Endoscopy Operational Policy

Department / Service:	Endoscopy	
Originator:	Loraine Mahachi Lynne Mazzocchi Gina Gill Dr Ian Gee	Endoscopy JAG/Governance Sister Endoscopy Directorate Manager Directorate Support Manager Consultant Gastroenterologist
Accountable Director:	Mr Richard Lovegrove	Clinical Director - Endoscopy
Approved by:	Endoscopy Directorate Group SCSD Governance Meeting	
Date of Approval:	28th April 2021	
Review Date: **This is the most current document and should be used until a revised version is in place**	28th July 2024	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust	
Target Departments	Endoscopy	
Target staff categories	All Endoscopy staff	

Policy Overview:

This policy outlines the processes followed in Endoscopy and provides reference material on these processes. This policy applies to all Endoscopy staff and all Multi-disciplinary teams involved with Endoscopy across the county. JAG requirements are referenced throughout the policy and processes set to follow JAG standards.

The Endoscopy units aim to provide a non-judgemental, confidential, patient focused environment.

Our mission

Working together with our partners in health and social care we will provide safe, effective, personalised and integrated care for the local population, delivered consistently across all services by skilled and compassionate staff.

4Ward is our Trust-wide culture change programme that is helping us build a more positive, supportive workplace for the benefit of our patients and colleagues. At its heart are the four 4Ward Behaviours. Our aim is to have all staff positively demonstrating these behaviours and working together to achieve our shared goals. The behaviours are:

- Do as we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together.

Key Amendments made to this document

Date	Amendment	Approved By:
March 2013	New Policy	
25/04/2016	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
August 2017	Document extended for 6 months as per TMC paper approved 22nd July 2015	TMC
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
October 2018	Revised policy document rewritten. Previous authors names removed. Document approved for two years at SCSD Governance Meeting	SCSD Governance Meeting
April 2021	Policy Revised and approved	SCSD Governance Meeting
16th April, 2024	Document extended for three months.	Karen Macpherson

Table of Contents

1. Introduction

2. Scope of this document

2.1. This policy applies to all staff involved in countywide endoscopy services: Alexandra Hospital, Redditch; Evesham Community Hospital; Kidderminster Treatment Centre; Malvern Community Hospital; and Worcestershire Royal hospital.

2.2. This policy is a guide to users and covers the main objectives of the Endoscopy Unit and is based on guidance from national documents.

2.3. The intention of all documents linked to this operational policy is to advance the practice of Endoscopy services provided in the Trust, to the levels and quality required by the National Guidelines and to surpass these requirements wherever possible. This policy supports standards set out by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) and aims to continuously achieve high standards.

2.4. The Operational policy will be supplemented with guidelines, standards and protocols prepared by the individual clinical disciplines, endoscopy staff and management and the Trust Board.

2.5. This document relates to all procedures undertaken in the Endoscopy Units and specific designated areas.

2.7. This policy includes activity undertaken by insourcing or locum teams within WAHT.

2.8. This policy applies to all staff involved with the care of patients attending the Endoscopy Unit for diagnostic or therapeutic procedures. This policy also applies to any staff associated with Endoscopy.

3. Definition of key terms

BCSP	Bowel Cancer Screening Programme
DATIX	Incident reporting system
Day case	A patient elected to be admitted during the course of the day with intentions of receiving care, who is not intended to require the use of a hospital bed overnight and returns home as scheduled.
Diagnostic	Diagnostic test is a medical test performed to aid in the diagnosis or detection of disease.
E-consent	Electronic consent system used to print forms to obtain consent from patients.
E-Roster	Flexible approach to meet the needs of the service scheduling (electronic)
ECH	Evesham Community Hospital
ERCP	Endoscopic Retro-grade Cholangio-pancreaticography (These procedures are performed in radiology)
ESR	Electronic Staff Record
EUG	Endoscopy User Group
FIT	Faecal Immunochemistry Test
FOB	Faecal Occult Blood Test
GIN	Gastrointestinal Endoscopy for Nurses
GRS	Global Rating Scores
Inpatient	Patient that requires an overnight stay as part of an elective or

	emergency admission.
JAG	Joint Advisory Group
JETS	JAG Endoscopy Training System
KTC	Kidderminster Treatment Centre
MCH	Malvern Community Hospital
NMC	Nursing & Midwifery Council
PDR	Personal Development Review
PEAT	Patient Environmental Action Team. Quarterly inspection to check that infection control, house-keeping and estates are in order.
RTT	Referral to Treatment
Therapeutic	Attempted remediation of a health problem following a diagnosis.
Unisoft	Electronic endoscopy reporting system – used to maintain endoscopy waiting lists, populate list templates, record and generate procedure reports and audit outcomes against national benchmarks
WRH	Worcester Royal Hospital

4. Responsibilities and Duties

4.1. Endoscopy Booking Co-ordinators/Receptionist/Secretaries
All Endoscopy Booking Co-ordinators/Receptionists are responsible for adhering to this policy and the incorporated Endoscopy Booking Policy.

4.2. Endoscopy Nursing Staff
All Endoscopy nursing staff are responsible for adhering to this policy.

4.3. Clinical Endoscopists
All Clinical Endoscopists are responsible for adhering to this policy.

4.4. Clinical Director for Endoscopy
Overall responsibility for this Operational Policy.

4.5. Directorate Management Team for Endoscopy
Overall responsibility for the non-clinical aspects of this Operational Policy and the Endoscopy Booking Policy.

4.6. Endoscopy Service Support Manager/Endoscopy Admin Team Leaders
Overall responsibility for the implementation, training, communication, adherence and evaluation of this policy and the Endoscopy Booking Policy.

4.7. Operational Policy Author
Ensure the requirements set out in this policy are followed.

4.8. Hospital staff linked with Endoscopy
All hospital staff linked to Endoscopy are responsible for adhering to this policy.

4.9 All Staff
Ensure that their practice is in line with key documents applicable to their work. Information regarding failure to comply with a policy must be reported to the line manager and, where it is appropriate, report this using the incident reporting system.

5. Policy Detail

5.1. Policy Statement

- The Endoscopy service at Worcestershire Acute Hospitals NHS Trust is provided across 5 hospital sites. These include Worcester Royal Hospital, Alexandra Hospital, Kidderminster Treatment Centre, Evesham Community Hospital and Malvern Community Hospital. The service provides care to adult NHS elective, emergency and cancer pathway patients as well as occasional private patients.

- Paediatric patients are treated at WRH only. A range of therapeutic and diagnostic endoscopic procedures are offered across the county. The majority of patients will be outpatients and procedures are usually undertaken within normal working hours. An out of hours bleed service is available for emergencies. The Trust provides training for both nursing and medical staff, in accordance with JAG, JETS and JETS workforce.

5.2 Site Information

- Malvern Community hospital is utilised by the Trust to provide Bowel Cancer screening. It has one procedure room, three recovery pods and two admission rooms. The nursing staff that provide this service are from the Worcester Royal Hospital endoscopy unit. The site has own decontamination unit with two pass-through endoscope decontamination washers and a drying cabinet.

- Alexandra Hospital in Redditch has 2 dedicated procedure rooms. The unit provides diagnostic and therapeutic endoscopy procedures and has an on-call gastrointestinal bleed service. It has recently commissioned a new decontamination facility with 3 double pass-through endoscope washer disinfectors. The unit has access to two admission rooms. There are separate male and female recovery areas with a total of 13 recovery spaces. There is a small waiting area to service the two rooms. It is acknowledged by the Directorate that this is too small an area. There are plans to relocate the unit to a larger template within the hospital which will support a dedicated three room facility.

- Kidderminster Treatment centre has two rooms one used for diagnostic GI procedures, and urology procedures. The unit has a decontamination facility, 2 admission rooms, 2 recovery beds and 4 chairs in recovery stage 2. There is a business case being developed to relocate the unit to a much larger footprint within the hospital which will support 4 rooms and a new decontamination facility.

- Worcester Royal Hospital has 3 procedure rooms. There are 2 admission rooms and separate male and female recovery areas with a total of 14 beds. The unit provides diagnostic and therapeutic endoscopy procedures and an on-call GIB service.

5.3 Leadership and Organisation

- Endoscopy services are part of the Specialised Clinical Services Division (SCSD) (See appendix for Endoscopy organisational Structure). The Division encompasses a huge variety of clinical services- from Outpatients and ambulatory activity to some of the most complex patients on our premises in Critical Care.

- The management team is comprised of the following: Directorate Manager, Matron, Consultant Clinical Director and Directorate Support Manager who is also the waiting list manager.
- The service is supported by band 7 JAG/Governance Practitioner who is responsible to steering quality governance, quality assurance and quality improvement within the service.
- Each endoscopy department unit is managed by a Band 7 nurse and supported by at least one Band 6 sister/charge Nurse.
- The endoscopy leadership team are responsible for the service and report directly to SCSD for both clinical governance and performance.

5.4. Endoscopy Directorate Meetings

- There is a leadership team comprising of clinical, nursing and managerial lead roles, each with defined responsibilities, there is a defined governance structure for the endoscopy service with clear lines of accountability
- The leadership team has the managerial, administrative and technical support to organise and deliver the service effectively.
- Endoscopy Directorate business meetings and governance meetings are held on a monthly basis. These meetings run separately but are held consecutively. The team work to an agenda to discuss endoscopy-specific items. Minutes are taken at all meetings and are made available to all staff. Any agenda items are sent to the Endoscopy Directorate Manager Secretary
- Endoscopy users group (EUG) meetings are held twice a year in each in quarter 2 and quarter 4. Clinical audits are presented and discussed at this meeting and any key learning shared within the service. The EUG ensures that there is a clear communication structure throughout the Endoscopy Service and to share and agree improvement ideas and processes, to support the organisation with the delivery of the countywide Endoscopy service strategy. The group will provide assurance that governance standards within the Trust are adhered to, along with providing evidence that all JAG GRS requirements are achieved and maintained.

5.5 Access and booking

- The endoscopy service has a dedicated booking team responsible for booking endoscopy procedures. They are supported by the booking team leaders and supervised by the directorate support manager.
- Where possible all appointments should be directly booked. Reasonable notice and choice should be offered to the patient and the appointment must be booked at the same time or within one day of the decision to admit.
- All diagnostic procedures are to be pooled across all Endoscopists appropriate to that procedure. Consultants reserve the right to choose to endoscope named patients on their lists. Patients requiring advanced therapeutic procedures may be nominated to specific consultant lists.
- The endoscopy unit will aim to meet the social, disability and cultural needs of patients accessing the service and these are recorded as a part of the nursing assessment.
- The unit will monitor demographic and/or language profile of the population served
- The Trust has provisions for interpreting service and the unit discourages the use of family and friends as interpreters during consent process. However, we encourage family involvement in patient care with the patient's consent.

5.6 Productivity and Planning

- The endoscopy waiting list coordinator/directorate support manager will be responsible for the waiting list management. She ensures regular administrative validation of waiting lists. Waiting list information is communicated to the endoscopy team at least monthly and will further be discussed in the Endoscopy User Group meeting and Directorate meeting.
- The endoscopy nursing team and Clinicians ensures capacity is flexed according to demand, this aim is to ensure waits for recall (surveillance) procedures are <6 weeks beyond the planned date and the waits are <2 weeks for urgent procedures and <6 weeks for routines.
- DNA and cancellation rates are monitored on a monthly basis. Action is taken when required to prevent the DNA rate exceeding 5%.

5.7 Admission (on the day of procedure)

- Patients are given an allotted arrival time, this may not be their procedure time (refer to booking policy).
- All patients must be admitted by a registered member of the nursing team in a private room.
- The nurse must keep an accurate record in the Endoscopy Integrated Care document.
- Due to Covid restriction, unfortunately a relative cannot accompany the patient. The presence of relatives in clinical areas is not permitted unless the clinical team determines that it is in the patients' best interest to do so (e.g. if the patient is a vulnerable adult or child).
- Patients requiring enema on arrival will be cared for in an area with dedicated toilet with washing facilities.
- Following the admission assessment, patients take a seat in the waiting room or go through to the second stage admission, where they can change in a private area.
- All patients should be cared for with respect and dignity and in single sex accommodation.

5.8 Paediatric Pathway (WRH only)

- Paediatric patients should be admitted to the children's ward prior to arrival to endoscopy by a dedicated paediatric nurse. All preparation for the booked procedure will be completed prior to the patient being transferred to the endoscopy unit. The patient is accompanied by parents and a paediatric nurse to attend the Endoscopy Unit for the procedure. Paediatric nurses stay with the patient prior to and during the procedure. Patients are then recovered in the paediatric ward. Paediatric patients are seen at the start of the list with dedicated toilet facilities and Consultants are advised prior to lists taking place.
    - Referral received in the Endoscopy Booking Office for children
    - The endoscopy booking office identifies a suitable appointment slot (usually a Thursday morning, primarily with Dr Hudson – Gastroenterologist).
    - Children are booked first on the morning list at 8:30am (if this for any reason is not possible, the endoscopy nurses liaise with the paediatric nurse to agree a suitable time and the patient is taken to and from the procedure room).

- The endoscopy booking office notifies the Children's Clinic of the endoscopy appointment date and time and checks that Children's clinic is available to accept the patient on the day of procedure.
- On the day of the procedure, the patient is admitted to the Children's Medical Day Case Unit located on Level 0 in the Children's Clinic.
- The patient is admitted by a dedicated Paediatric Nurse; the nurse assesses the patient and completes admission paperwork. If any further prep is required or a cannula is required, this is completed by the nurse. Children can opt to have a topical anaesthetic prior to having cannula inserted.
- Should the patient or patient's parents have any worries or concerns, they can be discussed with the play specialist or paediatric nurse.
- The Endoscopy staff collects the patient from the Children's Clinic and takes the patient to Endoscopy. The dedicated paediatric nurse remains with the patient at all times. The nurse is present throughout the procedure to provide reassurance and help with decisions on pain relief/sedation if required.
- If the patient requires the toilet whilst on the Endoscopy unit, they use the appropriate same sex toilet on the main corridor in the Endoscopy Unit.
- Following the procedure the patient is transferred back to Children's Clinic from the procedure room.
- Parents are allowed to remain with their child prior to the procedure and after the procedure.
- The patient remains in the Children's clinic until recovered and ready for discharge.

5.9 Safety

- All Patients who attend the units will have a named Consultant/Nurse Endoscopist who will perform the procedure and this clinician is responsible for the supervision of their medical care whilst in the department. The clinician will also ensure that the endoscopy procedure report is completed and send back to the GP and/or the named referrer.
- The individual needs of the patient will be assessed by the medical and nursing staff and the appropriate individualised care implemented and evaluated. Every effort will be made to maintain the individual's autonomy, independence and privacy and dignity.
- It is the responsibility of each member of the nursing team, to maintain standards of health and safety within the unit and to ensure a safe environment for staff, patients, their relatives and carers and any other visitors to the unit.
- It remains the nurse's responsibility to keep their knowledge and skills up-dated and provide support to other members of the unit team. Including having an active involvement in a teaching programmes and promotion of health.
- Worcestershire Acute Trust provides training for both nursing and medical staff, in accordance with JAG, JETS workforce & JETS.
- All endoscopy units are accessed by consultants and nurse Endoscopists who perform the endoscopy procedures.
- A visible register of all practising Endoscopists' and their competencies will be on view within each procedure room.
- The unit's aim is to provide a friendly, supportive, relaxed and safe environment for patients and their families.

- Endoscopy procedures will be carried out by appropriately trained Endoscopists and all assistants in procedure room will have undertaken appropriate training.
- All endoscopy units are equipped at all times with specialist equipment to provide the right care at the right time.
- There are local policies or protocols for the management of diabetes, anticoagulation, antiplatelet use, antibiotic and implantable devices in patients undergoing endoscopy.
- The Endoscopy service monitors general Quality and Safety Indicators as identified in the BSG Quality and Safety Indicators for Endoscopy. A review of all the BSG A-C auditable outcome and quality standards will be presented to the Endoscopy Business meeting once a year

5.9.1. NatSSIP (National Safety Standards for Invasive Procedures)

- NatSSIPs are standards that have been developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures.
- Local Safety Standards for Invasive Procedures (LocSSIPs) are how the Endoscopy unit within WAHT have implemented NatSSIP framework.
- For further information please refer to Endoscopy unit Local Safety Standards for Invasive Procedures (locSSIP) SOP which sets out the key steps and use of a pre- peri- and post-procedure safety checklist.
- Endoscopy nursing teams and Endoscopists ensure that care is harmonised and that key safety checks are performed using the endoscopy safety checklist.
- The safety checklist is integrated within the nursing document.
- The endoscopy teams on each site will meet before the start of their daily lists, (team huddle/team brief) to identify performance, staffing, priorities for the week, communication of list changes or equipment change and successes.

5.9.2. Audits/Adverse Events

- In line with JAG standards, the endoscopy directorate undertakes a number of BSG key quality indicators.
- Adverse events are reported on DATIX and sent to an investigator to action in line with the Incident Reporting Policy.
- All audits and adverse events are presented at Directorate Governance meetings and at EUG.
- Minutes and agreed actions are circulated to Directorate teams.
- Any audits that identify performance below acceptable standards, or whose complication rate is significantly higher than his/her peer group, are managed by the Clinical Director for endoscopy.

5.9.3 30 day Mortality and 8 day Re-admission

- All death or readmission of patients who have had an endoscopy procedure will be reviewed by Endoscopy Clinical Director and Endoscopy Governance Sister.
- These will be monitored on a monthly basis and discussed at Directorate governance and Endoscopy user group meeting.
- If the death or readmission is due to the endoscopy procedure, a Datix will be completed and reviewed by the Divisional Governance team who will advise if a serious incident (SI) investigation is required.

- Actions and learning will be cascaded to all staff and where required the Trust policy on management of performance will be followed.
- Mortality and re-admission report will be submitted to the Divisional Governance on a monthly basis to be escalated to Trust mortality group.

5.9.4 Oral Bowel Preparation Risk

- Mechanical bowel preparation can precipitate bowel obstruction in patients with stricturing lesions. This is a rare complication, but needs to be recognised.
- If a patient had taken full bowel preparation and has not had any bowel movements, the assessing Endoscopist should arrange for the patient to be seen in A&E or referred to the surgical team and an abdominal x-ray requested. Examination findings, actions taken by the Endoscopist and nursing interventions should be documented. An incident form should be completed using Datix.
- WAHT Endoscopy service complies with the Rapid Response Report NPSA/2009/RRR012 'Reducing risk of harm from oral bowel cleansing solutions' (2009).
- The Endoscopy service at WAHT uses Moviprep as a first line bowel cleansing agent and this policy recognises its authorisation for use in colonoscopy procedures for cleansing the bowel to ensure the bowel is free of solid contents. Other bowel preparation agents such as Klean Prep, Picolax and Plenvu are also in use.
- The colonoscopy referral form and Unisoft report had been authorised by Drugs and Therapeutic committee as a prescription for bowel preparation. Alternatively, registered professionals can supply bowel preparation under a PGD and professional must comply with the requirements of the PGD.
- All patients requiring bowel preparation solution in WHAT endoscopy services will be clinically assessed - especially vulnerable patients by the clinician ordering the endoscopy procedure (including GPs using the direct access route) to ensure that there is no contra-indication or special precaution for the use of a bowel cleansing solution. The colonoscopy referral form includes bowel preparation assessment questions, furthermore, assessment is carried out by 2WW triage nurse and at pre-assessment nurse either face to face or telephone or by review of medical records prior to postal supply of bowel preparation.
- All patients will have their bowel preparation authorised by the clinician at the same time as the endoscopy procedure is ordered.
- All patients requiring bowel preparation solution in WAHT endoscopy services will have an authorised clinical professional supply the bowel cleansing solution and written information sent to each patient.
- All patients requiring bowel preparation solution in WAHT endoscopy services will have department contact information should be available to patients to obtain advice of a clinical professional if needed.
- Bowel preparation will be stored and supplied in compliance with medicines regulations.
- The Endoscopy service will evaluate the effectiveness and safety of bowel preparation by auditing patient feedback, bowel cleanliness and review of incidents relating to bowel preparation.

5.9.5. Handling of specimens

- Whenever possible the need for a biopsy and associated equipment should be communicated to the team by the operator at the SIGN IN
- When a specimen is taken the operator must state the site to the team
- The specimen must be placed into an appropriate histology pot immediately
- The pot must be labelled immediately with the relevant patient identification sticker
- Apply the Biotrax specimen tracker sticker which indicates the site of specimen.
- The patient identification sticker details (name, DOB, PID number) must be cross checked against the patient wrist band
- A histology request must be placed via the ICE requesting system, documenting the details of the referring consultant responsible for taking action on the results. The Endoscopists must add the comment “please see Unisoft report” in the Clinical Details section of the ICE request. A Unisoft histology request must be printed and attached to the ICE request and sent together with the specimen pot to the laboratory.
- The operator must check the form details match the patient ID details on the pot.
- Completing the form and checking the pot label must occur before the next case. However, completing the form may occur after the formal SIGN OUT for logistical reasons
- Once the specimen and request form are appropriately labelled and filled out they must be checked by two registered healthcare professionals.
- The endoscopy nurse is responsible for entering the specimen details into the Specimen Book within the Endoscopy room.
- The specimen tracker form is to be kept and filed in patient medical records
- At WRH during a working day (Monday to Friday) the specimen is kept within the procedure room and sent to Pathology Lab after each session. The porter transporting the specimens should use the delivery book.
- At Alexandra, Kidderminster, Evesham and Malvern Hospitals the specimen should be taken to Recovery and placed in the specimen box for collection by porter to be transported to WRH.
- During the weekend/bank holiday the specimen is to be locked in procedure rooms and sent to the lab on the next working day.
- Consultant responsible for the patient must take appropriate clinical actions resulting from the pathology reports. Pathology reports should accessible with no undue delay.

5.9.6 Acromegaly, adrenal insufficient and diabetes insipidus patients

- The bowel preparation can increase the risk of becoming unwell in those that have adrenal insufficiency and/or diabetes insipidus. This is due to your medications not being absorbed properly and the risk of adrenal crisis, dehydration and altered electrolytes.
- Hypopituitary patients need to double the dose of their steroids during bowel prep. On the day of the colonoscopy they need to have IV hydrocortisone 100 mg pre-procedure and 50 mg 6hrly for 24 hrs. They can go back on usual dose of steroids provided no procedure related complications. Continuous infusion of hydrocortisone 200 mg over 24 hrs via pump maintains has better serum level of

cortisol than 6hrly doses. But for the practical purpose 50 mg four times per day can be used instead.

- For patients with diabetes insipidus and they can have usual dose of desmopressin via subcut injection or nasal spray instead of tablets.-
- Please seek assistant from Diabetes & Endocrinology department. Also refer to appendix 9- *The Pituitary Foundation- Colonoscopy Guidance and Information- A guide for acromegaly, adrenal insufficient and diabetes insipidus patients.*

5.9.7 Covid-19

- The COVID-19 pandemic is a novel coronavirus SARS-like respiratory infection that has spread rapidly around the world since first being described in the Wuhan province of China in December 2019. The coronavirus is spread through droplets, with airway and nasopharyngeal secretions being the main source of these.
- All upper GI and respiratory endoscopy procedures need to be regarded as aerosol generating procedures (AGP) therefore staff have to wear Filtering Face Piece 3 (FFP3) and PPE- Personal Protective Equipment.
- Staff must follow Trust policies on infection control and refer to the up-to-date version of *Endoscopy Response To Covid 19.*
- Staff should keep up to date and follow published national guidelines by the government https://www.gov.uk/coronavirus.
- All staff are to provide care according to and without limitation to Endoscopy Response To Covid 19 SOP but ALL should ensure you keep up to date with Trust and national guidance.

5.9.8 Post Colonoscopy ColoRectal Cancer (PCCRC)

- PCCRCs are defined as a diagnosis of colorectal cancer (adenocarcinoma) after a colonoscopy has been performed where no cancer was diagnosed (JAG accreditation programme - Guide to meeting the quality and safety standards, 2019).
- WHAT Endoscopy service will review all patients diagnosed with a colorectal cancer within 3 years after a 'negative' colonoscopy (ie no cancer detected).
- A PCCRC database is pulled onto Endoscopy WREN dashboard and will identify all patients who have a cancer diagnosis within 3 years for negative colonoscopy.
- These patients will be clerically and clinically investigate contributory factors of every case to determine the most plausible cause using the proforma drawn up by *World Endoscopy Organisation Consensus Statements on Post-Colonoscopy and Post-Imaging Gastroenterology* (2018).
- Appendix 11 details the follow the process.

5.10. Comfort

- The endoscopy unit acknowledges that procedures undertaken can be uncomfortable and undignified and therefore the service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy.
- The endoscopy directorate ensures that patients receive information ahead of time which provides a description of the level of discomfort to be expected during the procedure.
- Individual Endoscopists patient comfort scores are monitored as part of our audit process and if these fall below agreed levels, the Endoscopist is required to take remedial action and scores are reviewed again within 6 months.

- Nursing teams record comfort levels in the nursing record and actions taken recorded. An audit of nursing documentation is conducted bi-annually.

5.11 Quality

- Endoscopist must follow current evidence based practice and national guidelines in the management of patient undergoing endoscopy procedures.
- This policy does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.
- WAHT endoscopy units will actively monitor BSG auditable outcomes and quality standards for Endoscopists.
- Individual Endoscopists are given feedback on their performance including late outcomes (30 day mortality and 8 day unplanned admissions) at least 1x/year.
- If sub optimal performance by an Endoscopist is noted, actions are taken in response and if an Endoscopists performance does not reach acceptable levels after an agreed development period, the Endoscopy Clinical Director and Directorate governance committee reviews that individual's endoscopy practising rights.

5.11.1 JAG Annual Timetable

- In order to continuously achieve JAG standards an annual timetable is held with the Endoscopy JAG/Governance Sister and Endoscopy Directorate General Management.
- This timetable identifies when audits/surveys need to be undertaken.

Clinical audits will be presented Endoscopy users group (EUG) meetings held twice a year in each in quarter 2 and quarter 4.

5.11.2 BSG auditable outcomes and quality standards for endoscopy.

- A review of all the BSG A-C auditable outcome and quality standards will be presented to the Endoscopy Directorate meeting and the Endoscopy User Group meeting.
- The Endoscopy Clinical Director and Endoscopy JAG/Governance Sister have the ultimate responsibility to ensure all Quality and Safety Indicators are monitored. This has been delegated to different teams as identified below:
- 24hr emergency GI bleeding service: Patients admitted with acute GI bleeding will be admitted via emergency assessment unit and will be resuscitated using the agreed guidance on the emergency care medical assessment document. The Endoscopist will have access to a surgical opinion should this be required. There is provision to perform procedures under general anaesthetic should this be required. The Endoscopy Directorate will nominate a lead to audit the quality indicators as identified in the BSG Quality and Safety Indicators.

- Therapeutic GI Endoscopy: This includes oesophageal and colonic stenting and dilatation. There are provisions to undertake these procedures in the radiology department under fluoroscopic screening where there is difficulty in passing a guidewire /balloon catheter through the stricture. The Endoscopist has access to surgical and radiological opinions and management should this be required pre or post dilatation. A decision to deploy an oesophageal stent should be agreed at the Upper GI cancer multidisciplinary meeting. The Endoscopy Directorate will nominate a lead to audit the quality indicators as identified in the BSG Quality and Safety Indicators.

- PEG/NJ insertion: Patients requiring PEG placement are discussed and agreed to by the Trusts' Nutrition team. Consent and post procedure care are provided by the Nutrition team as per agreed guidelines. The Nutrition team is responsible for monitoring the quality standards required following PEG insertion as identified in the BSG Quality and Safety Indicators.

- ERCP procedures: The ERCP Endoscopists are responsible for monitoring the quality standards and auditable outcomes required following ERCP as identified in the BSG Quality and Safety Indicators.

- Bowel Cancer Screening Programme (BCSP): The BCSP Team are responsible for monitoring the quality standards and auditable outcomes required for BCSP colonoscopy as identified in the BSG Quality and Safety Indicators.

- EUS OGD & HPB: EUS Endoscopists are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate person.

- Cystoscopy: The urology team are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate person.

- Bronchoscopy & EBUS: The Respiratory team are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate person.

5.12. Appropriateness

- All referrals are clerically vetted by the booking coordinators for legibility, bowel preparation prescribed and that the request form is signed by the referring clinician. Any inaccuracies will be escalated to the referring clinician. An audit of the clerical vetting process will be conducted by the Directorate Support Manager once a year.
- Referrals from non-Endoscopist are clinically vetted for appropriateness by an Endoscopist. Once vetted, the patient is added to the waiting list.
- All patients should be referred against specific NICE guidelines using the approved referral form. An audit of compliance against referral guidelines should be undertaken annually.
- Audit results are discussed at Directorate Governance meeting and EUG meeting.
- Endoscopy units adhere to the local vetting policy. Please refer to Vetting on the Trust intranet.

5.12.1 Referral Rules

- Referrals are accepted and managed in the same way, independent of the route into the service. Please refer to the endoscopy referral guidelines.

5.12.2 Endoscopy Booking Policy

- For booking of endoscopic procedures please refer to the Endoscopy Booking Policy for referral, scheduling and booking rules.
- There is a range of communication methods and materials to ensure that patients are appropriately informed about what they should expect from the service.

5.12.3 Pre-Assessment

- Pre-Assessment is available for Colonoscopy procedures either face to face or by telephone or postal
- All appropriate patients will be given an appointment to be pre-assessed by a trained member of the nursing team the nurse discusses the procedure, sedation, bowel preparation (if required) and medication.
- Pre-assessment is undertaken to alleviate any worry about taking bowel preparation, reduce on the day waiting times, DNA rates, dedicated time is given to reassure patients and allow patients time to ask any questions regarding bowel preparation or the procedure they are booked to have.

5.13 Results

5.13.1. Electronic Reporting

- All patients undergoing an endoscopic procedure will have a report completed on the day of the procedure using the GI Reporting Tool (Unisoft).
- A copy of the endoscopy report is sent to the patients' GP the same day (or next working day). A copy is filed in the patients notes prior to leaving the department and a copy sent to the referrer or Endoscopist responsible for acting upon the results the same day (or next working day).
- If histopathology has been taken, results will be communicated to the appropriate clinician via the ICE reporting system.
- When photographs are taken, copies are kept with the patient's endoscopy report and are accessible through electronic patient record or on the Unisoft GI Viewing Tool.
- The requesting clinician / Endoscopist will undertake any actions and make recommendations within five days of receipt of the pathology report where necessary. Histology results are to be filed on the ICE reporting system once actioned.
- Patient requiring follow-up procedures will have the reports placed in a red tray for booking team to add onto Patient Waiting List (PTL).

5.13.2 Communicating Results to the Referrer

- The endoscopy nurses return the patient event packs (including paperwork) to the endoscopy booking office once the patient is discharged.
- The red-tray is retuned to booking office by the nursing teams and patients added to Patient Waiting List (PTL) unless if the repeat procedure is within 3 months and that should be booked straight away where possible before patient leaves the department.
- Paperwork is filed appropriately in the event notes, using the EZ notes event packs.

- A copy of the endoscopy report is sent to the referring Consultant and the patients GP with 24 hours of procedure (unless weekend list).
- The endoscopy booking co-ordinators check the endoscopy report. If a patient requires a repeat procedure, the endoscopy booking co-ordinator adds the patient to the repeat procedure waiting list.
- The endoscopy booking co-ordinators discharge the patient as per electronic local process.
- A copy of the endoscopy report is sent to the referring clinician or Endoscopist that scoped the patient, depending on the referral route.

5.14 Privacy & Dignity

- It is the responsibility of all staff to maintain patient's privacy and dignity and promote security of patients through their journey in Endoscopy.
- Each endoscopy unit in WAHT will have a nominated dignity champion.
- All staff must undertake Information Governance training on an annual basis to re-enforce patient confidentiality (refer to Code of Conduct for employees in Respect of Confidentiality).
- Endoscopy units ensure that a patient's privacy is adequately protected throughout the patient's endoscopy. Curtains are to be drawn in recovery and in the procedure room, when in use; doors are to be shut and 'do not enter signs' highlighted during all procedures. Staff will only enter the procedure room when a procedure is in progress in an emergency/urgent situation
- Endoscopy units all have access to quiet/private areas for conversations pre and post procedure with patients. Nursing staff document on the Nursing Admission Assessment Forms if a private room is not available to discuss clinical care.
- All patient information is kept safely and securely out of sight to ensure confidentiality is maintained (refer to the Health & Safety and Security Policy).
- Worcestershire Acute Hospitals NHS Trust adheres to the national rule of gender separation. Recovery areas are flexed to provide same sex accommodation (refer to Policy for the Provision of same sex accommodation for patients).
- All staff will follow the Trust safeguarding policy for adults and children and trained to the appropriately level to support the service.

5.15 Patient information & Consent

- Before an Endoscopy procedure is undertaken all relevant information should be given to the patient. These are available in hard copy in Endoscopy Unit or on the Trust intranet under "Departments and Services" in the "Endoscopy" section. The patient should be given an opportunity to ask questions prior to procedure, this could be done by clinicians or the nursing team.
- Before the start of the procedure, the patient should be given the opportunity to discuss the continuance of their consent or the withdrawal of consent in line with the guidelines. This can be either with the nurse looking after them or the Endoscopist.
- All published patient information leaflets are reviewed annually and updated as necessary. These are sent for review by the Key Documents Team and assigned a documents reference number prior to publication.
- Prior to any endoscopy procedure taking place, all patients must sign a consent form before entering the procedure room.

- All patients are given sufficient time to ask questions before consent is agreed and before entering the procedure room on the day.
- Patients who are unable to comprehend or retain information sufficiently to consent for themselves will require a full assessment under the Mental Capacity Act. Part 1 of a Consent Form 4 will need to be completed by the requesting clinician prior to the patient being admitted to the Endoscopy Unit.
- The use of family and friends as interpreters is discouraged, unless it is the patient's choice to use them as interpreters. This will be documented by the nursing staff on the named patient nursing admission assessment form.
- All endoscopy sites use e-consent forms, where appropriate. The e-consent is printed at the time of booking and sent to the patient together with procedure information in advance of their admission.
- Consent processes must be followed countywide according to the Policy for Consent in Examination and Treatment and local endoscopy processes.
- The Unit conduct a survey of on the consenting process via the Patients' Experience Survey annually.

5.15.1. Consent for high risk procedures and high risk patients

- Clinicians referring patients for high-risk procedures or high-risk patients (as above) should clearly identify additional risk factors on the referral form or Unisoft report.
- Two-stage consent should be performed for all high risk patients and for patients scheduled for 'high-risk' procedures.

High-risk patients are patients with ASA score of 3 or greater as defined by the ASA classification.

High-risk procedures are therapeutic OGD, PEG, ERCP and EMR.

Inpatient procedures

- A consultant to consultant referral is recommended.
- On receipt of an inpatient referral, the nursing team will perform both clerical and clinical vetting for appropriateness. If the procedure is deemed appropriate, nursing teams must print off procedure information and e-consent from eZ-notes. In addition, they must print page 1 and 2 of the nursing integrated document. All these documents can be printed from eZ-notes with patient demographics pre-populated.
- These documents must be given to the referring ward doctor to return to the ward and start the consenting process by providing the patient and carers with all relevant procedural information. Information must include an explanation of the risks of and alternatives to the procedure, and where applicable the risk of bowel preparation. The consent process will continue into the Endoscopy Unit where Endoscopist will confirm consent.

Elective procedures

- If a patient requires a repeat procedure with high risk intervention or if they are a high risk patient as above. Nursing teams must print off procedure information, e-consent from notes and page 1 and 2 of the nursing integrated document.
- The discharge nurse must provide the patient and carers with all relevant procedural information if appropriately trained to do so. Where applicable the risk of bowel preparation should be discussed. The Endoscopist on the day must address the patient's questions where nursing teams are unable to answer.

- Patients must be provided with contact number in case if they require any further information.

5.15.2. Withdrawal of Consent

- Where the patient has signed a consent form and subsequently changes their mind, the person obtaining consent or, the Endoscopist performing the procedure, must take account of the patients' wishes and record the withdrawal of consent in the patient's hospital records.
- Before the start of the procedure, the patient should be given the opportunity to discuss the continuance of their consent or the withdrawal of consent in line with this guideline either with the nurse looking after them or the Endoscopist.
- Withdrawal of consent should be recorded on Datix.

5.16 Aftercare

- Non-sedated patients are discharged from the procedure room or recovery area once the Endoscopist or nursing staff has discussed the results and after care with the patient.
- Sedated patients are not discharged until diet and fluids have been consumed (if applicable), their cannula has been removed and a responsible adult is available to collect the patient from the Endoscopy Unit. A competent adult will escort patient home and remain with them for a minimum of 12 hours following the endoscopic procedure. Refer to the Endoscopy Discharge Policy for further information.
- All patients are discharged following a conversation with the Endoscopist or nursing staff regarding their procedure. Patients are not to be discharged until the endoscopy nursing team completes all relevant paperwork and provides the patient with discharge information to include emergency contact numbers and follow up details. Any further procedures required are discussed with the patient (and booked if within eight weeks), any risks associated post-procedure are also discussed with the patient. Patients are discharged with verbal and written information. A patient centred discharge summary or the endoscopy report is handed to the patient upon discharge.
- Any patients with suspected malignancy are told so on the day of procedure, unless deemed inappropriate to do so.
- If patients require emergency treatment following their procedure at the Endoscopy Unit at Evesham, Kidderminster or Malvern, patients are transferred via Ambulance to Redditch or Worcester.
- For further information, please refer to endoscopy discharge policy – Appendix 7.

5.17 Surveillance Procedures

- Surveillance procedures will be validated both clerically and clinically according to latest guidance (refer to Endoscopy Booking Policy & BSG guidelines).
- Patients requiring a surveillance Endoscopy procedure must be informed that they have a surveillance procedure due or that recent guidelines have changed and their surveillance procedure has been postponed or cancelled.

5.18. MDT Co-Ordination

- Where necessary patients are linked to an appropriate MDT, managed by Cancer Services.

- Endoscopists refer patients to the MDT co-ordinator when required. Patients with a diagnosis of cancer (or suspected) are discussed at weekly MDT meetings. Discussions are held regarding management of patients with the appropriate peer scrutiny. Separate meetings are held for colorectal and upper GI malignancies. MDT's are held at Worcester Royal Hospital and are video-linked to enable staff at other sites to join the discussion.

5.19 Patient Involvement

- Patient Survey Questionnaires are distributed annually over a two month period to a mix of patients attending the Endoscopy Units.
- Patients are asked to feedback on these areas:-
  - Booking services
  - Invitation Materials
  - Consent
  - Comfort
  - Staff
  - Aftercare process
  - Privacy & Dignity
  - Sedation Options
  - Background
  - Social, disability and cultural needs
- Results are collated and reports produced.
- Action plans are created once results have been received and distributed to relevant Endoscopy teams.
- The results are reviewed by the Endoscopy Directorate Group once available – three-monthly and six-monthly.

5.20 Environment

- Endoscopy procedure rooms are cleaned at the end of each list - BSG guidelines are followed for decontamination of Endoscopes. Single use disposable equipment is used throughout the Endoscopy Units.
- Testing and revalidation of the Decontamination equipment and associated machinery is carried out according to national decontaminations requirements. An annual authorised engineer report for decontamination is actioned and approved by the organisation along with the annual Environmental checklist
- Staff must follow the standard of dress policy at all times. ID badges should be clearly visible. Protective clothing is provided and should be worn when on the endoscopy units. Endoscopists must wear theatre blues and appropriate footwear. The 'bare below the elbow' policy is to be adhered to. Lanyards are not permitted.
- To abide by the infection control policy, all infection control audits are documented monthly (audits such as, hand hygiene, daily/weekly cleaning and Fridge temperature charts). All staff abide by the rules set out in the COSHH policy and should follow the Operational Policy for storage and transfer of decontamination fluids.
- Any spillages over 5 litres in volume requires contact with the Fire Service (refer to Fire Policy). All staff must attend mandatory fire training annually.
- All rooms keep a supply of controlled drugs, provided by Pharmacy. These controlled drugs are kept in a double locked cupboard (refer to Controlled Drugs

Policy). Quarterly pharmacy audits for safe and secure handling and storage are completed and results fed back to each unit with action plans.

5.20.1. Equipment

- Endoscopy units all have a range of modern Olympus video endoscopes, with sufficient numbers of endoscopes to cover the booked lists.
- There is a computer in each endoscopy procedure room for immediate access to the Unisoft electronic reporting system. Image capture is available in most procedure rooms. Where image capture is not available, photographic printing equipment is provided.
- There is a dedicated area within each endoscopy unit to house the resuscitation trolley, oxygen, suction and emergency drug box. This is checked and signed daily by a designated member the endoscopy nursing team for medicines and equipment. The Resuscitation Department audit the completion of the documentation.

5.20.2 Decontamination

- The decontamination units across the county aim to provide effective endoscope decontamination service within a safe environment as required by the Health Act (2006).
- The department is required to provide a safe decontamination service that generates a clean and sterile product and is embedded as part of the service culture in support of successful clinical outcomes and the associated well-being of patients and staff (Health Technical Memorandum 01-01: Decontamination of reusable medical devices) and Health Technical Memorandum 01-06: Decontamination of flexible endoscopes Part A: Policy and management
- Routine decontamination of flexible endoscopes will take place in dedicated facilities that are compliant with the latest National guidelines / BSG / JAG / GRS standards and guidance and are fit for purpose. Compliance with standards will be established through an internal and external audit program. Results of on-going audits will provide evidence of any non-compliance issues that may require funding in order to maintain current JAG registration and certification. All items should be traceable through the various validated decontamination processes and be traceable to individual patients.
- All clinical endoscopy staff are trained to decontaminate endoscopes and operate all decontamination equipment within their endoscopy unit. All competencies will be monitored by decontamination Link Nurse, Endoscopy Managers and their deputies.
- Yearly audits are carried out using the relevant audit tools. Results are presented at the Endoscopy Directorate meeting and Trust-wide Decontamination meeting and actions arising to be dealt with in a timely manner.
- Decontamination services will be reviewed by the decontamination group chair and also the Decontamination Lead for the Trust.
- Further details are expanded in the on Decontamination Operational Policy, including management of decontamination of scopes in the event of washer failure on a site.

5.21 Teamwork & Workforce Delivery

- The unit aims to ensure that all staff are given the knowledge and skills to work efficiently and safely. There is a formal competency-based induction programme (which is reviewed annually). Staff are also encouraged, and offered, further training and development opportunities.
- All new staff will have a mentor and a comprehensive induction programme.
- All staff will have up-to-date mandatory training. This is monitored through the Electronic Staff Record.
- Staff will access training both internal and, where required, some external training.
- All staff are regarded as valuable team members.
- There are named individuals across the sites that are responsible for managing the rostering of Endoscopy staff to meet the service needs.
- All staff will have a work base but the service may require them to work across sites within the Trust.
- Skill mix is in accordance with BSG guidelines on the Endoscopy unit. The establishment of skill mix is reviewed at Directorate meetings.
- The unit manager is responsible for overall efficiency supported by juniors.
- The Endoscopy nursing teams use E-Rostering to record staff rotas.
- Staff sickness is recorded on either E-Rostering or ESR.
- Every member of staff receives an annual PDR with their line manager or General Manager, as per PDR Policy. This helps in identifying individual learning needs
- There is an agreed annual education and training plan which is completed by Endoscopy Unit Managers, the action plans should reflect staff and service training/development needs
- All staff are supported through lifelong learning.
- Workforce wellbeing questionnaires are handed to staff once a year surveys are completed and returned. Team engagement is encouraged, providing the questionnaire enables all staff to ensure they are listened to and respected and able to influence and improve care, the results from the survey are collated and action plans developed to improve on areas highlighted by staff or to feedback to staff on areas that require clarity. Results are discussed at the directorate meetings and reviewed 3 and 6 monthly.

5.21.1 Skill Mix

- Skill mix shall be in accordance with BSG Guidelines and local policy to ensure safe and quality clinical outcomes for the patient.

Area/Procedure	Staffing
Admission	1Registered Practitioner for 1room or 2 Registered Practitioner for 2 or more procedure rooms
Recovery	2 Registered Practitioner in each recovery area for 2 rooms or more and 1 Registered Practitioner for 1 room
Colonoscopy	2 Registered Practitioner
Gastroscopy	2 Registered Practitioner
ERCP	3 Registered Practitioner plus transfer Registered Practitioner
Bronchoscopy/EBUS	2 Registered Practitioner plus 1 Registered Practitioner for EBUS

Cystoscopy	1 Registered Practitioner and 1Clinical Support Worker (CSW)
Decontamination room	1-2 CSW for 1-2 room and 3 CSW for 3 or more rooms
Inpatient List	2 Registered Practitioner plus transfer Registered Practitioner

- Clinical Staff will rotate and work in all clinical areas of the unit and similarly clerical staff should be competent in all tasks within the booking office.
- More experienced staff are encouraged to develop sub-specialist skills in particular advanced procedures. E.g. ERCP and all staff will take on an extended link nurse role

5.22 Professional Development

5.22.1. Nursing staff

- The NMC requires qualified nursing staff to keep their knowledge and skills updated, with revalidation 3 yearly
- All staff (trained and untrained) receives a formal and informal training programme, this includes internal training sessions and sessions led by external providers (Manufacturing companies).
- Staff are encouraged to attend external training where funding permits.
- Monthly quality improvements sessions are provided to ensure the workforce are properly trained and competent and meet the requirements for revalidation
- All members of new staff will undertake Trust Induction. Following their induction, staff are required to attend Mandatory Training updates as directed. The service ensures all new staff are provided with a nominated mentor/trainer who will supervise them until identified competencies have been achieved to allow them to undertake their role independently.
- The service provides a documented matrix of staff competencies for all procedures undertaken. This is clearly displayed within the procedure rooms to ensure safe patient care
- Each site has dedicated nursing teams. All nurses are encouraged to work across sites to gain new skills and competencies. Nursing staff at Worcestershire Royal Hospital are specifically trained to assist with Bowel Scope lists
- Malvern Community Hospital is supported by the nursing team based at Worcestershire Royal hospital.
- The Matron / Directorate Manager completes an annual training needs plan which will be approved by management and learning & development department.

5.22.2 Orientation and Training

Registered Nurses/Practitioner

- Registered Nurses will complete a formal induction programme which includes the use of Training and Development programme booklet for nurses and completion of personal development plan within the first 6 months. In addition staff will assess their completion of learning contract and performance assessment criteria, adopted from the skills for health. On completion of the workbook, it is a requirement to complete the (Gastrointestinal Nursing) JETS workforce competences online.

- Newly Qualified Nurses will complete the preceptorship programme All Registered Nurses will ensure 100% attendance to mandatory training. Will maintain competence in drug administration.
- It is a requirement to complete medical device log annually and learning needs identified are to be completed in a timely manner in conjunction with Training Link Nurse. Complete JETS workforce competencies annually.

Clinical Support Workers

- Clinical Support Workers will complete a formal induction programme which includes the use of Training and Development programme and completion of personal development plan within the first 6 months. In addition staff will assess their completion of learning contract and performance assessment criteria, adopted from the skills for health. On completion of the workbook, it is a requirement to complete the (Gastrointestinal Nursing) GIN competences online.
- All Clinical Support Workers will ensure 100% attendance to mandatory training. Will maintain competence in drug administration.
- It is a requirement to complete medical device log annually and learning needs identified are to be completed in a timely manner in conjunction with Training Link Nurse. Complete JETS workforce competencies annually.

Administrative staff

- Administrative Staff will complete an induction programme.
- Administrative Staff will receive specific internal IT training – Oasis, Bluespier, Unisoft.
- Administrative staff are encouraged to progress and undertake courses relevant to their role and/or the service, i.e. Leadership courses

5.22.3. Non- Medical Endoscopist

- Non-medical Endoscopists currently undertaking procedures in the department are from a Nursing background and will maintain registration to the NMC.
- Independent non-medical Endoscopist will ensure all practical and legal risks have been addressed by undertaking robust training pathways and ensure their operation is agreed by Clinical Governance and Endoscopy User Group.
- The training programme developed by JAG is a requirement for all GI Endoscopists.
- Endoscopists in training must have a recognised supervisor and a process of mentoring is strongly advised for all independent non-medical Endoscopists.
- Non-medical Endoscopist will be monitored similarly to medical Endoscopists against the performance indicators below and will ensure an annual appraisal is completed.

5.22.4 Staff engagement

- The unit will assure the delivery of best quality services to patients and users and this can be achieved by developing an open culture where staff can raise any concerns.
- The Endoscopy Unit Manager operates an open-door policy and staff are encouraged to confidentially raise concerns.
- An endoscopy etiquette guide is available in the department and all staff are encouraged to promote a good working environment and promotes a good work-life balance

- All staff are invited to provide feedback once a year via a questionnaire on how well staff are cared for.
- All staff are encouraged to contribute views and ideas on service developments and discussions are held in the monthly staff meetings.
- All staff are encouraged to participate in the Trust's quarterly staff engagement questionnaire.
- All staff are encouraged to participate in the Trust's annual staff survey.
- All staff are encouraged staff engagement sessions with the Executive Team.

5.22.5 Staff safety

- The endoscopy unit promotes a working environment that is safe for employees and patients.
- Health and safety audits are conducted bi-annually and reported back to the Trust.
- Staff are encouraged to complete incident forms accessible electronically.
- Incident forms are discussed at the unit morning huddles and at the Directorate meeting. Action plans are completed by staff involved and fed back to the staff meeting to encourage reflective practice and to raise staff awareness.
- All staff will complete mandatory training within three months of appointment. All staff to maintain 100% attendance to annual mandatory training.
- Staff to complete medical device log annually and training needs identified to be actioned yearly. Specific Endoscopy training will be scheduled throughout the year utilising the audit days.
- The Endoscopy service promotes the health and wellbeing of staff members and staff are encouraged to access staff support services or referred to with staff's consent.

5.23. Training environment for Endoscopist

- Worcestershire Acute Hospitals provides training for junior medical staff and nurse Endoscopists.
- This policy will provide a brief outline of training support available for endoscopy within the department. For more detailed information and copies of training forms, please refer to the Induction pack for medical/surgical/nurse trainees.
- All trainee Endoscopists will be supervised until deemed competent to practice.
- A list of all trainees and their competencies is clearly displayed in all endoscopy procedure rooms.
- The endoscopy unit will ensure that a training list is supported by nursing staff that have been in their role for a minimum of one year and have completed their endoscopy competencies.
- Learning and training needs must be identified during induction.
- All trainees are given a training pack on arrival to the department, along with a unit induction.
- Where required endoscopy lists must be reduced/adapted to suit training needs.
- The endoscopy unit will ensure that there are sufficient lists to meet the needs of the trainees.
- All trainees will be supervised by a trainer who has undertaken the train the trainer course (TTT) and registered on JETS. Regular meetings should be held between trainer and trainee to continuously review progress.
- It is the trainee's responsibility to ensure that all assessments are regularly recorded on JETS (in accordance with JAG certification requirements for the procedure for which they are training).

- An annual unit training survey is undertaken and provides us with future actions for improvement. Trainees are encouraged to attend endoscopy user's group meetings and related governance, audit reviews.

5.24. Trainer Allocation and Skills of Trainee Endoscopist

- The Trust training lead is Dr Gee. He takes accountability to ensure that trainees have access to Unisoft and JETS. He will organise a dedicated trainer depended on skill need and location. He will instigate regular feedback and audit of JETS to ensure appropriate training requirement are met.
- Appendix 5 has a list of all trainers who have undergone Train the Trainer course.
- All staff undergoing training must be adequately supervised until they are deemed to be competent to practice alone.
- A list of all trainees, and their competency level is clearly displayed in each endoscopy room
- Individual learning needs must be identified at every meeting between trainer and trainee. An appropriate training plan must be devised and training given.
- National and local Trust Guidelines for training of staff in practical procedures are available online and must be adhered to e.g. JAG guidelines, safe sedation policy
- Trainees are required to undertake regular audit of all practice.

5.25 Assessment and Appraisal of Trainee Endoscopist

- All trainees undergo a full assessment on arrival and departure from the unit, have their training needs defined and their training planned.
- Trainees will be assessed regularly using DOPS on JETS (in accordance with JAG certification requirements for the procedure for which they are training).
- Once a trainee had been deemed competent to practice independently, their KPIs will be monitored regularly and reviewed alongside other Endoscopists according to the local audit calendar.
- If performance falls below acceptable standards, the Local Training Lead will support and manage performance as per 5.25.1 below.

5.25.1. Procedure for Dealing with Endoscopist Poor Performance

- 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 Clinician Lead will discuss the problem identified with the Endoscopist concerned.
- 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.
- 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 Clinician Lead 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.

- 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 Trust Policy for Managing Poor Performance.

5.26 Bowel Cancer Screening Programme & Bowel Scope

- WAHT provide Bowel Cancer Screening Programme to the local population (subjects) between the ages of 60 – 74.
- Bowel Scope Screening will apply to the local population aged 55 – 59.
- Further information can be found in the Bowel Cancer Screening Programme Operational Policy.

5.27. Local Policies (LAST)

Endoscopy units all refer and adhere to a number of local policies/processes held within the Trust. The following policies apply to endoscopy specifically and can be found within the endoscopy units (written or electronic form):-

- Guideline for the Management of Diabetes for patients undergoing endoscopy
- Warfarin and other anti-coagulant guidelines and procedures
- BSG Guidelines – antibiotic prophylaxis in gastrointestinal endoscopy
- Conscious sedation in adult endoscopy policy
- Interpreting documentation deaf direct and pearl linguistics
- Consent policy, consent to examination or treatment Form 4/consent booklet
- Access policy
- Waiting list guidance
- MRSA and *Clostridium difficile* policies
- Recruitment and selection policy
- Sickness absence, health & wellbeing policy
- Performance management policy
- Equality and diversity policy
- Bullying and harassment policy
- Standard of dress policy
- Endoscopy paediatric process

5.28. Complaints

The Endoscopy Units adhere to the Trust's complaints policy.
Compliments, comments and complaints leaflets are readily available on each Endoscopy Unit, along with patient feedback cards and friends and family cards. These are discussed at the EUG, Endoscopy Directorate Governance and fed into Divisional Governance meetings.

6. Implications of Non-Adherence

Non-adherence to this policy may result in:

- Failure to comply with JAG standards, this will lead to failure to achieve JAG accreditation and loss of income

- Clinical risk to patients or service or both
- Clinical risk to staff members
- Patients being put at unnecessary risk
- Financial consequences to the Trust if targets are not met
- Loss of BCSP
- Increased workloads for all endoscopy teams
- Potential damage to the countywide endoscopy services reputation, caused by negative patient feedback
- Increase in patient complaints
- Poor service to patients

7. Implementation of the Policy

7.1. Plan

- Consultation at Endoscopy Directorate Meeting
- Consultation at unit huddles and unit meetings
- Implementation to be evaluated using agreed monitoring tools
- Policy will be available in written and electronic form in all endoscopy units

7.2. Dissemination

- The Policy will be placed on the Trust's intranet page and all staff made aware through the use of the Trust Daily Brief.
- Policy will be distributed to all teams through team briefs.

8. Monitoring and compliance

Monitoring and compliance against this policy is the responsibility of the Endoscopy Directorate Group.

Monitoring will be carried out as described in the table below:

- GRS Standards – GRS submitted twice yearly. Feedback from JAG regarding accreditation status.
- JAG Audits – Audit Timetable kept and reviewed. Audits checked prior to GRS submissions.
- Patient & Staff Surveys – Annual surveys, reviewed prior to GRS submissions.
- Capacity & Demand – reviewed weekly, actions taken if necessary.
- Staff sickness – reviewed and monitored. Matron & Unit Managers receive report from Human Resources.

9. Policy Review

This policy will be reviewed 3 years from the date of approval.

10. References

References	Reference Address/Numbers
JAG, JETS WORKFORCE & JETS website	www.thejag.org.uk
BSG website	www.bsg.org.uk
Code of Conduct for Employees in Respect of	WAHT-IG-001

Confidentiality	
Health & Safety Policy	WAHT-CG-125
Security Policy	WAHT-CG-034
Policy for the Provision of Same Sex Accommodation for patients	WAHT-CG-521
Policy for Consent in Examination and Treatment	WAHT-CG-075V13.1
Infection & Prevention Policy	WAHT-CG-043
Endoscopy Discharge Policy	WAHT-MED-007
COSHH Policy	WAHT-CG-269
Fire Policy	
Mandatory Training Policy	WAHT-HR-039
Training & Development Policy	WAHT-HR-082
Induction Policy	WAHT-CG-008
Controlled Drugs Policy	WAHT-CG-580
Incident Reporting Policy	WAHT-CG-008
NMC website	www.nmc-uk.org
Guideline for the Management of Diabetes for patients undergoing IV Contrast, Endoscopy and Anaesthesia	WAHT-END-005
Warfarin and other anti-coagulant guidelines and procedures	WAHT-HAE-002
BSG Guidelines – Antibiotic Prophylaxis in Gastrointestinal Endoscopy	www.bsg.org.uk/clinical/guidelines/endoscopy
Conscious Sedation Policy	WAHT-MED-006
Interpreting documentation	WAHT-CG-682
Access Policy	WAHT-CG-613
Waiting List Guidance	Intranet – Documents – A-Z – Waiting List Guidance
MRSA and C.Diff Policies	WAHT-INF-016 & WAHT-INF-03
Recruitment & Selection Policy	WAHT-HR-004
Sickness Absence, Health & Wellbeing Policy	WAHT-HR-072
Performance Management Policy	WAHT-HR-009
Equality & Diversity Policy	WAHT-HR-445
Bullying & Harassment Policy	WAHT-HR-016

11. Background

11.1. Equality

The assessment conducted for this policy reveals no equality issues.

11.2. Financial Risk

Failure of JAG standards will lead to a 5% reduction in Best Practice Tariff. Failure to gain accreditation could also mean loss of BCSP and commitment to growth and service development.

11.3. Consultation

Feedback obtained from broad selection of staff opinions have been sought from Medical Endoscopist, Nurse Endoscopist, Nursing Managers, Directorate Management, and Booking Team Leader.

11.4. Approval

This policy will be approved by the Endoscopy Directorate Group.

Appendix 1: Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Appendix 2: Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Appendix 3: Endoscopy Surge Operational procedure

Endoscopy WAHT SOP v1.1 (5).docx...

Appendix 4: Endoscopy Local Safety Standards for Invasive Procedures (locSSIP)

SCOPE Local Safety Standards for...

Appendix 5 • The Pituitary Foundation- Colonoscopy Guidance and Information- A guide for acromegaly, adrenal insufficient and diabetes insipidus patients (2018)

Colonoscopy-Fact-Sheet-May-2018- pituita

Appendix 6- Endoscopy Response to Covid 19

Endoscopy SOP COVID-19 v1.18 (2).p

Appendix 7: WR5226 Endoscopy Integrated Care Document

SF WR5226 Endoscopy Integrate

Appendix 8: WR5728 Endoscopy Health Questionnaire Version

SF WR5728 Endoscopy Health Qu

Appendix 9: Upper GI MDT referral process

UGI MDT referral form.docx

Appendix 10: Lower GI MDT referral process

Colorectal Cancer v1.1.docx

Appendix 11: Post Colonoscopy ColoRectal Cancer (PCCRC) process

Post Colonoscopy ColoRectal Cancer Pr

Appendix 12: Process for managing large polyps

Polyp Guidelines v1.1.docx