

JAG

Joint Advisory Group
on GI Endoscopy

Users guide to achieving a JAG compliant endoscopy environment

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Introduction

A patient-centred high-performing endoscopy service requires clarity of standards and an effective process to monitor and enforce those standards. The GRS is a tool for quality improvement as well as for quality assessment. It is now the basis against which endoscopy units are measured for JAG Certification in the UK. Recent UK policy has led to some changes within the GRS, now aligning it closely to the JAG accreditation visit. This guidance is intended to support services in providing an environment which meets GRS and JAG requirements. The guide reflects best practice for all units, stand alone or within day case facilities, purpose built or adapted, existing or proposed new builds. Page 12 summarises the key essential and desirable criteria to achieve a Jag complaint endoscopy service. Endoscopy facilities should be separate from day surgery facilities in larger acute hospitals serving a population or 300,000. In smaller hospitals, endoscopy may be located within a shared day surgery unit.

A successfully performing service will comply with the GRS standards or have achievable action plans in place to meet them, and will have all procedures and pathways reflected in local policies. There are four domains that make up the endoscopy Global Rating Scale.

Figure 1. Endoscopy Global Rating Scale 2011

Clinical quality	Quality of the patient experience
Information/consent Safety Comfort Quality Appropriateness Communicating results	Equality and diversity Timeliness Booking and choice Privacy and dignity Aftercare Ability to provide feedback to the service
Workforce	Training
Skill mix review and recruitment Orientation and training Assessment and appraisal Staff are cared for Staff are listened to	Environment and training opportunity Endoscopy trainers Assessment and appraisal Equipment and education materials

The Patient Environment

1. General principles

- 1.1 Having an endoscopy can be an anxious and stressful time for a patient, and their relatives. The flow of the unit should progress a patient without unnecessary looping back.
- 1.2 A patient flow should have suitable disabled access and facilities for people who have problems with mobility or orientation (visual or hearing impairment). There should be at least one specially designed toilet suitable for disabled access within the department. This number should be increased according to throughput and local need.
- 1.3 The unit should be calm, with noise levels kept to a minimum. When telephones are used within patient areas, the call should not disclose patient identifiable details within hearing of other patients. The unit should be generally clean and organised, with no unnecessary equipment or around. There should be adequate general and clinical lighting, with the use of natural lighting where possible. The décor should be well maintained. Floors should be hardwearing and level, with no carpets in clinical areas. The presence of a TV, radio and reading materials in areas where patients wait to provide distraction is beneficial. There should be clear signposting for the area, which should be well co coordinated and maintained, and promote a warm, friendly atmosphere.
- 1.4 All areas should follow general safety and fire prevention principles, and risk assessments are undertaken for any hazards identified, with action taken to minimise risk and escalate irresolvable problems to the organisation.
- 1.5 Most units will require a combination of natural ventilation and mechanical ventilation or air conditioning, particularly for internal rooms. A maintenance review should be undertaken to ensure adequate temperatures and air changes in all rooms, particularly if they have undergone a change in purpose.
- 1.6 All patients should be asked from the start to the end of their journey if they wish to have their clinical care discussed in private.
- 1.7 Gender separation is required routinely from admission through to recovery, wherever patients are required to undress and change into a gown, or have received sedation and associated drugs. In areas where patients remain in their

own outdoor clothes, or if no sedation is given to any patient, gender separation is not required.

2. Reception and waiting

2.1 Appointments should be provided to allow phased admission of patient to the unit, reducing time in the unit pre procedure. This prevents overfilling of the waiting room and facilities.

2.2 Toilet facilities should be within or immediately nearby the waiting area. Access to these should not involve going into the restricted clinical area. Within the waiting area, separate gender toilets are not required.

2.3 The reception desk should be a low and open facility, so no sense of a barrier is presented. A lower counter area for wheelchair access is ideal. There should be clear signage offering patients the opportunity for private discussion of their details at endoscopy booking or appointment. The waiting area should have immediate access to the reception desk for observation and communication. There should be sufficient seating, and consideration should be given to seating for morbidly obese patients. Guidance is available to determine waiting room size and numbers of chairs (HBN 52 Accommodation for day care - Vol 2 - Endoscopy units Appendix 5).

2.4 Out with the clinical area, there should be no health records or patient identifiable details visible.

2.5 The presence of relatives in clinical areas is discouraged where it affects the privacy of other patients. They should not access the clinical area, unless under exceptional circumstances, and should be asked to remain in the waiting area or to return at a specified time. The needs of waiting patients take priority over carers if space is limited.

2.6 Where possible, a secondary entrance for in patients to arrive, and admitted patients should be used. This entrance should be linked to the hospital corridor, with access controlled to provide security for patients, staff and property. Access to the clinical area (post reception) should be via doors accessed only by clinical staff.

3. Patient assessment and preparation areas

3.1 There should be at least one separate room to undertake patient assessments, allow confidential discussions, and undertake cannulation and completion of consent.

3.2 If the unit provides administration of enemas, an en suite toilet and washing facility is required to one of the patient preparation rooms. A suitable alternative would be if this could be provided in a nearby clinical area. It is not acceptable for the two rooms to be separate.

3.3 Once a patient is required to undress and put on a gown, gender separation must take place. Separate changing facilities, with their own dedicated washing and toilets should be available. It is not acceptable for one set of toilet facilities to be used if it allows the genders to mix.

3.4 Any area where the patient is waiting before their procedure should promote relaxation, and is comfortable. A call system should be available. The following options are suitable:-

- ✓ Patients prepared and waiting in their own preparation room, then moving directly to the procedure
- ✓ Patients prepared and waiting in a cubicle, then moving immediately to the procedure
- ✓ Patients assessed and then prepared and moved to a gender specific sub waiting area with its own toilet facilities.

3.5 All patients who are wearing a gown should be offered dignity shorts, and wearing of footwear and a dressing gown should be promoted.

3.6 The service should identify a method of handing patients property throughout their endoscopy. This may be in the form of safe storage or moving it with the patient.

4. For patients prepared in the same area they are recovered post procedure.

4.1 It is best practice that patients who have not been treated do not meet patients who have been treated. Units should plan to work towards achieving this goal. Even if this process is used, gender separation is still required for all patients in England only. Other nations in the UK are encouraged to segregate patients as appropriate to the needs of patients.

- 4.2 The patient space for assessment, and later recovery should be curtained or screened, to provide general patient privacy, and to provide sufficient privacy to allow conversations beyond the hearing of other patients
- 4.3 When this model of patient flow is used, there should be sensitivity and discretion applied when giving post procedure patients drinks and snacks. Food aromas should not pervade the area e.g. toast.

5. The endoscopy room

5.1 Each procedure room should have the following as a minimum provision:-

- ✓ Easy access and room for the patient trolley with accessibility to all sides.
- ✓ Floor space for the endoscopist, two endoscopy assistants and a trainee
- ✓ Minimum of endoscopy equipment and cables on the floor or trailing, and a risk assessment undertaken to provide an achievable action plan.
- ✓ Space for a resuscitation trolley and emergency team to access the patient
- ✓ Desk space for the Endoscopy Reporting System and equipment, and record keeping
- ✓ Clinical preparation space for procedural equipment
- ✓ Controlled drug cupboard.
- ✓ Clinical grade storage space for endoscopy supplies required during the session
- ✓ Foot operated bins or sack stands
- ✓ Hand washing sink
- ✓ Emergency call system
- ✓ Oxygen and suction facilities
- ✓ Patient monitoring for pulse, blood pressure and SaO₂

5.2 There should be a complete range of modern endoscopy equipment available for use, with the ability to take still photography. An Endoscopy Reporting system is an essential feature in a modern endoscopy unit for:-

- ✓ Appointment management
- ✓ Session management and allocation
- ✓ Providing managerial, performance and clinical audits

5.3 An easily visible register of trainees allowed to perform specified procedures independently should be in each procedure room.

5.4 The endoscopy room should not be used a thoroughfare to storage etc whilst there is a patient within the room. The room should not contain unnecessary equipment.

5.5 Disruptions to the room once the patient has entered should be kept to an absolute minimum. Do not enter signs should be observed, and curtains provided inside the room or patient dignity shorts worn. Processes should be in place to ensure the room is not entered during the procedure. Telephone calls should be kept to a minimum. There should be blinds to external windows, preferably vertical wish maintain patient privacy, but allow natural lighting.

5.6 Personnel in the room should be kept to the minimum of required staff and observers, including medical students.

6. Fluoroscopy within the unit

6.1 If ERCP or X ray guided procedures are undertaken within the unit, there should be a trolley which is suitable for fitting beneath a "C" arm, allowing the endoscopist and nurse managing the patient easy access. Lead aprons stored on a medical grade hanging frame should be available for staff, which are appropriate to their size and weight.

7. Recovery and discharge

7.1 Patient recovery compromises two stages. The first stage may involve the patient being on a trolley, with each patient should having access to their own individual curtained space. Each recovery space should have its own oxygen and suction supply, and clinical monitor providing pulse, BP and SaO₂ monitoring. It is beneficial for each area to have a call system. There should be space between each trolley to gain access for resuscitation equipment and a team. A minimum gap should be 1.2m.

7.2 Advice is available on determining the number of recovery beds required, dependant on patient flow (HBN 52 Accommodation for day care - Vol 2 - Endoscopy units) As a general principle for a separate recovery area, 3-4 beds per procedure room provides suitable facilities.

7.3 The second stage of recovery is a communal seated area, where refreshments may be served. Patients in this area are dressed and have undergone initial recovery from sedation. Patients may be mixed gender within this area. If patients are mixed within this area, it must be separate from first stage recovery. A different room or room dividers may be used. For room dividers, these need to be fixed to the building structure and high enough to make the patients feel as if they are in a separate room. Access to additional clinical monitors is required in this area, without taking them from bed spaces occupied by a patient post procedure.

7.4 A recovery area should have toilet and washing facilities. If there are two recovery areas for gender separation, each area should have its own identified toilet. It is not acceptable for patients to leave recovery to access toilets.

7.5 The recovery areas whether separate or combined, as first and second stage recovery, or male and female recovery should have a dedicated base for patient records, and general communications. First stage recovery areas should have a hand washing sink. If any clinical procedures are undertaken in the second stage, e.g. removal of cannula's an additional sink is required, unless room dividers are used.

7.6 If patients are offered drinks, crockery should either be disposable or washed in an organisation approved dishwasher. Communal food for patients e.g. open unwrapped biscuits should be replaced by individual packets and the offer of hand wipes.

7.7 Once the patient is ready for discharge, there should be a separate room available for private discussion of their clinical care, with their relative if desired.

8. Resuscitation area

8.1 A dedicated area within the unit should be identified to house the resuscitation trolley, oxygen, suction and emergency drug box. This should be easily accessible to all areas in endoscopy.

9. Off the unit endoscopy

9.1 Endoscopic procedures are frequently undertaken within radiology, with patients undergoing assessment and recovery in the main endoscopy unit, or using endoscopy staff to undertake the procedure. The room where the procedure is undertaken should meet the same requirements as the endoscopy room, apart from having direct access to an endoscopy reporting system. Patients should not be left without registered nurse or an anaesthetic practitioner direct supervision post sedation. Any safe, dedicated area used either to fully recover the patient or to await transfer back to the endoscopy unit or ward should have oxygen, suction and patient monitoring for pulse, BP and SaO₂.

9.2 If endoscopes are used outside the unit, e.g. radiology or on call emergency endoscopy, the equipment and processes should be the same standards as outlined above.

10. The decontamination environment

- 10.1 Equipment reprocessing may take place within the unit, or on a sub site. In either case, dedicated decontamination facilities are required with clear separation of dirty and clean equipment and processes. The area should be safe and dry, and with easily cleaned medical grade surfaces for equipment preparation, and storage of supplies. Disinfectants should be stored according to their product sheets. Personal protective equipment and a spillage kit should be stored and available for use. Ventilation and extraction facilities should ensure staff are not exposed to hazardous chemicals. Doors to the facility should be kept shut, and it is preferable for them to have code locks.
- 10.2 Sinks for manual cleaning decontamination should be of adequate height to prevent back related injuries. In some units with staff of varying heights, adjustable or multiple sinks may be required. The number of sinks will depend upon the activity of the unit. As a minimum, a double sink with a double drainer is required. The sinks should be able to take the largest endoscope used in the department and completely submerge it. Each sink should have a system to check the detergent: water concentration and temperature. Manual leak facilities for scope testing should be available.
- 10.3 All endoscope reprocessing should be automated, with each AER being in good working order, and HTM compliant, and maintained in accordance with the manufacturers instructions. In units which have older non compliant machines, available adaptations from the manufacturer should have been accessed, and there should be a rolling programme and business plan to replace them. Both top loading and pass-through systems are acceptable. The AERS should be away from the splashes and airbourne debris from manual cleaning.
- 10.4 Following reprocessing, endoscopes should be stored in a medical grade storage cabinet, or endoscope drying cabinet until ready to be used. If a drying cabinet is used, a risk assessment should be undertaken for each cabinet. Lockable endoscope storage should be in a dedicated clean area, with access controlled to nominated personnel only. This may be within a decontamination facility, or on the endoscopy unit.
- 10.5 A separate handwashing sink should be available in addition to the endoscope cleaning sinks. If there is complete separation between dirty and clean areas, (full pass-through system) an additional handwashing sink should be available in the clean area.

10.6 When endoscopes are moved around the unit, scope trays identifying a clean or dirty instrument should be used. If endoscopes are moved outside the unit, a hard lid should be added for transportation. If endoscopes are moved outside the hospital, a lockable case or tray should be used.

10.7 The decontamination facility should have storage for a tracking system, and associated record keeping for processes and policies. Storage should be available for any dirty equipment awaiting transfer to sterile services for autoclaving.

11. Stock room and disposal area

11.1 There should be an area on the unit, or nearby for storage of major supplies, laundry etc. There should also be a dedicated area nearby for safe disposal of general and hazardous waste. Access to a sluice and facilities for use and disposal of urinals and bedpans is required.

12. Staff changing rooms and staff room

12.1 Staff should be able to access a dedicated changing area, with secure property storage, toilet and washing facilities on the unit or nearby. Larger units may have a dedicated staff room.

13. Additional facilities

13.1 Larger units, or those with a particular focus on high level or regional training provision should have access to a nearby seminar room with a video link to the endoscopy unit. On the unit, there should be a complete range of equipment for therapeutic and advanced technique endoscopy. Trainees should also have routine access to video photography during lists, and be able to enhance their training opportunities with imagers, models or simulators being either available or readily accessible.

14. Children and Endoscopy

14.1 As best practice, children should be neither admitted nor treated alongside adult patients. The preferred option is for them to be treated within their own unit. If such a facility is not available, a separate dedicated endoscopy list should be provided for them. If a concurrent adult and child session is required, there should be visible separation of the patients within the list. When possible, the communal areas (admission, recovery, pre discharge) divided by movable screens. This may be difficult to achieve, and it is seen as a preferable option for a child to attend the unit for the procedure only, being admitted and recovered directly on a paediatric facility.

References and additional resources

1. Health Building Notes 52 Vol 2 Accommodation for day care endoscopy units. London HMSO 1994.
2. JAG Accreditation Assessment version 1.2. The Accreditation office, the Royal College of Physicians of London.
3. Global Rating Scale –www.grs.nhs.uk

Summary of essential and desirable components of a JAG compliant endoscopy environment		
	Essential	Desirable
1	Location of unit	
1.1		Separate endoscopy unit for a population of $\geq 300,000$
2	General principles	
2.1		The flow of the unit should progress a patient without unnecessary looping back.
2.2	Disabled access and facilities for people who have problems with mobility or orientation (visual or hearing impairment)	
2.3	One specially designed toilet suitable for disabled access within the department.	Increased number of toilets according to throughput and local need.
2.4	Patients asked from the start to the end of their journey if they wish to have their clinical care discussed in private and the facilities to do so	
2.5	All areas provide a safe environment with unit décor well maintained. Adequate lighting, ventilation and temperature range	Some natural lighting and ventilation
2.6	Gender separation from admission to recovery, wherever patients are required to undress and change into a gown, or have received sedation and associated drugs	
3	Reception and waiting	
3.1	Toilet facilities within or immediately nearby the waiting area without going into the restricted clinical area	Appointments allowing phased admission of patients

3.2		A low and open reception desk, with a lower counter area for wheelchair access
3.3		A waiting area with immediate access to the reception desk
3.4	Sufficient seating to house throughput	Appropriate seating for patients with special requirements. Patients may require additional seating space to accommodate their needs.
3.5	Relatives remain outside clinical area unless there are exceptional reasons to enter	
3.6	Access to the clinical area (post reception) via doors accessed only by clinical staff	A second entrance for in patients
4	Patient assessment and preparation areas	
4.1	At least one separate room to undertake patient assessments and discharge for privacy	
4.2	En suite toilet and washing facilities in one preparation room if enemas are given. A suitable alternative would be if this could be provided in a nearby clinical area.	
4.3	Separate gender specific changing facilities, with their own dedicated washing and toilets	Patients in a gown should be offered dignity shorts, and wearing of footwear and a dressing gown should be promoted.
4.4	A method of handling patients property throughout their endoscopy	
5	Patients prepared in the same area they are recovered in post procedure	
5.1	A patient space for assessment, and later recovery should be curtained or screened	Patients who have not been treated do not meet patients who have been treated.
5.2		Food aromas do not pervade the area.

6	The endoscopy room	
6.1	<p>Easy access and room for the patient trolley with accessibility to all sides</p> <p>Floor space for the endoscopist, two endoscopy assistants and a trainee</p> <p>Minimum of endoscopy equipment and cables on the floor or trailing, and a risk assessment undertaken to provide an achievable action plan.</p> <p>Space for a resuscitation trolley and emergency team to access the patient</p> <p>Clinical preparation space for procedural equipment</p> <p>Controlled drug cupboard.</p> <p>Clinical grade storage space for endoscopy supplies required during the session</p> <p>Foot operated bins or sack stands</p> <p>Hand washing sink</p> <p>Emergency call system</p> <p>Oxygen and suction facilities</p> <p>Patient monitoring for pulse, blood pressure and SaO₂</p>	<p>Desk space for the Endoscopy Reporting System and equipment, and record keeping</p>
6.2	<p>Complete range of modern endoscopy equipment available for use, with the ability to take still photography</p>	
6.3	<p>Endoscopy reporting system</p>	
6.4	<p>Register of trainees allowed to perform specified procedures independently</p>	<p>No thoroughfare to storage or unnecessary equipment</p>

	Minimum entry to the room whilst patient within	Minimum of required staff in the room
7	Fluoroscopy within the unit	
7.1	For radiological guided procedures, a trolley suitable for a “ C “ arm to be used	
7.2	Lead aprons stored on a medical grade hanging frame	
8	Recovery and discharge	
8.1	Oxygen and suction supply, and clinical monitor to each curtained recovery space	Call system
8.2	Minimum gap of 1.2m between recovery trolleys.	3-4 beds per procedure room
8.3	Separate recovery rooms for males and females or room dividers. Room dividers fixed to the building structure and high enough to make the patients feel as if they are in a separate room.	
8.4	If a second stage recovery base, is used, additional clinical monitors are required	
8.5	Each 1 st stage recovery area should have toilet and washing facilities. If there are two recovery areas for gender separation, each should have its own toilet.	
8.6	1st stage recovery areas should have a hand washing sink. If any clinical procedures are undertaken in the second stage, e.g. removal of cannulas an additional sink is required, unless accessible room dividers are used	Dedicated base for patient records and general communications
8.7	Disposable crockery or crockery washed in an organisation approved dishwasher. Individual biscuits packs	Hand wipes

9	Resuscitation area	
9.1	Dedicated area within the unit should be identified to house the resuscitation trolley, oxygen, suction and emergency drug box	
10	Off the unit endoscopy	
10.1	Rooms, equipment and processes to the same standard for off unit or out of hours endoscopy, including decontamination	
10.2	Registered nurse or an anaesthetic practitioner remains with patient post sedation with oxygen, suction and patient monitoring	
11	The decontamination environment	
11.1	Dedicated decontamination facilities with clear separation of dirty and clean equipment and processes	Door to have code locks
11.2	<p>Medical grade surfaces</p> <p>Disinfectant storage</p> <p>Personal protective equipment</p> <p>Spillage kit</p> <p>Ventilation and extraction facilities according to chemicals used</p> <p>Doors shut at all times</p>	
11.3	Sinks for manual cleaning should be of adequate height to prevent back related injuries for all staff	Adjustable height sinks or sinks of multiple heights
11.4	Double sink with a double drainer to fully submerge the largest scope cleaned.	Automated water, detergent and temperature systems

	A system to check the detergent, water concentration and temperature. Manual leak testing facilities	
11.5	Automated endoscope reprocessing. AERs in good working order, and CFPP compliant, maintained in accordance with the manufacturers instructions	Pass through system of AERs
11.6	Endoscopes storage in a lockable medical grade storage cabinet	Endoscope drying and storage cabinets
11.7	Hand washing sink in decontamination area (two sinks if separate rooms for dirty and clean processes)	
11.8	Scope trays identifying a clean or dirty instrument. Hard lid for movement outside the unit. Lockable case or tray if moved outside the hospital.	
11.9	Tracking system Storage for any dirty equipment for sterile services	
12	Stock room and disposal area	
12.1		Storage for laundry, major supplies. Dedicated area nearby for safe disposal of general and hazardous waste. Access to a sluice and facilities for use and disposal of urinals and bedpans
13	Staff changing rooms and staff room	
13.1		Staff access to a dedicated changing area, with secure property storage, toilet and washing facilities on the unit or nearby Dedicated staff room.

14	Additional facilities	
14.1	Video photography for trainee lists	Nearby seminar room with a video link to the endoscopy unit. Complete range of equipment for therapeutic and advanced technique endoscopy. Imagers, models or simulators, are available or readily accessible.
15	Children and endoscopy	
15.1	<p>Separate dedicated endoscopy list for children if own facility not available</p> <p>Visible separation of adult and child patients in the unit if concurrent lists undertaken</p> <p>Children admitted and recovered directly in a paediatric facility.</p>	<p>Children treated within own unit.</p> <p>For concurrent adult/ child lists, communal areas (admission, recovery, pre discharge) divided by movable screens.</p>