Endoscopy for Upper and Lower Gastrointestinal Procedures Standard Operating Procedure UHL Gastroenterology LocSSIP

Change Description	**Reason for Change**
☐ Change in format	☒ Trust requirement

APPROVERS	**POSITION**	**NAME**
Person Responsible for Procedure:	Clinical Director The Alliance Head of Nursing Head of Operations	Maneesh Bhatia Judith Spiers Charlie Carr
SOP Owner:	Matron	Lynn Pilbrow Daniel Stendall
Sub-group Lead:	Sister – Endoscopy	Colette Green

Appendices in this document:

Appendix 1 : UHL Safer Surgery: **Endoscopy patient pathway with Sign In/Sign Out**
Appendix 2 : Patient Information Leaflet for *Endoscopy for Upper and Lower Gastrointestinal Procedures*
Available at:
[Having a Bravo® capsule pH monitoring study to test for digestive disorders (leicestershospitals.nhs.uk)]
[Having a flexible sigmoidoscopy (leicestershospitals.nhs.uk)]
[Having a colonoscopy to look inside your large bowel (leicestershospitals.nhs.uk)]
[Having a gastroscopy to look inside your upper digestive tract (leicestershospitals.nhs.uk)]
Appendix 3 : Bowel prep instructions
Appendix 4 : Alliance Endoscopy Team brief
Appendix 5 : DNA flow chart

Introduction and Background:

This document outlines Local Safety Standards for Invasive Procedures (LocSSIPs) carried out within the Endoscopy service at the LLR Alliance namely:

- Gastroscopy,
- Colonoscopy and
- Flexible Sigmoidoscopy

It is compliant with all National Safety Standards for Invasive Procedures (NatSSIPs).

The Alliance provides an Endoscopy service at 4 of the Alliance Hospitals.

Diagnostic and therapeutic treatment is provided to outpatient referrals.

Indications for treatment are multifarious. There must be a recognised gastric/cardiac/respiratory/urinary symptom or group of symptoms before Gastroscopy, Flexible Sigmoidoscopy, Colonoscopy is performed. Self-contained Endoscopy units within the Alliance (Loughborough, Melton, St Luke's and Hinckley) whilst not all purpose built, are designed to improve the patient flow providing safe and private therapeutic and diagnostic endoscopic procedures.
The units are governed by the Joint Accreditation Group (JAG) which is a national body that provides all NHS and private hospitals with standards based around set criteria. Application for accreditation occurs on a three yearly basis. Whilst the unit design is heavily influenced by JAG, accreditation is given only if the required standard is met.

Never Events:

Never event which could occur in this area:

- Wrong site surgery / wrong procedure
- Wrong patient
- Midazolam

Patient Sign In prevents wrong patient / wrong procedure

Low dose of Midazolam given and gradually work up to maximum of 3mg, at clinician discretion

List management and scheduling:

Referral process
Since March 2021 all referrals must be submitted via ICE referral system - Usually completed by Doctors or Specialist Nurses. NHS Consultants from other specialities and GP's will make patient referrals however these must be validated by an Endoscopist.
Some older paper referrals are still in use for patients referred before March 2021
Patient referrals received from GP's or hospital consultants are entered onto the HISS system. After an appointment has been made the details are placed onto UNISOFT- the Trust's GI reporting tool stating the minimum patient details as below:
Name
Address
DOB
Gender
S number (hospital system number – each person has a unique number)
Procedure
Source of patient i.e. in or outpatient
Allergies
Infection status

The UNISOFT system in due to be replaced by SOLUS in due course
Sessions populated with the required unit weighting is validated by the team administrator, nursing team and/or the Endoscopist who will make adjustments if appropriate. The list can be viewed on the system which is available to staff with appropriate access. Lists are printed, used in the procedure room for the duration of the session then removed and disposed of post use.
Changes are communicated verbally, via email and or by telephone consult. The use of abbreviations is avoided, but when accepted common abbreviations are used it is not assumed that all personnel are familiar with the abbreviations.

The tool has inbuilt the facility to flag special requirements or alerts for specific patients e.g. Latex allergy, diabetes.

Cancellations

Patients are contacted by telephone or face to face and offered the next available appointment. If unable to contact, patients are sent an appointment in writing with a 3 week notice period.
On the day patient cancellations are recorded. The next available date is offered if appropriate or recommended follow-up. The attached flow chart demonstrates how cancellations are dealt with to ensure patients do not slip through the net regarding follow-up etc (see flowchart, Appendix 5).

Lists are organised in units of 15 minute sections, with a view to undertaking 12 units per session. The lists are booked dependant on the skills of the Endoscopist, and booking rules for each Endoscopist are built in the booking system.

- All planned/surveillance cases are booked within 6 weeks of their due date.
- Validation of referrals and monitoring of patient bookings occur weekly during the administration team Endoscopy service manager. The process is overseen by the Alliance performance team at the weekly meeting.
- Capacity and demand at all 4 sites is coordinated by the administration team supported by their manager. The team co-ordinates Endoscopist' list cover and flexible sessions in conjunction with the unit's sister and clinicians.

Each type of procedure is given a unit waiting as per JAG recommendations and formulates the planning of each session.

- A department capacity report is completed weekly looking at the next 4 weeks' list cover.
- DNA figures are reported centrally; they are also included in the department's dashboard and monitored monthly. The service manager is to report on the figures and action any deterioration in position.

Pathology results will be sent to the Endoscopist who will report to the GP/patient within 5 days.

Patient preparation:

Prior to admission patients receive an information leaflet which describes the fasting, dietary or hydration preparation necessary for specified procedures if required.
Patients receive this information, via post, website or App
http://yourhealth.leicestershospitals.nhs.uk/library/chuggs/gastroenterology/endoscopy

Having a Bravo® capsule pH monitoring study to test for digestive disorders (leicestershospitals.nhs.uk)
Having a flexible sigmoidoscopy (leicestershospitals.nhs.uk)
Having a colonoscopy to look inside your large bowel (leicestershospitals.nhs.uk)
Having a gastroscopy to look inside your upper digestive tract (leicestershospitals.nhs.uk)

Patients are advised to fast for 6 hours before gastroscopy.
If undergoing colonoscopy, patients are advised to drink plenty of clear fluid after taking a prescribed bowel cleansing agent up to 2 hours before the procedure starts.
Patient's prescribed Bowel prep will receive dietary and preparation guidance as per UHL guidance (see advice sheets, Appendix 3).

It may be necessary for pre-procedural investigations such as blood tests for renal function, EGFR and INR. The results of which are checked before the appropriate bowel prep is dispensed.

The critical parameters are
Urea & electrolytes Sodium
133-146 mmol/L
Potassium 3.5 – 5.3 mmol/L
Urea 2.5 – 7.8 mmol/L
Creatinine 60 – 120 umol/L
eGFR 60-100 mL/min/173m2
INR-1.5-2.4 or within normal therapeutic range (Therapeutic
INR should be below 1.5 as per BSG guidelines).

Where possible Diabetic patients are placed first on the list to reduce their fasting times and patients with other special requirement are catered for accordingly.
Patients on anticoagulant therapy receive a bridging plan if required and patients are asked to seek advice from the department if they take anticoagulants.
Cardiology opinion is sought if necessary. Refer to anticoagulant bridging therapy policy, see references

Patient with bleeding disorders such as haemophilia are referred to LRI for their procedure as per UHL policy.

Patients with implantable devices eg Pacemakers must be identified before admission and if necessary cardiology opinion requested.
Where necessary, patients are discussed at Colorectal and Upper Gastro Intestinal MDT and results are fed back to the respective MDT responsible for the particular patient groups.
If the evidence mitigates, these patients are booked urgent 2 week wait appointments.

Consent

Patients are consented by the Endoscopist or by a trained member of the nursing team. Consent training is provided in-house and a number of elements must be undertaken before completion of the course. The requirements include

1. 1. Online UHL e-learning on consent and the mental capacity act,
2. 2. Attendance of a training day on Consent provided by senior staff of UHL Endoscopy team (programme available on request),
3. Supervised practice of competence recorded,
4. Final assessment of competence recorded by Consultant/Endoscopist/senior Nurse

Staff are required to provide a 1 yearly DOPS (Directly Observed Practical Skill) assessment form to their manager as evidence of ongoing competence. In house consent training commenced in 2014 and currently delivered by Endoscopy sister and Nurse Endoscopist

Infection Prevention

- Staff will adhere to the UHL uniform policy. Scrub suits are worn when undertaking procedural room work; Long hair must be tied back and off the shoulder and all staff are required to be bare below the elbow.
- ANTT technique is used when cannulation and IV medication is administered.
- Gowns are provided to patients having lower GI procedures
- Antibiotic prophylaxis is provided as per BSG guidelines
- Patients with known infection are scheduled for the end of the list minimising the risk of cross infection e.g. patients with MRSA infection
- Scopes are decontaminated in line with UHL policy
- Standard precautions are taken
- Rooms and equipment is routinely cleaned pre and post use and the domestic department provide a daily schedule of additional work as agreed.

PPE is available and used when appropriate

- COVID risks and PPE precautious where appropriate include use of long sleeved gown, Hood, surgical/FFP3/mask, gloves and theatre hat.
- Patients receive procedure information via post/app/website – all procedure information is available on Home (leicestershospitals.nhs.uk)
- Patients have access to either face to face or telephone translator where required as per trust policy http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Interpreting%20and%20Translation%20UHL%20Policy.pdf
- UHL Patient Identification Band Policy B43/2007 – all patients have name bands which are checked by nursing team pre-procedure and checked again by the team in the room
- Management of patients with disabilities - Only low risk patients have procedures in the Alliance. Patients are assessed on an individual basis and, if required, a rotunda or hoist is borrowed to aid transfer on and off trolley.

Workforce – staffing requirements:

The minimum staffing allowance and skill mix per procedure is as follows-

- Colonoscopy, Flexible Sigmoidoscopy and Gastroscopy = 1 RN, 1 HCA and the Endoscopist
- 1 staff trained in the decontamination process required for each session (where decontamination is delivered in house)
- 2 x RN for admissions, recovery and discharge

These are minimal staffing levels based on JAG guidelines.

The Alliance is a teaching hospital, therefore training and education is an important element of our service. Trainee Nurse Endoscopists are managed and supported by the lead Nurse Endoscopist. Training lists are reflective and contain a minimum of 8 equivalents dependent on the trainee who is supervised at all times

The trainee will be registered with JAG Endoscopy Training System (JETS) and complete Direct Observation of Procedure or Skills (DOPS) assessment forms.

Nurse Endoscopists will complete theoretical work in conjunction with Hull University or other accredited sites.

All new nursing staff will complete a local induction Training Programme. If not already working for this Trust they will also complete a trust induction and mandatory training day before commencing in post.
All nursing staff will be assigned a mentor and given an endoscopy specific competency book to work through and objectives will be set. This will be reviewed after 3 months and at appraisal annually.

Non substantive staff are provided with the external provider overview and are required to complete the temporary staffing induction record log book.

Mandatory and essential training is identified on e-UHL staff member's personal log in and must be completed. The sisters and head of service have access to their staff training records and will send reminders for anyone showing not completed.

Staff will be given the time to attend mandatory and essential to role training
Electronic rostering is provided for substantive nursing staff and is available 6 weeks in advance of time tabled shifts and is managed by the Endoscopy Sister, in line with Electronic Rostering guidelines.
The system allows for unfilled shifts to be offered to bank staff or agency if required.

The Trust has an ongoing recruitment programme in which staff for Endoscopy is actively sought.

Ward checklist, and ward to procedure room handover:
Handover is a verbal process where the ward nurse and endoscopy staff exchange relevant information concerning the patient confirming the completed checklist from the ward. During handover of patients, endoscopy staff confirms all details of the checklist are complete and correct. This will include Patient name S number DOB Nursing documentation is completed for every patient and include pre-assessment of medical and drug history as well as recording peri-procedural observations and post procedure instructions. Patient consent is undertaken in private room or area
Procedural Verification of Site Marking:
Not Applicable.
Team Safety Briefing:
The Staff Safety briefing (Appendix 4) Must occur at the start of any elective, unscheduled or emergency procedure session. The endoscopist and room staff must be present when the safety briefing takes place. This includes all staff in the room and will include the anaesthetist and ODP if propofol sedation is to be given. Appropriate management of highlighted issues will be implemented or escalation to the Matron or Head of Nursing if required.
Sign In:
Incorporated with time out with admission to procedure room document (Appendix 1).
Time Out:
Time Out is the final safety check that must be completed for all patients undergoing endoscopy before the start of the procedure • The sign in will take place in the procedure room • The patient will be encouraged to participate where possible • Any omissions, discrepancies or uncertainties must be resolved before proceeding • This will be lead by the Registered Nurse • All team members must be present and engaged as it is happening A separate time out checklist will be completed if there is a separate or sequential procedure happening on the same patient (e.g. a gastroscopy and a colonoscopy).

Performing the procedure:

Procedure specific positioning is required for upper or lower GI endoscopy eg colonoscopy:
Patient trolley or bed is equipped with side rails
Scope is checked – eg light, air, suction
Consumable therapeutic equipment checked before use e.g. polypectomy snare
Administration of drugs e.g. sedation is given in accordance with BSG guidelines and UHL Administration of medication policy. Only maximum safe dosage is drawn up to avoid over dosage. Reversal agent at hand in line with UHL sedation policy
If administering Entonox, safety information is obtained from the patient prior to administration ie head injury, ear infection or COPD.
Dentures removed for OGD and mouth guard inserted
Equipment checks performed before use e.g. lower setting of diathermy confirmed with Endoscopist for right colon
Patients receiving sedation are given oxygen 2 litres/min
Patients with pacemakers are pre assessed and the Cardiology Pacemaker clinic is contacted for advice re management peri procedure if required.

Monitoring:

Patients will be monitored throughout the procedure and the following observed :-

- O2 Sats
- Blood Pressure
- Pulse rate
- Respiratory rate
- BMs checked pre procedure for known diabetic patients
- If propofol is used capnography is available as standard (see sedation policy)
- Propofol is only administered by an anaesthetist

Pulse Oximetry, BP, monitoring takes place peri- procedure and during recovery with ECG and capnography available as required.

Prosthesis verification:

Not Applicable.

Prevention of retained Foreign Objects:

Sharps used are prepared away from the patient bedside and disposed of post-use as per UHL policy.

Radiography:

Not Applicable.

Labelling of specimens

Any specimens taken are labelled at the patient bedside. A diagram is made of the site of the specimen with a number that corresponds to a number on the specimen pot. Specimens will be labelled and checked against the patient's wristband immediately.

Sign Out:

Sign Out must occur before the patient leaves the procedure area. This includes:

- Confirmation of procedure/completion
- Confirmation that specimens have been labelled correctly
- Discussion of post-procedural care and any concerns
- Endoscopy report has been completed
- Equipment problems (include in team debriefing)
- Comfort score
- All documentation leaves the room with the patient

Patient leaves the room only when all documentation is complete (Appendix 1).

Handover:

Patients are taken to the recovery area where handover occurs between the nursing staff.
The qualified nurse receiving the patient will be provided with
Patient details
Procedure undertaken
Any concerns
Discharge plan
Requirement for further test eg Next Steps, endoscopy, CT

Team Debrief:

Team Debrief (Appendix 1). Post procedure specific debrief is currently undertaken.
A team debrief takes place in the procedure room at the end of the list all
team members should be present
The debrief includes:

- Things that went well
- Any problems with equipment or other issues
- Areas for improvement
- An action log

A named person for escalating issues

Post-procedural aftercare:

Patients are recovered in a designated recovery area where they will be monitored for as long as is required
Pulse O2, BP and BM if required.
Patients are observed for a minimum of 30 minutes after sedation or 15 minutes if no sedation given
Pain score
Possible complications post procedure are:
Pain Bloating
Hypotension
Nausea & vomiting
Bleeding
If patient remains in excessive pain the endoscopist must be informed to rule
out perforation

Discharge:

Nurse led discharge is provided before leaving the unit

Patients who have received sedation must remain in the recovery area for a minimum of 30 minutes before discharge
The patient must have a pain score below 5/10 Next
steps pathway (malignancy) advice is provided
Patients are provided with a copy of the procedure report and information re: findings
Advice sheets and emergency contact number
Follow up
Results and letter are sent to referring consultant or GP who discusses findings/report and next steps with patient.

Governance and Audit:

Errors, incidents and near misses are reported via datix and are investigated by the local senior nursing team. Incidents rated as moderate or above are reviewed by the corporate patient safety team, and investigated and if appropriate escalated as per the Trust incident reporting policy. Duty of candour legislation is followed as appropriate.

Learning from incidents is shared at the endoscopy users group, service meetings and local team meetings. Incidents that have been classified as moderate / Serious untoward incident or a never event will be shared at the CMG quality and safety board, and escalated to the Trust board.

Compliance with this LocSSIP will be monitored regularly by spot checks on the use of the team brief, sign-in checklist and team debrief and the results published regularly and discussed at the Alliance Quality and Safety meetings.
To submit monthly Safe Surgery Audit and WHOBARS assessment as per Safe Surgery Quality Assurance & Accreditation programme

Training:

The SOP will be disseminated and discussed with staff at ward/unit meetings. The Endoscopy users group will be responsible for the dissemination to medical staff.

Documentation:

Documentation is completed in the patient case notes, nursing process and procedure book. The report will be completed on the GI reporting tool.
All processes are signed at the appropriate stage of care by the individual responsible or concerned.

References to other standards, alerts and procedures:

National Safety Standards for Invasive Procedures, NHS England 2015:
https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety-standards.pdf

UHL Safer Surgery Policy: B40/2010
UHL Sedation Policy: Safety and Sedation of Patients Undergoing Diagnostic and Therapeutic Procedures B10/2005
UHL Consent to Treatment or Examination Policy A16/2002
UHL Delegated Consent Policy B10/2013
UHL Patient Identification Band Policy B43/2007
UHL Guideline: Anticoagulation management (“bridging”) at the time of elective surgery and invasive procedures (adult) B30/2016
UHL Sharps Management Policy B8/2013
Shared decision making for doctors: Decision making and consent (gmc-uk.org)
COVID and PPE: UHL PPE for Transmission Based Precautions - A Visual Guide
COVID and PPE: UHL PPE for Aerosol Generating Procedures (AGPs) - A Visual Guide
www.bsg.org.uk/clinical-resource/updated-endoscopy-in-patients-on-antiplatelet-or-anticoagulant-therapy-including-direct-oral-anticoagulants/
British Society of Gastroenterology: Guideline for obtaining valid consent for gastro-intestinal endoscopy procedures
British Society of Gastroenterology: Non-medical Endoscopists

END

Appendix 1

ENDOSCOPY UNITS

University Hospitals of Leicester NHS Trust

Caring at its best

Patient Label	Prefers to be known as:
	Time of admission:

Transport / Escort home:	
Carer after discharge:	Telephone:

ADMISSION CHECKLIST	
Ask patient 'have you ever been notified that you are increased risk of CJD or v CJD, for public health purposes? NO ☐ YES ☐ Please inform Nurse in charge if answer is yes.	
Identification band ☐	Nil by mouth from: ☐
Previous Endoscopy: ☐	**ENEMA** required on admission ☐
Confirm procedure: ☐	Pre procedure oral bowel preparation ☐ State:
Information read and signed by patient ☐ **Medical history checked by Nurse** ☐	Will Patient be flying in the next 2-3 weeks ☐
Any Mental capacity concerns ☐ Any communication issues ☐	**ANTICOAGULANT** therapy ☐ Aspirin, Warfarin, Clopidigrel, Enoxaparin, DOACS ....
Allergies: **LATEX** ☐	**ANTICOAGULANT** therapy stopped x .... days **INR** *(must be within 7 days)* .... ☐
Pacemaker ☐ **ICD** ☐	**Contact Pacing Clinic ext 2905 Yes** ☐ **N/A** ☐
The patient is aware that they will have further opportunity to talk with Doctor / Specialist Nurse performing the test and that they will need to sign a "Consent Form". By agreeing to sign the Consent Form they know they are confirming to have the test done but understand they can withdraw consent at any time ☐	
Have you travelled abroad? Yes ☐ No ☐	

	SEDATION
If the patient suffers with any of the following then Entonox <u>SHOULD NOT</u> be administered	**SEDATION REQUESTED ADULT** ☐ **ESCORT ARRANGED** ☐
Pneumothorax, lung abscess or emphysematous bullae and air embolism ☐	**PROPOFOL LIST** ☐ **ADULT ESCORT ARRANGED** ☐
Gross abdominal distension/bowel obstruction ☐	**NO ANTICHOLANERGIC (Buscopan)** **REASON: Driving** ☐ **Glaucoma** ☐ **Other** ☐
Head injury, suspected intracranial lesions, maxilla-facial injuries ☐	
Chronic obstructive airway disease (COPD) ☐	**NO SEDATION AND / OR ANALGESIA** **REASON: No escort/carer** ☐ **Driving** ☐ **Patient choice** ☐ **Other** ☐
Middle ear infection/surgery ☐	
Decompression sickness/recent underwater dive ☐	**ENTONOX REQUESTED** ☐
Intoxicated/confused/uncooperative ☐	**VERBAL CONSENT OBTAINED FOR ENTONOX** ☐

Has the Patient read the information sheet on Entonox YES ☐ NO ☐						**SUITABLE FOR ENTONOX** YES ☐ NO ☐			
Weight	**Waterlow**	**BM stix**	Temp	Pulse	B/P	R/R	O_2 Sats	**EWS**	Pain Score (1 – 10)
							%		Description:
ADMISSION NURSE: SIGNITURE:						RGN BAND: DATE:			

Revised January 2023 Version 15 Ward 25 Form.20

WATERLOW BY EXCEPTION

Assess by Age, Sex and Mobility. If score > 10 then continue

Sex / Age	*	**Mobility**	*	**Build / Weight for Height**	*	**Special Risk**
Male	1	Fully	0	Average	0	**Tissue Malnutrition**
Female	2	Restless / Fidgety	1	Above Average	1	Terminal Cachexia
14 – 49	1	Apathetic	2	Obese	2	Cardiac Failure
50 – 64	2	Restricted	3	Below Average	3	Peripheral Vascular Disease
65 – 74	3	Inert / Traction	4			Anaemia
75 – 80	3	Chair bound	5			Smoking
80 +	5					
Continence	*	**Risk Area Visual Skin Type**	*	**Appetite**	*	**NEEDS ACTION**
Complete / Catheterised	0	Healthy	0	Average	0	**11 – 14 AT RISK**
Occasional Incontinence	1	Tissue Paper	1	Poor	1	**15 – 24 HIGH RISK**
Catheter / Incontinence of Faces	2	Dry	1	NG Tube / Fluids only	2	**25+ VERY HIGH RISK / FRAIL**
Doubly Incontinent	3	Oedematous	1	NBM / Anorexic	3	**SCORE:**
Major Surgery	*	Clammy T ↑	1			
Abdominal Surgery	5	Discoloured	2			
Below Waist, Spinal	5	Broken / Spot	3			
On Table > 2 Hours	5	**Medication**	*	**Neurological Deficit**	*	
		Steroids, Cytotoxins Anti-inflammatory	4	eg Diabetes, CVA, MS, Paraplegia: Motor / Sensory	4 – 6	

PAIN ASSESSMENT TOOL

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Nil	**Discomfort**		**A Little Pain**		**A Lot of pain**		**Severe Pain**		**Excruciating**	

Screening for Falls Risk	
To be completed within 6 hours of admission, circle Y or N	
1. Is the patient aged 65 or older?	Y / N

2. Is the patient below the age of 65 but at high risk of falls due to an underlying medical condition? i.e. • 2 or more falls in the last 12 months • Fall during this admission • Unsafe / Unsteady mobility • Confusion or agitation • Brain injury / neurological condition / alcohol use / post surgery	Y / N

Promoting Health; "Are you happy with your lifestyle?"		
SMOKING		
Ask; Does the patient smoke or consume tobacco? If yes, how many a day?	**Yes**	**No**
Advise; "Stopping smoking is the best thing you can do for your health. Did you know that you are 4 times more likely to quit if you use an NHS stop smoking service."	**Yes**	**No**
Act; "Would you like me to make a referral / give you some leaflets about the services?"	**Yes**	**No**
Referral made to: STOP ☐ Declined ☐		
If the patient does not want stop smoking please record reason;		
ALCOHOL		
Ask; Does the patient drink alcohol? If yes, how many units a week? **OR** How many units a day?	**Yes**	**No**
1 unit = ½ pt 4% lager/beer/cider; 1 measure spirit; 1 small bottle alcopop 2 units = 1pt 4% lager/beer/cider; 1 glass wine; **3 units = 1 pt 5% lager/beer/cider; 1 large glass wine; 1 large bottle alcopop**		
Advise; "Aim to drink no more than 2 – 3 units a day (women), 3 – 4 units a day (men). Have at least 2 alcohol free days a week." Advice Given ☐	**Yes**	**No**
Act; "Would you like me to make a referral?"		
Referral made to Alcohol Liaison Service	**Yes**	**No**
If the patient does not want ALS referral please record reason;		

PROPERTY DISCLAIMER

Name: Hospital No: Ward: Site:

VALUABLES / DISCLAIMER

Valuables retained by patient

Tick as applicable:

- ☐ Spectacles: ____________
- ☐ Hearing Aid: ____________
- ☐ Dentures: ____________
- ☐ Pension Book: ____________
- ☐ Cheque Book: ____________
- ☐ Money: ____________
- ☐ Credit Cards: ____________
- ☐ Watch: ____________
- ☐ Rings: ____________
- ☐ Keys: ____________
- ☐ Mobile Phone: ____________
- ☐ Mobility aids: ____________
- ☐ Equipment (i.e. nebuliser): ____________
- ☐ No. items ____________

☐ Deposited with Patient Affairs Date: __________ Date returned: __________ Signature: __________

Security Seal Number:

Please list items deposited with Patients Affairs:

Valuables transferred with patient:

Valuables taken home:

Signature: __________

Disclaimer

Other property e.g. night clothes, toiletries:

You are advised to restrict to a minimum the amount of property, including cash and other valuables, brought into this hospital and to hand to the nurse in charge of your admission, as soon as possible, any articles you wish to be kept in safe custody for which a receipt will be given to you. You are responsible for property (including cash and valuables) belonging to you or your child not handed over for safe custody.

Notice is hereby given that University Hospitals of Leicester NHS Trust accepts no responsibility for the loss of, or damage to personal property of any kind, in whatever way the loss or damage may occur, unless deposited for safe custody.

☐ I have read and understood the disclaimer

☐ The disclaimer has been explained / read to me and I understand its contents

Signature of patient: __________

Date: __________

Time: __________

Signature on behalf of patient: __________

Name in print: __________

Parent/guardian/family/friend (please delete as appropriate)

NB: Any valuables surrendered for safe keeping must be listed in Patient Cash and Valuables Book.

DATE AND TIME	ADDITIONAL NOTES / COMMENTS	SIGNATURE

SIGN IN / TIME TO STOP

Carried out by all members of team to be present during the procedure including the Endoscopist Endoscopist:

Trainee:

Nurse 1:

Nurse 2:

Other:

	FURTHER DETAILS
Patient identity confirmed against completed consent form *(2 identifiers)*: YES / NO	
Team introduced to patient: YES / NO	
Team confirm procedure: (and with patient): YES / NO	
Consent form checked and signed YES / NO	
Anticoagulants/Antiplatelets: YES / NO	
(PLEASE LIST IF YES)	
Any known infections YES / NO	
Any special measures to be taken YES / NO	
Please specify and inform staff in decontamination Entonox YES / NO	
(IF REQUESTED COMPLETE CHECKLIST)	
Sedation: REQUESTED/REFUSED CHANGED DECISION TO HAVE/NOT HAVE	
Relevant medical conditions: YES / NO	
(PLEASE LIST IF YES)	
Allergies YES / NO	
(PLEASE LIST IF YES)	
Metal plates/Pins/Pacemaker YES / NO	
Glaucoma YES / NO	

Monitoring (oximeter on + BP) available ☐ O_2 and suction available: ☐ Equipment checked: ☐ **Any concerns/Questions:** Staff: ☐ Patient: ☐	

STOP THE LINE

DR R ROBINSON / DR M CRAM / K GODDARD REVISED BY BRENDA TAYLOR

DURING PROCEDURE

Procedure: OGD / F/S / COLON / EUS Endoscope used:	Time Started:	Time Completed:	Endoscopist:

Insertion of Cannula for Endoscopy procedure

Consent: Informed ☐ Implied ☐ Unable ☐

Adhered to Aseptic technique ☐ Skin Prep ☐

24g ☐ 22g ☐ 20g ☐ 18g ☐ **Lot No:**..........

Dressing applied: ………… No of attempts: ………..

Insertion Pain Tolerance Score:

1 Mild **2** Moderate **3** Severe **4** Unable

Local anaesthetic ☐ Flush post insertion ☐

Dentures Removed: Yes ☐		No ☐	N/A ☐
Glasses:	Yes ☐	No ☐	N/A ☐
Hearing aid:	Yes ☐	No ☐	N/A ☐
O_2 Administered at:		%/L	

Position of Cannula: ……………………………

By Whom: ………………………………………….

DRUG ADMINISTERED

DRUG	INITIAL DOSE	ROUTE	TIME	TOP-UP	TIME	TOP-UP	TIME	TOTAL	Checked by	Given by
Midazolam										
Diazemuls										
Pethidine										
Fentanyl										
Buscopan										
Propofol										
Lignocaine Throat Spray										

VERBAL ORDERS

Date	Time	Drug	Dose	Route	Time given	Ordered by	Given by	Checked by
		Adrenaline 1:10,000						
		Lignocaine throat spray						
		Indigo Carmine						
		"SPOT"						
		Acetic Acid + Sterile water						
		Lugols Iodine						
		Botox						
		Acetylcysteine + Infacol						
		Infacol						

PATIENT GROUP DIRECTIVES *(WRITE AND SIGN IN RED)*

Date	Time	Drug	Dose	Route	Time given	Given by	Checked by
		Phosphate enema					
		Sodium Chloride 0.9%					
		Entonox 50% oxygen 50% nitrous oxide					

OBSERVATIONS

	Time	B/P	P	R/R	O_2 Sats	Pain Score (1–10)	EWS
PRE							
PERI							
POST							
Comment:							

COMFORT SCORE 1-5

1. **Comfortable** - Talking / comfortable throughout
2. **Minimal** - One or two episodes of mild discomfort without distress
3. **Mild** - More than 2 episodes of discomfort without distress
4. **Moderate** - Significant discomfort experienced several times with some distress
5. **Severe** - Frequent discomfort with significant distress

UPPER GI

Biopsy ☐
Clo Test ☐
Hot Biopsy ☐
Polypectomy ☐
Polyp Retrieved ☐
APC ☐

Diathermy setting:
Position of Plate:
Gold probe ☐

Banding of varices
Injection of varices ☐
Gluing of varices ☐
Haemospray ☐
Sengstaken required ☐

COLORECTAL

Biopsy ☐
Hot Biopsy ☐
Polypectomy ☐
Polyp Retrieved ☐

No of Polyps:

Diathermy setting:

Position of Plate:

Proctoscopy ☐
Banding of Haemorrhoids ☐
Injection of Haemorrhoids ☐

QUALITY OF BOWEL PREP:

Good ☐
Satisfactory ☐
Poor ☐

POST PROCEDURE INSTRUCTIONS

Nil by mouth until:

To be reviewed by: ☐

O_2 required as per prescription ☐

Stent Insertion ☐ Size: Type: Dilatation ☐ Size: PEG: ☐ Type: length: NJ insertion ☐ Other:	Rigid Sigmoidoscopy Clips ☐ Polyloop ☐ ☐ Other:	Prescription required ☐ Standard post procedure instruction ☐ Therapeutic instructions ☐ Diathermy pad removed from patient Yes ☐ No ☐ N/A ☐ Other Instructions:

SIGN OUT	ACTIONS
Procedure confirmed ☐ Sedation/Analgesia given agreed ☐ Specimen identification and management completed ☐ Post procedure instructions confirmed ☐ Any equipment problems: ☐ Any patient issues ☐ Does this patient need next step appointment ☐	

Nurse: ………………………………………… Signature: ………………………………….. Band: ………..

RECOVERY

Hand over of care accepted by ………………………………… Signature ……………………………….. Band …………………. Time …………………		
Comments:		
Pain Score(1 – 10)		
Abdominal/Chest/Neck Pain		
Abdominal Distension		
Nausea/Vomiting		
Rectal Bleeding/Melaena		
Flatus Passed		
Cannula Insitu	**Yes / No**	
Eating and Drinking		NBM until:
Glasses/Dentures/Hearing aid Replaced		
Pre Procedure Mobility Status Achieved		

OBSERVATIONS

TIME										
B/P										
Pulse										
R/R										
O_2 Sat										
Temp ºC										
CNS										
BM Stix										
Pain Score										
EWS										

Early Warning Score (EWS)

Physiological parameters	**3**	**2**	**1**	**0**	**1**	**2**	**3**
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Oxygen Saturations	**≥97 on O_2**	**95-96 on O_2**	**93-94 on O_2**	**≥93 on Air 88-92**	**86-87**	**84-85**	**≤83**
Any supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	
Systolic BP	≤90	91-100	101-110	111-219			≥220
Heart Rate	≤40		41-50	51-90	91-110	111-130	≥131
Level of Consciousness				A			V,P or U

RESPONSE TO CLINICAL DETERIORATION OR CONCERN

EWS 0-2 or clinical concern EWS 0 → continue with 12 hourly obs EWS 1-2 → inform nurse in charge	• Repeat observation within 1 hour when EWS 1-2 • If remains 1-2 for 2 hours Nurse in Charge to determine frequencyof observation (no less than 4 hourly)

Score EWS 3 for 2 hours or clinical concern Use SBAR tool for all referrals If score 2 for 2 hours contact F1/F2/CT or Hospital @ Night through NerveCentre Request medical review within 60 mins Consider call Critical Care Outreach Team	• Registered nurse to re-check clinical obs and ensure appropriate nursing intervention have been completed • Hourly EWS for a minimum of 2 hours • Inform nurse in charge of patient's EWS score • Manual BP check if Systolic <90mmHg or >150mmHg • Ensure fluid balance monitoring is in place and patient has IV access • Could this patient have sepsis? • Start oxygen 15L via face mask with reservoir & review within 30 mins
EWS 4-5 or clinical concern Use SBAR tool for all referrals Contact F1/F2/CT or Hospital @ Night through NerveCentre Request medical review within 30 mins Refer to Critical Care Outreach Team	• Registered nurse to re-check clinical obs and ensure appropriate nursing intervention have been completed • Commence hourly EWS • Commence fluid monitoring, documenting all inputs and outputs and ensure patient has IV access • F1/F2/CT or Hospital @ Night Co-ordinator to contact SPR or Hospital @ Night Registrar • Management plan documented stating interventions and physiological parameters • Could this patient have sepsis? • Is the patient at risk of falling? Refer to Falls Assessment/Care Plan • Start oxygen 15L via face mask with reservoir & review within 30 mins
EWS ≥ 6 or deteriorating Use SBAR tool for all referrals Request urgent review by SPR Refer to Critical Care Outreach Team for review within 30 mins	• Commence ½ hourly EWS, 1 hourly fluid monitoring, consider catheterisation • Do ECG • Registered nurse to remain with patient • F1/F2/CT or Hospital @ Night Co-ordinator to contact SPR or Hospital @ Night Registrar • Do ABG and start oxygen 15L via face mask with reservoir • Registrar to discuss with Consultant • Refer to Acute Response Team (outreach) • Clear management plan documented stating physiological parameters and interventions required • If patient requires transfer to CCU then Consultant to Consultant referral usually required • Could this patient have sepsis?
Could this patient have sepsis?	If suspected, implement sepsis bundle as follows: • Oxygen • Blood culture • IV antibiotics • Fluid therapy and complete fluid balance chart • Serum Lactate • BM • Catheterise • Reassess for SEVERE SEPSIS with 1 hourly EWS

S Situation	**I am calling about** (patient name and location) **The patient's resus status is** (resus status) **The problem I am calling about is** …..……………………………………….. **I have just assessed the patient personally:** **Vital signs are:** B/P Pulse R/R Temp **I am concerned about the:** …………………………………………………….
B Background	**The patient's mental status is:** Alert and oriented to person, place and time Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly unable to swallow Comatose. Eyes closed. Not responding to stimulation **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm **The patient is not or is on oxygen:** The patient has been on ………. (L/min) or (%) oxygen for...........mins/hrs The oximeter is reading ....% The oximeter does not detect a good pulse and is giving erratic readings
A Assessment	**This is what I think the problem is** (say what you think is the problem) **The problem seems to be cardiac / infection / neurologic / respiratory** …………………………………………………………………………………… **I am not sure what the problem is but the patients is deteriorating.** **The patient seems to be unstable and may get worse, we need to do something.**
R Recommendation	**I suggest or request that you** (say what you would like to see done) Transfer the patient to critical care Come and see the patient at (this time) Talk to the patient or family about resus status Ask the on-call Registrar to see the patient now Ask for a Consultant to see the patient now **Are any tests needed:** Do you need any tests like CXR, ABG, ECG, U&E or BMP? Others? **If a change in treatment is ordered then ask:** How often do you want vital signs? How long do you expect this problem to last? If the patient does not get better when would you want us to call again?

DISCHARGE

Discharged Nurse by: ………………………………………… Signature: ……………………………..……

RGN Band: …………………………….. Time: ………………

Pain Score (1 – 10)		**Copy of consent** ☐ **Copy of report** ☐ **Copy of patient vs report** ☐ **Discharge advice and information given to:** ☐ Patient ☐ Patient and Escort ☐ **Advice sheets given:** Standard ☐ Therapeutic ☐ Other ☐
Abdominal/Chest/Neck Pain		
Abdominal Distension		
Rectal Bleeding/Melaena		
Nausea/Vomiting		
Flatus Passed		
Cannula Removed ☐ By Whom: Time Cannula in place: < 72 hours ☐ Same day ☐	**Removal reason:** Not required ☐ Other ☐ **Comments :**	**Prescription required given to:** Patient ☐ Escort ☐ N/A ☐
Glasses/Dentures/Hearing Aids Replaced		**No follow up/Follow up** OPD Given or already made ☐ OPD to be sent ☐ Virtual clinic – will be contacted ☐ By referring Consultant ☐ To contact GP ☐ Discharge to GP care ☐ Repeat/Further Endoscopy ☐ Other investigations required ☐ Next step appointment given ☐
Pre Procedure Mobility Status Achieved		
Patient Eating and Drinking		

B/P	Pulse	R/R	O_2 Sat	Temp °C	CNS	BM Stix	EWS

Fit for Discharge ☐

Patient satisfied that general comfort needs checked and addressed during Endoscopy episode
Yes ☐ **No** ☐

State any problems:

Suggestion sheet supplied if dissatisfied with care given **Yes** ☐ **Refused** ☐

SMOKING CESSATION REFERAL

Noted on admission - Would like help to stop smoking

Referral Type: Card Referral ☐ ICM ☐

DATE AND TIME	**ADDITIONAL NOTES / COMMENTS**	SIGNATURE

GUIDELINES FOR DISCHARGE FOLLOWING AN ENDOSCOPY PROCEDURE WITH OR WITHOUT SEDATION

Authorised professionals to discharge Must be:

- Registered nurse at level one
- Employed by the Trust at a minimum Band 5
- Familiar with NMC Code of professional practice (2008)
  The Scope of professional practice (2008)
  The Trust policy for adjustment and development of practice (2002) The Trust's Discharge Policy (UHL 2003)

Must have:

- Completed Endoscopy training section re discharge of a patient post procedure with patent information
- 3 months experience within an Endoscopy department
- Up to date knowledge and skills that they maintain
- Accountability for their practice

Patients may be discharged should the following be met:

- Patient comfortable with only minor discomfort related to trapped air. A pain score of less than 5
- There is no abdominal distension, rectal bleeding, haematemesis or melaena
- There is no severe abdominal, neck or chest pain
- No EWS issues

The minimum discharge criteria are met:

- Ability to stand unaided and walk without support or achieved pre procedure mobility status
- Stable vital signs
- Minimal nausea
- Toleration of oral fluids (unless post non-sedated Gastroscopy)
- Appropriate aftercare and escort home if required
- Ability to pass urine if Buscopan administered and pass wind following a colonoscopy / sigmoidoscopy

Earliest discharge times post procedure should be no less than 15 minutes if no sedation given or 30 minutes with sedation

Information to be given at discharge:

This will be given to either patient or patient and escort depending on patient's choice and if sedation has been given

- The nurse will give verbal information of findings from generated report and, discharge advice information with a contact number for the Endoscopy department
- Relevant healthcare advice and information will be given with any follow up appointments and prescription required
- The patient will be seen by any required Clinical Nurse Specialist and contact numbers given accordingly
- A copy of Consent form will also be given at discharge unless endoscopist states otherwise

To comply with NMC Guidelines for record keeping.

If you use this pathway please use black ink and sign relevant part of document.

Cannula and Product Labels:

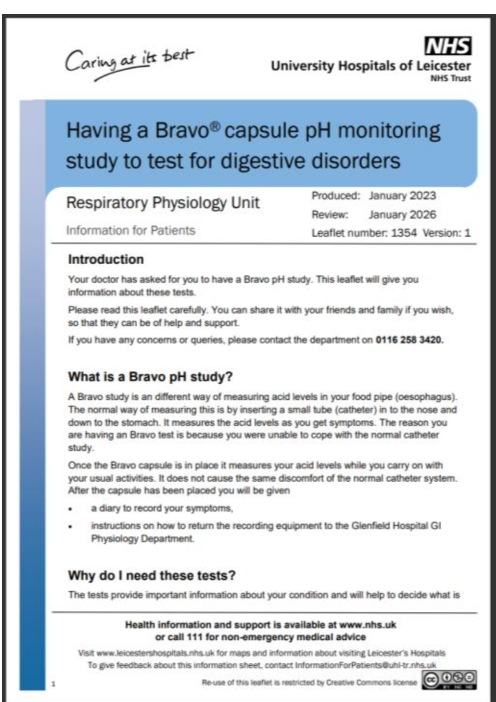
Appendix 2

[Having a Bravo® capsule pH monitoring study to test for digestive disorders (leicestershospitals.nhs.uk)]

[Having a flexible sigmoidoscopy (leicestershospitals.nhs.uk)]

[Having a colonoscopy to look inside your large bowel (leicestershospitals.nhs.uk)]

[Having a gastroscopy to look inside your upper digestive tract (leicestershospitals.nhs.uk)]



Caring at its best

NHS University Hospitals of Leicester NHS Trust

Having a Bravo® capsule pH monitoring study to test for digestive disorders

Respiratory Physiology Unit

Information for Patients

Produced: January 2023
Review: January 2026
Leaflet number: 1354 Version: 1

Introduction

Your doctor has asked for you to have a Bravo pH study. This leaflet will give you information about these tests.

Please read this leaflet carefully. You can share it with your friends and family if you wish, so that they can be of help and support.

If you have any concerns or queries, please contact the department on **0116 258 3420.**

What is a Bravo pH study?

A Bravo study is an different way of measuring acid levels in your food pipe (oesophagus). The normal way of measuring this is by inserting a small tube (catheter) in to the nose and down to the stomach. It measures the acid levels as you get symptoms. The reason you are having an Bravo test is because you were unable to cope with the normal catheter study.

Once the Bravo capsule is in place it measures your acid levels while you carry on with your usual activities. It does not cause the same discomfort of the normal catheter system. After the capsule has been placed you will be given

- a diary to record your symptoms,
- instructions on how to return the recording equipment to the Glenfield Hospital GI Physiology Department.

Why do I need these tests?

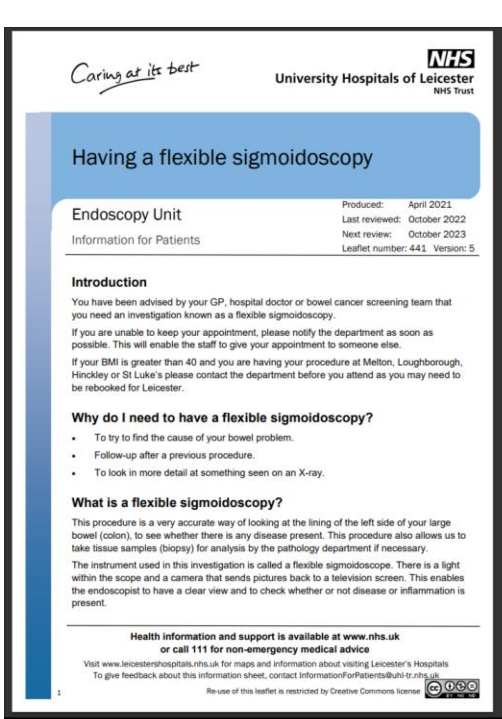
The tests provide important information about your condition and will help to decide what is

Health information and support is available at www.nhs.uk or call 111 for non-emergency medical advice

Visit www.leicestershospitals.nhs.uk for maps and information about visiting Leicester's Hospitals
To give feedback about this information sheet, contact InformationForPatients@uhl-tr.nhs.uk

1

Re-use of this leaflet is restricted by Creative Commons license



Caring at its best

NHS University Hospitals of Leicester NHS Trust

Having a flexible sigmoidoscopy

Endoscopy Unit

Information for Patients

Produced: April 2021
Last reviewed: October 2022
Next review: October 2023
Leaflet number: 441 Version: 5

Introduction

You have been advised by your GP, hospital doctor or bowel cancer screening team that you need an investigation known as a flexible sigmoidoscopy.

If you are unable to keep your appointment, please notify the department as soon as possible. This will enable the staff to give your appointment to someone else.

If your BMI is greater than 40 and you are having your procedure at Melton, Loughborough, Hinckley or St Luke's please contact the department before you attend as you may need to be rebooked for Leicester.

Why do I need to have a flexible sigmoidoscopy?

- To try to find the cause of your bowel problem.
- Follow-up after a previous procedure.
- To look in more detail at something seen on an X-ray.

What is a flexible sigmoidoscopy?

This procedure is a very accurate way of looking at the lining of the left side of your large bowel (colon), to see whether there is any disease present. This procedure also allows us to take tissue samples (biopsy) for analysis by the pathology department if necessary.

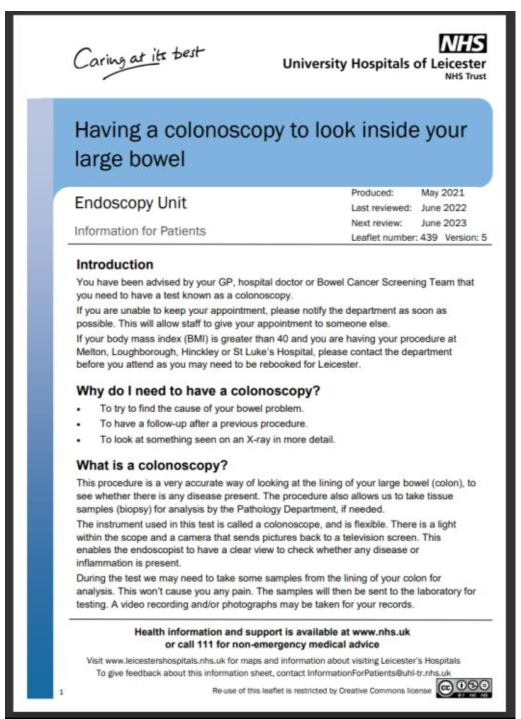
The instrument used in this investigation is called a flexible sigmoidoscope. There is a light within the scope and a camera that sends pictures back to a television screen. This enables the endoscopist to have a clear view and to check whether or not disease or inflammation is present.

Health information and support is available at www.nhs.uk or call 111 for non-emergency medical advice

Visit www.leicestershospitals.nhs.uk for maps and information about visiting Leicester's Hospitals
To give feedback about this information sheet, contact InformationForPatients@uhl-tr.nhs.uk

1

Re-use of this leaflet is restricted by Creative Commons license



Caring at its best

NHS University Hospitals of Leicester NHS Trust

Having a colonoscopy to look inside your large bowel

Endoscopy Unit

Information for Patients

Produced: May 2021
Last reviewed: June 2022
Next review: June 2023
Leaflet number: 439 Version: 5

Introduction

You have been advised by your GP, hospital doctor or Bowel Cancer Screening Team that you need to have a test known as a colonoscopy.

If you are unable to keep your appointment, please notify the department as soon as possible. This will allow staff to give your appointment to someone else.

If your body mass index (BMI) is greater than 40 and you are having your procedure at Melton, Loughborough, Hinckley or St Luke's Hospital, please contact the department before you attend as you may need to be rebooked for Leicester.

Why do I need to have a colonoscopy?

- To try to find the cause of your bowel problem.
- To have a follow-up after a previous procedure.
- To look at something seen on an X-ray in more detail.

What is a colonoscopy?

This procedure is a very accurate way of looking at the lining of your large bowel (colon), to see whether there is any disease present. The procedure also allows us to take tissue samples (biopsy) for analysis by the Pathology Department, if needed.

The instrument used in this test is called a colonoscope, and is flexible. There is a light within the scope and a camera that sends pictures back to a television screen. This enables the endoscopist to have a clear view to check whether any disease or inflammation is present.

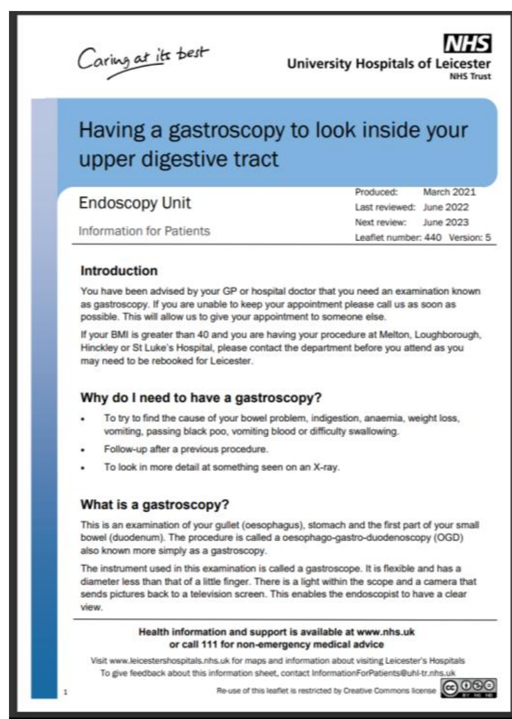
During the test we may need to take some samples from the lining of your colon for analysis. This won't cause you any pain. The samples will then be sent to the laboratory for testing. A video recording and/or photographs may be taken for your records.

Health information and support is available at www.nhs.uk or call 111 for non-emergency medical advice

Visit www.leicestershospitals.nhs.uk for maps and information about visiting Leicester's Hospitals
To give feedback about this information sheet, contact InformationForPatients@uhl-tr.nhs.uk

1

Re-use of this leaflet is restricted by Creative Commons license



Caring at its best

NHS University Hospitals of Leicester NHS Trust

Having a gastroscopy to look inside your upper digestive tract

Endoscopy Unit

Information for Patients

Produced: March 2021
Last reviewed: June 2022
Next review: June 2023
Leaflet number: 440 Version: 5

Introduction

You have been advised by your GP or hospital doctor that you need an examination known as gastroscopy. If you are unable to keep your appointment please call us as soon as possible. This will allow us to give your appointment to someone else.

If your BMI is greater than 40 and you are having your procedure at Melton, Loughborough, Hinckley or St Luke's Hospital, please contact the department before you attend as you may need to be rebooked for Leicester.

Why do I need to have a gastroscopy?

- To try to find the cause of your bowel problem, indigestion, anaemia, weight loss, vomiting, passing black poo, vomiting blood or difficulty swallowing.
- Follow-up after a previous procedure.
- To look in more detail at something seen on an X-ray.

What is a gastroscopy?

This is an examination of your gullet (oesophagus), stomach and the first part of your small bowel (duodenum). The procedure is called a oesophago-gastro-duodenoscopy (OGD) also known more simply as a gastroscopy.

The instrument used in this examination is called a gastroscope. It is flexible and has a diameter less than that of a little finger. There is a light within the scope and a camera that sends pictures back to a television screen. This enables the endoscopist to have a clear view.

Health information and support is available at www.nhs.uk or call 111 for non-emergency medical advice

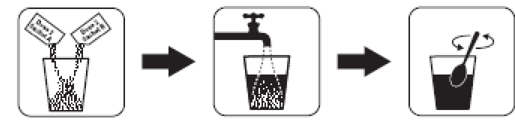
Visit www.leicestershospitals.nhs.uk for maps and information about visiting Leicester's Hospitals
To give feedback about this information sheet, contact InformationForPatients@uhl-tr.nhs.uk

1

Re-use of this leaflet is restricted by Creative Commons license

Appendix 3

How and When to take Plenvu

Morning appointment	**Afternoon Appointment**
Light breakfast and light lunch	Light breakfast and light lunch
At 6pm day before procedure: 1. Open the carton and remove the Dose 1 sachet. 2. Pour the contents of Dose 1 into a measuring container that can hold 500 ml of water. 3. Add water to make up to 500 ml and stir until all the powder has dissolved. This may take up to approximately 8 minutes. After dose 1 drink an extra 500ml of clear fluids. Water, clear soup, diluted cordial/clear fruit juice (without pulp), herbal tea, black tea or coffee (without milk) are all suitable.	**At 6pm day before procedure:** 1. Open the carton and remove the Dose 1 sachet. 2. Pour the contents of Dose 1 into a measuring container that can hold 500 ml of water. 3. Add water to make up to 500 ml and stir until all the powder has dissolved. This may take up to approximately 8 minutes. After dose 1 drink an extra 500ml of clear fluids. Water, clear soup, diluted cordial/clear fruit juice (without pulp), herbal tea, black tea or coffee (without milk) are all suitable.
Approximately 8pm on day before procedure: 1. After at least 1 hour from finishing dose 1, pour the contents of Dose 2 Sachet A and Dose 2 Sachet B into a measuring container that can hold 500 ml of water. 2. Add water to make up to 500 ml and stir until all the powder has dissolved. This may take up to approximately 8 minutes. After dose 2, drink an extra 500ml of clear fluids. You can continue to drink clear fluids until 1 hour before your test. ***Do not eat while taking Plenvu and until after your clinical procedure***	**On day of procedure at 6am:** 1. Pour the contents of Dose 2 Sachet A and Dose 2 Sachet B the contents of Dose 2 Sachet A and Dose 2 Sachet B into a measuring container that can hold 500 ml of water. 2. Add water to make up to 500 ml and stir until all the powder has dissolved. This may take up to approximately 8 minutes.  After dose 2, drink an extra 500ml of clear fluids. You can continue to drink clear fluids until 1 hour before your test. ***Do not eat while taking Plenvu and until after your clinical procedure***

Appendix 4

Alliance
Endoscopy Team Briefing

To involve the Endoscopist, Nursing staff, Students
(Anaesthetist & ODP if in attendance)

Date:	**Comments**
Endoscopist:	
Start Time:	
Introduction and role of all team members	
Do we have the correct number and skill mix of staff?	
Who is the unit Co-ordinator today?	
Room Nurse in Charge is?	
Are there any changes to the list order ? i.e. Infection risk	
Outcome forms must be completed for each patient	
Use the 2ww specimen protocol where necessary	
Have all stock levels and equipment safety checks been made?	
Any other issues?	
Debrief	**End Time:**
What went well today?	
If list over ran, what are the reasons?	
Have all specimens been appropriately labelled i.e. 2ww	
Have any equipment problems been rectified?	
Could anything have been done differently to improve patient safety or room efficiency?	

Appendix 5

Standard operating procedure for patients that Do Not Attend (DNA) their endoscopy appointment.