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| **Blackpool Teaching Hospitals NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that they are not placed at a disadvantage over others. The Equality Impact Assessment Tool is designed to help you consider the needs and assess the impact of your policy in the final Appendix.** | | |

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# Purpose

The purpose of this document is to set out the operational policy of the endoscopy service at Blackpool teaching Hospitals. The Endoscopy Unit sits within the Gastroenterology Unit (“Gastro Unit”) and is managed by the Unscheduled Care Directorate. It consists of 4 endoscopy rooms providing 47 sessions per week, including 3 Endoscopic retrograde cholangiopancreatography (ERCP) sessions undertaken in the Farage Unit and 2 sessions run by Respiratory medicine for Bronchoscopy.

The unit has 10 trolley spaces in the recovery area, 1 bed, 5 admission prep rooms and a pre procedure seating area.

The endoscopy unit provides both in-patient and outpatient service for patients requiring endoscopic procedures, comprising:

* Gastroscopy – Diagnostic and Therapeutic
* Colonoscopy – Diagnostic and Therapeutic
* Flexible Sigmoidoscopy
* ERCP
* Endoscopic ultrasound scan (EUS) – upper gastrointestinal (UGI) and Hepato-Pancreato-Biliary (HPB) intervention
* Percutaneous endoscopic gastrostomy (PEG)
* Bronchoscopy
* Endobronchial Ultrasound Bronchoscopy (EBUS)
* Capsule Endoscopy
* Venesection
* Gastrointestinal (GI) Physiology
* Ascitic Drain Service
* Biologics administration

# Target Audience

This policy is to provide guidance for all users of the endoscopy service, clinicians, nursing staff, clerical staff and patients.

# Policy

## Gastro Unit Values

The Gastro Unit Values were created from ideas put forward by the whole Gastro team. This will give our service users clear evidence of the care, treatment and behaviours they can expect to receive when attending our unit. This will also give all staff a clear picture of the values and behaviours expected from all team members. Our Values are displayed in poster form in patient waiting areas. (Appendix 1)

* **Excellence** – Striving to offer the best possible service for our patients.
* **Professional** – Always acting professionally and displaying a positive patient and staff focused attitude.
* **Motivational** – Demonstrating enthusiasm about our service and offering ideas and thoughts on how we can constantly improve.
* **Helpful** – Always there to offer a helping hand.
* **Compassionate** – Showing empathy and ensuring dignity for both patients and colleagues.
* **Friendly** – Ensuring all patients and staff feel valued and cared for Smile!
* **Reflective** – Reflects on how own behaviour and attitude can affect patients and colleagues.
* **Competent** – Takes responsibility for own practice ensuring skills and knowledge are kept up to date.
* **Communicators** – Can communicate effectively on all levels, remember to listen!
* **Togetherness** – Promotes teamwork and encourage mutual respect amongst colleagues and other multidisciplinary team members.
* **Can do Will Do** – Endeavours to find ways of making things work.
* **Nurturing** – Demonstrates respect empathy and understanding to the team as a whole.
* **Trustworthy** – is honest, trustworthy respects confidentiality and exhibits integrity at all times.
* **Dependable** – Reliable and consistent in all situations.
* **Responsible** – Always takes responsibility for own actions.
* **Punctual** – Always on time and ready to perform.
* **Time Management** – Organises workload and tasks in a timely manner.
* **Orderly** – Takes pride in our unit and endeavours to keep everything clean, organised.

Appendix 1 – Gastro Unit values

## Control of Infection

The endoscopy unit is totally committed to controlling the spread of infection between our patients and staff. To this end the following must be strictly adhered to

* Endoscopists and nursing staff MUST change into scrubs for their lists.
* The endoscopist and the assisting nurses to wear disposable plastic aprons and gloves for each patient. Universal precautions are performed with every patient.
* All Trolleys are cleaned between patients with disinfection wipes.
* All surfaces used are cleaned between each patient with surface disinfectant wipes.
* Oxygen saturation (SpO2) probes and blood pressure cuffs are cleaned between each patient with surface disinfection wipes.
* Imager, when used, must be cleaned between patients.
* Weekly hand washing audits are carried out.
* Weekly environmental audits are carried out.

The Trust Policy ‘Infection Prevention in the Acute Setting’ must be adhered to.

## Endoscopy Timetable

### Weekly timetable

There are 47 endoscopy sessions throughout the week.

There are up to 10 sessions per day.

Patients access this service through outpatient and in-patient referrals.

### Opening Times

* The Endoscopy Unit is open on Monday, Tuesday, Friday and Saturday from 08:00am to 18:00pm and on Wednesday and Thursday from 8:00am to 21:00pm.
* Session times are 8:30am-12:30pm for morning and from 13:30pm to 17:30pm for afternoon sessions
* The staff are flexible with their working times depending on service needs.
* There is currently a 24 hour emergency On Call GI Bleed and Colonic Stent rota.

## Endoscopy Management

### Unit Management

* Head of department & Endoscopy Lead
* Directorate manager
* Service Manager – manages the day-to-day operations for the Unit including administrative functions and list management.
* Endoscopy Training Lead:
* Clinical Nurse Manager

### Unit Staff

* All staff are regarded as valuable members of the team
* Staff will be given access, where appropriate, to additional training
* All staff will have access to a regular forum where relevant issues may be discussed
* All staff within the unit will be clear about access to their immediate line manager
* All staff working within the unit will be competent in the roles they undertake
* Where staff are training within the unit appropriate supervision and support will be given
* The commitment to training and education of all staff is a high priority. The Unit has a dedicated Training and Development Sister who coordinates the nurse training on the Unit.
* Upon commencement nursing staff will be given a supernumerary induction period with a mentor.

## Endoscopy Staffing

### Endoscopy Staffing includes

* Consultant Gastroenterologists
* Consultant Colorectal Surgeons
* Consultant in Acute Medicine
* Nurse Endoscopists
* General Practitioner (GP) Endoscopist
* Consultants in Respiratory Medicine
* Matron
* Clinical Nurse Manager
* Senior Nursing Staff
* Trainees – Medical and Nursing
* Staff nurses / Assistant practitioners / healthcare assistants
* Administration staff
* Stock and Environment Lead
* Multidisciplinary work force to support unit – i.e. X-ray, Path. Lab. Etc.
* Ancillary staff, domestic, porters, laundry etc.

## Gastro Unit Administration

3.6.1 There are waiting list booking clerks within the Unit dedicated to all specialties, managed by the Assistant Service manager.

3.6.2 Each Consultant endoscopist has a named secretary.

3.6.3 We have a named Reception supervisor

3.6.4 We have dedicated reception staff who welcome patients into the Unit and process their admission details

3.6.5 We have a dedicated full time assessment nurse (band 5) who will undertake the assessment of patients with varying degrees of complexity/safety issues/specialist needs. Consultant input will be utilised if necessary for the booking of these patients.

3.6.6 Admissions - waiting list staff are responsible for the day-to-day management of all waiting lists.

* Adding patients to the waiting list.
* Arranging appointments for patients
* Managing urgent appointments i.e. cancer 2 week waits etc.
* Manage cancellations

3.6.7 Reception Staff are responsible for the day to day front of house services including:

* Booking patients into the Gastroenterology Unit
* Pulling notes for procedures
* Preparing notes for procedures
* Processing Did not Attends (DNA’s)
* General Administration and clerical duties
* Providing typed lists for each session
* Updating filing in patients charts on discharge

3.6.8 Consultant Endoscopists’ secretaries are responsible for.

* Ensuring all referral letters, lab and x-ray reports are available to consultants when required
* Providing results letters to GP

3.6.9 Additional duties required of admin staff within the unit

|  |  |
| --- | --- |
| Managing booked admissions | Waiting List Staff |
| Answering GP queries | Medical Secretary for appropriate endoscopist |
| Re-appointing DNA’s if required after clinical review | Reception Supervisor |
| Writing specific letters to GPs | Medical Secretary for appropriate endoscopist |
| Ensure clear audit trail of patients available | Reception Supervisor |
| Continuing audit – waiting times standards | Service Manager |
| Weekly validation of long waiters | Service Manager |
| Co-ordinating admin staff leave | Reception Supervisor/ Assistant Service Manager |

## Patient Pathway

### Out Patient Pathway

3.7.1.1 Pre-admission

* Patients are informed by phone call or letter of their day of admission. Instructions regarding date, time, fasting instructions, medication queries and preparation procedures will have been provided via the patient information leaflets. These have been prepared in line with the Trust’s policy on the publication of patient information
* There are staggered appointment times for attendance
* All endoscopy lists are available from the diary on the Unit, showing date, session, time, procedure to be performed and the correct appropriate patient details.
* All notes will already be in the Unit

3.7.2 Patient arrival

* Patients for endoscopy report to the main reception desk upon arrival.
* Patients are admitted and details confirmed on PAS, they are given a patient care pathway and asked to fill in the health questionnaire on it, patients are then directed to the appropriate waiting area.A dedicated nurse admits patients for each endoscopy room
* The patient is guided from the reception area to an admission room

Patient details are checked and confirmed

* The patients’ health questionnaire is checked with them, admission documentation is completed including the initial stage (sign-in) of the modified World Health Organisation (WHO) endoscopy checklist.
* The patient is weighed and base line observations are recorded, including blood glucose and INR as necessary.
* Informed written consent is obtained by a competent person in the privacy of the admission room, or confirmed if consent was obtained prior to admission (e.g. In outpatient clinic).
* Patients are given dignity shorts to put on under their clothes if having a lower gastrointestinal procedure. This is done in the privacy of the admission room.
* The patient is taken to the pre procedure seating area.
* Patients are cannulated if required.
* Patients are kept informed of the wait times for procedures by their admitting nurse
* The appropriate nurse from the procedure room collects the patient from the preprocedure seating area ensuring they check the patient’s identification.
* Patients are able to remove any necessary clothing behind a curtain in the procedure room.
* Patients are made comfortable on a trolley.
* A blood pressure cuff and oxygen saturation probe is placed on the patient.
* WHO Time out is completed by all procedure room staff.
* Throat spray or sedation is given as required.
* Endoscopy procedure is undertaken by competent endoscopist.
* Modified WHO Endoscopy checklist is completed prior to the patient leaving the room
* On completion of all parts of the procedure, the patient may be discharged if clinically appropriate and safe to do so. Alternatively, should recovery be necessary, the patient is transferred to the recovery area.
* The procedure is logged in to the endoscopy room logbook
* Procedure room nurse provides written and verbal handover to recovery staff.
* Post procedure monitoring is carried out by the discharge nurse in the recovery area.
* Patients are offered refreshments before discharge if appropriate.
* Endoscopist/nominated staff give patient results of procedure verbally and written.
* Patient is accompanied home by a responsible adult if required.
* Patients are discharged on the hospital system prior to the patient leaving the Unit.
* Relatives and or friends of patients are not routinely allowed in the clinical area. Many factors influence this including confidentiality, space limitations, privacy and dignity, infection risk. If a patient has a special request for a relative to accompany them to the clinical area then this will be considered alongside patient need. This will include the needs of the patient requesting the accompaniment and the needs of other patients in the clinical areas.’

### 3.7.3 In Patient Pathway

* Referral received on the Gastro Unit from ward.
* Referral vetted by Gastroenterology Consultant.
* Patient allocated place on appropriate list.
* Endoscopy nurse attends ward to pre-assess patient, consent patient (unless consent 4) and give pre procedure patient information to patient.
* Patient attends Unit for procedure.
* The patient pathway continues as per Outpatient protocol, with the patient discharged to ward rather than home.
* Appendix 2 – Outpatient Care Pathway.
* Appendix 3 – Inpatient Care Pathway.

## Clinical Staffing

### Structure

The Head of Department maintains overall responsibility for the implementation of protocols and maintenance of good clinical practice within the Unit. To this end, he/she is required to work alongside the Matron and Clinical Nurse Manager.

### Skill-mix

All clinical staff that carry out procedures in the unit must be appropriately competent and experienced. All trainees must be adequately supervised and supported.

### Nursing Staff

* Skill mix in accordance with British Society of Gastroenterology (BSG) Guidelines on staffing on Endoscopy Units.
* Clinical Nurse manager responsible for overall efficiency supported by Unit Sisters.
* Access to Specialist Nurses available as appropriate.
* Endoscopy rooms and recovery area to be staffed by an appropriate skill mix of senior nurses trained in endoscopy procedures supported by junior staff.
* Nurses / Assistant Practitioner’s / Healthcare Assistants will be assessed to achieve appropriate competency to allow the safe execution of lists.
* Nurses / Assistant Practitioner’s / Healthcare Assistants will be encouraged to maintain their competency by a process of self-assessment by utilising the therapeutic matrix situated on the Unit.
* Staff will rotate through all areas of the unit and should be competent to work in all clinical areas where required.
* More experienced staff are encouraged to develop sub-specialist skills in particular advanced procedures, e.g. ERCP, EUS, Bronchoscopy, Stenting.
* A multi-disciplinary team approach is practiced – ensuring effective communication.
* Staff adhere to BSG Guideline and unit policies.
* Staff training is competency based and all staff have a Directly Observed Procedural Skills (DOPS) based training file. These DOPS are re-assessed annually.
* All staff must have up to date mandatory training.
* All new staff will have a mentor and a comprehensive induction programme.
* All newly qualified nurses will be supported through a Trust preceptorship programme as well as local induction and training.
* Staff will participate in annual appraisal.

## Medical Staff

3.9.1 The Unit will be accessed by medical staff from all disciplines that have a responsibility for patients attending the unit. Patients who attend the unit will have a named consultant / endoscopist who is responsible for the supervision of their medical care in the unit. All medical staff performing procedures within the unit will have had their sessions discussed and agreed in their current job plans and will be adhering to the Endoscopy Global Rating Scale (GRS) guidelines.

3.9.2 There is a register of Clinicians within the unit who are deemed competent to carry out endoscopy independently. This states which procedures they have been signed off for. No one can perform independently (i.e. unsupervised) unless his or her name is registered.

3.9.3 This includes locums and trainees. All new trainees undergo formal induction.Trainees have access to a supervised, appropriately adjusted dedicated training list every week. Ad hoc training lists are available and adjusted as needed.

## Procedure for dealing with Endoscopist Poor Performance

3.10.1 If regular audit identifies an endoscopist whose performance is below acceptable standards or, whose complication rate is significantly higher than his/her peer group, the Endoscopy Lead Clinician will discuss the problem identified with the endoscopist concerned.

3.10.2 If it is agreed that the problem is real and there are no confounding factors or extenuating circumstances the endoscopist will be observed over another audit cycle. If the endoscopist does not agree that there is a genuine problem, there will be a discussion in the next quarterly audit meeting (with the data anonymised) where a decision will be made as to what action is required.

3.10.3 If the problem persists, the endoscopist will be mentored and re-audited. If after this period there are still concerns, the endoscopist will not perform any further procedures until he/she has undergone a period of re-training to a satisfactory standard.

Junior doctors that have been “signed off” will be removed from the unit register that allows them to work independently. They will not be put back onto the register until the Lead Clinician is satisfied with their performance. Following a period of re-training he/she will continue to be audited via the usual process for all endoscopists.

3.10.4 If problems continue to be an issue with any particular endoscopist their permanent exclusion from performing all endoscopic procedures will become a consideration under Trust Governance procedures. All Poor Performance will be managed in line with national guidelines.

## Training and Development

3.11.1 All staff undergoing training must be adequately supervised until they are deemed to be competent to practice alone.

3.11.2 A list of all trainees, and their competency level is clearly displayed in each endoscopy room.

3.11.3 Individual learning needs are identified / appropriate training given, enabling staff to develop their competences and make a fuller contribution to the service.

3.11.4 Competency based training takes place.

3.11.5 Use of models which are available in the unit is encouraged.

3.11.6 Where National Guidelines for training of staff in practical procedures are available these will be followed e.g. Joint Advisory Group (JAG) guidelines, safe sedation policy.

3.11.7 Continuing education is provided for all staff.

3.11.8 Regular audit of all practice is required.

3.11.9 Medical staff are given a structured induction to the Unit

## Multidisciplinary team Links

3.12.1 All patients, where relevant, will be linked to the appropriate Multi-disciplinary (MD) team.

3.12.2 All patients with a diagnosis of cancer (definite or probable) will be discussed at the relevant MDT meeting.

3.12.3 Upper GI MDT and Colorectal MDT take place on a Friday lunch time.

3.12.4 Information about these patients will be added to tracking system - SCR by the MDT co-ordinator for the relevant speciality.

3.12.5 Close links with the Liver Service, Alcohol liaison Team, Nutrition Team, Inflammatory Bowel disease Team, Colorectal Nurses and The Gastroenterology Ward are fostered within the Gastroenterology Unit.

## Performance Indicators

Indicators of unit performance will include the following:

* Percentage DNA rates
* Proportion of lists cancelled
* Total activity (Outpatients- Inpatients)
* Predicted activity (Outpatients- Inpatients)
* Waiting times
* Percentage of urgent referrals
* Appropriate monitoring of BSG auditable outcomes and quality standards
* Nursing Care indicators monitored monthly
* Staff sickness rate monitored
* Friends and Family test results
* Annual patient survey
* Annual staff survey
* User feedback & survey

## Referral Protocols

3.14.1 Patients will be referred to the unit from:

* Out- Patient referrals
* GP
* In- Patient referrals
* Emergencies from the Emergency Department and the Acute Medical Unit
* External Hospital Transfers

3.14.2 The referral guidelines are available for all common endoscopic procedures on the Trust intranet and in the Gastroenterology Department.

3.14.3 All referrals made for endoscopy should be made based on the referral guidelines using the appropriate referral forms.

3.14.4 Referrals by consultant endoscopists do not require vetting and can be booked directly.

3.14.5 The Unit operates a 24 hour emergency GI Bleed service.

3.14.6 Vetting of Outpatient Referrals

* All referrals from non-endoscopic physicians / surgeons must be vetted by a consultant endoscopist with appropriate prioritisation prior to booking.
* Incomplete or inappropriate referrals should be returned or the vetting endoscopist should discuss with the referring team to improve future referrals.
* Straight to test GP fast track referrals for gastroscopy are based on National Institute for Health and Care Excellence (NICE) fast track guidance and can be booked without vetting.
* Routine Open Access (OAE) GP gastroscopy referrals must be made using the OAE referral form (based on NICE guidance) and are vetted by the nurse endoscopists or GP endoscopist. OAE referrals not meeting criteria should be discussed with a Consultant Endoscopist.
* Endoscopy referrals by nurse practitioners should be reviewed/countersigned by a Consultant.
* Referrals for colonoscopy and therapeutic endoscopic procedures (e.g. dilatation, ERCP, polypectomy, etc.) should be countersigned by a Consultant and should be vetted / prioritised by a Consultant Endoscopist.
* Junior doctors, with the exclusion of ST3+ Gastroenterology trainees can request diagnostic gastroscopy / flexible sigmoidoscopy without having the request countersigned by a Consultant. The referral will be vetted and prioritised by a Consultant Endoscopist when the referral is received.
* Audit of the endoscopy referral process including appropriateness, completion of referral forms and timeliness of vetting should take place on at least an annual basis.
* Results of this audit will be fed back to the referrers.

3.14.7 Principles of referral for day case investigations/ treatment

* Patients accessing this service are usually ambulant and come from their own home.
* Patients will usually not require overnight stay following the procedure (except in cases of complications or for ERCP). Where patients do require an overnight stay they will be transferred to an in-patient facility.
* Patients should be able to manage any preparation for the procedure at home. Where a patient is unable to prepare for a procedure at home e.g. bowel preparation, they may be admitted to hospital at the discretion of the consultant. This admission must be arranged by the responsible team.
* The unit will facilitate patients unable to administer their own enemas at home.
* These will be administered in the admission prep room which is adjacent to toilet facilities.
* Patients who require sedation for the procedure must be accompanied home and demonstrate that they have a responsible adult who is able to stay with them overnight.
* For patients who should require General Anaesthetic (GA), please refer to the GA Endoscopy booking policy.

3.14.8 Vetting of inpatient referrals

* All inpatient endoscopy referrals should be faxed to endoscopy reception. The referrals should be brought promptly by the receptionist to the endoscopy nurse co-ordinator.
* All inpatient endoscopy referrals should be vetted and prioritised by a consultant endoscopist within 12 hours of receipt of referral during working hours or within the next 12 hours of the next working day if received at weekends or bank holidays.
* Inappropriate or incomplete referrals will be returned to the referral team, or the vetting consultant endoscopist should discuss with the referring team to improve future referrals.
* Referrals for colonoscopy and therapeutic endoscopic procedures (e.g. dilatation, ERCP, polypectomy etc.) should be countersigned by a consultant and be vetted by a consultant endoscopist.
* Junior doctors can request diagnostic gastroscopy / flexible sigmoidoscopy without having the request countersigned by a consultant. The referral will be vetted and prioritised by a consultant endoscopist when the referral is received.
* Auditing of the endoscopy referral process including appropriateness, completion of referral forms and timeliness of vetting should take place on at least an annual basis.
* Results of this audit will be fed back to the referrers.

3.14.9 Validating sequential or surveillance Endoscopies

* Patients are only added to the sequential / surveillance list at the request of the consultant gastroenterologist/surgeon using the criteria established by the British Society of Gastroenterology (BSG).
* All patients on the surveillance/sequential list will undergo initially administrative (clerical) and then clinical validation.
* This validation will take place at least 8 weeks prior to the date of their planned procedure, with the patient being informed in advance of the date of the procedure.
* BSG guidelines (1, 2) will be used to validate the surveillance/sequential endoscopy cases.
* Validation is carried out by nurse endoscopists after retrieving the notes.
* Patients who do not meet the BSG guidelines criteria for surveillance will be removed from the surveillance list and a letter with explanation and contact number sent to the patient, responsible secondary care physicianand GP.
* Patients may also be removed from the sequential list at their request,for other medical reasons (e.g. general medical fitness, complicating illness etc.) or through lack of response to contact requests. In these cases both the patient and GP will be informed by letter (if necessary after discussion with the responsible Consultant).
* Audit of the validation process should take place at least annually.

3.14.10 Administrative Validation

* The surveillance waiting list is validated regularly by a waiting list booking clerk to ensure that all patients have a documented due date for their next endoscopy where appropriate. This includes a review of recent endoscopy reports and either subsequent removal from the waiting list, or the documentation of a further follow up date.
* The Service Manager runs a regular report to establish the number of patients on the waiting list without an appointment date, how long they have been on the waiting list, and the average wait for procedures.
* Regular ad hoc checks are carried to validate any patients that are dated over 6 weeks (routine) or 2 weeks (urgent) to ensure that this is due to patient choice rather than capacity issues.
* Information relating to number of patients on the waiting list, average waits etc are communicated to the endoscopy team monthly as part of the Unit meetings and user group meeting

Appendix 4 Referral form related to Endoscopy.

## Booking protocols

### Waiting List Management

* The functions of waiting list administration and bookings are managed by dedicated waiting list booking clerks within the unit.
* Incoming referrals are collated by the waiting list booking clerk and added to the waiting list. Incomplete forms with inadequate information will be returned to the referrer.
* Any referrals that require vetting (in line with the unit vetting policy) will be passed to a consultant gastroenterologist.
* Any requests outside established guidelines may be returned to the referrer.
* All patients on the surveillance waiting list are contacted at least 2 months prior to their procedure being due. The patients are advised by letter that their case will be reviewed in line with the latest clinical guidelines prior to their procedure.

### Pooling of waiting lists

* All referrals are added to a pooled waiting list unless a specific consultant is requested by the referring clinician. Wherever possible endoscopists will backfill lists that are vacant as a result of annual leave, ward cover etc. This is reviewed by the Service Manager and capacity flexed accordingly.

### Booking Procedure

* Wherever possible patients will come to the department directly from their outpatient appointment, and their date for endoscopy agreed with them at that point. These patients will have been prescribed, and handed, their bowel prep in outpatients, where appropriate.
* Once a referral is received into the department this is entered on to the HISS system by the waiting list booking clerks, and the breach date documented on the referral form.
* All routine referrals must be booked within a maximum of 6 weeks, and urgent appointments within 2 weeks. Where this is not possible due to lack of capacity it should be escalated to the Service Manager prior to booking.
* Where face to face booking is not possible all patients are contacted by telephone in the first instance to arrange a mutually agreed appointment date. The waiting list booking clerk will attempt to contact the patient on two separate occasions. If the waiting list clerk is still unable to make contact by telephone an appointment may be issued by post or a letter seeking contact sent to the patient.
* The waiting list booking clerk will ensure that where the appointment cannot be agreed by telephone, the patient is given adequate notice. Wherever possible this should be 3 weeks for routine patients.
* When a date is agreed (either by telephone or letter) confirmation is sent to the patient detailing the admission details along with their bowel preparation and procedure information sheet. A map of the hospital is also enclosed where required.
* The patient can ring the unit for further information before attendance if required. The contact number can be found on the letter.
* If the procedure is required under General Anaesthetic this will be arranged as per GA Endoscopy booking policy.
* There is a preoperative assessment service provided by Pre Assessment Nurses for patients who are considered at risk for complications, e.g. ERCP, Chronic obstructive pulmonary disease (COPD), history of Cardio Vascular (CV) problems, diabetic or on anticoagulants, or require a capacity to consent assessment. Advice will be sought from the Alcohol Liaison Service for patients who are alcohol dependent. The pre assessment nurse will contact the patient by telephone to carry out the assessment, and then agree an appointment as appropriate.

### DNA’s and Cancellations

* All DNA’s and cancellations on the day must be documented and recorded in the patient record on the Patient Administration System (PAS).
* Patients will be removed from the waiting list if they DNA and the requesting clinician are informed. Fast Track patients will not be removed until they DNA on 2 occasions, at which point the referring clinician will be informed.
* Where a patient re-arranges their appointment on more than 3 occasions they will be removed from the waiting list and the referring clinician advised.
* All DNAs and cancellations are monitored and recorded monthly by the Service Manager. These figures are reported at the Endoscopy Unit meetings where they are discussed and action taken if needed.
* If the Unit needs to cancel a patient the scheduler must telephone the patient and inform them of the cancellation and offer the patient alternative admissions dates.
* The patient’s admission details must be changed on the Hospital Information Support System (HISS).

### Scheduling

* The unit aims to fully utilise all procedure rooms daily. Patients are booked onto the scoping lists in accordance with the document “Endoscopists and Competencies” which outlines the number of units per list to be booked for each endoscopist, and the type of endoscopic procedure that they are able to perform independently. These parameters have been agreed with the Head of Department.

## Consent

### Documentation

For endoscopy procedures, it is essential for health professionals to document clearly both a patient’s agreement to the intervention and the discussions, which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient’s notes if necessary), or through documenting in the patient’s notes that they have given oral consent.

As well as the doctors experienced nurses working on the Gastro Unit who have undertaken consent training can consent patients for endoscopic procedures.

### Written Consent

Consent is often wrongly equated with a patient’s signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent giving, not a binding contract. Where appropriate Trust interpreter policy is adhered too.

### Withdrawal of consent

See policy for withdrawal of consent during endoscopic procedures.

### Process to Follow when Patients Lack Capacity to Give or Withhold Consent

Under English law, no one is able to give consent to the examination or treatment of an adult who lacks the capacity to give consent for themselves, unless they have been authorised to do so under a Lasting Power of Attorney for health or they have the authority to make treatment decisions as a court appointed deputy. Therefore, in most cases, parents, relatives or members of the healthcare team cannot consent on behalf of such an adult. However, the Mental Capacity Act sets out the circumstances in which it will be lawful to carry out such examinations or treatment.

* Patients have a clear right to withdraw their consent during an endoscopic procedure, which may result in an incomplete examination or treatment.
* During conscious sedation patients requests are as valid as those made without sedation.

3.16.4

Patients who withdraw consent during gastroscopies, endoscopic ultrasound (EUS), endoscopic retrograde cholangio pancreatogram (ERCP), sigmoidoscopy and colonoscopy

* The nurse (head nurse) looking after the patient during the procedure should acknowledge and respond to all comments and requests from the patient. The nurse must ensure that the endoscopist is aware of the patient’s comments and requests and also any distress or pain the patient is experiencing. The nurse must document the comfort score on the nursing documentation.
* If the patient asks for the procedure to stop the endoscopist must halt the procedure. The endoscopist must try to make the patient more comfortable by endoscopic manoeuvres such as deflation / partial withdrawal and discuss with the patient and nurse the options of terminating the procedure, administering more analgesia / sedation or change of technique (positioning, abdominal pressure etc.). If the patient still wants the procedure terminating the endoscopist must start to withdraw the endoscope immediately.
* Rarely, when a therapeutic procedure such as a sphincterotomy or polypectomy is at a crucial stage and in which failing to sedate adequately or terminating the procedure would endanger the patient, the nurse and endoscopist can agree to give more sedation immediately.
* In difficult or contentions circumstances, it is essential that the endoscopist takes into account the opinion of the health professionals present at the time.
* Trust and local procedures regarding sedation and consent always apply (CORP/PROC/102, Consent to Examination or Treatment, see section 7). Failure to comply with withdrawal of consent guidance must be reported as an untoward clinical incident (CORP/PROC/101, Untoward Incident and Serious Incident Reporting, see section 7).

### Assessing Capacity

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. The impairment or disturbance can be permanent or temporary. If there is evidence of:

* an impairment or disturbance that affects the way their mind or brain works (for example a disability, illness or trauma, or the effect of drugs or alcohol)

If so

* Is the impairment or disturbance sufficient to render the person unable to make that specific decision at the time it needs to be made?

The act states that a person is unable to make a decision for him/herself if they are unable to:

* Understand the information relevant to the decision.
* Retain the information long enough to be able to make the decision.
* Use or weigh up the information as part of the decision-making process.
* Communicate their decision (this includes talking, using sign language and simple muscle movements such as blinking an eye or squeezing a hand)

Assessing a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient’s capacity, why the health professional believes the treatment to be in the patient’s best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. This information should be entered in the patient’s notes.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient’s situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult’s best interests. Where the consequences of having, or not having, the treatment is potentially serious, a court declaration may be sought.

### Best Interests

The legal requirements in the Mental Capacity Act are underpinned by five statutory principles. One of these key principles is that any act done for, or any decision made on behalf of, a person who lacks capacity must be done, or made, in that person’s best interests. This principle applies to health professionals as it does to anyone working with and caring for a person who lacks capacity. The Act also creates a new offence of ill treatment or wilful neglect of someone who lacks capacity by someone with responsibility for their care or with decision-making powers.

The Mental Capacity Act provides healthcare professionals with protection from civil and criminal legal liability for acts or decisions made in the best interests of the person who lacks capacity. The Act makes it clear that when determining what is in a person’s best interests a healthcare professional must not make assumptions about someone’s best interests merely on the basis of the person’s age or appearance, condition or any aspect of their behaviour.

All relevant factors and circumstances that the healthcare professional is aware of relating to the decision in question must be considered.

Healthcare professionals must take the following steps:

* Consider whether the person is likely to regain capacity and if so whether the decision can wait.
* Involve the person as fully as possible in the decision that is being made on their behalf.

As far as possible, consider:

* the person’s past and present wishes and feelings (in particular if they have been written down)
* any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question, and any other relevant factors, and
* other factors that the person would be likely to consider if they were able to do so.

As far as possible, consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

* anyone previously named by the person lacking capacity as someone to be consulted
* anyone engaging in caring for or interested in the person’s welfare
* any attorney appointed under a Lasting Power of Attorney for Health
* any deputy appointed by the Court of Protection to make decisions for the person

For decisions about serious medical treatment, where there is no one appropriate other than paid staff, healthcare professionals have to instruct an Independent Mental Capacity Advocacy (IMCA).

If the decision concerns the provision or withdrawal of life-sustaining treatment, the person making the best interests decision must not be motivated by a desire to bring about the person’s death.

Further guidance on interpreting best interests is provided in chapter 5 of the Code of Practice.

In cases of serious doubt or dispute about an individual’s mental capacity or best interests, an application can be made to the Court of Protection for a ruling.

### Process to follow when patient lacks capacity

Where an adult patient does not have the capacity to give or withhold consent to treatment then this must be documented in the patient’s health record, including an entry informing of who else was involved in the decision making process, i.e. family members consulted and a copy of the capacity to consent assessment form if available.

For any decision involving an invasive procedure (including dental treatment), or where there is conflict within the family, or where there are adult safeguarding issues:

Consent form 4 must be completed to document why the health professional believes the patient to lack capacity and the treatment to be in the patient’s best interests, and the involvement of people close to the patient.

## The Sedated Patient (All Procedures)

3.17.1 The sedation used for all endoscopic procedures is “conscious sedation”. This has been defined as:

“A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drug and techniques used to provide conscious sedation should carry a margin of safety wide enough to render loss of consciousness unlikely.” BSG Guidelines 2003

3.17.2 If purposeful or verbal responsiveness is lost the patient requires a level of care identical to that needed for general anaesthesia.

3.17.3 When a patient has been sedated it is a reasonable assumption that the patient has impaired ability to give valid consent. The anticipated effect of sedation is that the patient will be able to communicate, but is in a relaxed state. However, sedation is unpredictable and patients are affected in different ways. The decision to stop the procedure is a matter of clinical judgement. There must be a balance between the level of distress being experienced by the patient and the need to complete the endoscopy at that time.

3.17.4 Once either the patient or the nurse has raised concern during the procedure, the endoscopist should stop the procedure and reassess the situation. In some instances it will be in the patient’s best interest to continue the procedure and complete a specific aspect of the procedure e.g. Duct clearance or stent insertion. This must be fully explained to the patient before the start and after the procedure once fully recovered from the sedation.

3.17.5 If the patient wishes the procedure to be stopped whilst under the influence of conscious sedation:

“The endoscopist should try to establish whether the patient has the capacity to withdraw a previously given consent. If capacity is lacking, it may be justified to continue in the patient’s best interest” DOH Reference Guide to Consent to Examination or Treatment 2009.

3.17.6 In addition to the endoscopist, nurses attending the patient during the procedure have a duty to minimise the risk to that patient. One nurse will be responsible for monitoring the patients’ blood pressure, pulse, and respiratory rate and inform the endoscopist of any results out of the expected range.

3.17.7 Doses of sedation or analgesia can be repeated according to clinical need and in line with National and Local Guidelines. However in certain types of patient’s e.g. those with liver disease, increased doses of sedation can cause increased confusion/disinhibition rather than increased co-operation or tolerance to the procedure. Additionally, increased doses of sedation can induce respiratory depression, a potentially life threatening condition.

## Discharge Following Possible malignancy

### Process

* Allow suitable time for any sedation to have dispersed from the patient’s system
* Establish whether a relative/partner or suitable companion is required to be present (if the patient wishes) to support the patient
* Be fully prepared with necessary information before embarking on any discussion.
* Ensure discussions take place in private setting, quiet and comfortable, with an adequate numbers of seats
* If English is not the first language, interpreting service should be used, not the patient’s relative. Patients with special needs should have the appropriate support available. (if no interpreter with patient firstly please call the 002 bleep holder who will have a list of interpreters in the hospital, if no interpreter available please use language line 08453109900)
* The endoscopist, supported by a trained nurse, should give the news.
* If the patient has a suspected upper GI malignancy the endoscopy procedure report will be sent to the Upper GI Nurse Specialist. If it is a suspected colorectal malignancy the endoscopy procedure report will be sent to the colorectal nurses.
* The endoscopist will arrange urgent staging CT as required.
* The patient will be given contact details for the relevant specialist nurse as a point of contact following discharge from the unit. (patients need to be informed these specialist nurses will not be able to give them information on results and treatment however are there as a source of information and support.)
* Patients will be informed that they will be contacted regarding any follow up appointments, further tests and results.
* Have to hand relevant leaflets etc. to allow patient to take home and digest information in their own time.
* Nurses will document what the patient has been told and what information has been given to the patient ensuring a copy of the report goes to the relevant specialist nurse.
* If the patient has not been told of the possible diagnosis the Dr should document the reason for this in the notes. Ensure a copy of the report goes to the relevant specialist nurse.

## Endoscopy Reporting

### Process

* The Endoscopist must enter all of the information from the procedure on to the endoscopy reporting softwareas soon as the procedure is completed
* A copy of the report is placed in the notes by the discharging staff nurse.
* A copy is sent to the coding department
* A copy is given to the patient if deemed appropriate by the endoscopist and a further copy for their GP
* The patient notes are then sent to the individual medical secretaries who then action the outcome of the report.

## Dealing With patient complaints

### Process

* Complaints will be forwarded to Unscheduled Care Complaints.
* Unscheduled Care Complaints will forward to the Unit Nurse Manager asking for a detailed response to the complaint.
* Clinical Nurse Manager will send a detailed response to the complaint back to unscheduled Care complaints.
* Unscheduled Care Complaints will then answer the complaint according to the Trust’s Policy and within agreed timescales.
* The Clinical Nurse Manager of the Unit will deal with all informal complaints.
* All complaints will be discussed at the endoscopy users group meeting every month and appropriate action plan will be agreed.

## Poor Comfort Results

### Process

Please see 3.10.

## Adverse Incident Reporting

3.23.1 This Trust welcomes knowledge of adverse events as an opportunity to learn for the benefit of our patients and staff. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, malicious intent to harm, theft or fraud, disciplinary policies will not be used for investigatory purposes.

3.23.2 The Trust utilises the Safeguard Risk Management System in which the Incident Module is hosted to report all incident information, this is provided by Ulysses.

3.23.3 An incident can be described as an event or circumstance which could have resulted or did result in unnecessary harm, damage or loss to a patient, staff member, visitor or organisation.

3.23.4 A trigger factor is a prompt for staff to generate an untoward incident report. The following general criteria must always trigger a report under the Untoward Incident Reporting

* Where it is suspected that any person was put at risk was injured or died as a result of an action or lack of an action by a member of Trust staff including agency staff and contractors.
* Was injured or died as a result of any procedure, or instructions, lack of proper procedures or a failure to follow current procedures or instructions.
* Was put at risk, was injured or died due to faulty equipment, drugs or an unsafe environment.
* Where a member of staff at work, a patient or others at risk, harms him or herself or commits suicide whilst in the Trusts care or employment.
* A fire, flood, theft or other event, which endangers the safety of staff, patients, and the public, causes injury or death or causes substantial damage and or loss to the Trusts capital or other assets.
* Any incident resulting in financial or material loss for a staff member or patient.
* An incident that had the potential to cause harm but was prevented through the barriers and control measures in place.

3.23.5 It is the responsibility of each Divisional Quality Manager / Governance Lead to ensure that their staff are aware of these trigger factors and are reporting relevant incidents.

The core patient safety trigger factors are: -

* Medication error
* Unexpected serious injury/death e.g. inpatient fall resulting in fractured neck of femur.
* Tissue viability incident i.e. a pressure ulcer developed whilst an in patient
* Missed or incorrect diagnosis
* Inappropriate treatment
* Poor, unsafe or inappropriate discharge
* Patient suicide or self-harm
* Patient record and record keeping issues
* Patient abuse
* Death in custody
* Venous Thromboembolism

3.23.6 Infection Prevention and Control and Outbreaks trigger factors are: -

* Any deliberate or unavoidable breach in Infection Prevention and Control Policies. E.g. Methicillin-resistant Staphylococcus aureus (MRSA) Care Pathway not followed
* Incidence of MRSA Bacteraemia.
* Any disruption to services / supplies, which may have an impact on Infection Prevention and Control e.g. linen, consumables i.e., pulp products, Chloraprep.
* Any delays in equipment repair which may have an impact on Infection Prevention and Control. E.g. blocked sinks or macerators.
* Pest Control, infestation of flies, ants and silverfish
* Outbreak i.e. diarrhoea and vomiting, scabies

All of the above incidents are to be also reported directly to the Infection Control Team.

3.23.7 The core Health and Safety trigger factors are:-

* Unexpected injury/death
* Sharps incidents
* Violence and aggression
* Security incidents
* Lost property
* Equipment failure
* Patient absconding
* Manual handling injuries
* Exposure to harmful substances
* Other incidents resulting in any injury or ill health
* Staff, patient or visitor accident
* Damage to Trust property
* Environmental hazards

3.23.8 Staff on the Gastro Unit should report any incident which would indicate one of these triggers on the intranet incident reporting system.

3.23.9 Incidents will go to all relevant personnel and be answered by the most appropriate person.

* Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents will be reported immediately to the Health and Safety lead
* In the case of a red incident (likely to warrant an impact score of 4 or 5) a route cause analysis will need to be performed.
* These incidents (impact score 4 or 5) will be assessed by Clinical Governance and Risk management to decide if they are serious incidents under investigation.

3.23.10 Incidents will be discussed at the monthly Gastro Unit Meetings and action plans devised as necessary.

## Recording Endoscopy Complications

3.24.1 Endoscopy complications are recorded on the endoscopy reporting software and an incident report form is completed on the Trust Intranet. (please see 3.21)

3.24.2 All endoscopy complications are discussed at the Monthly Gastro Unit meeting.

## Out of Hours Endoscopy

3.25.1 The Gastro Unit provides a 24 hours emergency upper GI bleed and colonic stent service.

3.25.2 When a patient is referred with a suspected upper GI bleed or a need for colonic stenting out of hours the Endoscopist On call will review the referral and decided if the patient is stable enough to have the procedure.

3.25.3 If the procedure is to go ahead switchboard will contact the two endoscopy nurses on call who will come into the hospital to assist the endoscopist with the procedure.

## Communication

3.26.1 Effective Departmental communication is accomplished by:

* Morning Handover is held in at the nurses station at 07:45 each morning, all nursing staff are present.
* Monthly Gastro Unit and Gastro User Group Meetings are held and minutes recorded.
* Regular staff meetings-minuted
* A General Diary is kept at the nurses station
* Notice boards are utilised throughout the unit.

Appendix 5 Morning Handover Sheet

## Pathology and Handling of Specimens

3.27.1 Pathology specimens are obtained during a number of procedures. These include histopathology, cytology and microbiology specimens. In addition, blood samples may be taken before or after the endoscopy.

* All specimens obtained from a patient will be placed in appropriate containers and then immediately labelled with the patient’s details. The nurse in the room and endoscopy assistant/nurse will be responsible for checking that the correct details and labelling corresponds with specimens taken from patients.
* Histology request forms must accompany samples, Hand written requests must be photocopied and copy attached.
* Special specimens: where special or non-routine specimens are required the responsible clinician must agree special requirements with pathology
* Samples will be taken to Pathology twice a day but endoscopy staff.

## Decontamination of endoscopes

3.28.1 All endoscopes are processed in the centralised endoscope decontamination unit.

## Radiation Protection

3.29.1 When an X-ray imager is used on the unit it is operated by a competent person from the radiography department. Medical staff with radiation protection training may operate the screening switch. All staff should observe radiation protection (lead gown, thyroid protection for close operator e.g. air way nurse)

3.29.2 Lead gowns are stored on the unit for use and they are serviced once a year.

## ERCP

ERCP (outpatients and inpatients) is performed in the Farage Interventional Unit (3 dedicated sessions per week). Out of hours ERCP is performed in emergency theatres using portable fluoroscopy (C-arm).

## Bowel Cancer Screening and Bowel scope screening

Our unit is a screening centre for both NHS Bowel cancer screening and Bowel Scope screening. This is delivered through SSPs and Bowel screening endoscopists.

## Resuscitation trolley

2 named nurses ensure that all resus equipment checks are carried out as per trust policy (appendix). Gastro unit resus trolley is checked every morning by a qualified nurse and this is documented and subsequently audited by the trust resus team to ensure compliance. If used the trolley has an immediate check once the emergency has ended.

## Audits

* 30 day mortality and 8 day re-admission audits are completed regularly and reviewed every three months retrospectively
* An annual Patient Satisfaction Audit is carried out.
* An annual Staff Satisfaction Survey is carried out.
* Clinical Audits are undertaken in accordance with National and Local guidelines and presented regularly at the Unit User group meetings.

| Attachments | |
| --- | --- |
| **Appendix Number** | **Title** |
| Appendix 1 | Gastro Unit values |
| Appendix 2 | Outpatient Care Pathway |
| Appendix 3 | Inpatient Care Pathway |
| Appendix 4 | Referral form related to Endoscopy. |
| Appendix 5 | Equality Impact Assessment Form |

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| --- |
| Procedural Document Storage (Hard and Electronic Copies) |
| Electronic Database for Procedural Documents |
| Held by Procedural Document and Leaflet Coordinator |

|  |  |  |
| --- | --- | --- |
| Locations this Document Issued to | | |
| **Copy No** | **Location** | **Date Issued** |
| 1 | Intranet | 07/09/2017 |
| 2 | Wards, Departments and Service | 07/09/2017 |

| Other Relevant / Associated Documents | |
| --- | --- |
| **Unique Identifier** | **Title and web links from the document library** |
| CORP/GUID/090 | Breaking Bad news/Significant News  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-GUID-090.docx> |
| CORP/POL/116 | Infection prevention In the Acute Setting  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-116.docx> |
| CORP/PROC/022 | Interpretation and Translation Procedure  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-022.docx> |
| CORP/PROC/101 | Untoward Incident and serious Incident reporting  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-101.docx> |
| CORP/PROC/102 | Consent to examination or treatment  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-102.docx> |
| CORP/PROC/633 | Complaints Management  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-633.docx> |
| GASTRO/POL001 | [Booking Gastroscopies, Colonoscopies and Endoscopic Retrograde Cholangio Pancreatography (ERCP’s) Requiring a General Anaesthetic](http://fcsharepoint/trustdocuments/Documents/GASTRO-POL-001.docx)  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/GASTRO-POL-001.docx> |
| GASTRO/POL/004 | [Policy on Vetting and Validating Endoscopy Referrals](http://fcsharepoint/trustdocuments/Documents/GASTRO-POL-004.docx)  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/GASTRO-POL-004.docx> |
| GASTRO/POL/007 | Endoscopy Department – Referral, Booking and Scheduling Policy  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/GASTRO-POL-007.doc> |
| GASTRO/PROC/006 | Withdrawal of Consent During Endoscopic Procedure  <http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/GASTRO-PROC-006.doc> |

| Supporting References / Evidence Based Documents |
| --- |
| **References In Full** |
| [Clinical Guidelines - British Society of Gastroenterology](http://www.google.co.uk/url?url=http://www.bsg.org.uk/clinical-guidelines/index.html&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjm45jDi_TRAhVB6RQKHd5JDfcQFggVMAA&usg=AFQjCNELPkX_DSDi84Lsexpm4RQEAVfRLg)  [www.bsg.org.uk/clinical-guidelines/index.html](http://www.bsg.org.uk/clinical-guidelines/index.html) |
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| Guidelines for the training, appraisal and assessment of trainees in gastrointestinal endoscopy  <http://www.bsg.org.uk/pdf_word_docs/jag_recommendations_2004.pdf> |
| JETS Endoscopy Training programme GIN  <https://www.jets.nhs.uk/gin/> |
| [NICE | The National Institute for Health and Care Excellence](https://www.google.co.uk/url?url=https://www.nice.org.uk/&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwj_xPaYjPTRAhWBchQKHbglAtQQFggeMAI&usg=AFQjCNFk62xwoMD-D6z6qShIK0SHEDG1rQ)  [https://www.**nice**.org.uk/](https://www.nice.org.uk/) |
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| Consultation / Acknowledgements with Staff, Peers, Patients and the Public | | |
| --- | --- | --- |
| **Name** | **Designation** | **Date Response Received** |
| Dr XX | Consultant gastroenterologist |  |
| Dr XX | Consultant gastroenterologist |  |
| Dr XX | Consultant Gastroenterologist |  |
| Sr XX | Gastro Unit Sister |  |
| Sr XX | Gastro Unit Sister |  |

| Definitions / Glossary of Terms | |
| --- | --- |
| BSG | British Society of Gastroenterology |
| COPD | Chronic obstructive pulmonary disease |
| CV | Cardio Vascular |
| DNA’s | Did not Attends |
| DOPS | Directly Observed Procedural Skills |
| ERCP | Endoscopic retrograde cholangiopancreatography |
| EUS | Endoscopic ultrasound scan |
| GA | General Anaesthetic |
| GI | Gastrointestinal |
| GRS | Endoscopy Global Rating Scale |
| GP | General Practitioner |
| HISS | Hospital Information Support System |
| HPB | Hepato-Pancreato-Biliary |
| IMCA | Independent Mental Capacity Advocacy |
| JAG | Joint Advisory Group |
| MD | Multi-disciplinary |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| NICE | National Institute for Health and Care Excellence |
| OAE | Open Access |
| PAS | Patient Administration System |
| PEG | Percutaneous endoscopic gastrostomy |
| RIDDOR | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations |
| SpO2 | Oxygen saturation |
| UGI | upper gastrointestinal |
| WHO | World Health Organisation |

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| Author / Divisional / Directorate Manager Approval | | | |
| **Issued By** | XX | **Checked By** |  |
| **Job Title** | Gastro Unit Nurse manager | **Job Title** | Gastro Unit meeting |
| **Date** | May 2017 | **Date** | May 2017 |

| Appendix 1: Gastro Unit values |
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| Appendix 2: Outpatient Care Pathway |
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| Appendix 3: Inpatient Care Pathway |
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| Appendix 4a: Referral form related to Endoscopy – ERCP |
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| Appendix 4b: Referral form related to Endoscopy – Ultrasound |
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| Removed by JAG to reduce file size |

| Appendix 4c: Referral form related to Endoscopy – Lower GI |
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| Removed by JAG to reduce file size |

| Appendix 4d: Referral form related to Endoscopy – Upper GI |
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| Removed by JAG to reduce file size |

| Appendix 3: Equality Impact Assessment Form | | | | | | | | | | | | | | |
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| **Department** | Gastro | | | **Service or Policy** | CORP/POL/010 | | | **Date Completed:** | | | |  | | |
| **GROUPS TO BE CONSIDERED**  Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders. | | | | | | | | | | | | | | |
| **EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED**  Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation. | | | | | | | | | | | | | | |
| **QUESTION** | | | **RESPONSE** | | | | | | | **IMPACT** | | | | |
| Issue | | | Action | | | | Positive | | | | Negative |
| What is the service, leaflet or policy development?  What are its aims, who are the target audience? | | | To ensure that employees of Blackpool Teaching Hospitals NHS Foundation Trust and contracting organisations are provided with a high quality occupational health service | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/ development impact on community safety   * Crime * Community cohesion | | | No | | |  | | | |  | | | |  |
| Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need. | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population? | | | No | | |  | | | |  | | | |  |
| How does the service, leaflet or policy/ development promote equality and diversity? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact? | | | No | | |  | | | |  | | | |  |
| Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups | | | No | | |  | | | |  | | | |  |
| Will the service, leaflet or policy/ development   1. Improve economic social conditions in   deprived areas   1. Use brown field sites 2. Improve public spaces including creation of green spaces? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/ development promote equity of lifelong learning? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/ development impact on transport?  What are the implications of this? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person’s ability to remain at home? | | | No | | |  | | | |  | | | |  |
| Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups? | | | No | | |  | | | |  | | | |  |
| Does the policy/development promote access to services and facilities for any group in particular? | | | No | | |  | | | |  | | | |  |
| Does the service, leaflet or policy/development impact on the environment   1. During development 2. At implementation? | | | No | | |  | | | |  | | | |  |
| **ACTION:** | | | | | | | | | | | | | | |
| **Please identify if you are now required to carry out a Full Equality Analysis** | | | | | | | **~~Yes~~** | | **No** | | **(Please delete as appropriate)** | | | |
| **Name of Author:**  **Signature of Author:** | |  | | | | | | | **Date Signed:** | | | |  | |
|  | | | | | | | | | | | | |  | |
| **Name of Lead Person:**  **Signature of Lead Person:** | |  | | | | | | | **Date Signed:** | | | |  | |
|  | | | | | | | | | | | | |  | |
| **Name of Manager:**  **Signature of Manager** | |  | | | | | | | **Date Signed:** | | | |  | |
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