Gastroenterology Operational Policy

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Contents

1. Introduction 4
1.1 Purpose of policy 4
1.2 Roles and Responsibilities 4
1.3 Consultation 5
1.4 Training Requirements 5
1.5 Monitoring and Review Arrangements 5
1.6 Dissemination 5
2. Endoscopy Unit 5
2.1 Purpose 5
2.2 Unit layout 6
3. Referral criteria 7
3.1 Objectives 7
3.2 MoH Faster Cancer Treatment pathways 8
3.3 6-week diagnostic referral 8
3.4 Guidance notes for accepting referrals 8
4. Booking process 9
4.1 Gastroenterology and specialty referrals for outpatient endoscopy. 9
4.2 E-Referrals 9
4.3 Straight to test endoscopy / open access endoscopy 9
4.4 Acute / In-patients 9
4.5 Pre-Assessment Clinic (PAC) 9

Back to Contents

4.6 Patient Information 10
4.7 Anticoagulation 10
4.8 Diabetic patients 10
4.9 Infection control 10
5. Cancellations and DNA (Did Not Attend) 10
6. Out of hours 11
7. Scheduling rules 11
8. Endoscopy reporting system 12
8.1 Dual procedures 12
8.2 Pathology reports 12
9. Waiting list management 12
9.1 Objectives 12
9.2 Attendees 13
9.3 Management of waiting times 13
9.4 Reporting 13
9.5 Patient Tracker 13
10. Performance and productivity 13
11. Patient flow 13
11.1 Outpatient referrals 13
11.2 Inpatient referrals 14
11.3 ERCP 15
11.4 HALO/EMR/SBE/ Oesophageal physiology 16
11.5 Consent process 16
11.6 Privacy and Dignity 16
11.7 Confidentiality 16
11.8 Interpreting 16
11.9 Family members and support persons within the endoscopy room. 16
11.10 Aftercare 17
12. Decontamination 17
12.1 Personal Protective Equipment 17
12.2 Spillage Protocol 17
13. Adverse events 17
14. Workforce 17
14.1 Medical staff 17
14.2 Management 18
14.3 Nursing Staff 18
14.4 Administration staff 18
14.5 Staffing establishment 19
14.6 Staff Shortages 19
14.7 Staff sickness absence 19
15. Non Clinical Support 19
15.1 Orderlies 19
15.2 Cleaning Staff 19
16. Staff training 19
16.1 Gastroenterology website 19
16.2 Medical staff 20
16.3 Nursing staff 20

Back to Contents

16.4 Administration staff....20
17. Associated documents....20
18. Disclaimer....20
19. Corrections and amendments....21
Appendix 1 Anticoagulant and antiplatelet management for patients having an endoscopic procedure....22
Appendix 1a: CHADS2 Score....26
Appendix 1b: Algorithm for patients on oral anti-platelets....27
Appendix 1c: Algorithm for patients on oral anti-coagulants....28
Appendix 1d: Algorithm for patients on IV anti-coagulants....29
Appendix 1e: Algorithm for patients on injected anti-thrombotics....29
Appendix 2 Information and guide for patients with Diabetes on insulin - gastroscopy, bronchoscopy or ERCP....30
Appendix 2a Information and guide for patients with Diabetes on insulin - colonoscopy....32
Appendix 2b Information and guide for patients with Type 2 Diabetes on orals or diet alone - colonoscopy....35
Appendix 3 Endoscopy Unit standardised protocol for on call out of hours....37
Appendix 3a Out of hours medical help and advice following endoscopic procedures....38
Appendix 4 Pathology specimen and result handling....40

Back to Contents

1. Introduction

1.1 Purpose of policy

The purpose of this policy is to define the roles, responsibilities and operational systems for the nursing and medical staff working within the Endoscopy Unit. This will enable efficient utilisation and provision of a quality endoscopy service.

This is in line with the Auckland DHB vision:

Healthy communities | World-class healthcare | Achieved together
Kia kotahi te oranga mo te iti me te rahi o te hāpori

The Auckland DHB values form the basis for all interactions in the department:

Value	Description
Welcome – Haere Mai	We see you, we welcome you as a person
Respect – Manaaki	We respect, nurture and care for each other
Together – Tūhono	We are a high performing team: colleagues, patients and families
Aim high – Angamua	We aspire to excellence and the safest care

Meeting our obligations under Te Tiriti is necessary to realise the overall aim of Pae Ora (healthy futures for Māori). The principles of Te Tiriti o Waitangi provide the framework for how we meet our obligations under Te Tiriti in our day-to-day work.

- Preamble – Whakawhanaugatanga
- Kāwanatanga
- Tino Rangatiratanga
- Ōritetanga
- Wairuatanga

The Gastroenterology department will adhere to the Te Toka Tumai Tikanga Best Practice policy to protect the rights/rites of Māori, respect tikanga of manawhenua and practically contribute to prociding services that are responsive to Māori needs and interests.

1.2 Roles and Responsibilities

The Gastroenterology Service Clinical Director and Operations Manager

- Ensuring that a comprehensive operational policy for the Endoscopy unit is developed, agreed and reviewed.
- Ensuring staff within their area of responsibility are made aware of the policy.
- Ensuring the policy is implemented within their areas of responsibility.

Clinical Service Manager and Endoscopy Lead are responsible for:

- Ensuring all staff in their areas of responsibility are aware of and understand the policy.
- Investigating any failure to follow the policy.

Endoscopy Unit Manager and training lead are responsible for:

- Ensuring all staff are aware of and work within the revised policy and will be able to evidence their awareness.
- Including the operational policy within local induction procedures.
- Ensuring that all staff have access to the current copy of the policy.

Back to Contents

All staff (Medical, Nursing and administration)

- Have a responsibility to ensure they are aware of the operational policy and that they act in accordance with the policy at all times.
- Will ensure the Nurse Unit Manager and General Manager is aware of all incidents/failures that affect the operational policy.

1.3 Consultation

The policy has been developed in consultation with the following stakeholders:

- Clinical Lead
- Endoscopy Lead
- Endoscopy users
- Infection Control

1.4 Training Requirements

Training requirements have been considered but will not have any significant impact for this policy. Please refer to Endoscopy training manual 2021 which can be accessed via Gastroenterology team site on Hippo.

1.5 Monitoring and Review Arrangements

There will be an annual review to ensure the effectiveness of the policy. The key indicators will be:

- Audit of local induction, nursing and medical
- Audit of nursing and medical understanding of systems

1.6 Dissemination

The policy will be disseminated via Gastroenterology, Colorectal Surgery and Respiratory Service Clinical Directors, and through Endoscopy Users group.

2. Endoscopy Unit

2.1 Purpose

The purpose of the Endoscopy unit is to deliver a service for both inpatients and outpatients who require diagnostic investigations for a variety of upper and lower gastrointestinal conditions.

The core services provided are:

- Upper GI Endoscopy (Diagnostic and Therapeutic)
- Lower GI Endoscopy (Diagnostic and Therapeutic)
- ERCP (Diagnostic and Therapeutic) and Spyglass
- Bronchoscopy (Diagnostic and Therapeutic)
- EBUS (Diagnostic and Therapeutic)
- Advanced endoscopic techniques including:
    - Endoscopic mucosal resection and dissection
    - Radiofrequency ablation
    - Enteroscopy

- Capsule Endoscopy
- pH and manometry
- Infusion services

2.2 Unit layout

The Endoscopy unit consists of the following:

2.2.1 Auckland City Hospital

There is no dedicated Endoscopy Unit Reception. Patients arrive at the Level 6 Outpatient Department.

- Main waiting area
- Reception desk

Admissions area:

- Two private interview rooms
- One private interview room with facilities for enema preparation.

Procedure rooms:

- Room 1 (negative pressure system for bronchoscopy)
- Room 2
- Room 3

Recovery room:

- Ten recovery bed spaces

There is no facility for sex segregation pre- or post-procedure.

2nd Stage recovery and discharge:

- Seated discharge area, within the recovery area.
- Six recliner chairs - also used for day case infusions.

Decontamination:

- Dirty utility
- Clean utility

Restrooms/facilities:

- Two patient toilets in recovery area
- Shower facility plus WC in recovery area
- Single staff toilet
- Separate male/female staff changing room

Storage:

- Locked drug and medical supply room
- Equipment storage
- Domestic supplies
- Linen

Shared areas:

- Staff room
- Motility room

2.2.2 Greenlane Clinical Centre

Reception area:

- Main waiting area
- Reception desk

Admissions area:

- Two admission rooms

Procedure rooms:

- Room 1

Recovery room:

- Six recovery bed spaces

There is no sex segregation pre- or post-procedure.

Discharge:

- Seated discharge area, within the recovery area.

Decontamination:

- Dirty utility
- Clean utility

Restrooms/facilities:

- Single patient toilet outside of the recovery area
- Staff toilet
- There is one shared staff changing room

Storage:

- Locked drug and medical supply room
- Equipment storage
- Domestic supplies
- Linen

Shared areas:

- Staff room

3. Referral criteria

3.1 Objectives

The main objective of the Endoscopy unit is to undertake both diagnostic and therapeutic procedures as required.

Referrals fall into the following categories:

- High Suspicion of Cancer (HSC) - P1
  - Patients with proven or highly suspected cancer who require either an upper or lower endoscopy procedure within the P1 (2 week) diagnostic target.
- Urgent Non-HSC - P1
  - Patients who require urgent endoscopy within 2 weeks such as patients with suspected inflammatory bowel disease
- Non-urgent (routine) - P2
  - Patients who require either an upper or lower routine endoscopy procedure within the P2 (6 week) diagnostic target.
- Surveillance
  - Patients who require a structured surveillance follow up to detect the need for further treatment at appropriate follow up intervals for individual conditions.

3.2 MoH Faster Cancer Treatment pathways

The endoscopy unit adheres to the Ministry of Health criteria for the diagnosis and treatment of gastrointestinal cancers.

“90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.”

Endoscopic procedures form part of the first specialist appointment (FSA) if a patient is triaged straight to test from the GP referral. If the referral is triages as P1 (HSC), then the procedure should be performed within 2 weeks. If the patient has already had an FSA, the department has until 31 days on the target to provide diagnostic testing. In reality, this is 2 weeks from referral from the FSA.

3.3 6-week diagnostic referral

The Endoscopy unit adheres to the 6-week diagnostic referrals as described in the ADHB.

All referrals are received into the administration department of the unit via fax, letter, in person or e-Referral system. Referrals are collated daily (Mon-Fri) and added to the waiting list by the administration team.

Referrals are triaged daily according to a rota by a member of the Consultant Gastroenterology team.

Surveillance referrals are clinically and administratively validated to ensure that the repeat is still appropriate and conforms to current unit and national guidance for surveillance procedures.

3.4 Guidance notes for accepting referrals

Referrals will only be accepted provided 3 unique patient identifiers are clearly displayed on each referral. These can include the following:

- Name
- Date of Birth

- Hospital number

In the event of non-compliance, the referral will be returned to the parent team.

4. Booking process

The Endoscopy unit adheres to the booking process as described by the Auckland District Health Board Patient access, booking and choice policy under 'Policies and Guidelines'.

4.1 Gastroenterology and specialty referrals for outpatient endoscopy.

There is no direct booking capacity at ADHB.

For all patients who are seen in outpatient clinics on site and deemed to require a diagnostic procedure, a paper referral is required. This can be either the ADHB internal referral form or alternatively a copy of the clinic letter copied to the Bookings Clerk at ACH.

Referrals from non-Gastroenterology clinicians are added by Central Referrals Office to the electronic referrals. This is reviewed daily by the nominated Gastroenterology SMO.

Once vetted as appropriate, the patient is sent a letter containing the admission date and asked to ring the department to confirm if the date is suitable, alternative dates are agreed if required.

4.2 E-Referrals

All referrals are triaged by the designated consultant. Patients are triaged to either clinic or endoscopy. Priority is determined by triaging SMO according to ADHB protocols.

4.3 Straight to test endoscopy / open access endoscopy

The majority of the referrals are booked direct to test, with a small percentage to out-patients.

4.4 Acute / In-patients

The ward areas can fax or deliver the referral to the main office on the Endoscopy unit. The referral is then vetted by the clinician. The ward is contacted via telephone to inform of procedure allocation and to discuss preparation of the patient. Emergency procedures or procedures requiring movement of equipment off the endoscopy unit either require Gastroenterology Registrar review first or discussion with a senior member of the gastroenterology team.

4.5 Pre-Assessment Clinic (PAC)

This is not currently in place at present. Plans to trial PAC are in discussion with principles outlined below.

Patients requiring colonoscopy will be reviewed by the nursing team in a pre-assessment clinic, either in person or by telephone. The patient is provided with a date for PAC at least 2-3 weeks prior to scheduled procedure admission date. The PAC nurse will assess if a patient requires a bed pre or post procedure. The bed is then booked by the administration staff.

The Pre-assessment nurse completes the following:

- Patients history
- Explains and consents for the procedure
- Provide information regarding the bowel preparation.

If a patient fails to attend the PAC, the colonoscopy slot is passed back to the bookings team. The patient and the GP are informed of removal from waiting list.

4.6 Patient Information

All patients are provided with an information leaflet which describes the relevant procedure in detail. These information sheets are available on the Gastroenterology website.

4.7 Anticoagulation

The Endoscopy unit adheres to the BSG/ESGE guidelines for anticoagulants. The guidelines can be seen in Appendix 1. Flow charts should be readily available for quick reference on the endoscopy unit floor.

4.8 Diabetic patients

All patients who have diabetes are asked to contact The Endoscopy department for advice before their procedure, this information is on the patient information advice sheets.
The guidelines can be seen in Appendix 2, Appendix 2a and Appendix 2b

4.9 Infection control

All known infection risks should be placed on the end of the list. All members of staff adhere to the ADHB Infection Control policy regarding personal protective equipment.

5. Cancellations and DNA (Did Not Attend)

A patient is recorded as DNA if they do not arrive at their allocated appointment slot and no prior notice is given of this intention.

For straight to test GP referrals, a DNA occurs if the patient is not available/present at the agreed appointment date, time and location. A cancellation in advance, even if on the day, is not treated as a DNA.

In concordance with Auckland District Health Board Patient Access, Booking and Choice policy, for patients who have failed to attend their endoscopy appointment, the clinician will review the referral and clinical notes. Patients will be discharged back to the care of their GP having first ensured that:

1. The appointment was clearly communicated to the patient.
2. Discharging the patient is not contrary to their best clinical interest.
3. The clinical interests of vulnerable patients are protected.
4. The relevant clinician (usually an SMO) has been consulted.
5. Discharging the patient will not create further inequities.

Care should be taken to ensure that barriers to access for Māori whānau have been identified and addressed. Support from the Kaiarahi Nahi team is available for patients who are on a surgical

waiting list, and their endoscopy procedure is required to progress on their surgical pathway. The referral to Kaiarahi Nahi will be made by the surgical team and not the Gastroenterology Service. He Kāmaka Waiora kaumātua are available for whānau who need cultural support.

Where the responsible clinician believes that one of these criteria applies, the patient can be offered a further appointment. All patients should be discharged to the care of their GP following a second DNA. The patient's GP and the patient should be contacted on each occasion a patient fails to attend their appointment.

Secondary and tertiary care referrals for care diagnostic and therapeutic endoscopy, if a patient has failed to attend a diagnostic test the patient will be returned to the clinical team with a view to discharge. ADHB policy is that the patient will be discharged back to the care of their GP, providing it is not contrary to their best clinical interest. All patients should be discharged to the care of their GP following a second DNA of a diagnostic test or pre-operative assessment.

6. Out of hours

The unit provides a 24 hour 7 days a week out of hours emergency endoscopy service. The Gastroenterologists and Endoscopy nursing staff follow an agreed rota system for on call commitments. The protocol can be seen in Appendix 3.

7. Scheduling rules

The unit has an agreed system for point allocation for each endoscopy procedure:

Procedure	**Points**
Colonoscopy	1 (Diagnostic) 4+ (Therapeutic based on estimated procedure time)
OGD	1 (Diagnostic) 2 (Therapeutic) 2+ (therapeutic based on estimated procedure time)
Flexible Sigmoidoscopy	1
ERCP/EUS	3
Bronchoscopy	2
EBUS	3

A standard service list – outpatient and inpatient - list has 12 points; however these are adjusted where necessary for training when the list is reduced to 8 points. The lists are mixed procedures unless otherwise determined by the list endoscopist skillset e.g. colorectal service lists do not have upper GI procedures.

8. Endoscopy reporting system

The Endoscopy unit uses the Provation Endoscopy Reporting System.

Endoscopy reports record all procedural, operator and patient follow up details. All reports are finalised and printed on completion of each procedure. A copy of the report will be available on the ADHB results server (éclair / Concerto) where possible. In instances where the procedure is done without the online reporting system, a copy of the report is written in the patient case notes by the endoscopist. The endoscopists should put a retrospective report onto Provation if done off-line e.g. if procedure done in another department such as ICU.

8.1 Dual procedures

In the event of a dual procedure sedation is recorded for the first procedure to reflect what was given for that procedure, and for the second procedure to record what has been given in total for the two procedures.
E.g. for gastroscopy and colonoscopy

- 25mg fentanyl and 2mg midazolam were administered prior to the gastroscopy and then a further 25mg fentanyl for the colonoscopy

This would be recorded as

- Gastroscopy Fentanyl 25mcg, midazolam 2mg;
- Colonoscopy Fentanyl 50mcg, midazolam 2mg

In the example above, current audit of sedation for the colonoscopy would report a total dose of 25mcg of Fentanyl. Despite the patient receiving a higher dose of sedation.

This method will standardise the documentation of sedation use and allow for more accurate auditing of sedation doses used and related patient comfort.

8.2 Pathology reports

All outpatient pathology reports go directly to the list supervising endoscopist. It is the responsibility of the endoscopist to action histology results within 5 working days of receipt of the histology result. Inpatient histology results are sent directly to the referring ward team.
The process can be seen in Appendix 4.

9. Waiting list management

9.1 Objectives

A weekly capacity planning meeting has been agreed and the main objective is to monitor and review waiting times. A standard agenda consists of the following reviews:

- Demand
- Capacity-Identifying and agreed action of any shortfalls
- Scheduling
- List Utilisation
- Breaches

- Backfilling
- Key constraints

9.2 Attendees

- Endoscopy lead
- Clinical Service Manager
- Charge Nurse
- Administration Manager

9.3 Management of waiting times

The unit effectively utilizes the Patient Tracking List to manage waiting times.

9.4 Reporting

A summary of demand, capacity and activity is presented at the business meetings.

9.5 Patient Tracker

The Endoscopy unit has a nominated patient tracker who validates the waiting list.

10. Performance and productivity

Endoscopy productivity is collected through GRS productivity tool. The results are analysed and acted upon. These include the following which are displayed and discussed at the monthly business meeting:

- Room utilisation
- Staff utilisation
- Extent of backfilling
- Utilisation of the scheduled time
- Start and finish times
- 6-week rule compliance

A monthly performance meeting is held with the General Manager, Director Adult Medical, Clinical Director, Nurse Unit Manager, and Operations Manager.

11. Patient flow

11.1 Outpatient referrals

Patients are referred to the unit from their GP or outpatient clinics, on arrival patients report to the reception area. The administration clerk will book the patient in on the computer system and ask to wait in the seated waiting area.

The admitting nurse will call the patient and escort them to the admission room. The admitting nurse will clerk, consent and (if necessary) obtain intravenous access in the patient.

The next stage is dependent on the procedure to be carried out:

OGD	• The patient is asked to wait on the bed

Back to Contents

Flexible Sigmoidoscopy	• Enema administered at bed space • The patient is asked to wait on their bed once changed into gown
Colonoscopy	• The patient is asked to wait on their bed once changed into gown

The admitting nurse will escort the patient into the procedure room. The admitting nurse will undertake a “time out” hand-over to the procedure room endoscopist. This should confirm the correct patient and procedure using the WHO checklist criteria as well as any concerns highlighted during the admission process including allergy status. Two nursing staff will assist the clinician in preparing the patient and undertaking the procedure. The first of the nursing staff will support the patient throughout the procedure, whilst the second will assist the clinician.

On completion of the procedure the patient will be transferred to the recovery area. The recovery nurse will complete the patient’s observations.

When sufficiently recovered, patients are escorted to the 2nd Stage Recovery area, the patients are offered the opportunity to discuss their care in private. The discharge nurse will explain the procedure findings and any necessary follow up arrangements. Patients are offered a drink and food as appropriate. Patients will be discharged into the care of family or friends.

If there is a delay in patient pick-up, the transit lounge can be utilized as a safe place for patients who have has sedation to recover whilst awaiting their transport home.

The recovery nurse will contact the relevant ward area for patients that require an overnight stay. The patient will be escorted to the ward area with the transit nurse and hospital orderly.

11.2 Inpatient referrals

Patients are referred from inpatient ward areas.

The unit coordinating nurse will contact the relevant ward to ensure the following are completed:

- Patient fasted (if relevant)
- Consent obtained
- Interpreter is arranged if required
- Anticoagulation is optimised
- Intravenous access
- Oral bowel prep has been administered (if required)
- Provide time for enema to be administered on the ward (if required)
- Any contact precautions (such as ESBL)

The coordinating nurse will inform the orderly when to collect the patient from the relevant ward.

On arrival the patient is transferred to the recovery area to wait. Two nursing staff will assist the clinician in preparing the patient and undertaking the procedure. The first of the nursing staff will support the patient throughout the procedure, whilst the second will assist the clinician in preparing and operating clinical equipment.

Back to Contents

On completion of the procedure the patient will be transferred back to the recovery area. The recovery nurse will complete the patient's observations.

When sufficiently recovered the recovery nurse will contact the transit nurse to hand over and the orderly who will escort the patient back to the ward area. The transit team will them hand over care back to the ward team.

11.3 ERCP

The designated Gastroenterology administration team work closely with the designated consultants and are responsible for planning the lists.

ERCP procedures are performed in the radiology suite of the Hospital.

Both nursing and medical staff from the Endoscopy unit are assigned to work in the radiology suite/theatres on the designated days.

For outpatients:
The admission nurse will complete the documentation, ensuring the patient

- Appropriately fasted
- Consent obtained
- Bloods within agreed parameters
- Antibiotics given if required

For inpatients:
The allocated Endoscopy nurse will contact the ward to ensure the following is completed:

- Patient fasted (if relevant)
- Consent obtained (normally obtained by the gastroenterology ward team)
- Bloods and coagulation within agreed parameters
- Antibiotics given if required

The procedure room nurse will inform the Endoscopy orderly when to collect the patient from the relevant ward.

On arrival the patient is transferred straight to the fluoroscopy room. Three nursing staff will assist the clinician in preparing the patient and undertaking the procedure. One of the nursing staff will support the patient throughout the procedure; the other nurses will assist the clinician in preparing and administering any necessary analgesia and sedatives plus supply and operate clinical equipment as required.

On completion of the procedure the patient will be transferred to the recovery area. The recovery nurse will complete the patient's observations.

When sufficiently recovered the recovery nurse will contact the transit nurse (to hand over) and the orderly to escort the patient back to the ward area. Care will be handed back to the ward team by the transit nurse.

11.4 HALO/EMR/SBE/ Oesophageal physiology

These procedures are performed in the endoscopy procedure rooms; patient management prior to entering the room is as with standard endoscopic procedures (11.1 and 11.2). Two or three nursing staff will assist the endoscopist in preparing the room for the procedure and care for patient. Numbers of staff will depend on the case complexity. Experienced nursing staff will lead with the assistance of the procedure. Additional junior team members may assist in order to receive training and exposure but should not be routinely the primary assistant to the clinician until deemed competent to do so.

11.5 Consent process

Procedure consent is obtained after discussion with the patient, by the admitting nurse on the day of and prior to their procedure. This should be done in the interview room and not within the procedure room.

For patients who are unable to sign their consent, staff will adhere to the Auckland DHB Consent policy. Friends and family are recommended not to be used as an interpreter unless in person or phone interpreter is not available to proceed with the consent process. The patients have been sent information leaflets regarding their procedure prior to the day. In the event of occasions during endoscopic procedures when patients appear to withdraw consent due to distress or discomfort an agreed process is followed. Detailed consent process can be accessed through Auckland District Health Board Informed consent policy under 'Policies and Guidelines'.

11.6 Privacy and Dignity

All patients having a lower examination are asked to wear a hospital gown prior to and during the procedure. The patient's property remains in their care throughout the procedure. Patient's privacy is adequately protected in procedure rooms and there are processes in place to ensure the room is not entered during the procedure. Privacy and dignity of all patients is formally reviewed annually by endoscopy unit patient survey.

11.7 Confidentiality

Within the confines of the endoscopy unit, as much care as possible is taken to ensure there is no identifiable patient information on display. In the event of a patient being informed of suspected malignancy, the clinician will make the decision to let the patient know prior to discharge. The clinician, nurse, patient and relatives will be spoken to using one of the interview rooms.

11.8 Interpreting

All patients with communication needs are offered a professional interpreter. The use of untrained interpreters (family and friends) is discouraged unless in person or phone interpreter is not available during the consent process. There are exceptions to using an untrained interpreter which is outlined in Auckland District Health Board Interpreters policy under 'Policies and Guidelines'.

11.9 Family members and support persons within the endoscopy room.

The presence of family members in the endoscopy room is the sole decision of the endoscopist performing the procedure. Detailed guidance can be accessed through Auckland District Health Board Support Personal in Operating Rooms, Procedure Rooms and Endoscopy Suite policy under 'Policies and Guidelines'.

Back to Contents

11.10 Aftercare

All patients are provided with discharge aftercare patient advice sheets that include contact numbers for advice both in and out of hours. These are also available on the Gastroenterology website. The Endoscopy unit has an agreement with the Healthline as the out of hours contact; the policy can be seen in Appendix 3a.

12. Decontamination

The unit adheres to the Auckland District Health Board Decontamination policy. The Health Board has a designated Decontamination lead.

12.1 Personal Protective Equipment

All endoscopy staff are required to wear hospital provided surgical scrubs and appropriate closed toe footwear. Eye protection and face shields are available for all staff. Auckland District Health Board Uniform, Surgical Attire/Scrub Clothing and Professional Presentation policy under 'Policies and Guideline' has further information about personal protective equipment.

12.2 Spillage Protocol

The unit adheres to the Auckland District Health Board Medications – Cytotoxic Spillage policy under 'Policies and Guidelines'.

Addition protocols can be found in the Auckland District Health Board EPARM Section 14 Hazardous materials incident on the endoscopy unit.

13. Adverse events

Adverse events and the action taken are recorded in the designated adverse events file located in each of the endoscopy rooms and the Endoscopy unit office. These incidents are then discussed, and action agreed at the unit meetings. The staff is to follow the Auckland District Health Board Risk management framework policy under 'Policies and Guidelines' and complete risk incidents where required.

14. Workforce

14.1 Medical staff

Consultant Gastroenterologists:
The unit has 10 Gastroenterologists (approximately 6.0 FTE) and their prime functions are to deliver Specialist Gastroenterology Services both in the unit and on the wards. This includes the in-patient and outpatient endoscopy services as well as consultations.

The Speciality Clinical Director has overall responsibility.

Subspecialist interests include:

- Endoscopy

- Nutrition
- Hepatology
- IBD
- Training
- Bowel Cancer Screening (tba)

The Gastroenterologists undertake the following rotas:

- Emergency endoscopy rota 1:8
- Weekend ward round cover 1:8

Colorectal Surgical Consultants, registrars, and on occasion fully trained fellows, work along with the 8 Gastroenterologists to perform the necessary procedures in Endoscopy. This is likely to expand over the foreseeable future with the inclusion of Nurse Endoscopists.

14.2 Management

The unit is supported by a Nursing Unit Manager (NUM) and an Operations Manager. These positions are not exclusive to Gastroenterology/Endoscopy but are shared with Respiratory and Infectious Disease services.

14.3 Nursing Staff

The unit is staffed with the following nursing staff:

Designation	FTE
Charge Nurse Manager	1.0
Level 4 registered nurse	3.7
Level 3 registered nurse	5.4
Level 2 registered nurse	5.0
Technician	1.0

The unit also has the following specialist practitioners:

Designation	FTE
IBD Nurse specialist	0.6

14.4 Administration staff

The unit is staffed with the following admin staff

Designation	FTE
Team Support	0.5
Schedulers	3.0

Back to Contents

14.5 Staffing establishment

The Charge Nurse Manager is responsible for ensuring the staffing establishment and skill mix is reviewed and altered as required in anticipation of service changes and future vacancies.

14.6 Staff Shortages

In the event of a sudden reduction in the normal nursing, admin and medical staffing levels, the following action should be taken:

- The senior staff member should assess the skill mix and numbers of staff allocated to work and ensure the unit can be staffed safely
- Staff currently working should be asked if they could work at short notice to cover the shift if deemed necessary
- Discuss with the Nurse Unit Manager and request if staff from other areas can assist to cover shortfall
- Nurse Unit Manager to request bureau/resource nurses/HCA to support
- In the event of staff shortages which may influence patient safety, flow and or activity, the General Manager of Adult Medical must be informed
- In the event of medical staff absences, the Service Clinical Director and/or designated Clinical Lead should be informed.

14.7 Staff sickness absence

Staff absence due to illness will be managed in accordance with the Auckland District Health Board Managing sick leave-Guide for managers policy under 'Health and Safety'.

15. Non Clinical Support

15.1 Orderlies

The unit is supported by one designated orderly. The orderly is based on the unit and allocated to Endoscopy work only. Out of their working hours the main Hospital orderly pool, is contacted.

15.2 Cleaning Staff

The unit is supported by cleaning staff managed via Non Clinical Support Services.

16. Staff training

The Endoscopy unit supports a proactive approach to staff development.

16.1 Gastroenterology website

The Endoscopy unit has a designated Gastroenterology website and includes information regarding all the relevant training available.

This is an evolving system and information will be increased and updated over time.

Back to Contents

16.2 Medical staff

An allocated Gastroenterologist is responsible for the training of medical staff. The training lead agrees with the individual medical staff an agreed competency and training plan. Training is carried out according to NZ Conjoint Committee standards.

The aim is to have medical training resources available on the Gastroenterology website. Endoscopy training manual can be accessed via Gastroenterology team site on Hippo.

16.3 Nursing staff

Newly employed staff enter a probationary and preceptor-ship period. The member of staff follows a structured induction package.

All members of nursing staff are offered the opportunity to undertake a variety of in and out of house training. Endoscopy resource manual is available on Gastroenterology team site on Hippo.

16.4 Administration staff

Newly employed admin staff members enter a probationary and preceptor-ship period. The member of staff follows a structured induction package.

All staff members both medical and non-medical are required to undertake mandatory training as detailed in the Auckland DHB training policy.

17. Associated documents

Auckland DHB wide documents

- Decontamination policy
- Emergency Preparedness & Response Manual
- Infection Control policy
- Informed consent policy
- Interpreters policy
- Managing sick leave - Guide for managers policy
- Medications - Cytotoxic Spillage policy
- Patient access, booking and choice policy
- Risk management framework policy
- Support Personal in Operating Rooms, Procedure Rooms and Endoscopy Suite policy

Endoscopy Department specific documents

- Endoscopy resource manual 2018
- Endoscopy training manual 2021

18. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their

own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

19. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.

Appendix 1 Anticoagulant and antiplatelet management for patients having an endoscopic procedure

1. Purpose of guideline

The risk of endoscopy in patients prescribed anticoagulant and antiplatelet therapy depends on the risks of procedural haemorrhage versus thrombosis due to discontinuation of therapy. This guideline seeks to facilitate the safe and effective care of these patients when undergoing endoscopic procedures within the Endoscopy Unit at Auckland District Health Board.

The purpose of this document is to ensure that all Endoscopy staff are aware of the process to follow when a patient is on anticoagulant and/or antiplatelet medication and requires an endoscopic procedure. The purpose is also to provide Medical and Nursing Staff with guidelines for how to appropriately manage anticoagulation and antiplatelet agents for patients prior to an endoscopic procedure.

This guide does not cover patients on anticoagulant or antiplatelet agents who have evidence of acute gastrointestinal haemorrhage. This is a medical emergency and the patient's medical team should be notified immediately.

2. Definitions

Term	Definition
Anticoagulants	An anticoagulant is a medication that either treats or prevents blood clots, often called a 'blood thinner'. Both warfarin and DOAC are examples of anticoagulants.
Direct Oral Anticoagulants (DOAC)	DOAC refers to a group of new anticoagulant medications. DOAC are direct because they block a single blood clotting factor to treat or prevent blood clots. DOAC begin working faster than warfarin and leave the body faster than warfarin. Examples include dabigatran (Pradaxa), rivaroxaban (Xarelto), apixaban (Eliquis). The advantage of these agents over warfarin is that they do not require monitoring with blood tests: the INR is not useful in judging the therapeutic effect on blood clotting. However, the disadvantage is that reversal of their anticoagulant effect is more challenging.
Warfarin	Warfarin and other vitamin K antagonists are anticoagulants used in a variety of clinical settings. These agents can be easily reversed with vitamin K, Fresh Frozen Plasma (FFP), or prothrombin complex concentrates (PCCs), conferring a significant advantage over DOAC.
Antiplatelets	Platelets play a major role in the body's ability to form clots – both thrombus formation and thrombus growth. Platelets are also involved in initiating inflammation, endothelial dysfunction, atherosclerosis, and acute vascular ischemic events. Some of the known compounds that inhibit platelet activation include inhibitors of cyclooxygenase [COX]-1 (e.g. aspirin, ibuprofen), and P2Y12 inhibitors (e.g. clopidogrel, ticagrelor).
Dual Antiplatelet Therapy (DAPT)	DAPT refers to the dual therapy of aspirin plus another antiplatelet agent, such as clopidogrel (Plavix) or ticagrelor (Brilinta). DAPT is commonly used for patients with coronary artery disease.

Back to Contents

3. For patients undergoing **low-risk** endoscopic procedures

This section pertains to patients undergoing the following procedures:

- Gastroscopy and/or colonoscopy +/- biopsy (most diagnostic procedures)
- Device–assisted enteroscopy without polypectomy
- Cold snare polypectomy less than 10mm

a) Oral antiplatelets

Aspirin	• Continue therapy
Dipyridamole	• Continue therapy
Clopidogrel (Plavix), Prasugrel (Effient), Ticagrelor (Brilinta)	• Continue therapy

b) Oral anticoagulants

Warfarin	• Continue therapy
	• Check INR less than seven days before endoscopy appointment
	  ○ If INR within therapeutic range, continue usual daily dose
	  ○ If INR above the therapeutic range but <5, reduce daily dose until INR returns to therapeutic range
	  ○ If INR is >5, seek advice from medical staff, gastroenterology consultant or registrar.
	• Warfarin should continue after endoscopy has been performed. If unsure (for example if bleeding occurred during procedure), seek advice from medical staff as to when to restart warfarin after the procedure.

DOAC e.g. dabigatran (Pradaxa), rivaroxaban (Xarelto), apixaban (Eliquis)	• Omit DOAC on morning of procedure. Restart DOAC after the procedure unless there has been a complication such as bleeding, in which case seek advice from medical staff.

c) Injected anticoagulants

Enoxaparin (Clexane)	• Continue therapy
Heparin infusion	• Continue therapy

4. For patients undergoing **high-risk** endoscopic procedures

This section pertains to patients undergoing the following procedures:

- All bronchoscopic procedures
- Polypectomy larger than 10mm
- Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
- Endoscopic Mucosal Resection (EMR) or Endoscopic Submucosal Dissection (ESD)
- Dilation or stenting of strictures
- Therapy of varices
- Percutaneous Endoscopic Gastrostomy (PEG) insertion
- Endoscopic UltraSound (EUS) with Fine Needle Aspiration (FNA)
- Argon Plasma Coagulation (APC)
- HALO Radiofrequency Ablation
- Large segment Barrett's oesophagus

Back to Contents

a) Oral antiplatelets

Aspirin	• Continue therapy
Dipyridamole	• Continue therapy
Clopidogrel (Plavix), Prasugrel (Effient), Ticagrelor (Brilinta)	It is important to know the indication for these medications being prescribed - the risk of stopping these medications may outweigh the risk of haemorrhage during the endoscopic procedure. For patients with coronary artery stents, a High Risk Condition: • Patients' with coronary stents in situ have a high thrombotic risk if antiplatelet drug therapy is interrupted. Elective high risk endoscopy should therefore be avoided where possible after stent placement when patients are most prone to thrombosis. This is during the first six weeks for bare metal stents, and during the first 12 months for drug-eluting stents. • Liaise with a cardiologist • If more than 12 months after insertion of drug-eluting coronary stent or more than six weeks after insertion of bare metal coronary stent, consider stopping all antiplatelets <u>except</u> aspirin which should continue For patients with a Low Risk Condition such as ischaemic heart disease, without coronary stent, cerebrovascular or peripheral vascular disease: • Stop antiplatelet agent 7 days before bronchoscopy, 5 days before all other high-risk endoscopic procedures. • Continue aspirin, if prescribed • Consider starting 75mg aspirin if not prescribed. • Antiplatelet therapy should be resumed following the procedure as soon as there is adequate haemostasis, usually the morning after the procedure.

b) Oral anticoagulants

Warfarin	When considering how to manage patients on warfarin who require a high risk endoscopic procedure, it is helpful to weigh up the risk of haemorrhage versus the risk of thromboembolism. This requires consideration of the indication for anticoagulation, history of any thrombotic events and the type of endoscopic procedure and its associated risks of bleeding. For High Risk Conditions, e.g. prosthetic metal heart valve in mitral position, prosthetic heart valve and AF, AF and mitral stenosis or other valvular disease, less than 3 months after VTE • Stop warfarin 5 days before endoscopy • Start low molecular weight heparin (LMWH) two days after stopping warfarin • Give last dose of LMWH at least 24 hours before procedure with usual daily dose • Post-procedure, continue LMWH until INR is appropriate for the patient. For Low Risk Conditions, e.g. prosthetic metal heart valve in the aortic position, xenograft heart valve, atrial fibrillation (AF) without valvular

Back to Contents

<table>
<tr><td></td><td>disease, more than 3 months after venous thromboembolism (VTE), thrombophilia syndromes (liaise with haematologist)
Stop warfarin 5 days before endoscopy
Check INR the day prior to procedure to ensure INR<1.5
Restart warfarin evening of procedure with usual daily dose unless given advice to the contrary by the endoscopist.
Check INR after one week (or earlier as required) to ensure adequate anticoagulation</td></tr>
<tr><td>DOAC e.g. dabigatran (Pradaxa), rivaroxaban (Xarelto), apixaban (Eliquis)</td><td>Stop drug at least 48 hours before procedure.
For dabigatran with creatinine clearance (eGFR) 30-50ml/min, take last dose of drug 96 hours before bronchoscopy or 72 hours before all other high-risk procedures.
For any patient with rapidly deteriorating renal function, a haematologist should be consulted.
Restart DOAC on the evening of the procedure unless given advice to the contrary by endoscopist.</td></tr>
</table>

c) Injected anticoagulants

<table>
<tr><td>Enoxaparin (Clexane)</td><td>If the patient is on a prophylactic dose (often 20mg or 40mg daily): withhold for 12 hours.
If the patient is on a therapeutic dose (often 1 mg/kg every 12 hours): withhold for 24 hours</td></tr>
<tr><td>Heparin infusion</td><td>Infusion should be stopped six hours prior to endoscopic procedure. Liaise with Endoscopy Nurse Coordinator (extension 25577) as to what time to stop the infusion.
Restarting heparin will depend on the risk of post-procedure haemorrhage but is usually the same day as the procedure. Seek advice from the medical team, gastroenterology consultant or registrar.</td></tr>
</table>

References

- Gage, B.F., van Walraven, C., Pearce, L., Hart, R.G., Koudstaal, P.J., Boode B.S., Petersen, P. (2004). Selecting patients with atrial fibrillation for anticoagulation: Stroke risk stratification in patients taking aspirin. Circulation;110(16), 2287-92.
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Associated Auckland DHB documents

- Medication administration

Back to Contents

- Informed consent
- IV Therapy
- Guidelines on Oral Anti-platelets for Endoscopic Procedures [via gastroenterology intranet page]
- Guidelines on Oral Anticoagulants for Endoscopic Procedures [via gastroenterology intranet page]
- Guidelines on IV Anticoagulants for Endoscopic Procedures [via gastroenterology intranet page]
- Guidelines on IV Anti-thrombotics for Endoscopic Procedures [via gastroenterology intranet page]

Clinical forms

- CR4102 Endoscopy Pre-procedure Checklist
- CR4054 Endoscopy Procedure In-Patient Form
- CR4092 or POS4092: Endoscopy Assessment Outpatient

Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

Appendix 1a: CHADS2 Score

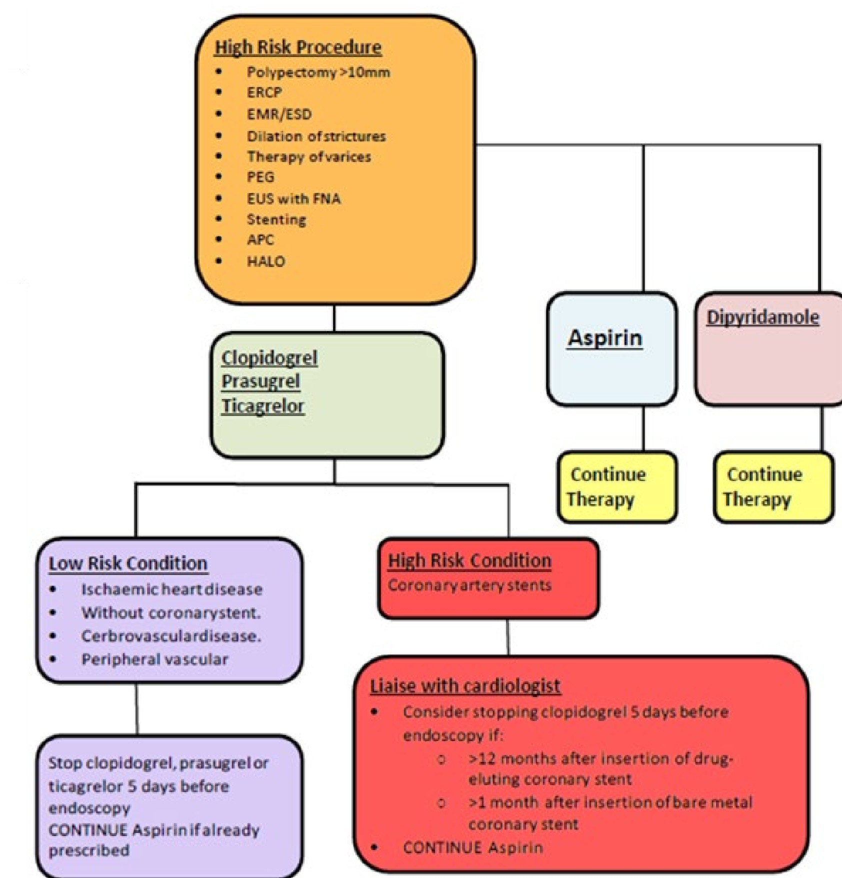
The CHADS2 score is one of several risk stratification schema that can help determine the 1 year risk of an ischemic stroke in a non-anticoagulated patient with non-valvular AF.

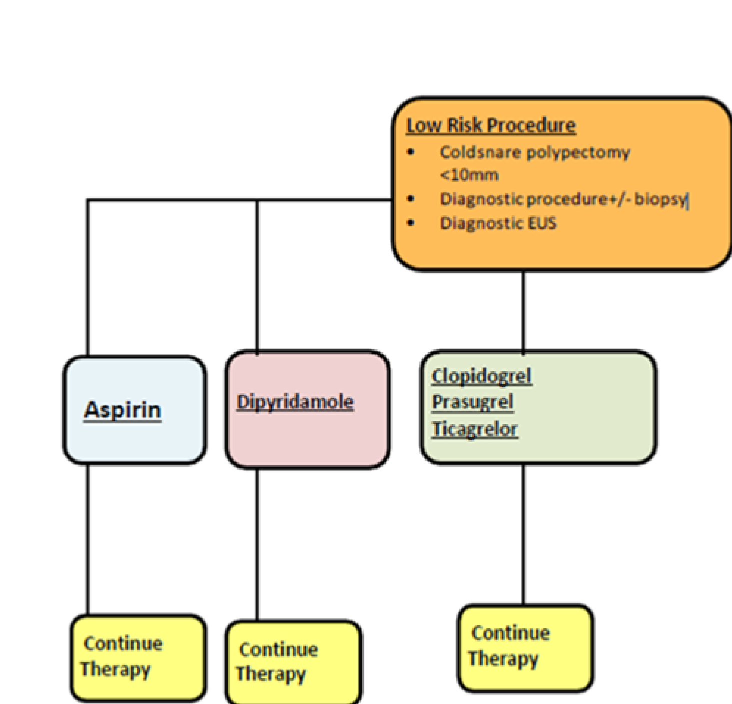
Criterion	**Points**
Congestive heart failure, past or current	1 point
Age ≥75 years	1 point
Diabetes mellitus	1 point
Stroke (ischaemic), transient ischaemic attack or thromboembolism	2 points

For a CHADS2 score of 0, the annual stroke risk is 0.8-3.2%, increasing to up to 18.2% annual stroke risk for patients with a score of 6.

Back to Contents

Appendix 1b: Algorithm for patients on oral anti-platelets

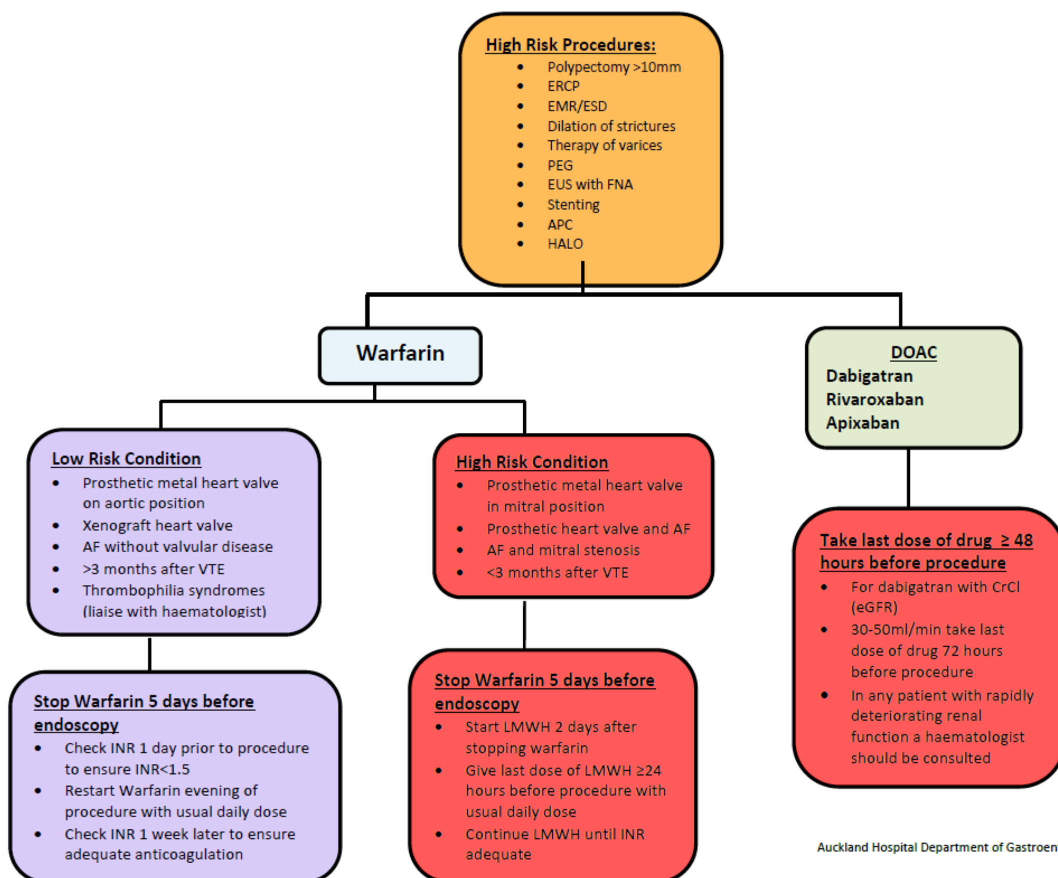


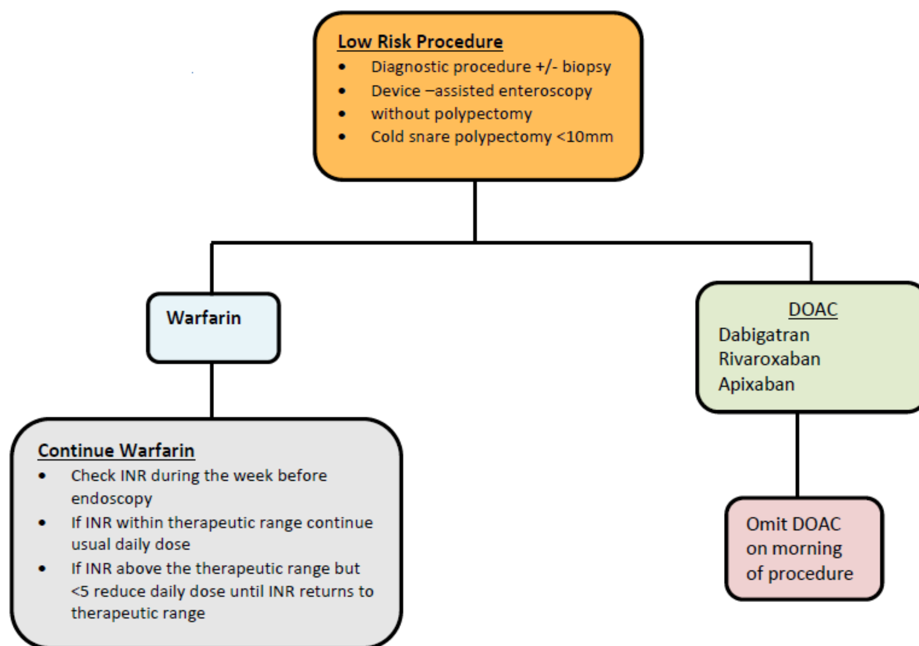


(EUS: Endoscopic Ultrasound, ERCP: Endoscopic Retrograde Cholangiopancreatography, EMR: Endoscopic Mucosal Resection, ESD: Endoscopic Submucosal Dissection, PEG: Percutaneous Endoscopic Gastroenterostomy, FNA: Fine Needle Aspiration, APC: Argon Plasma Coagulation)

Auckland Hospital Department of Gastroenterology & Hepatology Jan 2017

Appendix 1c: Algorithm for patients on oral anti-coagulants

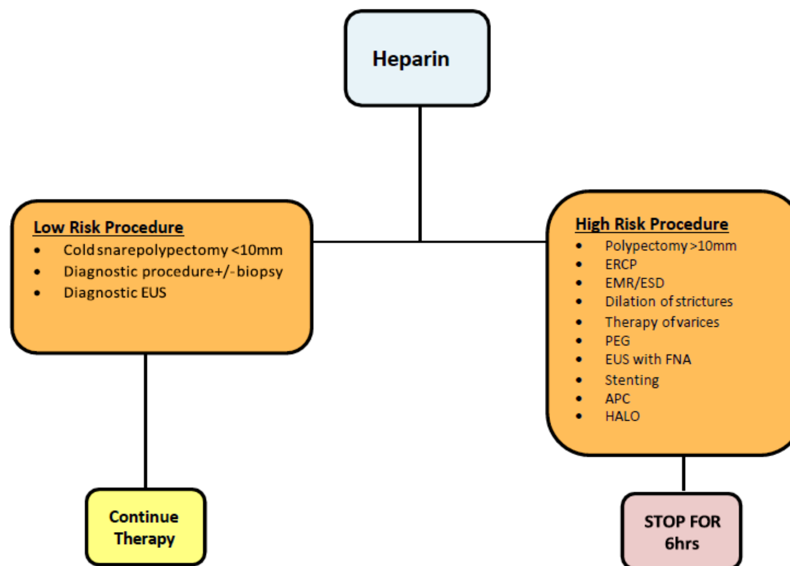




Auckland Hospital Department of Gastroenterology & Hepatology Jan 2017

Back to Contents

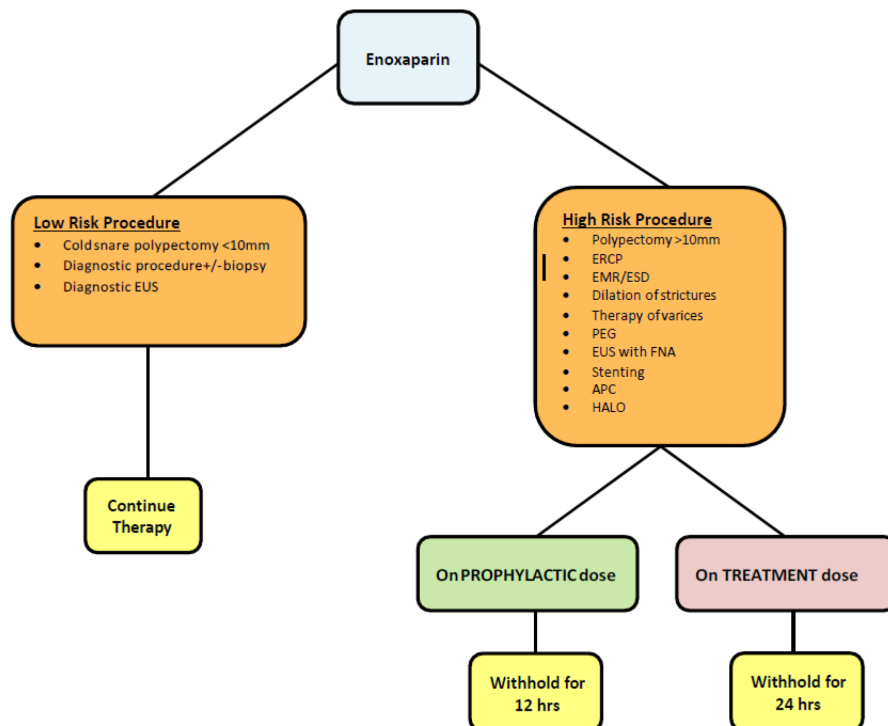
Appendix 1d: Algorithm for patients on IV anti-coagulants



(EUS: Endoscopic Ultrasound, ERCP: Endoscopic Retrograde Cholangiopancreatography, EMR: Endoscopic Mucosal Resection, ESD: Endoscopic Submucosal Dissection, PEG: Percutaneous Endoscopic Gastroenterostomy, FNA: Fine Needle Aspiration, APC: Argon Plasma Coagulation)

Auckland Hospital Department of Gastroenterology & Hepatology Feb 2017

Appendix 1e: Algorithm for patients on injected anti-thrombotics



(EUS: Endoscopic Ultrasound, ERCP: Endoscopic Retrograde Cholangiopancreatography, EMR: Endoscopic Mucosal Resection, ESD: Endoscopic Submucosal Dissection, PEG: Percutaneous Endoscopic Gastroenterostomy, FNA: Fine Needle Aspiration, APC: Argon Plasma Coagulation)

Auckland Hospital Department of Gastroenterology & Hepatology Feb 2017

Back to Contents

Appendix 2 Information and guide for patients with Diabetes on insulin - gastroscopy, bronchoscopy or ERCP

(In addition to the preparation instructions from the Gastroenterology Department)

Name **(LABEL)** **Address, phone**

Diabetes Doctor or Nurse:

Test your blood Glucose levels 4 x a day – Aim for levels 6-12mmol/l
Usual Insulin Regimen: - *complete table*

Insulin	Breakfast	Lunch	Dinner	Bed

Insulin regimen for your Gastroscopy: *complete table*
Fasting from 12 midnight

Insulin	Breakfast	Lunch	Dinner	Bed

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Oral hypoglycaemics Metformin, Glipizide, Gliclazide, Vildagliptin, Galvumet, Pioglitazone, Exanatide and Acarbose **Oral SGLT-2 inhibitors (Gliflozins)** Dapagliflozin (Forxiga) Empagliflozin (Jardiance) Canagliflozin (Invokana)			w/h until after the test Restart with next regular meal	
Long acting insulin (morning) (Humulin NPH, Lantus, Protophane)			½ usual dose	Restart usual dose
Long acting insulin (evening) (Humulin NPH, Lantus, Protophane)		½ usual dose	Restart usual dose evening	

Back to Contents

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Short acting insulin (one or more injections) (Actrapid, Apidra, Humalog, Novorapid, Humulin R)			w/h morning Restart with next regular meal	
2-3 injections of pre-mixed insulin (Humulin 30/70, Mixtard 30, Penmix 30, Penmix 40, Penmix 50, Humalog Mix 25, Humalog Mix 50, NovoMix 30)			½ usual dose Restart normal dose evening	

****If you have any uncertainty at all ask your GP or Diabetes Nurse for assistance. ****
The phone number for the Diabetes Service is 6309980.

Back to Contents

Appendix 2a Information and guide for patients with Diabetes on insulin - colonoscopy

(In addition to the preparation instructions from the Gastroenterology Department)

Name **(LABEL)** **Address, phone**

Diabetes Doctor or Nurse:

Usual Insulin Regimen:

Insulin	Breakfast	Lunch	Dinner	Bed

If you are using an Insulin Pump, continue with usual basal rates prior to the day of the procedure. On the day of the procedure use a temporary basal rate with a 10% -20% reduction until you have completed the recovery phase. Lock the pump so you are not tempted to adjust anything during the recovery phase as you will be under the influence of medications. Once you are cleared to eat and go home, return to the usual basal rate.

We recommend that you talk to your Diabetes Nurse Specialist for individualised guidance

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2 days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Oral hypoglycaemics Metformin, Glipizide, Gliclazide, Vildagliptin, Galvumet, Pioglitazone, Exanatide and Acarbose		Take normal morning dose then w/h	w/h until after the test Restart with next regular meal	
Oral SGLT-2 inhibitors (Gliflozins) Dapagliflozin (Forxiga) Empagliflozin (Jardiance) Canagliflozin (Invokana)	Stop	Stop	Stop	Restart
Long acting insulin (morning) (Humulin NPH, Lantus, Protophane)		½ usual dose	½ usual dose	Restart usual dose
Long acting insulin (evening) (Humulin NPH, Lantus, Protophane)		½ usual dose	Restart usual dose evening	

Back to Contents

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2 days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Short acting insulin (one or more injections) (Actrapid, Apidra, Humalog, Novorapid, Humulin R)		Usual dose at breakfast From lunchtime reduced doses approx. ½ usual dose at lunch & evening meal time (taken with clear fluids see list*)	w/h morning Restart with next regular meal	
2-3 injections of pre-mixed insulin (Humulin 30/70, Mixtard 30, Penmix 30, Penmix 40, Penmix 50, Humalog Mix 25, Humalog Mix 50, NovoMix 30)		½ usual dose	½ usual dose Restart normal dose evening	
Tablets & insulin	Stop - SGLT-2 inhibitors (Gliflozins)	• Stop - SGLT-2 inhibitors (Gliflozins) • Take all other diabetes tablets in the morning then w/h • Insulin - follow advice above	• Stop - SGLT-2 inhibitors (Gliflozins) • All other diabetes tablets w/h & restart with next regular meal • Insulin - follow advice above	

Additional information

The below information is copied from diabetes management and can be relayed to assist patients to prepare for their procedures.

- Managing your diabetes if you are on insulin will probably be easier if you have a morning appointment.
- Don’t worry if your blood glucose level is not as well controlled as usual, as long as it is above 4mmol/L but below 15mmol/L.
- Bring your blood glucose meter, monitoring records, insulin and injecting equipment with you to the appointment. Also bring some jellybeans/juice or whatever you would normally use to manage a hypo.
- Depending on how much carbohydrate you manage to take when you are on just fluids, and what your blood glucose levels are, you will need less insulin than usual. It is important to monitor your blood glucose levels at least four times a day, pre-meals and pre-bed and more often if you have any symptoms of hypoglycaemia.
- If you have any questions about your diabetes, please telephone the Auckland Diabetes Centre Tel: (09) 630 9980 between 8.30am and 4.00pm and ask to speak to the Duty Nurse.

*Carbohydrates in clear fluids

These clear fluids have a similar amount of carbohydrate to one medium slice of bread (15g of carbohydrate):

- 150ml clear unsweetened apple juice
- 125ml grape juice

Back to Contents

- 100ml of Lucozade
- 30ml of clear fruit cordial (not lime)
- 150ml lemonade
- 100ml clear jelly
- Five dextrose tablets

If **nursing staff** require further assistance with the management of diabetes for a patient contact the: Diabetes Nurse Specialist on 021466667.

Appendix 2b Information and guide for patients with Type 2 Diabetes on orals or diet alone - colonoscopy

(In addition to the preparation instructions from the Gastroenterology Department)

Name **(LABEL)** **Address, phone**

Diabetes Doctor or Nurse:

Usual oral hypoglycaemic medication;

Medication	Breakfast	Lunch	Dinner

The day before your colonoscopy when on clear fluids only and using bowel prep:
Omit all oral hypoglycaemics (listed here)

Medication	Breakfast	Lunch	Dinner

After the Procedure when you are able to eat and drink again, take your usual oral medications when they would normally be due.

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Oral hypoglycaemics Metformin, Glipizide, Gliclazide, Vildagliptin, Galvumet, Pioglitazone, Exanatide and Acarbose		Take normal morning dose then w/h	w/h until after the test Restart with next regular meal	
Oral SGLT-2 inhibitors (Gliflozins) Dapagliflozin (Forxiga) Empagliflozin (Jardiance) Canagliflozin (Invokana)	Stop	Stop	Stop	Restart

TREATMENT TYPE	DAY BEFORE PREPARATION DAY (2days prior)	PREPARATION DAY (day prior)	PROCEDURE DAY	DAY AFTER PROCEDURE
Long acting insulin (morning) (Humulin NPH, Lantus, Protophane)		½ usual dose	½ usual dose	Restart usual dose
Long acting insulin (evening) (Humulin NPH, Lantus, Protophane)		½ usual dose	Restart usual dose evening	
Short acting insulin (one or more injections) (Actrapid, Apidra, Humalog, Novorapid, Humulin R)		Usual dose at breakfast From lunchtime reduced doses approx. ½ usual dose at lunch & evening meal time (taken with clear fluids see list*)	w/h morning Restart with next regular meal	
2-3 injections of pre-mixed insulin (Humulin 30/70, Mixtard 30, Penmix 30, Penmix 40, Penmix 50, Humalog Mix 25, Humalog Mix 50, NovoMix 30)		½ usual dose	½ usual dose Restart normal dose evening	
Tablets & insulin	Stop - SGLT-2 inhibitors (Gliflozins)	• Stop - SGLT-2 inhibitors (Gliflozins) • Take all other diabetes tablets in the morning then w/h • Insulin - follow advice above	• Stop - SGLT-2 inhibitors (Gliflozins) • All other diabetes tablets w/h & restart with next regular meal • Insulin - follow advice above	

****If you have any uncertainty at all ask your GP or Diabetes Nurse for assistance. ****
The phone number for the Diabetes Service is 6309980.

Back to Contents

Appendix 3 Endoscopy Unit standardised protocol for on call out of hours

1. Purpose

The purpose of this protocol is to define the roles and responsibilities of on call nursing and medical staff working within the Endoscopy Unit. This will enable efficient on call service delivery for patients and minimise the confusion of responsibilities.

2. Identification of on call staff

It is a requirement that each call out must be staffed by a minimum of two nursing personnel. It is the responsibility of the Charge Nurse (CN) to ensure that the on call rota is published a month in advance. If an on-call staff member is sick, CN will provide an emergency cover. CN will approve on call swaps after discussion.

The Consultant Gastroenterologist on call rota is accessible on the Auckland DHB shared N: drive for all ward areas to access.

There is an on call phone for nursing staff use; this has all consultant phone details available in the memory.

3. Responsibility of lead on call nurse: from Monday to Friday

On Call during the week is from 16:30 to 07:30.
The lead nurse is responsible for liaising with the named consultant.

Between the hours of 16:00 to 08:00 the on call consultant Gastroenterologist/registrar will contact the nursing staff on call if they are required to attend for emergency endoscopy.

The procedure can be carried out on the department if the on call Consultant Gastroenterologist states this is appropriate. Alternatively, the Consultant may deem it more appropriate or necessary to endoscope the patient elsewhere, such as theatres, DCCM or the ED.

4. Responsibility of lead on call nurse: from Friday to Monday

On call during the weekend is from 16:30 on Friday to 07:30 on Monday.
The lead nurse is responsible for liaising with the named Consultant.

5. Communication between nursing staff

It is the responsibility of the lead nurse to take the patient personal details, medical condition and procedure required. Location and time of proposed procedure should be clarified at this time.
The lead nurse must relay this information to the second on call nurse.

6. Responsibilities of on call nurses

The on call nurses are responsible for the transportation of the endoscopy stacks, ERBE machine and emergency trolley from the gastroenterology department to the theatre. The lead nurse should complete the patient pre-checks in accordance with the gastroenterology department's protocol.

Once the procedure is completed, the ERBE machine and emergency trolley are placed back on the gastroenterology department. A record of the patient details are recorded in the acute on call endoscopy list. The record should include the patient full details, date, procedure, therapeutic intervention, staff and consultant attending.

A note should be left for senior staff informing them of the time the team left the department and estimated time of arrival home if called out overnight. For call outs, nurses follow the MECA rule including the 9-hour break.

Back to Contents

Appendix 3a Out of hours medical help and advice following endoscopic procedures

Name: ________________________________ **NHI:** ________________________
Date of call: ____________________
Name of nursing staff providing advice: ____________________________________

Symptoms: ____
____
____

Advice given: ____
____
____

****Please fax this record to Endoscopy Unit ext 25583 or give to the Gastro HO or Registrar following morning who will follow-up with patient****

During working hours 0730-1630 Monday to Friday

Please transfer the patient to endoscopy unit nursing staff to manage if they have any of the following symptoms:

- Severe abdominal pain
- Haematemesis (vomiting blood)
- Passing blood per rectum
- Pyrexia greater than 38.0˚C

They are advised to seek urgent medical advice

Outside above hours and Statutory Holidays

Gastro Reg phone is manned until 10pm if further advice needed.

Ask the patient not to drive himself or herself but ask a family member to escort them. If the patient is unable to provide their own transport safely, advise them to call for an ambulance.

Telephone the Emergency Department and inform them to expect the patient and provide a brief handover including the patients' personal details, procedure undertaken, and symptoms experienced by the patient.

Back to Contents

Complaint			Advice	Other info
Pain	Severe		Attend ED	
	Mild		Simple analgesia and call back in 1 hours, if not settled to attend ED	
Pyrexia	Mild, asymptomatic		Simple paracetamol, call back if not settled	
	>38®C Symptomatic	Rigor Chills Tachycardia dizziness	Attend ED / call 111	
Haematemesis			Attend ED / call 111	
Rectal bleeding	Small volume	Well Asymptomatic	Monitor and contact endoscopy unit in am if persist	
	Large volume Or symptomatic	Dizziness Collapse Pain	Attend ED / call 111	

Any other issues?

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Appendix 4 Pathology specimen and result handling

There are currently 3 streams of pathology generated from the following groups:
1. Urgent histology from outpatients
2. Routine histology from outpatients
3. Histology obtained during in-patient endoscopy (both routine and urgent)

JAG and GRS recommendations are that:
- There are processes in place to ensure that pathology reports are received by the endoscopist (or referrer) responsible for acting upon them within five days of receipt of the report and
- If the endoscopist has responsibility for taking action or making recommendations based on the pathology reports, action is taken, or recommendations are dispatched within five days of receipt of the report.

Open access / straight-to-test referrals

Currently at Auckland DHB, there is no designated open access endoscopy list. Patients referred by their GP for a straight-to-test upper GI endoscopy are listed onto the next available and suitable endoscopy slot. This means there are multiple endoscopists, performing the examinations.

Histology reports are uploaded by the pathology department directly onto éclair making them available to the referring GP. However, many GPs would prefer a letter with interpretation of the results or advice as required, e.g. duodenal biopsies demonstrating “raised intra-epithelial lymphocytes” would generate blood testing for coeliac disease within the gastroenterology clinic but not all GPs may appreciate the significance.

Auckland DHB handling of benign open access results

- If a clinician endoscopist is performing the open access endoscopy:
  - The histology should be sent as belonging to that endoscopist to interpret and inform the GP of the result.

- If a trainee endoscopist is performing the endoscopy:
  - The list supervising consultant is the designated named consultant for the result with responsibility for informing the GP.

- If a nurse endoscopist is performing the endoscopy:
  - The designated supervising consultant will accept responsibility for the result. Should that consultant be away at that time, the result will pass to the clinician checking that consultant’s results.

- If further action is required from the histology, such as referral for surveillance:
  - It is the responsibility of the endoscopist to advise the GP to undertake the referral.

Auckland DHB handling of suspected malignant open access/ STT histology

There is no responsibility for the Endoscopy Unit at Auckland DHB to undertake the upgrade of patients; however, this may place unnecessary delays in the patient care pathway. Where feasible and clinically appropriate, we will instigate the management of new cancers diagnosed from open access endoscopies and external referrals.

It is the responsibility of the endoscopist to ensure that the histology is sent as Urgent and that the patient is upgraded appropriately. This can be done by informing the appropriate Clinical Nurse Specialist and should be documented, along with any discussion held with the patient, on the endoscopy report.

Back to Contents

The report must be completed on the electronic system and available to the GP within one working day of the endoscopy by the endoscopist.

If further investigations are organised, these should be under the name of the endoscopist unless there is a designated supervising consultant or default consultant in the case of trainees and nurse endoscopists. Further investigations that are organised should also be clearly documented to allow the appropriate MDM office to commence tracking of the patient.

It is the responsibility of the referring clinician to act upon and inform the patient of the histology results within five working days of report being approved.

Routine histology- Inpatients

All histology samples should be sent from the Gastro Unit marked for return of results to the referring clinician.

It is the responsibility of the referring clinician to act upon and inform the patient of the histology results.

References

- General Medical Council: Good Medical Practice - Sharing Information with Colleagues -Paragraph 52 details responsibility for informing a patients' General Practitioner the results of investigations
- General Medical Council: Good Practice Guidance – Working with Colleagues - paragraph 41 provides guidance on team working.
- General Medical Council: Management for Doctors provides further guidance on managing a team (see paragraph 50).