CLINICAL MONITORING AND SAFE DISCHARGE OF PATIENTS ATTENDING THE ENDOSCOPY UNIT GUIDELINE

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

Recovery documentation and discharge planning is integral to the discharge of patients recovering from endoscopic procedures. It is essential that those who have received intravenous conscious sedation return to normal conscious levels before discharge and that a written record of recovery observations and events are documented.

This guidance is provided to enable qualified staff to safely discharge patients attending the Endoscopy unit using documented criteria.

Lead Clinician(s)

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Approved by SCSD Divisional Governance Meeting on: 20th November 2019

This is the most current document and is to be used until a revised version is available: 20th November 2022

Key amendments to this guideline

Date	Amendment	By:
12.07.06	Guideline approved on behalf of Clinical effectiveness Committee	Dr Newrick Mrs Doherty
Nov 2008	Guideline approved on behalf of Clinical effectiveness Committee	Mrs Doherty
02.08.10	Policy reviewed. Only change – updated references.	D Hathaway
11.05.12	Policy reviewed. Changes – Guideline 2.	D Hathaway
14.06.12	Policy reviewed. Changes to names of staff involved.	K Hinton / D Hathaway
12.07.12	Advised that document is not a policy, considered as guidelines. Amended document accordingly.	K. Hinton
07.12.15	Guideline approved by Endoscopy directorate meeting	
25.6.2015	Addition of entonox and more specific guidance for method of endoscopy	H Livett
November 2017	Document extended whilst under review	TLG
December 2017	Sentence added in at the request of the Coroner	
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
Jan 2019	Original author Karen Jeffries has since left organisation and name removed from revised document.	L Mahachi
November 2019	Guideline title amended to 'Clinical monitoring and safe discharge of patients attending the endoscopy unit guideline'	SCS Divisional Governance Meeting

CLINICAL MONITORING AND SAFE DISCHARGE OF ALL PATIENTS ATTENDING ENDOSCOPY INCLUDING BOWEL CANCER SCREENING GUIDELINE

Introduction

Clinical Monitoring:

Endoscopic procedures can be undertaken with medication or without medication. Whether a patient had intravenous medication or not for the procedure, it is imperative that all patients' vital signs are monitored to enable a safe discharge. Academy of Medical Royal colleges Safe Sedation Practice for Healthcare Procedures Standards and Guidance (2013) should be followed.

Medication used during procedures or pre-existing comorbidities can contribute to patents deteriorating during endoscopy or during recovery. Benzodiazepines are common choice of sedative either alone or in combination with an opiate are usual in GI procedures. Such combination may increase the risk of oxygen desaturation and cardiorespiratory complications. There are also reported links between the use of local anaesthetic sprays and the development of pneumonia after gastroscopy. In addition incidents have been reported locally where patient have suffered vasovagal during cystoscopy, hysteroscopy and sigmoidoscopy. It is therefore momentous that all patients are monitored as per table below.

Please note:

1) Safety and monitoring should be part of a quality assurance programme for endoscopy units.
(2) Resuscitation equipment and drugs must be available in the endoscopy and recovery areas.
(3) Staff of all grades and disciplines should be familiar with resuscitation methods and undergo periodic retraining.
(4) Equipment and drugs necessary for the maintenance of airway, breathing, and circulation should be present in the endoscopy unit and recovery area (if outside the unit) and checked regularly.
(5) A qualified nurse, trained in endoscopic techniques and adequately trained in resuscitation techniques, should monitor the patient's condition during procedures.
(6) Before endoscopy, adverse risk factors should be identified. This may be aided by the use of a check list.
(7) The dosage of all drugs should be kept to the minimum necessary. There is evidence that benzodiazepine/opioid mixtures are hazardous.
(8) Specific antagonists for benzodiazepines and opioids exist and should be available in the event of emergency.
(9) A cannula should be placed in a vein during endoscopy on 'at risk' patients.
(10) Oxygen enriched air should be given to 'at risk' patients undergoing endoscopic procedures.
(11) The endoscopist should ensure the well-being and clinical observation of the patient undergoing endoscopy in conjunction with another individual. This individual should be a qualified nurse trained in endoscopic techniques or another medically qualified practitioner.
(12) Monitoring techniques such as pulse oximetry are recommended.
(13) Clinical monitoring of the patient must be continued into the recovery area.
(14) Records of management and outcome should be collected and will provide data for appropriate audit (Bell1991).

Requirements for clinical monitoring of endoscopy patients

(Deteriorating patients should be monitored using the NEWS chart and intervene as per accompanying action table)

Procedure	Admission (Full set obs)	Procedure room (continuous monitoring of pulse & O2 sats in addition to below)				Recovery- Full set obs (Sedated/therapy pt- every 15min for at least 45 mins. Entonox & Non-sedation one full set)
		On trolley	After Sedation	Caecum/ Midway	End (full set obs)	
Colonoscopy- No sedation or with Entonox	√	√ pulse & O2	×	√ full set obs	√	√ (Once) (Unless EMR or therapy then x3)
Colonoscopy Sedation	√	√ pulse & O2	√ full set obs	√ full set obs	√	√
Gastroscopy- throat spray	√	√ pulse & O2	×	×	√	√ (If not discharging straight from room)
Gastroscopy – Sedation	√	√ pulse & O2	√ full set obs	×	√	√
EUS with Sedation	√	√ pulse & O2	√ full set obs	√ full set obs	√	√
Sigmoidoscopy- No sedation or Entonox	√	√ pulse & O2	×	×	√	√ (Unless EMR or therapy then 3 set of obs)
Sigmoidoscopy- Sedation	√	√ pulse & O2	√	×	√	√
Gastroscopy- GIB	√	√ pulse & O2	√	√	√	√
ERCP	√	√ full set obs	√ full set obs	√ full set obs	√	√
Bronchoscopy / EBUS with Sedation	√	√ pulse & O2	√ full set obs	√ full set obs	√	√
Cystoscopy	√	√ pulse & O2	×	×	√	Discharged straight from room
Hysteroscopy	√	√ pulse & O2	×	×	√	Discharged straight from room

Discharge planning:
Recovery documentation and discharge planning is integral to the discharge of patients recovering from endoscopic procedures. It is essential that those who have any procedure with or without intravenous conscious sedation, opiates or Entonox return to normal preadmission consciousness and physical state before discharge. Documentation of recovery observations and events must be completed and signed prior to discharge.

Guidelines

A registered nurse trained within endoscopy will complete the discharge check list prior to the arrangement for patients going home or ward. All Bowel cancer screening patients will be seen by a Screening Nurse Practioner prior to final discharge

Any adverse events or complications prior to discharge should be discussed with the nurse in charge and the endoscopist who performed the procedure. Should any of the following criteria not be met then a record will be kept in the adverse event book and where necessary a Datix will be completed. The patient should have mental capacity if there is any doubt then a mental health assessment should be completed. Ward staff should be aware of the 'Patient taking own discharge form', a copy should be kept with the patients' notes. All of the events should be objectively documented in the nursing history sheets. If patient refuses to sign the form – a full and comprehensive record is required, the GP needs to be informed, police on the non-emergency number (101) if necessary (particularly if sedated and driving). Social care is contactable on: 08456072000 if advised to do so by consultant.

<u>Checks prior to discharge</u>
Lignocaine used for upper gastrointestinal endoscopy

- Discharge from the room or recovery area as appropriate
- Stable vital signs
- Pain free or pain score as prior to admission
- Nausea free
- All appropriate information given to patient verbally and written; including nil by mouth for 1 hour post procedure

Follow up, from procedure is documented on the report, nursing documentation and patient information, unless consultant deems unsuitable.

Lignocaine and sedation utilised for upper GI procedures

- Patient is transferred to the recovery area complete with handover, monitoring and oxygen provision as per trust guidance
- Discharge as per Sedation guidance below
- Fluids and diet should not be offered for 30 minutes – 1 hour post procedure.

Sedation and/or opiates only:

- Transferred to recovery area prior to discharge
- O2 is given during the recovery period as per Trust guidelines
- Monitoring post procedure (including BP and pulse oximetry)
- Stable vital signs
- Pain free or pain score as prior to admission
- Nausea free
- Alert and orientated as prior to admission
- Tolerating diet and fluid
- Venflon removed and documented post diet and fluid
- Suitable transport home.
- Responsible adult to stay with patient for 12 hours

Follow up from procedure is documented on the report, nursing documentation and patient information, unless consultant deems unsuitable.

Entonox then discharge should be to the recovery room

- Stable vital signs.
- Pain free or pain score as prior to admission
- Nausea free
- Alert and orientated as prior to admission

Follow up from procedure is documented on the report, nursing documentation and patient information, unless consultant deems unsuitable.

- The registered nurse will document, sign and date the discharge check list.

Any deviation from the above must be discussed with the appropriate medical staff and fully documented.

Monitoring Tool

STANDARDS
1. Accurate documentation of discharge will be audited twice yearly and discussed at Tri County Endoscopy Meeting. Clinical Governance aware of results and action plan completed according to need
2. Datix and adverse events are monitored monthly at the County Wide Endoscopy Meeting. Clinical Governance aware of results and action plan completed according to need.
3. Annual patient survey completed with a focus on patient aftercare. Discussed within each unit and at Tri County Endoscopy Meeting, Clinical Governance and Patient Services

References

- Academy of Medical Royal colleges (2013) Safe Sedation Practice for Healthcare Procedures Standards and Guidance. The Academy of Medical Royal Colleges, London.
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- Bell, G D (1991) Recommendations for standards of sedation and patient monitoring during gastrointestinal endoscopy. Gut, 32,823-827 British Society of Gastroenterology M A Quine, G D Bell, R F McCloy, J E Charlton, H B Devlin, A
- Hopkins (1995) Prospective audit of upper gastrointestinal endoscopy in two regions of England: safety, staffing, and sedation methods. Gut; 36: 462-467 British Society of Gastroenterology
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- Somchai Amornyotin (2013) Sedation and monitoring for gastrointestinal endoscopy. World J Gastrointest Endosc. 2013 Feb 16; 5(2): 47–55. Published online 2013 Feb 16. doi: 10.4253/wjge.v5.i2.47
- Dunkley I et al (2018) UK consensus on non-medical staffing required to deliver safe, quality-assured care for adult patients undergoing gastrointestinal endoscopy. Frontline Gastroenterology 2018;0:1–11

Contribution List

Key individuals involved in developing the document

Name	Designation
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Circulated to the following individuals for comments

Name	Designation
Members of the Endoscopy Directorate/JAG meeting	

Supporting Document 1 - Equality Impact Assessment Tool To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Transgender	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment & mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	Yes	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact Human Resources.**Supporting Document 2 – Financial Impact Assessment**

It is the responsibility of every individual to check that this is the latest version/copy of this document.

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval