Haemorrhoid Banding Standard Operating Procedure
UHL Colorectal Surgery (LocSSIPs)

Change Description	Reason for Change
☐ Change in format	X Trust requirement

APPROVERS	POSITION	NAME
Person Responsible for Procedure	Head of Service & Consultant Colorectal Surgeon, colorectal surgery	Mr Sam Sangal
SOP Owner:	Head of Service & Consultant Colorectal Surgeon, colorectal surgery	Mr Sam Sangal

Appendices in this document:

Appendix 1: LocSSIPs safety checklist for use in the outpatient department.

Introduction and Background:

Covers the following – banding of haemorrhoids (rubber band ligation). This is a standard treatment for large internal symptomatic haemorrhoids based on national guidelines from NICE and Association of coloproctologists of GB.

Indications for banding are

- Bleeding internal grade 2 haemorrhoids
- Partially prolapsing grade 3 haemorrhoids.

Contraindications

- Grade 4 external haemorrhoids
- Patients on warfarin / Clopidogrel/ Rivaroxaban (stop accordingly prior to procedure according to UHL bridging policy)
- Associated anal fissure.

Procedure is carried out in following clinical areas as a day case.

-Colorectal out patients

-Endoscopy department.

-Operating theatre.

Procedure does not require any anaesthetic or post procedure analgesia.

Referral process –

- Referred by GP to colorectal clinic
- Referred to endoscopy as straight to test/ from clinic for sigmoidoscopy and banding
- Scheduled on colorectal endoscopist's list.

List management and scheduling:

Patients are booked through endoscopy waiting list as per urgency and consented by trained Endoscopist / nurse. The endoscopy list are prepared to include up to 6 bandings/ list and is at the discretion of the Endoscopist to assess whether banding is required following sigmoidoscopy.

When banding is done in clinic they are not listed in advance and banding equipment is to be available in colorectal clinics.
Banding Equipment: Suction machine, suction tubing, Disposable Pre loaded automatic bander, Disposable Proctoscope with light source, Aquagel.
Clinic nursing staff should be familiar in the use of the banding equipment and are trained in accordance.

The minimum data set includes Patient name, S number/ NHS number, Date of birth, procedure to be undertaken and location of procedure.

Patients are listed on colorectal endoscopy lists and nurse endoscopists trained to do banding of haemorrhoids.

DNAs from clinic are discharged in line with UHLDNA policy. DNA from Endoscopy are given a 2nd appointment within 3 weeks.

Patient preparation:

Outpatient banding –

- No formal preparation needed.
- Patient assessed in clinic with proctoscopy if banding is required.
- Verbal consent taken – procedure and risk explained by doctor.
  -Post procedure per anal discomfort and bleeding.
- Banding kit available in clinic
- Banding not done if patient is on anticoagulation therapy – patient is rebooked after stopping anticoagulation and necessary bridging plan if required as per trust anti coagulation guidelines.

Endoscopy unit banding

- Procedure coupled with diagnostic sigmoidoscopy or colonoscopy
- Receive full bowel prep at home / phosphate enema on admission to endoscopy.
- Patient comes fasted and diabetic patients are done on a morning list at the start of the list.
- Delegated consent for endoscopy and banding done by trained endoscopy staff / Endoscopist on standard UHL trust consent form 2.

Workforce – staffing requirements:

For outpatient banding only a clinician and nurse assistant is required. It is done as an office procedure as described above.

For procedure done in endoscopy department staffing level is same as for a standard endoscopy room staffing which is staffed by endoscopy floor control / matron.
Induction and training of endoscopy staff is undertaken by matron.
These procedures are done 'In Hours' defined as 8.30 to 16.30 hours.
Nurse endoscopists training to do banding are directly supervised by consultant colorectal surgeon / Endoscopist.

Ward checklist, and ward to procedure room handover:

Patient in endoscopy is accompanied to the endoscopy suite by an HCA or ward nurse and handed over to qualified member where patient details , consent and procedure are checked and confirmed

Procedural Verification of Site Marking:

Not Applicable.

Team Safety Briefing:

Applicable in endoscopy only when banding is combined with colonoscopy / sigmoidoscopy.

All members of endoscopy team are present for the team brief which is generic at the start of the list. Since patients are admitted in a staggered fashion individual patient briefing is done as the list progresses.

Team safety briefing in outpatient clinic – the clinician will brief the nursing assistant on the procedure required.

Sign In:

- Sign in confirmed at the start of the procedure in endoscopy room. Patient is asked to confirm identity, procedure, allergies and consent. In the outpatient clinic the clinician will confirm the patient's identity with the nursing assistant and patient.

Time Out:

Time out is not applicable in the outpatient clinic as this is combined with the Sign In identity check.
In the endoscopy suite It is done at the beginning of the procedure prior to administration of sedation if required.

- Qualified member of staff will lead this
- All team members must be present and engaged as it is happening
- That is will occur immediately before the procedure start
- That any omissions, discrepancies or uncertainties must be resolved before staring theprocedure

Performing the procedure:

Patient is positioned appropriately, maintaining patient dignity and monitoring (Endoscopy only).
Monitoring is not required in the outpatient clinic.

Monitoring:

Monitoring will consist of use of a saturation probe to monitor O2 saturations and pulse. This may be supplemented with blood pressure monitoring if required. When sedation is used monitoring is compliant with the UHL Sedation Policy.

Prosthesis verification:

Not Applicable.

Prevention of retained Foreign Objects:

Not Applicable.

Radiography:

Not Applicable.

Sign Out:

Sign out must occur before the patient leaves the operative /procedure (endoscopy) area which should include:

- Confirmation of procedure
- Confirmation that any specimens have been labelled correctly
- Discussion of post-procedural care and any concerns
- Equipment problems to include in team debriefing

Handover:

No handover is required in the outpatient department. In the endoscopy suite the usual handover to recovery staff takes place.

Team Debrief:

No formal debrief takes place in the outpatient area.
In the endoscopy suite a formal debrief should occur after every list in order to highlight what went well, what needs improving, and to form an action plan if there are any ongoing issues.

Post-procedural aftercare:

Routine post sigmoidoscopy or colonoscopy monitoring in recovery area as per endoscopy SOP.
No specific monitoring for banding required.

Discharge:

Information leaflet on banding given to patient on discharge.
Banding only patients are not routinely followed up in clinic.
Endoscopy result is given to patient as a discharge letter.
Copy of result sent to GP and referring consultant.

Governance and Audit:

A safety incident is defined as an unanticipated or unintended event which has caused harm or could potentially cause patient harm. These will be reported on datix and the patient safety team will be responsible for subsequent investigation and disseminating any learning events. Each site has a surgical M
+ M meeting where these events related to banding will be captured and discussed.
To submit monthly Safe Surgery Audit and WHOBARS assessment as per Safe Surgery Quality Assurance & Accreditation programme.

Training:

Endoscopy and clinic staff are trained in handling banding equipment by existing trained senior nursing staff and Endoscopist.

Documentation:

Details of the banding performed in endoscopy will be captured by GI tool including the result.
In outpatients the appended sticker is used to record the procedure and that the necessary safety checks have been carried out.

In clinic this is recorded in patients' notes and clinic letter.

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 Guideline: Anticoagulation management ("bridging") at the time of elective surgery and invasive procedures (adult) B30/2016

END

Appendix 1: LocSSIPs safety checklist for use in the outpatient department.

Outpatients invasive procedure checklist:

Sigmoidoscopy with banding of piles

Patient name:

DOB:

S number or NHS number:

Name of chaperone/assistant:

……

Operator

……

Verbal consent taken: Yes ☐

Patient on anticoagulation or clopidogrel? Yes ☐ No ☐

Length of scope inserted: …. .. Cm

Findings:

Banding performed: ……

Biopsies taken? N/A ☐ Yes ☐ No of specimens ……

Specimens labelled correctly Yes ☐

Post-procedure leaflet given to patient? Yes ☐ No ☐

Date: …… Signed: ……

STOP THE LINE

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