WAHT-KD-021

Right result to Right Patient

Key Document code:	WAHT-KD-021	
Key Documents Owner:	Emma Duggan	Bowel Cancer & Bowel Scope Screening
		Manager
Approved by:	Bowel Screening Operational Meeting	
Date of Approval:	29 th November 2022	
Date of review:	29 th November 2025	

Key Amendments

Date	Amendment	Approved by
19 th June 2019	Documents extended for 6 months whilst reviewed	Emma Duggan
11 th Feb 2020	Documents extended for 6 months whilst review and approval is processed	Emma Duggan
27 th July 2020	Documents extended for 6 months during COVID-19 period	QGC/Gold Meeting
1 st March 2021	Document extended for 6 months as per Trust agreement 11/02/2021	
16 th July 2021	Documents extended for 6 months whilst review and approval is processed	Emma Duggan/ Mr Stephen Lake
November 2022	Document approved with no amendments	SCSD Governance Meeting

Introduction

The purpose of this guideline is to ensure that the right patient is treated and given the right results throughout the screening pathway.

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Please note that the key documents are not designed to be printed, but to be used on-line. This is to ensure that the correct and most up-to-date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours and should be read in conjunction with the key document supporting information and/or Key Document intranet page, which will provide approval and review information.

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PATHWAY Clinic preparation	The admin team are responsible for reviewing the BCSS (IT system) on a daily basis for positive FIT referrals. New referrals are checked against the hospital PAS system to ensure that the data matches (Name, NHS number, DOB, Address, GP). Hospital notes are requested for Wye Valley patients and patient labels printed for WAHT patients by the admin team and placed in clinic folder with a copy of the clinic list.
Clinic reception/ SSP appointment	Clinic receptionist is provided with details of expected patients by SSP. On meeting each patient, the SSP will confirm the patient's name, DOB, address and GP and check that these details match the BCSS. Telephone contact details are entered onto BCSS. If BCSS details do not match, the patient is advised to update their GP with their personal details.
Endoscopy	On arrival in endoscopy the patient's details and notes are checked by the admitting endoscopy nurse. A name band is applied for subsequent identity checks throughout the endoscopy admission. Once the patient has entered the Endoscopy room a WHO checklist is carried out. Before the procedure the screening colonoscopist enters the patient's hospital number from the hospital notes into Unisoft (Endoscopy Reporting system) then and creates and prints the procedure report at the end of the procedure. SSP carries out identity checks, name, date of birth and address. Once confirmed with patient, procedure report information is presented to the patient on discharge.
Histology	The histology request form from Unisoft and ICE accompanies specimens to the lab. Specimens are labelled with patient identification labels and BCSP green stickers. The histology reporting system (ICE) is checked daily by the SSPs. When available, the report is printed and matched against BCSP documentation, for the SSP to complete the BCSS dataset.
Post Investigation Contact	The telephone details are taken from BCSS. Name, NHS number, and hospital number matched to endoscopy and histology report before the
MDT	Details (Name, NHS number, Hospital number and DOB) of patients for MDT discussion are emailed to MDT co-ordinators by the SSP, using the MDT referral forms for Wye Valley and WAHT. Notes are located by MDT co-ordinator. SSP attends MDT to present patient's case and results of discussions are emailed to SSPs and discussed with screening colonoscopist using hospital details.

Surveillance

When notified that a surveillance patient is due the Health Check form is generated from BCSS. On receipt of the Health Check form a telephone clinic appointment will be made. Another test in same episode Endoscopy report, patients' notes and histology are used by the SSP to discuss with the screening colonoscopist the need for further investigation. This is booked using the above procedures.

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