EGGNZ guide to the provision of evidence for Endoscopy Unit Service and Facility Standards for New Zealand Audit.

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Introduction

The purpose of this document is to provide a provisional outline of the evidence to assist endoscopy units in preparation for an external audit against the recently published Endoscopy Unit Service and Facility Standards for New Zealand (https://endoscopyquality.co.nz/resources/)

The National Bowel Screening Programme (NBSP) has engaged an independent auditing company, the DAA Group, to audit all MoH cancer screening programmes. EGGNZ understands that audits of endoscopy units providing NBSP services will be undertaken some months *after* the local implementation of the programme.

The auditors will work with Endoscopy Guidance Group for New Zealand (EGGNZ) and other key stakeholders to develop endoscopy audit processes, including a range of evidence which units will be required to provide.

Most of the audit standards are based on the NZGRS and are already established in every DHB. The success of quality improvement in endoscopy is highly dependent on an effective Endoscopy User Group. The documented activity and outcomes of this group can provide a substantial body of evidence required by the auditors.

It should be noted that this document identifies the key, or minimum, evidence required but this is not an exhaustive list and staff are encouraged to add any additional evidence to demonstrate that standards have been met. Audit will involve a review of documented evidence, together with staff and patient interviews and observation of practice.

Further help can be obtained from the National Endoscopy Quality Improvement Programme (NEQIP) team, and many examples of proformas, questionnaires, policy documents and surveys can be found on the Knowledge Management System (KMS) of the NEQIP website (https://nz.jagaccreditation.org/).

Standard 1.0 Service Management

Standard 1.1: Leadership and organisation The unit has a structure for leadership, governance and accountability with clear reporting lines within the organisation.			
	Audit standard criteria	*Evidence guide*	*GRS links*
1.1a	There is a designated endoscopy clinical lead.	• Evidence of a named CL with description of role and responsibilities	1.1
1.1b	There is an endoscopy leadership team comprising clinical, nursing and managerial lead roles, each with defined responsibilities.	• Evidence of an endoscopy leadership team with description of roles and responsibilities, including the time commitment allocated to support leadership functions.	1.2
1.1c	There is a defined governance structure based on the Endoscopy User Group with clear lines of reporting and accountability.	• Evidence of an established Endoscopy User Group (EUG) with documented terms of reference (ToR). The ToR should detail the quality governance structure and functionality with clear reporting lines within the organisation • Minutes of meetings	1.4
1.1d	There is an annual audit plan for the service with named leads and timescales for completion.	• A documented annual rolling audit plan for the service. This should include: ○ Named leads for all key audits ○ Clear timescales for audit completion (this should include clinical quality data monitoring and NZGRS audits as well as patient and staff surveys	1.5
1.1e	The clinical endoscopy leadership team have dedicated, non-clinical time in their job plans/roles to lead the service.	• Examples of timetables or job plans	1.7
1.1f	There are defined processes and timescales to review and maintain all policies and standard operating procedures.	• A system of document management control including owners and dates of review for all key documents. Note: each document should have this information recorded on it.	1.8
1.1g	The endoscopy leadership team has the managerial and administrative support to organise and deliver the service effectively.	• Minutes of meetings, demonstrating regular managerial presence, including EUG/operational and strategic planning meetings • Identification of roles within unit including all endoscopy	1.9

		administrative staff (reception, booking and scheduling)	
1.1h	The service has appropriate technical support to enable effective service delivery.	• Review of overall service delivery by the Clinical Auditors	1.10
1.1i	The endoscopy leadership team has access to timely and appropriate information on capacity, demand and waiting times on which to base operational and planning decisions.	• EUG meeting minutes • Minutes of Capacity and demand meetings • Ready access to data	1.11
1.1j	The endoscopy leadership team review and set the service's strategic objectives on an annual basis and develop plans to achieve these objectives.	• Review of the service definition and operational plans (including resources) at least annually. This can be demonstrated through EUG or other planning/operational minutes	1.12
1.1k	There are systems in place to ensure that the leadership team seek and receive feedback about their performance on an annual basis.	• Staff survey • Individual or team feedback (informal or formal) • 360 degree feedback process	1.14
1.1l	There is an annual process in place to consider and plan resources for new service developments.	• Evidence of a service development plan. This should be linked to the service's strategic objectives (1.1j)	1.15

Standard 1.2: Policy and procedure management The endoscopy unit has documented quality assurance and clinical policies and procedures that are regularly updated and shared with unit staff to ensure a high-quality service.		
	Audit standard criteria	*Evidence guide*
1.2a	Policy and procedure documents are centrally accessible and available to all staff.	• Demonstration of hard copy or electronically available documentation at each endoscopy site
1.2b	All policy and procedure documents are reviewed and updated two-yearly, or earlier if required	• Evidence of review dates of documents
1.2c	All relevant staff are notified of changes to all policies and procedures.	• Evidence of key memoranda and circulation lists • EUG and operational meeting minutes

Standard 1.3: Appropriateness of endoscopy procedure The unit implements and monitors systems to ensure appropriate referrals for all endoscopy procedures.			
	Audit standard criteria	*Evidence guide*	*GRS links*
1.3a	There are referral guidelines available for all diagnostic procedures.	• Evidence of referral guidelines	5.1
1.3b	There is a local policy for prioritising referrals.	• Evidence of a documented policy	5.2
1.3c	Endoscopy referral forms enable the provision of sufficient clinical information to permit prioritising of the appropriateness of the referral against guidelines.	• Referral forms (assessment of relevance to be done by clinical audit team)	5.3
1.3d	Referral guidelines for procedures other than direct access have been agreed by all who perform those procedures.	• Meeting minutes and documented correspondence (e.g. emails, written feedback) to show appropriate consultation	5.5
1.3e	All referrals from non-endoscopists within primary and secondary care are prioritised by an endoscopist who performs that procedure, unless agreed 'direct access' protocols exist.	• List of clinicians who undertake grading and the list of the procedures they are credentialed to perform.	5.6
1.3f	Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.	• Evidence of inpatient triaging process • Unit operational policy	5.7
1.3g	An audit of the prioritising process is undertaken once per year, with an action plan formulated where problems are identified.	• Documented audit and action plan	5.8
1.3h	All referral guidelines are reviewed on an annual basis, with amendments disseminated to appropriate stakeholders.	• Evidence of review of guidelines and circulation list	5.10

Standard 1.4: Access and booking ***There are systems and processes in place to ensure that the service is accessible, timely and patient- centred.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
1.4a	The service has agreed processes to support endoscopy	• Booking and scheduling rules, which should be documented	10.1

	waiting list management, booking and scheduling practices.	within the unit operational policy • Waiting list management policy • Demonstration of process, e.g. an example of patient booking and scheduling	
1.4b	Roles and responsibilities for the management of waiting lists, booking and scheduling are clearly defined and documented.	• Operational policy • Names and roles of booking staff	10.2
1.4c	There is an agreed process for determining and monitoring the capacity of each endoscopy list.	• Documentation of the duration and composition of lists • Allocation of points system or equivalent to reflect procedure complexity	10.4
1.4d	The service has a process for identifying patients at risk of breaching waiting times and these are appropriately escalated and actioned.	• Documented in the local waiting list policy • Evidence of wait list management processes (e.g. minutes of meetings, wait list data)	10.5
1.4e	There is a process for pooling of referrals to ensure that patients are booked in turn.	• Booking and scheduling policy • Waiting list management policy	10.6
1.4f	All inpatient procedures are performed within the timescale allocated by the grading clinician.	• Evidence of the date and time of referral, grading and performance of procedures	10.7
1.4g	The endoscopy service achieves optimum endoscopy wait times as per national and local requirements.	• Evidence of waiting time data for all procedures. This must include colonoscopy wait time indicator (CWTI) data.	10.8
1.4h	All urgent inpatient upper gastrointestinal and ERCP (where available) procedures are performed within 24 hours.	• Evidence of the date and time of referral, grading and performance of procedures	10.9
1.4i	There is an electronic scheduling system that facilitates efficient booking and scheduling.	• Evidence of electronic scheduling system	10.10

Standard 1.5: Delivery and planning ***There are policies, processes and schedules in place to ensure that resources and capacity are used effectively.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
1.5a	Agreed delivery and planning (productivity) metrics are documented in the service operational policy.	• Evidence of unit operational policy	11.1
1.5b	There is a weekly review of waits, demand, capacity and	• Evidence of weekly meetings	11.2

	scheduling.		
1.5c	There is sufficient flexibility in job plans to enable backfilling of vacant lists.	• Evidence of scheduling to show backfilling of lists, e.g. timetabling	11.3, 11.9
1.5d	Booking efficiency is monitored (through DNA and cancellation monitoring) at least monthly and is fed back to endoscopy staff and the Endoscopy User Group (EUG).	• Evidence of DNA and cancellation data • EUG meeting minutes	11.4
1.5e	The service offers a contact service for all patients before the date of the procedure to identify and address any logistic, transport and social issues to avoid late cancellations/non-attendance.	• Evidence of contact service for patients, e.g. patient letters, patient information sheets, clinical documentation	11.5
1.5f	Demand, capacity and utilisation data are used on an on-going basis for business planning to ensure sufficient capacity, and the service has an agreed production or service plan if shortfalls are identified.	• Meeting minutes • Business plans	11.8
1.5g	There is an annual planning and delivery report for the service with an action plan to support service planning.	• Meeting minutes • Business plans, production plans • Annual report for the service	11.7

Standard 1.6: Endoscopy workforce capability

The endoscopy unit has an appropriately trained workforce.

	Audit standard criteria	*Evidence guide*	*GRS links*
1.6a	There are policies and systems in place to ensure that there are sufficient competent staff within the service with an appropriate mix of skills to enable delivery of the service.	• Unit policies • Training and induction policies • Training provision • Staff allocation rotas	15.1
1.6b	The service rosters staff according to service activity and competency level. Allocation of the workforce must be based on the expected duration and complexity of the service activity.	• Rotas to be assessed by clinical auditors	15.2
1.6c	There is a process in place to ensure that all new team members receive a service-specific induction.	• Induction policy • Staff survey	15.3

1.6d	There is a training needs analysis for all new staff that supports the needs of the service.	• Documented evidence of assessment of training needs	15.4
1.6e	There is a training needs analysis for substantive staff when there is a change or adoption of new practice, when team members leave, during succession planning or at least yearly, which is agreed by the appropriate senior manager responsible for each workforce group.	• Evidence of training sessions	15.5
1.6f	All staff have undergone Treaty of Waitangi and Tikanga/kawa Maori training.	• Documented evidence	15.6
1.6g	A workforce skill-mix review is completed on at least an annual basis for all functions of the service and an impact assessment of the gaps is made and objectives are agreed on how these will be addressed in the immediate year.	• Documented evidence of workforce skill-mix review	15.7
1.6h	There are processes to ensure the recruitment of suitable staff in a timely manner.	• Evidence of recent recruitment	15.10
1.6i	Feedback on the service specific induction programmes is gathered from staff at least annually, with modifications as required.	• Annual staff survey and/or specific post induction feedback	15.12
1.6j	Workforce development plans are in place to address anticipated demand over the next 2–5 years.	• Documented evidence • Meeting minutes (planning, operational)	15.15
1.6k	The service has an active approach to succession planning for senior staff roles.	• Evidence of training, deputising roles	15.16
1.6l	There are appropriate numbers of suitably trained staff for the level of sedation being administered on each list.	• Evidence of sedation training of endoscopy staff • Staff rotas	

Standard 1.7: Personnel / list composition *(only applicable to NBSP practice)* NBSP endoscopy is performed with the appropriate staffing, skill-mix and time to perform quality procedures.			
	Audit standard criteria	*Evidence guide*	*Guidance*
1.7a	All NBSP colonoscopists are credentialed to meet EGGNZ Individual standards.	• Credentialing documentation	Reference: *The Endoscopy Guidance Group for New Zealand. (2017). Endoscopy Standards for Individual Colonoscopists Performing Bowel Cancer Screening in New Zealand.*
1.7b	There is a minimum of three colonoscopists with appropriate NBSP credentialing to deliver NBSP services.	• Credentialing documentation • Names of NBSP colonoscopists	The minimum recommended number of NBSP colonoscopists is three to ensure service continuity. This criterion is designed to ensure that the provision of NBSP colonoscopy does not fall to a single endoscopist. Three endoscopists will allow continuity of the service, taking into account cover for leave, sickness, and to allow for variations in other duties. Refer to: *The Endoscopy Guidance Group for New Zealand. (2017). Endoscopy Standards for Individual Colonoscopists Performing Bowel Cancer Screening in New Zealand.*
1.7c	There are appropriate numbers of suitably trained staff for the level of sedation being administered on each list.	• Evidence of sedation training of endoscopy staff • Staff rotas	Reference: *ANZCA. (2014). PS09: Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures. Melbourne, Australia: Australian and New Zealand College of Anaesthetists*
1.7d	The clinical nursing team directly engaged in NBSP lists will be appropriately trained, have the right skill mix and be regularly assessed.	• Staff rotas • Evidence of appraisal, training and development	Gastroenterology Knowledge and Skills Framework (KSF) Directly Observed Practical Skills (DOPS) Refer to: *www.nzno.org.nz/groups/colleges_sections/colleges/nzno_gastroenterology_nurses_college/resources*
1.7e	There is a maximum of 5 cases per 4 hour list.	• Evidence of list composition	
1.7f	There is access to a timely anaesthetic-assisted sedation list for appropriate cases, as required.	• Booking and scheduling process	

Standard 2.0 Facilities

Standard 2.1: Endoscopy unit facilities The unit provides a person-centred, safe, comfortable, accessible, clean, clinically and culturally appropriate environment.			
	Audit standard criteria	*Evidence guide*	*Guidance*
2.1a	**Reception area** The reception area is of sufficient size to accommodate the expected throughput for the unit.	• Physical measurement of unit • Evidence of patient numbers passing through unit	Recommended sizes as per Schedule of Accommodation -. *Australasian Health Infrastructure Alliance. (2016). Australasian Health Facility Guidelines - Part B - Health Facility Briefing and Planning 0270 - Day Surgery Procedure Unit*.
2.1b	**Waiting area** The waiting area can accommodate the usual number of patients and other family/whānau people who would be waiting at any time.	• Physical measurement of unit • Evidence of daily patient throughput	
2.1c	**Office area** The office area is of sufficient size to support administrative functions.	• Physical measurement of unit • Evidence of patient numbers passing through unit	
2.1d	**Preparation and holding area** The preparation and holding area are of sufficient size and appropriate facilities are provided to enable patients to change and toilet prior to undergoing procedures and wait in a suitably discrete location under supervision of staff. Facility must have appropriate space for patient preparation - enemas etc.	• Physical measurement of unit • Evidence of patient numbers passing through unit	
2.1e	**Procedure room fittings and features** Minimum requirements for any endoscopy procedure room include: • A minimum of two suction ports (for patient and instrument)	• Verification by clinical auditors	Procedure rooms are appropriately constructed, fitted out and maintained in accordance with NZS 8134.1.4. *Standards of New Zealand. (2018). Health and Disability Services Standards. NZS 8134.0.2018*

	• Oxygen and accessory equipment • Access to hand-washing facilities • Intercom or emergency call system • Data ports • Adjustable and appropriate lighting • Appropriate temperature and ventilation		Recommended sizes as per Schedule of Accommodation -. *Australasian Health Infrastructure Alliance. (2016).* If conscious sedation is given – requirements as per ANZCA PS09 (2014) If under General Anaesthesia –refer to *ANZCA. (2012). PS55 - Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations.*
2.1f	Additional equipment required for procedures involving radiological examination: • X-ray equipment such as Image • intensifier • Radiation protected room • X-ray aprons / thyroid collars / belts/ gloves • X-ray monitoring devices (for staff)	• Verification by clinical auditors	Refer to *Gastroenterological Society of Australia. (3rd Edition 2006: Reprinted 2011). Endoscopy: Standards for Endoscopic Facilities and Services. Victoria: Digestive Health Foundation*
2.1g	Appropriate ventilation and filtration for units performing bronchoscopy.	• Verification by clinical auditors	Refer to: *Australasian Health Infrastructure Alliance. (2016). Australasian Health Facility Guidelines - Part B - Health Facility Briefing and Planning 0270 - Day Surgery Procedure Unit.*
2.1h	**Separate reprocessing area** There must be a separate reprocessing area adjacent to the procedure rooms. • Adequate sinks and bench areas • Ultrasonic cleaning machine • Medical air / Compressed air • Filtered water • Storage drying cabinets (clean area) see also 3.1j.	• Verification by clinical auditors	Recommended sizes as per Schedule of Accommodation -. *Australasian Health Infrastructure Alliance. (2016).* Refer to - *Standards of New Zealand. (2014). Reprocessing of reusable medical devices in health service organizations. AS/NZS 4187:2014.* Refer to: *Gastroenterological Society of Australia. (3rd Edition 2006: Reprinted 2011). Endoscopy: Standards for Endoscopic Facilities and Services. Victoria: Digestive Health Foundation*
2.1i	**Clinical support areas**	• Verification by clinical auditors	Recommended sizes as per Schedule of

	Dedicated and separate storage should be provided for a range of stock, consumables and equipment.		Accommodation -. *Australasian Health Infrastructure Alliance. (2016).*
2.1j	**Consulting / Interview room** Consulting rooms are located appropriately close to the recovery room, are constructed to ensure patient privacy and confidentiality of discussions and contain furniture and fittings.	• Verification by clinical auditors	
2.1k	**Nurses' station** There should be a nurses' station for preparation and recovery.	• Verification by clinical auditors	
2.1l	Accessible staff room.	• Verification by clinical auditors	
2.1m	Staff toilet & changing rooms.	• Verification by clinical auditors	
2.1n	Patient toilet and changing area (including disability and bariatric access facility).	• Verification by clinical auditors	Facilities are provided to protect patient privacy including provision for disabled patients and preparation rooms for enemas. There is wheelchair access to the facility and procedural rooms which complies with disability regulations in accordance with NZS 8134.1.4. *Standards of New Zealand. (2018).*
2.1o	Waste disposal area.	• Verification by clinical auditors	
2.1p	The recovery area has separated stage 1 and 2 facilities. Stage 1 requires: • Vital sign monitoring • Suction, • Oxygen and • Call facilities	• Verification by clinical auditors	Refer to: *ANZCA. (2020). PS04 - Statement on the Post-Anaesthesia Care Unit.* The recovery area is: • appropriate to the number of procedures and in accordance with NZS 8134.1.4 Standards of New Zealand. (2018). • appropriately located adjacent to the procedure room and is freely accessible by a normal recovery trolley.

			• appointed with appropriate equipment and emergency systems per bed space.
2.1q	There are systems in place to ensure that access to particular areas is restricted where appropriate (includes decontamination).	• Verification by clinical auditors	Refer to NZGRS measure. 9.9 for guidance.
2.1r	The endoscopy unit is of appropriate size to allow safe flow of patients and staff through the facility in case of emergency.	• Verification by clinical auditors	The discounted circulation rate should be 35% - as per Schedule of Accommodation. *Australasian Health Infrastructure Alliance. (2016).*
2.1s	Where children are managed in a procedure unit, there is some separation between children and adults.	• Verification by clinical auditors	*Refer to: ANZCA. (2019). PS29- Guideline for the Provision of Anaesthesia Care to Children.*

Standard 3.0 Equipment

Standard 3.1: Essential hardware The equipment should be of sufficient quantity and quality to meet the service requirements.			
	Audit standard criteria	*Evidence guide*	*Guidance*
3.1a	There is sufficient volume of equipment to match service demand.	• Verification by clinical auditors	Volume of equipment should be sufficient to maximise efficiency, avoid patient delays and ensure patient safety. Reprocessing times and unexpected equipment malfunction should be taken into account.
3.1b	**Endoscopy Equipment** • A range of endoscope sizes to cope with anticipated difficulties, [adult or paediatric] • High Definition White Light Endoscopes with appropriate HiDef video screens	• Verification by clinical auditors, and unit inventory	Including paediatric diameter endoscopes, and a long colonoscope. Refer to: *Gastroenterological Society of Australia. (3rd Edition 2006: Reprinted 2011). Endoscopy: Standards for Endoscopic Facilities and Services. Victoria: Digestive Health Foundation.*

	• Narrow Band / Blue Light Imaging capability		Note: Magnetic Positioning Devices improve Caecal Intubation Rates (CIR) and reduce the sedation needs for patients, as well as aiding localisation of lesions. They are a recommended additional item of equipment, but not deemed essential at this time.
3.1c	**Endoscopy Accessories** There should be an adequate supply of accessories suited to the endoscopic interventions undertaken within the unit including: • Forceps • Snares (range of sizes, braided and single filament) • Injection needles • Dilators and guide wires • Loops • Clips • Coagulation device(s) – e.g. Heater probe, Coag-Grasper forceps • Spray catheters (and appropriate chromoendoscopy chemicals) • Other devices appropriate to achieve haemostasis	• Verification by clinical auditors	Refer to: *Gastroenterological Society of Australia. (3rd Edition 2006: Reprinted 2011). Endoscopy: Standards for Endoscopic Facilities and Services. Victoria: Digestive Health Foundation*
3.1d	Carbon dioxide insufflation is available	• Verification by clinical auditors	
3.1e	Endoscopy-specific Electro Surgical Unit (ESU) ESUs are required to have integrated circuitry that, at a minimum, allows blending, variation and alternation of cutting and coagulation current as well as mono and bipolar delivery.	• Verification by clinical auditors	Refer to: *J.F Rey, U. Beilenhoff et al.. (2010). European Society of Gastrointestinal Endoscopy (ESGE) guideline: the use of electrosurgical units. European Society of Gastrointestinal Endoscopy (ESGE)* Refer to: *American Society for Gastrointestinal Endoscopy (ASGE). (2013). Electrosurgical generators - Technology Status Evaluation Report*.
3.1f	Patient monitoring system for continuous CO_2 monitoring, oxygen	• Verification by clinical auditors	Refer to: ANZCA PS09 (2014)

	saturation and automated blood pressure measurement.		

3.1g	Ancillary Equipment
	• Procedural Trolleys which:
	  ○ Allow head tilt, (Trendelenburg and reverse Trendelenburg)
	  ○ Have brakes,
	  ○ Have safety rails
	• Stethoscope
	• Access to ECG monitoring
	• Means of measuring glucose and ketones
	• Transportable oxygen cylinder
	• Portable suction
	• Device to measure patient core temperature
		• Verification by clinical auditors	

3.1h	**Resuscitation Equipment** Each facility shall have ready access to resuscitation equipment (for adult and paediatric patients where appropriate), including: • A range of equipment for advanced airway management (for example, masks, oropharyngeal airways, laryngeal mask airways, laryngoscopes and endotracheal tubes). • A means of inflating the lungs with oxygen (for example, a self-inflating bag and mask) • Adequate intravenous access equipment • Intravenous fluids including normal saline, dextrose etc.	• Verification by clinical auditors	Refer to - *ANZCA Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations (PS55), 2012*

	• Full range of emergency drugs, including sedation reversal agents • Portable oxygen with equipment for delivery to the patient e.g. Hudson Mask/Nasal Prongs • Portable suction • Defibrillator		
3.1i	**Endoscopy Reporting System**, with capacity to provide auditable outcome data.	• Verification by clinical auditors • Review of endoscopy reports • Demonstrated process for audit	
3.1j	**Reprocessing** The unit has: • Automated reprocessing for endoscopic equipment, using an Automatic Flexible Endoscope Reprocessor. • Drying and storage cabinets	• Verification by clinical auditors	As referenced in standard *AS/NZS 4187:2014*

Standard 3.2: Maintenance of equipment ***All equipment is suitable, functional, accessible, up-to-date and appropriately maintained for optimal performance.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
3.2a	Guidelines and standards for endoscope decontamination are easily accessible in the unit.	• Evidence of GENCA/GESA guideline: ○ Infection Control in Endoscopy. Third edition 2010, reprint 2011 https://www.genca.org/public/5/files/Endoscopy_infection_control%20(low).pdf ○ Australian/New Zealand Standard (AS/NZ 4187:2014) Reprocessing of reusable medical devices in health service organisations. Standards New Zealand	9.2
3.2b	Testing and validation of the decontamination equipment and associated machinery is carried out according to national decontamination requirements and guidance and action is taken if necessary, on results which fall outside the	• Evidence of maintenance log • Evidence of organisational policy which includes processes for testing and validation in line with national guidance requirements https://www.gesa.org.au/resources/infection-control-in-endoscopy/	9.3

	acceptable parameters.		
3.2c	There is a designated decontamination lead who has overall responsibility for endoscopy decontamination practice.	• Name of designated lead for decontamination	9.6
3.2d	There are systems in place to ensure that access to particular areas is restricted where appropriate (includes decontamination).	• Evidence of swipe card or similarly secure access	9.9
3.2e	There are systems in place to ensure equipment is appropriate and available for patients, staff, children and those with particular needs.	• Visual inspection for ease of disabled access, including that patients with bariatric, geriatric and, where applicable paediatric issues can be accommodated	9.10
3.2f	There are systems in place to ensure the management and control of environmental conditions (includes decontamination).	• Reference to documents referenced in NZGRS 9.11: ○ GESA Standards for Endoscopic Facilities and Services. Third Edition 2006: reprinted 2011: https://www.gesa.org.au/resources/clinical-guidelines-and-updates/endoscopy-standards- for-facilities-and-services/ ○ GENCA/GESA guideline: Infection Control in Endoscopy. Third edition 2010, reprint 2011 https://www.genca.org/public/5/files/Endoscopy_infection_control%20(low).pdf	9.11
3.2g	There are systems in place to ensure the maintenance and quality assurance of all equipment with corresponding records (includes decontamination).	• A matrix of endoscopes with maintenance contracts and checks. • A planned preventative maintenance schedule and full service history records for all endoscopy equipment.	9.12
3.2h	There are systems in place to ensure that equipment replacement is planned (includes decontamination equipment).	• Evidence of planned replacement of equipment with inclusion in the organisation's capital replacement programme. • Minutes of meetings • Planned budgets	9.13

Standard 4.0 Medication

Standard 4.1: Storage of medication

All medication is safely and appropriately stored, with the correct level of security and access.

	Audit standard criteria	*Evidence guide*
4.1a	The service has a policy on the storage of controlled medications.	• Evidence of policy document
4.1b	The service has a policy on the maintenance of a	• Evidence of policy document

	controlled drug register.	
4.1c	The service has a policy on the storage, use and disposal of medications.	• Evidence of policy document

Standard 4.2: Administration of medication ***All medication is appropriately and safely administered.***		
	Audit standard criteria	*Evidence guide*
4.2a	The unit has a policy on administration of all medications used in the endoscopy unit.	• Evidence of policy document
4.2b	The unit has a policy on the administration of sedation and/or anaesthesia in endoscopy.	• Evidence of policy document
4.2c	Staff prescribing and administering sedation for endoscopy have been locally credentialed.	• Evidence of credentialing for sedation for each endoscopist, which can be provided by the local credentialing committee

Standard 5.0 Quality and Safety

Standard 5.1: QI programme involvement ***The service works collaboratively to implement an active quality assurance programme with an ethos of continuous quality improvement (CQI).***		
	Audit standard criteria	*Evidence guide*
5.1a	The service is engaged in the National Endoscopy Quality Improvement Programme (NEQIP), using the New Zealand Global Rating Scale (NZGRS) as the service improvement tool.	• Evidence of census completion, NEQIP reports and action plans • Meeting (EUG or other, e.g. quality meetings) minutes demonstrating review of NZGRS and action plans
5.1b	The service has an annual audit programme incorporating all relevant NZGRS audit activities.	• Evidence of annual audit programme
5.1c	There is an established EUG which provides leadership and quality governance of the endoscopy service with defined terms of reference and clear lines of reporting and accountability.	• Minutes and ToR of EUG

Standard 5.2: Patient safety processes ***The endoscopy service has processes in place to identify, respond to and learn from adverse events.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.2a	Systems are in place for monitoring adverse events within the endoscopy service.	• Evidence of the organisation-wide event reporting system and compliance with the National Adverse Events Reporting Policy for NZ Health and Disability Services (Health Quality and Safety Commission 2017) • Evidence of review processes by the endoscopy service which must include learning from adverse events	2.1
5.2b	There is routine use of an endoscopy pre, peri and post procedure safety checklist.	• Evidence of endoscopy safety checklists	2.2
5.2c	The service requires a patient's fitness for oral bowel cleansing agents to be assessed and documented prior to bowel preparation being dispensed.	• Evidence of processes to ensure that a patient's fitness for bowel preparation is verified and documented. Verifying fitness may be done by the referrer, as evidenced on referral forms or may be included as part of nurse led pre-assessment processes	2.3
5.2d	The leadership team review adverse events at least every 3 months (For NBSP services the requirement is monthly).	• Evidence that all adverse events are collated on a regular basis and discussed as a standing item every 3 months (monthly for NBSP) at EUG meetings	2.4
5.2e	There are local policies or protocols for the management of diabetes, anticoagulation, antiplatelet use, antibiotic and implantable devices in patients undergoing endoscopy.	• Evidence of policy/protocol documents	2.5
5.2f	The endoscopist and the endoscopy nurses meet before each list to identify any potential problems, including high-risk patients or procedures, and to anticipate the need for equipment or accessories.	• Documented evidence e.g. unit operational policy	2.6
5.2g	A process is in place for identifying and reviewing all deaths occurring within 30 days of an endoscopic procedure and all unplanned admissions within 30 days of an endoscopic procedure.	• Documentation and policy outlining the process • Evidence of discussion at Morbidity and Mortality meetings with endoscopists in attendance	2.9
5.2h	Reviews of 30-day mortality include an assessment of the appropriateness of the procedure and any contribution of the procedure itself to the cause of death.	• Documented evidence • Evidence of discussion at Morbidity and Mortality meetings	2.10

5.2i	Actions required in response to learning from adverse events are implemented within 3 months of being reported.	• Documented evidence • Evidence of discussion at Morbidity and Mortality meetings and EUG meetings	2.11
5.2j	The unit has systems in place to monitor and act upon outcomes from upper gastrointestinal (GI) bleeds and mortality and readmission resulting from procedures.	• Documented evidence • Evidence of discussion at Morbidity and Mortality meetings and EUG meetings	2.7, 2.8, 2.12, 2.13, 2.14

Standard 5.3: Respect and dignity

The unit implements and monitors systems to ensure that the privacy, dignity and security of all patients are respected throughout their journey.

	Audit standard criteria	*Evidence guide*	*GRS links*

5.3a	The service has a respect, dignity and security policy, which includes the care and cultural considerations of all patients accessing the service.	• Evidence of local policy
		• Evidence of examples of how this policy is applied in the unit, including:
		  ○ Staff introductions
		  ○ Name badges
		  ○ Interpretation and translation policy
		  ○ Universal accessible signs for toilets and bathrooms
		  ○ Privacy curtains
		  ○ Side-tying gowns,
		  ○ Bariatric facilities and equipment
			7.1

5.3b	There are policies for safeguarding vulnerable adults and children within the department.	• Evidence of local DHB policies • There should also be a description within the unit operational policy of how vulnerable patients are cared for within the unit	7.2
5.3c	There is a range of communication methods and materials to ensure that patients are appropriately informed about what they should expect from the service.	• Evidence of communication methods, e.g. Written patient information, website, and/or specialised communication such as pictures/video	7.4
5.3d	There are facilities available for any clinical conversations to be held in private.	• Verification by clinical auditors	7.6
5.3e	Patient-identifiable material is not openly displayed in areas accessible to other patients, relatives or carers.	• Physical inspection	7.8
5.3f	The patient experience of privacy and dignity is formally assessed at least annually using patient feedback methods.	• Evidence of inclusion in the patient experience feedback survey and/or other methods e.g. suggestion box, focus groups, complaint process	7.10

5.3g	The presence of relatives in clinical areas is not permitted unless the clinical team determines it to be in the patient's best interest to do so (e.g. if the patient is a vulnerable adult or a child).	• This should be stated in the unit operational policy	7.11
5.3h	Appropriate pre and post-procedure separation for all patients is provided from the admission stage onwards in the patient journey, including the recovery area.	• Verification by clinical auditors	7.9, 7.13

Standard 5.4: Consent process (including patient information) ***The unit implements and monitors systems to ensure that informed patient consent is obtained for each procedure.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.4a	There is a published patient information sheet available for all procedures performed in the service.	• Evidence of patient information sheet/leaflets	8.1
5.4b	There is a policy within the service for informed consent which includes withdrawal of consent during an endoscopic procedure.	• Evidence of consent policy with inclusion of withdrawal of consent	8.2
5.4c	All patients are given time to ask questions about the procedure before consent is agreed and before entering the procedure room on the day.	• Patient interview • Evidence that this is included within the patient feedback survey • Findings of survey	8.3
5.4d	All consent forms are signed by the patient or their representative before the patient enters the endoscopy room.	• Evidence of consent policy • Observation of consent processes • Patient feedback	8.4
5.4e	There is a documented process in place for obtaining informed consent for those who are unable to sign on their own behalf.	Evidence of the consent policy	8.5
5.4f	'High-risk' patients and patients scheduled for 'high-risk' procedures are informed of the additional risk by the endoscopist carrying out the procedure and there is a process to document this.	• Evidence of inclusion within the consent policy	8.6
5.4g	High-risk groups undergo pre- assessment before the date of the procedure to prepare them properly for	• Evidence of pre-assessment processes (clinic or telephone assessment)	8.7

	procedures.		
5.4h	Non-compliance of any consent issue is recorded as an adverse event.	• Evidence of consent policy • Evidence of adverse event reporting systems	8.9
5.4i	There is a process to review and update all patient information annually.	• Evidence of patient information sheets renewal date, and evidence of incorporating changes in response to patient feedback. • Evidence of review of web based patient information • Evidence of a DHB controlled document system	8.10

Standard 5.5: Patient comfort ***The unit ensures that it implements and monitors systems to ensure optimal comfort of patients at all stages of their care.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.5a	Patients receive information ahead of time which provides a realistic description of the level of discomfort to be expected during the procedure.	• Evidence of inclusion within written patient information • Patient feedback survey questionnaire • Findings of survey	3.1
5.5b	The service is able to use CO_2 insufflation.	• Verification by clinical auditors	3.2
5.5c	Nurses monitor and routinely record patient pain and discomfort during and after the procedure using a validated scoring scale.	• Evidence of endoscopy reporting documentation • Evidence of peri procedure nursing documentation	3.3
5.5d	Patient comfort scores are reviewed at least twice per year by the endoscopy leadership team and data are fed back to individual endoscopists.	• Evidence of review and feedback • Evidence of patient comfort scores as a standing agenda item at the EUG meetings	3.4
5.5e	There is a documented process for remedial action and six- monthly review when an endoscopist's patient comfort scores fall below agreed levels.	• Evidence of documented process, this should be included within a local policy on the management and support of endoscopist underperformance.	3.5
5.5f	A process is in place for review of an individual's endoscopy practice by the service clinical lead and/or the organisation's senior leadership team where patient comfort levels do not reach acceptable levels after a remedial period.	• Evidence of a local policy on the management and support of endoscopist underperformance.	3.6
5.5g	The service is able to offer a full range of sedation	• Evidence of booked lists with anaesthetic service support	3.7

	techniques including provision of anaesthetic services to maximise comfort, minimise patient anxiety and perform highly technical endoscopy.		

Standard 5.6: Results of endoscopy procedures ***The unit implements and monitors systems to ensure robust and timely interpretation, reporting and communication of results.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.6a	All endoscopy reports are completed on the day of the procedure and include follow-up details.	• Evidence of completed reports filed in hard copy or electronically via the patient management system. • Review of 20 random patient records from a representative number of endoscopists	6.1
5.6b	There is a process for referring patients with a suspected or definite cancer diagnosis to the appropriate multidisciplinary team (MDT).	• Evidence of the referral pathway process	6.3
5.6c	Endoscopy reports are sent to the patient's GP and also to the referring clinician (if different) within one working day of the procedure.	• Electronic evidence • Evidence of reporting process, in the absence of automated dispatch of report	6.4
5.6d	The service has a robust process to track suspected and unexpected malignant histology.	• Evidence in unit policy manual – review of histology • Demonstration of process	6.5
5.6e	There are local processes in place to identify who reviews and approves pathology reports when received by the service.	• Evidence of the documented process within the unit operational policy This should also include the processes for non-substantive staff (e.g. locum endoscopists)	6.6
5.6f	There is a local policy outlining the process for timely dissemination (within 5 working days of receipt of the report) of additional information to referring clinicians.	• Evidence of the process relating to the date of dispatch of additional information within the local unit operational policy	6.7
5.6g	If a cancer is suspected at the procedure, the patient is referred to the relevant cancer clinical nurse specialist (CNS) or equivalent either before discharge from the service or within one working day.	• Evidence of cancer referral pathway documents	6.9
5.6h	All endoscopy reports are communicated electronically on the day of the procedure.	• Evidence on PMS • Fax records, PDF records • Physical demonstration of systems	6.10

Standard 5.7: Clinical quality assessment ***The unit implements and monitors systems to ensure the clinical and technical quality of all procedures performed.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.7a	Key quality indicators and auditable outcomes for procedures performed in the service are available in the department in accessible form.	• A summary of the systems in place to monitor the relevant KPIs and auditable outcomes. • EUG minutes showing evidence of feedback from KPI audits and agreed action plans	4.1
5.7b	Systems are in place for monitoring by the EUG (or equivalent) quality indicators and auditable outcomes for endoscopy.	• Evidence of policy • EUG minutes • Evidence of systems to assess and monitor	4.2
5.7c	Individual endoscopists are given feedback on their procedure key performance indicators (KPIs) at least twice per year. Note: for units providing bowel screening services, KPI data collation and feedback processes are mandated by the NBSP on a three-monthly basis.	• Evidence of audit reports • Evidence of anonymised data presented at EUG meetings as a regular agenda item	4.3
5.7d	Individual endoscopists are given feedback on their late outcomes (30-day mortality and 30-day unplanned admissions) at least twice per year. Note: for units providing bowel screening services, collation and feedback of late outcomes data are mandated by the NBSP on a three-monthly basis.	• Evidence of audit reports • Evidence that all unplanned admissions and mortality are reviewed and discussed either at EUG or Morbidity and Mortality meetings, with results fed back to individual endoscopists	4.4
5.7e	The service has a policy on managing endoscopist performance and the action required if levels are not achieved and maintained.	• Evidence of a policy on underperformance of endoscopists	4.5
5.7f	There is an endoscopy reporting system (ERS) in place to capture immediate procedural and performance data.	• Evidence of an ERS	4.6
5.7g	The service collects and audits separate data for inpatients who undergo endoscopy. This is used to assess the indication, waiting times, auditable outcomes and	• Evidence of an inpatient audit at least twice per year with action plans formulated	4.9

	quality indicators.		
5.7h	The service collects details of all 'off unit' gastrointestinal endoscopy that occurs in the organisation. This is audited and action plans are formulated.	• Evidence that the unit has set up systems to identify patients seen 'off unit' (i.e. in a separate department such as the intensive care unit or emergency department) and assess their indication and outcomes • Evidence that off unit data is inputted into the audit system	4.10
5.7i	There are processes in place to provide feedback and report on quality of bowel preparation for colonoscopy	• Evidence of a bowel preparation audit	-

Standard 5.8: Post procedure care and aftercare ***The unit implements and monitors systems to ensure that patients are prepared for discharge and understand what the plan of care is thereafter.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.8a	There are procedure-specific aftercare patient information sheets for all procedures performed in the service.	• Evidence of patient information sheets	12.1
5.8b	There is a 24-hour hospital-based contact number for patients who have questions and experience problems, and the contact is aware of the protocol to advise and manage patients.	• Evidence of 24 hour contact number, with staff trained in endoscopy manning the phone.	12.2
5.8c	All patients are told the outcome of the endoscopic procedure prior to discharge.	• Evidence of operational policy document that includes a section on aftercare including how patients are informed of the procedure outcome and next steps.	12.4
5.8d	All patients are provided with verbal and written information about the next steps appropriate for their care including follow up arrangements.	• Documented on report – discharge summary • Post endoscopy information sheets	12.5
5.8e	All patients are informed if further information from pathological specimens will be available, from whom and when.	• Documented on discharge summary and post endoscopy information sheets	12.6
5.8f	All patients are offered a copy of the endoscopy report or a patient-centred version of it. If this is deemed inappropriate, the reason is recorded in the file.	• Patient audit feedback results	12.7

Standard 5.9: Patient involvement ***The unit implements and reviews systems to ensure that patients are able to feed back on their experience of the service and that the feedback is acted upon.***			
	Audit standard criteria	*Evidence guide*	*GRS links*
5.9a	The endoscopy service complaints procedure is documented and is clearly available for patients, relatives, whānau and carers to access.	• Evidence of the organisational complaints procedure and its availability to patients, whānau and carers	13.1
5.9b	There are processes in place to ensure that complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon.	• Evidence of organisational complaints procedure and process including local policy • Examples or summary of patient complaints, recommendations and outcomes • Feedback methods to patients, carers and staff • Evidence of how the unit learns from its complaints and implements recommendations made	13.4
5.9c	The service conducts an annual patient feedback survey on the patient experience in endoscopy. Patient feedback is discussed at EUG meetings, with action planning, and review.	• Evidence of annual patient feedback survey • Analysis of results and recommendations/actions from the patient feedback survey. • EUG meeting minutes showing evidence of patient feedback with agreed action plans	13.5, 13.6
5.9d	The service uses more than one method to obtain patient feedback on a regular basis.	• Evidence of additional patient feedback methods which may include focus groups, patient fora and invited comments (e.g. suggestion box in waiting area	13.7
5.9e	A summary of patient feedback and changes made is available for patients to view.	• Evidence of change e.g. Information may be presented in waiting areas (e.g. posters/leaflets which send the message “you said, we did”).	13.8
5.9f	Patients participate in planning and evaluating services.	• Evidence of patient involvement. This may be at unit or DHB level • Evidence of meeting minutes where patient representation was included	13.11