ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Web Logbook Quick Reference Guide

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How to Use this Manual

This manual describes the setup and operation of the Web Logbook.

Section 1: Introduction – provides an overview of the Web Logbook

Section 2: Technical Requirements – describes recommended system requirements.

Section 3: Getting Started – describes system features, layout of the initial interface screen and the initial set up.

Section 4: Entering and Editing Data – describes how to create, edit and view logbook and account data.

Section 5: Generating Reports – describes the reports that can be generated.

Section 6: Mobile User Guide – describes how to access the Web Logbook on a mobile or handheld device.

Section 7: Appendix – contains details on line entries and optimising Firefox.

This document has been prepared for Trainees, Supervisors and Fellows who may or may not have had previous experience in the use of an electronic logbook system. This guide is designed to provide a quick reference for users. For a more comprehensive guide to Web Logbooks please refer to the Web Logbook Manuals.

It is recommended that the INITIAL SETUP in Section 3 be completed upon entering the Web Logbook for the first time to ensure a more efficient use of the system.

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1. Introduction

The Royal Australasian College of Surgeons has developed a web-based logbook, which aims to enrich education, and training experiences, promote communication between the Trainee, Supervisor and Training Board, and provide summary and individual reporting functions. To ensure a high level of access for surgeons the logbook will be available using a web-based system, through a variety of technologies including mobile and handheld devices that are web enabled. It is envisaged that there will be progression towards the establishment of an audit system available to Fellows.

Features of the Web Logbook include:

- Data entry fields,

- Diagnosis, pre and post management driven by ICD-10 compatible list,

- Operations based on CMBS codes that have been categorised for short name, body part, anatomical zone, access and magnitude/complexity,

- Hospitals,

- Supervisors,

- Complications, and

- Additional specialty data fields.

This information has been written to assist Trainees, Supervisors and Fellows to use the Web Logbook to record procedures during their surgical training.

There has been considerable consultation in the preparation of this manual however, feedback, positive or critical, from users of the manual is welcomed. Please email your comments to logbooks@surgeons.org.

2.   Technical Requirements

The following subsections describe the recommended system requirements and user configurations necessary for you and your organisation to utilise the Web Logbook system.

2.1   Internet Connection

The system is designed to minimise server response and page download times.

2.2   Browser Types

The Web Logbook has been tested with these browsers:

- Internet Explorer (v6.0 and above),
- Mozilla Firefox (v1.0.6 and above),
- Safari (v2.0 and above), and
- Standard Mobile Phone Browsers capable of displaying HTML.

2.3   Screen Resolution

This application is designed for use on a desktop PC with a screen resolution of 1024X768 pixels or above. The site design will remain centred horizontally and vertically when accessed by users with large screen settings.

2.4   User Roles

Web Logbook allows users to have different roles, controlling their level of responsibility and permissions.

User	*Roles*
Trainee	Trainee can create records and refer their records onto the allocated supervisor.
Fellow	A fellow can create and edit their own records, without submitting records to a supervisor.
Supervisor	Supervisors can view all records that have been referred to them from each trainee that they have been assigned to.
System Administrator	Administrators can view all records, modify the system and create new users.

2.5   User Assistance

Click to launch the user manual, to launch the Frequently Asked Questions or to send an email to logbooks@surgeons.org.

3. Getting Started

3.1 Documentation Conventions

The following conventions have been utilised in this manual when describing different areas of the database and providing step-by-step instructions.

Convention	*Explanation*
Boldface	Indicates a button, keyboard key or other element you need to locate or select i.e. Save, Cancel, Send to Supervisor. Web Logbook modules will also be in bold and referred to as **Logbook Module**, **Reports Module** and **Account Module**.
[Bold]	Indicates a field on the screen i.e. [First Name]
Menu > Item	Instructs you to select the named menu and then submenu.
TAB NAME	Indicates a tab in the Web Logbook i.e. ACCOUNT.
Courier New	Indicates text that will appear in a field.

3.2 Logging In

1. Open your preferred Internet browser and login to the College website.
   Note: You need to have cookies enabled to access the application

2. Select Online Logbooks

3. The Logbook application opens in a new window.

4. Click Login to accept the Terms and Conditions and access the Web Logbook.
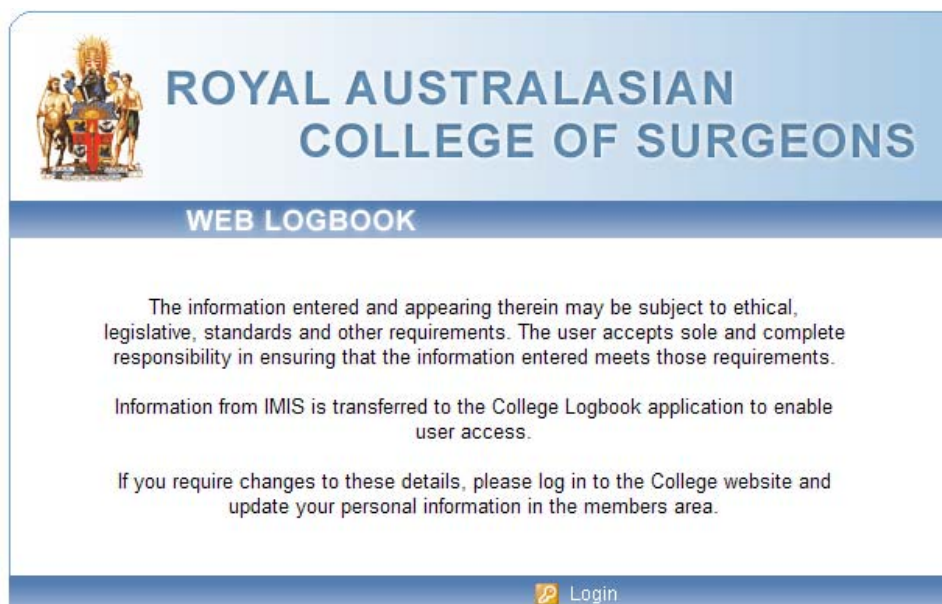
3.3 Web Logbook Interface

The following section describes the layouts of the Web Logbook interface.
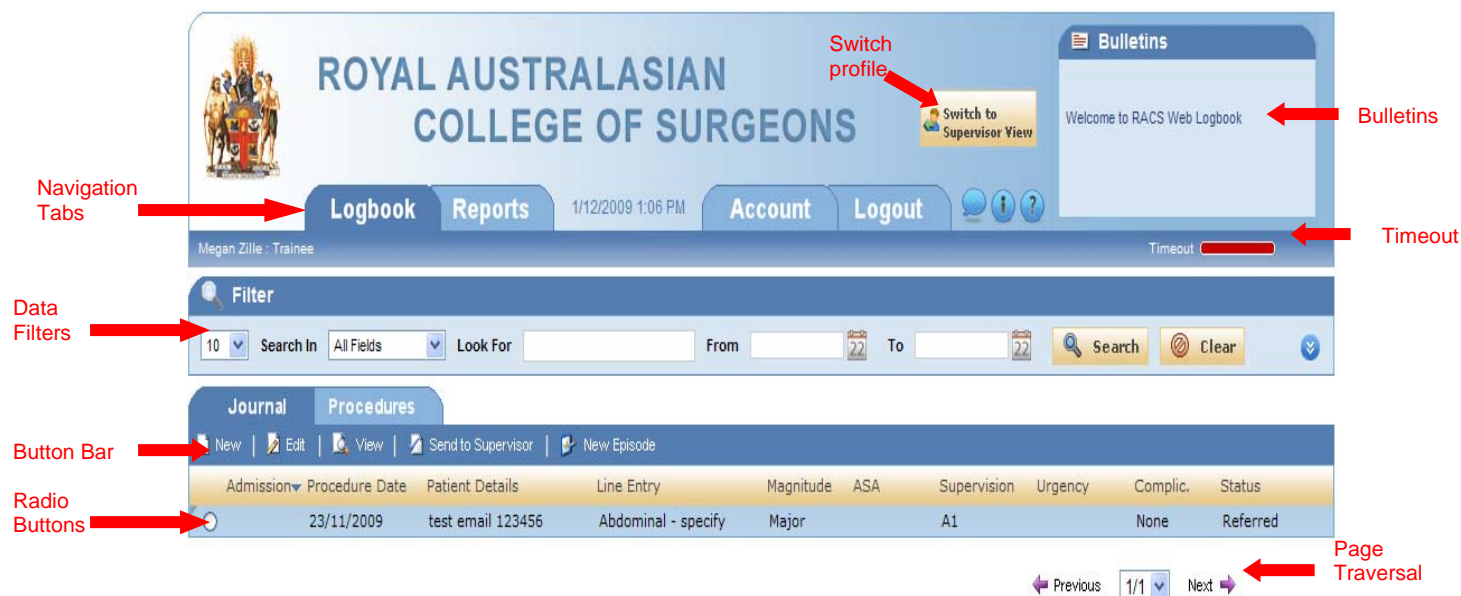
3.3.1 Bulletins

Bulletins are displayed on every page in Web Logbook. The Bulletins window displays a scrolling list of the bulletins that are active for the current user.

3.3.2 Button Bar

The Web Logbook features a common set of function buttons. The functions vary according to the user profile. These buttons perform the described action on the selected logbook item.

Button	Details
New	Opens the New Logbook Item form, allowing you to create new logbook items.
Edit	Opens the Edit Logbook Item form, displaying current information for the selected logbook item. This information is editable.
View	Opens the View Logbook Item form, displaying current information for the selected logbook item. This information is not editable.
New Episode	Opens the New Episode Logbook Item, allowing you to create a new episode for the selected patient.
Send to Supervisor (Trainees only)	This button sends the selected logbook item to your supervisor for review. *This item now has a status of 'referred' and is no longer editable.*
Complete (Fellows only)	This button will mark the selected record as complete. *This item will now have a status of 'complete' and is no longer editable.*
Switch to Supervisor/Fellow (Supervisors only)	This button enables a Fellow who is also a Supervisor to switch between their profiles.

3.3.3 Command Buttons - Trainees

The forms in the Web Logbook feature command buttons. These buttons perform the described action on the data selected on the current screen.

Button	*Details*
Save	Saves the information entered in to the current form and returns you to the list of logbook items.
Cancel	Cancels any changes made to the logbook item that is currently open and returns you to the listed items.
Send to Supervisor	Sends the information entered into the current form to your supervisor and returns you to the list of logbook items. *This item now has a status of 'referred' and is no longer editable.*
Add	Adds a new item to the current list.
Remove	Deletes the selected item in the current list.
Search	A pop up list appears displaying all the relevant items for a particular option. Allows you to search and add items.
Done	Adds the selected item/s for a particular option.
Edit Favourites…	Allows you to edit the list of favourites for a particular option.

3.3.4 Command Buttons – Fellows

Button	*Details*
Save	Saves the information entered in to the current form and returns you to the list of log book items.
Cancel	Cancels any changes made to the logbook item that is currently open and returns you to the listed items.
Add	Adds a new item to the current list.
Remove	Deletes the selected item in the current list.
Edit Favourites…	Allows you to edit the list of favourites for a particular option.

3.3.5 Command Buttons – Supervisor

Button	Details
Accept	Changes the status of the record to Accepted and returns the supervisor to the listed items.
Reject	Changes the status of the record to Rejected and returns the supervisor to the listed items.
Cancel	Returns the supervisor to the listed items without changing the status of a record.
Add	Adds a new item to the current list.
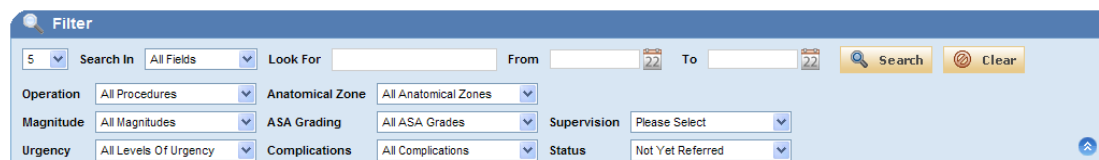
3.3.6 Data Entry

There are a number of types of input that are found throughout the Web Logbook application.

Data Input	Details
Check Box	Are used instead of option buttons if an option is not required. Multiple boxes can be checked.
Date Selection	In order to select a date into a date field, click on the **Month/Year** on the Date Picker, then click the Year that appears, you will get a view where you can select one of 10 years, and then scroll 10 years at a time, as per below screenshots, using the arrows either side of the displayed year. This way it takes a few seconds to select a date in e.g. 1960.
Drop Down Lists	Drop-Down lists are frequently used to restrict entry to data. Select anywhere on the drop-down box to display the available list. Select the desired entry by clicking on the one you wish to select.
Option Button	The option buttons are used to allow the selection of one item only from a list. Selecting an option button shown at the front of a list item will allow you to perform the available actions on that item.
Text Boxes	Text boxes are frequently used to obtain input with minor limitations. Simply enter the desired text (alphabetical or numerical) in the text box. There may be a limit on the number of characters that can be entered into certain text boxes.

3.3.7 Data Filters

Data Filters appear at the top of the page wherever there is a list of items that can be filtered. The filter window can be expanded at any time to reveal more filtering options by clicking the **Expand** button at the right of the window.

You can collapse the filter window back again by pressing the **Collapse** button at the right of the window.

A filtered page of results can be viewed by selecting values from the drop-down lists and/or typing in keywords and then pressing **Search**. If **Clear** is pressed, the filter will be cleared and all items will be displayed in the list. The records-per-page filter will retain its settings even after the Clear button is pressed. This setting can only be changed manually.

3.3.8 Navigation Tabs

The Navigation Tabs are displayed on every page in Web Logbook. They allow quick access to all of the main sections of Web Logbook. They appear at the top of the page and can be selected by clicking anywhere on the tab. The functions of the first three tabs will be explained in greater detail in further sections of this manual.

The **LOGOUT** tab securely logs you out of the system once you are finished.

3.3.9 Page Traversal

A blue bar appears, at the bottom of the screen, when viewing a list of items in Web Logbook. This allows navigation through the pages of the list. This bar scrolls with the screen so that it is always accessible.
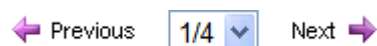
The **Previous** button takes you to the previous page of the list. The **Next** button takes you to the next page in the list. It is also possible to select a specific page by selecting the drop-down between the **Previous** and **Next** button.

3.3.10 Item Selection

To select an item from a list simply select the radio button that is shown at the front of the list item.

	Procedure Date▲	Patient Details	Line Entry	Magnitude	ASA	Supervision	Urgency	Complic.	Status
○	07/10/2009	henry Jones 753159	Aneurysm/dissection r..	Major		S3		None	Not Yet Referred
○	06/10/2009	Peter Smith	Laparotomy - explorat..	Major		S2		None	Not Yet Referred

Selecting an item will allow you to perform the available operations on that item.

Hovering over an item with the mouse will display more information about the item in a tooltip.

3.3.11 Timeout

The Web Logbook will timeout after twenty minutes without a command. You can track your timeout status which is indicated at the top right hand corner of the screen. The red bar reduces over time.

3.4 Initial Setup

It is recommended that the following steps be completed upon entering the Web Logbook for the first time.

3.4.1 Account Preferences – Trainee/Fellow

After logging in to the log book system for the first time, you need to setup your preferences.

1. Select the **Account** tab.

2. Select the **Personal Details** page.
   These details are populated using your information registered in iMIS. If you require changes, please log in to the College website and click 'update your personal information' in the members area.

   NOTE: Please check the email address listed is the one you want to use for your logbooks account.

3. Update actual rotation dates.

4. Click the Email Reminders button to activate email notification.
   A tick appears to indicate option is selected, click on this field again to deselect.

5. Select Save to store changes.

6. Select the **Training Post** page.
   Check the information for surgeons in the unit and your supervisor.

7. To add a surgeon select Add.
   The Choose surgeon pop up is displayed.

8. Select a relevant name and click Done.

9. To remove a surgeon, select the relevant name and click Remove.

10. To select a surgeon as a supervisor select the relevant name and click Select as Supervisor.

If you are working in more than one hospital, tracking the case load in each facility will be important, ensure all hospitals are listed.

11. To add a hospital make a relevant selection from the left hand column click arrow button >>> to add to column on right.

12. To remove a hospital make a relevant selection from the right hand column click arrow button <<< to remove from column on right.

3.4.2 Account Preferences - Supervisor

After logging in to the log book system for the first time, you need to setup your preferences.

1. Select the **Account** tab.

2. Select the **Personal Details** page.
   Check the information for **Specialty** and contact details is correct. Update if necessary.

3. Select the Email Reminders option to activate email notification.

4. Select the relevant reminder frequency e.g.: hourly, daily, weekly etc...
   This option allows you to select the frequency for receiving email notification of
   logbook records submitted by your trainee/s for approval.

5. Select Save to store changes.

3.4.3   Clinical Diagnoses - Favourites

If you are required to use the Expanded dataset to enter clinical diagnoses, it is more time
effective to do this initially and then continue to modify/update these as you gain experience.

1. Select the **LOGBOOK** tab.

2. Select the **New** button from the button bar.
   The **NEW LOGBOOK ITEM** tab appears allowing the user to add a new record to the
   logbook.

3. Enter a fictional patient called My Favourites in the **MINIMUM DATASET** tab and fill in
   the basic details.

4. Select the **EXPANDED DATASET** tab

5. Within the pre-management diagnosis area, select **Edit Favourites**.
   A screen will load containing nearly every diagnosis recognised by the ICD10 coding
   system.

6. Query the list by typing in a word in the search area or alternatively interrogate each
   of the headings and pursue the tree/branches for the diagnosis/description you are
   after.

7. Click the appropriate check boxes to select the items.
   NOTE: A maximum of 20 items can be selected.

8. Select **Done** to save these items to the **[Favourites]** drop down list.

9. Repeat this process for the post-management diagnosis area. Although time
   intensive to set up, this facilitates the individual patients being entered later on.

10. Click **Save** at the bottom of the **MINIMUM dataset** tab.
    The screen closes and you are returned to the main Journal/Procedures screen

4. Entering and Editing Data

4.1 Account Module

The **Account Module** is accessed by clicking the **ACCOUNT** tab at the top of the page and is used to complete the following tasks:

- Verify personal details,
- Update training post information

4.1.1 Personal Details

The personal details page will show by default. You can access this page from other sections of the **Account Module** by pressing the **Personal Details** button on the left hand side of the page.

These details are populated using your information registered in iMIS. If you require changes, please log in to the College website and click 'update your personal information' in the members area.

NOTE: Please check the email address listed is the one you want to use for your logbooks account.

Field	*Data Description*	*Data Input*
[Given Name]	Used to specify the first name of the user	Text
[Last Name]	Used to specify the last name of the user	Text
[Preferred Name]	Used to specify an informal name if different from the first name	Text
[iMIS ID]	Unique RACS number used to identify the user.	
[Actual Rotation Start Date]	Used to record the actual start date of the users current rotation.	Date Selection
[Actual Rotation End Date]	Used to record the actual end date of the users current rotation.	Date Selection
[Mobile Number]	Used to record the mobile phone number of the user.	Text
[Email Address]	Used to record the email address of the user.	Text
[Specialty]	Used to record the specialty of the user.	Drop down list
[Supervisor]	Used to record the current supervisor of the user. Populated from the **Training Post** screen.	
[Email Reminders]	Used to identify whether the user would like	Check Box

	to receive email reminders.	
[Reminder Frequency] **(Supervisor only)**	Used to set the frequency for email reminders	Check Box
[Supervisory Period] **(Supervisor only)**	Used to record the period of supervision.	Text

Make relevant changes, select **Save** to save the changes to the system and refresh the page. Selecting **Cancel** will cancel your changes and refresh the page.

4.1.2 Training Post

The training post section allows you to enter information relating to the current rotation. You can access this page by clicking the **Training Post** button on the left hand side of the page.

4.1.2.1 Surgeons in Unit

This section contains information about the specific unit. You can add and remove surgeons from the unit by selecting the **Add** and **Remove** buttons under the Surgeons in unit window.

4.1.2.1.1 Adding a surgeon

1. Click **Add**.
   The Choose Surgeon pop up appears.

2. Navigate through the lists of names using the numbers at the bottom, or search for a particular surgeon using the search functionality.

3. Click the name to select it.

4. Click **Done** to add it to your Surgeons in unit.

4.1.2.1.2 Selecting a surgeon as your Supervisor

1. Select a surgeon's name from the Surgeons in unit window.

2. Click **Select as Supervisor.**
   This will automatically fill in the supervisor details (name, email and mobile phone number).

4.1.2.2 Hospitals

The bottom section of the page contains information about hospitals in your area. The list on the left contains all the hospitals on the system. The list on the right contains all the hospitals you have nominated as your favourites. You can add and remove hospitals from your favourites list by selecting them in the windows and pressing the relevant arrow buttons.

4.1.2.2.1 Adding a hospital to your favourites

1. Select the hospital from the window on the left.

2. Click the right pointing arrows.
   The hospital is added to the list on the right.

4.1.2.2.2 Removing a hospital from your favourites

1. Select the hospital from the window on the right.

2. Click the left pointing arrows.
   The hospital is removed from the list on the right.

4.1.2.2.3 Adding a new hospital

1. Click the feedback link if you require a **New Hospital** to be added.

4.2 Logbook Module – Trainee/Fellow

The Logbook module displays all of your logbook items and provides the ability to create/edit/view items. You may also refer logbook items to your supervisor through this module.

The Logbook module is accessible by selecting the **LOGBOOK** tab from the navigation tabs at the top of the screen.

There are two ways of viewing logbook items as indicated by the **JOURNAL** and **PROCEDURES** tabs.

4.2.1 Journal View

In the **JOURNAL** tab you will see a list of all your records ordered by admission date. Each logbook item shows the **[Procedure Date]**, **[Patient]**, **[Line Entry]**, **[Magnitude]**, **[ASA]**, **[Supervision]**, **[Urgency]**, **[Complications]** and **[Status]**.

These logbook items can be sorted by any of these properties. Click the appropriate heading at the top of the list. For example, to sort by line entry, click the words **Line Entry**. This will sort the records in ascending order as indicated by a down arrow. Clicking **Line Entry** again will turn the arrow upside and sort the records in descending order.

Using the mouse pointer, hover over the option button to reveal a pop up window displaying a summary of the record.
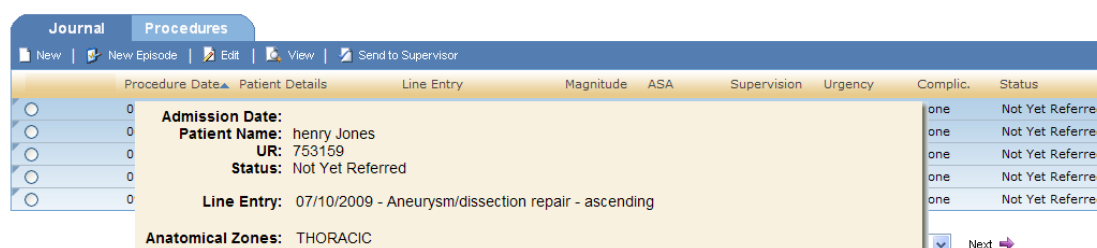
4.2.2 Procedures View

In the **PROCEDURES** tab you will see a list of all your records ordered by line entry, excluding those with a **[Status]** of `Accepted`. Each logbook item shows the **[Admission Date]**, **[Procedure Date]**, **[Patient]**, **[Line Entry]**, **[Magnitude]**, **[ASA]**, **[Supervision]**, **[Urgency]**, **[Complications]** and **[Status]**.

These logbook items can be sorted by any of these properties. Click the appropriate heading at the top of the list. For example, to sort by patient, click the word **Patient**. This will sort the records in ascending order as indicated by a down arrow. Clicking **Patient** again will turn the arrow upside and sort the records in descending order.

4.3 New Logbook Record – Minimum Dataset

To create a new logbook item, select the **New** button from the button bar. The **MINIMUM DATASET NEW LOGBOOK ITEM** tab appears allowing the user to add a new record to the logbook. The tab contains the following areas:

- Patient Details,
- Operation/Non Operation Details,
- Comments History.

4.3.1 Patient Details

1. Enter the first and last names of the patient.

2. Enter the patient UR number.

3. Enter the date of birth of the patient, in dd/mm/yyyy format or click on the calendar icon to select a date. The age of the patient will be automatically calculated, or alternatively can be entered without the date of birth.

    NOTE: To select a date click the calendar icon, click the **Month/Year at the top**, then click the **Year** that appears, a view allowing you to select one of 10 years is displayed, you can then scroll 10 years at a time, using the arrows either side of the displayed year.

4. Select the relevant hospital from the **[Hospital Name]** dropdown list.

5. Select either `Non Operative Management` or `Operative Procedure` from the **[New Record]** dropdown list.
    NOTE: Selection of a **[New Record]** will display additional fields. For **Non Operative Management** go to Step 6 for **Operative Procedure** go to step 11.

4.3.2 Non Operative Management

6. Select the type of non-operative management applied to the patient from the **[Non Operative Management]** dropdown list.

7. Select the relevant outcome from the **[Outcome]** dropdown list.

8. Select the relevant level of supervision from the **[Level of Supervision]** dropdown list.

9. Select the relevant supervising surgeon from the **[Supervising Surgeon]** dropdown list.

10. Click **Save** at the end of the Editing New Non Operative Procedure section.
    To add another procedure return to step 5.

4.3.3 Operative Procedure

11. Select the relevant sort option from the **[Sort]** dropdown list.

12. Select the relevant anatomical zone from the **[Anatomical Zone]** dropdown list.

13. Select the relevant line entry from the **[Line Entry]** dropdown list.

14. Select the actual procedure displayed in the **[Procedure]** box.
    NOTE: This will be added to your **[Favourites]** which stores the last 10 ten procedures selected. In future you can simply select from your favourites list.

15. To remove a procedure, click the relevant item and select **Remove**.

16. Enter the date of the procedure or click on the calendar icon to select a date.

17. Select the relevant level of supervision from the **[Level of Supervision]** dropdown list.

18. Select the relevant supervising surgeon from the **[Supervising Surgeon]** dropdown list.

19. Click **Save** at the end of the Editing New Operative Procedure section.
    To add another procedure return to step 5.

4.3.4 Comments History

The **[Comments History]** field displays comments recorded against the procedure. To enter a comment in the **[Enter Comments]** field type in the relevant comment and click **Add.** The comment is displayed in the **[Comments History]** section together with the user's name and date.

NOTE: An error message will appear if the record is incomplete when **Save** or the **EXPANDED/ADDITIONAL DATASET** tabs are selected.

4.3.5 Send Logbook Record to Supervisor

If you are satisfied with the logbook record, you can send it to your supervisor for review. Selecting this option automatically saves the record and returns you to the **JOURNAL** view.

1. Click **Send to Supervisor**.
   The record will be saved and sent directly to your Supervisor. The status of the logbook item will change from 'Not yet referred' to 'Referred'. You can no longer edit this item, unless your supervisor chooses to reject the record.

4.3.6 Save Logbook Record

If you have not already sent the record to your supervisor, click the **Save** button at the bottom of the screen to save the information and return to the **JOURNAL** view. The logbook item has a status of 'Not yet referred'. Select **Cancel** to discard the information entered and return to the **JOURNAL** view.

4.4   Expanded Dataset

The EXPANDED DATASET tab allows for the following additional information to be entered.

4.4.1   Patient Details

Field	Data Description	Data Input
[Gender]	Used to specify the gender of the patient. Mandatory field.	Option Button
[Admission Date]	Used to record the admission date of the patient. Mandatory field.	Date Selection
[Discharge Date]	Used to record the discharge date of the patient.	Date Selection
[Recognised Co-morbidities]	Used to record the co-morbidities of the patient. May select more than one or remove an incorrect selection.	Drop down list

4.4.2   Pre and Post Management Diagnosis

Field	Data Description	Data Input
[Filter Favourites]	Used to filter the diagnoses saved as Favourites.	Drop down list
[Favourites]	Used to specify the primarily used diagnoses for the logbook user.	Drop down list
[Details]	Populates automatically when a Favourite is selected.	

4.4.3 Procedure Details

The following fields are not initially visible. To access these fields select the relevant procedure listed under **[Operation/NonOperation Details]** then select **Edit**.

Field	Data Description	Data Input
[Magnitude]	Used to record the magnitude of the procedure. Populated automatically when a procedure is selected.	
[ASA Grade]	Used to record the anaesthetic assessment of the patient.	Drop down list
[Level of Urgency]	Used to specify the need for the procedure.	Drop down list
[Complications]	Used to specify the complications that occurred during or after the procedure.	Drop down list
[Complication Grade]	Used to record the postoperative grade of complication.	Drop down list

4.4.4 Supervisor & Comments

Field	Data Description	Data Input
[Supervisor Status]	Used to identify the status of the record i.e. `Not Yet Referred, Referred, Accepted, Rejected, Complete.`	
[Comments History]	Used to record comments against this record.	`Text`

4.5   Additional Specialty Dataset

Some specialties require collection of further data which is captured in the **ADDITIONAL DATASET** tab. At any time you can navigate back and forth between the New **LOGBOOK ITEM** and **ADDITIONAL DATASET** tabs as long as all mandatory fields have been completed.

Additional datasets available are:

- Aetiology,

- Bariatric,

- Bi-National Cancer Colorectal Audit,

- Breast,

- Colonoscopy,

- Endoscopy,

- Prostate Audit,

- Tonsillectomy Audit,

- Endoluminal Aortic Stent Graft, and

- MVSA

4.6   Edit Logbook Record

To edit a logbook record, from the **JOURNAL** view;

1. Click the **option button** in front of the desired record in the list.

2. Select the **Edit** button from the button bar.
    The **MINIMUM DATASET EDIT LOGBOOK ITEM** tab appears displaying the information currently entered for the selected logbook item.

3. Make relevant changes

4. Select **Save** to save the changes and return to the **JOURNAL** view, or select **Cancel** to close the form without saving any changes made.

4.7   View Logbook Record

To view a logbook record, from the **JOURNAL** view;

1. Click the **option button** in front of the desired record in the list.

2. Select the **View** button from the button bar.
    The **MINIMUM DATASET VIEW LOGBOOK ITEM** tab appears displaying the information currently entered for the selected logbook item.

3. You are not able to edit any of the fields. Once you have finished viewing the record click **Cancel** to return to the **JOURNAL** view.

4.8   Send Logbook Record to Supervisor

To send a logbook record to your supervisor, from the **JOURNAL** view;

1. Click the **option button** in front of the desired record in the list.

2. Select **Send to Supervisor**.
    The status of the logbook item will change from 'Not yet referred' to 'Referred'. You can no longer edit this item, unless your supervisor chooses to reject the record.

4.9   New Episode

To enter a new episode for a patient, from the **JOURNAL** view;

1. Select the relevant patient record from the list and then select the **New Episode** button from the button bar.
    The **NEW EPISODE LOGBOOK ITEM** tab appears displaying the [**Patient Details]** information currently entered for the selected logbook item.

2. Enter the new episode. Refer 4.4.2 Non Operative Management or 4.4.3 Operative Procedure.

4.10   Supervisor Status Code Change

When you log in after your supervisor has made a status code change (i.e. `accepted` or `rejected` one of your records), you will be prompted to view all records for which changes have been made. Press **View** to display the updated records, selecting **Cancel** will display all records.

4.11   Complete Logbook - Fellows

When satisfied with the logbook item, you can mark it as complete by pressing the **Complete** button. The status of the logbook item will change from 'Draft' to 'Complete' and you are no longer able to edit this item.

Select **Save** to save the information and return to the **JOURNAL** view. Select **Cancel** to cancel the information and return to the **JOURNAL** view.

4.12   Logbook Module - Supervisor

To access the Supervisor section of Logbooks after logging into the system click the Switch to Supervisor View button.
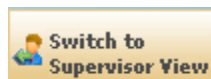
The Logbook module displays logbook items that have been referred by your trainees and provides the ability for you to **View** / **Accept** / **Reject** these items.

The Logbook module is accessible by selecting the **LOGBOOK** tab from the navigation tabs at the top of the screen.

Each logbook item shows the **[Procedure Date]**, **[Trainee Name]**, **[UR]**, **[Line Entry]**, **[Magnitude]**, **[ASA]**, **[Supervision]**, **[Urgency]**, **[Complications]** and **[Status]**.

These logbook items can be sorted by any of these properties. Click the appropriate heading at the top of the list. For example, to sort by procedure, click the words **Procedure**. This will sort the records in ascending order as indicated by a down arrow. Clicking **Procedure** again will turn the arrow upside and sort the records in descending order.

Using the mouse pointer, hover over the option button to reveal a pop up window displaying a summary of the record.

4.12.1 View / Accept / Reject Records

Button	*Details*
View	This will open a form with current information as entered by the trainee but is not editable.
Accept	Changes the status of the record to `Accepted` and returns the supervisor to the remaining listed items.
Accept All Records	Changes the status of all the records to `Accepted`.

To view a record,

1. Select the option button next to the record and click **View.**
   The logbook item as recorded by the trainee will open, allowing you to review all the information entered.

2. Select either **Accept** or **Reject**

3. To add a comment type your remarks into the **[Enter comments]** field and press the **Add** button.
   NOTE: It is mandatory to enter a comment when rejecting a record. An error message will appear to remind the supervisor to **Add** a comment.

The supervisor is also able to accept a record without viewing it first by selecting the option button for the relevant record and clicking the **Accept** button.

Selecting the **Accept All Records** button will accept all records at once without having to select or view them.

To return to your Fellow profile click the Switch to Fellow View button.

5   Generating Reports

5.1   Reports Module – Trainee/Fellow

The Reports module is accessible by selecting the **REPORTS** tab from the top of the screen. When this tab is selected the report options will be displayed to allow the user to define and run any of the available reports.

5.1.1   Creating a Report

The reporting process is a 3 step process:

1. Select the report you would like to run,
2. Adjust the report filters and select report data, and
3. Press **Generate Report** and save the Adobe Acrobat PDF file to your computer.

5.1.2   Existing Reports

Currently the reports under development are:

- Non Operative Summary,
- Individual Patient Transcript,
- Summary, and
- Web Logbook Summary

NOTE: Currently none of the fields in these reports is mandatory.

There are a number of fields that may appear in these reports. They include:

Field	Data Description	Data Input
[From Date]	Used to specify the start of the date range required for the report.	Date Selection
[To Date]	Used to specify the end of the date range required for the report.	Date Selection
[From Age]	Used to specify the start of the age range required for the report.	Date Selection
[To Age]	Used to specify the end of the age range required for the report.	Date Selection
[Select Patient]	Used to specify which patient is required for the report. If unsure as to which patient, select the **Choose Patient…** button to reveal more detail.	Drop Down List
Choose Patient…	Used to specify which patient is required for a report providing more detail including **UR Number** as well as a search facility.	Command Button

5.1.2.1 Non Operative Summary Report

The Non Operative Summary Report counts the procedures in a specified date and age range.

The Non Operative Summary Report contains the following filters:

- From Date,
- To Date,
- From Age, and
- To Age.

To report upon a specific date range enter the From and To dates in dd/mm/yyyyy format or click on the calendar icon to select a date.

To report upon a specific age range enter the From and To Age birthdates in dd/mm/yyyy format or click on the calendar icon to select a date.

5.1.2.2 Individual Patient Transcript

The Individual Patient Transcript Report is a detailed report containing all the data entered by the user for a particular patient.

The Individual Patient Transcript Report contains the following filters:

- Select Patient,
- From Date,
- To Date,
- From Age, and
- To Age.

To report upon a specific date range enter the From and To dates in dd/mm/yyyyy format or click on the calendar icon to select a date.

To report upon a specific age range enter the From and To Age birthdates in dd/mm/yyyy format or click on the calendar icon to select a date.

If the user is unable to select a patient from the drop down box, the **Choose Patient…** button opens a further search function which provides more detail to determine the patient required for the report.

5.1.2.3 Summary Report

The Summary report counts the procedures (line entry) in a specified date and age range and lists the records `Not Yet Referred` to the users' supervisor as well as a summary table of operations entered grouped by Anatomical Zone and Complexity.

The Summary Report contains the following filters:

- From Date,
- To Date,
- From Age, and
- To Age.

5.1.2.4 Weblogbook Summary Report

The Weblogbook Summary report lists the procedures (cmbs) in a specified date and age range and lists the records `Not Yet Referred` to the users' supervisor grouped by Anatomical Zone and Complexity.

The Summary Report contains the following filters:

- From Date,
- To Date,
- From Age, and
- To Age.

5.2 Reports Module - Supervisor

The Reports module is accessible by selecting the **REPORTS** tab from the top of the screen. When this tab is selected the report options will be displayed to allow the user to define and run any of the available reports.

5.2.1 Creating a Report

The reporting process is a 3 step process:

1.   Select the report you would like to run,

2.   Adjust the report filters and select report data, and

3.   Press **Generate Report** and save the Adobe Acrobat PDF file to your computer.

5.2.2 Existing Reports

Currently the reports under development are:

- Non Operative Summary,

- Individual Patient Transcript,

- Summary, and

- Web Logbook summary

NOTE: Currently none of the fields in these reports are mandatory.

There are a number of fields that may appear in these reports. They include:

Field	Data Description	Data Input
[From Date]	Used to specify the start of the date range required for the report.	Date Selection
[To Date]	Used to specify the end of the date range required for the report.	Date Selection
[From Age]	Used to specify the start of the age range required for the report.	Date Selection
[To Age]	Used to specify the end of the age range required for the report.	Date Selection
[Select Patient]	Used to specify which patient is required for the report. If unsure as to which patient, select the **Choose Patient…** button to reveal more detail.	Drop Down List
Choose Patient…	Used to specify which patient is required for a report providing more detail including **UR Number** as well as a search facility.	Command Button
[Select Person]	Used to specify which trainee is required for the report.	Drop Down List
[Select Trainee]	Used to specify which trainee is required for the report.	Drop Down List
[Available Trainees/Persons]	Lists the trainees currently attached to the supervisor.	
[Selected Trainees/Persons]	Used to specify which trainee is required for the report.	

5.2.2.1 Non Operative Summary Report

The Non Operative Summary Report counts the procedures in a specified date and age range for a particular trainee.

The Non Operative Summary Report contains the following filters:

- Select Person,
- From Date,
- To Date,
- From Age, and
- To Age.

5.2.2.2 Individual Patient Transcript

The Individual Patient Transcript Report is a detailed report containing all the data entered by the user for a particular patient.

The Individual Patient Transcript Report contains the following filters:

- Select Patient,
- From Date,
- To Date,
- From Age, and
- To Age.

To report upon a specific date range enter the From and To dates in dd/mm/yyyyy format or click on the calendar icon to select a date.

To report upon a specific age range enter the From and To Age birthdates in dd/mm/yyyy format or click on the calendar icon to select a date.

If the user is unable to select a patient from the drop down box, the **Choose Patient…** button opens a further search function which provides more detail to determine the patient required for the report.

5.2.2.3 Summary Report

The Summary report counts the procedures of selected trainees in a specified date and age range and lists the records `Not Yet Referred` to the users' supervisor as well as a summary table of operations entered grouped by Anatomical Zone and Complexity.

The Summary Report contains the following filters:

- Available Persons,
- Selected Persons,
- From Date,
- To Date,
- From Age, and
- To Age.

5.2.2.4 Weblogbook Summary Report

The Weblogbook Summary report lists the procedures (cmbs) in a specified date and age range and lists the records `Not Yet Referred` to the users' supervisor grouped by Anatomical Zone and Complexity.

The Summary Report contains the following filters:

- From Date,
- To Date,
- From Age, and
- To Age.

6. Mobile User Guide

This section explains how to use the Web Logbook on a Mobile or handheld device.

The Web Logbook mobile system has been developed using standard HTML browsers. If your mobile phone is a WAP xHTML, HTML enabled phone, you may be unable to access the logbooks mobile interface.

6.1 Logging In

To log onto Web Logbook, you must first open the internet browser on a mobile or handheld device.

Locate the Internet Explorer shortcut on your device (usually in the menu/Start menu) and tap/select it to open the browser.

Once it has opened, enter the following address into the address bar:

http://racs.cmoglobal.com/mobilepages

You should be presented with the following screen:

Enter your login and password into the appropriate fields and then tap the 'Login' button.

6.2   Web Logbook Main Screen

When you log into Web Logbook you will see a screen similar to the following:

Note: If this is your first time logging in, you will not see any records – you need to create them first!
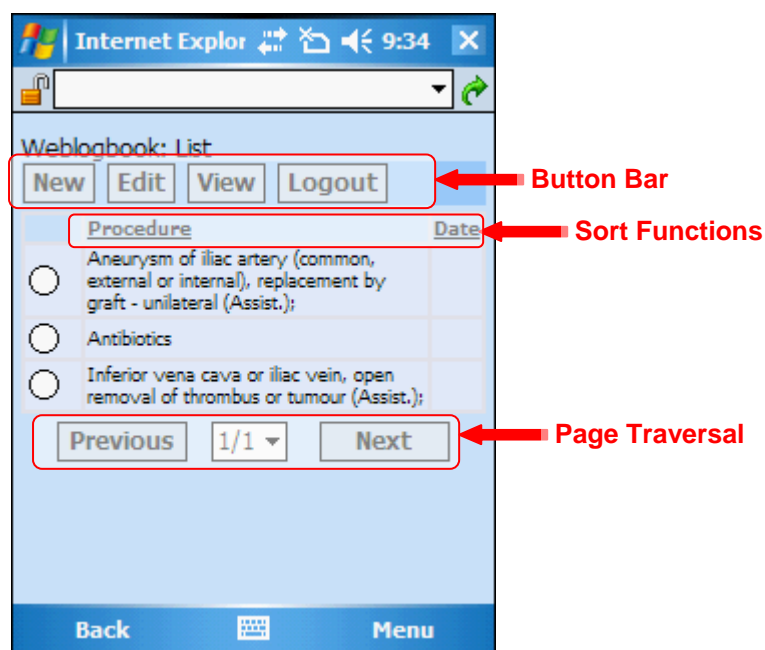
6.2.1   Button Bar

The New, Edit and View buttons allow you to create new logs, edit existing logs or simply view existing logs. The Logout button logs you out of the system.

6.2.2   Sort Functions

Your records can be sorted alphabetically by procedure name or by date performed. To switch between sorting types, click the 'Procedure' or 'Date' links.

6.2.3   Page Traversal

The main screen will display 5 records a time. To go to another page of records, either use the 'Previous' and 'Next' buttons, or select a specific page using the dropdown box.

6.3   Entering Data into Web Logbook

6.3.1   Text Boxes

To enter text into text boxes, simply select the appropriate text box and use your preferred method of text entry to enter the data. To change the method of data entry, select the up arrow on the bottom right of the screen.   You can choose between Block Recogniser, Keyboard, Letter Recogniser and Transcriber.

6.3.2   Drop Down Menus

To enter data from a drop-down box, first select the drop-down box and then a list of available entries will be displayed. Select the desired entry to populate this field. If the desired entry is not present you may be able to enter your own customised entry into the drop-down menu. Do this by selecting the text section of the drop-down box and entering text in as you would for a text box (see above Text Boxes).
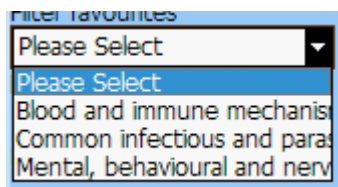
6.4 Creating a new record

To create a new record, tap the 'New' button at the top of the main screen. The following menu will appear at the top of each section:
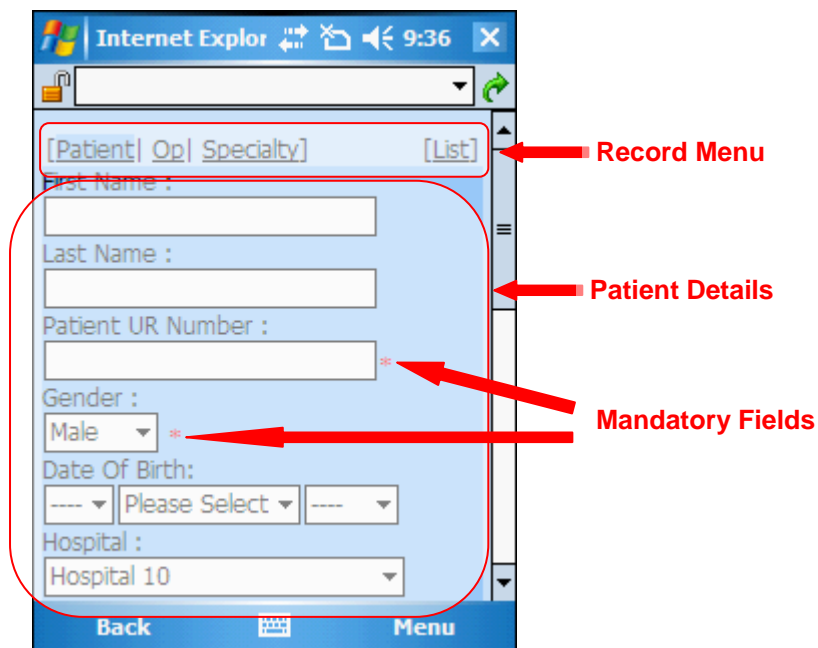
The 'Patient', 'Op' and 'Specialty' are links to each of the three sections in a record, whilst the 'List' link will take you back to the main (list) screen.

6.4.1 Patient Details

The first section that you will see is Patient Details (abbr. Patient). Fill out the fields using text entry and dropdown selection.

NOTE: Fields with a red asterisk (*) next to them are mandatory and must be completed before any other pages can be accessed.

When adding pre-management or post-management diagnoses, you may either select a diagnosis from the 'Favourites' dropdown list or type in one manually.

When selecting a diagnosis from the dropdown list of favourites, you can first filter this list by selecting an item from the 'Filter favourites' dropdown list. To enter a diagnosis manually, type the name in the text field and select the add button.

Please note: the entered diagnosis name must match a diagnosis available from the database, otherwise an error will appear.

To remove a diagnosis, tap it to select it and then press the 'Del' button.
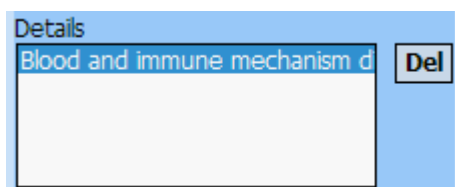
When you have filled out the patient's details satisfactorily, please click the 'Jump to Operation Details' button to go to the next section.
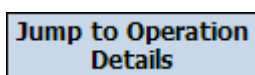
6.4.2   Operation Details

The Operation Details (abbr. Op) section requires you to first select whether the record type should be 'Non Operative Management' or 'Operative Procedure'. Fields will appear specific to the record type that you select.

If you select 'Non Operative Management', you will then be able to provide the procedure recommended and the outcome, as well as any other comments.

If you select 'Operative Procedure' you must specify the procedure(s) undertaken. When you select a procedure from the Procedure box, it will automatically populate in a window underneath. You can add as many procedures to this window as you like. To delete a procedure, tap it to select it and then press the 'Del' button.
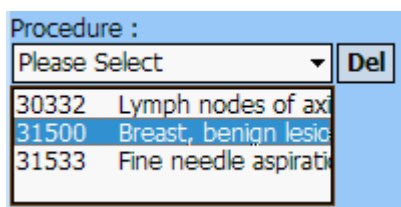
You will also need to provide details on the procedure such as:

- Level of supervision,

- Level of urgency, and

- The supervising surgeon's name.

You are able to add any complications in the same way that a procedure is added (i.e. you can select multiple procedures or delete them using the 'Del' button).

Complication grade and additional comments are also able to be added.

When you are finished completing Operation Details, press the 'Jump to Specialty Details' button to go to the next section.

Jump to Specialty Details

At this point you can also press the 'Save and go to List' button to save the record and go back to the main screen of the application.

Save and go to List

6.4.3 Specialty Details

The Specialty Details (abbr. Specialty) section allows you to enter information relating specifically to the patient's condition.

This section requires you to first select which additional dataset of information you require – breast, colonoscopy or endoscopy. Each of these options has a different set of fields associated to it.

When you have completed this section, press the 'Save and go to List' button to save the record and go back to the main screen of the application.

6.5 Editing an existing record

To edit an existing record, in the list view, tap the option button to the left of the record details to select it and then press the 'Edit' button.
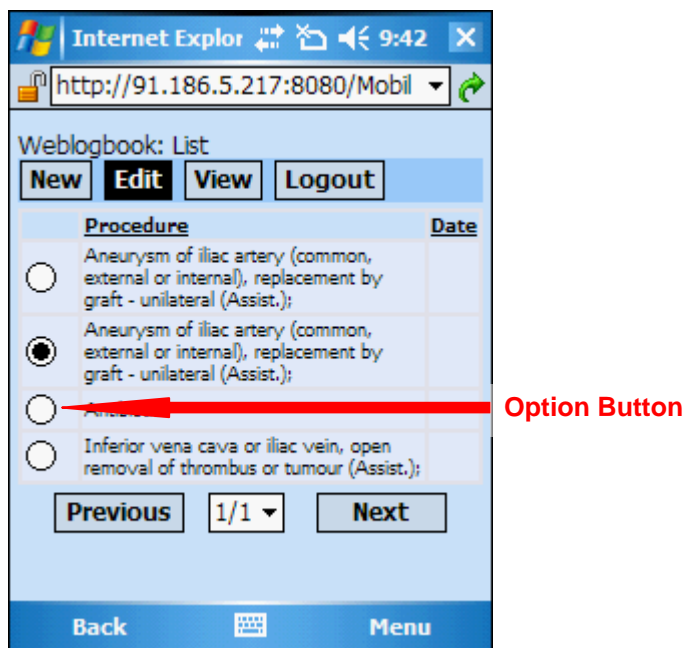
This will present the user with all of this patient's information that is able to be edited.

When you have finished editing, go to the Operation Details (Op) section and press 'Save and go to List' at the bottom.

6.6   Viewing a record

To view a record, in the list view, tap the option button to the left of the record details to select it and then press the 'View' button.
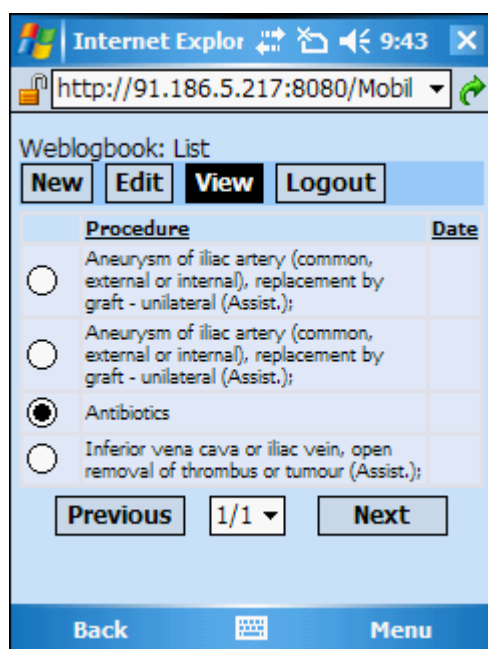
This will present the user with all of this patient's information in read only view. If you would like to edit this information you will need to go back to the list of records, select the desired record and choose 'Edit'.

When you have finished viewing the record, press the 'List' link to go back to the main screen.

7.   Appendices

Appendix 1 – Line Entries

Cardiothoracic Surgery

SHORT DESCRIPTOR / LINE ENTRY
Abdominal - specify
Aneurysm
Aneurysm/dissection repair - Arch
Aneurysm/dissection repair - ascending
Aneurysm/dissection repair - descending
Aneurysm/dissection repair - ventricular
Angiogram - diagnostic
Anti-reflux operation - laparoscopic
Anti-reflux operation - open
Anti-reflux operation - open
Aortic Root replacement/repair - homograft
Aortic Root replacement/repair - prosthesis
Aortic Root replacement/repair - valvesparing
Arrhythmic surgery - Combined LA & RA
Arrhythmic surgery - LA
Arrhythmic surgery - RA
Arrhythmic surgery - ventricular
Artery Harvesting - other
Artery Harvesting - radial
Biopsy
Bronchoscopy
Bronchoscopy - flexible
Bronchoscopy -Rigid
Cardiac tumour - excision
Cardiac valve repair/replacement - aortic
Cardiac valve repair/replacement - mitral

Cardiac valve repair/replacement - multiple
Cardiac valve repair/replacement - pulmonary
Cardiac valve repair/replacement - tricuspid
Cardiac valve replacement
Cardiothoracic - other
Catheterisation - therapeutic
Chest wall - reconstruction
Chest wall - thoracoplasty
Circulatory support - BiVAD
Circulatory support - ECMO
Circulatory support - LVAD
Circulatory support - RVAD
Congenital - other
Coronary artery grafting - distal coronary
Coronary artery grafting - endarcterectomy
Coronary artery grafting - off pump
Coronary artery grafting - on pump
Coronary artery grafting - other
Coronary artery grafting - proximal aorto-coronary
Coronary artery grafting (whole case)
Electrode Insertion
Gastrectomy – Bilroth I partial
Gastrectomy - total
Gastrostomy open
Intrathoracic tumour
Lung operation
Lung surgery - lobectomy
Lung surgery - pneumonectomy
Lung surgery - segmentectomy
Lung surgery - wedge excision
Mediastinoscopy

Mediastinoscopy
Myomectomy
Myotomy - specify
Myotomy - specify
Oesophageal – specify
Oesophageal – specify
Oesophageal dilatation
Oesophageal resection
Oesophagectomy
Oesophagoscopy - diagnostic
Oesophagoscopy - therapeutic
Oesophagoscopy +/- Biopsy
Other
Pacemaker lead insertion or removal - transverse endocardial
Pericardectomy
Pericardial drainage
Pneumonectomy
Removal foreign body - endoscopic
Sternal wires removal
Sternal wound debridement
Sternotomy - open (primary)
Thoracoscopy
Thoracotomy
Thoracotomy/VATS - decortication
Thoracotomy/VATS - pleurectomy
Thoracotomy/VATS - pleurodesis
Thoractomy – specify
Thoractomy / thoracoscopy (not for trauma)
Tracheostomy
Transplant - heart
Transplant - lung

Tumour Excision
Ventral hernia repair - major

General Surgery

SHORT DESCRIPTOR / LINE ENTRY
Abdominal - specify
Abdominal abscess drainage
Abscess drainage
Abscess/haematoma/fluid drainage
Access Surgery for Haemo-Dialysis
Adhesiolysis
Adrenalectomy
Amputation - major limb
Amputation - minor
Amputations - digital
Anal sphincter repair
Anal/rectal/perianal - specify
Aneurysm
Anoplasty
Anterior resection
Anti-reflux operation - laparoscopic
Anti-reflux operation - open
A-P resection - abdominal
A-P resection - perineal
Appendicectomy (open or laparoscopic)
Axillary Dissection
Axillary lymph node sampling
Banding/injection of haemorrhoids
Bariatric surgery
Bile duct exploration - open
biliary – other specify
Breast abscess drainage
Breast Augmentation

Breast biopsy
Breast reconstruction
Breast Surgery - Other
Bronchoscopy
Bronchoscopy - flexible
Bronchoscopy -Rigid
Burn injuries
Burr holes
Cholecystectomy +/- cholangiogram - laparoscopic
Cholecystectomy +/- cholangiogram - open
Choledocho-jejunostomy
Circumcision
Closure of stoma
Colectomy - partial
Colectomy - total
Colonic lavage - on table
Colonoscopic dilation
Colonoscopic polypectomy
Colonoscopy
Colorectal - specify
Colostomy / ileostomy - revision
Craniectomy / craniotomy
Critical limb ischaemia
Cystoscopy / urethroscopy
Defunctioning colostomy / ileostomy
Diagnostic laparoscopy
Dupuytrens Surgery
Endoscopic gastrostomy/jejunostomy
Endoscopic procedures - other
Endoscopic removal of/ablation of lesion
ERCP

ERCP and insertion of stent
ERCP and sphincterotomy
Ex skin/subcutaneous lesion
Excision - simple
Excision following needle localisation
Excision of Large and/or Deep lesion (+/- DC)
Fasciotomy
Fem(pop)tibial bypass(incl pedal)
Femoral hernia
Femoro-distal bypass graft
Fibreoptic sigmoidoscopy
Gastrectomy – Bilroth I partial
Gastrectomy - total
Gastro-enterostomy
Gastrostomy open
Haemorrhoidectomy
Hartmann's - reversal of
Hartmann's procedure
Hemicolectomy - right
Hepatic resection - major
Hepatico-jejunostomy
Hydrocoele/cyst
Ingrown toenail operation
Kidney Transplant
Laparotomy - exploratory / diagnostic
Laparotomy - specify
Laparotomy for GI atresia
Laparotomy for major trauma
Liver – other specify
Liver biopsy
Liver tumour

Lung operation
Lung surgery - lobectomy
Lung surgery - pneumonectomy
Lung surgery - segmentectomy
Lung surgery - wedge excision
Lymph Node Biopsy
Lymph node dissection (not axillary)
Mastectomy - simple
Mastectomy - subcutaneous
Mediastinoscopy
Minor procedure (meningeal biospy, EVD, ICP monitor, Ommaya reservoir etc.)
Myotomy - specify
Nephrectomy
Nerve Decompression, other than CT
Oesophageal – specify
Oesophageal dilatation
Oesophageal resection
Oesophagectomy
Oesophagoscopy - diagnostic
Oesophagoscopy - therapeutic
Oesophagoscopy +/- Biopsy
Oophorectomy
Other
Pancreatic – other specify
Pancreatic pseudocyst
Pancreatico-duodenectomy
Parathyroidectomy
Perianal abscess/fistula in ano
Pilonidal sinus
Plastic - minor
Pneumonectomy

Procto-colectomy
Rectal prolapse abdominal repair
Rectal prolapse perineal repair
Removal foreign body - endoscopic
Repair fractures – specify
Salivary gland excision
Skin Graft
Small bowel resection
Splenectomy (not for trauma)
Sternal wound debridement
Subareolar excision of ducts
Tendon repair
Testis - exploration of
Thoractomy – specify
Thyroidectomy – lobectomy
Thyroidectomy – subtotal
Thyroidectomy – total
Tracheostomy
Trans-anal tumour resection
Transplant - lung
Trauma – specify
Umbilical, paraumbilical, epigastric hernia
Under-run gastro-duodenal bleeding vessel
Vagotomy +/- drainage procedure
Varicocoele
Varicose veins
Vasectomy
Ventral hernia repair - major
Wide excision / quadrantectomy
Wound debridement / repair - major
Wound exploration/debridement/repair

Neurosurgery

SHORT DESCRIPTOR / LINE ENTRY
Cranio-cervical junction (decompression, tumour, Chiari, trans-oral procedure etc.)
Cranio-facial procedure
Craniotomy
Endoscopic Procedures (3rd ventriculostomy etc)
Epilepsy procedure
Hydrocephalus: Other
Hydrocephalus: Shunt insertion or revision
Hydrocephalus: Shunt removal
Infection: Cerebral Abscess, SD empyema, Spinal
Minor procedure (meningeal biospy, EVD, ICP monitor, Ommaya reservoir etc.)
Other major procedure
Pain procedure (DREZ, Cordotomy, Stimulator etc.)
Pain: Trigeminal Decompression, Balloon, RF etc.)
Peripheral Nerve major (Brachial plexus operation, nerve graft, cervical rib etc)
Peripheral Nerve minor (Carpal tunnel, ulnar nerve transposition, sural nerve biopsy)
Repair fractures – specify
Spinal discectomy/foraminotomy (any level)
Spinal dysraphism
Spinal fusion - anterior - non-instrumented
Spinal fusion - posterior - instrumented
Spinal fusion - posterior - non-instrumented
Spinal fusion instrumented (any level)
Spinal Laminectomy/Laminoplasty (any level)
Spinal procedure: other
Spinal tumour (Extradural)
Spinal tumour/AVM/Fistula (Intradural)
Stereotactic (DBS, Biopsy, Lesion creation)
Trauma Craniotomy (EDH, SDH, Depressed skull fracture etc.)

Trauma: Other (dural repair etc.)
Tumour Craniotomy: Glioma, Metastasis
Tumour Craniotomy: Meningioma
Tumour resection - specify
Tumour: Pituitary (any method)
Tumour: Skull base (includes acoustic neuroma)
Vascular: Aneurysm - Clipping, trapping, etc
Vascular: AVM, cavernoma, Moya-moya

Orthopaedic Surgery

SHORT DESCRIPTOR / LINE ENTRY
Amputation
Anterior Ethmoidal Artery Ligation
Arthrodesis
Arthroplasty
Arthroscopic surgery - diagnostic
Arthroscopic surgery - theraputic
Arthroscopy
Biopsy
Bone Graft
Bony Fixation(s) - internal or external
Bony Reconstruction
Electrode Insertion
Exostoses Removal
Finger Tip Repair / terminalisation
Fracture open reduction - ankle
Fracture open reduction - tibia
Fracture open reduction - upper limb
Fractures closed reduction
Hips - CDH
Implant or Expander Insertion
Implant or Expander Removal
Neurectomy
Orthopaedic - major
Orthopaedic - minor
Osteotomy
Other
Recurrent dislocation
Repair fractures – specify

Revision
Rheumatoid Hand Surgery
Rotator cuff & decompression
Spinal discectomy/foraminotomy (any level)
Spinal procedure: other
Spine
Synovectomy
Tendon Sheath Incision
Total Joint replacement - primary
Total Joint replacement - revision
Tumour Excision

Otolaryngology Head & Neck Surgery

SHORT DESCRIPTOR / LINE ENTRY
Adenoidectomy
Adenotonsillectomy
Angiofibroma External - any approach
Angiogram - diagnostic
Anterior Ethmoidal Artery Ligation
Arthrodesis
Arthroplasty
Arthroscopic surgery - theraputic
Arthroscopy
Atticotomy
Aural Polypectomy
Biopsy
Bone Graft
Bony Fixation(s) - internal or external
Bony Reconstruction
Bronchoscopy & Foreign Body Removal
Bronchoscopy +/- Biopsy
Cauldwell Luc
Choanal Artesia Repair
Cochlear Implant
Dressing or Exam under Anaesthetic
Ear Foreign Body Removal
Ear Reconstruction
Ear Surgery - Other
Ear Toilet Micro-inspection Suction
Endolymphatic Sac Operation
Ethmoidectomy
Ethmoidectomy External

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Ex thyroglossal cyst
Excision - simple
Excision of Large and/or Deep lesion (+/- DC)
Exostoses Removal
Exploration
Facial Nerve Decompression Through Horizontal & Vertical Segments
Frontal Sinus Ablation / Osteoplastic Flap
Frontal Sinus Trephine
Head & neck – other
Implant or Expander Insertion
Labyrinthectomy
Laryngectomy Hemi Vertical
Laryngectomy Supraglottic
Laryngectomy Total
Laryngofissure / External Operation on Larynx
Laryngoplasty - Other
Laryngoscopy Direct +/- Biopsy
Lateral Rhinotomy
Lymph node dissection (not axillary)
Lysis Tongue Tie
Mastoid Obliteration
Mastoidectomy Modified Radical
Mastoidectomy Revision
Maxillectomy
MaxilloFacial Osteotomy (inc.mandible)
Meatoplasty
Meatotomy
Minor procedure (meningeal biopsy, EVD, ICP monitor, Ommaya reservoir etc.)
Myringoplasty
Nasal Septal Surgery
Nasal Septum - Turbinate, Cautery, Diathermy or Reduction

Nerve Decompression, other than CT
Nerve Graft
Nose EUA +/- Nasal Packing
Nose Foreign Body Removal
Nose Fracture Reduction
Orbital Decompression
Oro-antral Fistula Repair
Ossicular Reconstruction
Other
Pain: Trigeminal Decompression, Balloon, RF etc.)
Pharyngeal pouch surgery
Plastic - minor
Polypectomy - Other
Reduction Facial Fracture [Not Nasal]
Removal foreign body
Repair fractures – specify
Salivary gland excision
Sinus endoscopy
Skin Graft
Stapedectomy or Revision
Sternomastoid division for torticollis
Submandibular Gland Excision
Synovectomy
Tonsillectomy
Tonsillectomy Quinsy
Tracheal Resection
Tracheostomy
Transposition
Tumour Excision
Tumour: Skull base (includes acoustic neuroma)
Turbinectomy

Uvulo-palato-pharyngoplasty
Vascular - other
Vessel reconstruction

Paediatric Surgery

SHORT DESCRIPTOR / LINE ENTRY
Anoplasty
biliary – other specify
Biopsy
Bronchoscopy
Bronchoscopy - flexible
Bronchoscopy -Rigid
Calculi -closed
Cardiothoracic - other
Chest wall - reconstruction
Chest wall - thoracoplasty
Circumcision
Cranio-cervical junction (decompression, tumour, Chiari, trans-oral procedure etc.)
Ex thyroglossal cyst
Femoral hernia
Gastrostomy button - change
Gastrostomy open
Herniotomy
Hirschsprung's definitive surgery
Infection: Cerebral Abscess, SD empyema, Spinal
Intrathoracic tumour
Laparotomy for GI atresia
Liver biopsy
Lung operation
Lung surgery - lobectomy
Lung surgery - pneumonectomy
Lung surgery - segmentectomy
Lung surgery - wedge excision
Meatotomy

Mediastinoscopy
Minor procedure (meningeal biopsy, EVD, ICP monitor, Ommaya reservoir etc.)
Neonatal surgery (including PDA) - other major
Oesophageal resection
Orthopaedic - major
Orthopaedic - minor
Other
Other major procedure
Paediatric - other specify
Pain procedure (DREZ, Cordotomy, Stimulator etc.)
Pain: Trigeminal Decompression, Balloon, RF etc.)
Pericardial drainage
Peripheral Nerve major (Brachial plexus operation, nerve graft, cervical rib etc)
Peripheral Nerve minor (Carpal tunnel, ulnar nerve transposition, sural nerve biopsy)
Plastic - major
Plastic - minor
Pyeloplasty
Removal foreign body
Spinal discectomy/foraminotomy (any level)
Spinal dysraphism
Spinal Laminectomy/Laminoplasty (any level)
Spinal procedure: other
Sternomastoid division for torticollis
Sternotomy - open (primary)
Tendon repair
Thoracoscopy
Thoracotomy
Thoracotomy/VATS - decortication
Thoracotomy/VATS - pleurectomy
Thoracotomy/VATS - pleurodesis
Thoracotomy / thoracoscopy (not for trauma)

Tracheostomy
Transplant - lung
Tumour Excision
Tumour: Skull base (includes acoustic neuroma)
Urological (not circumcision) - specify
Vascular: Aneurysm - Clipping, trapping, etc
Vessel reconstruction

Plastic & Reconstructive Surgery

SHORT DESCRIPTOR / LINE ENTRY
Abdominoplasty
Abscess drainage
Abscess/haematoma/fluid drainage
Amputation
Amputation - minor
Arthrodesis
Arthroplasty
Axillary Dissection
Bone Graft
Bony Fixation(s) - internal or external
Bony Reconstruction
Breast Augmentation
Breast reconstruction
Breast Surgery - Other
Congenital - other
Dermabrasion / Chemical peel / Laser resurface
Dupuytrens Surgery
Ex skin/subcutaneous lesion
Excision - simple
Excision of Large and/or Deep lesion (+/- DC)
Finger Tip Repair / terminalisation
Fracture Reduction - hand
Fracture Reduction - jaws (mandible or maxilla)
Free Flap / Dissection
Implant or Expander Insertion
Implant or Expander Removal
Ingrown toenail operation
Ligament Repair

Liposuction
Lymph node dissection (not axillary)
Lymph node dissection (not for breast)
Mastectomy - subcutaneous
Microvascular Anastomosis(es)
Myo-cutaneous flap
Nerve Decompression, other than CT
Nerve Repair - major
Other
Peripheral Nerve major (Brachial plexus operation, nerve graft, cervical rib etc)
Pilonidal sinus
Plastic - major
Plastic - minor
Plastic - other specify
Rheumatoid Hand Surgery
Skin Graft
Soft tissue tumour resection
Spinal fusion instrumented (any level)
Spinal procedure: other
Sternal wound debridement
Sternotomy - close
Synovectomy
Tendon repair
Tendon Sheath Incision
Wound debridement / repair - major
Wound exploration/debridement/repair

Urology

SHORT DESCRIPTOR / LINE ENTRY
Adrenalectomy
Biopsy
Bladder cystectomy
Calculi -closed
Circumcision
Dilatation & Stent
Endoscopic resection bladder tumour/prostate
Hydrocoele/cyst
Laparotomy - exploratory / diagnostic
Nephrectomy
Other
Prostate - open enucleation
Prostate - radical prostatectomy
Prostate or bladder neck incision or deep loop biopsy (including deroof abscess) using any energy source
Pyelolithotomy
Pyeloplasty
Suprapubic cystotomy
Testis - exploration of
Ureter, open exploration and ureterolysis, partial or total ureterectomy or ureterolithomy
Ureteric operation - specify
Urological - other specify
Varicocoele
Vasectomy

Vascular Surgery

SHORT DESCRIPTOR / LINE ENTRY
Amputation - major limb
Amputation - minor
Aneurysm
Aneurysm/dissection repair - Arch
Aneurysm/dissection repair - ascending
Aneurysm/dissection repair - descending
Angiogram - diagnostic
Angioplasty
Aorto-iliac reconstruction
Bypass - autologous
Bypass - autologous/prosthetic
Bypass - Prosthetic
Cannulation - cardioplegia
Cannulation - cerebral perfusion
Cannulation for cardiopulmonary bypass - central
Cannulation for cardiopulmonary bypass - femoral
Cardiothoracic - other
Carotid body tumour
Congenital - other
Critical limb ischaemia
Dilatation & Stent
Endarterectomy
Endovascular Procedure
Fem(pop)tibial bypass(incl pedal)
Femoro-distal bypass graft
Iliofemoral bypass
Intra-aortic balloon pump
Laparotomy - specify

Minor procedure (meningeal biopsy, EVD, ICP monitor, Ommaya reservoir etc.)
Peripheral Nerve major (Brachial plexus operation, nerve graft, cervical rib etc)
Removal foreign body
Revision
Rib resection
Sympathectomy
Tendon repair
Tumour
Varicose veins
Vascular - other
Vascular repair
Vessel reconstruction

Appendix 2 - Optimise Firefox

If you use Mozilla Firefox as your browser, it is possible to tune it to run faster by following these steps:

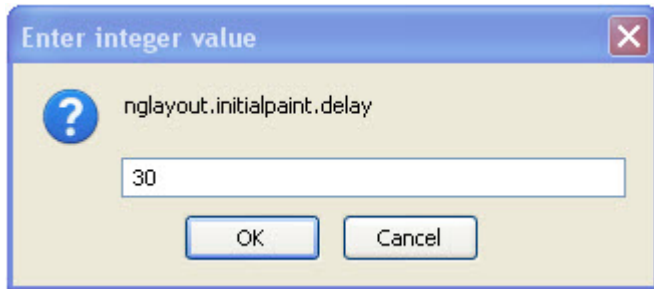1. Type *about:config* into the address bar and hit return.

2. Type *network.http* in the filter field
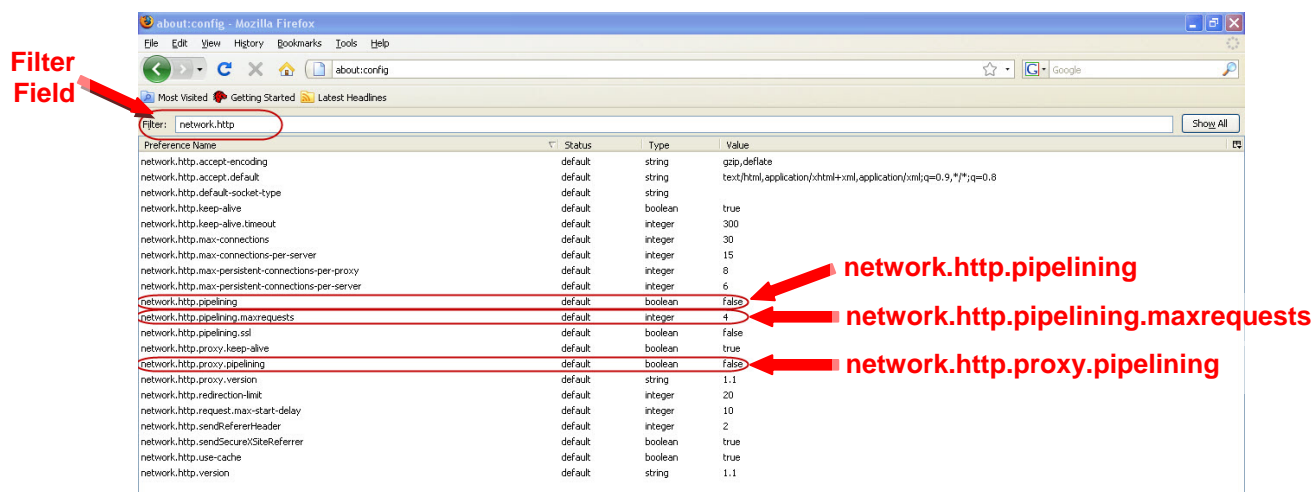
3. Double click network.http.pipelining (this should change it from false to true).

4. Double click network.http.proxy.pipelining (this should change it from false to true).

5. Double click network.http.pipelining.maxrequests and enter 30 into the popup window that appears.

6. Right click anywhere and choose New -> Integer. Enter *nglayout.initialpaint.delay* into the preference name field and press OK.
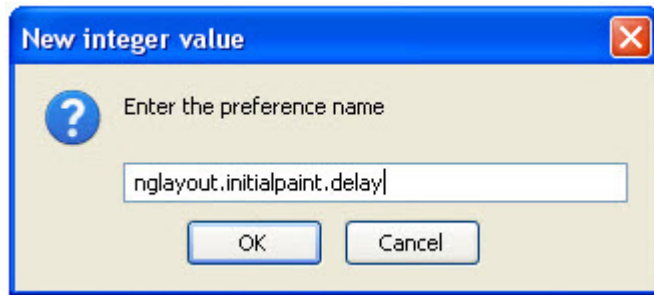
7. Then enter *30* into the next field titled Enter integer value and press OK.

8. Close and then reopen Firefox.