ELECTIVE SURGICAL WAITING LIST MANAGEMENT GUIDELINE

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MINISTRY OF HEALTH-ETHIOPIA

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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

HEALTH SERVICE QUALITY DIRECOTRATE

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ABBREVIAITONS

ESWL	Elective Surgical Waiting LIst
GP	General Practitioner
HDU	High Dependency Unit
HIP	Hospital Initiated Postponment
HO	Health Officer
HSP	Health Service Provider
ICU	Intensive Care Unit
IT	Information Technology
MRN	Medical Record Number
MRU	Medical Record Unit
NRFS	Not Ready for Surgery
NESUC	National Elective Surgery Urgency Category
OPD	Out Patient Department
OR	Operating Room
QI	Quality Improvement
RFA	Request for Admission
RFS	Ready for Surgery
SWOSS	Surgical Waiting List and OR Scheduling System
TAD	Tentative Admission Date

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FORWARD

Ethiopia has been committed to ensuring that essential and emergency surgical care is accessible and affordable to its citizens. During the first Health Sector Plan, the Ministry of Health has developed and implemented two strategies- the National Healthcare Quality Strategy (NQS) and Saving Lives Through Save Surgery Strategy (SaLTS) - that mainly aimed to improve the quality and safety of surgical care. In addition, the SaLTS initiative was launched in response to the World Health Assembly resolution-68/15 and envisioned making accessible and affordable essential and emergency surgical and anesthesia care part of the universal health coverage.

Among the key pillars in the SaLTS strategy has been quality management. In line with quality improvement projects, improvement of surgical care has been initiated and has shown encouraging results. Improving the quality of surgical care will be strengthened by introducing the elective surgical waiting list system . The elective surgical waiting list guideline is a guideline, which incorporates equitable service provision of surgical eligible patients.it opreats by introducing ideas that add values in elective surgical waiting list service provision. These include ctagirizing patients with ther clinical urgency category with specific time frame. It also have system to address issues related to timelinessness equitbble acsses and monitering and evaluation approach for the service.

This guide, therefore, provides a detailed guide to execute elective surgical wating list service management process . In addition, it will help to improve quality of surgical care, surgical efficiency, and surgical safety practices among the facilities.

As improvement demands teamwork and a multidisciplinary approach, I would like to call upon all relevant stakeholders: hospitals , surgical associations , developmental parteners , all care providers, and health managers/leaders at all level to work hand in hand towards standardizing elective surgical waiting list service , and implementing the guiding principles to lelective surgical wating list continuum of care.

Finally, I would like to take this opportunity to extend my warm appreciation to all individuals and organizations who have actively participated in the development of this guideline.

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1. INTRODUCTION

Surgical and Anesthesia cares are essential for the treatment of many conditions and represent an integral component of a functional, responsive, and resilient health system. In view of the large projected increase in the incidence of cancer, road traffic injuries, and cardiovascular and metabolic diseases in LMICs, the need for surgical services in these regions will continue to rise substantially from now until 2030. Reduction of death and disability hinges on access to surgical and anesthesia care, which should be available, affordable, timely, and safe to ensure good coverage, uptake, and outcomes.

The Saving Lives through Safe Surgery (SaLTS) Program (2016-2020), Ethiopia's safe surgery strategic plan, was established to address the enormous unmet need for basic surgical care services. The Ethiopian surgical care strategy is well aligned with global and local recommendations, including WHO recommendations and the Health Sector Transformation Plan (HSTP) and quality strategy of the Government of Ethiopia. Ethiopia prioritized surgical and anesthesia services as part of comprehensive primary health care packages, in accordance with the country's vision of ensuring health care quality and equity, and in recognition of the critical role that EESC can play in meeting universal health coverage goals. The SaLTS II program has remained the nation's flagship initiative, garnering support from key stakeholders including health leaders.

As part of the health sector transformation plan and Salts II strategy, the ministry has created a new system called the elective surgical waiting list management system to help facilitate surgical service provision. In the delivery of elective surgery services, the system can define the roles and responsibilities of health service providers (HSPs), hospitals, and key personnel. Maintain a consistent and structured approach to managing waiting lists for elective surgery. Patient-centered elective surgery services are encouraged, as is timely and equitable patient access to elective surgery services based on clinical need.

1.1. Purpose

Surgical Waiting list Management System reflect the health system’s strong commitment to the delivery of quality elective surgical services.

The purpose of this guideline is to:

- Define the responsibilities of Health Service Providers (HSPs), patients, hospitals and key Personnel with regards to the delivery of elective surgical services,
- Ensure a consistent and structured approach to the efficient management of elective surgery waiting lists, and
- Support timely and equitable access to elective surgery services in accordance with clinical need
- Support provision of safe and people-centered elective surgical services.

1.2. Principles

1. Active Waiting List Management:-

Waiting lists are actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes and that elective surgical waiting list (ESWL) management practices are transparent, efficient and people-centered.

The hospital shall consider:-

- The scheduling of surgery is undertaken in consideration of available capacity
- Minimising the impact and inconvenience to patients whose surgery they postpone while managing the elective surgical waiting list.

2. Equitable access

- All patients are to be prioritized based on their assigned clinical urgency category, individual clinical urgency and length of wait. Where no clinical urgency differentiation exists within categories, patients are to be treated in order of their registration onto the waiting list in accordance with the ‘first come, first served’ principle.
- All patients receiving public healthcare services regardless of financial status, shall receive treatment in a hospital with the same high quality of care and treatment, and access to hospital services.
- Patients are provided with easy to understand information about access to elective surgery and their rights and responsibilities

3. Timeliness of Surgery

- Elective surgery in the public hospital system is provided through the use of waiting lists, which are registers of patients who are waiting for elective care.
- Patients are placed on a waiting list and can be assigned to category 1, 2, and 3 depending on the seriousness of their condition.
- Health facilities shall prepare their urgency categorization list based on types of services they provide which will be used for national standard urgency categorization in the near future.
- Health facilities are to ensure patients are managed and treated within the assigned clinical urgency category timeframe:
    - Category 1 – procedures that are clinically indicated within 30 days.
    - Category 2 – procedures that are clinically indicated within 90 days.
    - Category 3 – procedures that are clinically indicated within 365 days.

4. **Safety and Quality**

- Health facilities are responsible for ensuring procedures and processes are in place to optimize the safety and quality of the elective surgery journey. These should be monitored and reviewed via continuous quality improvement.

Influencers of the capacity of the public health system to provide elective surgery

1- Demand for emergency surgery,
2- Demand for the surgical specialty,
3- Demand for hospital beds due to emergency and urgent medical care,
4- The supply of surgeons, anaesthetis, nursing staff and theatre capacity,
5- Scheduling and management practices, and
6- Effective discharge planning of patients from hospital.

1.3. Roles and Responsibilities

Responsibilities of the Hospital

Hospitals have a responsibility for ensuring compliance with the contents of this document, and that processes are in place to:

- Implement the framework of ESWL which seeks to
    - Support active management of patients waiting for elective surgery
    - Support best practice in elective surgery waiting list management

  - Identify the roles and responsibilities of hospitals, surgeons, patients and other stakeholders
  - Improve communication among patients, hospitals, and referring surgeons
  - Support meaningful reporting to the public by hospitals and the government
- Identify staff roles and responsibilities
- Ensure the data quality and integrity of reported data
- Regularly review individual hospital performance against Locally and Nationally set key performance indicators
- Train and educate staff managing elective surgery and the waiting lists

Responsibilities of the Patient:

- Follow the procedures and advice outlined in the information provided
- Give written consent to the procedure/treatment
- Advise the hospital of any change in desire to undergo the procedure/treatment
- Follow hospital admission procedure and advise of any changes to the proposed admission, such as availability or change of address or other contact details
- Attend any preadmission appointments as required and present on the day of admission

Responsibilities of the central triage and registration unit

- Register patients demographic and clinical information
- Identify elective surgical candidates
- Assign patients to the appropriate Out Patient Department(OPD)

Responsibilities of the General Practitioner (GP)/ Health Officer(HO) at OPDs:

- Evaluate, investigate and diagnose the patient and link to the appropriate referral clinic.
- Arrange referral for patients to a hospital that has surgeons with the appropriate expertise and the least waiting time for the anticipated surgical procedure (outpatient waiting time and travelling time should also be considered)
- Provide the hospital with appropriate health information and personal details of the patient while referring to other facility.
- Liaise with the surgeon if there is a change in any indications for surgery or a change in patient's health that may have implications for surgery and treatment.

Responsibilities of the Surgeon/delegate:

- Evaluate, investigate, diagnose and decide on the management of the patient
- Assign a clinical priority urgency category for the procedure/treatment using the facility/National Elective Surgery Urgency Category list
- Explain the proposed procedure/treatment, options for treatment and potential complications and the anticipated length of stay, using an interpreter if required.
- Surgeons must advise patients of their current waiting time for surgery if added to their elective surgery waiting list. This ensures the patient is informed about their approximate wait time and can make an informed decision regarding their care that may include proceeding with the referring surgeon, being referred to another surgeon and/or exploring other options such as utilising private health facilities.
- Explain that the procedure may be performed by another surgeon and/or another hospital
- Consent forms are to be completed and signed by the surgeon and patient contemporaneously at the referral OPD.
- Initiate prompt and appropriate communication with the consulting GP regarding the proposed management of the patient
- If a patient is classified as staged, the time interval when the patient will be ready for surgery should be indicated
- surgeons should ensure that they are able to perform the patient's surgery within the clinical priority urgency category timeframe that they assign (excepting patients who may require multimodality therapies as parts of their treatment plan e.g. some colorectal surgery).
- Ensure that Request For Admission (RFA) forms are legible and the minimum data set is completed
- Attach completed RFA's and consent form on the patient chart and send the patient to the preanesthesia clinic on the same day.
- If consent is provided by the person prior to their current admission, they are to have their consent reconfirmed on the ward during the preoperative conference and/or in the OR waiting area prior to transfer into the theatre suite.
- Make timely rounds and decide on the discharge of patients

- provide as much notice of intended leave or resignation as possible (minimum of six (6) weeks). As a result the surgeons should not submit category 1 RFA's when they will be away, unless they have pre-discussed a management plan with the relevant body.
- All surgeons are to review the provided Wait List on a quarterly basis. This information will enable the clinician to provide patients with an accurate estimation of their current waiting times
- Collaborate with the liaison team in reviewing and managing the waiting list and verify with the hospital management

Responsibilities of the liaison Office:

- Comply with local procedures/protocols for administrative processes that support this guideline (such as national Peri-operative guideline)
- Verify the facility/National Elective Surgery Urgency Categories list is available at surgical OPDs and liaison
- Accept patients with RFAs and preanesthetic evaluation, and register them on the surgical waiting list and complete the RFA form
- Give appointment with maximum expected day of admission based on clinical urgency category of the patient and according to the hospital's waiting list burden.
- Give all the information related to the preadmission, hospital stay processes, discharge plan and provide written document to the patient (Appendix 02)
- Notify the hospital management about surgical backlog status and engage in the backlog management
- Prepare list of shortnotice/standby patients and call the patients accordingly.
- Update the waiting list status to the patient if there are any changes to the waiting list
- Ensure all documentation and electronic data input is accurate, legible and complete
- Undertake all relevant audits to ensure all documentation and electronic data input is accurate, legible and complete
- Assist in planning for patients surgery and patient notification for surgery and pre-admission appointments
- Call the patiens based on the waiting list and start the admission process
- Review and manage all patients listed on the elective surgery waiting list

- Provide the audited surgical Wait List on a quarterly basis for departments, OR director and the medical director

Responsibilities of the ward nurse

- The ward nurse shall facilitate the discharge process of patients on timely basis
- The ward nurse shall report number of available beds post-discharge to the liaison office on a timely basis
- The ward nurse shall accept the patients from the liaison office
- Shall provide timely Peri-operative nursing care

Responsibilities of the anesthesia team

- Conduct preanesthesic evaluation at the preanesthesia clinic
- link the patient within five days to the liaison office to be enrolled in to the surgical waiting list with a compeleted preanesthesic evaluation and consent form.
- Conduct preanesthesic evaluation of the patient on the day of admission before admission to the ward
- Evaluate the patient and attend the pre-operative conference according to the national peri-operative guideline

Responsibilities of operation room director and equivalent positions

- Ensure clinician compliance with this guideline
- Leads the pre-operative conference
- Notify cancelled patients to the liaison office
- Notify operating theatre readiness to the liaison office and hospital managemet
- Ensure appropriate resources and infrastructure essential to the efficient operation of elective surgery services are available
- Ensure processes are in place for optimizing utilization of available theatre resources and minimizing hospital-initiated postponements
- Compile and report OR related indicators and data elements to HMIS office

Responsibilities of medical director and equivalent positions

- Ensure clinician compliance with this guideline.

- Guide waiting list management actors to execute activities based on their role and responsibilities.
- Allocate adequate human resource, supplies and infrastructures needed for the efficient management of surgical wait list
- Approve and avail the facility/National Elective Surgery Urgency Categories list in the necessary areas such as liaison office and OPDs
- Engage in evidence based decision making and coordinate problem solving activities on surgical waiting list management.
- Oversee quality improvement projects on surgical waiting list management
- Act as an adjudicator for issues that require resolution regarding ESWL management
- Review the quarterly Surgical waiting list audit and act accordingly
- Create a learning platform that would help to spread bestpractices among departments

Responsibility of the clinical governance and quality directorate or equivalent

- Participate in quarterly waiting list audit activities
- Work with liaison office and other clinical staff in designing and following QI projects
- Advocate surgical waiting list activities inorder to obtain buy in by hospital leaders
- Ensure waiting list management indicators are included in PMT meetings
- Participate in actions related to data quality assurance and reporting data integrity verification.
- Identify departments with best practices for managing ESWL and support learning transfer between departments using various strategies.

Responsibility of system admin/IT professional:

- Deploy SWOSS on local server
- Setup the system
- Create users (liaison, quality and OR..)
- Maintain and update the system
- BACKUP Database on weekly basis
- Act as an admin
- Provide need based end user training

- Collaborate with liaison and surgeon in recording prioritized patients after patient is added on ESWL.

2. SURGICAL PATIENT LINKAGE AND CATEGORIZATION

2.1. patients linked for elective surgery

All patients linked for an elective surgery procedure must have a completed RFA and preanesthesia evaluation form. The RFA, preanesthesia evaluation forms, anesthesia and surgical consent to treatment located in the patient chart, will only be accepted if completed by surgeon and anesthetist/anesthesiologist.

The surgeon must:

- Assign a clinical priority urgency category consistent with the facility/National Elective Surgery Urgency Category list and provide a clinically verifiable reason to assign a different category (if required)
- Ensure patients are fully informed about the risks and benefits of the procedure and have consented to the treatment offered
- Inform the patient of an approximate waiting time for surgery
- Ensure patients are ready for surgery and ready to accept a surgery date
- Complete a consent for the surgery (i.e. consent to be completed by the surgeon performing the surgery) or his delegate.
- Receive a signed written consent from the patient. This consent shall be reconfirmed on the ward during the preoperative conference and/or in OR waiting area prior to transfer into the theatre suite.
- Complete an approved RFA Form ensuring the minimum data set is complete, legible and accurate
- Ensure the RFA is signed and dated
- Forward the completed RFA and surgical consent form to the preanesthesia clinic on the same day
- Inform patients that they will be admitted under the care of the admitting or another surgeon
- Inform patients that the location of their surgery can vary and they will be allocated a surgery site appropriate to their surgical requirements

- Ensure that they are able to perform the patients surgery within the clinical priority urgency category timeframe that they assign (excepting patients who may require multimodality therapies as part of their treatment plan e.g. some colorectal surgery)

The anesthetist/anesthesiologist shall:

- Complete preanesthesia evaluation form and link within five working days to the liaison office to be enrolled in the ESWL
- link patients who are deemed unfit for surgery to the respective OPD for optimization.
- Complete the ansthesia consent form and attach to the patient's chart

2.2. Elective Surgery Categorisation

- Categorisation of elective surgery patients is prioritised by clinical urgency and is required to ensure patients receive care in a timely and clinically appropriate manner.
- A clinical urgency priority is assigned by the surgeon using the facility/National Elective Surgery Urgency Categories list as a guide.
- Categories assigned outside the guidelines must have a clinically verifiable reason documented in the section provided on the RFA.
- RFAs received with a clinical priority urgency category outside the guideline and no documentation of a clinically verifiable reason will be managed in accordance with the facility/National Guidelines. The Specialist Surgeon will be notified by letter that this has occurred.

Elective Surgery is categorised into the following 3 categories which are defined as:

Category 1: Procedures that are clinically indicated within 30 days.
Category 2: Procedures that are clinically indicated within 90 days.
Category 3: Procedures that are clinically indicated within 365 days.

2.3. Re-classification of the Clinical priority Urgency Category

- Re-classification of a patients assigned clinical priority urgency category to higher category (eg category 2 to category 1) **must only** occur following a clinical assessment/review of the

patient by a surgeon and reflect a change in the patient's condition that has occurred after the patient has been added to the elective surgery waiting list. This review shall be done through face to face assessment

- Reclassification to a lower category (category 1 to category 2) the patient must be directly informed by the clinician, and reasons given to the patient.
- Re-classification cannot occur following a review of clinical notes only, but can occur following receipt of investigative results that indicate a deteriorating, or improving condition.
- Re-classification is independent of the outlined processes related to the National Elective Surgery Urgency Category Guideline when a patient is first added to the elective surgery waiting list.
- Re-classification must not be used to facilitate 'on time' surgery when difficulties in scheduling may arise.
- Authority to reclassify a patient's clinical priority urgency category may only be undertaken by the Consultant or Delegate, who must complete the reclassification of clinical priority form, stating a clinical reason for the change. The clinical reason for the change may reflect deterioration in the patient's condition or an improvement/reassessment of the patient's condition. The re-classification will not be processed if the following information is not complete.
    1. Date of Clinical Review:
    2. Original Clinical Priority Category:
    3. New Clinical Priority Category:
    4. Clinical reason for re-classification
    5. Authorising Doctor name and Signature
- Documentation of a re-classification must be recorded in the patient electronic record (SWOSS) giving the reason for the change. Patients must be advised of any change in their clinical priority urgency category.
- Should the surgeon complete a new RFA form assigning a new clinical urgency category, this can only be accepted if the patient has signed the consent form **or** there is evidence that a clinical review/assessment of the patient has occurred.

- If the new RFA has a different **principle procedure** listed, the original waiting list entry should be removed from the SWOSS. The new RFA is then logged onto the elective surgery waiting list with the new procedure listing date retroactively set to the original listing date.
- If the new RFA has a **minor** change to the procedure, i.e. the principle procedure remains the same, the wait listing entry should be amended and the new RFA attached to the original RFA.
- Documentation of the changes must be recorded in SWOSS.
- The liaison team in collaboration with relevant stakeholders of the facility will conduct monthly audits of all re-classifications of clinical urgency and maintain records of the audit results for reporting as required to hospital senior management team.

Prioritizing Elective Surgery

If priority needs to be given for a patient with out changing the former category the clinician is to write the reasons for giving priority and link the patient to the liaison office. The liaison head will be the one who have the privilege to give priority suggested by the surgeon on to the SWOSS. If the liaison head is not available the IT admin assigns the priority.

The prioritization of patients to be booked from the ESWL is based on the 'first come, first served' principle, which aims to achieve fairness and equity of access to elective surgical services by ensuring that

- Patients are treated in order of their assigned clinical urgency category
- Within each category patients are treated in the same order as they are registered onto the waiting list unless clinically indicated and/or in exceptional circumstances

Patient prioritization may require consultation and negotiation with the surgeon, the Head of Department and as required, the relevant Executive/s responsible for surgical services. When arranging a theatre list, the attending surgeon is to liaise with the personnel responsible for managing the ESWL to ensure full utilization of available operating theatres Based upon the following considerations:

Waiting Time

Priority for admission is to be given to patients who have waited longer than the recommended time for their assigned urgency category. When patients are assigned the same

urgency category and all other relevant factors are equal, the longest waiting patient is to receive priority.

Previous Postponement

Patients whose surgery has previously been postponed for hospital initiated reasons are to be given priority and rescheduled as soon as possible.

Complexity and Resource Utilization

A mix of complex and less complex cases are frequently combined in theatre lists to maximize theatre time. It is appropriate where necessary to prioritize less complex cases with shorter waits to fill theatre lists. Where possible the longest waiting of these cases are to be included. The same principle applies to short notice (stand by) cases to replace cancellations

Geographic Issues

Consideration is to be given to patients who are required to travel a significant distance (i.e rural to urban) for surgery. Where possible, multiple appointments should be coordinated on the same day/visit to minimize travel time and costs. Geographic location (i . e . distance to be travelled and catchment area) are not to hinder the selection of patients being scheduled for treatment.

Additional Factors for Consideration

- Type of surgery required
- Patient co-morbidities
- Medication requirements
- Patient social and community support
- Availability and appropriateness of day surgery
- The need for other treatments while awaiting surgery

2.4. New Procedures

- The medical director must formally approve new procedures not previously undertaken.
- Clinicians must also be appropriately licenced to undertake the procedure before patients are added to the elective surgery waiting list.
- A doctor may only link or refer patients for addition to the elective surgery waiting list for procedures when the clinician has been licenced by the respective licencing authority.

- Surgical procedures should only be conducted at the hospital by an appropriately skilled clinician and where the infrastructure exists to enable the proposed procedure to be performed.

2.5. Completion of the Request for Admission Form (RFA)

The following minimum data set on the RFA Form is to be obtained by the surgeon:

- Patient's full name
- Patient's address
- Patient's contact information (home, work & mobile telephone)
- Patient's sex
- Age
- Medical record number
- Presenting problem
- Planned procedure/treatment
- Clinical priority urgency category and a clinically verifiable rationale if required
- Expected date of admission
- If classified as staged or deferred the **suspension review date** (time interval when the patient will be ready for surgery)should be indicated. The category selected should reflect the time window of when the surgery is to be performed.
- Estimated length of stay
- Admission ward
- Estimated operating time
- Operating surgeon (if different)
- Surgeon's name and address
- Doctor to sign and date the RFA
- Liaison office sign and date

Other relevant information should be included on the RFA that may include:

- Significant medical history
- Specific preadmission requirements
- Special operating theatre equipment
- Requirement for an Intensive Care Unit/High Dependency Unit bed post procedure

2.6. Submitting a Request For Admission

- Completed RFAs must be submitted directly to the liaison office within 5 working days of RFA being signed and dated.
- RFAs for urgent category 1 patients who require surgery within 7 days must be labeled as "urgent" by the surgeon and taken directly to the preanesthesia clinic, where the evaluation will be completed and the RFA will be sent to the liaison office within 72 hours.
- The liaison should keep a record of patients labelled as urgent category 1 patients

2.7. Processing a Request For Admission (RFA)

For all categories RFAs:

- The liaison will obtain any other relevant health information from other health professionals (surgeons, anesthesia team) and inform the patient about surgery requirements and ask the patient readiness for surgery.
- After obtaining consent of readiness, the patient will be added to the Elective Surgery Waiting List (ESWL).
- The liaison will appoint patients based on the facility/national clinical urgency category timeframe
- The liaison will register RFAs on the SWOSS
- Give all the information related to the surgical, preadmission, hospital stay, and discharge plan processes

N.B. Urgent category 1 patient

- After RFAs for urgent category 1 patients submitted to the liaison office the patient will be given the maximum appointment date (i.e. 7 days)
- All information will then be communicated to the surgeon, OR team and ward team.

2.8. Listing Date

A patients *listing date* will be the date the RFA and preanesthetic evaluation is *accepted.* The acceptance date can be the same as the received date or not. "Acceptance" will be deemed when the following are complete:-

- The minimum RFA and preanesthetic evaluation data set is completed

- The RFA form and preanesthetic evaluation form is signed and dated
- It is within facility/National Elective Surgery Urgency Category (ESUC) guideline, or a clinically verifiable rationale is documented supporting the change in category
- The surgeon is available and able to provide the patient with a date for surgery within the clinical priority urgency category timeframe that they assign (excepting patients who may require multimodality therapies as part of their treatment plan e.g. some colorectal surgery)
- Patients should be placed on the electronic elective surgery waiting list within one working day of acceptance of a completed RFA and preanesthetic evaluation form
- RFAs received 1 month or more after being signed and dated by the referring surgeon will not be accepted and will be returned to the referring surgeon for review.
    - RFAs not accepted will be returned to the referring surgeon accompanied by a notice explaining the reason for return.
    - It is the surgeon's responsibility to progress any further action required and inform the patient should they not be placed on the elective surgery waiting list for a procedure.

2.9. Variations from Standard Bookings

Procedure/treatment not provided - if a procedure/treatment is not provided at the hospital, the RFA cannot be accepted. The surgeon should be informed and alternative arrangements negotiated with managing team (i.e. Surgical department head and medical director).

New Procedures-The medical director must formally approve new procedures not previously undertaken. Surgeon must also be appropriately licenced to undertake the procedure before patients are added to the elective surgery waiting list. A surgeon may only refer patients for addition to the elective surgery waiting list for procedures when he/she has been licenced by the respective licencing authority. Surgical procedures should only be conducted at the hospital by an appropriately skilled clinician and where the infrastructure exists to enable the proposed procedure to be performed.

Bilateral Procedures - e.g. right and left hip replacements. A RFA will only be accepted for one procedure unless the bilateral procedure is occurring in the same admission (bilateral cataracts excluded). This is to ensure that the patient has been reviewed and assessed as clinically ready to undergo the subsequent procedure.

Multiple bookings - can be accepted if the treatments/procedures are **independent** of each other e.g. cataract extraction and joint replacement. The surgeon must specify which procedures are prioritised. This may be indicated by the clinical priority urgency category assigned to both bookings e.g. if one is category 2 (within 90 days) and the other is category 3 (within 365 days) then the category 2 takes precedence. However if both RFAs have the same clinical priority urgency category the surgeon should identify on the RFA which procedure is to be prioritised.

The patient should remain Ready for Surgery (RFS) for both procedures until a surgery date is assigned to the first procedure, at which time the second procedure is made Not Ready for Surgery (NRFS). Advice should be received from the doctor or patient when they can become RFS for the second procedure.

The only exception to the above is for ongoing regular treatment e.g. change of supra pubic catheters.

If the procedures are dependent on each other (such is the case for patients having multimodality treatments), the patient can be listed for both procedures but listed as RFS for the surgery that needs to be completed first and NRFS for the subsequent procedure until the patient is cleared following the first procedure.

Duplicate bookings - a RFA will not be accepted for the same procedure with different surgeons at the same hospital; or for the same procedure at a different hospital. The patient is to be advised of the situation and asked to make a decision as to the preferred waiting list they wish to remain on.

3. MANAGING PATIENTS ON THE WAITING LIST

Hospitals must actively manage their elective surgical waiting lists (ESWLs) to provide patients with timely and appropriate access to elective surgery. This requires a health system-wide approach to waiting list management and co-ordinated care, knowing the workforce, infrastructure and case complexity in elective surgery management.

Keeping Fit for Surgery

The responsibility for keeping fit for surgery is a collaborative commitment between the patient, the treating physician the anesthesia team, the liason office and supporting staff of the hospitals.

The Treating physicians and liaison office staffs are to work with the patient to ensure that they:

- meet pre-operative health requirements necessary for surgery to proceed
- know what to do if they believe their condition has deteriorated while waiting for surgery
- know how to best manage their condition while waiting for elective surgery
- How and whom they have to communicate if the need arises

3.1. Calculating Waiting Times

The **Listing Date** is the date of acceptance of the **request for admission (RFA)**. Calculation of waiting time starts from this date.

Calculation of a patient's waiting time includes only the time a patient is **ready for Surgery (RFS)**.

Waiting time thus reflects a genuine waiting period. Periods when patients are **not Ready for Surgery (NRFS)** should be excluded in determining waiting time.

3.2. 'Treat in turn'/first come first serve

The principle of 'Treat in turn' is one that can be applied to assist in the management of elective surgery and waiting times.

The basis of this principle is that patients are treated in accordance with their urgency category but that within each urgency category, most patients are treated in the same order as they are added to the waiting list.

The aim is to treat a minimum of 80% of people in turn, (rather than 100%), because differing patient requirements (as judged by the treating surgeon) and other aspects (such as efficient use of operating theatre time and training of surgical trainees) also should be taken into consideration.

Treatment in turn assists in standardizing urgency categorization as it provides greater predictability for the time patients wait. This should assist in ensuring that patients appropriately categorized as category 2 are not assigned to category 1, ensuring they are treated within 90 days.

As such, thresholds have been established to prevent elective cases in category 2 and 3 being booked prematurely unless clinically indicated and/or in exception circumstances. The thresholds stipulate that category 2 patients should not be allocated a booked date for surgery earlier than 31 days after listing on the ESWL and no later than 90 days. Category 3 patients should not be allocated a booked date for surgery earlier than 91 days after addition to the ESWL and no later than 365 days.

Example

If C1, C2 C3 patients come to be listed on the same date (January 1)

- C1 should be listed from January 1 -30
- C2 should be listed staring from February 1- March 30 (31 days after listing on the SWOSS and no later than 90 days
- C3 should be listed staring from April 1- December 30 (91 days after listing on the ESWL and no later than 365 days

The ‘treat in turn’ principle and compliance with booking thresholds will be monitored and breaches reported on a **quarterly** basis and tabled at the medical director and department head for discussion and any subsequent actions.

3.3. Clinical Review

Clinical Review is **defined** as a review of a patient on the waiting list to ensure that their waiting time remains appropriate for their clinical condition. This can happen if the patient condition is changed or deteriorated while he is on waiting list. Review will be initiated during any visit to the health institution.

- Following a clinical examination, the patient may be reassigned a different priority rating from the initial category based on the clinical assessment

- Assigned physician can initiate a patient review, as some conditions will change while the patient is waiting for treatment. The patients should remain in their current clinical priority category while undergoing clinical review (they should not be moved into NRFS)
- Following the clinical review, a new RFA is not required unless the original procedure being undertaken has changed

The **major objectives** of a clinical review are to determine:

- Change in the clinical condition of the patient
- Any required changes in the patient's clinical urgency priority for the procedure
- If admission is still required

The clinical review can be facilitated by the Liaison officer or equivalent and conducted by an appropriate clinician:

- Treating surgeon or delegate
- General Practitioner (GP)

3.4. Ready for Surgery (RFS)

A **RFS** patient is defined as a patient who is prepared to be admitted to hospital or to begin the process leading directly to admission for surgery. Patients should only be added to a waiting list (that is, regarded *as ready for surgery* for the purpose of monitoring waiting times, and for the purpose of allocation of a surgery date), when the patient is personally and clinically ready for surgery. This means that they should only be regarded as 'in the queue' when they are ready for surgery and waiting times should only be measured for the time the patient is ready for surgery.

Patients deferred for personal reasons should not be added to a waiting list until they are ready for surgery. The patient should be suspended from the waiting list if they defer after being initially ready for surgery.

3.4.1. Delayed Patients

A patient remains classified as **RFS** if their admission is postponed/delayed due to reasons other than the patient's own availability, e.g., unavailability of doctor, operating theatre nor bed.

The hospital should consult the patient possible options and act accordingly eg send patient back home, admit for free etc.

3.4.2. Declined Patients

The hospital must record the reason for patients declining a planned admission date on the electronic waiting list and on the patient's RFA.

3.5. Not Ready for Surgery (NRFS)

A **Not Ready for Surgery patient** can be defined as a patient who is not available to be admitted to hospital until a future date, and is either:

- **Staged**:- Staged patients have undergone surgery or some other treatment and are waiting for follow-up surgery that needs to occur at a particular, known time in the future – usually within a time period measured in days or weeks, rather than months or years.
- **Pending improvement of clinical condition** - Patients for whom surgery is indicated, but not until their clinical condition is improved, for example, as a result of a clinical intervention.
- **Deferred:-** Patients who for personal reasons are not yet prepared to be admitted to hospital.

3.5.1. Not Ready for Surgery – Staged Patients

- Staged patients have undergone surgery or some other treatment and are waiting for follow-up surgery that needs to occur at a particular, known time in the future – usually within a time period measured in days or weeks, rather than months or years.

  The follow-up surgery can be:

  - Part of a 'package' of surgery, for example, removal of the fixation device after an initial surgical episode for the internal fixation of a fracture
  - Checking a patient's status after an initial surgical episode, for example, a check cystoscopy after initial urological cancer surgery

- A surgical episode after non-surgical care, for example, rectal cancer surgery 6-8 weeks after neoadjuvant chemo radiotherapy for colorectal cancer
- A surgical episode for a pediatric patient, indicated at a future developmental stage

- Once the identified NRFS staged timeframe is completed the patient then returns to the RFS category as indicated by the treating doctor.
- Staged patients should be designated as ready for surgery at the beginning of the window of time during which their procedure is indicated. They should be allocated to the urgency category that is appropriate to the timeframe.

  For example:

  - For the rectal cancer surgery example above, the patient should be added to the waiting list as urgency category 1 and made NRFS for 6 weeks after their neoadjuvant chemo radiotherapy. The patient should then be made RFS. Their waiting time would be measured from the time they are ready for surgery, that is, from the point in time 6 weeks after their chemo radiotherapy
  - If a patient needs a check cystoscopy between 12 and 15 months after their initial urological cancer surgery, they should be staged for the 12-month period after the initial surgery, and then have their status changed to ready for surgery, in the urgency category. Their waiting time would be measured from the time their status changes to ready for surgery that is 12 months after their original surgery

3.5.2. Not ready for surgery – Pending Improvement of Clinical Condition

- Category one patients who are identified as not ready for surgery (NRFS) because of a medical condition that requires treatment or management, must have an appointment for the medical condition arranged within 48 hrs of being made NRFS and have a scheduled appointment within 5 working days
- Patients who are waiting for an implant can be made NRFS until a Tentative admission date is assigned
- Category 2 and 3 patients can only be made NRFS following a Clinical PAC (Pre-anesthesia clinic) assessment which clearly identifies the patient as NRFS pending

improvement of clinical condition. This decision must be documented in the patient's electronic record when the patient's status is changed to NRFS

- A patient cannot be deemed NRFS where a documented Tentative admission allocated
    - Exclude patients who have had their surgery postponed and surgery is being planned for a specific date in the future

3.5.3. Not Ready for Surgery – Deferred for Personal Reasons

- These are patients who are not ready for surgery for personal (non-clinical) reasons, such as work commitments.
- Patients who are NRFS at listing date should not be added to a waiting list until their personal circumstances are resolved and they are ready for surgery. Their urgency category should be assigned at that time.
- Once placed on the list, any time subsequently spent deferred should be subtracted from the amount of time recorded as waiting. The maximum cumulative length of time for a patient deferring their procedure for personal reasons is:

- Category 1 - 15 days (however, patient deferring their treatment in this category should be discussed with the referring doctor)
- Category 2 - 45 days
- Category 3 -120 days

Examples:

A patient classified as category 1 on the RFA arrives at Liaison to be appointed for surgical admission on March 1. The liaison officer gave the patient an appointment date of March 30. The officer called the patient for admission on March 29, but the patient deferred due to social reasons. The liaison officer then asked the patient when it would be convenient for him, and he replied, "April 12." As a result of the liaison officer's after communicating the admitting surgeon, considering the maximum postment day for category 1 patients is in this case is 15 days, the patient is reappointed for April 14 by taking into account the date the patient could be scheduled for surgery. The total waiting time of the patient will be 30 days (i.e. time subsequently spent deferred (15 days) subtracted from the amount of time recorded as waiting (45), 45-15=30).

- If a patient fails to attend a pre-admission clinic appointment, then their risk for surgery remains undetermined. In this case their status on the waiting list should be discussed with their treating surgeon.
- A decision to remove the patient from the waiting list may be made if a patient defers more than two offers or exceeds the maximum number of NRFS days.

For deferred, or staged patients, a **suspension review date must be recorded on the RFA:**

- **Suspension Review Date (SRD)**:
    - SRD is defined as the date when it is estimated or recorded on the RFA that a deferred or staged patient will become ready for admission, i.e. RFS. A suspension review date must be set each time a patient:
        - Is added to the waiting list as a staged admission (NRFS) or defers admission whilst on the waiting list
        - Status changes from RFS to NRFS
        - Status remains NRFS following a clinical assessment
    - A **Managing NRFS Patient Report**, listing details of each patient whose suspension review date will become due in the following month, must be generated at least monthly. Following an assessment, patients will either:
        - Be assigned another review date
        - Be returned to Ready for Surgery within the appropriate clinical priority category
        - Have a planned admission date scheduled
        - Be removed from the waiting list (documentation is mandatory on the system)

3.6. Admission Process

Effective admission and discharge processes are required to ensure optimal use of operating theatre time and hospital beds.

Equity and Priority of Access for Admission - the following **criteria** must be

considered when selecting patients from the waiting list for admission:

- Clinical priority urgency category
- The length of time the patient has waited in comparison with similar category patients
- Previous delays
- Pre-admission assessment issues/factors e.g., those having to travel long distances
- Resource availability e.g. theatre time, staffing, equipment and hospital capacity

Relevant **consultation with** staff from:

- Surgical Referral clinic/OPD
- Operating theatre
- Medical Record Unit(MRU)
- Pre-anesthesia clinic
- Liaison office
- Other Departments if relevant e.g., Medicine, Radiology
- Social services for an effective communication to handover patient care post discharge.

Tentative Admission Date:

A **Tentative Admission Date** is the proposed date that a patient on the waiting list will be admitted for care. This date is to be entered on the electronic waiting list.

Once a Tentative admission date is confirmed the patient should be contacted by phone to determine acceptance of admission from the liaison office.

Patients should be supplied with relevant information for their hospitalization, including the proposed length of stay, discharge procedures and post operative care and follow up.

The below table indicates the recommended timeframes for allocation of a tentative admission date:

Clinical Priority Category	**Recommended allocation of TAD**
No patient in Category 1 should wait longer than **30 days**	TAD on listing or within 5 days
No patient in Category 2 should wait longer than **90 days**	TAD within 45 days

No patient in Category 3 should wait longer than **365 days**	TAD within 270 days

Table 1: Recommended time frame for allocation of TAD

Short Notice Patients:

- Patients may agree to be available at "short notice" to have their surgery performed.
- This is to be indicated in the electronic waiting list. For example, if there is a cancellation, the hospital liaison office should maintain a list of patients who are available to have their procedure/treatment performed at short notice.
- Patients should be asked to indicate a preparedness to accept short notice of admission.
- The hospital should determine what period of time prior to admission is regarded as short notice and for which procedures short notice is appropriate.
- Patients who decline an admission date that is offered at short notice are not recoreded as having declined an offer of admission.
- If a patient has been called in a short notice and their procedure doesn't go a head a denfineat planed date of admission should be made to ensure the patient is not further inconvenienced.

Pre-admission Assessment:

Patients must be clinically assessed before admission to the hospital to confirm suitability to undergo the intended procedure/treatment, associated anesthetic and necessary discharge plans.

3.7. Hospital Initiated Postponement (HIP)

Hospital initiated postponements must be minimized. Decisions to postpone a patient's surgery must involve relevant medical and peri-operative staff, the Liaison office staffs and senior hospital management.

Patients who are postponed by the hospital, physician or for clinical reasons, remain "Ready for Surgery" "delayed" and the following actions taken:

- Inform the patient of the postponement with the maximum amount of notice
- Category 1 patients and patients postponed on the day of procedure/treatment must be notified by a member of the surgical team.
- Appropriate peri-operative management staff can notify all other patients, although it is preferable for the treating physician or delegate to speak with the patient
- Postponed patients must have priority over others not previously postponed

- Postponed patients are to be placed on the next available procedure/treatment list, appropriate to the patient's clinical priority
- If a patient has been postponed twice and cannot be treated within the appropriate clinical priority timeframes, the hospital must actively investigate options for the procedure/treatment to be undertaken at another public hospital.
- Offer the following support options to the patient, where relevant:
    - Contact a family member or friend
    - Counselling services
    - Access to a complaints service
    - Organize the rescheduled date for procedure/treatment and notify the patient of the new admission date on the day of postponement or within 5 working days.
    - Provide information about what they should do if their condition deteriorates
    - The opportunity to discuss with a doctor, medical issues that might arise as a result of the postponement
    - The contact details of the liaison Office, should they require further information

3.7.1. Reporting of Hospital Initiated Postponements (HIPs)

To ensure consistency of reporting of HIPs the following method is to be used: -

- Elective theatre dates are booked for 5 working days in advance
- Patients are phoned to confirm their availability, and a 'Tentative admission date is entered into system.
- HIPs are reported on all patients that have been notified of a surgery date
- The Waiting List Entry in System is checked for each patient to confirm patient notification has occurred
- Recorded on the electronic waiting list and RFA

3.8. Patient Initiated Postponement:

When a patient postpones an agreed date for procedure/treatment for personal or social reasons, a patient- initiated postponement should be:

- Recorded on the electronic waiting list and RFA
- Reviewed to determine if:

- A new date is to be scheduled
- The patient is to be categorized as "Not Ready for Surgery" "deferred", or Removed from the waiting list based on the criteria (see table 2)
- Patients are only permitted to **postpone maximum of two (2) times for personal or social reasons**, unless there are justifying circumstances.

3.9. Patient who fail to attend for the treatment

Patient must be removed from the ESWL following the patient's second failure to attend without good cause and without prior notice to the hospital. This includes the failure to attend pre-admission outpatient clinic appointments. The hospital should exercise discretion on a case-by-case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other un avoidable circumstances. The hospital must have robust procedures to administratively and clinically manage patients who fail to attend.

3.10. Patients who are not contactable

Once registered on the ESWL, the patient is to be informed of their responsibility to notify the hospital of any changes to their contact details and the outcome for failing to do so. Patients who are not contactable by the hospital must be removed from the ESWL, provided the hospital has made reasonable attempts to contact the patient. This includes attempts to identify the patient's correct contact details via:

- The patient's treating Specialist
- The patient's GP
- The hospital's medical records
- By calling for patient or attendant for three consecutive time
- Other sources of information may include a telephone directory search, contact through health extension professionals/workers, and in some circumstances, contact with next of kin (e.g. minors).

If a patient arrives for treatment/procedure and decides to cancel after admission, the following steps should be taken:

- The surgeon should be advised
- The reason for cancellation should be recorded and an appropriate clinician should discuss the requirement for surgery with the patient'

- The patient should be discharged
- If the surgery is still clinically required and the patient agrees, the patient should be re-booked on day of discharge with original listing date
- If the patient still decides not to under go the surgery he/she will be removed from the waiting list

4. DEMAND MANAGEMENT

- A quarterly review of the waiting lists will be undertaken in order to identify clinical specialties experiencing a high demand of patients exceeding their clinical priority time frames and a report generated.
- The respective department will be sent a copy of this report, for their response in writing within 14 days outlining an action plan to manage their long wait patients.
- All reports and responses will be forwarded to the Medical Director and OR director for information and discussion with the Heads of departments.

Initial strategies to manage the demand should include:

- Clinical Review
- Transfer of Patients to Doctors with a shorter waiting time
- Transfer of Patients to another facility
- Increase theatre utilization as approved by OR Director
- Exercising Demanded based OR table reallocation
- Use of short notice lists
- Utilize catchment facilities

4.1. Demand Management Escalation

If it is established that the treating physicians is unable or unlikely to be able to provide treatment in the recommended timeframe and where initial management strategies have been implemented and not reduced the demand, patients will be referred to another clinician and service in order for their treatment to be completed.

4.2. Transferring Patients to another Facility for surgery

- A patient may be listed at one hospital and subsequently requires transfer to a different hospital for a procedure.
- The majority of patients requiring transfer to another hospital will be for a clinical reason and to ensure the surgery occurs in the safest and most appropriate setting. In this case the requesting hospital provides the request as soon as possible with a clinical rationale.
- Liaison office contact the liaison officer Bookings at the receiving hospital to advise of transfer.
- Liaison send Request for Admission form to receiving facility and notify patient and surgeon of transfer.
- If a patient is already listed for a surgical procedure, which is clinically appropriate at a hospital, equipment unavailability cannot be deemed as the reason for transfer. In this instance the hospital should make every attempt to loan the equipment for the procedure to be undertaken. Discussion should occur between Theatre Managers at both facilities. If a compromise is unable to be reached on the most appropriate facility to undertake the procedure the issue will be referred to the hospital medical directors.

The following steps must be followed when a transfer occurs across facilities: -

- The booking at the hospital where the patient will be treated is entered onto the waiting list with the same listing date and history as the booking at the original hospital, and with the current clinical priority category when the RFA is received from the initiating hospital
- The booking at the original hospital should be removed only when confirmation of the patient's booking is received at the receiving hospital and documented using the following reason codes:
- Removal reason code for interhospital transfer – *Transferred to another hospital's waiting list*

4.3. Removing Patients from the Waiting List

In addition to removal from the waiting list once the planned procedure is performed, patients may need to be removed from the waiting list for other reasons

Hospitals should exercise discretion on a case- by- case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances.

<table>
<tr><th>Reason</th><th>Category 1, 2 & 3 Actions</th></tr>
<tr><td>Patient declines treatment or
requests removal for other reasons.</td><td rowspan="3">• Contact the patient's treating doctor informing them of the removal of the patient from the waiting list unless the treating doctor advises otherwise within 5 working days
• Obtain authority for Category 1 (30 day) patients prior to removal from the waiting list
Once decision is made to remove a patient from waiting list:
• Remove the patient from the waiting list
• Advise the treating physician that the patient has been removed
• Advise the patient of the removal on the waiting list
• Document all actions in the electronic record</td></tr>
<tr><td>Patient deffered treatment on 2 occasions or in deferring exceeds the total cumulative maximum number of NRFS days:
Cat 1 > 15 days
Cat 2 > 45 days
Cat 3 > 120 days</td></tr>
<tr><td>Patient fails to arrive for treatment on 2 occasion without giving prior notice and with no justifying circumstances.</td></tr>
<tr><td>Patient not contactable
on 3 occasions (By phone) for category 1 every 2 days for category 2 every 5 days for category 3 every 10 days</td><td>Attempt to obtain the patient's correct contact details via all the outlined methods below:
• Referring doctor, medical records, next of kin & telephone directory search
• Remove the patient from the waiting list
• Advise referring doctor and treating physician that patient has been removed
• Document actions on the RFA and the electronic record</td></tr>
<tr><td>Patient deceased</td><td>• Obtain verification (usually verbally from the patient's relative, general practitioner or treating physicians)
• Remove patient from the waiting list
• Document all actions on the RFA and the electronic record</td></tr>
</table>

Table 2: Reasons for removing a patient from waiting list and their action

Note: If a patient was initially removed from the waiting list due to reasons other than admission and in the following month the waiting list record needed to be re-activated for the same procedure, then the patient should be re-booked with the original listing date and history (clinical priority category and delays etc.).

5. RECORD KEEPING

Hospitals must keep accurate records of waiting list information.

5.1. Postponement of Planned Admission

- Records are to be maintained in the patient's electronic record for patients postponing their elective surgery, and the reason for postponement is to be documented.
- A patient's postponement history should be readily available to staff making decisions about postponing future patients.

5.2. Removal of Patients from the Waiting List (other than admission)

- All patients who have been removed from the waiting list (other than admission) require documentation in the patient's electronic record detailing the reason for removal and the date of removal.
- Treating physician will be informed.

Removal Reason	**Information to be Recorded/Filed (RFA & Electronic)**
Patient Deceased	• Record the name of the person who has notified the hospital that the patient is deceased
Non contactable	• Evidence of contact: ◦ documentation of attempts to contact through referring physician, medical records, next of kin & telephone directory search
Decline treatment or clinical review/not required	• Documentation that the patient is advised to contact the admitting surgeon • Obtain authority for **Category 1 (30 day)** patients prior to removal from waiting list

Fail to Arrive for Treatment	• Documentation that:
	  ◦ patient has failed to arrive for treatment on the planned admission date on 2 occasions without prior notice and without good reason
	  ◦ the patient is advised to be clinically reassessed by the treating physician

Table 3: Removal of patients from waiting list

6. AUDITING THE WAITING LIST

6.1. Clerical Audit

- The Central liaison Office is responsible for conducting and monitoring the clerical audit program across the hospitals, maintaining clerical audit standards and addressing issues arising from the audits.
- All patients on the waiting list should be contacted if they have been waiting for six months or longer from listing date, to ascertain if they still require admission. Two contacts should be attempted, both by phone
- On completion of clerical audits, a summary report must be sent to the medical director, OR director, and respective departments.
- Documentation of the patient audit must be made in the patient's electronic record, including responses received and the action taken.

6.2. Request for Admission (RFA) Audit

The liaison office is responsible for a review of the waiting list and must be undertaken quarterly to ensure that accurate information is provided to clinicians and administrators on request.

The liaison officer will assess the RFA for accuracy by cross checking patients listed on system under each surgeon, against RFAs held in patients' chart, utilizing the following minimum data set.

1. Patient details:

- Full name
- Age or Date of birth
- Medical record number (MRN)
- Sex
- Address
- Phone number

2. Clinical details:

- Diagnosis
- Proposed procedure
- Clinical priority category

The liaison officer will document all necessary amendments or updates in the patient record, to provide a clear audit trail.

7. DOCTOR'S LEAVE – TEMPORARY OR PERMANENT

- Includes Annual, Study, Conference and Unplanned sick or bereavement leave
- To ensure appropriate theatre scheduling, it is recommended that surgeons provide as much notice of intended leave or resignation as possible (**minimum of 6 weeks**). Leave includes annual, study and conference.
- The hospital will ensure appropriate communication of scheduled reduced activity periods, announced public holidays and recognized holiday periods.
- The hospital will develop and implement plans, in consultation with appropriate clinicians and services, regarding these periods.
- A patient's clinical priority category and listing date does not change as a result of doctor's leave.
- Patients whose clinical priority cannot be met during a period of leave may not be booked on that surgeon's waiting list. A management plan for affected patients should be developed and implemented for all leave

Affected patients are those who during the leave period:

- Already had a planned admission date
- Will exceed their clinical priority timeframe during the leave period.

A patient's management plan should ensure affected patients:

- Are assured that their queue order will not be affected
- Know who the replacement doctor will be
- Are advised if clinical review is required
- Are provided with information regarding their expected waiting time
- A management plan for affected patients should be developed and implemented for all leave in consultation with the referring surgeon, Head of the Liaison office, Head of Departments and OR Director.

7.1. Resignation, Retirement or Sudden Death

Following notification of planned and unplanned resignation or retirement, sudden death or failure to be reappointed, or notification of intention not to renew a contract no further patients will be added to the doctor's waiting list. A management plan for affected patients already listed requires:

- Consultation with Head of Departments, OR Director, Medical director and Head of the liaison office.
- Location of a replacement treating doctor in consultation with Head of Departments, OR Director, Medical director and Head of the liaison office.
- Clinical review (within 3 months) is required for patients remaining on departing doctor's waiting list
- All patients will be clinically and/or administratively reviewed and a plan developed by the Head of departments

8. DEFINITIONS

Definition	Explanation
Urgent category 1 patient	is a category 1 patient but needs treatment within a 7days of time frame which pronounced as an urgent category 1 by a surgeon
Emergency surgery	is defined as surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency surgery also includes unplanned surgery for admitted patients (re-operation) and unplanned surgery for patients already waiting for an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).
Elective Surgery	is defined as planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list(clinical urgency category).
A waiting list	is a list of people who are eligible for surgical procedure and waiting to get the treatment at a scheduled time based on their procedural category.
Backlog	is the accumulation of not performed surgical procedures that would have been conducted within the scheduled time frame with respect to the surgical procedure category.
Acceptance date	Is the day that the liaison office accepts the request for admission as legitimate. Acceptance of the RFA will be deemed when the following are complete: • The minimum RFA data set is completed • The RFA form is signed and dated

Addition to the waiting list	Is adding the patient to the electronic waiting list immediately upon acceptance of a complete, accurate, and legible RFA form. As soon as a decision is made that a patient is in need of admission to the hospital and the admission is not required within 24 hours, the surgeon should complete a RFA form and forward it to the preanesthesia clinic immediately. The preanesthetic clinic should complete preanesthetic evaluation checklist and link to the liaison office within 5 working days. The date the RFA is accepted becomes the patient's listing date. This date is used in the calculation of the waiting time.
Admission	Admission is defined as the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment. There are two types of Admission: Emergency Admission is defined as an admission for the purpose of treating trauma or acute illness subsequent to an emergency presentation. Elective admission is defined as an admission that is planned and able to be scheduled in advance for the treatment of patients with problems that call for elective surgery.
Admission Date	Date on which an admitted patient commences an episode of care
Admitted patient	A patient who undergoes a hospital's admission process to receive treatment and/or care
Payment type	is the anticipated financial decision the patient will make when admitted for the planned procedure/treatment. Classifications are: • CBHI • Private Wing • Credit • Out of Pocket (public)

Clerical Audit	A clerical audit is a regular and routine clerical check that the information the hospital has of patients waiting for admission is correct. It will facilitate the identification of patients who no longer require admission or who have duplicate bookings
Clinical Priority Urgency Categories	A clinical priority urgency category is allocated to a patient based on the surgeon's assessment and the respective hospital category list of the priority with which a patient requires elective admission. Clinical priority categories are: Category 1 • Procedures that are clinically indicated within 30 days Category 2 • Procedures that are clinically indicated within 90 days Category 3 • Procedures that are clinically indicated within 365 days
Clinical Review	Review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition.
Day of surgery admission (DOSA)	Day of surgery admission - patients are admitted into hospital on the day of their procedure and remain in hospital for at least one post-operative night.
Day care Surgery (DO)	Day Only Surgery involves the patient being admitted and discharged on the day of surgery. Also referred to as Day Surgery.
Declined Patient	A patient who declines a planned admission date for treatment.
Demand Management	Is a set of Processes and Strategies initiated to manage the number of patients exceeding their clinical priority urgency timeframes waiting on the Waiting list for elective surgery.
Estimated date of discharge	is the anticipated day a patient will be discharged from a hospital after the patient is admitted and recovers from the procedure.
Electronic waiting list	Patient administration/ management system used by the hospital to manage the waiting list e.g. SWOSS
Listing Date	Listing Date is the date of Acceptance of the RFA Form. Calculation of waiting time starts from this date.
Listing Status	Indicates the status of the person on the waiting list that is the extent to which a patient is ready and available for admission. This may

	change while the patient is on the waiting list e.g., after a clinical review. The patient may be: • Ready for Surgery (Category 1, 2 or 3) • Not Ready for Surgery (Staged or Deferred)
Ready for Surgery (RFS)	A Ready for Surgery is defined as patients who are prepared to be admitted to hospital or to begin the process leading directly to admission for surgery. The process leading to surgery could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.
Ready for Surgery - "Delayed"	A patient is regarded as Ready for Surgery but delayed where the hospital decides to postpone admission and reschedule a person's planned admission date because of: • Non-availability of operating theatre (staff, equipment, resources etc.) • Non-availability of bed • pressure of emergency admissions • Non-availability of doctor It is mandatory to indicate the reason for the patient's admission being delayed.
Not Ready for Surgery (NRFS)	A Not Ready for Surgery patient can be defined as a patient who is not available to be admitted to hospital until a future date and is either: • Staged – (Planned or Clinically unfit) • Deferred (not ready for personal reasons) A postponement of admission by the hospital does not render the patient Not Ready for Surgery. These patients should remain on the waiting list as they are still genuinely waiting, but are delayed.
Not Ready for Surgery - "deferred" for personal reasons	A deferred patient is a patient who for personal reasons are not yet prepared to be admitted to hospital. Examples include patients with work or other commitments that preclude their being admitted to hospital for a time. It is mandatory to indicate a reason for deferring.

	The reason a patient is deferred may be reported as follows: • A patient is going on holidays and will be unavailable for admission • A patient is unable to obtain home support • A patient is unable to accept a date due to work commitments • A patient is unable to accept a date for other significant reasons e.g., personal career Patients may not be added to the waiting list as Not Ready for Surgery deferred.
Not Ready for Surgery - "staged" patients	• Patients who have undergone a procedure or treatment and are waiting for follow-up elective surgery, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission for surgery, because the patient's clinical condition means that the surgery is not indicated until some future, planned period of time. • It is mandatory to indicate a reason for staging
Not Ready for Surgery "Pending Improvement of clinical condition" patients	• Patients for whom surgery is indicated, but not until their clinical condition is improved, for example, as a result of a clinical intervention. Examples include patients who require a cardiac work-up before a total hip replacement and patients with respiratory insufficiency that requires physiotherapy to maximize respiratory function before a hernia repair. For such patients, a decision has already been made that surgery should take place. Patients should not be regarded as 'not ready for surgery – pending improvement of their clinical condition' when they are undergoing monitoring or investigations before a decision is made as to whether surgery is required
Tentative admission date	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
Planned length of stay	The number of nights the patient is expected to stay in hospital as an inpatient. This information will be used for discharge planning and bed management.
Planned procedure	The planned procedure is the procedure or treatment the patient is to undergo when admitted.
Postponement	Rescheduling of a patient's elective admission due to hospital related reasons or personal reasons.
Pre-admission anesthesia evaluation	is the process of determining a patient's readiness for the desired procedure or treatment, accompanying anesthesia, and discharge arrangements before the patient is admitted to the hospital.

Presenting Problem	The problem or concern that is the reason for seeking health care or assistance.
Request for Admission form (RFA)	Requests for admission to hospital need to be on an approved form and contain a minimum data set as specified in this framework
Specialty	Treating physicians's area of clinical expertise. Where a treating physicians undertakes surgical procedures that can be classified into different specialties then the treating physicians will have a different list for each specialty (e.g. Obstetrics/Gynecology). The broad categories required for reporting are: • Cardiothoracic • ENT • General Surgery • Gynecology • Neurosurgery • Ophthalmology • Orthopedic • Plastic • Urology • Vascular
Short Notice/ Standby Patient	Are patients who agree to be available on a "short notice" to have their surgery performed if there is a cancelled procedure.
Status Review Date (SRD)	This is the date determined for an assessment (clinical or administrative) of a deferred or staged person (i.e., Not Ready for Surgery) to determine if the patient has become ready for admission to the hospital at the first available opportunity (i.e., Ready for Surgery).
Treating physician	The medical officer/senior clinician (a visiting practitioner, staff treating physicians or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted.
Waiting Time	Time a patient spends as Ready for Surgery.
Patients who missed their appointments	Patients who are under their clinical category time frame but missed their appointment date stated for their respective time.

9. APPENDICES

Appendix 01: Admission Request Form

MRN_____ Full name of the patient _____ Sex____Age___
Address : Region_____ Zone/Subcity_____Woreda_____
Contact Phone1 _____ Contact Phone2 _____
Department _____
Patient Diagnosis _____ Procedure Category _____
If Reasons Category_____
Planed Procedure/ treatment_____
Suspension Review date: DD/MM/YY ____/_____/_____
Operating surgeon _____ Estimated operathing time _____
Date of admission request: DD/MM/YY__/___/_____
Name of Admitting Physician_____ Signature of physician _____
Liaison Officer name _____
Date of registered on ESWL: DD/MM/YY ____/_____/_____
Estimated date of admission: DD/MM/YY _____/_____/_____
Admission Ward_____ Estimated length of stay DD/MM/YY _____/_____/_____
Liaisons Officer Signature _____
Additional information, if nesscerry :- • Significant medical history • Specific preadmission requirements • Special operating theatre equipment • Requirement for an Intensive Care Unit/High Dependency Unit bed post procedure
Reason for postponement

***Appendix 02: Pation Information sheet* (የተገልጋይ መረጃ መስጫ ቅጽ)**

የታካሚ ስም፡ _____

የታካሚው ካርድ ቁጥር፡ _____

የተመዘገቡበት ቀን፡ _____

አልጋ የሚይዝበት ግምታዊ ቀን፡ _____

ቀጠሮ የሚሰጥበት ቦታ፡_____

ማሳሰቢያ

1. **ከላይ ከተሰጠዎት ቀጠሮ በፊት ከህመሙ ጋር ተያያዥነት ያለው ማንኛውም አይነት ድንገተኛ የጤና ችግር / እክል ከገጠመዎት የህክምና ካርደዎትን በመያዝ በድንገተኛ ህክምና ክፍል በመገኘት መታከም የሚችሉ መሆኑን እንገልፃለን፡፡**
2. **የህክምና ወረፋዎት ደርሶ በሰጡት ስልክ ቁጥር ሲደወል ካላነሱ ወይም እመጣለሁ ብለው ካልመጡ ከወረፋው ላይ የሚሰረዙ መሆኑን እንገልፃለን፡፡**
3. **ያልጋ ወረፋ ደርሶዎት ሲመጡ የጤና መድህን አባል ከሆኑ የታደሰ የጤና መድህን በመያዝ፤ ከሌለዎት ህክምናዎትን የሚሸፍን ወጪ/ገንዘብ/፤ ማንነቶትን የሚገልፅ መታወቂያ፤ካጠገቦት ሆኖ የሚያስታምም እና ለማስታመም እድሜው የደረሰ/ች ሰውና ተቀያሪ አልባሳት ይዘው መምጣት ይኖርበዎታል፡፡**
4. **ወረፋ ደርሶዎት ወደ ሆስፒታሉ ሲመጡ የታዘዘልዎ ምርመራ ካለ ውጤት ይዘው መምጣት እንዳይረሱ፡፡**

ከዚህ በላይ ያሉትን ለመረዳቴ በፊርማዬ አረጋግጣለሁ ስም፡ _____ ፊርማ _____

Appendix 03: Physician notification form for category lists not inline with facility/National category list

Patient MRN Patient Name	Liaison Officer name: _____
Request Date: DD/MM/YY__/___/_____	Response Date: DD/MM/YY__/___/_____
Diagnosis: _____	Liaison phone number: _____
Assigned Procedure Category: _____	New procedure Category: _____
Name of Admitting Physician: _____	Reason for new procedure category:
Admitting Physician Signature: _____	Liaisons Officer Signature: _____
Remark:	

Appendix 04: Patient Notification support tool for liaison officers

S.No	Patient notification checklist		
1	Informed of being added to the waiting list for elective surgery and that they would be advised of the procedure's date once an admission date has been set	Yes ☐	No ☐
2	Probability of receiving treatment from the admitting surgeon or another specialist	Yes ☐	No ☐
3	Possibility of being sent to another hospital	Yes ☐	No ☐
4	Probability of postponing a booked surgery to make way for urgent or life-threatening cases, but the hospital will make every effort to avoid such postponements and to reschedule delayed patients as soon as practicable.	Yes ☐	No ☐
5	Advised to visit the hospital for evaluation if his or her clinical condition changes.	Yes ☐	No ☐
6	Informed to notify of any changes to his/her contact details, decided not to proceed with the procedure for any reason or going to be unavailable for any extended period.	Yes ☐	No ☐
7	Informed that he or she might be removed from the waiting list in consultation with his or her specialist if: • The hospital is unable to contact him/her in three different days • He or she fails to appear for the procedure without providing the hospital with prior notice. • He or she postponed surgery on two occasions for personal or social reasons.	Yes ☐	No ☐

Appendix 05: PERSONAL DETAILS

Section 1: Change of Patient Details:

Date:_____

Name_____ MRN_____

Region _____ Zone/subcity _____ Wereda/Kebele _____ "Ketena"/"Got" _____

Telephone (H) _____Telephone (W) _____Telephone (M) _____

Data filled by:- Name:_____ Signature:_____

Appendix 06: Patient Waiting List audit tool

Please place the number of patient response code under the patient response column below

Audit date:_____

S. N	Patient Name	MRN	Category	Patient Response Code	Contact #
Audited by:- Name:_____ Signatre:_____					

NB: Patients who have been waiting for 6 month and above must be included in the ESWL audit.

Patient Response Options code:
Code 1. I still require my surgery and I am ready for surgery at this time
Code 2. I still require my surgery but not at this time (not available in this time frame): **2a.** Financial reasons **2b.** Social reasons **2c.** Other
Code 3. I don't require my surgery because I have already been operated
Code 4. I don't require my surgery because I don't want to be operated
Code 5. I don't require my surgery because I have a new comorbidity
Code 6. Patient is deceased/passed away
Code 7. Patient could not be reached via telephone

Appendix 07: NATIONAL ELECTIVE SURGERY URGENCY CATEGORY GUIDELINE

CARDIO THORACIC SURGERY

Selected Common Procedures	Usual Urgency Category
Congenital cardiac defect/s	2
Coronary artery bypass grafting	2
Heart valve replacement	2
Lobectomy / wedge resection / pneumonectomy	1
Pleurodesis	2

OTOLARYNGOLOGY HEAD AND NECK SURGERY

Selected Common Procedures	Usual Urgency Category
Adenoidectomy	3
Ethmoidectomy	3
Functional endoscopic sinus surgery	3
Laryngectomy	1
Mastoidectomy	3
Microlaryngoscopy	2
Myringoplasty/tympanoplasty	3
Myringotomy	3
Nasal cautery	3
Nasal polypectomy	3
Nasendoscopy	2
Panendoscopy	1
Parotidectomy/submandibular gland – excision of	2

Selected Common Procedures	Usual Urgency Category
Pharyngoplasty	3
Pharynx – excision of	2
Pressure equalising tubes (grommets) - insertion of	3
Radical neck dissection	1
Rhinoplasty (indication as noted in Excluded Procedures)	3
Septoplasty	3
Stapedectomy	3
Sub-mucosal resection	3
Tonsillectomy (+/- adenoidectomy)	3
Turbinectomy	3

GENERAL SURGERY

GENERAL SURGERY	**Usual Urgency Category**
Anal fissure – surgery for	2
Axillary node dissection	1
Breast lump – excision and/or biopsy	1
Cholecystectomy (open/laparoscopic)	3
Cholecystectomy (open/laparoscopic) with biliary pancreatitis	1
Cholecystectomy (open/laparoscopic) with potential common bile duct stone or severe frequent attacks (two within 90 days)	2
Colectomy/anterior resection/large bowel resection	1
Fistula in Ano	3
Fundoplication for reflux disease	3
Haemorroidectomy	3
Herniorrhaphy – femoral/inguinal/incisional/umbilical	3
Lipoma – excision of	3
Malignant skin lesion – excision of +/- grafting	1
Mastectomy	1
Obstructing hiatus hernia (para-oesophageal hernia)	2
Parotidectomy /submandibular gland – excision of	2
Parathyroidectomy	2
Pilonidal sinus surgery	3
Resection & Anastomosis for GI malignancy	1

GENERAL SURGERY	Usual Urgency Category
Resection & Anastomosis for lBD	1
Resection & Anastomosis for redundant Sigmoid	2
Skin lesions (not malignant) – excision of	3
Thyroidectomy/hemi-thyroidectomy	2
Truncal Vagotomy with bypass Surgery	2
Whipples	1

GYNAECOLOGY SURGERY

GYNAECOLOGY SURGERY	**Usual Urgency Category**
Bartholin's abscess drainage	1
Bartholin's cyst – removal of	3
Curettage and evacuation of uterus	1
Colposcopy	2
Cone biopsy	1
Endometrial ablation	3
Female sterilisation	3
Hysterectomy (abdominal / vaginal / laparoscopic)	3
Hysteroscopy, dilatation and curettage	2
Laparoscopy for dye studies / endometriosis	3
Large loop excision of the transformation zone cervix (LLETZ)	2
Mirena insertion	3
Myomectomy	3
Salpingo-oophorectomy / oophorectomy / ovarian cystectomy	2
Stress incontinence surgery	3
Vaginal repair - anterior / posterior	3
Warts - diathermy of	3

NEUROSURGERY

NEUROSURGERY SURGERY	Usual Urgency Category
Carpal tunnel release	3
Cerebral haematoma – evacuation of	1
Cervical discectomy and fusion unless neurological deficit	3
Chiari malformation decompression	3
Common peroneal nerve release	2
Craniotomy for removal of tumour (neurological deficit)	1
Craniotomy for removal of benign tumour(no neurological deficit)	3
Craniotomy for ruptured aneurysm	1
Craniotomy for un-ruptured aneurysm	2
Cranioplasty	3
Discectomy with foot drop	1
Intracranial lesion (for example abscess/arteriovenous malformation) – removal of	1
Laminectomy	3
Muscle biopsy/temporal artery biopsy	1
Nerve decompression of spinal cord	2
Pedicle screw fusion	3
Posterior fossa decompression for haemorrhage, tumour or syrinx	1
Untethering of spinal cord	2
Ventricular peritoneal shunt for obstructive hydrocephaly	1
Ventricular peritoneal shunt for normal pressure hydrocephaly	2

OPHTHALMOLOGY SURGERY

OPHTHALMOLOGY SURGERY	**Usual Urgency Category**
Blepharoplasty (indication as noted in Excluded Procedures)	3
Cataract extraction (+/- intra-ocular lens insertion)	3
Cataract extraction (+/- intra-ocular lens insertion) with angle closure glaucoma	1
Cataract extraction (+/- intra-ocular lens Insertion) with severe disability	2
Chalazion - excision of	3
Corneal graft	3
Dacrocystorhinostomy	3
Ectropion – correction of	3
Examination of eye under anaesthesia	2
Probing of naso-lacrimal Duct	3
Pterygium - excision of	3
Ptosis – repair of	3
Squint - repair of	3
Trabeculectomy	2
Trabeculectomy with high intra ocular pressure	1
Vitrectomy (including buckling/cryotherapy)	2
Victrectomy (including buckling/cryotherapy) with retinal detachment or infection)	1

ORTHOPAEDIC SURGERY

ORTHOPAEDIC SURGERY	Usual Urgency Category
Anterior cruciate ligament reconstruction	3
Acromioplasty	3
Arthrodesis	3
Arthroplasty – revision of	2
Arthroscopy	3
Arthroscopy shoulder / sub acromial decompression	3
Bunion (hallux valgus) - removal of	3
Dupuytren's contracture release	3
Exostosis – excision of	3
Fracture non-union - treatment of	2
Ganglion - excision of	3
Hammer/claw/mallet toe – correction of	3
Meniscectomy	3
Muscle or tendon length – change of	3
Nerve decompression	2
Osteotomy	3
Rotator cuff - repair of	3
Shoulder joint replacement	3
Shoulder reconstruction	3
Tendon release	3
Tenotomy of hip	2
Total hip replacement	3
Total knee replacement	3

PAEDIATRIC SURGERY

PAEDIATRIC SURGERY	Usual Urgency Category
Branchial apparatus remnant –removal of	2
Circumcision (indication as noted in Excluded Procedures)	3
Congenital pulmonary lesion – removal of	1
Dermoid cyst - removal of	2
Fundoplication	2
Herniorrhaphy - epigastric/umbilical	3
Hydrocoele – repair of	3
Hypospadias - repair of	2
Inguinal herniotomy/herniorrhaphy for age < 6 months	1
Inguinal herniotomy/herniorrhaphy for age > 6 months	2
Lingual or maxillary frenulum surgery	3
Neonatal surgery (e.g. hirschsprungs, anorectal, malrotation, oesophageal atresia)	1
Nephrectomy for congenital abnormality	2
Orchidopexy	2
Pectus surgery	3
Pyeloplasty	2
Pyogenic granuloma - removal of	1
Skin lesion- excision of	3
Thyroglosssal remnant –removal of	2
Toenail surgery	3
Ureteric - re-implantation	2

PLASTIC & RECONSTRUCTIVE SURGERY

PLASTIC & RECONSTRUCTIVE SURGERY	**Usual Urgency Category**
Breast prosthesis - removal of (indication as noted in Excluded Procedures)	2
Breast reconstruction (indication as noted in Excluded Procedures)	3
Breast reduction (indication as noted in Excluded Procedures)	3
Cleft lip and palate – repair of	3
Dupuytren's contracture release	3
Lipoma – excision of +/-grafting	3
Lymphangioma – surgery for	3
Malignant skin lesion – excision of +/- grafting	1
Rhinoplasty (indication as noted in Excluded Procedures)	3
Skin lesions, non-malignant – excision of	3
Scar revision (for reasons other than cosmetic)	3
Trigger finger / thumb release	2

UROLOGICAL SURGERY

* National guideline category changed by Urology Unit Director

UROLOGICAL SURGERY	Usual Urgency Category
Bladder neck incision	3
Circumcision (indication as noted in Excluded Procedures)	3
Cystectomy	1
Cystoscopy	3
Epididymal cyst - removal of	3
Hydrocele - repair of	3
Hyposadias – repair of	3
Lithotripsy	2
Meatoplasty	3
Nephrectomy	1*
Orchidectomy	1
Orchidopexy	3
Prostatectomy (transurethral or open) for benign disease	3*
Prostate biopsy	1
Pyeloplasty	2
Retrograde pyelogram	2
Stone/s urinary tract – removal of	2*
Uretero-pelvic junction - correction of	2
Ureters re-implantation	3
Ureteric stent - insertion of	1
Urethra – dilatation of	2

VASCULAR SURGERY

VASCULAR SURGERY	**Usual Urgency Category**
Abdominal or thoracic aortic aneurysm by any means	1
Amputation of limb	1
Bifurcated aortic graft	1
Carotid endarterectomy	1
Dialysis access surgery	2
Femoro-popliteal bypass graft	2

Appendix 8: SWOSS installation guide

Software requirement

- Ubuntu server 20.04 LTS

Hardware requirement

- Server (8 GB RAM not less than 100 HDD)

Installation step

1. Clone swoss source code from MOH repo

   git clone https://repo.moh.gov.et/gebreyohannes/swoss.git

```
Last login: Thu Dec  8 06:08:25 2022 from 192.168.117.178
pc@swoss:~$ git clone https://repo.moh.gov.et/gebreyohannes/swoss.git
```

2. Change directory to swoss and run the installation swoss.sh script

   cd swoss

   . /swoss.sh

```
c@swoss:~$ cd swoss
c@swoss:~/swoss$ ./swoss.sh
```

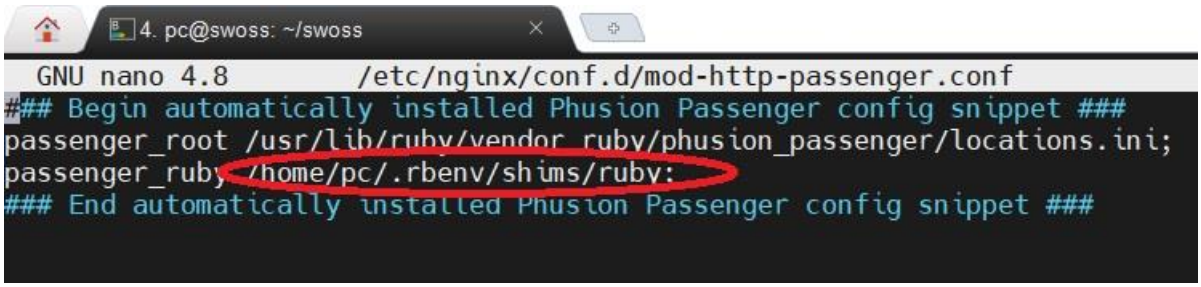
3. Follow the following instructions to setup database and nginx server

sudo nano /etc/nginx/conf.d/mod-http-passenger.conf

```
postgres@swoss:~$ sudo nano /etc/nginx/conf.d/mod-http-passenger.conf
```

--- change the passenger_ruby line to match the following ---

passenger_ruby /home/<current_user>/.rbenv/shims/ruby;



Remove the default nginx config

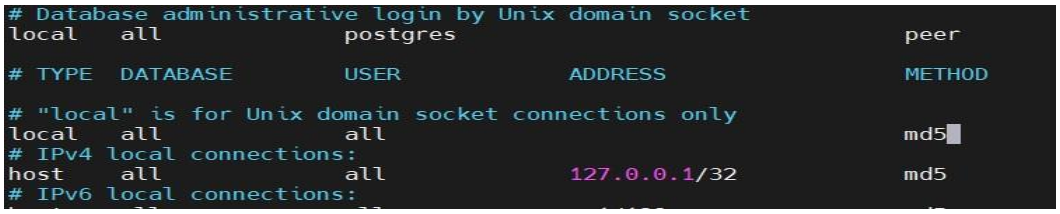
sudo rm /etc/nginx/sites-enabled/default

- **Creating a PostgreSQL Database**
  - ✓ sudo su - postgres
  - ✓ createuser --superuser --createdb --createrole --replication --pwprompt swoss
    --- set password to be: postgres

  - ✓ createdb -O swoss swmoss_prod
  - ✓ exit
  - ✓ Restart postgres (sudo nano postgresql restart)

sudo nano /etc/postgresql/12/main/pg_hba.conf

- --- change localhost peer to md5



- **Restart nginx server (sudo nano service nginx restart)**

- **<u>Set DATABASE_URL</u>**

  - ✓ Note: replace <password> with the password you set above for swoss

export DATABASE_URL= postgresql://swoss:<password>@localhost:5432/swmoss_prod

RAILS_ENV=production bundle exec rake db:create

RAILS_ENV=production bundle exec rake db:migrate

RAILS_ENV=production bundle exec rake db:seed

- **Create virtual server**

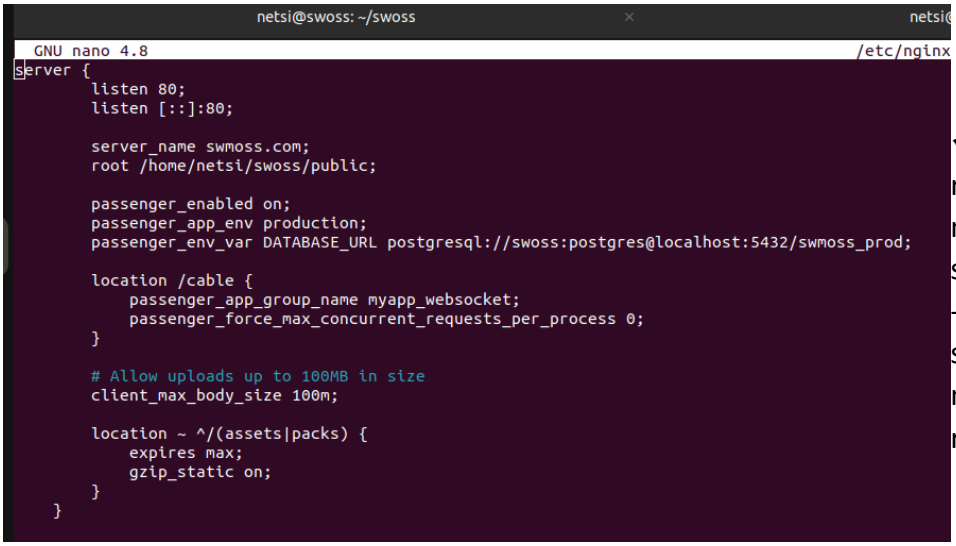
sudo nano /etc/nginx/sites-enabled/swoss

--- copy the following lines and paste

```
server {
    listen 80;
    listen [::]:80;

    server_name swmoss.com;
    root $HOME/swoss/public;

    passenger_enabled on;
    passenger_app_env production;
    passenger_env_var DATABASE_URL $DATABASE_URL;

    location /cable {
        passenger_app_group_name myapp_websocket;
        passenger_force_max_concurrent_requests_per_process 0;
    }

    # Allow uploads up to 100MB in size
    client_max_body_size 100m;
```

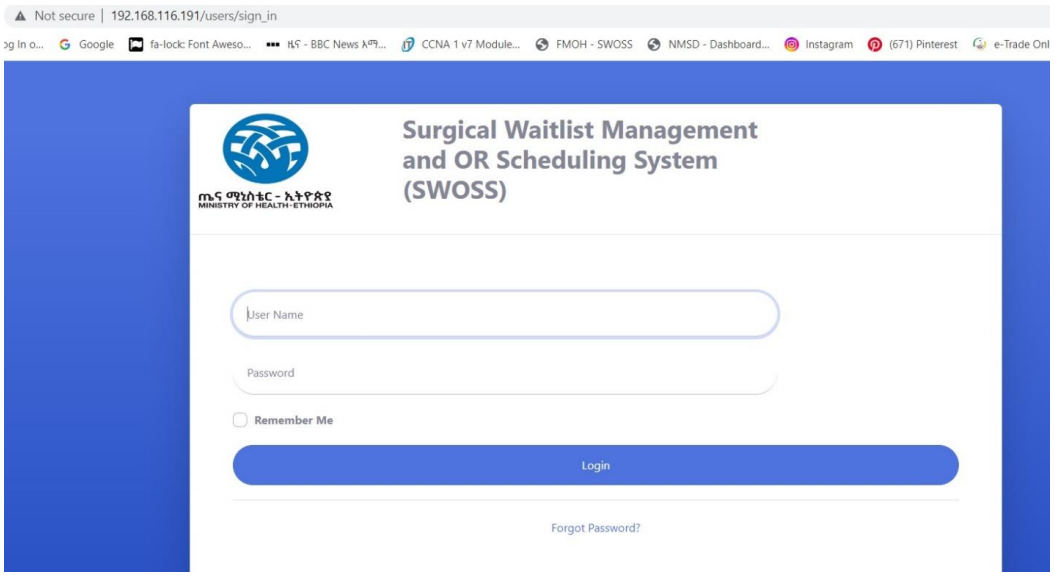
```
    location ~ ^/(assets|packs) {
      expires max;
      gzip_static on;
    }
  }
```

Note: *Make sure $HOME and $DATABASE_URL replaced by your local home directory as shown as below*



✓ Finally restart the nginx server
- sudo service nginx restart

4. **<u>Open browser and write the server <ip address></u>**



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