be sterilized processed.
- i. The last very important measure in setting up the operating rooms is determining the way in which surgical instrumentation will be decontaminated and then re-sterilized. The host facilities that LEAP works with generally have an area designated for decontamination. Operating room staff at host hospitals often have the capacity for steam sterilization; that being said, it is important to test to insure the sterilizers work. LEAP also insures that the steam sterilization meets the recommended practices as outlined by AORN's Perioperative Standards and Recommended Practices (2012) (see attached Appendix E). The set-up team will run a trial sterilization load with a chemical integrator to insure parameters of sterilization are acceptable. If the integrator strip color does not move into the acceptable range the temperature and/or duration of the sterilization cycle is adjusted until this requirement is met. The local operating room personnel are accommodating and will assist in this process. In the event that there are not steam sterilizers or they are broken LEAP will go to the approved method of high level disinfection (HDL). This method requires a sterile soak and rinse basins that LEAP will have packed in case of this event. For this process, LEAP uses a glutaraldehyde based formulation also known by the trade name of Cidex® (see Appendix F). This will require a separate sterile set-up adjacent to the operating rooms. It is important to have an unobstructed area for ventilation and safety purposes of this disinfectant. The set-up will contain one basin with the Cidex® solution and the second basin will contain sterile water used for rinsing the Cidex® off the instrumentation prior to use on the patient.

Upon completion of the operating room set-up, the set-up team will assist with the completion of the evaluations. Once both teams have finished, the set-up team will walk the evaluation team of surgeons, anesthesia providers, and nurses through the layout and flow of the operating room.

This is a time of communication and collaboration and in the event concerns arise from any team member, they are discussed and addressed as appropriate. At this time if concerns arise from any team member they are addressed and discussed the day before the surgical cases begin. Upon the agreement from all team members that the perioperative environment is safe for surgery, the team will then set up for the first surgical cases of the next day. Once the operating rooms are ready to go, the team will travel back to the arranged accommodations for dinner and rest.

Operating day routine. The operating day routine is pretty consistent throughout the trip. The operating room schedule typically begins at 0730 and is slated to end at 1700. A typical day consists of:

- a. Breakfast will be provided where your accommodations; time varies but usually at 0600
- b. Travel to the hospital departs between 0630 and 0645
- c. Arrive at the hospital at 0700
- d. Surgical cases to begin around 0730
- e. Breaks are coordinated amongst the operating room by the circulating nurse team lead
- f. Lunch is brought to the hospital and coordinated amongst the operating room team
- g. Frequently the operating day will not end as scheduled.
- h. Once the last surgical case comes out of each operating room, the entire team, physicians included, break down the room, take out the trash, and mop the room.

- i. Instrumentation is decontaminated and re-sterilized for the next day if steam sterilization is available. If steam sterilization is not available, the team will leave the instrumentation clean and soak in the HDL in the morning prior to the first surgical case.
- j. The operating room team will then set up the operating room and pull supplies for the first surgical case of the next day.
- k. The entire mission team will not leave the hospital until the recovery room team has handed off communication on the last surgical patients of the day to the hospital nursing staff that will care for LEAP's patients during the night.
- l. Transportation is coordinated back to the accommodations
- m. Dinner is usually waiting for the team upon arrival to host accommodations.
- n. It is advisable to get plenty of rest as you often have long days ahead of you

It is expected that you be ready to go on time. Some prefer to shower in the evening and some in the morning; you can coordinate this schedule with your roommates. I have found it helpful to layout my scrubs for the next day and have my hospital daypack (see Appendix G) packed and ready to go.

Nursing process in a developing country. Perioperative nursing is a decisive and dynamic process of delivering care to a specific patient population. The nursing process that perioperative nurses use in North America differs to some degree while practicing in a developing country. Spry (2005) identifies that perioperative nurses apply the nursing process in a set framework. The nursing process is an avenue to bring nursing practice into perspective with critical thinking in guiding perioperative nursing care (Rothrock, 2007). Spry acknowledges that perioperative nursing focuses on equipment, instrumentation, and technical skills within the nursing process with the end goal similar to any other nurses practice; to provide

care that will elevate the patient's wellness after surgery to an equal to or greater level prior to surgery. Perioperative mission nursing varies in the traditional sense of how you practice in the United States. Often the perioperative nurse does not go out and meet the patient and their family outside of the operating room in the traditional preoperative setting. While mission work strives on efficiency to provide safe care to as many patients as possible in a limited amount of time; you, the perioperative nurse, wears many hats such as turning over the operating room and decontaminating and sterilizing instrumentation tasks that are usually supported by ancillary staff in the conventional perioperative setting in North America. However, when the opportunity presents itself, perioperative mission nurses are guided in the same nursing process model that consists of: assessment, nursing diagnosis, outcome identification, planning implementation, and evaluation (Rothrock, 2007). On occasion when the you as the perioperative nurse gets to pick up the patient in pre-op, she follows the conventional method of reviewing the medical chart, validating important findings, and receiving hand-off communication from the preoperative nurse. There is no formal method of documentation of nursing diagnosis but perioperative mission nurses are cognizant of the potential common risks for: infection, injury, anxiety, fluid and electrolyte imbalance, and hypothermia. After the initial assessment, interpretation of data, and identification of nursing diagnosis the perioperative mission nurse plans her patient care accordingly. This is where knowledge and experience guide the seasoned perioperative nurse in his/her practice. The perioperative nurse will set her priorities for care and move to the next step in the nursing process; that of implementation. The perioperative nurse will respond with critical thinking in response to the patient's status or modify and change surgical activities based on the patient's status or change in condition. Evaluation includes checking and observing the patient response to interventions implemented. However, the last phase of the nursing process,

Rothrock posits that this is an ongoing component to providing care and attaining positive patient outcomes.

Although there is no formal documentation required by perioperative mission nurses that practice with LEAP; it is with professional responsibility and accountability that you, perioperative mission nurse, continues to provide patient care in a similar manner to which they practice in North America.

AORN Perioperative Standards and Recommended Practices. Pre, intra, and post mission trip the AORN Standards are adhered to as closely as possible; recognizing that travel conditions and conditions in the developing country lend perioperative nurses to recognize that some deviation from the recommended practices are deemed acceptable. Having a sound and competent understanding and practice of the recommended practices will assist you as the perioperative mission nurse in recognizing deviations to the norm and adjusting practice to within an acceptable level. Some of the perioperative recommended standards worth mentioning in this guide that perioperative mission nurses encounter frequently are:

Storage and Transport of Supplies (AORN, 2012).

- a. Sterilized materials stored in manner to insure sterilization
 - a. The recommended storage range for supplies is <75°F and relative humidity not to exceed 70%.
 - b. Challenges to this recommendation are modes of travel once outside LEAP storage, during flight, and in the host country.
- b. Transportation of sterile items should be controlled
 - a. Challenges for this recommendation are during the mode of travel the shifting of supplies causing pressure and movement.

Perioperative nurses strive to keep supply package integrity intact by packing in plastic bags and packing to decrease shifting of surgical supplies.

Environmental Cleaning. Operating rooms in developing countries are challenged in maintaining a clean working/surgical environment. A couple of recommendations to keep in mind to provide the patient with the utmost clean surgical environment are:

- a. A clean environment needs to be established (AORN, 2012)
 - a. A challenge for this recommendation is that operating room ventilation systems in some of the developing countries are nonexistent or antiquated. Some host hospitals have window air conditioning units blowing in air and dust directly from outside straight into the operating room. Ceiling fans are often used to cool rooms and to keep unwanted insects from around the sterile field and they also blow dust directly down on the surgical site. Another test to our normal practice is that the operating room tables are usually in questionable condition. Often the beds are rusted and dirty. Table mattresses are torn and not clean and no linen available to cover the mattresses.
 - b. LEAP perioperative nurses strive to overcome these challenges by redirecting the airflow in the rooms from directly hitting the surgical field. During the set-up day, the team cleans all the furniture in the room with germicidal wipes. The bed is inspected and depending on the condition of the mattress, it is cleaned and covered with an impervious surgical drape.

Maintaining a sterile field. This is probably the most challenging recommended practice to follow and maintain an eye on as there are many variables that come into play that will test every fiber of your perioperative being.

- a. Functioning and moving within a sterile field (AORN, 2012)
 - a. Operating rooms across the world vary in their size and orientation. Doors open directly into other operating rooms and air in the operating rooms are not set to positive pressure as recommended. Some operating rooms have you taking one patient through another to get to the next operating room. Gowns provided in host countries are usually made out of cotton and are not impervious. Sterile items are opened to the field but you will often find mosquitoes landing on the sterile mayo stand and sterile back table. As mentioned earlier, ceiling fans are a fixture in some operating rooms and have direct air flowing into the sterile field blowing dust and debris throughout the sterile area.
 - b. LEAP works hard to challenge the patient flow in the operating room to insure the safest possible environment for the patients. LEAP will often plan surgeries to avoid mixing of patients and set up the sterile field to decrease the chance of contamination. The use of ceiling fans is not only for patient safety but the surgical team as well. In India, I was told by one of the operating room technicians that the fan blows down on the surgical area to keep mosquitoes and other insects from potentially landing and spreading malaria to the patient and team.

Post Mission

Post mission work begins in the developing country on the last surgical day as the operating room schedule begins to finish. This process entails cleaning equipment and instrumentation, gathering up supplies, repacking and relabeling the mission supplies and equipment into the trunks for travel.

The first step is for the lead nurse to establish an area where the process of organizing and repacking the equipment and supplies will take place. He/she will identify tables that can be used to lay out the supplies and equipment prior to repacking; patient stretchers are often useful for this purpose if tables are not readily available. Once this area is identified, you may begin by emptying all of the trunks that have been used as storage for surgical supplies during the mission and lay the supplies on the tables. Remove all of the airline baggage tickets from the trunks/duffels/boxes. Place the trunks in numerical order and pack the trunks starting at the first one. During the mission trip supplies are used thus when traveling home fewer trunks are needed. It is easier to keep track of the trunks if they are kept in numerical order. If the team packed in duffel bags, those are rolled up and packed along with the equipment and supplies into the trunks and not used on the return trip. You will then need to line the trunks with large garbage bags.

The second step you will be involved in is the process of cleaning. As the surgical cases are finished and the rooms close down, all the equipment and power cords must be thoroughly wiped down with a germicidal wipe. All the instrumentation is to be terminally cleaned, repackaged into the sterilization containers, but not re-sterilized. The surgical supplies are inspected to insure sterility has been maintained. Once these steps are completed, all of the equipment, instrumentation and surgical supplies are then placed on the packing table.

The third step is the process of re-packing the equipment, instrumentation, and surgical supplies. You will be using the packing list to begin to re-pack. Keep in mind the weight limit of fifty pounds; if a scale is available, weigh and record each trunk as it is packed. Once all of the trunks are packed, seal them with the plastic zip ties.

The fourth step in the host country is to thoroughly clean the operating room and replace all the equipment and supplies back as you found them. There was a mission trip to the Dominican Republic that I volunteered for. When we reached the hospital we attempted to speak with the operating room personnel and ask which rooms LEAP could use and where we could store our equipment and supplies; we were ignored. The staff never spoke to us even though we continued to try to engage in conversation with them. We invited them into the operating rooms to observe surgery hoping that this act of professionalism would engage them; nothing. For the first two days of the mission trip there was not a reciprocated relationship. It was not until the third day that one of the nurses actually spoke to our mission director and expressed her appreciation for our continued attempts to speak with the staff. She informed us that a previous team came into their operating room, and without asking moved all their equipment and supplies around. Then at the end of the mission they left the place a mess for the operating room staff to clean up. This left a very bad impression and the operating room personnel assumed that we were going to treat them the same way. By the end of the week the staff engaged and came into the operating rooms to observe surgery, asked questions, and even offered to help. It is important to build and maintain a positive relationship with host hospitals to show LEAP's commitment to continue to partner with them for future mission trips. We encourage a positive interaction so they may learn from us and that we may learn from them.

The final stage in post mission work is done back home at the LEAP warehouse. You as part of the team will meet at the ware house to unpack the trunks and restock them to their appropriate storage location. The equipment is plugged in and tested prior to storage and the instrumentation is taken to a local facility and thoroughly was then sterilized. These steps help to ensure the two co-directors of supply and nursing have an accurate inventory and assessment of equipment and supplies for the upcoming mission trips.

Personal Preparedness

It is an exciting and often overwhelming time when you personally prepare for travel to a developing country. Whether traveling on a short mission trip, somewhere close to the North America like Belize or Haiti, or on a longer trip across the continents to countries such as India or Zimbabwe there are multiple things to consider.

When you have agreed to be a LEAP volunteer for a mission trip it is important to read the communication from the mission director in the months, weeks, and days ahead of the trip to stay apprised of the necessary details and requirements you may need to act on. The mission director will send out frequent emails about the logistical items and packing requirements prior to your departure. Whether it is your first trip or fifth, the excitement and anticipation of your journey can be nerve wracking. If you plan well in advance of your travel date, it will decrease your last minute stress and anxiety and offer a calmer start to the valuable mission experience you have chosen to embrace.

Logistical Requirements

Consideration must be taken when the plan to volunteer on a medical mission trip is undertaken. Depending on the country of destination there are may be items that you will be personally responsible and required to produce prior to the trip.

Passport. You will need to insure you have a passport. This is proof of your identity and nationality while you travel abroad. If you do not have one, plan several months in advance to obtain one. The passport application normal processing time is from 4-6 weeks and for expedited 2-4 weeks at an additional fee. If your departure date is less than fourteen days away you may need to visit and/or consult with the nearest passport agency closest to you for urgent passport needs (Bureau of Consular Affairs, 2012). If you hold a current passport it is important to insure that at least six months remains on the life your passport. Some countries require a visitor or tourist visa and require that your current passport has a minimum of six months left before expiration.

Visas. Some countries require formal permission to enter their country. This authorization is granted in the form of a travel visa in which you must apply for well in advance of your date of departure. The mission director will advise you if the country you are traveling to requires one. Some country consulates are now outsourcing their visa services and a link to the application process is found on their individual respective consular website. For example, a mission trip to India requires a visa in order to enter into the country. The application process only takes 7-9 working days but there are certain requirements and documents such as your passport that must accompany the application. If your travel is within 7-9 working days then there is an application process that takes 24-48 hours that you must do in person which requires that you must travel to the nearest Consulate General of India closest to you. In addition to the application process most countries require that you have at least six months left on your own passport in order to apply for a visa. There is also an associated fee which you must consider. India requires that you apply for a one, five, or ten year visa with the latter costing close to two hundred dollars (Consulate General of India, 2012). Keep in mind that your visa can be denied.

If that happens, all application fees are forfeited. LEAP had one surgeon who received a denial letter. He appealed several times and despite numerous letters of support and recommendation he was never granted a visa or access to the country.

The key to receiving a visa is to start the process early to avoid any potential delays.

Licensure. Most countries require some professional information from you so that you may be issued a temporary license. This only applies to those nurses who will be providing direct patient care. You may be asked to provide a copy, or notarized copy, of your nursing license as well as a copy of your current Basic Life Support (BLS) card and when applicable a copy of your Advanced Life Support (ALS) card as well. If you hold a certification, a copy of that is recommended as well. Some countries are a bit more stringent and require more than the basics listed above. Zimbabwe, for example, requires documentation of your transcripts from post-secondary school(s), as well as a copy of the attained degree, two letters of professional recommendation, a letter of good standing from your direct supervisor, and an affidavit on your ability to speak English. All of these documents must be notarized, sent to the mission director so they may be forwarded to the country several months in advance of your departure.

Immunizations. LEAP does not require you to have your immunizations up to date or produce documentation to that point, however, LEAP recommends for your personal safety and those you are traveling with that you highly consider having your immunization record reviewed. Your local county health department can review your record and based on the country of intended travel, recommend, administer, and document further inoculations. Be aware that immunizations are not cheap and you could spend up to two hundred dollars to protect assist in protecting your health while abroad. If you are a practicing health care worker, your employer may have already required you to have the recommended routine preventative inoculations, such

as diphtheria/pertussis/tetanus (DPT), hepatitis B, and influenza. Other inoculations you may have could date back to your childhood and adolescent immunization schedule such as polio, varicella, meningitis, measles/mumps/rubella (MMR), pneumococcal, and meningococcal (CDC, 2012). Depending on the country and the time that you travel, booster shots to your current immunizations may be recommended. For instance when traveling to Haiti, it is recommended that you are inoculated for hepatitis A and typhoid in addition to your routine vaccinations. Some countries, depending on the time of the year have mandatory inoculations that you will be required to show proof of immunization. If this applies while you are traveling with the LEAP Foundation you will be advised of this in advance of the trip. My advice is to visit your physician or local county health agency as soon as you know your country of destination and departure date. Some immunizations can be taken in pill form over a series of days prior to your departure and will have a longer lasting effect. For example, the typhoid vaccine if taken in pill form will last for five years, however if you do not have the time prior to departure for the pill regime you can get an injection which will only cover you for two years. Similarly, the hepatitis A series is recommended prior to travel with one shot six months ahead of the other. So to complete it takes six months. However, do not fear if you only get one shot, the vaccine still assists in decreasing your chance of acquiring the disease until you receive your second shot.

Health. It is important for self-reflection on your current health status. It is recommended that you visit your primary healthcare provider to discuss your impending travel. Insure you have enough of your prescription medications for the duration of the trip, if applicable. When possible have your doctor order your prescriptions with the generic name and dosage for easy identification if something was to happen while abroad (Kidder & Kealy. eds., 2008). Discuss the need for a prescription for anti-malarial medication. Many developing

countries fall within the tropical regions of the world where mosquitoes carry malaria and dengue fever. Visit your physician well in advance as some of anti-malarial medication regimes need to be started up to a week prior to departure. It is also important to discuss the need for as needed medication such as antibiotics or anti-diarrheas. Since you will be traveling with a medical team of physicians you will have a wealth of knowledge with you to advise you if and when the needs for these types of medications arise. For example, traveling to developing countries does not come without risk of gastrointestinal disruption from bacteria in food or water; the threat to your health is real. Having Ciprofloxacin available will treat most intestinal infections as well as typhoid fever if needed. Some of the airline flights are lengthy. Sitting for long periods of time increases the risk of deep vein thrombosis (DVT). Discuss your risk with your physician as an anticoagulant prophylaxis may be recommended based on your physical health status. Suggested over-the-counter and prescription medications are listed in Appendix H for consideration. Planning early ensures that you get all the necessary information for a healthy travel experience.

Trip Insurance. Traveling with LEAP does not include any form of insurance so an important consideration you will need to decide upon is the need for trip insurance. Review your current insurance plan to see if there are provisions for you when you travel outside your coverage area. Trip insurance can cover a multitude of items from single coverage to comprehensive with a variety of options for medical, trip cancellation, and lost luggage to name just a few. If there comes a time when you are in need of medical care abroad, the mission team can only help with certain medical services. If the need for hospitalization arises the cost rests on each individual. If an emergency happens at home while you are abroad, trip insurance can help defer the costs of last minute changes in flight plans.

Safety. LEAP will provide you with travel information, an itinerary, and a contact person and number while you are in the host country. Please ensure you disseminate this information to your family, friends, and/or significant others. It is recommended that you give a copy of your passport to a designated person at home as well as scan it into a secure electronic file that easily accessible and can be emailed. This will help in the event your passport gets lost or stolen. It is also recommended that you keep an extra copy tucked somewhere in your luggage away from your passport again in the instance that your passport gets lost or stolen you will have a hard copy to provide to the consulate in the country in which you are traveling in.

Along with safety prior to your travel is your safety while abroad. Research the country that you are traveling to. Traveling to a developing country means you will be stepping out of your modern conveniences and into a country of poverty with a low socioeconomic status. For example, in some countries, gold and jewelry are seen as a sign of wealth, leave flashy diamond rings and earrings at home, a simple band will do. Travel in pairs; never go out without checking with the mission director. For example, when I was in India our host facility was a Christian Mission Hospital that was enclosed on a compound in the heart of the village. When we were finished for the day some of the team wanted to visit the market just outside the walls of the compound. As they headed for the gate they were warned not to go outside because it was a time when the Muslim and Hindi religions were at odds and there was religious unrest. In addition it was also communicated that if we were working on a Christian mission compound then we must all be Christian. So for our safety we did not leave the compound.

Money. The matter of money always surfaces. The country of destination, length of stay, and your personal need for souvenirs will help you decide on how much money you need. LEAP coordinates food in the host country so you will not have to pay unless you go out to a restaurant;

however meals while traveling to and from are on your own. Most countries take the United States (US) dollar. It is important to understand the exchange rate of the country you are traveling to thus insuring you are not misled and overpay. A rule of thumb that I have adopted is taking two hundred dollars in small bills. Many marketers will barter to sell their wares so small bills will come in handy. If you have out only a few small bills at one time it may lessen the appearance to the local residents that you are a wealthy tourist. Traveler's checks have seemingly gone by the wayside and credit cards have become more accepted worldwide. It is essential to contact your credit card company to tell them your travel dates and countries you will be visiting. This will avoid the chance of the card being denied due to 'unusual' activity. It is also important to keep record of your credit card numbers and company phone numbers separate from your purse or wallet. In the event that your card is lost or stolen you will have the ability to cancel the card. Only use credit cards in stores that appear reputable, these stores are usually in the mainstream of tourism and are easily recognizable. Some developing countries still use carbon copy receipts, make sure you ask for the carbon or watch to insure it is destroyed.

Technology. The use of technology abroad can be confusing. The mission director of LEAP will have an international cell phone that can be used by team members. However, if you want to take your own personal cell phone, call your local carrier and ask the specifics on data and roaming charges as some have to be turned off abroad to avoid additional expensive charges. Some carriers can offer an international plan for a specific date range which works well when traveling on short mission trips. Friendly reminder, cell phone, laptops, and cameras are a sign of wealth in some developing countries, keep them well secured at all times. Charging technology differs from country to country so adapters/converters may be required.

Food and Water. Meals are provided once you reach the host facility. You are responsible for your meals to and from your destination. Consider the country of travel and try similar cuisine locally prior to your trip. For example, try Indian cuisine at a local restaurant to see how your system tolerates the spices. As food preferences go, I know my system does not like strong spices so when I travel to India I pack an array of power and granola bars to compliment what food is available that my system can tolerate. I also pack a jar of peanut butter for quick protein and energy. The operating days can be long so hard candy is a welcome boost when you need a little extra energy. Our travel takes us to some of the warmest climates in the world so it is advisable to avoid food items that may melt.

Drink only bottled water. LEAP coordinates with the host facility to insure we have bottled water available at all times. When possible, buy a bottle of water as you leave the airport of the host country to insure you will have the ability to hydrate yourself until you reach your final destination. An important note is to inspect the bottled water prior to consuming, make sure the seal is intact and that the water is indeed clear. Speaking from experience, I bought bottled water at a small store in India. When I was back on the bus I twisted off the lid but I did not feel the break in the seal. When I held up the bottle to the light it was upon further inspection I noticed the water was cloudy. It is also important to note that to keep your mouth closed while in the shower and only brush your teeth with bottled water. To maintain hydration in some of the hotter humid climates, I find it helpful to take flavored drink powder with electrolytes and add to the bottled water as needed.

Bedding. LEAP has worked to arrange accommodations in most countries that supply bedding. However, if the need arises you will be informed to bring bedding and/or sleeping bag.

I usually travel with a small inflatable pillow and light fleece throw for the plane. These items also serve to augment the bedding that is provided by the host facility.

Packing and Personal Necessities

Packing. Preparing for a medical mission is seemingly a simple task; however there are many things to take into consideration. The country of destination, length of stay, and extra requirements are all factors that can help in the packing process. LEAP will provide information such as how much luggage you are allowed and the weight allowance. In most instances when traveling to countries in the Middle East, Asia, or Africa you will get one piece of luggage plus your carryon. LEAP will then use your allotted second checked bag for mission supplies. The weight limit for international travel is usually fifty pounds. If your bag exceeds the weight limit, you are responsible for the additional fee. Depending on your destination you may either be allowed one checked bag and a carryon or you might be limited to only a personal carryon. Short trips close to home in the Caribbean and Central and South America are usually limited to only a carryon. Once you know how long your trip is and what you are baggage you are allowed, start planning early and make a list on what you want to take. It is also helpful to research the weather in your mission country and adjust your packing list accordingly.

A couple of helpful hints that have worked for me have been to pack in a garbage bag inside your suitcase or backpack and pack clothing in heavy duty Zip-loc® bags. Underwear, one pair of socks and one pair of scrubs, fit perfectly in a gallon bag. What this does is allow for you to remove extra air when packing as well as protect your clothing from such things as dust when you travel to India or rain when you travel to tropical regions. Covered transport for luggage is not guaranteed.

A suggestion for carryon luggage is to pack like you have lost your luggage; an extra set of clothing, personal hygiene items, and medications are recommended. What exactly to bring depends on what your priorities are and what you can live with and can live without (see Appendix I for suggested items).

Psychological Risk. Leaving family behind and working long hours can contribute to feeling isolated and depressed while traveling abroad (Butcher, 2004). Identify ways, prior to the trip that work to alleviate stress for you. Often when the excitement of the journey to developing country wears off, reality of the mission sets in and some people become stressed. Faced with an unfamiliar work environment, no familiar faces, new routines, and long work hours be sure to communicate and ask questions. The best advice I can give you is if you are starting to feel stressed look to seasoned mission workers for advice and help. Do not isolate yourself or feel embarrassed. At some point in time, all volunteers feel overwhelmed and stressed. The earlier you talk about this the easier it is for others to help you work through it.

Personal Necessities. Everyone's needs are different when talking about personal necessities. When thinking about shampoo and conditioners; look at trial sizes or combination shampoo and conditioners. Liquid soap is easier to enclose than a bar of and its container. Quick dry towels are another item that packs nicely in a small space. I suggest packing a roll of toilet paper; depending on the country of travel some places do not have any or the supply available is limited. Personal hand sanitizer is a must. LEAP will pack a large bottle for the operating room that you can refill your personal bottle from. If you wear contacts, do not forget the solutions and a spare pair with glasses to back-up them up. Lotion and powder, some countries are dry and some humid. Insect repellent is another must. Sun screen, lip balm, and sunglasses are often needed depending on the country and time of year of the mission trip. A reminder for the ladies

is to anticipate if you need personal feminine hygiene supplies as in some instances they are not readily available. Pack personal razors if needed. Hair dryers and curling irons are a personal preference; however I should remind you that you are on a mission trip.

Outside the need for personal necessities are items that I commonly travel with that you might want to consider; a pocket knife, small sewing kit, compass, book/map of the country, flip flops for the shower, knee high support stockings for the plane ride and long days in the operating room, electrical converter adapters (as needed), pen, journal, flashlight, camera, camera battery, and an I-Pod®.

As I have imparted knowledge and my pearls of wisdom mostly from my extensive travel and military history, my last important piece of advice to you is to be well prepared in advance for any and all situations. Do not wait until the last minute to pack. Get plenty of rest the week before travel to help insure you stay healthy. Know and acknowledge your strengths and limitations. Be aware of your surroundings and be an informed traveler; mission work is an incredible journey to partake in but it comes with risks to your health and person when you travel out of your comfort zone and into developing countries. There are many resources available for your perusal in both electronic and paper form, take advantage of your resources (Appendix J).

Dissemination of Information

I believe that information and education is for sharing. I have always been of the mindset to build and develop those that will one day replace you; grow your own. This guide takes into consideration of theory, practice standards, and personal experience; not everything can be learned in a classroom or by a textbook, some is learned from clinical experience and trial and error. This guide will be used for perioperative nurses embarking on their journey to perioperative mission nursing in developing countries. It is my intention that this guide is used

to support a perioperative nurses professional practice by engaging in reflection on their current practice and how it will need to be adapted in a developing country perioperative environment that comes with many unforeseen challenges.

My hope is that this guide may be developed into a poster presentation and submitted for consideration at an upcoming AORN National Convention to encourage others to venture into the world of perioperative mission nursing.

Limitations

This guide cannot be used as a teaching manual for those without a perioperative nursing practice foundation from which to draw upon. This guide offers a limited snapshot into AORN's Perioperative Standards and Recommended Practice book and suggests that perioperative nurses continue to stay apprised of the ongoing standards as they are updated each year. It is important to understand that this perioperative mission nursing guide is limited in information based on my individual experiences with LEAP and may not be a strong resource for other mission foundations practices.

It is important to also recognize that this guide give examples of real life perioperative mission nurse experiences so that others may learn and grow from others that have gone before them.

Future Considerations

I would like to review this guide book in one year after having given it to several perioperative nurses to evaluate its relevance, effectiveness, and usability.

As LEAP continues to grow and expand I would like LEAP to consider developing a book in which a perioperative mission nurse has a chapter as well as a surgeon chapter,

anesthesia chapter, and chapters on the specific countries in which LEAP continues to support from a surgical mission perspective.

Summary

In summary I would like to quote the vision and mission statements from AORN on perioperative nursing:

Vision statement. “The Association of periOperative Registered Nurses is the leader in advocating for excellence in perioperative practice and health care” (AORN, p. 8).

Mission statement. “AORN’s mission is to promote safety and optimal outcomes for patients undergoing operative and other invasive procedures by providing practice and support and professional development opportunities to perioperative nurses. AORN will collaborate with professional and regulatory organizations, industry leaders, and other health care partners who support this mission” (AORN, p. 8).

Understanding that perioperative nursing is a dynamic and multi-disciplinary field of nursing to work in is how this guide book was conceptualized. No one can teach all but one can teach some. If my guide book affects the practice of one perioperative mission nurse to alleviate stress associated with mission nursing or avoid any of the challenges I have encountered then my intent of the guide has been successful.

My passion is perioperative nursing and it is with this passion that I take my practice beyond the borders of North America to the patients of the world. My goal is to educate and inspire others to do so as well.

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Appendix A

Watson's Carative Factors

1. The formulation of a humanistic-altruistic system of values
2. The instillation of faith-hope
3. The cultivation of sensitivity to one's self and to others
4. The development of a helping-trust relationship
5. The promotion and acceptance of the expression of positive and negative feelings
6. The systematic use of the scientific problem-solving method for decision making
7. The promotion of interpersonal teaching-learning
8. The provision for supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment
9. Assistance with the gratification of human needs
10. The allowance for existential-phenomenological forces

From Watson, J. (1985). *Nursing: The philosophy and science of caring*. Boulder, Colorado: University Press of Colorado

Appendix B

Ecuador - 2012

Estimated Cases = 30

Packing for Lips and Palates
+ 2 small burns

Sterile Supplies	Quantity	Pulled	Trunk #
Ace Wrap	3		
Alcohol swabs	25		
Avitene	3		
Basin - small round	4		
Blade - 10	25		
Blade - 11	100		
Blade - 15	100		
Blade - Beaver 6700	50		
Blade - Beaver 6900	50		
Blade - Beaver 6910	15		
Bovies	25		
Butterfly 19ga	6		
Colorado tip	4		
Combs	2		
Cotton (small)	2		
Cottonoids - 1/2" x 6" (pk of 10)	3		
Cottonoids - 3/4" x 6" (pk of 10)	3		
Cotton tip applicators (pk of 10)	5		
Drape 3/4	15		
Drape - Mayo stand	30		
Drape - Table Cover	4		
Drape - 1000	5		
Drape - Split	2		
Fibrillar	5		
Gelfoam (5 large and 3 small)	8		
HA - granules 2cc	2		
HA - granules 5cc	2		

HA - syringes	2		
Hypo needle - 18ga 1 1/2"	50		
Hypo needle - 25ga 1 1/2"	50		
Hypo needle - 27ga 1/2"	50		
Kerlix	4		
Kittner	5		
Sterile Supplies	Quantity		
Kling	4		
KY Jelly	5		
Marking pen	10		
Mastisol	20		
Medicine cup	75		
Nasal Sizers (sizes 1-14 / 4 per size)	variety		
Needle boards (double)	13		
Nu-Knit	5		
Prep trays	4		
Quickie Prime	2		
Razor	2		
Red rubber catheter 10fr	2		
Red rubber catheter 12fr	2		
Red rubber catheter 14fr	4		
Red rubber catheter 16fr	2		
Rubberbands (on Q-tips)	2		
Soak basins (set of two)	2		
Sponge 4x4 - prep (pack of 20)	4		
Sponge - raytec (pack of 10)	30		
Sponge - lap (pack of 5)	4		
Stapler	4		
Steri-strips 1/2"	10		
Suction tubing	32		
Surgicel	5		
Syringe - 3cc	35		

Syringe - 10cc	10		
Syringe - blue bulb	25		
Tegaderm - small	2		
Tegaderm - medium	2		
Tegaderm - large	4		
Telfa - small	5		
Telfa - large	5		
Tongue depressor	30		
Towels - blue (pack of 10)	4		
Vag pack - throat pack	3		
Xeroform - 1 x 8"	2		
Xeroform - 5 x 9"	2		

Nasal Box	Quantity	Pulled	Trunk #
Aquaplast	variety		
Brown tape (roll)	1		
Denver splints	3		
Doyle Splints	5		
Eye pads	2		
Mastisol	5		
Steri-strips - flesh colored	5		

Instruments	Quantity	Pulled	Trunk #
Eye shields (pair)	3		
Lip/Palate set	2		
Micro France Forceps	2		
Misc - peel packs	yes		
Nasal set	1		
Nasal sizers	2		

Equipment	Quantity	Pulled	Trunk #
Bovie machines	2		
Extension Cords	2		

Headlights	3		
Headlight - batteries	3		
Headlight - recharger cords	2		
Headlight - wall plug cords	2		
Powersurge protectors	4		
Suction machines	2		
Suction cannisters	3		

Non - Sterile Supplies	Quantity	Pulled	Trunk #
Scrub Brushes	15		
Bovie pads - pediatric	5		
Bovie pads - adult	5		
Coban	3		
Protective Eye wear	10		
Gloves - exam - small	100		
Gloves - exam - medium	100		
Gloves - exam - large	100		
Hats	20		
Masks	50		
Shoe covers	50		

Medications / Solutions	Quantity	Pulled	Trunk #
Afrin	2		
Bacitracin ointment	6		
Betadine prep solution (4oz btl)	Ecuador to provide		
Bonnie Blue	1		
BSS	3		
Epinephrine (1:1000) (30ml)	2		
Local	10		
Ropivacaine	5		

Cleaning Supplies	Quantity	Pulled	Trunk #
Enzymatic	35		

Germacidal wipes (box)	50		
Marker	1		
Pipe cleaners	2		
Suction Cleaner / Wire Brush	variety		
Syringe 10cc	1		
Wire brush	1		
Zip ties	25		

Sterilizing Supplies	Quantity	Pulled	Trunk #
Indicator steam tape (roll)	1		
Indicators	10		
Peel packs	variety		
Instrument clips	10		
Filters	4		

Suture	Quantity	Pulled	Trunk #
Suture	all		

Gloves	Quantity	Pulled	Trunk #
Dr. Mitchell (6 Reg)	35		
Dr. Majiti (7)	35		
Gay	35		
Shera	35		
Wendy	20		
Jackie	20		
Prep Gloves	40		

Appendix C

Dr. Hobar (7 ½ Gloves) Cleft Lip Repair – Preference List

Instruments	Soft Supplies
<ul style="list-style-type: none"> • Bishop Harmon's x 2 • Black Handle Tenotomy Scissors (short) • Black Handle Suture Scissors (short) • Mosquitos (Hartman) x 3 • .5 forceps x 2 • Skin Hooks <ul style="list-style-type: none"> ○ Double small x 2 ○ Single small x 2 ○ Double medium x 1 ○ Single medium x 1 • Freer • Joseph elevator (small) • Yankaeur suction • Frazer tip suction <ul style="list-style-type: none"> ○ #6 ○ #8 • Needle holders 4" x 2 • Caliper • Round knife handles x 2 • Towel clip x 2 	<ul style="list-style-type: none"> • Raytec x 5 • Bovie with Colorado (red) needle tip • Suction tubing • Blue bulb syringe • ½ needle board • Q-tip – sharpened to a point – will use to tattoo skin • Wire - piece about 4 inches long • Plastic medicine cup – bonnie blue • Custard cup – saline • Silver med cup – local • #15 blade • #11 blade • 6700 beaver blade • 27ga needle ½ inch x 1 for tattoo • Steri strips cut in half (eyes and tongue stitch) • Throat pack (moistened)
Suture	Draping
<ul style="list-style-type: none"> • 5-0 Nylon P-3 clear - muscle • 2-0 Silk – throat pack • 2-0 Chromic SH – tongue stitch • 5-0 Chromic P-3 • 5-0 Monocryl P-3 • 6-0 Nylon P-3 black • 4-0 Nylon PC-5 black – prn nasal stent • 4-0 Nylon P-3 clear – prn – hold 	<ul style="list-style-type: none"> • Under the head <ul style="list-style-type: none"> ○ One third of a ¾ sheet ○ Blue towel around head ○ Towel clip for blue towel • Body <ul style="list-style-type: none"> ○ ¾ sheet – cut slit in top to make a split sheet
Prep	Dressing
<ul style="list-style-type: none"> • Intranasal • Intraoral • Facial into hairline, down to neck, down to behind ears • Include prepping around ETT 	<ul style="list-style-type: none"> • Ointment to the lip • Steri-strip to tape down tongue stitch to cheek

Appendix D

Equador – 2012

Trunk/Duffel/Box Weights

Specialty	Box #	Weight Going	Trunk Assigned To	Weight Coming Home	Trunk Assigned To
Operating Room Supplies	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
PACU	9				
	10				
	11				
	12				
Anesthesia	13				
	14				
	15				
	16				
	17				
	18	Overweight anesthesia machines			
	19				

Appendix E

Spaulding Classification System			
Device Category	Level of Disinfection	Effectiveness of Method	Examples
Critical Items that come into contact with blood-stream or sterile body tissues	Sterilization <ul style="list-style-type: none"> • Steam Chemical sterilants <ul style="list-style-type: none"> • Glutaraldehyde 	Sterilization kills all microbial life including pathogenic and nonpathogenic microorganisms and spores	<ul style="list-style-type: none"> • Surgical instruments • Urinary catheters
Semicritical Items that come in contact with mucous membranes or non-intact skin	High-level disinfection <ul style="list-style-type: none"> • Glutaraldehyde-based formulations 	High-level disinfection kills all microorganisms but not necessarily a large number of bacterial spores	<ul style="list-style-type: none"> • Laryngoscope handle and blades

Sterilization Parameters for Typical Flash Cycles				
Type of Sterilizer	Load Contents	Time	Exposure Temperature	Drying Time
Gravity Displacement Sterilizer	Metal / no lumens	3 minutes	270° F to 275° F Or 132°C to 135°C	0 to 1 minute
	Metal items / with lumens / porous items (plastic/ rubberbands) complex devices such as power equipment/drills	10 minutes	270° F to 275° F Or 132°C to 135°C	0 to 1 minute

Dynamic Air- Removal (Prevacuum)	Metal / no lumens	3 minutes	270° F to 275° F Or 132°C to 135°C	N/A
	Metal items with lumens and porous items	4 minutes or 3 minutes	270° F (132°C) or 275°F (135°C)	N/A

From Association of periOperative Registered Nurses. (2012). *Perioperative Standards and Recommended Practices*. USA: AORN.

Appendix F

High-Level Disinfection				
Chemical	Advantages	Disadvantages	Concentration	Contact time/ conditions
Glutaraldehyde solutions	Numerous published studies of use. Relatively inexpensive. Excellent compatibility with materials.	Respiratory irritation from glutaraldehyde vapor. Pungent and irritating odor. Relative slow mycobactericidal activity. Coagulates blood and fixes tissue to surfaces. Allergic contact dermatitis.	2.5% glutaraldehyde automated endoscopic reprocessor 1.12% glutaraldehyde and 1/93% phenol	5 minutes at 95° F (35°C) (28 day maximum reuse) 20 minute contact time at 77° F (25°C) (14 day maximum reuse)

Adapted from Association of periOperative Registered Nurses. (2012). *Perioperative Standards and Recommended Practices*. USA: AORN.

Appendix G

Day Pack Suggestions

(Adjust as needed)

- Back Pack
- Wear or take scrubs
- Water bottle
- Visa/passport
- Money
- Snacks/candy/power bars
- Protective eyewear
- Pen/sharpie
- Nursing scissors
- Camera
- OR hat
- OR shoes if not wearing them
- Journal
- Flashlight
- IPod (physicians will bring speakers/docking stations)
- Insect repellent
- Headache medicines (if applicable)
- Support stockings (if applicable)
- Toilet paper

Appendix H

Medication Suggestions

Over the Counter	Prescription
<ol style="list-style-type: none">1. Antipyretic2. Anti-diarrheal3. Stool Softener4. Cold remedies5. Allergy remedies6. Headache remedies7. Sleep remedies8. Antifungal medications<ol style="list-style-type: none">a. Footb. Private areas	<ol style="list-style-type: none">1. Anti – malarial2. Antibacterial (ciprofloxacin / levofloxacin)3. Personal prescriptive medications (as applicable)

Appendix I

Personal Packing Suggestions

Personal Attire	Professional Packing
<ol style="list-style-type: none"> 1. Shirts 2. Pants 3. Capri pants 4. Shorts 5. Socks 6. Underwear 7. Shoes (hiking/sandals/tennis shoes) 8. Sleeping attire (remember you may be sharing a room with one or a few roommates) 	<ol style="list-style-type: none"> 1. Scrubs 2. Scrub hats 3. Shoes 4. Protective eyewear 5. Scissors <p>Hints:</p> <ul style="list-style-type: none"> • Shoes covers are provided so OR specific shoes not needed, street shoes can be worn then covered. • When traveling to India or Zimbabwe there is the ability to launder clothing for three days so you can pack accordingly.
Toiletries	Other
<ol style="list-style-type: none"> 1. Shampoo / Conditioner 2. Soap 3. Comb / brush 4. Toothbrush / toothpaste 5. Contact lenses / solution 6. Glasses 7. Make-up (if applicable) 8. Feminine hygiene products (if applicable) 	<ol style="list-style-type: none"> 1. Flashlight 2. Journal 3. Pen 4. Book 5. Travel blanket 6. Travel pillow 7. Map / Book on the country 8. Small sewing kit 9. I-Pod / Headphones 10. Support stockings 11. Blow dryer / Curling iron 12. Sunscreen 13. Insect repellent 14. Light rain jacket or poncho 15. Lip balm 16. Toilet Paper 17. Pocket knife 18. Granola bars 19. Power bars 20. Powder drink packets 21. Peanut Butter

Appendix J
Traveling Tip Resources

Websites:

1. Center for Disease Control and Prevention (CDC). Travelers Health.
<http://wwwnc.cdc.gov/travel/>
2. U.S. Department of the State. International Travel.
http://travel.state.gov/travel/travel_1744.html

Books:

1. Fodor's 1,001 Smart Travel Tips
2. Lonely Planet books have a guide book for every country.