



Netcare Healthcare UK Ltd

Extended Choice Network

Procedure Patient Care Pathway

F35 – Large Intestine Colonoscopy

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Other Notes

Reference to one gender can be interpreted to imply as belonging to either gender.

This HRG covers a range of procedures, all of which are found in Version 3.5 of the HRG Reference Manual, however these are examples of the types of procedures and this is not an exhaustive list.

Examples of procedures:

- H228 Diagnostic endoscopic examination of Colon
- H259 Diagnostic Endoscopic exam low bowel using fibrotic sigmoidosope
- H289 Diagnostic Endoscopy examination sigmoid colon using rigid sigmoidoscope
- H412 Perianal excision of lesion of rectum

TABLE OF CONTENTS

SECTION ONE

Generic Clinical Pathway – Key Entry/ Exit Points

1.1 Entry Point – Referral	5
1.2 First Outpatient Appointment	6
1.3 Pre-Admission Clinic	6
1.4 Hospital Discharge	7
1.5 Post Discharge Complications	8
1.6 Follow Up Assessment – Final Exit	9

SECTION TWO

Clinical Pathway – The Clinical Aspects

2.1 Anaesthetic Assessment	11
2.2 Allied Healthcare Professional Assessment	12
2.3 Admission and Pre-Operative Preparation	12
2.4 Surgery	13
2.4.1 Theatre/ Endoscopy and Recovery	13
2.5 Ward	15
2.6 Clinical Discharge	16
2.7 Outcomes to be Measured	17

SECTION ONE

Generic Clinical Pathway

1.1 Entry Point - Referral

The patient's journey begins when they are referred by a GP, (or RHSB), to a BMI hospital of their choice for a specific type of treatment selected from the Directory of Service.

The referral will consist of a provisional appointment made on the Choose and Book System supported by a referral letter detailing information of relevant past medical history, current medication and clinical symptoms.

The referral will be submitted via Choose and Book as a directly bookable service. There will also be provision to accept referrals either electronically or paper based using safe haven fax or secure email.

An initial clinical triage of the referral must be performed within 24 hours to ensure that the patient's referral is appropriate for the services offered in the Directory of Service and there are no obvious exclusions.

The patient will then have their referral either accepted or rejected.

If the referral is rejected, this will be recorded on all the appropriate information systems detailing the reason for rejection and, where appropriate, offering advice and guidance to the GP, (or RHSB), on an alternative care pathway.

If the referral is accepted, the appointment will be confirmed on the appropriate information systems and the patient will be notified of their appointment. The patient will then attend their outpatient appointment.

Where possible at the first outpatient appointment all appropriate tests and investigations should be undertaken. This will include a nurse pre-admission assessment should surgery be required.

RHSB = Referring health service body.

1.2 First Outpatient Appointment (Consultant Led)

Each patient will undergo a full clinical assessment including:

- Clinical History
- Clinical Examination
- Appropriate diagnostics, (recommended by the Radiological Test Guidelines from the Royal College of Radiologists)

Diagnosis will be made and a care pathway will be discussed with the patient.

In line with IRMER unnecessary investigations should be avoided and therefore recent copies of results can be accepted to support a diagnosis.

There will be occasions when additional diagnostics of a more complex nature will be required, i.e. CT/ MRI scan, and it will be necessary for the patient to book an appointment to undergo this specific diagnostic test. They will then be required to revisit the consultant to discuss further the findings and conclude the clinical pathway.

Should surgical intervention not be required the patient will exit the pathway at this point and be referred back to the GP, (or the RHB), offering advice and guidance on an alternative care pathway where appropriate.

Written, informed consent will be obtained from the patient, and in addition written consent for the disclosure of any clinical data for the purpose of research or audit.

Once a diagnosis has been confirmed and surgery deemed appropriate the patient will receive a detailed patient information leaflet on the intended procedure.

The patient can now book a date for surgery.

1.3 Pre-Admission Clinic (Nurse Led)

This can take place in one of three ways:

- At time of first appointment
- By telephone
- Or at a second outpatient attendance

The requirement at a pre-admission clinic will vary dependant upon the procedure for which the patient attends however in all cases any outstanding information required for the patient documentation will be collected and any information already recorded will be validated.

All pre-operative tests are as per NICE guidance for pre-operative investigations.

Picolax, oral aperient will be given to the patient (if no contraindications) with a full explanation of how and when to use in advance of the appointment. The patient will further be advised of the course of action and what to do if the bowel preparation does not work. Written instructions will also be provided.

MRSA screening will be undertaken as local Policy dictates.

Where there are social, community, cultural or disability support requirements these should be identified in advance of admission to facilitate timely discharge.

1.4 Hospital Discharge

The patient will only be discharged if the treating Surgeon is satisfied that the recovery pathway has progressed to a level that is safe and there is minimal risk of complications should the patient be discharged from hospital.

Patients will be discharged in the majority of cases to their own homes under the supervision of district nursing and community services. However, in some circumstances they will be discharged to supported nursing care. This requirement will have been identified at the assessment as part of the pre-admission clinic.

On discharge patients will receive all information regarding use of medication, where appropriate, mobilisation techniques and helpful hints will be explained by the staff. This information will be contained in the relevant patient information brochure. Patients will receive advice and date/s of follow up appointments, suture removal if applicable or additional tests or X-rays that may be necessary during the follow-up part of their pathway.

An emergency out of hours contact number will be issued to the patient to allow support should any adverse clinical incident occur. This contact information is reinforced in the patient information leaflet. This does not however prevent the patient from attending their nearest Accident and Emergency department. However, should this occur patient's repatriation will be promoted to facilitate ongoing clinical governance.

On leaving the hospital the nurse responsible for the patient's discharge will ensure the patient is provided with a discharge summary detailing the procedure that they have undergone, their condition on discharge and their clinical requirements and medication expected during the recovery period.

Subsequent to this the GP, (and the RHSB), will receive a full doctor to doctor discharge letter.

Where necessary, discharge medication will be provided for a minimum of 7 days.

At the point of discharge from the hospital patients will be asked to complete a Patient Satisfaction questionnaire. On completion the questionnaire will be captured in the relevant information system.

1.5 Post Discharge Complications

Most elective surgery is successful but inevitably, from time to time complications can occur. Any associated postoperative complications that occur are the responsibility of the BMI hospital to treat and/ or manage in accordance with the specific clinical pathway. This will be for a minimum of 28 days and up to a maximum of 1 year, procedure specific.

Education of the patient during their hospital stay is important to ensure that they are able to identify complications when they do occur. They should be made aware of the likely signs and symptoms of both major and minor complications and be advised on what action to take should these occur. In addition the patient must be assured that they can call the hospital for advice and assistance at any time, day or night.

When a patient is discharged, they are given a contact number that will allow them easy 24 hour access to clinical advice from a healthcare professional. A patient who calls for advice with a clinical question will always have the opportunity to speak to a member of the clinical staff and also the RMO where appropriate. All such triage calls are documented to ensure a consistent audit trail for the care of these patients. Every patient who makes such a call will have the opportunity of attending the hospital to be seen by the RMO, although in most situations this will not be necessary.

If it is clear from the conversation that the patient is presenting an acute clinical emergency they will either be advised to come to the hospital immediately or to call 999 depending on what is most appropriate.

Whilst the majority of complications will be treated in a BMI hospital on occasions dependant on the clinical presentation and the specific BMI facility it may be necessary to refer on to the nearest acute NHS facility, i.e. where ICU/ CCU is not available.

1.6 Follow up Assessment - Final Exit

On discharge the patient will have been given an appointment for a follow up assessment. Every patient will receive one follow up appointment as a minimum and for the majority of procedures these will normally occur at 6 weeks however specific pathways will indicate otherwise, e.g. vasectomy – 12 weeks due to post vasectomy testing. The frequency of subsequent follow up appointments will be determined by the clinical outcome.

Following attendance at a follow-up appointment and satisfaction that the patient is fully recovered and the condition for which they were referred has now been successfully treated the patient will be discharged complete back the GP.

In the event that the patient requires additional procedures or ongoing care or an ongoing care plan, guidance and support will be given to the GP and patient.

SECTION TWO

Clinical Pathway

F35 - LARGE INTESTINE COLONOSCOPY

2.1 Anaesthetic Assessment

Most patients are given Intravenous conscious sedation for colonoscopy. Doses will be titrated to patient tolerance.

Should a patient require a general anaesthesia, the anaesthetist will carry out an anaesthetic assessment and will complete a full anaesthetic history to determine whether the patient is fit for procedure and anaesthesia.

The anaesthetist will assess the batch of investigations that were conducted prior to the assessment clinic. Should the Anaesthetist feel that a test requires repeating in order for a suitable assessment of the anaesthetic risk to the patient, she/ he will request this by referral to the pathology or radiology services.

In some cases, depending on the time taken to perform these confirmatory investigations, a second pre-operative appointment may be scheduled. For example if the patient did require a cardiac assessment and was being seen at the pre-operative clinic on the weekend or out of consulting hours.

Therefore, prior to being booked for colonoscopy the patient may undergo additional tests and investigations relevant to the procedure and the patient's risk factors at the BMI hospital OPD clinic.

Patients will be classified by the Anaesthetist based on their anaesthetic risk profile as follows:

- ASA 1 – No systemic disease;
- ASA 2 – Mild systemic disease;
- ASA 3 – Major systemic disease;
- ASA 4 – Incapacitating systemic disease; and
- ASA 5 – Emergency surgery.

Patients in ASA 3 will be assessed as to their suitability for surgery in conjunction with the type of surgery to be performed. Patients in ASA 4 and 5 will be considered unsuitable for the elective surgery at the BMI Hospital.

The patient's suitability for surgery will be assessed as:

1. Suitable for surgery;
2. Provisionally suitable for surgery pending results of additional tests or specialist assessments or pending resolution of current flare up of systemic disease, i.e. uncontrolled Hypertension or diabetes. These patients will be referred back to the referrer or if necessary NHS consultant for resolution of the current illness or additional testing prior to surgery;
3. Should the patient have a minor medical illness such as a urinary tract infection or an upper respiratory tract infection or mild dermatitis which

will settle with minor treatment, they can be treated by the Netcare Consultant (if appropriate) with a deferred date for surgery agreed with the patient; and

4. Unfit or unsuitable for type of surgery proposed.

The anaesthetist will assess the patient's chronic medication status and will advise the patient regarding adjustment or cessation of medication prior, during or after surgery as necessary.

2.2 Allied Healthcare Professional Assessment

Consultation with the physiotherapist will occur to assess the patient's functionality and assist in the preparation of the patient's rehabilitation and home care plans.

BMI staff will take this into account when assessing the patients at the pre-admission clinic. It will assist them in determining the rehabilitation plan and any equipment requirements that the patient might have on discharge. BMI staff will liaise with their colleagues in the community to assist with the planning for the patient's discharge back into the community. This will occur after the pre-operative admission clinic assessment and followed up during the inpatient stay. Prior to discharge the BMI hospital team will ensure that all is in place for the patient to go home, including physiotherapy, nursing, equipment and referral letters.

2.3 Admission and Pre-Operative Preparation

Patients will arrive at the BMI hospital 2 hours ahead of the procedure on the day.

The patient's preoperative assessment and the results of any tests or x rays will accompany the patient and will be available to the medical team on request.

Nursing staff will welcome and orientate the patient to the Ward, identify the patient, check the patient's information and history and complete the procedures indicated on a pre-operative checklist in order to prepare the patient for endoscopy.

Bowel function following the Picolax, oral aperient will be checked. If the bowel function is not 'clear', further disposable enema may be needed to ensure the bowel is empty.

The medical team will review the pre-operative consultation, assess medication and prescribe pre-medication. The written informed consent form will be signed as confirmed with the patient by the surgeon.

Fasting protocols of 6 hours for food and 2 hours for clear fluids will have been followed, or fasted as indicated by the oral aperient instructions.

A signed preoperative check list will be completed by the escorting nurse to ensure the patient has been correctly prepared for the surgery.

The patient will be escorted to theatre/ Endoscopy area by a member of the ward nursing staff.

2.4 Surgery

2.4.1 Theatre/ Endoscopy and Recovery

Theatre/ endoscopy staff will formally receive the patient into theatre/ Endoscopy with the required documentation.

Nursing staff will check the ID of the patient, that fasting protocols have been followed, verify the procedure and site to be operated on and check that all preoperative procedures have been carried out.

Intravenous access will be established, and oxygen administered (monitored with pulse oximetry) prior to sedating the patients.

The amount of sedation or analgesia required for any procedure varies according to the patient's age, prior use of medication, associated illnesses and anxiety level its use will be decided on in consultation with the "Guidelines on Safety and Sedation during Endoscopic Procedures, September 2003". Patients will be given rapid onset sedatives and/or analgesics as necessary. In all cases, the minimal dose which provides the desired effect will be given. Midazolam 5mg should be the maximum dose and elderly patients should be given 1-2mg initially with a sensible pause period to observe the effects. Doses in excess of Pethidine 50mg and Fentanyl 100 mcg are seldom required and elderly patients will usually receive 50% of these doses. Midazolam and pethidine/Fentanyl synergistically enhance the patient's tolerance of endoscopy. (Hyoscine butylbromide 20mg may also be given). Drugs such as propofol or ketamine can be used if required by the anaesthetist if attending.

Intra-operatively:

Preparation of the theatre, instruments and packs will be defined by rigid aseptic techniques and protocols.

The surgical procedure will be carried out in accordance with best current clinical practice. The surgeon will comply with the guidance issued by the Royal College of Surgeons of England "Guidance on Surgical Practice" – The surgeon will be on the relevant specialist register of the GMC and be registered as a consultant on BMI hospitals Register.

First Line (emergency equipment) will be available.

Vital signs will be monitored by continuous assessment (usually by employing electronic monitoring) to detect early signs of patient distress before compromise to vital functions occurs.

Supplemental oxygen administration reduces the extent of oxygen desaturation and should be used in all patients, where there is impairment of pulmonary function due to administration of Intravenous sedation/anaesthesia and where prolonged procedures are anticipated.

The exact procedure used depends on the type of endoscopy and choice of anaesthesia.

The patient will be positioned lying on their left side with bent knees and Intravenous sedation will be administered.

After sedation, and whilst preserving the patient's dignity the patient's bed linen and gown will be removed just prior to the surgeon introducing the endoscope and maneuvering it into position. Lubricating jelly will have been applied to the scope.

The physician/surgeon may look at the area under investigation directly through the endoscope, or view transmitted pictures appearing on a nearby monitor. The doctor may simply make a diagnosis and take a biopsy. Pictures of the endoscopy findings may also be taken.

Findings will be recorded and if a biopsy is taken, laboratory protocols will be followed.

All procedures, drugs, consumables and instrument usage will be recorded, together with the physician/surgeon's operating notes.

Post Operative Management:

Post-operatively the patient will be transferred to the recovery room where monitoring and documentation will continue.

- A formal handover between the operating endoscopy nurse and the recovery nurse will take place.
- The patient will be placed on oxygen if required and vital signs will be monitored and the level of consciousness assessed.
- Medication will be administered as per the doctor's prescription.

Post operative care will be as per instruction of the surgeon and in line with the specific procedure performed.

The patient will only be discharged from the recovery room to the Ward when the patient achieves a total score of 4 or less on the following Post Anaesthesia Discharge score:

<p><u>Level of Consciousness Score</u></p> <p>0 Alert 1 Drowsy 2 Asleep (rousable) 4 Asleep (unrousable)</p>	<p><u>Airway Score</u></p> <p>0 Own 1 Support needed 2 Support device needed</p>
<p><u>Pain Score</u></p> <p>0 No pain 1 Mild pain 2 Moderate pain 3 Severe pain</p>	<p><u>Nausea Score</u></p> <p>0 None 1 Mild 2 Persistent nausea 3 Vomiting</p>
<p><u>Wound/ Dressing Score</u></p> <p>0 Dry intact 1 Slight bleeding/ discharge 2 Heavy bleeding/ discharge</p>	<p><u>Circulation</u></p> <p>0 BP & pulse +/- 20% of pre-op norm 1 BP & pulse +/- 21% - 39% of pre-op norm 2 BP & pulse +/- 40% of pre-op norm</p>

Complications:

Should an intra-operative or post-operative complication arise that warrants referral to a secondary acute facility, transfer will be arranged according to the protocol negotiated with the local acute NHS trust.

2.5 Ward

On arriving in the post-operative ward, the patient will be admitted according to local protocol.

The post operative patient will be cared for by the named nurse and the multidisciplinary team.

Vital signs will be recorded on return from theatre.

Once the sedation effects have worn off the patient will be offered fluids and diet. The patient will be advised to have light diet for 24 hours and can then return to normal diet.

An on-duty on-site RMO will oversee all general daily clinical aspects of the patient's care post-operatively in conjunction with the nursing staff, consultant surgeon on call, and anaesthetist on call.

2.6 Clinical Discharge

The following criteria will be used to establish whether a patient can be discharged:

- Normal vital signs consistent with the patient's age and stable pre-surgical levels;
- Able to ambulate without help;
- The patient is afebrile;
- No vomiting at proposed time of discharge;
- No indication of thrombo-embolic disease;
- Minimal dizziness. Patient should not experience dizziness – however if the patient does experience dizziness it should be only present upon standing and should not interfere with mobilization consistent with what they could achieve pre-operatively;
- No unusual bleeding or discharge related to the procedure;
- No signs of respiratory distress, stridor or croup cough;
- Able, alert, aware of surroundings and aware of what has taken place;
- Pain-free or pain adequately controlled by oral analgesics;
- Able to void urine and bowels are functioning normally;
- All cannula and drains are removed and the sites are clean and dry;
- Skin is intact and the patient has a satisfactory Waterlow scale.

Nursing documentation will include a discharge check-list.

The hospital's multidisciplinary health team will prepare the patient for the rehabilitative phase at home and feel confident in the patient's level of independence with activities of daily living.

TTO's should not normally be required.

Clinical Follow Up:

On discharge the patient will be advised of when and how their follow up assessment will occur and any other post operative care requirements i.e. wound dressings, suture removals.

The patient will receive a minimum of one follow up appointment occurring no later than 6 weeks post operative procedure.

It is recognised, there will be some procedures within this HRG group that will require more than one follow up appointment. Therefore additional follow up appointments will occur as dictated by the procedure undertaken in line with best clinical practice guidelines to ensure a successful clinical outcome.

On satisfaction that the patient is fully recovered from the condition for which they were referred and successfully treated, the patient will be discharged back to the G.P.

All outcomes will be monitored through standard KPIs (Key performance indicators) returns.

In the event that the patient requires additional procedures or ongoing care, guidance and support will be given to the G.P. and patient.

2.7 Outcomes to be Measured

- Patient satisfaction;
- Complications - Infection rates;
- Readmission;
- Quasar Nursing Audit;
- Additional KPIs required for the contract.