Colonoscopy Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care and management of having elective colonoscopy procedures throughout the WA Country Health Service (WACHS).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

This policy has been aligned with the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Colonoscopy Clinical Care Standard that WACHS facilities and staff are responsible for.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility. Refer to the staffing section for credentialing of clinicians.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency.

3. Considerations

Techniques to produce deep sedation (with potential loss of consciousness) or general anaesthesia, must not be used unless there is a doctor credentialed to give anaesthesia present for these cases.
Refer to ACSQHC Colonoscopy Clinical Care Standard: Quality Statement 5 – Sedation, for further information and the WACHS Procedural Sedation Clinical Practice Standard.

4. General Information

Colonoscopy involves direct visualisation of the lower gastrointestinal (GI) tract from the rectum to the ileocaecal valve and the distal ileum using a long flexible endoscope.[1,2] It is almost always performed with the patient under sedation.[3]

It is a complex task that requires the colonoscopist to manipulate the colonoscope effectively in order to visualise the bowel, while performing therapeutic interventions such as removing polyps or tissue samples when required.[17]

High quality colonoscopy is critical to the early detection and treatment of bowel cancer. Removal of polyps and adenomas may prevent bowel cancer developing, while early diagnosis of bowel cancer can improve treatment outcomes and survival. Colonoscopy can also identify those who require regular colonoscopy surveillance due to having an increased risk of bowel cancer.[17]

5. Indications for Procedure

Colonoscopy is performed for diagnostic and therapeutic indications[4] including;

Signs/symptoms
Abnormal imaging
Lower gastrointestinal bleeding and unexplained iron deficiency anaemia
Lower gastrointestinal symptoms (e.g. chronic diarrhoea)
Screening/surveillance
Colon polyp
Colon cancer
Inflammatory bowel disease
Therapeutic
Polypectomy
Localisation of lesion
Foreign body removal
Decompression of sigmoid volvulus
Decompression of colonic pseudo-obstruction
Balloon dilation of strictures
Palliative treatment of bleeding or stenosed neoplasms
Placement of percutaneous endoscopic cecostomy tube

6. Contraindications

Colonoscopy is contraindicated in the following situations[4,21]:

- When the risk of the colonoscopy outweigh the expected benefits
- Consent cannot be obtained for a non-urgent procedure
- Documented acute diverticulitis
- Fulminant colitis

7. Risk and complications

The quality of colonoscopy is important for minimising the risk of complications from the procedure. Risk increases with age, with the number of colonoscopies and when polyps are removed. While the risk of complication is relatively small, a large number of people undergo colonoscopy, many of whom are not diagnosed with any disease.[17]

Complications associated with colonoscopy include:

- Risks of the procedure itself such as:
    - Abdominal pain or discomfort: The most commonly reported minor complications of colonoscopy are bloating, abdominal pain and/or discomfort.[12]
    - Bleeding from the site of biopsy or polyp removal: Bleeding is most often associated with polypectomy, although it can occur during diagnostic colonoscopy. [12,13]
    - Perforation of the colon wall during colonoscopy: may result from mechanical forces against the bowel wall, barotrauma, or as a direct result of therapeutic procedures. Early symptoms of perforation include persistent abdominal pain and abdominal distention. Later, patients may develop peritonitis[14]
    - Ileus: temporary arrest of intestinal peristalsis is rare following colonoscopy.[14]
    - Post polypectomy electrocoagulation syndrome: a combination of pain, peritoneal irritation, leukocytosis and fever post colonoscopy may result from post polypectomy burn injury.[3,14]
    - Infection: A rare occurrence, with non-adherence to colonoscope reprocessing regimens the common cause.[12]
- Risks associated with bowel preparation including dehydration and electrolyte imbalances which can be serious.
- Complications arising from sedation or anaesthesia, such as:
    - Localised irritation of the arm vein at the site of injection of sedatives.[13]
    - Deeper sedation than required.[10]
    - Cardiopulmonary complications: related to sedation, including transient hypoxemia, hypertension, cardiac arrhythmias.[12]

Potential risks associated with procedural sedation (as outlined in the ANZCA PS09 Guidelines on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures – section 2.2):

“Practitioners who administer procedural sedation and/or analgesia should be aware that the transition from complete consciousness through the various depths of sedation to general anaesthesia is a continuum and not a set of discrete, well-defined stages.

The margin of safety of drugs used to achieve sedation and/or analgesia varies widely between patients and loss of consciousness with its attendant risk of loss of protective reflexes may occur rapidly and unexpectedly.

Therefore practitioners, who administer sedative or analgesic drugs that alter the conscious state of a patient, and those who supervise recovery from sedation, must be prepared to manage the following potential risks:

- Depression of protective airway reflexes and loss of airway patency.
- Depression of respiration.
- Depression of the cardiovascular system.
- Drug interactions or adverse reactions, including anaphylaxis.
- Unexpectedly high sensitivity to the drugs used for procedural sedation and/or analgesia which may result in unintentional loss of consciousness, and respiratory or cardiovascular depression.
- Individual variations in response to the drugs used, particularly in children, the elderly, and those with pre-existing disease.
- The possibility of deeper sedation or anaesthesia being used to compensate for inadequate analgesia or local anaesthesia.
- Risks inherent in the wide variety of procedures performed under procedural sedation and/or analgesia."

8. Clinical Communication

Clinical Handover

Information exchange is to adhere to the Department of Health Clinical Handover Policy using the iSoBAR framework.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Documentation

An individualised management plan is to be documented in the patient's health records as soon as practicable, in regard to this CPS.

Procedural documentation includes "the quality of the bowel preparation, whether caecal intubation was achieved (with photo-documentation if feasible), withdrawal time, clinical findings, the details of polyps removed, how they were removed and whether they were retrieved".[17]

Post Procedure instructions are to be documented in the patient health record by the Surgical Team/ Gastroenterologist/ Endoscopist, including, but not limited to:

- procedure performed
- findings
- post procedure instructions
- frequency of observations, in the absence of site specific protocol

Refer to the WACHS Documentation CPS.

Patient/Carer information

There are a number of ways patients and carers can obtain specific information relating to hospital admissions, transfers and discharge from hospital. Relevant documents can be located via:

- Australian Commission on Safety and Quality in Health Care – Colonoscopy Clinical Care Standard Consumer Fact Sheet
- Procedure Specific Information Sheets (PSIS) – E03 Colonoscopy or E11 Upper GI Endoscopy and Colonoscopy, as relevant

9. Staffing Requirements

Refer to 'Quality statement 6 – Clinicians' of the ACSQHC Colonoscopy Clinical Care Standard[17]:

> "A patient's colonoscopy is performed by a credentialed clinician working within their scope of clinical practice, who meets the requirements of an accepted certification and recertification process. Sedation or anaesthesia, and clinical support are provided by credentialed clinicians working within their scope of clinical practice".

Procedural specialists are to provide evidence of certification as part of the credentialing process (refer to the WACHS Medical Credentialing and Compliance Requirement Guideline).

Further information on staffing requirements is available from:

- ACORN Standards for Perioperative Nursing in Australia (15th Edition)
- ANZCA) Guidelines on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures (2014)

Staff must adhere to safety and quality processes within the procedural/ theatre environment, including use of the WACHS Surgical Safety Checklist.

10. Equipment Required

- Infection control requirements regarding equipment must be adhered to. Refer to the Gastroenterological Nurses College of Australia (GENCA) - Guideline for Infection Control in Endoscopy - Endorsed for Use in Clinical Practice Policy.
- Equipment must be appropriate for the age/size of the patient.
- Equipment must be checked, serviced and calibrated in accordance with manufacturer's recommendations to ensure reliability and accuracy.
- Staff must follow the manufacturer's operating instructions.

11. Pre Procedure Key Points

- Ensure the patient has received information relating to the intended procedure (refer to bowel preparation and patient/carer information sections) and has given appropriate informed consent (refer to ACSQHC Colonoscopy Clinical Care Standard: Quality Statement 3 – Informed decision making and consent for further information).
- Patient identification and procedure matching processes are undertaken.
- Patient privacy and dignity is maintained.
- The presence of a chaperone is offered where appropriate to patient and clinician requirements.
- The opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer has been provided where appropriate to the patient's language or communication requirements. (See WA Health Language Services Policy.)
- **Infection Control Considerations:** Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

Bowel Preparation

Refer to 'Quality statement 4 – Bowel Preparation' of the ACSQHC Colonoscopy Clinical Care Standard.[17]

> "A patient booked for colonoscopy receives a bowel preparation product and dosing regimen individualised to their needs, co-morbidities, regular medicines and previous response to bowel preparation. The importance of good bowel preparation for a quality colonoscopy is discussed with the patient. They are provided with consumer-appropriate instructions on how to use the bowel preparation product and their understanding is confirmed."

A successful colonoscopy relies on effective bowel preparation to clear the colon of faeces. Inadequate preparation may result in:

- Poor visualisation of the mucosa[5]
- Decreased rate of polyp and adenoma detection
- Increased patient discomfort
- Cancellation and/or repetition of the procedure and bowel preparation

Bowel preparation routines vary between WACHS settings, however all have the following in common [6,7]:

- Diet Modification: The patient is advised to follow a low residue/ fibre free diet, commencing a number of days before the colonoscopy.

- Oral lavage solution: The patient is instructed to consume bowel preparation solution (laxative medication that causes diarrhoea) in the day/ hours prior to the colonoscopy.

Quality statement 4 (bowel preparation) recommends a split-dose regimen "as this results in a higher quality colonoscopy examination compared with ingestion of the entire preparation on the day or evening before the colonoscopy, and has been associated with increased adenoma detection rates. Typically this involves splitting the standard dose of the bowel preparation between the day before and the morning of the colonoscopy (3-6 hours before the planned start of the procedure)".[17]

Use of the split dose regimen should involve consultation between the colonoscopist and sedation proceduralists to ensure this regimen is appropriate for the patient.

As patient compliance is the most important factor affecting the success of bowel preparation[6], it is essential the patient is provided with clear, unambiguous information about the bowel preparation regimen to be followed (use interpreter services where necessary).

Clearly explain the purpose of bowel preparation, the importance of following the prescribed procedure, the regimen and the potential side effects of the bowel preparation products. Allow the patient appropriate time to ask questions and confirm that they understand what to do and its importance. Provide a telephone number for any enquiries that patients may have as the bowel preparation proceeds.[17]

The patient may experience difficulty completing the preparation solution due to the large volume of fluid required to be consumed, and adverse events associated with bowel preparations, including:

- abdominal pain and cramping
- fullness or bloating
- peri-anal irritation and soreness
- nausea and vomiting.

Alternative bowel preparation may sometimes be provided for patients with poor tolerance of bowel preparation or previous poor preparation.

Consider whether a patient with relevant co-morbidities needs specific health or personal support whilst undergoing bowel preparation, for example, overnight admission for patients who are unlikely to manage bowel preparation independently.[17]

The effectiveness of the patient's bowel preparation must be determined by clinical staff prior to the procedure. The following stool specimen examples (Figure 1) indicate if a patient is ready for colonoscopy procedure. If output is cloudy further bowel preparation (e.g. an enema) may be required; discuss with the patient's surgical team / follow local site protocols regarding additional bowel preparation.[8]

Figure 1: Stool specimen examples following bowel preparation for colonoscopy

Brown and cloudy, indicates **not** ready for colonoscopy[8]

Bowel ready for colonoscopy

Medications

Typically, patients can continue taking their regular medications ahead of a colonoscopy. Ensure patients on diabetes medicines, anticoagulants, antiplatelets or other medicines are provided with individualised instructions about how to adjust their medicines and manage their condition as they undergo bowel preparation.[17]

Iron supplements should be stopped at least one week before colonoscopy because they may affect visualisation of the intestinal mucosa. Patients taking anticoagulation medicine will need to be assessed on an individual basis to determine appropriate management peri-procedural. Typically antiplatelets can be continued, however this requires individual assessment and is a balance of the patient's risk of thromboembolic events and the risk of bleeding around the surgical procedure.[7]

Sedation

Refer to 'Quality statement 5 – Sedation' of the ACSQHC Colonoscopy Clinical Care Standard.[17]

Before colonoscopy, a patient is assessed by an appropriately trained clinician to identify any increased risk, including cardiovascular, respiratory or airway compromise. The sedation is planned accordingly.

The risks and benefits of sedation are discussed with the patient.

Sedation must be administered by a credentialed practitioner working within their scope of practice, and provided as described in the Australian and New Zealand College of Anaesthetists guidelines (SP09) with respect to[17]:

- The number of staff present during the sedation and their level of training, competence and scope of clinical practice.
- Facilities, equipment and medicines.
- Administration of sedation.
- Monitoring of patients during the colonoscopy and in the recovery room.

Insertion, management and documentation of peripheral intravenous cannulae as per the WACHS Peripheral Intravenous Cannulae (PIVC) Management Clinical Practice Standard.

General

Refer to the WACHS Pre and Post Procedural Management Clinical Practice Standard for general pre procedure information. In addition:

- Nurse to ensure admission paperwork is completed and patient is oriented to the site.
- Relevant health records are available for reference.
- Appropriate bloods have been taken e.g. FBC and INR if indicated.
- Haemoglobin should be within normal limits for elective procedures.
- Check allergies for sedatives or opioids. (Intravenous sedatives are used as relaxant pre procedure and opioids are given to reduce discomfort[9]).
- Refer to the WACHS Diabetes – Inpatient Management Clinical Practice Standard for fasting/procedure care (Section 11)

12. Procedure

Refer to 'Quality statement 7 – Procedure' of the ACSQHC Colonoscopy Clinical Care Standard.[17]

When a patient is undergoing colonoscopy their entire colon (including the caecum) is examined carefully and systematically. Documentation as to whether caecal intubation was achieved is required (with photo-documentation if feasible).[17]

To optimise detection and management of disease and minimise adverse outcomes for the patient, the adequacy of bowel preparation, clinical findings, biopsies, polyps removed, therapeutic interventions and details of any adverse events are documented in the health record.

All polyps removed are submitted for histological examination. Refer to the WACHS Specimen Collection (including phlebotomy) and Pathology Results Clinical Practice Standard.

13. Post Procedure

- Observations should be recorded at clinically indicated intervals and should include level of consciousness, oxygen saturation, respiratory rate, pulse rate, blood pressure, comfort level and temperature.[20]
- Check for rectal bleeding, informing the surgeon/colonoscopist if bleeding is evident.
- Administer oxygen therapy as prescribed by medical officer until patient is fully recovered. Cease oxygen therapy when the patient is alert and oxygen saturations are compatible with pre procedure levels.

- Check patency of IV sites, (if a cannula with port is in use this needs to be flushed with 0.9% normal saline). IV cannulae should not be removed until the patient has eaten and drunk fluids without vomiting. Remove prior to discharge from the day surgery area. Document removal appropriately (refer to WACHS Peripheral Intravenous Cannulae (PIVC) Management Clinical Practice Standard)
- Allow time for the effects of sedation to wear off, which may take 2-3 hours depending on the patient's age, physical condition and sedating agent(s) used.[10]

  Patient can eat and drink on return to the day surgery ward, however if the patient underwent both gastroscopy and colonoscopy confirm if throat spray was given prior to gastroscopy. If given, wait one (1) hour prior to hot fluids.

- Patients who meet WACHS discharge criteria may be discharged home, in the care of a competent/responsible adult. Refer to the 'Discharges from Day surgery/ Short stay surgical units' section in the WACHS Admission, Discharge, and Intra-hospital Transfer Clinical Practice Standard.
- Clinical Practice Standard for information on the Post Anaesthetic Discharge Scoring System (PADSS).
- Consider admission for a patient at high risk of an adverse outcome if they are to be discharged without adequate adult support at home, or who is otherwise not suitable for discharge.[17]

14. Discharge Information

Refer to 'Quality statement 8 – Discharge' of the ACSQHC Colonoscopy Clinical Care Standard[17]

- Before discharge, the responsible clinician or their delegate should talk to the patient and briefly describe what happened during the colonoscopy, whether the colonoscopy was completed satisfactorily, initial observations, whether biopsies or polypectomies were performed, and if any adverse events occurred.
- Advise patients of any arrangements for follow-up medical consultation and when final results and recommendations will be provided to them and their referring clinician.
- On discharge, ensure the patient is provided with:
  - A follow up appointment, or information explaining how this is to be arranged.
  - Information on resuming medications
  - Written post procedure information. The Department of Health Colonoscopy, and Upper GI Endoscopy and Colonoscopy Procedure Specific Information Sheets include instruction when to seek further medical advice if the person experiences:
    - abdominal pain
    - significant or continued bleeding per rectum
    - a high temperature.

Re-enforce to patients discharged home on the day of procedure that they should be discharged into the care of a responsible adult. Sedation can cause amnesia in some patients, and patients are advised not to drive, operate machinery, or sign legal documents for 24 hours post procedure.[10]

15. Compliance

Evaluation, audit and feedback processes are to be in place to monitor compliance with this CPS.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

16. Monitoring

WACHS is required to implement the Quality Statements of the ACSQHC Colonoscopy Clinical Care Standard[17] and monitor indicators that are its responsibility.

The clinical indicator data required and the sharing of this information will be coordinated by WACHS Safety Quality.

17. Relevant Legislation

(Accessible via: Western Australian Legislation or ComLaw) sites)

- *Carers Recognition Act 2004*
- *Disability Services Act 1993*
- *Equal Opportunity Act 1984*
- *Equal Opportunity Regulations 1986*
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Occupational Safety and Health Act 1984*
- Occupational Safety and Health Regulations 1996
- *Pharmacy Act 1964*
- *Medicines and Poisons Act 2014*
- *Medicines and Poisons Regulations 2016*
- *Privacy Act 1988*
- *Public Sector Management Act 1994*

18. Relevant Standards

National Safety and Quality Healthcare Standards

- Clinical Governance Standard: 1.1, 1.7, 1.8, 1.11, 1.23, 1.24, 1.27, 1.28, 1.29, 1.33
- Partnering with Consumers Standard: 2.4, 2.9, 2.10
- Preventing and Controlling Healthcare-Associated Infection Standard: 3.5-3.13, 3.14
- Communicating for Safety Standard: 6.9, 6.10, 6.11
- Recognising and Responding to Acute Deterioration Standard: 8.10-8.13

19. Related WA Health Policies

- WA Clinical Alert (Med Alert) Policy
- Clinical Handover Policy
- Clinical and Related Waste Management Policy
- Clinical Incident Management Policy
- Correct Patient, Correct Site and Correct Procedure Policy and Guideline for WA Health Services (2nd Edition)
- Credentialing and Defining Scope of Clinical Practice Policy
- National Hand Hygiene Initiative in Western Australian Healthcare Facilities
- Recognising and Responding to Acute Deterioration Policy
- WA Health Consent to Treatment Policy
- WA Health Language Services Policy
- Western Australian Patient Identification Policy 2014

20. Relevant WACHS documents

- Admission, Discharge, and Intra-hospital Transfer Clinical Practice Standard
- Clinical Observations and Assessments Clinical Practice Standard (physiological, neurovascular, neurological and fluid balance)
- Diabetes – Inpatient Management Clinical Practice Standard
- Gastroenterological Nurses College of Australia (GENCA) - Guideline for Infection Control in Endoscopy - Endorsed for Use in Clinical Practice Policy
- Medical Credentialing and Compliance Requirement Guideline
- Peripheral Intravenous Cannulae (PIVC) Management Clinical Practice Standard
- Pre and Post Procedural Management Clinical Practice Standard
- Procedural Sedation Clinical Practice Standard
- Specimen Collection (including phlebotomy) and Pathology Results Clinical Practice Standard

21. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

22. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Colonoscopy Clinical Practice Standard.

23. References

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24. Definitions

Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged
Discharge	Discharge is the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care.
Patient	A person who is receiving care in a health service organisation
Procedural Specialist	Procedural specialists are medical practitioners or dental practitioners who have undertaken recognised medical education and further training in the performance of surgical and procedural techniques including the administration of anaesthesia, usually within a defined medical specialty. (Definition source: Council of Procedural Specialists - https://cops.asn.au/)

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