Worcestershire Acute Hospitals NHS Trust

Completion of Bowel Cancer Screening System Datasets and Adding Episode Notes to Bowel Cancer Screening System

Key Document code:	WAHT-KD-021	
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Approved by:	Bowel Screening Operational Meeting	
Date of Approval:	24th April 2017	
Date of review:	11th February 2022	

Key Amendments

Date	Amendment	Approved by
19th June 2019	Documents extended for 6 months whilst reviewed	Emma Duggan
11th Feb 2020	Documents extended for 6 months whilst review and approval is processed	Emma Duggan
27th July 2020	Documents extended for 6 months during COVID-19 period	QGC/Gold Meeting
1st March 2021	Document extended for 6 months as per Trust agreement 11/02/2021	
16th July 2021	Documents extended for 6 months whilst review and approval is processed	Emma Duggan/ Mr Stephen Lake

Introduction

The Bowel Cancer Screening System is the dedicated national IT system for administration of and data capture for the Bowel Cancer Screening Programme.

This guideline outlines the process for completing Bowel Cancer Screening System datasets and circumstances in which an episode note should be added to Bowel Cancer Screening System.

The NHS Bowel Cancer Screening Programme, Guide Book for Programme Hubs and Screening Centres, Version 3 section 5.9 states that the SSP is responsible for ensuring that all the screening datasets are completed and that outcomes from all the screening episodes are entered on the Bowel Cancer Screening System. Furthermore IGU 16 states that clear, accurate and complete records must be kept of assessments, treatments and results and in addition relevant discussions with patients should also be recorded. It goes on to set out that all data must be recorded in real time or where this is not possible recorded on an identical paper proforma which must be transferred to the Bowel Cancer Screening System by the end of the next working day.

Scope of This Document

This document applies to BCSP Specialist Screening Practitioners (SSPs) and administrative staff working within the Herefordshire & Worcestershire Bowel Cancer Screening Programme.

Implementation

This guideline will need to be implemented when having contact with patients within the Bowel Cancer Screening Programme (BCSP) and when completing datasets for these patients. All BCSP staff will be notified of this documents existence and it will form part of the induction plan for new staff.

Please note that the key documents are not designed to be printed, but to be used on-line. This is to ensure that the correct and most up-to-date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours and should be read in conjunction with the key document supporting information and/or Key Document intranet page, which will provide approval and review information.

Completion of Datasets

In accordance with the National Office guidance, it is necessary:

- To record all data required by Bowel Cancer Screening System on a paper proforma, where real time data capture is not possible.
- To input any data recorded on paper proforma by the end of the next working day.
- That where the data drives the patient episode (e.g. investigation dataset) the data is input only by the SSP who collected it.
- That records are clear and accurate.
- That original records are not tampered with in any way.
- Any changes or additions made to entries or paper records by a second party are clearly marked as such.
- That no data is falsified in order to progress a patient along the pathway.
- That where data cannot be completed in full an episode note is created to explain which elements are incomplete and why. If this information is to become available at a later date, the system must be updated as soon as possible.
- That investigation datasets correspond with the colonoscopy report and histology report.

Episode / Subject / Additional Care Needs Notes

The Bowel Cancer Screening System has the functionality to record notes against a patient's record. There are three types of notes and each has a different function. These are set out below:

- Episode notes are episode specific e.g. patient rescheduled colonoscopy.
- Subject notes apply to the patient rather than the current episode e.g. patient prefers to be contacted by mobile phone.
- Additional Care Needs notes allow for the recording of a patient's disability which staff may need to be aware of when interacting with the patient e.g. patient is deaf.

Notes should be used to record any events not recorded within a dataset e.g. ad-hoc telephone calls, discussions within clinic etc.

Incomplete Datasets

Incomplete datasets are monitored by the lead administrator and discussed at the monthly team meetings. For further details see Guideline for Running 'Missing Data' Reports.

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