BowelScreening Pilot

Endoscopy Manual

10 March 2015

Contents

Abbreviations and acronyms

BSP	**BowelScreening Pilot**
CNS	**Clinical Nurse Specialist**
CQI	**Continuous Quality Improvement**
CTC	**Computerised Tomographic Colonography**
DHB	**District Health Board**
DNA	**Did Not Attend**
GA	**General Anaesthetic**
GP	**General Practitioner**
iFOBT	**Immunochemical Faecal Occult Blood Test**
WDHB	**Waitemata District Health Board**

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1. Purpose

The purpose of this manual is to document the processes carried out by the Endoscopy Unit with respect to the BowelScreening Pilot (BSP).

The target audience for the document includes:

- Endoscopy Unit staff
- BSP endoscopists
- Nursing staff
- LabPLUS staff
- Radiology staff
- WHDB Gastroenterology Department.

2. Overview of the BowelScreening Pilot

2.1 About the BowelScreening Pilot

Waitemata District Health Board (WDHB) has been funded by the Ministry of Health (the Ministry) to plan and implement a four-year bowel screening programme pilot. This BowelScreening Pilot (BSP) is a population-based screening programme that offers screening for bowel cancer to all people between 50-74 years of age resident in the WDHB area and eligible for publicly funded healthcare.

The BSP commenced in January 2012 and will be completed in December 2015.

The main goal of the BSP is to determine whether organised bowel screening can be introduced in New Zealand in a way that is effective, safe and acceptable for participants, equitable and economically efficient.

2.2 Contact details for the BowelScreening Pilot

Contact details for the BowelScreening Pilot	
BSP	**Contact**
Information Line	0800 924 432
Website	www.bowelscreeningwaitemata.co.nz
Email address	info@bowelscreeningwaitemata.co.nz
Programme Manager	09 484 0256 or 0274 912 163
Clinical Director	021 718 249
Clinical Nurse Specialist	09 837 8892 x6892

2.3 How the BowelScreening Pilot operates

The Coordination Centre

The BSP is operated through a Coordination Centre. The Coordination Centre uses a database (the BSP Register) to invite all eligible people for screening twice during the four-year pilot period.

The screening test

The BSP uses an immunochemical faecal occult blood test (iFOBT) to detect blood in the bowel motion. As cancers and polyps bleed intermittently, the presence of blood can indicate that a person is at a higher risk of having cancer.

If blood is detected when a sample is tested by the laboratory, the participant will receive a positive screening result and be referred for a colonoscopy to find the cause of the blood. Positive results are managed by the Endoscopy Unit.

Participants who receive negative results are returned to the screening programme and recalled for screening in two years.

3. The Endoscopy Unit

3.1 Role of the Endoscopy Unit

Endoscopy services for the BSP are provided by the Endoscopy Unit, located within the General Surgery Unit at Waitakere Hospital. BSP Endoscopy Unit staff are funded by the BSP and report to the Gastroenterology Service.

The Endoscopy Unit is responsible for managing participants with positive iFOBT results, including:

- conducting telephone or face-to-face pre-assessments with all participants referred for a colonoscopy
- scheduling colonoscopy procedures
- providing information, support and bowel preparation product to ensure correct bowel preparation
- documenting all aspects of the colonoscopy procedure, and outcomes, on the BSP Register
- arranging alternative procedures and referrals for treatment as required.

Colonoscopies are carried out by WDHB staff, supplemented by private providers who work on a fee-for-service basis.

3.2 Endoscopy Unit staff

The Endoscopy Unit is staffed by a Clinical Nurse Specialist (CNS), 5 full-time equivalent registered nurses, and 1.4 full-time equivalent administrators.

Staff roles and responsibilities

The following table shows the staffing breakdown of the Endoscopy Unit, and staff roles and responsibilities.

Staff Roles		
Role title	**Role purpose**	**Role responsibilities**
Clinical Director	Provide clinical leadership to the BSP to ensure the clinical workforce and service delivery meet the needs of participants in the BSP and the requirements of a formal screening programme	• Work in partnership with the Programme Manager to plan systems and processes to ensure successful programme implementation • Lead BSP quality assurance activities with the support of the BSP Quality Lead • Meet with other clinical leads and clinicians • Work with the BSP Programme Manager to ensure programme participants receive the best possible service • Ensure clinicians have the appropriate skills and training for the delivery of BSP services • Review BSP data and monitor outputs • Carry out clinical administrative duties

Endoscopy Lead	Lead the quality assurance programme for the BSP and ensure all clinical practices comply with statutory requirements and best practice	• Undertake BSP endoscopy procedures • Assist with management of referrals and prioritisation • Lead audit • Review clinical care and health outcomes for participants • Be involved in the bowel cancer pathway including participating in the Regional Bowel Cancer Network • Refer to and liaise with surgeons and cancer services where cancers are suspected/detected • Participate in multidisciplinary meetings (MDMs) to improve patient outcomes • Provide leadership in internal audit of all colonoscopy performance data for the BSP
Clinical Nurse Specialist (CNS)	Ensure all participants in the BSP with positive iFOBT results receive colonoscopy services of the highest possible clinical standard which conform to the BSP Quality Standards	• Undertake pre-assessment and referrals management for participants with positive results • Manage participants with positive results when there is no primary care involvement • Identify and manage complex cases • Run pre-assessment clinics • Liaise with primary care in relation to overdue/missing referrals and complex cases • Confirm bookings and educate participants on bowel preparation and the colonoscopy procedure • Actively follow up participants who are unable to be contacted or who DNA at colonoscopy • Provide clinical leadership to BSP nurses • Manage endoscopist schedule • Maintain a record of endoscopists' credentials • Train and support endoscopists about the BSP • Interpret histology results • Enter results into the BSP register • Participate in and contribute to Coordination Centre team, Endoscopy Unit, Quality Assurance and Clinical Governance Group meetings • Monitor quality and audit criteria in accordance with Ministry of Health guidelines • Work in collaboration with the Quality Lead to develop, implement and review BSP endoscopy and patient management policies, procedures, standardised forms and letters • Follow up and review readmissions following colonoscopy and presentation of cases to the Endoscopy Review Group

		• Notify Quality Lead of all issues, incidents or identified risks to be entered onto the appropriate register for further management • Input pre-assessment, diagnostic test and histology data onto the BSP Register • Enter correct screening pathway updates for participants following alternate options • Contact participants who have elected private colonoscopy, and ensure all diagnostic and treatment data is entered onto the BSP Register
Endoscopy Unit Nurses	Ensure all participants in the BSP with positive iFOBT results receive colonoscopy services of the highest possible clinical standard which conform to the BSP Quality Standards	• Provide comprehensive pre-assessment services for BSP participants with positive results • Enter participant data onto the BSP Register • Provide nursing services across the Endoscopy Unit
Administrators	Support the management of the BSP patient cohort for colonoscopy procedures within the recommended Ministry of Health and BSP guidelines	• Manage waiting lists • Manage colonoscopy lists in conjunction with CNS and Endoscopy Lead with reference to BSP process requirements • Plan appointments to ensure optimal utilisation of available appointment times • Data entry in the i.PM and BSP systems • Generate results letters • Create and update colonoscopy lists in theatre and endoscopy schedule • Manage colonoscopy room time by appropriate scheduling of participants • Set colonoscopy lists in conjunction with specialists and within Ministry of Health and BSP guidelines • Create theatre sessions in i.PM • Check referrals in the Register • Load referrals in i.PM ready for pre-assessment • Enter patients in ProVation for reporting purposes • Create histology letters in Soprano and send to consultants for approval • Send histology letters to patients after approval • Order stationery • Ensure correct stationery is in packets • Send prep sheets etc to Copy Centre for photocopying • Order bowel preparation from pharmacy • Liaise with Anaesthetic Dept for GA Lists • Order exit tickets • Go through schedule with CNS • Confirm appointments • Reception duties • Liaise with courier over any non-delivery

3.3 Policies

The following table lists the BSP policies followed by the Endoscopy Unit.

BSP Policies	
Policy name	**Summary**
Active Follow-up Management	Outlines the process to follow for participants who have not responded to the BSP invitation, or are unable to be contacted following a positive iFOBT result.
Cancer Referral Management	Outlines the referral process for BSP participants diagnosed with cancer, including cancer suspected at the time of colonoscopy and when diagnosis is confirmed by histopathology results.
CTC Referral Management	Outlines the referral process to follow for BSP participants who require a Computerised Tomographic Colonography (CTC).
Endoscopy Nurse–Patient Management	Details the role of endoscopy nurses in the positive results patient management pathway, including participants notified of a positive result by their GP and referred to WDHB Booking and Scheduling who have not been notified of a positive result by their GP by Day 10, or who do not have a GP involved.
Histology Results Management	Outlines the process to follow for management of histopathology results (excluding cancer) in the BSP.
iFOBT Kit Management	Outlines the management of iFOBT kits in the BSP.
Management of Positive iFOBT Participants with Exclusion Criteria	Details the process required for managing participants who test positive but are then found to fit the exclusion criteria.
Positive Results Management	Outlines the process involved in managing participants with a positive iFOBT result.
Referral Management	Details the referral process for participants with a positive iFOBT result in the BSP, and outlines the process for General Practices and the role of WDHB Booking and Scheduling in the referral pathway.
BSP- Adverse Event and Incident Management Plan	Outlines the process to follow when reporting an incident or potential risk within the BSP. Used in conjunction with the WDHB Incident Management policy.
Safety of Community Staff – BowelScreening programme	Outlines personal safety procedures for staff working within the BSP to either prevent or manage unsafe situations when delivering health care within the community setting.
Telephone and Personal Contact	Outlines the communication protocols for staff with regard to telephone contact in the BSP.

Transport of Histology Samples	Details the transport pathway for histology samples in the BSP.
Anticoagulant Management for Outpatients having an Endoscopic Procedure	Outlines the process to follow for BSP participants on anticoagulants who may require enoxaparin (Clexane®) bridging.
Colorectal MDM – ToR	Sets out the terms of reference for colorectal multidisciplinary meetings.
DNA Management	Outlines the process to follow if participants Did Not Attend (DNA) a scheduled face-to-face pre-assessment, a scheduled colonoscopy or a scheduled CTC in the BSP.
Withdrawal of Consent During Endoscopy	Sets out the expectations and actions to be undertaken by clinical staff if a participant withdraws consent during the colonoscopy procedure.
Bowel Screening Programme Family History Screening Process	Sets out the family history screening process.

3.4 Resources

The Endoscopy Unit has developed a number of resources to assist with processes. These include:

- Pre-assessment forms and guidelines
- Bowel preparation sheet
- Low-fibre diet for colonoscopy preparation
- Diabetic colonoscopy management sheet
- Family History Questionnaire.

4. Management of participants with positive iFOBT results

Policy references

Positive Results Management	Outlines the process involved in managing participants with a positive iFOBT result.
Endoscopy Nurse–Patient Management	Details the role of endoscopy nurses in the positive results patient management pathway, including participants notified of a positive result by their GP and referred to WDHB Booking and Scheduling who have not been notified of a positive result by their GP by Day 10, or who do not have a GP involved.
Referral Management	Details the referral process for participants with a positive iFOBT result in the BSP, and outlines the process for General Practices and the role of WDHB Booking and Scheduling in the referral pathway.
Telephone and Personal Contact	Outlines the communication protocols for staff with regard to telephone contact in the BSP.

Letter reference

SR-02	Subject result – Positive

4.1 Overview

The Endoscopy Unit is responsible for managing participants who receive a positive iFOBT result from their BSP test.

LabPLUS, the testing laboratory, sends results electronically to the BSP Register and participants' GPs (as named on the consent form) via HL7 messaging on Healthlink. The Endoscopy Unit can access results on the Register.

Participants with positive iFOBT results are referred to the Endoscopy Unit by their GP. GP referrals are faxed or sent by e-referral to the WDHB Booking and Scheduling Service**.** The Service registers the BSP referrals in i.PM and sends referrals to Waitakere Hospital via the internal mail system.

On receipt of a GP referral, the Endoscopy Unit contacts the participant, conducts a pre-assessment and, if appropriate, schedules a colonoscopy appointment. The Endoscopy Unit couriers an information pack and bowel preparation materials to the participant.

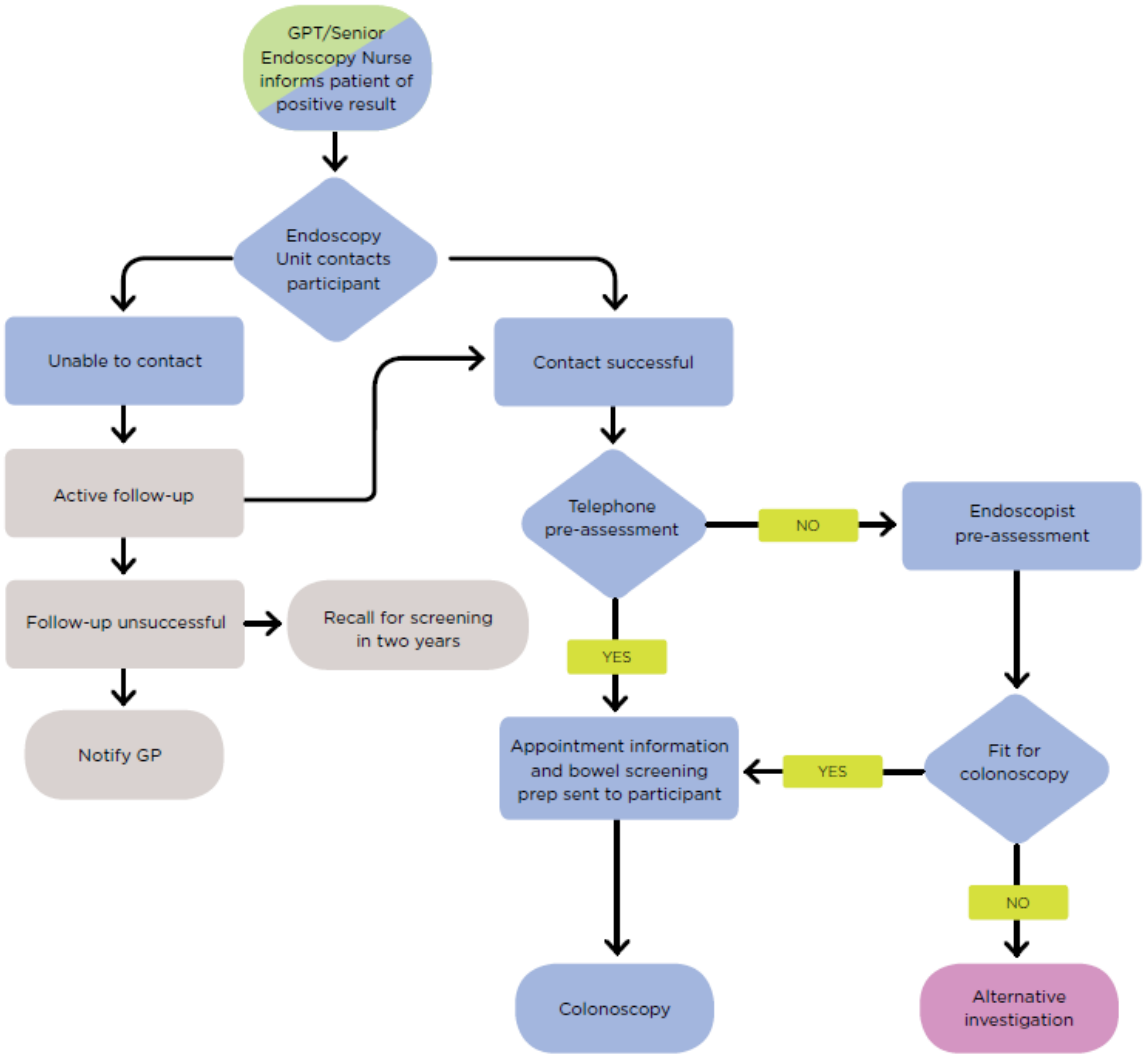
If a participant does not have a GP or does not want their GP involved, or if a GP does not make a referral within 10 working days, an Endoscopy Unit nurse will make direct contact with the participant to discuss the positive result and undertake pre-assessment for colonoscopy.

The Quality Standard relating to time to colonoscopy is that for 95% of people with a positive result, the date of the first appointment offered will be within 55 days of the positive result being entered into the BSP Register.

Participants who require ongoing surveillance are referred to the WDHB Gastroenterology Service and are considered to have left the screening programme.

Participants diagnosed with cancer or who need treatment for any other reason are referred to the Colorectal Unit at North Shore Hospital and are considered to have left the screening programme.

Figure 1: Management of participants with positive results



Participants with a named GP

Participants with named GPs should be notified of positive results by their GPs and referred for colonoscopy within 10 working days of the result being received at the practice. WDHB Booking and Scheduling should then receive a fax or e-referral from the GP. GP referrals are undertaken using the same method as for referrals to Gastroenterology Department.

If a participant with a named GP has not been referred within 10 working days, the Endoscopy Unit (CNS) will follow up within 15 working days.

Participants without a named GP

Participants with a positive result and no named GP are contacted by the Endoscopy Unit (CNS) within 15 working days.

Participants who choose private colonoscopy

Some participants choose to have a colonoscopy in the private sector. This is documented in the participant's screening episode. The test kit consent form includes consent for the Endoscopy Unit to access histology results and record outcomes from private procedures on Eclair as part of evaluation and monitoring for the BSP. Reports are obtained from the private provider and results entered onto the Register.

Participants who have a colonoscopy in the private sector who are not referred for surveillance or treatment are recalled for screening in five years.

4.2 Participants who are not contacted by their GP

Policy reference

Active Follow-up Management	Outlines the process to follow for participants who have not responded to the BSP invitation, or are unable to be contacted following a positive iFOBT result.

Letter reference

GD-02	GP discharge (non-response / DNA pre-assessment)

Follow up

If a GP does not make a referral for a participant with a positive iFOBT within 10 working days, responsibility for follow-up transfers to the Endoscopy Unit.

As positive results are available to the Endoscopy Unit, referrals can be anticipated. If a referral is not received within 10 working days, this generates a work task for the Endoscopy Unit on the Register.

Within 15 working days, the CNS:

- checks the computer system to see if the referral has been logged at WDHB Booking and Scheduling
- telephones the participant's GP
- telephones the participant, if necessary
- if appropriate, makes a referral to Community Support Workers, who may make a home visit.

The number of participants with named GPs who are not referred within 10 working days is very low.

Where contact is delayed

Participants may be unable to be contacted within the 15-day timeframe, for example if they are overseas. In this case the CNS will put the participant on a pathway hold. This involves putting a work task on the Register and filing their referral under the month they are expected to return. The task will then come up in that month.

Where a GP has made a referral but not contacted the participant

If a GP makes a referral but does not inform the participant, the Endoscopy Unit informs the participant of their positive result. A record is made on the issues register and followed up by the Programme Manager.

4.3 Participants who cannot be contacted

Policy reference

Active Follow-up Management	Outlines the process to follow for participants who have not responded to the BSP invitation, or are unable to be contacted following a positive iFOBT result.

Letter reference

PD-02	Discharge (non-response / DNA pre-assessment)

If attempts to contact a participant are unsuccessful, the CNS sends the participant a letter with a copy to their GP (if applicable) outlining the positive result and encouraging the participant to contact their GP or the Endoscopy Unit.

The participant can be referred for a colonoscopy if they contact their GP or the Endoscopy Unit at any time during the BSP.

4.4 E-referrals

Electronic referrals have been piloted as part of a regional project. The BSP was one of the service groups selected for the pilot. The process requires GPs to complete a template which is sent by email to WDHB Booking and Scheduling.

4.5 Participants who decline colonoscopy

Letter references

GD-03	GP discharge (no agreement to proceed with diagnostic tests)
PD-03	Discharge (no agreement to proceed with diagnostic tests)

Participants who decline colonoscopy are sent a letter by the Endoscopy Unit, copied to their GP. The letter confirms that they have received a positive result and are declining a colonoscopy, and advises that they can contact the Coordination Centre at any time if they change their mind.

Pre-assessment is completed for participants who decline, and the outcome is recorded as declined colonoscopy. They are put on a two-year recall for screening. They can be reactivated if they contact the Endoscopy Unit and indicate that they now want a colonoscopy.

If a participant withdraws at this point, they need to seek re-enrolment if they want to participate at a later date.

Participants who initially decline but attend later

If a participant initially declines but later attends for a colonoscopy, the participant's management and referral to colonoscopy should be discussed between the participant's GP and the Clinical Director. If the participant contacts the Coordination Centre or Endoscopy Unit directly, the Clinical Director will initiate contact with the participant's GP (if applicable).

Following the colonoscopy, the participant will either be recalled for screening in five years, put on surveillance, or referred for treatment.

Participants who delay colonoscopy

A participant may delay colonoscopy for reasons such as personal commitments or other health issues. An Endoscopy Unit nurse will put the participant on a 'pathway holiday' within the Register and create a work task for a future date to generate an alert for an Endoscopy Unit nurse to contact the participant.

5. Pre-assessment

Policy references

Endoscopy Nurse–Patient Management	Details the role of endoscopy nurses in the positive results patient management pathway, including participants notified of a positive result by their GP and referred to WDHB Booking and Scheduling who have not been notified of a positive result by their GP by Day 10, or who do not have a GP involved.
Telephone and Personal Contact	Outlines the communication protocols for staff with regard to telephone contact in the BSP.

5.1 Overview

The purpose of colonoscopy pre-assessment is to determine the participant's health fitness for the procedure and provide the participant with full information, including possible risks and outcomes.

Pre-assessment is undertaken by an Endoscopy Unit nurse, generally over the telephone, using the pre-assessment form. The majority of participants will undergo a telephone pre-assessment at the time of Endoscopy Unit nurse contact within 15 days of their positive result.

Pre-assessment is comprehensive and includes:

- discussion of the possible causes of the positive iFOBT result
- explanation of the colonoscopy procedure, including risks
- assessment of the participant's suitability for the procedure
- management of medications and medical issues
- explanation of the bowel preparation process, including risks
- scheduling of a colonoscopy appointment on a day and time that suits the participant
- advice that a support person may accompany the participant to colonoscopy
- provision of contact details in case the participant has any queries prior to the colonoscopy
- assessment of the participant's need for cultural support and/or assistance with travel
- confirmation of the need for an interpreter, if applicable
- confirmation of discharge arrangements (transport plans / support person).

Pre-assessment may take from five minutes to half an hour to complete.

Participants are asked to call and confirm their colonoscopy appointment. If they do not call, an administrator from the Endoscopy Unit will call them to confirm.

Complex cases are discussed with the Endoscopy Lead.

Evidence shows that the process of offering an appointment as part of pre-assessment leads to lower DNA rates. Nurse-led colonoscopy pre-assessment ensures support for the participant and liaison between the Endoscopy Unit and the Coordination Centre.

The pre-assessment form is held in the participant's clinical record.

Timeframe for offering pre-assessment

The interval between a participant's receipt of a positive iFOBT result and their colonoscopy pre-assessment is minimised to reduce anxiety. The quality standard is for the first-offered pre-assessment to be within 15 working days for at least 95% of participants.

Participants are offered a telephone pre-assessment, or face-to-face pre-assessment if required, at a time convenient to the participant. The first-offered pre-assessment and the chosen pre-assessment time are documented for audit purposes.

Support for participants between pre-assessment and colonoscopy

Participants are invited to call the Endoscopy Unit with any questions prior to their colonoscopy appointment. The BSP Quality Standards require that assistance be available to participants outside of usual work hours. The BSP holds a contract with Healthline for participant contact outside of Endoscopy Unit hours.

Participants who are considered high-risk for DNA, including those who have failed to attend a previous colonoscopy appointment, are telephoned prior to their colonoscopy appointment.

Quality Standard for colonoscopy information

The BSP Quality Standards require that 95% of participants referred for colonoscopy receive appropriate information.

Face-to-face pre-assessment

If a participant requires a face-to-face pre-assessment, this is arranged by an Endoscopy Unit nurse with the participant and the Endoscopy Lead. Face-to-face pre-assessment is only required occasionally as most situations can be managed by other means (for example, the use of interpreters in a three-way teleconference in the case of language difficulties).

Fit for colonoscopy

Participants deemed fit for colonoscopy are offered an appointment for the procedure during pre-assessment. The Quality Standard is that 95% of people with a positive result must be offered their first appointment date within 55 days of the positive result being entered into the BSP Register.

Participants assessed as fit and who consent to colonoscopy are sent:

- confirmation of their positive result
- confirmation of the colonoscopy date
- "BowelScreening – Further Investigation" brochure

- Bowel Preparation Information Sheet
- low fibre dietary advice sheet
- bowel preparation tablets and sachets
- culturally appropriate support to attend, if required
- information on links to local support services
- "Family History Questionnaire".

High risk for colonoscopy

Participants assessed as high-risk for colonoscopy require precautions to be taken to minimise risk during the procedure. High-risk individuals include those:

- receiving anticoagulant medication
- with insulin-dependent diabetes mellitus
- with prosthetic heart valves
- undergoing dialysis
- receiving immunosuppressing medication
- with a previous history of endocarditis.

Participants may also be deemed high-risk for colonoscopy due to significant co-morbid disease. In this situation, the CNS will discuss the case with the Endoscopy Lead and/or other specialists and facilitate a decision on appropriate management. The participant's GP is involved in this process.

Participants not fit for colonoscopy / failed colonoscopy

A small number of participants have had a failed colonoscopy or are not able to tolerate the bowel preparation.

Participants who have had a failed colonoscopy are referred for a CTC or a GA colonoscopy.

Participants deemed not fit for colonoscopy are referred for a CTC.

5.2 Exclusion criteria

Policy reference

Management of Positive iFOBT Participants with Exclusion Criteria	Details the process required for managing participants who test positive but are then found to fit the exclusion criteria.

Information on exclusion criteria for participation in the BSP is included with the test kit mailed to participants. However, some participants take the test even though they do not meet the criteria. The exclusion criteria are reviewed as part of pre-assessment, and responsibility for determining a participant's ongoing involvement in the BSP sits with the Clinical Director or Endoscopy Lead.

Symptomatic waiting list

People who are symptomatic should not participate in the BSP. However, if a symptomatic participant is on a symptomatic waiting list and receives a positive result from the BSP, they will be scheduled an appointment within the BSP and can attend whichever appointment is available first. Participants will generally receive an appointment more quickly through the BSP.

5.3 Participants who do not attend scheduled pre-assessment

Letter references

GD-02	GP discharge (non-response / DNA pre-assessment)
GD-03	GP discharge (no agreement to proceed with diagnostic tests)

If a participant does not attend a pre-arranged telephone or face-to-face pre-assessment, or wishes to withdraw from the BSP at this point, a letter to the participant and their GP is generated. The participant is advised they can change their mind and continue in the screening pathway at a later date.

6. Bowel Preparation

6.1 Overview

Effective bowel preparation supports improved polyp detection and caecal intubation, while poor bowel preparation is associated with failure to reach the caecum and hinders the detection of lesions[1].

The BSP uses the bowel preparation product used by WDHB.

Bowel preparation is discussed with participants as part of pre-assessment. People who live rurally, or further away from the Endoscopy Unit, are generally given afternoon appointments to assist with their bowel preparation arrangements.

6.2 Bowel preparation in the case of other health issues

Participants with complex health issues or co-morbidities may be admitted to Waitakere Hospital for their bowel preparation. The Endoscopy Unit generally arranges to have a participant admitted to hospital for this purpose once every three to four weeks.

In cases of multiple sensitivities to conventional bowel preparations, or in complex cases, the Endoscopy Lead and an Endoscopy Unit nurse work with the participant to find a suitable alternative.

6.3 Participants with diabetes

Diabetic medications need to be adjusted for participants with diabetes as part of preparation for colonoscopy. The Endoscopy Unit, in collaboration with Diabetes Services, has developed an information sheet to assist participants with diabetes.

[1] Harewood GC. Sharma VK, and de Garmo P. *Impact of colonoscopy preparation quality on detection of suspected colonic neoplasia*. Gastrointest Endosc. 2003. 58(1): 76-79.

7. Informed consent

7.1 Overview

The BSP follows the WDHB policy on informed consent.

Informed consent for colonoscopy or other diagnostic procedures is a process commencing with the provision of information in pre-assessment. The process for obtaining informed consent comes under the general endoscopy process and procedure, with the addition of specific advice on risks and complications associated with the BSP. These include that the perforation rate is less than 1 in 1,000, that significant bleeding is less than 1 in 500, and the process for return of tissue if participants choose to have it returned.

Informed consent is documented on a form which is completed prior to the procedure. The form is signed by the participant outside the procedure room.

The BSP carries out continuous quality improvement for informed consent. This includes auditing informed consent forms as part of evaluation and monitoring and reporting results to endoscopists. The BSP Quality Standards require participant satisfaction surveys to be carried out annually and retained for audit purposes.

7.2 Information provided prior to colonoscopy or other diagnostic procedure

Information provided to participants prior to a procedure includes:

- information about the procedure, including the potential complications and risks
- what happens if a biopsy is required, that biopsy samples may be taken and retained, and how to request the return of samples
- what to expect after the procedure
- recovery from the procedure.

Participants must have an opportunity to ask questions and be satisfied that their questions have been answered appropriately.

7.3 Return of polyps

Policy reference

Histology Results Management	Outlines the process to follow for management of histopathology results (excluding cancer) in the BSP.

As part of the informed consent process, participants must be asked if they want their biopsy samples returned. If they do, the testing laboratory must be notified and the participant must collect the sample from the laboratory.

LabPLUS has a detailed process for return of samples.

7.4 Withdrawal of consent

Policy reference

Withdrawal of Consent During Endoscopy	Sets out the expectations and actions to be undertaken by clinical staff if a participant withdraws consent during the colonoscopy procedure.

Participants may withdraw consent for colonoscopy or other diagnostic procedure at any stage.

Withdrawal of consent has been noted to be problematic where a participant requests that the procedure be stopped when it is already underway. A participant may request that the procedure be stopped as it is too painful, but in some cases participants have requested that the procedure be stopped and failed to recall this afterwards due to the effect of being sedated.

7.5 Participants with a family history of bowel cancer

Policy reference

Bowel Screening Programme Family History Screening Process	Sets out the family history screening process.

A Family History Questionnaire is sent out with the bowel preparation information. Participants are asked to bring the completed questionnaire to their colonoscopy appointment for discussion prior to the procedure.

At the time of documenting informed consent, the endoscopist reviews the Family History Questionnaire and determines if the participant should be referred to the New Zealand Familial Gastrointestinal Cancer Registry (NZFGCR). If the participant consents, the questionnaire is faxed to the NZFGCR. The participant will then receive a letter from the NZFGCR and be offered an appointment. The family history screening process is currently under review by the Ministry of Health and may be modified if a national roll-out is confirmed.

8. Colonoscopy

Policy references

Cancer Referral Management	Outlines the referral process for BSP participants diagnosed with cancer, including cancer suspected at the time of colonoscopy and when diagnosis is confirmed by the histopathology results.
Histology Results Management	Outlines the process to follow for management of histopathology results (excluding cancer) in the BSP.
Transport of Histology Samples	Details the transport pathway for histology samples in the BSP.
Anticoagulant Management for Outpatients having an Endoscopic Procedure	Outlines the process to follow for BSP participants on anticoagulants who may require enoxaparin (Clexane®) bridging.

Letter references

PD-07	Discharge – surveillance
SR-01	Subject result – Normal
SR-02	Subject result – Positive

8.1 Overview

Colonoscopy is the first diagnostic procedure offered following a positive iFOBT result. Pre-assessment is undertaken and if the participant is deemed suitable for a colonoscopy, an appointment is offered.

Colonoscopy for the BSP is provided by a dedicated unit at Waitakere Hospital (the Endoscopy Unit). The Unit has capacity to deliver 2500 colonoscopies a year. The Unit follows the Gastroenterological Society of Australia's Standards for Endoscopic Facilities and Services and associated guidelines provided by the Gastroenterological Nurses College of Australia (GENCA). The Unit is also guided by the Endoscopy Global Rating Scale for New Zealand.

Colonoscopy reporting is done on ProVation MD under the National Bowel Cancer Screening pro-forma. The system has a specific drop-down field for bowel screening.

The balance of responsibilities under the BSP differs from that of symptomatic patients, with GPs responsible for pre-assessment in symptomatic patients.

During the colonoscopy procedure, the process under the BSP differs in the retrieval and treatment of polyps. Each polyp retrieved is potted individually for laboratory histology and reporting on the BSP Register.

The endoscopist who performs the colonoscopy will convey the result to the participant before they leave the Endoscopy Unit, and give the participant the

ProVation report to take home. The ProVation report is also sent to the GP. If there is no histology taken the patient will also receive a letter, copied to their GP, approximately 10 days after the colonoscopy, confirming the result and the recall to screening timeframe.

Colonoscopy reports are collected through the ProVation endoscopy system and outcomes from colonoscopy are recorded on the BSP Register.

8.2 Endoscopists

Colonoscopies are undertaken by WDHB gastroenterologists and surgeons, augmented by fee-for-service private providers. New endoscopists are required to supply performance data demonstrating that they have performed 250 colonoscopies in the past 5 years and have a caecal intubation rate of ≥ 90% and a withdrawal rate of ≥ 6 minutes. As many endoscopy units do not monitor endoscopy performance, the data may be provided from self-monitoring. The BSP Quality Standards indicate that colonoscopies should have been provided as part of bowel screening, but initially, new endoscopists' experience will be in the symptomatic service. Practising certificates and indemnity insurance are reviewed prior to engagement.

Scheduling and communication

It is not desirable to cancel scheduled colonoscopies on the day due to the bowel preparation required by participants. However, scheduling of endoscopists is complicated due to the number of endoscopists and the overlapping of staff across the three Endoscopy Unit theatres.

Communication with endoscopists is managed by the Clinical Director.

Weekly meetings are held between the Coordination Centre and the Endoscopy Unit. The Endoscopy Review Group meets fortnightly and there is an Endoscopy Unit nurse team meeting once a month. The Endoscopy Review Group is guided by Terms of Reference.

8.3 Performance standards for endoscopists

Colonoscopy performance data is collected for each individual endoscopist who performs BSP colonoscopies. Endoscopists are monitored against performance standards by the Endoscopy Lead, and provided with a three-monthly report that includes completion rates, withdrawal times, intubation rate and the rate of polyp recovery.

The overall adenoma detection rate is collected, but currently individual adenoma detection rates are not.

Individual data is clinically audited and included in the overall monitoring for the BSP by the BSP Data Manager. All reporting to the Ministry is non-identifiable. The Endoscopy Lead analyses the overall and individual colonoscopy performance data on a three-monthly basis.

8.4 Quality and safety indicators for colonoscopy

The BSP Quality Standards require that:

- all endoscopists working in the BSP are approved to work in the BSP by the Endoscopy Lead
- 100% of screening colonoscopy outcomes are reported in the BSP Register
- 100% of screening colonoscopy results (excluding histopathology) are reported to the participant's GP within 5 working days after the procedure
- 100% of participants receive the results of all colonoscopy procedures (including histopathology) within 20 working days of the final procedure
- all endoscopists working in the BSP receive six-monthly performance feedback from the Endoscopy Lead and these records are available for external audit as de-identified data.

Non-identifiable colonoscopy performance information is reviewed quarterly by the Clinical Director and Endoscopy Lead. This is part of the monitoring data reported to the Ministry.

The BSP Data Manager provides a three-monthly standard report of all auditable outcomes and quality standards related to colonoscopy performance data, which informs a standard report for internal and external auditing requirements.

8.5 Participants with English as a second language

Interpreters are engaged for participants who have English as a second language. They attend the entire colonoscopy procedure with participants, until discharge instructions are provided.

The Endoscopy Unit generally provides interpreters two to three times a week.

Family members are not used as interpreters.

8.6 Outcomes from colonoscopy

Approximately 30% of participants will not have any polyps identified during their colonoscopy. These participants are referred back to their GP and scheduled to be recalled for screening in five years.

Participants diagnosed with bowel cancer or high-risk polyps are referred for treatment, or enter the surveillance programme run by WDHB. Participants' GPs are notified and these participants are considered to have exited the BSP.

Participants diagnosed with bowel cancer or other disease requiring ongoing surveillance are referred to the General Surgical or Gastroenterology Department and exited from the BSP.

Surveillance is undertaken in accordance with Surveillance and Groups at Increased Risk of CRC (NZGG, 2004) and Management of Early CRC (NZGG, 2011).

8.7 DNAs for colonoscopy

Policy reference

DNA Management	Outlines the process to follow if participants Did Not Attend (DNA) a scheduled face-to-face Colonoscopy Pre-Assessment, a scheduled Colonoscopy or a scheduled CTC in the BSP.

The BSP has processes to minimise DNAs, including flexible appointment options, reminders and provision of further information if required. The number of DNAs to colonoscopy is monitored and evaluated.

8.8 Decontamination and infection control for colonoscopy

The Endoscopy Unit follows these standards for infection control:

- Infection Control in Endoscopy (GENCA, 2nd edition)
- Health and Disability Services (Infection Prevention and Control) Standards (SNZ 8134: 2008).

BSP providers are recommended to refer to the endoscope reprocessing web-based education resource at www.health.qld.gov.au/EndoscopeReprocessing.

Section three of the BSP Quality and Procedures Manual provides an Endoscopy Reprocessing Audit Tool Kit for guidance for endoscopy facilities.

8.9 Provision of normal results

Letter reference

SR-01	Subject result – Normal

Endoscopy Unit nurses use theatre results lists to identify normal results. The CNS gives an administrator a list for generating 'normal' results letters.

9. Histopathology results

Policy references

Transport of Histology Samples	Details the transport pathway for histology samples in the BSP
Histology Results Management	Outlines the process to follow for management of histopathology results (excluding cancer) in the BSP.
Cancer Referral Management	Outlines the referral process for BSP participants diagnosed with cancer, including cancer suspected at the time of colonoscopy and when diagnosis is confirmed by the histopathology results.

Letter references

SR-02	Subject result – Positive
PD-07	Discharge – surveillance
SR-01	Subject result – Normal

9.1 Overview

Approximately 70% of participants have histology samples taken during colonoscopy. Histology samples taken during colonoscopy are preserved in formalin and triple-packed for courier to LabPLUS. Each participant's samples are accompanied by a BSP-specific laboratory form. A manifest sheet is completed with all participants' names and the number of specimens being sent, and faxed to the laboratory as a safety check prior to being put in with the specimens. Samples are then transported from Waitakere Hospital by direct courier to LabPLUS each workday evening. LabPLUS records the number of specimens received on the manifest sheet and faxes it to the Endoscopy Unit.

Histology results are reported on Eclair within ten working days, and accessed by the Clinical Director, Endoscopy Lead or CNS.

Pathologists are required to report BSP histopathology results using a standardised BSP-specific reporting format.

9.2 Cancerous polyps / lesions identified at colonoscopy

In most cases it is possible to identify a cancer during a colonoscopy. The endoscopist advises the participant if they have identified a polyp or lesion that appears to be cancerous, discusses further tests and treatment options, and provides the participant with written information.

Participants are referred to a colorectal surgeon if the endoscopist considers that they have cancer. If the endoscopist is only suspicious that the polyps/lesions may be cancerous they may wait for histopathology results.

Due to the sedation required for the procedure, participants may not recall the discussion with the endoscopist following the procedure. It is usually possible to have the participant's support person present so they can repeat the information to the participant at a later date. The CNS is also present and can be contacted for information and support prior to the first specialist appointment.

Participants with cancerous polyps or lesions identified at colonoscopy are referred for a specialist appointment and discussed at an MDM meeting. They leave the screening pathway at this point. The current standard requires the specialist appointment to happen prior to the MDM.

9.3 Cancerous polyps / lesions identified at histopathology

Occasionally cancer is not identified at the time of the colonoscopy but is identified on histological analysis. LabPLUS immediately advises the Clinical Director who contacts the participant to advise them of the results.

9.4 Notification to GPs

GPs are notified of their patients' results by provision of the ProVation report. Reports are hand sent. Some endoscopists will telephone the participant's GP to advise them of a malignancy.

9.5 Quality Standards

The BSP Quality Standards require that:

- 95% of specimens submitted from colonoscopy are authorised and relayed to the referrer within 10 working days of receipt of the specimen in the laboratory
- histology is reported using a standardised reporting format
- results are forwarded in the agreed codes and electronic format
- the histopathologist must attend multidisciplinary meetings (MDM) when required.

9.6 Provision of histopathology results where treatment is not required

Results of histopathology include the size and type of polyps and whether they are high or low grade.

Participants with histopathology who do not require treatment will be placed on one-, three- or five-year surveillance, or recalled to screening in five years, as per the Histology Results Management policy. Surveillance is managed by the Gastroenterology Department.

The administrator sends a results letter to the participant, with a copy to their GP, for all histopathology results.

10. Referral to other diagnostic procedures from colonoscopy

Policy reference

CTC Referral Management	Outlines the referral process to follow for BSP participants who require a CTC.

10.1 Overview

In the case of an incomplete colonoscopy a participant may be referred for a CTC or rebooked for a GA colonoscopy, at the discretion of the endoscopist.

A CTC is usually preferred if the endoscopist has managed to examine most of the bowel and has not found any polyps. If polyps have been found a GA colonoscopy may be preferred as it is likely that further polyps will be present.

If a colonoscopy is unable to be completed due to a large obstruction or growth, completion may be attempted with a smaller scope, or the participant may be referred for surgery.

10.2 Quality Standards

The BSP Quality Standards for referral for other diagnostic procedures from colonoscopy are:

- The first available appointment offered for an alternative procedure is within 5 working days of the endoscopist's decision (if deemed unfit for colonoscopy)
- CTC is carried out within 20 working days of the endoscopist's decision if participant deemed unfit for colonoscopy
- A date for CTC is offered within 5 working days of the incomplete colonoscopy, except in the case of a polypectomy, in which case the CTC should not take place until 6 weeks after the incomplete colonoscopy
- Following incomplete colonoscopy further procedures are undertaken within 20 working days
- 90% of participants receive results of all final procedures within 7 working days
- 100% of providers of CTC comply with the CT Colonography Standards as endorsed by Royal Australasian New Zealand College of Radiologists (RANZCR).

11. Readmissions

11.1 Overview

Readmissions are monitored as part of continuous quality improvement (CQI) within the BSP. A weekly report is generated of all readmissions, within 30 days of colonoscopy procedures performed in Waitakere endoscopy rooms. The CNS uses this report to identify and report on BSP participants who have been readmitted.

The CNS identifies the reason for readmission from the discharge reports on Concerto. Details relating to participants who are readmitted for a reason related to the colonoscopy, such as bleeding, perforation, or pain, are recorded on a BSP-specific readmission form and formally reviewed by the Clinical Director and Endoscopy Lead at fortnightly review meetings.

Incident reports are also prepared for the wider DHB. Mortalities are monitored via a weekly report as part of CQI.

12. Referral to surveillance

Letter reference

PD-07	Discharge – surveillance

12.1 Overview

Participants requiring surveillance are referred to a surveillance programme as recommended in the clinical guidelines *Surveillance and Management of Groups at Increased Risk of Colorectal Cancer* (NZ Guidelines Group, Ministry of Health, 2004) and not recalled for screening. Surveillance is undertaken by the WDHB Gastroenterology Department.

13. Referral to Multidisciplinary Team Meetings (MDMs)

Policy reference

Colorectal MDM – ToR	Sets out the terms of reference for colorectal Multidisciplinary Meetings.

13.1 Overview

All participants diagnosed with cancer are referred to a specialist and have their case discussed at a multidisciplinary meeting (MDM). Participants referred to an MDM are exited from the screening pathway.

Multidisciplinary teams are groups of professionals from diverse disciplines who come together to provide comprehensive assessment and consultation.

MDMs may include:

- patient navigator/psychosocial support
- Endoscopy Unit nurse/colorectal nurse specialist
- histopathologist
- radiologist
- colorectal surgeon
- gastroenterologist/surgeon/physician
- medical oncologist
- radiation oncologist.

The MDM ensures that all appropriate diagnostic tests, all suitable treatment options, and the most appropriate treatment recommendations are generated for each patient.

13.2 Quality standards

The BSP Quality Standards require that:

- 95% of BSP participants requiring clinical follow-up have been referred to and seen by an appropriate specialist within 10 days of diagnosis
- 100% of BSP participants diagnosed with cancer are referred for presentation at an MDM within 20 days from diagnosis.

14. Treatment

14.1 Overview

Participants may require treatment for cancer or other disease.

Treatment may involve surgery at North Shore Hospital, or radiation or chemotherapy at Auckland City Hospital. The BSP does not fund treatment.

Treatment data and outcomes and histopathology information on participants who have undergone surgery is collected by the Clinical Director and recorded on the BSP Register for monitoring and evaluation.

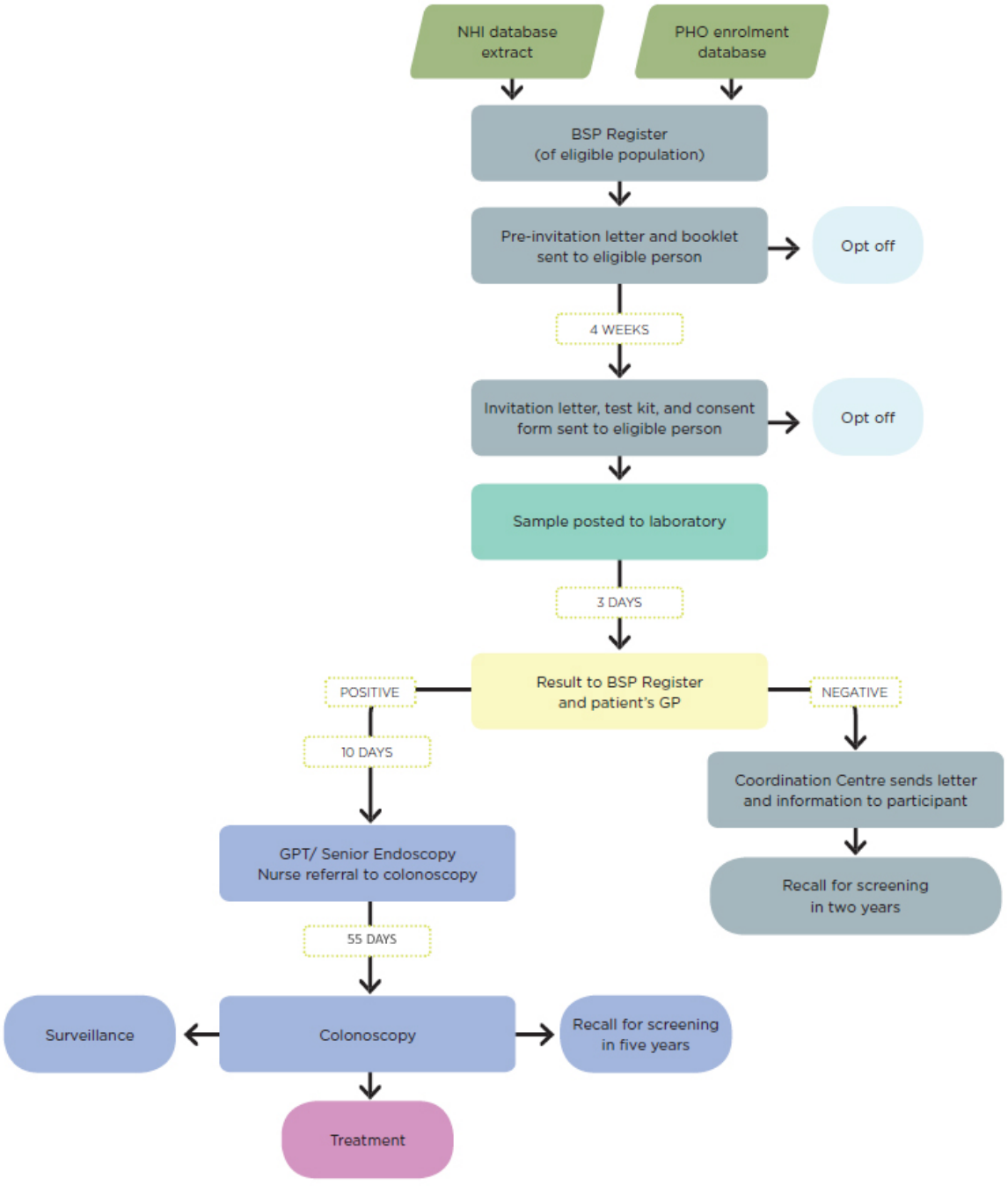
Participants who have treatment for large polyps may be moved to surveillance following their surgery, if appropriate.

Participants requiring treatment for cancer are not recalled for subsequent screening.

Appendix 1: The screening pathway

The following figure represents the screening pathway for people who have not previously participated in the BSP.

Figure 2: Screening Pathway



Note: the timeframe between the pre-invitation and invitation letters is now two weeks.

Appendix 2: Letters and consent form

The following table records letters and forms used in the BSP.

Histology letters provided by the Endoscopy Unit sit outside the BSP system.

BSP Letters and Consent Form	
Code	**Description**
IL-00	Consent form
IL-01	Pre-invitation (without GP details)
IL-02	Pre-invitation (with GP details)
IL-03	Invitation (with GP details) plus consent form and test kit
IL-04	Invitation (without GP details) plus consent form and test kit
IL-05	Invitation (self-enrolled with GP details) plus consent form and test kit
Il-06	Invitation (self-enrolled without GP details) plus consent form and test kit
IL-07	Invitation (priority populations with GP details) plus consent form and test kit
IL-08	Invitation (priority populations without GP details) plus consent form and test kit
IL-09	Second Cycle Invitation plus consent form and test kit
RT-01	New test kit and consent form (returned incomplete kit, did not include consent form)
RT-02	Retest (spoilt / expired kit)
RT-03	Retest (spoilt, user error, no date, no barcode, delayed in transit, leakage)
RT-04	Retest (technical failure)
RL-01	Test kit reminder
RL-02	Reminder of retest (participant with spoilt kit has not returned the retest)
GD-02	GP discharge (non-response / DNA pre-assessment)
GD-03	GP discharge (no agreement to proceed with diagnostic tests)
GD-04	GP discharge (not suitable for diagnostic tests)
GD-05	GP discharge (non-response / DNA diagnostic test)
GD-06	GP discharge (suspended due to other medical condition)
GD-07	GP discharge (surveillance)

PD-02	Discharge (non-response / DNA pre-assessment)
PD-03	Discharge (no agreement to proceed with diagnostic tests)
PD-04	Discharge (not suitable for diagnostic tests)
PD-05	Discharge (non-response / DNA diagnostic test)
PD-06	Discharge (suspended due to other medical condition)
PD-07	Discharge – surveillance
SR-01	Subject result – Normal
SR-02	Subject result – Positive

Appendix 3: Brochures

The following table records the brochures used in the BSP.

BSP Brochures		
Code	**Name of brochure**	**Latest version**
HP5401	BowelScreening – All about BowelScreening	Dec 2013
HP5400	BowelScreening – Your Quick Reference Guide	Dec 2013
HP5674	Test Kit Instructions	Dec 2013
HP5407	BowelScreening – Further Investigation	July 2013
HP6408	BowelScreening – All Clear	Dec 2013
BSCAE01	BowelScreening – Free for 50-74 year olds in Waitemata	Oct 2011

Appendix 4: Forms

Colonoscopy Pre-Assessment Form

Waitemata District Health Board

Best Care for Everyone

First Name: _____ Gender: _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NH#: _____

Ward/Clinic: Consultant:

Bowel Screening Programme

Colonoscopy Pre-Assessment Form

Colonoscopy Appointment		**Endoscopy Room (1, 2 or 3)**	
Date of Telephone Call / Interview			

-Check Name, Date of Birth and Address

Name			
D.O.B			
Country of Birth			
Address			
Contact Details	**Home:**	**Work:**	**Mobile:**
G.P Details			
Administrator Information			

If on the telephone confirm that the time is suitable and ensure privacy

-Do you require an interpreter? (State language) **YES/NO**

Give explanation of positive iFOBT result and rational for colonoscopy

-Did your ***G.P*** or ***Practice Nurse*** provide the iFOBT result? (Circle if appropriate) **YES/NO**

-Did you have a face-to-face consultation regarding the result with your G.P? **YES/NO**

Give an overview of:

Colonoscopy procedure ☐

Risks and complications ☐

Sedation ☐

Explain the rationale for the assessment.

Do you have or have ever had any of the following	**YES**	**NO**	**Comments**
DIABETES			
Diet/ Tablets / Insulin / (Refer to Diabetes Policy)			
MEDICATIONS – INCLUDING NON-PRESCRIBED/ HERBAL **Please list:**			
ALLERGIES / SENSITIVITIES			
Any previous issues with sedation?			
ANTI-COAGULANTS			
Are you on plavix, warfarin, aspirin, dabigatran? (Refer to Anti-Coagulant Policy)			**Reason on therapy:** **Referred to Lead Endoscopist** Yes ☐
CARDIOVASCULAR			
Stroke			
Heart Attack / IHD			

Review December 2013

Waitemata District Health Board

Best Care for Everyone

First Name: _____ Gender: _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Ward/Clinic: Consultant:

	YES	NO	Comments
Heart Valve Disease / Artificial Valve			
Endocarditis / Heart Failure			
Pacemaker / Defibrillator / Arrhythmia			
High / Low Blood Pressure			
Angina / Chest Pain			
RESPIRATORY			
Breathing problems			
Asthma			
COPD / Emphysema			
Sleep Apnoea			
SURGICAL CONDITIONS			
Abdominal or pelvic surgery			
Joint replacements			
MEDICAL CONDITIONS			
Renal Failure			
Liver Disease			
Anaemia			
Blood disorders/Bleeding Disorders			
Epilepsy / Seizures			
Recent Radiotherapy / Chemotherapy			
Glaucoma			
Arthritis			
Infectious Diseases (i.e. Hepatitis)			
Have you ever been nursed in isolation?			
BOWEL HABITS (constipation)			
Have you had any previous endoscopy procedures?			
Any known Bowel Disease / Crohns / Ulcerative Colitis / Diverticular Disease / Bowel Cancer / Symptoms / Treatment			
Family History of Bowel Cancer			
WEIGHT			
OTHER RELEVANT INFO			

Bowel Preparation Explained (Include advice around taking current medications) **YES/NO**

-Do you have any particular cultural, religious or special needs? (State) **YES/NO**

-Do you have any mobility or transport issues? **YES/NO**

-Do you have a responsible adult to collect you and stay with you for the first 12 hours? **YES/NO**

Give contact numbers to participant and inform them that information will be sent to them

Nurse completing form (print and sign) _____

Consultation required with Endoscopy Lead	**Outcome:**
Declined colonoscopy	**Date GP notified/Letter sent:**
Needs in-patient colonoscopy	**Arrangements made:**
Requires cultural support	**Arrangements made:**

Readmission Clinical Review Template

Patient's Label

Date of Procedure	**Date of Admission**	**Date of Discharge**	**Length of Admission**

Colonoscopy Details

Endoscopist:
Difficulty of procedure:
Polyps: ▪ Number _____ ▪ Size (largest) _____ ▪ Technique (of largest) _____ ▪ Type S ☐ or P ☐ ▪ Risk Factors i.e. on anti-coagulants

Readmission Details
▪ Reason ▪ Investigation ▪ Treatment

Reviewed by: _____ **Signature:** _____

Date of Review: _____

Outcome of Review:

Developed February 2012

Waitemata District Health Board
Best Care for Everyone

Surgical & Ambulatory Services
Bowel Screening Programme & Gastroenterology

Anticoagulant Management for Outpatients having an Endoscopic Procedure

Contents

1. Overview

Purpose

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 medication and require an endoscopic procedure.

Scope

The services and staff involved in the delivery of Endoscopy. This includes, but is not limited to, WDHB Endoscopy Staff, Bowel Screening Programme staff, WDHB Pharmacy, Community Pharmacies and Primary Care Teams.

2. Anticoagulant Management Process

Step	Description
One	
Symptomatic Services	The Senior Doctor identifies that the patient is on an anticoagulant, the reason they are on the therapy and risk factors.
Bowel Screening Programme	The Clinical Nurse Specialist (CNS) identifies that the patient is on an anticoagulant, the reason they are on therapy and the risk factors. *This will be in the General Practitioner's referral or established during the colonoscopy pre-assessment.*
Two	
Symptomatic Services	(Go to Step Three)
Bowel Screening Programme	The CNS discusses case management with the BSP Lead Endoscopist
Three	
Symptomatic Services	The Senior Doctor makes a recommendation regarding anticoagulant management using the CHADS2 Score and completes the "Gastroenterology Dept WDHB Antiplatelet & Anticoagulation Planning Sheet" (attached to referral) *(see Anticoagulation and Antiplatelet Guidelines Policy)*
Bowel Screening Programme	The BSP Lead Endoscopist makes a recommendation regarding anticoagulant management using the CHADS2 Score and documents the

BowelScreening
Check Yourself Out

Waitemata

BowelScreening Coordination Centre, P.O. Box 33190, Takapuna, Auckland 0740 | Ph: 0800 924 432 | Fax: (09) 484 0202 | www.bowelscreeningwaitemata.co.nz

Colonoscopy Bowel Preparation Glycoprep-C

Please be sure to read these instructions at least 3 days before your procedure to ensure you understand them.

- The bowel needs to be flushed clean so that the doctor can see the inside of your colon clearly. This is achieved by following these instructions carefully.
- To be effective you must drink all the Glycoprep-C even if you think you are clear after only drinking some of it.
- Remember to stay near a toilet after commencing the Glycoprep-C, as diarrhoea will occur. Individual responses to laxatives may vary and may work within 30 minutes or up to 3 hours.
- A vital part of this preparation is the extra fluids that you drink. Not only does this prevent dehydration, it forms an important part of the cleansing process.

Medications

- If you are taking iron tablets please stop 5 days prior to the test.
- If you are taking blood thinning medications other than aspirin, please phone 10 days before your appointment if this has not already been discussed with the Endoscopy nurse.
- If you suffer from nausea it is advisable to contact your GP before taking the preparation to get anti-nausea medication.

Tips for taking Glycoprep-C

- If you feel bloated, try a short walk.
- If you feel cold or shivery, wrap up warmly
- If you feel nauseated, have a break or slow down drinking the Glycoprep
- Cleaning your teeth and tongue may help or use a straw.
- One or two barley sugar sweets may help with the taste.
- Anal soreness may occur due to multiple bowel motions. Apply Vaseline to anal area before starting Glycoprep-C to minimise this.

On the day of your appointment come to - Waitakere Hospital Surgical Unit, Ground floor, Entrance 'C'. Please phone us if you have problems with the preparation for your colonoscopy: 09 837 8892

Please turn this page over for more important information

Instructions

3 days before your appointment

- Take your regular medications.
- Start low fibre diet using attached diet sheet as a guide.
- Avoid eating nuts and food with seeds or skins, e.g: tomato, kiwifruit, corn, and grainy breads.
- Do not drink red or purple drinks until after your procedure.

2 days before your appointment

- Take your regular medications.
- Continue low fibre diet.
- Drink plenty of fluids.

1 day before your appointment

- You may have a low fibre breakfast **then take the two Bisacodyl laxative tablets** with a large glass of water.
- Eat an early light lunch. **Do not eat after 12 midday, until after your procedure**.
- Drink at least 10 glasses of **clear fluids** during the day, (see diet sheet).
- Take your regular medications 1 ½ hours prior to beginning, or 1 ½ hours after completing Glycoprep-C, to allow for absorption.
- Diabetics on metformin and/or gliclazide; do not take the evening dose.
- Disregard the instructions on the Glycoprep-C packets. Dissolve the content of each packet of Glycoprep-C in one litre of tap water (total 3 litres). Refrigerate all 3 litres if you wish.
- At 4pm start drinking 2 litres of the Glycoprep solution. You should drink a glass every 5-10 minutes, aiming to complete 2 litres in 2 hours. **It is important that you take all 2 litres of Glycoprep-C**.
- Continue drinking clear fluids up until 1 hour before your appointment time to prevent dehydration.

✔ day of procedure

- **No solid food allowed**
- For a **morning appointment** you must take the 3rd litre of Glycoprep-C between 5-6am.
- For an **afternoon appointment** you must take the 3rd litre of Glycoprep-C between 7-8am.
- Take regular medication with a small amount of water.
- Do not take your diabetes medication or insulin unless advised to do so by the diabetes team. Please bring it with you to the hospital.
- Discharge time is generally 2-3 hours from admission time.
- As you are given sedation, you cannot drive and you **must** have a responsible adult to take you home and remain with you for the rest of the day.
- You cannot wait outside for them or catch a taxi or bus alone.

Waitemata District Health Board
Best Care for Everyone

Low Fibre Diet for Colonoscopy Preparation

A low fibre diet reduces the volume of your bowel movements which helps when cleaning out your bowel prior to colonoscopy.

Please follow the food guide below:

After midday the day before procedure:
CLEAR FLUIDS ONLY

Food Groups	Allowed	Avoid
Bread, Cereals, Rice, Pasta, Noodles	White bread / crumpets / English muffins. Processed breakfast cereals e.g. *Rice Bubbles™, Cornflakes™, Special K™* White rice/ pasta, sago, tapioca, semolina. White flour, cornflour, custard powder. Plain sweet and savoury biscuits or cakes.	Wholemeal / wholegrain bread, fruit bread / rye bread. Wholegrain breakfast cereals or any with fruit, nuts or coconut, e.g. Muesli, *All Bran™, Weetbix™* Oats and oat bran, Muesli bars Brown rice, pasta, maize wholemeal flour, wheat germ. Sweet and savoury biscuits or cakes made with wholemeal flour, nuts, dried fruit or coconut
Vegetables	**Ensure all vegetables are peeled and well cooked** Potato, pumpkin and zucchini. Cauliflower and broccoli tips Spring onions, lettuce, asparagus spears and button mushrooms. Strained vegetable juice.	All raw vegetables. Any vegetables not listed in the "allowed" column
Fruit	Pawpaw and melon (no seeds), banana. Well-cooked fruit with no skin or pips. Canned fruits except pineapple. Strained fruit juice.	Fruit with skin, pips or of very "fibrous" texture. Dried fruit. Any other fruits not listed in the "allowed" column
Milk, yogurt, cheese	All varieties of milk Plain yoghurt, custard, vanilla, plain cheese, plain or flavoured ice cream.	Ice cream or gelato containing dried fruit, nuts or coconut Products containing "chunky fruit" pieces
Meat, fish, poultry, eggs, nuts, legumes	Chicken (no skin), fish, turkey, ham. Tofu Eggs	Legumes e.g. Baked beans, lentils, soy beans, kidney beans. Nuts and seeds.

Please turn over

Food Groups	Allowed	Avoid
Other	All fats including butter, margarine, salad dressings, mayonnaise. Sugar, honey, syrups, ice-cream toppings Boiled lollies, jubes, chocolate with no fruit, nuts or coconut Spreads without seeds or skin. Soup made from allowed ingredients Desserts made from allowed foods e.g. junket, jelly, custard, ice cream Gravy, salt, pepper, dried herbs, spices	Popcorn, coconut, crunchy peanut paste, chocolate with nuts and fruit Chutney and pickles
Clear Fluids (After 12 midday, day before colonoscopy)	Water, tea or coffee **with no** milk, light coloured 'fizzy' drinks (lemonade, ginger ale) cordial, lucozade.	Red or purple drinks

Sample low fibre meal plan:

Breakfast:

- 1 glass strained fruit juice.
- Rice bubbles with milk. Sugar optional.
- White toast / bread / crumpets, with margarine / butter.
- Honey/ jam/ vegemite.
- Egg / cheese, if desired.

Lunch:

- Chicken / fish / ham / egg / cheese.
- White bread and margarine / butter.
- Tinned fruit and custard or plain cake.
- Cup of tea or coffee.

Dinner:

- Strained soup.
- Chicken / fish / ham / egg / cheese.
- Potato, white rice or pasta.
- Small serve of "allowed" vegetables.
- Bowl of plain ice cream.
- Cup of tea or coffee.

Between meals:

- Cup of milo made with milk.
- Plain cake / biscuits / cracker biscuits.
- Tub of plain yoghurt.