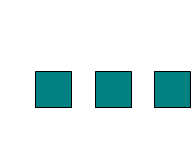
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**ENDOSCOPY OPERATIONAL POLICY**

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| **A) SUMMARY POINTS** |
| * Outline the purpose of Poole Hospital Foundation Trust Endoscopy Unit |
| * Outline the philosophy of the Unit |
| * Reflect the practices undertaken throughout the Unit |
| * Act as a guideline for all current and new Endoscopy staff |
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|  |
|  |
| **B) ASSOCIATED DOCUMENTS** |
| * Endoscopy Department Standard Operating Procedures |
| * Business Continuity Policy |
| * Endoscopy Admissions Procedures Policy |
| * Local Safety Standards for Invasive Procedures LocSSip |
| * Endoscopy Training Policy |
| * Trust Policies and Procedures |
| * Endoscopy Users TOR |

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| --- | --- |
| **C) DOCUMENT DETAILS** | |
| **Author:** | XX/ XX |
| **Job title:** | Senior Sister/ Senior Admissions Officer |
| **Directorate:** | Medical |
| **Version no:** | 2 |
| **Target audience:** | Endoscopy Users Group |
|  |  |
| **Approving committee / group:** | Endoscopy Users Group |
| **Chairperson:** | Dr XX |
| **Review Date:** | March 2019 |

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| --- | --- | --- | --- | --- | --- | --- |
| 1. **VERSION CONTROL** | | | | | | |
| **Date of Issue** | **Version No.** | **Date of Review** | **Nature of Change** | **Approval Date** | **Approval Committee** | **Author** |
| 28.1.14 | 1.1 | 28.1.15 | 13.6 added |  | EUG | XX |
| 20.11.14 | 1.2 | 20.11.15 | Organisational structure amended |  | EUG | XX |
| 1.03.17 | 2 | 1.03.20 | Policy review and re-write, |  | EUG | XX |

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| --- | --- | --- | --- |
| 1. **CONSULTATION PROCESS** | | | |
| **Version No.** | **Review Date** | **Author** | **Level of Consultation** |
| 2 | 1.03.17 | XX | EUG 12.04.2017 |
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1 **Introduction**

This policy is relevant to all Endoscopy staff and Endoscopy Users. The policy will be updated every 2 years or as regulations or new guide lines dictate

**2 Purpose**

The Purpose of the policy is to:

* Outline the framework of the Endoscopy unit and the strategic delivery of endoscopic services for the Trust and the community.
* Inform and support Endoscopy staff, current and new, as well as the multi -disciplinary teams Trust wide who rely on or who request endoscopic services.
* It aims to aid individuals in their understanding of the variety of endoscopic procedures undertaken in the department, along with an explanation of the patient pathway.
* To set out the roles and responsibilities of those working in the unit.

3. **Definitions**

This policy will outline the function and operation of the Endoscopy Unit, including the

Admissions process in managing the waiting list.

3.1 **Acronyms**

* AIRs form – Adverse Incident Reporting form
* ALIT – Any List in Turn
* APC – Argon Plasma Coagulation
* AQP – Any qualified provider
* BCSP – Bowel Cancer Screening Programme
* BSS – Bowel Scope Screening
* BDE- Bi –directional endoscopy – OGD/ Colo
* Bowel Preparation – a laxative used to clear the digestive tract prior to colonoscopy and flexible-sigmoidoscopy
* CaMIS/ e-CaMIS– Clinical and Management Information System used at Poole Hospital NHS Foundation Trust
* Colo – colonoscopy
* DATIX – electronic AIR system
* Dil – Dilatation; therapeutic procedure entailing the expansion of the GI tract
* DNAs – Did Not Attend; patients who fail to attend their allocated appointment without notification
* DOPS – Direct Observation of Procedural Skills
* DTA – Decision to Admit date; the date in which a clinician decides a patient requires an intervention (therapeutic or diagnostic)
* Endoscopy Diary – programme used to allocate appointments
* EMR – Endoscopic Mucosal Resection; fluid assisted polypectomy
* ERCP – Endoscopic Retrograde Cholangeopancreatography`
* EUG – Endoscopy Users Group Meeting
* EUS – Endoscopic ultrasound
* EBUS – Endoscopic bronchial ultrasound
* Fast Track – suspected cancer referrals that require an appointment within two weeks
* Freka – a gastroscopy tube which is inserted into the stomach to allow for feeding and medication
* F/S – Flexible-sigmoidoscopy
* FFT – Friends & Family Test
* GA – General Anaesthetic
* GAVE- Gastric Antral Vascular Ectasia
* GI – Gastrointestinal tract
* GI Reporting Tool – software used to produce procedure reports
* GIST- Gastro Intestinal Stromal Tumour
* GRS – Endoscopy Global Rating Score
* HPB – Hepatic Pancreatic Biliary
* HR – Human Resources
* IBD – Inflammatory bowel disease
* IDA – Iron Deficiency Anaemia
* JAG – Joint Advisory Group on GI Endoscopy
* JETs – JAG Endoscopy Training System
* MDT – Multi-Disciplinary meetings which take place for each clinical specialty
* OGD – Oesophageal Gastroduodenoscopy, also known as a Gastroscopy
* ODP – Operating Department Practitioner
* PALS – Patient Advice and Liaison Service
* PB1 – Partial Booking letter 1; letter sent to patients to inform them to contact the department to arrange an appointment
* PEG – Percutaneous Endoscopic Gastrostomy; tubing inserted into the stomach for feeding
* PEXACT - a balloon gastroscopy tube which is inserted into the stomach to allow for feeding and medication
* PP – Private Patient
* PPIs – Proton Pump Inhibitors; medication used to treat GI ulcers
* RTT – Referral To Treatment; this refers to the 18 week period in which non-urgent patients should begin treatment
* Sedation – this is not a general anaesthetic; sedation is used as means of relaxing the patient during a procedure
* TCI card – To Come In card; document detailing the procedure, referrer, decision to admit date, and any other relevant information
* TOR – Terms of Reference
* TET – Training the Endoscopic Trainers course
* TTT – Training The Trainers course
* +/- (plus or minus) – an additional treatment which may or may not be necessary.
* 2 WW– Two week wait

**4. ENDOSCOPY**

4.1 ENDOSCOPY PHILOSOPHY

Our aim is to provide optimum care for patients undergoing diagnostic and therapeutic procedures. Patient’s individual needs will always be the primary focus of our nursing care. The Endoscopy team will strive to achieve specialist care and maintain every aspect of patient’s dignity and confidentiality. The team will act as the patient’s advocate within the wider multidisciplinary team and support the patient throughout their short stay. By educating and informing the patient and their carer, we will facilitate continuity of care and safe transfer into their home environment.

The objectives of the department are to:

* Provide patient’s with sufficient knowledge that will empower them to make informed choices.
* Ensure patients retain their personal dignity by giving care with respect, reassurance and privacy whilst maintaining total confidentiality, and in accordance with their cultural and religious beliefs.
* Form a Partnership of Care by implementing the team model of nursing in order to ensure continuity of care from admission to discharge.
* Uphold the values of the Poole Approach.

4.2 OVERVIEW OF THE SERVICE

The Endoscopy Unit undertakes the following therapeutic and diagnostic procedures:

* OGD
* Therapeutic OGD (dilatation, oesophageal stent insertion, PEG insertion,gluing and banding of varices, APC, treatment of upper GI haemorrhage)
* Colonoscopy
* Therapeutic Colonoscopy (polypectomy, stent insertion, dilation, colonic tattooing, EMR)
* Flexible Sigmoidoscopy (banding of haemorrhoids)
* Bronchoscopy including cryotherapy and trans-bronchial needle aspiration)
* Thorocoscopy
* ERCP
* EUS
* EBUS

A surveillance programme is also adhered to, which ensures that patients at risk of GI cancer/abnormalities are invited back to Endoscopy within the appropriate timeframe. As the Hub for the Bowel Cancer Screening Programme (BCSP) for the South West of England, the department carries out 2.5 BCSP lists per week and 3.5 BSS lists over a four-week rotation. OGD, flexible-sigmoidoscopy and colonoscopy training lists are provided to support the training of Trainee Endoscopists. Further details on the training programme can be found in section.

4.21 The service is contracted to deliver 6 sessions at Wimborne Community Hospital as AQP- :

* Lead Clinician
* Governance to provide an endoscopist.
* Business continuity

4.3 LOCATION AND ACCOMODATION

The Endoscopy Unit at Poole Hospital Foundation Trust is situated in the Philip Arnold Unit (Entrance 6).

The Unit consists of three procedure rooms, one of which has X-ray facilities; all are equipped to be able to perform therapeutic and diagnostic colonoscopy, gastroscopy, flexible-sigmoidoscopy and EUS, and the facility to provide bronchoscopy, EBUS and Thorocoscopy.

The decontamination facilities, which are delivered by the Sterile Services Department, are also housed within the unit. This purpose built facility; comprises of four pass through automated endoscopic re-processors (AER), with eleven asynchronously functioning bays which support endoscopic reprocessing for the Unit and theatres, ITU and OPD.

Hepa-filtered cabinets enable the storage of a range of scopes, including specialist scopes, to be available for up to 7 days. The entire process has complete track and traceability throughout the use of the reprocessing cycle

Other accommodation consists of:

* Clean utility room
* Endoscopy administration managers office
* 3 Patient admissions rooms
* 2 discharge rooms / one of which is a breaking bad news room
* 2 gender segregated recovery wards
* 2 gender segregated pre-procedure waiting areas
* 1 side room / private patient area
* Sluice
* Storage room for general consumables
* Linen storage
* Admissions office
* Sister’s office
* Team office
* Staff room
* Staff changing facilities
* Six WC facilities, twoof which has disabled access

4.4 OPENING TIMES

The department currently functions Monday – Friday 08.00-19.00, Wed to 22:00hrs and every other Saturday AM for inpatients (excluding Bank Holidays)

An out-of-hours service for emergency Upper GI Haemorrhage patients is provided by an on-call endoscopist and endoscopy nurse. Weekdays 19:00 – 06:00hrs and 24 hrs weekends and Bank Holidays

4.5 ENDOSCOPY SESSION PLAN

Scheduling of sessions in Endoscopy runs on a four-week timetable (please refer to the Endoscopy Admissions Policy for an example of the timetable) This is subject to change due to leave, additional lists and the flexibility of the Nurse Endoscopist and clinicians to put on lists

4.6 PATHWAYS

4.6.1 Clinical pathways

Clinical pathways are agreed with local commissioners.

**4.6.2 REFERRAL AND VETTING PROCESS**

All referrals for Endoscopy are vetted according to the Admissions SOP. The department operates a list pooling system, under which patients are assigned to an Endoscopist as per their clinical need, not the referring clinician. However, particular patients require various input/treatment, and consequently there are some specifications as to which clinicians perform the procedure.

Referrals will only be accepted if they are made through the proper documentation; this includes Choose and Book forms, open access forms, TCI cards from outpatients, inpatient referral form, internal surveillance form, Dorset Cancer Network Fast Track referral form, and letter/email from Poole Hospital NHS FT Endoscopist. If a referral does not meet the necessary criteria, the referral is returned to the referring clinician.

Referrals must be categorised as either “Routine” or “Urgent”; routine patients should be seen within six weeks of the DTA, and urgent/suspected cancer referrals should be seen within two weeks of the DTA. It is the role of the admissions office to ensure that patients receive an appointment within these timeframes, and to provide the patient with all the relevant information regarding the procedure and the preparation needed. Please see the Admissions SOP for full details.

The admissions office accepts referrals from a range of sources including:

* EXTERNAL REFERAL

All external referrals (those from Primary Care, other clinical specialities, and other Hospitals) are vetted and countersigned by an Endoscopist. The Endoscopist decides, based on the information given, what procedure (if any) the patient requires, and the urgency of the procedure (Routine or Urgent). This will also identify if there are any particular requirements, such as therapeutic input. The Endoscopist may return the referral to the referring source if there is not enough clinical information on which to base a decision. This does not apply when referrals are received from an outpatient clinic appointment.

* OUTPATIENT REFERAL

Patients who are referred for an Endoscopy from an outpatient appointment may, if they wish, bring their TCI to the Endoscopy reception desk immediately after their outpatient appointment to book their Endoscopy slot.

Inpatient referrals

Inpatient referrals must be reviewed and signed by an Endoscopist to ensure the referral is appropriate, before the patient is allocated a slot.

* SURVEILLANCE PATIENTS

Patients who have been previously diagnosed and/or treated for cancer, as well as those who require on-going monitoring are placed onto a surveillance programme, in which they are transferred onto the active waiting list once they are due for their procedure. These patients are validated clerically and clinically prior to allocation of an appointment.

Two months prior to the TCI date for surveillance patients, a letter is sent to inform the patient that their clinical notes will be reviewed; upon nurse endoscopist / senior nurse, and where indicated, clinician review, a further letter is be sent to the patient explaining the outcome of the review, and whether or not the patient requires an Endoscopy procedure at this time or if it is being delayed to a future date.

If it is decided that the patient should attend for a surveillance procedure, a PB1 is sent to the patient, asking them to contact the department to arrange an appointment.

Please refer to the **Endoscopy Surveillance SOP** for full DETAILS

* Fast Track referrals

Dorset Cancer Network Fast Track referrals indicate a patient requires an urgent appointment within two weeks. Fast Track referral forms are reviewed by a Clinicianto determine whether the patient should come straight to test or to an outpatient’s appointment.

Those directed straight to test, are contacted by a Staff Nurse who determines if the patient is fit for bowel preparation (if necessary) and clarification of symptoms. Where appropriate this will be further discussed with a Clinician.

* + 1. appropriatness of Referrals

Vetting is an on-going process; at the time of test, a vetting form is completed by the Endoscopist regarding the appropriateness of the referral. Where an inappropriate referral is identified, this is fed back to the referrer.

In the event that problems are identified with inappropriate referrals, an action plan with a timeframe will be implemented. This may be communicated to the local commissioners.

General Practitioner indicates on referral if fit for prep.

* + 1. Waiting list management

The management of the booking process is reviewed regularly and discussed at the admission office monthly meetings. Any changes to the booking process agreed within these meetings are shared with the Senior Sister and monitored at following monthly meetings.

* Monitoring and Validating the waiting list

The Endoscopy Administration Manager extracts the waiting list from CaMIS weekly to monitor and validate the waiting list to ensure that the booking process has been implemented appropriately. This report is also used to identify any patients who require expediting (i.e. have waited over six weeks or who are going to wait over six weeks). Referral data gathered from this report is also used to determine capacity needs.

* Monitoring of DNAs and patient cancellations

Depending on the referral, patients can cancel an appointment up to two times before being taken off the waiting list and the referral returned to the requesting clinician.

All patients who fail to attend without notification (DNA) will be removed from the waiting list and the referral returned to the requesting clinician.

A quarterly report is generated by the Information Department which looks at the number of DNAs and patient cancellations. This is reviewed as a standing item at Endoscopy User Group meetings.

4.7 ADMISSION CRITERIA AND ENSURING ACCESS FOR ALL

There are no restrictions on age, co-existing conditions or mobility with regards to adult patients, unless the relevant Endoscopist determines so.

* All Paediatrics under 12 years old will be accommodated in the Day Case Unit or Children’s Unit, and the procedure will be undertaken in theatre, supported by Endoscopy staff.
* All children aged between 12 and 16 years old will be able to select whether they are treated on an adult or paediatric list.
* Adults with Learning Disabilities or Vulnerable Adults will be assessed and arrangements will be made in accordance with their individual needs.
* The department is able to book translators and signers in line with the Trust’s Interpreting and Translating Services Policy.
* Hospital transport can be made arranged through the admissions office for those with mobility issues.
* Patient information leaflets can be made available through PALS, in braille and other languages.
* Bariatric equipment is available as required and is used in line with the Trusts Bariatric Policy.

For those patients who require a GA for their procedure, this is done in line with the agreed GA pre-assessment SOP for adults and juveniles.

* 1. ENDOSCOPY LISTS

The Endoscopy Administration Officer uploads the Endoscopy list templates onto the Endoscopy diary weekly. This ensures that the Diary is able to show all available slots for the next six weeks and prevents the booking of patients beyond six weeks.

Endoscopists must give a minimum of six weeks’ cancellation notice as per Trust Policy, this is to ensure that cancelled lists do not go live on the Diary (as lists are put onto the Diary six weeks’ in advance).

The Endoscopy Administrative Manager liaises with the Senior Sister to ensure there is sufficient staffing and the list can go ahead before it is put onto the Diary.

Each list has 10 slots, except for training lists and Nurse Endoscopist lists which generally have 8 slots. Some Endoscopists have 12 slot lists, which are mutually agreed between the department and the Endoscopists.

Morning lists begin at 09:00 and run until 12:30. Afternoon lists begin at 13:30 and end at 17:00. GI bleeder sessions are done in between morning and afternoon lists. There is a Saturday in- patient urgent session.

4.8.1 APPOINTMENT ALLOCATION

Please refer to the Endoscopy Admissions Procedures Policy for the full process.

When a referral is received by the office and has had all the appropriate sign-offs, the admissions officer will look on the Endoscopy Diary to find the next appropriate slot according to the patient’s needs and the requesting clinician’s instructions. All efforts will be made to ensure that patients are put on appropriate Endoscopist lists, for example, medical patients are allocated on medical Endoscopist lists.

Choose and Book patients are informed of the choices available on the Endoscopy Diary. Patients are given a choice of at least three appointments.

Patients who are not referred through Choose and Book are sent a PB1 letter, asking them to contact the department to agree a suitable appointment. Patients are given a choice of at least three appointments.

4.8.2 Admission

Upon arrival at the Unit, patients check in using self-service system, a receptionist is available to assist and amend details as require as per **Admissions SOP** in compliance with the **Trust Information Governance Policy.** Relatives and friends are welcome to wait with the patient until the Nurse comes to admit them, however, in order to maintain the privacy and dignity of the patients undergoing procedures and establishment restrictions, relatives and friends are unable to remain in the department until collection.

Nursing staff will collect the patient from the reception area, and lead them into the department, indicating the facilities within the department.

The admissions process consists of a series of health checks to ensure the patient is fit for the procedure and gaining consent from the patient. The procedure is explained to the patient, what to expect during and after the procedure, the options available regarding sedation, and the risks associated with the procedure.

Inpatients are collected from the wards by Endoscopy Porter Support Workers; it is only on confirmation that patients are appropriately prepared for the procedure and have signed consent forms that the patient will be collected from the ward to attend Endoscopy in accordance with the **Trust Transfer Policy.**

4.8.3 Consent

All patients are asked to sign a consent form before entering the procedure room, to indicate they agree to have the procedure, understand the associated risks, and agree to any relevant treatment in the case of an emergency, including blood transfusion. This is undertaken in line with the **Trust’s Consent Policy**.

The department adheres to the **Mental Capacity Act**; in cases where the patient is deemed to lack capacity, the relevant clinician with make a decision based on clinical need. Please see the **Endoscopy Consent Policy** for full detail.

* + 1. Procedure

Patients will either walk into the procedure room or are transferred to the procedure room on their trolley; this is dependent on patient’s mobility.

All patients who have intravenous (IV) sedation will have had an IV cannula inserted by the admitting Nurse. These patients will have supplementary oxygen and monitoring of blood pressure, pulse, oxygen saturation and respiration throughout the duration of the procedure. Those undergoing General Anaesthesia will be under the care of an anaesthetist and ODP.

* + 1. Recovery

Following the procedure, patients are returned to the recovery area; where they will remain on the trolley until the immediate post-procedure recovery is complete. Once patients are sufficiently fit to do so, they may get dressed and move to the step-down recovery/discharge area. Here they will be offered refreshments whilst they await discharge.

* + 1. DISCHARGE

Discharges are carried out in accordance with the Endoscopy Discharge SOP

Only registered Nurses who have the appropriate assessment and discharge skills may discharge patients; this takes place in the interview room to maintain patient confidentiality, where the outcome of the procedure is discussed, including suspicion of malignancy (only if suitable). It is here that the discharge plan is discussed and reinforced with the patient and relative/carer, if applicable.

If appropriate, the patient will be referred to the Colorectal/Upper GI Cancer Nurse Specialist, who will be made aware and visit the patient where possible before discharge.

If the Endoscopist requests a repeat scope to be performed following a course of treatment (e.g. a course of PPIs) or period of monitoring, the referral and TCI card will be made at the same time; the Nurses will liaise with the admissions office to agree an appointment prior to the patient being discharged.

Any take home medication prescribed from the unit will be free of charge.

Inpatients will be transferred back to their ward when fit and ready; Endoscopy Porter Support Workers transfer patients between Endoscopy and the wards with a trained Nurse as required see Trust Transfer Policy.

* + 1. REPORTING

A report must be generated for all GI endoscopic procedures performed using Unisoft’s GI or Lung Reporting Tool. The report includes any findings during the procedure, any biopsies taken and any follow up details (e.g. medication re-scopes).

At the time of the endoscopy report being generated, four copies are printed; one is filed in the patient notes, one for the referring Consultant/GP, one for the patient (only if suitable), and one for the Clinical Coding Department.

All patients are offered a copy of the endoscopy report, only if it is deemed suitable. If it is not deemed suitable, this is recorded in the patient notes.

Endoscopy reports are sent by post to the referring Consultant/GP within one working day. Reports for inpatients are returned with the patient.

Where a cancer diagnosis is expected a copy of the report will be faxed to the relevant MDT co-ordinator.

4.8.8 PATHOLOGY RESULTS

If biopsies have been taken, this is recorded on the endoscopy report and the patient informed when results will be available. It is the responsibility of the Endoscopist to act on biopsy reports. Histology forms should have the name of the Endoscopist, and a copy sent to the referrer if appropriate.

Histology reports should be seen by the Endoscopist and appropriate action taken within five working days of receipt of the report. For cancer diagnosis, a copy of the histology report should be dispatched to the referrer within one working day of receipt of the report and communicated to the relevant MDT.

Patients not requiring a hospital follow up appointment are discharged back to the care of their GP. Patients are advised to obtain pathology results through their GP after two to 3 weeks.

**5. ROLES AND RESPONSIBILITIES**

5.1 Management and responsibilities

The Endoscopy Unit sits within the Medical Clinical Care Group. The Endoscopy management team are accountable to the Deputy Chief Operating Officer, Care Group Manager, Clinical Director and Matron.

The management team is responsible for:

* Promotion of the service
* Efficient and effective use of the unit
* Managing the endoscopy waiting list
* Liaising with commissioners, stakeholders, public users, other departments and other trusts

The Endoscopy Unit Sister is responsible for the management of the Unit; including the management of the nursing staff in conjunction with the Deputy Sisters /Charge nurses, the make-up and utilisation of the lists, the running of the department, the admissions office and liaising with clinical colleagues

The Endoscopy Clinical Lead collaborates with the Endoscopy Sister to define overall strategy for the unit; this includes monitoring of clinical performance through regular auditing, developing and improving clinical pathways, and providing a link between Endoscopists and the department

Nursing staff are responsible for all aspects of caring for patients undergoing Endoscopy from admission, throughout the procedure to discharge.

Admissions Officers are responsible for receiving appointment requests, distributing these for validation and classification, finding appropriate appointments and communicating said appointment with all who will be involved (patient, clinician, nurses).

Clinical responsibility for the patient lies with the endoscopist, which includes Consultants, Associate Specialists, identified Specialist Registrars (SpR 1-5) and Nurse Endoscopists.

**Care Group Manager - Medicine**

**Clinical Lead**

Medical Clinical Care Group

**Endoscopy Senior Sister**

**Medicine - Matron**

**Endoscopy Clinical Lead**

**Lead Nurse Endoscopist**

**Band 8a**

**Deputy sister/charge nurse Band 6**

**Endoscopy Admin Manager**

**Band 5**

**Staff Nurse**

**Band 5**

**Nurse Endoscopist**

**Band 7**

**Vacant**

**Assistant Endoscopy Practitioner Band 4**

**Admissions Officers**

**Band 3**

**Senior Auxiliary**

**Band 3**

**Receptionist**

**Band 2**

**Ward Clerk**

**Band 2**

**HCA/Patient Support Worker**

**Band 2**

5.2 Unit staff

* Staff Establishment

The nursing establishment consists of a Band 8 Senior SisterBand 8 Lead Nurse Endoscopist, 3 Deputy Sisters, 1 Deputy Charge Nurse Staff Nurses, Assistant Endoscopy Practitioners, Senior Auxiliary Nurses, HCA, Patient Support Workers and a Ward Clerk.

Administrative and clerical support is provided by an Endoscopy Administration Officer, Admissions Officers and a Receptionist.

The staffing establishment is reviewed on a regular basis to ensure it meets the needs of the service and to ensure an appropriate skill mix.

* Skill Mix

The unit has a multi-skilled workforce, which enables efficient, flexible working. All new Nursing staff undergo a comprehensive competency based training programme with experienced staff members acting as mentors. Staff are fully supported in the attainment of relevant Post-Registration courses.

* Induction

All new Health Support Workers, Nurses and Student Nurses are issued with a Knowledge and Skills Competencies workbook to provide an introduction to the clinical area, to identify knowledge & skills relevant to the clinical area and to support personal development. All new staff are assigned a mentor (who is trained in learning and assessing) and an associate mentor.

* Appraisals and Training

The unit adheres to the Trust HR policies with regards to appraisal, performance and attendance. Individual performance reviews are undertaken annually, unless there is a need for more frequent review and support.

All staff undertakes regular mandatory core and clinical skills training as required. The regularity of attendance is measured and reported to the Board on a quarterly basis.

A training needs assessment is conducted annually to identify any additional training for staff to support their personal development and communicated to the Education Department. When staffs are unable to access in-house training, staffs are able to access training from external providers.

Staff surveys are conducted annually; these cover areas such as work/life balance, training provision, appraisals and work environment. At Ward meetings, action plans are discussed and agreed with appropriate timeframes.

5.3 Communication

* Daily morning Briefings

Daily morning briefing sessions are held at 08.00 on the Ward to confirm nursing allocations, lists and any other arising matters. These meetings are logged in the Team Meeting book for members of staff who begin work after 08.00.

* Ward Meetings

Ward meetings are held regularly in which discussions regarding the day-to-day running of the unit, as well as wider Trust news. Nursing staff are briefed on any changes to current practice, policy and procedure. Staffs also have the opportunity to raise any ideas, issues and concerns.

Ward meetings provide an opportunity for staff training, both in-house and external providers.

Endoscopy Users Group (EUG).

All staff involved with Endoscopy, including Clinicians, Care Group Managers and Divisional Directors are invited to attend quarterly EUG meetings. This group is chaired by the Endoscopy Clinical Lead and is an opportunity for formal communication between Endoscopists and the department.

30 day mortality and 7 day readmission are reviewed and presented at quarterly EUGs. Where appropriate and necessary, action plans are decided and agreed at EUG.

Matters arising from Clinical Governance and training issues can also be discussed.

* Communicating beyond Endoscopy

The Senior Sister meets with the Care Group Manager and/or Matron as required and finance representative.

The Senior Sister (or her deputy) attends the monthly Heads of Department meeting and Divisional Risk Management meetings to report on the performance and risks within the unit.

Formal reports on performance relating to access targets, risk, finance, activity, HR and strategy are communicated through the management structure to the Division and the Board.

5.4 AUDITS

A rolling audit programme is in place to correspond with the requirements of GRS. It includes patient and staff satisfaction surveys, vetting and outcomes of endoscopy e.g. completion rates and sedation rates. All operators are included (both independent Endoscopists and those in training). These are presented and reviewed at the meetings with action points being determined. Where appropriate (e.g. colonoscopy outcomes), the results are sent to individual’s and when necessary, action plans are drawn up for suboptimal performance.

5.5 EUG

* All staff involved with Endoscopy, including Clinicians and Care Group Managers are invited to attend quarterly EUG meetings. This group is chaired by the Endoscopy Clinical Lead in accordance with terms of reference **TOR** is an opportunity for formal communication between Endoscopists and the department.

Standing items on the agenda are:

* + - Adverse incidents (new and monitoring of previous incidents).
    - Fast Track Audit results.
    - 30 day Mortality and Morbidity Audit results.
    - Readmission (within seven days) Audit results.
    - Compliments and Complaints.
    - FFT results.
    - Comfort Score Audit results.
    - Audit of Quality Standards.
    - Operational Policy Review (2 yearly).
    - Review of patient information (2 yearly or more frequent if needed).
    - Review **of Endoscopy SOPS**, guidelines and documentation (2 yearly or more frequent if needed).
    - Waiting list & performance (including DNAs, cancellations, breaches and booking process review twice yearly).
    - Patient satisfaction survey.
    - Where appropriate and necessary, action plans are decided and agreed at EUG.
    - Matters arising from Clinical Governance and training issues can also be discussed.

5.6 PATIENT feedback

A patient satisfaction survey is undertaken annually; appropriate action plans and timeframes are agreed at EUG.

There are on-going feedback forms (FFT) available in the department for patients/relatives to complete. Any suggestions made by patients are reviewed by the department and decisions are made at EUG and appropriate actions taken forward with immediate effect.

Patients are invited to join a readership panel with PALS.

6 Training

6.1 Endoscopist Training

Trainee Endoscopists are issued with an Induction Package which outlines departmental information, information on supervision and assessment, relevant guidelines and processes as well as an individual training plan which will be discussed and agreed with the Training Lead.

Trainees should provide regular feedback on trainers using JETS, in which trainers will receive annual feedback from the Training Lead. Areas of concern about training from the feedback will be discussed with the trainer and an action plan agreed. A further feedback analysis will be provided within six months; if there is no improvement, the trainer will no longer be able to train and will continue with normal lists.

The Unit’s Lead Nurse Endoscopist will line manage and support the training of Trainee Nurse Endoscopists. Trainee Endoscopists (SpR/Consultants) will be supported by the department’s Endoscopists. The department has identified Endoscopy staff to support the training of Endoscopists.

Please see the Endoscopy **Training Policy** for full details.

6.2 Monitoring Endoscopist competence

* Trainee Endoscopists

All trainees must be registered with JAG; trainees will undergo a review of experience by the Training Lead. Trainees must attend an endoscopy foundation course at the start of training if this has not already been completed. Trainees must be registered with JETS and complete the formative DOPS forms. Summative assessments will be arranged when the necessary criteria are met.

Supervision of trainee Endoscopists should continue until the trainee is signed off by a Consultant as competent, once JAG criterion is met. A register of trainees permitted to work independently is kept within the unit.

If completion rates, sedation levels or comfort scores (or any other relevant competence) falls outside the acceptable ranges (according to JETS), the trainee is expected to attend additional training lists. All procedures will be re-audited within three months.

Trainees failing to show an improvement in competence will be considered for further basic endoscopy training courses and targeted training for a further three months when a further assessment by independent trainers will be performed. Should no improvement be seen, Trainee Endoscopists will be advised against continuing training in Endoscopy.

* Endoscopists

Endoscopy trainers should have completed a **TTT/TET** course.

The numbers of procedures, sedation levels, completion rates, comfort scores and patient acceptability (for colonoscopy) is audited twice yearly as part of GRS comfort audit. Results are fed back within three months of the audit by the Lead Clinician.

If the results of an audit are deemed unsatisfactory for a particular Endoscopist:

* Discussion will be held between the Lead Clinician and the Endoscopist concerned.
* Re-audit after three months..
* Review following a further three months to check for improvement.
* If there is no noticeable improvement, it is at the discretion of the Lead Clinician as to what action will be taken; may include a period of compulsory retraining.
* If the Endoscopist fails to engage with the recommendations/retraining, they will no longer be permitted to perform Endoscopic procedures and may include referral to doctors/Trust disciplinary process.

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6.3 PATIENT COMFORT LEVELS

During the procedure, patient comfort levels are monitored continually and action is taken to address patient discomfort in accordance with the **Unit’s Consent Policy**.

Patient comfort score audits are undertaken twice yearly; this is reviewed by the Lead Clinician. It is the responsibility of the Lead Clinician to feedback to all of the Endoscopists regarding their patient comfort scores.

If the results of an audit are deemed unsatisfactory for a particular Endoscopist:

Discussion will be held between the Lead Clinician and the Endoscopist concerned

Re-audit after three months including a review of the Endoscopist’s safe sedation practice and technique and further assessment of comfort scores

Review following a further three months to check for improvement

If there is no noticeable improvement, it is at the discretion of the Lead Clinician as to what action will be taken; may include a period of compulsory retraining

If the Endoscopist fails to engage with the recommendations/retraining, they will no longer be permitted to perform Endoscopic procedures and may include referral to doctors/Trust disciplinary process.

**7. Monitoring Compliance and Effectiveness of the Document**

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The compliance with this policy will be the responsibility of the Medical Care Group, General Managers, Lead Clinician and Endoscopy Users Group

**8. Supporting Documents**

* Trusts Major Incident Policy
* Trusts Consent Policy
* Information Governance Policy
* Trusts Bariatric Policy
* Decontamination Policy
* Adverse incident Reporting Policy
* Trusts Interpreting and Translating Policy

**9. Review**

Policy review will be at two years or sooner as required to address significant change. Two year review date March 2019

**11. Equality Impact Assessment**

EQUALITY IMPACT ASSESSMENT Appendix ??

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| Date of assessment: | January 2009 reviewed January 2014 |
| Care Group or Directorate: | Nursing and Governance |
| Author: | Mandy Baker |
| Position: | Assistant Director of Nursing- Governance |
| Assessment Area:  (i.e. procedure/service/function) | Controlled documents such as policies, procedures, protocols, guidelines and standards |
| Purpose: | To outline the process and provide guidance on the procedures to be followed for the creation, approval, publication and review of all trust procedural documents. |
| Objectives: | To guide staff on how to prepare documents and inform process/procedures for ratification and dissemination ensuring the style is concise, clear and using unambiguous terms and language. |
| Intended outcomes: | Ensuring a standardised approach is adopted throughout the Trust to ensure high quality and consistent corporate identity is maintained. |

What is the overall impact on those affected by the policy/function/service?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ethnic Groups | Gender groups | Religious Groups | Disabled Persons | Other |
| High/Medium/ Low | High/Medium/ Low | High/Medium  /Low | High/Medium  /Low | High/Medium/  Low |
| Low | Low | Low | Low | Low |

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| Available information: |

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| Assessment of overall impact:  Format specified for documents will make them easier to read and standardisation will make it easier to find and search information. |

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| Consultation:  Hospital Executive group/ Operational management group/ HR/ Matrons |

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| Actions: None identified |