3. Standardized Patient Discharge
Guidelines for Endoscopy Facilities

Quality Management Partnership

INTENDED USE OF THIS RESOURCE

The endoscopist is responsible for providing written post-discharge instructions to patients who have undergone colonoscopy. This guideline outlines the minimum requirements for the written post-discharge instructions that are provided to the patient, family member, and/or legal guardian at or before discharge following a colonoscopy procedure.

General discharge requirements include:

- An anesthesiologist or physician is responsible for writing the discharge order for a patient following the colonoscopy procedure. The decision to discharge must be based on an objective discharge scoring system.
- Patients who have received sedation or analgesia should be accompanied by a responsible adult when leaving the clinic. Patient safety and access to care are two important components of quality that must be appropriately balanced. In rare cases, patients may be unable to make arrangements to be discharged in the company of a responsible adult. Colonoscopy facilities must have a process to manage these exceptional cases.
- Prior to or during discharge, appropriate verbal and written post-discharge instructions must be provided to the patient as well as the accompanying adult as indicated unless the patient requests otherwise. Written discharge information must be written in plain language (a sixth grade reading level is recommended). When possible, a copy of the completed procedure report should be provided to the patient.

For a full list of evidence consulted in creating this resource, please see the accompanying document titled *Background and Resource Summary – The Early Quality Initiatives (EQIs) – Quality Improvement Resource Package for Endoscopy/ Colonoscopy.*

RATIONALE

The rationale of this document is to:

- Improve patient recall of endoscopy findings and the management plan
- Improve patient compliance with the management plan
- Decrease patient anxiety
- Increase patient knowledge about how to obtain final endoscopy results
- Improve patient understanding of what to do if complications arise after a colonoscopy
- Contribute to the provision of consistent discharge information to all patients, ensuring that key messages are available to all patients upon discharge

Disclaimer: We encourage you to use and benefit from these documents. However, please be aware that this document has been prepared for informational purposes only. The recommendations included in this document are not intended to take the place of the professional skill and judgment of health care providers.

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The College of Physicians and Surgeons of Ontario

GUIDELINES

Written discharge information must include the following key components:
1.0 Information about the patient, staff & facility ➤ Name of endoscopy facility & contact information ➤ Patient identifiers (e.g., name, age, DOB, sex, etc.) ➤ Date of procedure ➤ Name(s) of endoscopist and/or assistants, including names of trainees and/or fellows ➤ Name of referring physician
2.0 Description of procedure details& adverse events ➤ Name of endoscopic procedure that was performed ➤ Interventions that were performed, if applicable (e.g., biopsy, polypectomy). Include excision/resection details: o Number and location of biopsies and/or polyps o Excision/resection methods (e.g., snare ± cautery, hot biopsy, piecemeal versus en bloc resection, etc.) ➤ Description of adverse events (intra- and/or post-procedure), including documentation of interventions and outcomes (if applicable)
3.0 Description of key findings ➤ Anatomical description and/or diagram of major and minor findings, using standard terminology and descriptors ➤ Overall impression, using standard terminology and descriptors
4.0 Description of management plan ➤ Instructions regarding medication prescriptions (if applicable). Specific instructions about restarting anti-coagulation medications must be provided (if applicable). ➤ Plan for communicating histopathology results (if applicable) ➤ Description of the discharge plan and immediate follow-up plan, including details regarding additional tests and/or referrals that are indicated as well as any medication changes (if applicable) o If the follow-up plan will be determined once the final histopathology report is available, state that this is the case o If the follow-up plan differs from standard practice, state the reason(s) for the discrepancy

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5.0 Description of common side effects & potential complications

- Description of common colonoscopy side effects that are normal and will pass, including:
  - o Discomfort and/or tenderness at the IV site
  - o Bloating and/or abdominal cramping from insertion of air during the procedure
  - o Soft and/or abnormal bowel movements
  - o Light bleeding and/or streaks of blood in stool on the day of the procedure and for a few days after the procedure
  - o Dehydration
  - o Headache
  - o Light-headedness and/or drowsiness (if sedation and/or analgesia was administered)

- Description of concerning and/or unexpected symptoms and actions to take if the patient experiences these symptoms (e.g., call the colonoscopy facility, go to the nearest emergency room). For example, most colonoscopy-related complications occur within 48-72 hours after the procedure. If you experience any of the following symptoms or if you have other concerns, call your endoscopist [insert telephone number] or go to the nearest emergency department.
  - o Rectal bleeding other than minor spotting (bloody, black, or tarry stools) within 2 weeks of the procedure
  - o Fever or chills
  - o Severe abdominal pain or bloating that does not pass
  - o Chest pain
  - o Difficulty breathing

6.0 Instructions regarding activity, diet & medications

- Colonoscopy facilities must have standards for 24 hour activity restrictions for those patients who receive sedation or analgesia. Patients who receive sedation or analgesia and their accompanying adult must be informed of the effects of sedation/analgesia and instructions regarding 24 hour activity restrictions must be provided in the written discharge information. The Canadian Association of Gastroenterology (CAG) and the Canadian Anesthesiologists' Society (CAS) have published relevant guidelines regarding activity restrictions. Activity restrictions listed in the discharge information may include, but are not limited to, the following:
  - o No driving and/or operating vehicles/machinery
  - o No use of power tools/appliances
  - o No consumption of alcohol or other sedative drugs
  - o No significant decision-making
  - o No heavy exercise
- Instructions for resuming prescription medications (if applicable; e.g., anticoagulants)
- Instructions regarding diet and fluid intake (if applicable)

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4. Pre- and post-procedure guidelines and checklists for endoscopy facilities

Quality Management Partnership

INTENDED USE OF THIS RESOURCE

This resource includes two components:

- Guidelines outlining the minimum requirements for patient information that should be collected, and, activities that should be completed prior to and after a colonoscopy procedure
- Three sample checklists including a *Day-of Procedure Pre-Procedural Checklist, Procedure Room Pre-Procedural Checklists and Post-Procedural Checklist*

The Partnership suggests that:

- Facilities use the pre- and post-procedure guidelines to compare their current processes to those outlined in the guidelines to identify existing gaps and to ensure that the minimum requirements outlined in these guidelines are integrated into the facility's provision of colonoscopy services.
- Where facilities are completing the activities recommended in the guidelines **but may not be adequately documenting the completion of important pre- and post-procedure activities, the three checklists provided may be used to efficiently document the completion of these activities.**

> *The intent of providing these sample checklists is not to duplicate existing processes for documentation. If the completion of the activities outlined on the checklists are documented using existing clinical documentation processes, the Partnership does not prescribe the use of the checklists provided.*

For a full list of evidence consulted in creating this resource, please see the accompanying document titled *Background and Resource Summary – The Early Quality Initiatives (EQIs) – Quality Improvement Resource Package for Endoscopy/ Colonoscopy.*

BACKGROUND

The following resource, including pre- and post-guidelines and the three accompanying checklists aim to:

- ensure that all important activities are completed prior to and after a colonoscopy is performed
- improve communication within the care team and between the care team and the patient
- standardize pre- and post-procedural activities across Ontario facilities

Note: The *Out-of-Hospital Premises Inspection Program (OHPIP) Program Standards* (2013) published by the College of Physicians and Surgeons of Ontario (CPSO) were reviewed during the development of this tool and its content generally aligns with these standards. One area of distinction is the requirement for a "surgical pause". The *OHPIP Program Standards* companion document (*Guide to Applying the Out-of-Hospital Standards in Endoscopy/Colonoscopy OHPs/ IHFs, 2014*) indicates that a "surgical pause" is not required for endoscopy/colonoscopy premises and that it is sufficient to conduct a two-stage verification process where the patient and the intended procedure is verified and documented by two different premises staff. However, the following guideline does include components to be verified by the care team immediately prior to endoscope insertion because this will enhance communication within the care team and prepare them adequately for the procedure.

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