Royal Cornwall Hospitals
NHS Trust

Trans-Nasal Endoscopy Service Standard Operating Procedure

V1.1

October 2024

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1. Introduction

1.1. This document outlines the local safety standards for invasive procedures carried out within the endoscopy service at satellite clinics for Trans-Nasal endoscopy.

1.2. This version supersedes any previous versions of this document.

1.3. It is compliant with all national safety standards for invasive procedures.

1.4. Trans-Nasal endoscopy (TNE) is a procedure undertaken by endoscopy services using an ultra-thin gastroscope. The scope is passed via the nose and serves as an alternative provision for diagnostic upper gastrointestinal investigations, +/- biopsies. Scope size is between 5 - 6 mm in diameter; the biopsy channel is also thinner than standard gastroscope at 2 – 2.4 mm in size. All other connections and functions are like the standard trans-oral gastroscope and utilise the same stacking equipment (Olympus scope and stack used at RCHT for TNE).

1.5. If unable to access both nostrils, there will be an attempt via the mouth with the same scope. If that fails, the patient will need booking for re-scope with sedation.

1.6. The indications for trans-nasal are like those for gastroscopy.

1.7. The advantage of TNE endoscopy over gastroscopy is that most patients find the procedure more comfortable, and often have little gagging. Patients can talk during the procedure and can be discharged straight after the procedure, with no recovery time needed. With patients not requiring sedation, they do not need to be accompanied for the procedure and can drive themselves home. Patients are also able to resume normal work and activities following the procedure.

1.8. Due to the thinner diameter of the scope, it can sometimes become floppier in some individuals with difficult anatomy. Large hiatus hernias or previous surgery/trauma can limit the advancement of the scope by the endoscopist. The smaller working channel also limits the range of endoscopic accessories, but more modern scopes have enabled wider accessory availability and scope suction has also been improved. Though biopsies taken with TNE scopes are of a smaller size, they are of comparable diagnostic accuracy.

1.9. TNE has similar risks for perforation (1 in 10,000) and bleeding (1 in 5000) as OGD but causes less cardiovascular stress thereby useful in high-risk cardiac patients or elderly. It also induces less gagging, so fewer patients experience a sore throat post procedure. An additional risk carried by TNE is bleeding from nose (epistaxis) which is minimal in most cases and can be rectified in most cases by pinching the nose and sitting with the upper body pushed forward.

1.10. The procedure carries a potential risk of transmitting CJD/vCJD by breaching olfactory mucosa. (See RCHT Patients who are Symptomatic or at increased risk of transmissible Creutzfeldt–Jakob disease (CJD) Policy).

1.11. The procedure is highly ambulatory and does not require the typical lying down position and can be performed in a sitting position; thereby there is no need for a bigger room and could also be performed in a clinic setting. TNE scope along with stack, a chair for the patient, along with some accessories such as biopsy forceps and nasal spray mostly suffice for a regular TNE procedure.

1.12. This SOP should be read in conjunction with the following documents:

- Endoscopy Unit Procedure Room Clinical Guideline.
- Endoscopy Unit Practice Standards Clinical Guideline.
- Consent to Examination or Treatment Policy.
- Decontamination Policy.
- Recording Physiological Observations and NEWS2 in Adults Clinical Policy.
- Incident Management Policy.
- Safety Standards in Surgery and Invasive Procedures.
- Use of Formalin Policy.

1.1. **Abbreviations:**

Acronym	Information
AER	Automatic Endoscope Preprocessor.
BNF	British National Formulary.
BSG	British Society of Gastroenterology.
CAL	Clinical Admin Lead.
CJD	Creutzfeldt-Jacob disease.
CLO	Campylobacter-Like Organism.
DO	Diagnostic Oesophago-gastro duodenoscopy (Gastroscopy).
DOPS	Direct Observational of Practical Skills.
DNA	Did Not Attend.
ED	Emergency Department.
ENT	Ear, Nose and Throat department.
ESGE	European Society Gastrointestinal Endoscopy.
GI	Gastrointestinal.
HESA	Health Edge Scope Application.

Acronym	Information
ILS	Intermediate Life Support.
INR	International Normalised Ratio.
JAG	Joint Advisory Group.
NEWS	National Early Warning Score.
PGD	Patient Group Directive.
POP	Pharmacy Ordering Portal.
PPE	Personal Protective Equipment.
RCH	Royal Cornwall Hospital.
RCHT	Royal Cornwall Hospitals Trust.
SOP	Standard Operating Procedure.
TCI	To Come In.
TNE	Trans-Nasal Endoscopy.
vCJD	variant Creutzfeldt-Jacob disease.
WCH	West Cornwall Hospital.
WHO	World Health Organisation.
2WW	Two Week Wait.

2. Purpose of this Standard Operating Procedure

2.1. The aim of this Standard Operating Procedure (SOP) is to:

2.1.1. Outline safe working procedures relating to the provision of trans-nasal endoscopy in satellite clinics.

2.1.2. Standardise the safe, efficient, and effective practice required for the preparation, care and recovery of patients undergoing a trans-nasal endoscopy.

2.1.3. Identify the standards required by all staff, involved with the trans-nasal endoscopy service so they are clear to the standards expected.

3. Ownership and Responsibilities

3.1. The Trans-nasal Endoscopy Service in Satellite clinics is shared care between the responsible clinician, the Service Manager for Gastroenterology, bookings team, Clinical Matron, Endoscopy Unit Leader, endoscopy pre-assessment service, endoscopy nursing team and decontamination team, each having their own distinct responsibility to ensure the best outcome for the patients.

3.2. **Role of the Referrer**

The Referrers are responsible for:

- Referring only eligible patients for a TNE in accordance with 4.2.6.1.
- Completing detailed referral.

3.3. **Role of the Consultant Nurse (Clinical Endoscopist)**

The Nurse Consultant is responsible for:

- Constructing and managing the TNE Vetter of the week rota.

3.4. **Role of the Clinical Endoscopist (Vetting Service)**

Clinical Endoscopists are responsible for:

- Vetting patients when allocated on TNE Vetter of the week rota.
- Vetting patient identified by the booking office.

3.5. **Role of the Clinical Endoscopist (Undertaking Procedure)**

Clinical Endoscopists are responsible to:

- Be familiar with this SOP.
- Complete all required training to work in the TNE Service.
- Read and sign all appropriate PGD's related to the TNE Service.
- Maintain patient records on the HICCS Reporting System.
- Communicate with patients declining procedures on the day.
- Be aware of patient's vital signs and respond to escalations.
- Follow 5 Steps of Safer Surgery.
- Deliver list Team Brief and Debrief.
- Discharge patient straight from procedure room giving procedural findings and discharge information.
- Reconfirm consent verbally when converting from Trans-Nasal to Oral Procedure.

3.6. **Role of the Service Manager**

The Service Manager is responsible for:

- To be familiar with this SOP.

- To be a point of escalation regarding the service.
- To provide senior management support to colleagues operating this service.
- Monitor compliance of this SOP and escalate to appropriate responsible person / team for resolution where compliance not met.
- Monitor and co-ordinate capacity and demand of service.

3.7. **Role of the Clinical Admin Lead**

The Clinical Admin Lead is responsible for:

- To be familiar with this SOP.
- Ensuring that the standards and practises detailed in this SOP are shared with the administration teams.
- Ensuring standards are adhered to.
- Ensuring that colleagues are appropriately trained to work in the service.
- Validating of referrals and monitoring patient bookings within six weeks of their due date.

3.8. **Role of the Booking Office**

All staff members are responsible for:

- Screening TNE Referrals in accordance with 4.2.2.1.
- Communicate patients for vetting with the TNE Vetter of the week.
- Add patients to pre-assessment service.
- Add patients to the TNE waiting list.
- Booking patients in clinical urgency and then chronological order.
- Booking utilising all capacity (Up to 20 procedures).
- Sending correspondence and patients information to patients.

3.9. **Role of the Clinical Matron**

The Clinical Matron is responsible for:

- To be familiar with this SOP.
- To be a point of escalation regarding the service.
- To provide senior nursing support to colleagues operating this service.
- Monitor compliance of this SOP and escalate to appropriate responsible

person / team for resolution where compliance not met.

- Monitor and co-ordinate quality and safety issues within the service.

3.10. **Role of Unit Leader Endoscopy**

The Unit Leader is responsible for:

- To be familiar with this SOP.
- Ensuring that the standards and practises detailed in this SOP are shared with clinical team.
- Ensuring standards are adhered to.
- Ensuring the appropriate staffing levels are allocated to the service.
- Ensuring that colleagues are appropriately trained to work in the service.
- Ensure colleagues read and sign all appropriate PGD's related to the TNE Service.
- Assess and maintain the Risk Assessment for the use of Formalin.

3.11. **Role of Endoscopy Pre-Assessment**

The Endoscopy Pre-Assessment Service is responsible for:

- Completing timely pre-assessment of all TNE patients on both standard and urgent pathways.

3.12. **Role of Decontamination**

The Decontamination Service is responsible for:

- The decontamination and preparation of Endoscopes.
- Transporting TNE Service vehicle and equipment.

3.13. **Role of Individual Colleagues**

All staff members are responsible for:

- Read and sign all appropriate PGD's related to the TNE Service.
- Complete all required training to work in the TNE Service.
- Obtained informed consent for procedure.
- Admit and care for patients who are accessing the TNE Service.
- Support patient and their family/friend when there is a wish that they are present for admission process / procedure.

- Provide information and where appropriate escalate concerns / patients declining procedure to the Clinical Endoscopist.
- Communicated declined, cancelled on the day and DNAs to the booking office.
- Monitoring, record, respond and escalate when appropriate to patient's vital signs.
- Maintain traceability of scopes and their use through the HESA system.
- Prepare scopes ready for procedure.
- Complete 'bedside clean' of scopes as per (Appendix 8).
- Monitor medication stock levels and reorder as required.
- Monitor sundry equipment stock levels and restock to the agreed stock levels in the care cart. (Appendix.7).

4. Standards and Practice

4.1. List Management and Scheduling.

4.1.1. Referrals

The procedure is referred through an electronic based referral system (Called Electronic Referral System - ERS) direct from GP or internal referrals (via Maxims).

4.1.2. Vetting

4.1.2.1. The referral is screened by the Booking Office according to set suitability criteria in section (4.3.6.1).

4.1.2.2. Those patients who meet the criteria are added to a list and then sent electronically to the TNE Vetter of the week.

4.1.2.3. This will happen daily (each weekday excluding bank holidays).

4.1.2.4. These patients are added to the code VT (vetting).

4.1.2.5. The TNE Vetter of the week will document suitability for the procedure in the 'notes section' on the referral on maxims and notify the booking office mailbox when the total list of patients has been vetted.

4.1.2.6. Once vetted the patients will be processed by the Booking Office.

4.1.2.7. Those patients who do not meet the criteria will be processed for a procedure on the acute hospital site using standard process.

4.1.2.8. The TNE Vetter Rota will be constructed by the Nurse Consultant (Clinical Endoscopist) and will include our Upper GI Clinical Endoscopist colleagues.

4.1.2.9. Those assigned to this rota are accountable for any cover arrangements when unable to complete this duty.

4.1.3. Pre-Assessment

4.1.3.1. All patients will be offered pre-assessment.

4.1.3.2. Patients on the standard pathway will need to complete pre-assessment prior to procedure.

4.1.3.3. Patients on the Urgent pathway will be encouraged to complete pre-assessment, but it will not inhibit meeting the 2WW standard.

4.1.4. Booking

4.1.4.1. Patients are placed on the waiting list for a TNE procedure at a satellite clinic after vetting and are moved to DO code (Diagnostic OGD)

4.1.4.2. Patient are added to the Ultramed R System for pre-assessment after successful vetting and an electronic link is sent to the patient for completion. This is a different link to the standard pre-assessment questionnaire.

4.1.4.3. Patients are allocated a TCI (To Come In) according to clinical urgency and then chronological date order.

4.1.4.4. Patients on an urgent pathway are given a TCI without confirmation of completion of pre-assessment.

4.1.4.5. Patients on a standard pathway are only given a TCI once completion of pre-assessment.

4.1.4.6. All planned / surveillance cases are booked within six weeks of their due date.

4.1.4.7. Validation of referrals and monitoring of patient bookings occur daily by the Team Leader and Clinical Admin Lead (CAL).

4.1.4.8. Capacity and demand at different sites are coordinated by the administration team supported by their manager.

4.1.4.9. Each all-day list will have capacity for a maximum of 16 procedures.

4.1.4.10. The lists are expected to start at 08:00hrs and conclude at 18:00hrs.

4.1.4.11. The day will be broken down into an AM and PM session.

4.1.4.12. On commencement of service capacity will be agreed and built up to the agreed model of service delivery.

4.1.4.13. The agreed maximum model of capacity is: 16 (8 AM and 8 PM).

4.2. Inclusion / Exclusion Criteria

4.2.1. Booking Office Criteria

4.2.1.1. The booker will screen referrals and move to the standard process (for TNE or Gastroscopy) all those patients that are included in the below contraindications list, due to their suitability for a TNE in a satellite clinic.

4.2.1.2. These patients will follow the process to have their procedure at either RCH or WCH hospital sites.

4.2.2. Service Criteria

4.2.2.1. Contraindications for TNE in satellite clinics:

4.2.2.2. Patient history of frequent epistaxis.

4.2.2.3. Known abnormalities in nasopharynx.

4.2.2.4. Recent surgery (6 weeks) or history of trauma to nose / palate / nasopharynx.

4.2.2.5. Patients referred for Barrett's surveillance.

4.2.2.6. Patients requiring any endoscopic intervention apart from biopsy.

4.2.2.7. Hereditary haemorrhagic telangiectasia.

4.2.2.8. Patients with known hiatus hernia.

4.2.2.9. Patients identified prior to the day of procedure as requiring Form 4 Consent.

4.3. Pre-Assessment

4.3.1. Patient will be pre-assessed on the Ultramed system.

4.3.2. Patient will be pre-assessed using a specific shortened questionnaire specifically designed for the TNE procedure in satellite clinics.

4.4. Patient Preparation

4.4.1. Patient prior to procedure will receive a letter detailing appointment information, instructions, and a Patient Leaflet Nasal Gastroscopy (RCHT 2041) (Appendix 3).

4.4.2. Information sent to the patient in 4.5.9 will include details about the procedure, preparation, aftercare.

4.4.3. Patients must be fasted for 6 hours before procedure.

4.4.4. Sips of water with medications are allowed up to 2 hours before procedure.

4.4.5. Patients on antiplatelet or anticoagulant therapy will follow current national guidelines: “Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update”.

4.4.6. On the day patients will be prepared in an admission room allocated by Departmental Sister, where should they wish a third party (family/friend) be present this will be facilitated and supported by the clinical team.

4.4.7. During admission the team will confirm that the patient has no communication needs or mental capacity needs and note this in the nursing record. Should there be any problems, these must be resolved before continuing with the admission.

4.4.8. The Registered Nurse who admits the patient will:

- Confirm with the patient that patient details are correct (medical notes, patient labels, wrist band, ensuring minimum of 3 sheets of labels/wristband), This will be confirmed with the patient.
- Apply wristband.
- Confirm Nil by Mouth Status (and escalate non-compliance to the Endoscopist).
- Discuss the procedure highlighting patient understand the risks and alternatives.
- Ensure the patient has a realistic expectation of discomfort and may withdraw consent.

4.4.9. Should the patient decide not to have the test at this point, the Endoscopist will be informed.

4.4.10. The patient will be offered and opportunity to talk with the Clinical Endoscopist who will review and discuss risks and benefits with the patient.

4.4.11. If the outcome of this discussion results in no procedure the booking office will be informed, and a letter will be sent to the referrer via the booking office.

The Nursing Team will inform the booking office of 4.5.17 via email to the generic rch-tr.adminendoscopy@nhs.net email.

4.5. Room Preparation

4.5.1. The satellite procedure room will be unlocked by the relevant onsite

representative.

4.5.2. Colleagues will set the room up as in accordance with published guidelines: Endoscopy Unit Procedure Clinical Guideline and Endoscopy Unit Practice Standards Clinical Guideline.

Additional standards due to offsite location are:

- Car cart will be transported and delivered by the TNE Service Vehicle.
- Medication needs to be collected from the designated onsite storage area (or transported locked box) and then stock levels checked for the listed activities.
- The Endoscopy Stack System will be collected from the designated onsite storage area (or TNE Service Vehicle) and set up in the procedure room.
- Specific procedural medications will be prepared in line with this SOP.
- Observations and emergency equipment will be tested at the start of each list.

4.6. Consent

4.6.1. Clinical Teams will use the procedure specific consent form entitled 'Trans-nasal Endoscopy' (CHA4839)Transnasal Upper GI Endoscopy (Appendix 4).

4.6.2. Consent is completed by a trained clinician (Medical, Nursing or AHP).

4.7. The Procedure

4.7.1. TNE is performed on patients that are not sedated.

4.7.2. Topical nasal anaesthesia is used for the procedure (Lidocaine Hydrochloride 5% w/v and Phenylephrine Hydrochloride 0.5% spray).

4.7.3. This medication is covered by a Patient Group Directive (PGD) END-12.

4.7.4. This medication vial and applicator is single patient use.

4.7.5. The procedure is performed with the patient in the upright seated position.

4.7.6. Nasal anaesthesia spray is prescribed on a paper chart by an endoscopist, or administration is covered by the appropriate PGD.

4.7.7. Nasal anaesthesia spray is administered by the Registered Nurse to both nostrils prior to entering the procedure room. During patient's preparation, this is administered 10 to 30 minutes before the procedure.

4.7.8. 4 sprays initially into each nostril (Divided into 2 sets of 2 administrations and equivalent to Lidocaine Hydrochloride 5% w/v 26mg and Phenylephrine Hydrocloride 0.5% 2.6mg) is sprayed in accordance with the guide in appendix 9.

4.7.9. Infacol (simethicone) (5mls) with sterile water (45mls) is administered to all patients prior to nasal anaesthesia, during the admission process by the registered nurse. This helps to reduce bubbles in the stomach allowing the endoscopist a clear view.

4.7.10. Infacol can also be used as a flush during the procedure through the endoscope channel.

4.7.11. This preparation will be mixed as a concentration of 22mls of Infacol to 1000ml of sterile water (equating to ¼ strength of pre-medication drink).

4.7.12. Flushing of the endoscope will not exceed 150ml of this solution (132mg dose).

4.7.13. This flush will be recorded on the procedure report.

4.8. Biopsies.

4.8.1. The collection and recording of biopsies will be standard practice and colleagues will follow ENDO 19 Process: Specimen processing in room.

4.8.2. Biopsies obtained at Satellite Clinics will be collected on their routine specimen collection round.

4.9. Converting from Trans Nasal Endoscopy to Oral Approach.

4.9.1. Where it is not possible to pass the nasal scope through the nasal cavity (Due to narrowing nasal tubes, nasal pathology, or patient discomfort) the patient will be offered the opportunity to have the procedure via the mouth.

4.9.2. The same nasal scope will be used.

4.9.3. Consent will have been gained for converting approach before the start of the procedure as part of the standard consenting process. This would be re-confirmed prior to conversion.

4.9.4. Additional local anaesthetic throat spray, Topical Xylocaine (lidocaine hydrochloride 10%), will be administered by the Endoscopist.

4.9.5. The patient will be positioned left laterally.

4.9.6. A mouth guard will be positioned to protect the scope and patients' teeth.

4.9.7. On converting to the oral approach (Gastroscopy) the additional

colleague in patient admission will be called into the procedure room to maintain the patient's airway.

4.10. Patient Monitoring and Escalation of Care

4.10.1. Patient Monitoring.

4.10.1.1. Patients will have a pre-procedure Blood Pressure on admission.

4.10.1.2. Patients will be monitored throughout the procedure with the following standard observations:

- Oxygen Saturations.
- Pulse rate.
- Consciousness.
- Patient comfort.

4.10.1.3. Additional observations can be taken at the discretion of the responsible practitioner.

4.10.1.4. Standard observations taken during the procedure are documented on The Patient Profile (CHA4010).

4.10.1.5. Additional Patient observations will be recorded on a NEWS Chart (Appendix 5).

4.10.2. Escalation of Care.for the Deteriorating Patient.

4.10.2.1. In the event of a sick and deteriorating patient colleagues will escalate as appropriate and follow local site action plans to summon help. Following local policy and procedures.

4.10.2.2. The sites Resuscitation Trolley, Emergency Equipment and Oxygen will be available for the service.

4.10.2.3. Colleagues should at the beginning of a list highlight the policy and process of escalation of care prior to the commencement of the list.

4.10.2.4. Where required colleagues will call 999 for Emergency Response.

4.10.3. Epistaxis.

4.10.3.1. Epistaxis is a recognised complication during a TNE.

4.10.3.2. Where standard first aid actions do not stop bleeding and for patients whose epistaxis does not settle with pressure, a Naso-Pore Sponge or a Rapid-Rhino^{R} should be inserted.

4.10.3.3. The Endoscopists will be trained in how to deal with this

medical emergency.

4.10.3.4. The Registered Nurses will be trained in supporting the Clinical Endoscopist with this medical emergency.

4.10.3.5. Colleagues will follow Guidance on the management of Epistaxis (Appendix 11).

4.10.3.6. Epistaxis is a recognised complication and should be recorded on the hospital's incident management system.

4.10.3.7. In the rare event that bleeding is severe the patient will be transferred to the Royal Cornwall Hospital Emergency Department to be seen by ENT.

4.11. Patient Discharge

4.11.1. Patients are discharged after their procedure using a Criteria Led Discharge.

4.11.2. Criteria for Discharge:

- The patient must be comfortable.
- There are no signs of bleeding from the nose (Epistaxis).

4.11.3. Information and Advice on Discharge.

- Patients are provided with a copy of the procedure report and verbally informed regarding findings.
- If malignancy is suspected patients will be counselled about the next steps of their pathway.
- Patients are provided with a patient advice leaflet – 'Following your gastroscopy' (Upper GI endoscopy / OGD) (RCHT275) – This leaflet includes guidance on when they are able to eat and drink, emergency contact details and follow up plans.

4.12. Procedure Reporting and Results

4.12.1. The procedure is recorded on the HICCS system (Scorpio).

4.12.2. A copy of the procedure report is given to the patient.

4.12.3. A copy of the procedure report is sent to the referrer automatically.

4.12.4. Internal referral results are seen on Maxims.

4.12.5. External referral results are emailed from HICCS system (Scorpio) straight to referrer.

4.12.6. Histology results are sent to referrer to review and action.

4.13. Decontamination

4.13.1. Decontamination Provision.

4.13.1.1. Scopes will be provided, decontaminated and ready to clinically use using SURESTORE Storage and Endoscope Transport System.

4.13.1.2. Prior to clinical use the Endoscopes will require flushing with normal saline for 30 seconds as per appendix 8 due to the SURESTORE™ Storage and Endoscope Transport System using hydrogen peroxide 3% during the decontamination and storage process.

4.13.1.3. Endoscopes after use will be socially cleaned by the clinical team and correctly packaged.

4.13.1.4. Endoscopes will be decontaminated after use at the Royal Cornwall Hospital main site.

4.13.2. Home Site to Vehicle Process.

4.13.2.1. Scopes will be vacuum packed using SURESTORETM.

4.13.2.2. Scopes will be transported in lockable cabinet trolleys.

4.13.2.3. The cabinet trolleys will be directly loaded into the transport vehicle by a decontamination representative and secured using the brakes on all 4 wheels.

4.13.3. Vehicle to Clinic Setting.

4.13.3.1. At the destination the cabinet trolley is wheeled to a designated ‘clean area’ and opened by a colleague from the decontamination team.

4.13.3.2. Once at the designated ‘clean area’, the scopes will then be removed from the lockable cabinet and placed in the holding stack ready for use by a colleague from the decontamination team.

4.13.3.3. The lockable cabinet trolley will then be placed in a designated ‘dirty’ area ready to be able to receive the ‘used’ scopes.

4.13.4. Endoscope Preparation.

Colleagues will prepare scopes ready for use using the guide in Appendix 8.

4.14. Documentation

4.14.1. The patient records will be held in a legacy folder on the day; an administrator at the satellite site will create these folders.

4.14.2. The created patient record will include Patient Profile, Procedure Specific Consent Form and Printed Referral from Maxims.

4.14.3. Paper Records.

4.14.3.1. Patient profile (CHA 4010).

4.14.3.2. Procedure Specific Consent Form / Consent Form 1.

4.14.3.3. Prescription Chart.

4.14.3.4. NEWS Chart.

4.14.4. Electronic Records.

4.14.4.1. MyEndo – Pre-Assessment Document.

4.14.4.2. HICSS Scorpio Reporting System.

4.14.4.3. MAXIMs.

4.15. WHO Surgical Safety Checklist

4.15.1. TNE lists will adhere to the 5 steps of safer surgery.

4.15.2. The WHO Surgical Safety Checklist for Endoscopy will be used for all patients (Appendix 6).

4.15.3. Step 1: Team Brief.

4.15.3.1. The Endoscopist performing the procedure is responsible for delivering and ensuring that the Team Briefing occurs.

4.15.3.2. All team members must be present when the safety briefing takes place.

4.15.3.3. All non-essential activity is to cease to enable colleagues to listen and concentrate.

4.15.3.4. The Team Brief will be conducted in the clinical room where the procedure will be carried out.

4.15.3.5. The briefing will include:

- Introductions
- List order
- Equipment required.
- Local policy for escalation of care

4.15.4. Step 2: Sign-In.

4.15.4.1. This forms the final safety checks that must be completed for all patients undergoing endoscopy before the start of the procedure, and should be undertaken as follows:

- The sign in will take place in the procedure room.
- The patient will have to confirm details throughout the WHO checklist verbally.
- Any omissions, discrepancies or uncertainties must be resolved before proceeding.
- This will be led by the endoscopist.
- All team members must be present and engaged is the process.

4.15.5. Step 3: Timeout.

Not completed in Endoscopy Service as part of WHO.

4.15.6. Step 4: Sign out.

Sign out must occur before the patient leaves the procedure area this, is completed by the practitioner in the room and the endoscopist **This should be a clear stop moment**.

This includes:

WHO sign out appears not to have been carried out ensuring all staff members were engaged.

- Confirmation of procedure/completion.
- Confirmation that specimens have been labelled correctly (as required).
- Discussion of post-procedural care and any concerns.
- Endoscopy report has been completed.
- Equipment problems (include in team debriefing).
- Comfort score.
- All documentation leaves the room with the patient.
- Patient leaves the room only when all documentation is completed.

4.15.7. Step 5: Debriefing.

4.15.7.1. A team debrief takes place in the procedure room at the end of the list.

4.15.7.2. The Endoscopist will lead the debrief.

4.15.7.3. All team members must be present during team debriefing. The debrief includes:

- Things that went well.
- Any problems with equipment or other issues.
- Areas for improvement
- An action log.
- A named person for escalating issues.

4.16. Resources

4.16.1. Equipment.

4.16.2. A standard list of sundry equipment will be provided and transported to the satellite clinics in the service vehicle to support clinic provision (Appendix 7).

4.16.3. Sundry equipment will be stored in a care cart and transported in the service vehicle.

4.16.4. A standard list of medications will be either provided and transported to the satellite clinics in the service vehicle, or with agreement stored locally to support clinic provision (Appendix 7).

4.16.5. Medications will be securely stored in a locked cupboard or in a transported locked box.

4.16.6. The Endoscopy Unit Registered Nurse at the end of the list will review stocked medication and order medications up to agreed stock level.

4.16.7. Medications for satellite sites will be ordered on POP (Pharmacy Ordering Portal) by the Endoscopy Registered Nurse for delivery at the satellite site.

4.16.8. Colleagues at the satellite site will accept medication and store in a dedicated area for the TNE Service.

4.16.9. The equipment and other emergency medications will be checked and restocked by a nominated colleague in the Endoscopy Unit the following day.

4.16.10. Formalin.

4.16.10.1. The use of Formalin will be governed by the ‘Use of Formalin policy’.

4.16.10.2. Colleagues should also note the satellite site policy ‘IC/015/23 Cleaning Strategy, Policy and Manual.’

4.16.10.3. The stock will be order as part of routine practice in The Endoscopy Unit.

4.16.10.4. Formalin pots will be transported in Histopathology red transport boxes.

4.16.10.5. The Risk in Endoscopy Practice will be assessed and recorded on the Trusts Risk Assessment System and shared with colleagues.

4.16.10.6. Each site will have its own Risk Assessment which will include communication and response plan.

4.16.10.7. Formalin spillages will follow the appropriate response as highlighted in the policy.

4.16.10.8. Spills will be recorded on the Trusts incident management system. In addition, it is a requirement to liaise with the Nurse in Charge for the Community Site to report on their incident management system.

4.16.10.9. Spills on a satellite site will require addition reporting and escalation: In Hours – Departmental Team Leader and Site Matron, Out of Hours – On call Manager via local Switchboard.

4.16.11. Workforce.

4.16.11.1. The minimum safe staffing levels and skill mix per procedure is:

- The Endoscopist.
- 1 Registered Nurse.
- 1 Healthcare Support Worker.
- 1 Decontamination Assistant.

4.16.12. Training.

4.16.12.1. Colleagues’ delivery the TNE lists will be Gastroscopy trained via the JAG Endoscopy Training System and must have completed Direct Observation of procedure or Skills (DOPS) assessment forms. In addition, they must spend time with the ENT service (two Clinics) and either have attended the ‘International Trans-nasal Endoscopy Training Workshop’ or a minimum of two observed lists under supervision of a TNE competent practitioner.

4.16.12.2. Endoscopists must have followed JAG Guidance in TNE training.

4.16.12.3. Colleagues must be up to date with mandatory / essential training identified.

4.16.12.4. All Endoscopists will have a current ILS certification.

4.16.12.5. The Registered Nurses will have a current ILS certification.

4.16.12.6. The Endoscopists will be trained in how to deal with the medical emergency of Epistaxis.

4.16.12.7. This will be recorded on Healthroster skills 'Management of Procedure Complication - Epistaxis'.

4.16.12.8. The Registered Nurses will receive training in an awareness of how to support in the treatment of the medical emergency of Epistaxis.

4.16.12.9. This will be recorded on Healthroster skills 'Awareness of Procedure Complication - Epistaxis'

4.17. Governance and Audit

4.17.1. Accidents, incidents and near misses will be reported on the trust incident management system.

4.17.2. The specialty governance structure and leadership team will communicate learning and actions required to the wider team.

4.17.3. The Trans Nasal Endoscopy Service will be reviewed as part of the generic audit review process and reported into the specialty governance framework.

4.17.4. Patient experience and feedback will be captured using the standard process.

5. Dissemination and Implementation

5.1. This procedure will be available on the organisation's document library.

5.2. There will be a hard copy available to view within the Endoscopy Unit and with the equipment for satellite clinics.

5.3. The endoscopy users' group will be responsible for the dissemination of this procedure to medical staff.

5.4. The departmental Unit Leader will be responsible for ensuring that the clinic staff have been suitably trained and orientated before delegating this duty.

5.5. The service manager will be responsible for ensuring that the administration colleagues have been suitably trained and orientated before delegating this duty.

5.6. The procedure will be emailed to existing specialty colleagues and highlighted at specialty business and governance meetings.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Training Compliance. Incidents and Trend Analysis. Complication Rates. Patient Experience. Endoscopist KPIs.
Lead	Speciality Triumvirate Leadership Team.
Tool	Personnel Records. Incident Reporting System. FFT. National Endoscopy Database.
Frequency	Ongoing monitoring through localised Business and Governance.
Reporting arrangements	Operational discussions reporting into ENDOMAX. Performance reports through Speciality Business and Governance Meetings into Care Group Care Board.
Acting on recommendations and Lead(s)	Specialty Triumvirate Team leading on recommended actions with departmental and sub-specialty leads.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a negotiated timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This SOP will be reviewed every three years or earlier depending upon national guidance and or local audit.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Trans-Nasal Endoscopy Service Standard Operating Procedure V1.1.
This document replaces (exact title of previous version):	Trans-Nasal Endoscopy Service Standard Operating Procedure V1.0
Date Issued / Approved:	October 2024.
Date Valid From:	October 2024.
Date Valid To:	October 2027.
Author / Owner:	Unit Leader Endoscopy.
Contact details:	01872 252113.
Brief summary of contents:	SOP setting out guidance for service delivery of the Trans-nasal Endoscopy Service on Satellite Sites.
Suggested Keywords:	Endoscopy, Trans-nasal, TNE, Satellite Sites.
Target Audience:	**RCHT:** Yes **CFT:** Yes **CIOS ICB:** Yes
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Speciality Triumvirate. Speciality Business and Governance Meeting. Care Group Triumvirate. Care Board.
Manager confirming approval processes:	Roz Davies, General Manager, Specialist Services and Surgery (SSS).
Name of Governance Lead confirming consultation and ratification:	Michele Reed – Deputy Governance Manager, (SSS).
Links to key external standards:	N/A.
Related Documents:	None required.

Information Category	Detailed Information
Training Need Identified:	Yes. Documented in SOP.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Gastroenterology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2023	V1.0	New	
September 2024	V1.1	Amended post Patient Safety Investigation Response Framework	Jan Crapp. Clinical Matron Specialist Services and Surgery.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Trans-Nasal Endoscopy Service Standard Operating Procedure V1.1.
Department and Service Area:	Endoscopy
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Jan Crapp Clinical Matron Specialist Services and Surgery.
Contact details:	01872 253439

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Endoscopy and support colleagues working within the TNE Service.
2. Policy Objectives	To ensure all staff are aware of the process is surrounding the TNE service.
3. Policy Intended Outcomes	Safe and appropriate care of patients using the TNE service. Staff are aware of standards in practise within the TNE service.
4. How will you measure each outcome?	Audit as stated.
5. Who is intended to benefit from the policy?	Colleagues and patients receiving care under the TNE Service.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: Yes • Local groups/ system partners: No • External organisations: Yes • Other: Yes
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Endoscopy Colleagues. CPFT Satellite Sites. Patients. Health Education England.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** None.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age.	No	
Sex (male or female).	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.).	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.).	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership.	No	
Pregnancy and maternity.	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.).	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

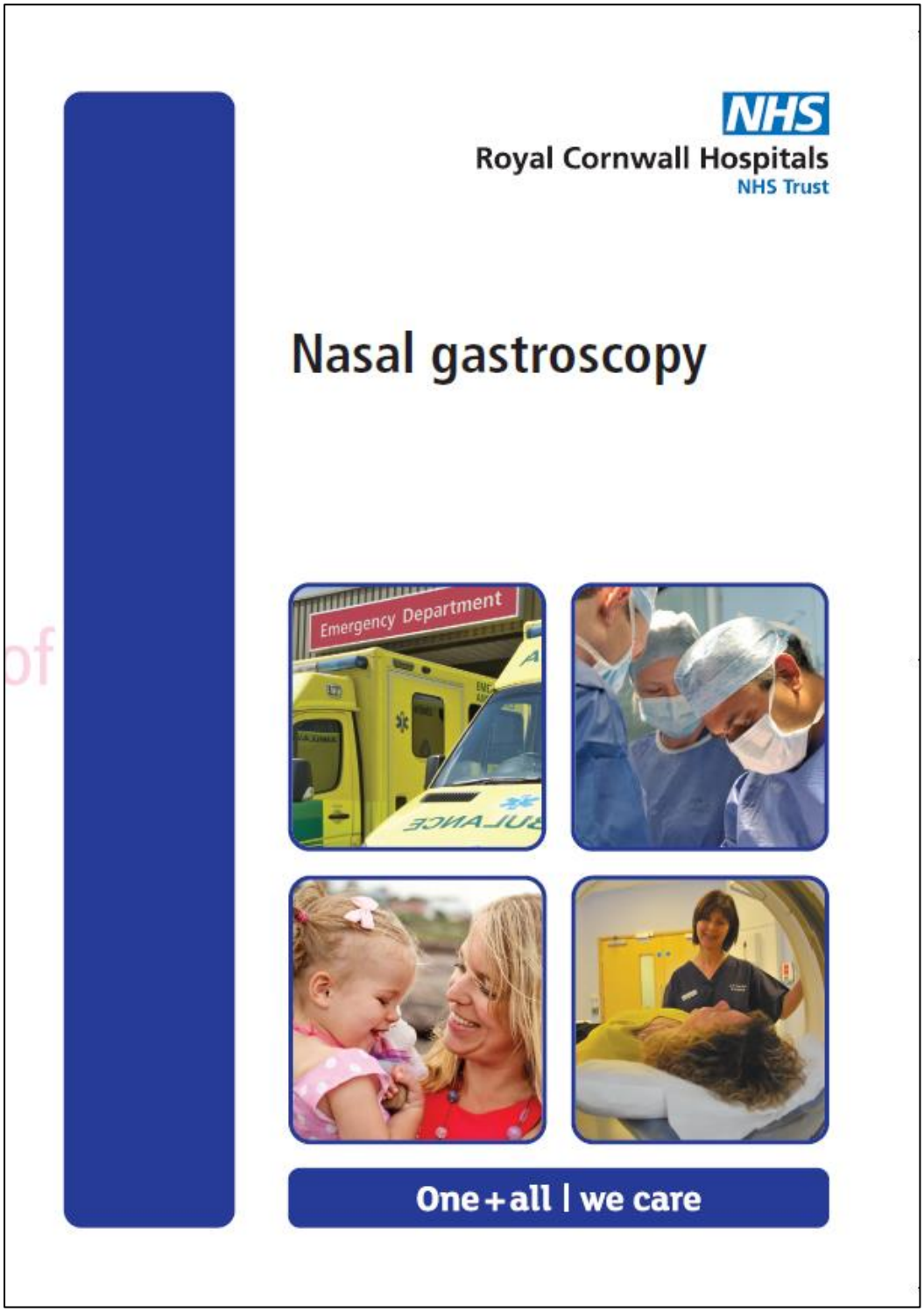
I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Jan Crapp Clinical Matron Specialist Services and Surgery.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Patient Information Leaflet Nasal Gastroscopy (RCHT 2041)

Sent by booking office.



Appendix 4. Procedure Specific Consent Form

Trans-nasal Upper GI Endoscopy - (CHA4839)[Transnasal Upper GI Endoscopy]

PLEASE PRINT WHOLE FORM DOUBLE SIDED ON YELLOW PAPER

Patient Information to be retained by patient

NHS
Royal Cornwall Hospitals
NHS Trust

Transnasal Upper GI endoscopy

affix patient label

What is this?

A transnasal upper GI endoscopy (sometimes called a nasal gastroscopy or TNE) is a procedure that allows the endoscopist to look directly at the lining of your oesophagus, stomach and around the first bend of your small intestine. A long flexible tube (gastroscope) with a bright light and camera at the end is passed through one of your nostrils, down into the back of the throat and then into your oesophagus.

Why do I need it?

We use this procedure to help diagnose and treat symptoms and conditions that affect your oesophagus, stomach and upper intestine. It can help find the cause of unexplained symptoms you may be having as well as diagnosing diseases such as gastric ulcers, oesophageal strictures and cancers.

Are there any alternatives?

The alternatives would be to either have a procedure called a barium swallow or barium meal. This would involve you drinking some fluid and X-rays being taken to enable the medical team to assess your ability to swallow and manage food and fluids. These do not allow us to collect any tissue samples and are also less informative than an endoscopic investigation.

How do I prepare for it?

You should have nothing to eat and drink for **6 hours** (and preferably overnight) before the procedure.

If this procedure is your first – please stop taking any of these medications for 14 days before your procedure:

- Omeprazole (Losec)
- Lansoprazole
- Pantoprazole
- Esomeprazole (Nexium)
- Ranitidine (Zantac)

If your procedure is for follow up on your condition – please continue to take these medicines. If your procedure is for an assessment for anti-heartburn or reflux surgeries, please stop these 10 days before.

If you are taking medication to thin your blood such as Warfarin or Clopidogrel your specialist should have discussed this with you and given you clear instructions. If they have not, please contact the department using the phone number in your letter. If you take Warfarin, please make an appointment at your GP surgery to have an INR test as close as possible to your procedure (maximum 3 days before). We may have to cancel your procedure if we do not have an up-to-date INR.

What does it involve?

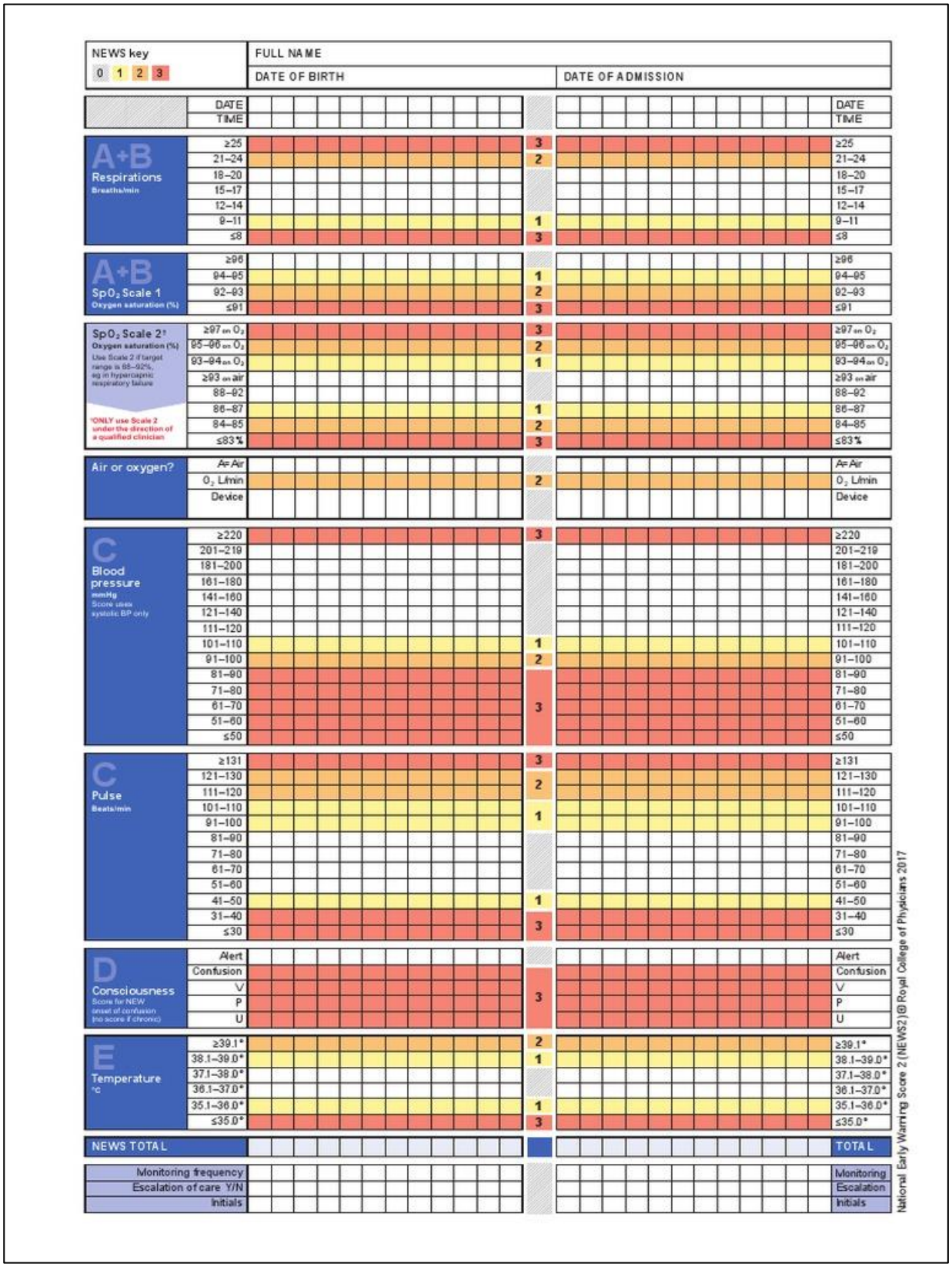
You will receive a letter with your appointment time – this is not the time your procedure will start but will ensure that the team have enough time to go through the paperwork and complete this consent documentation.

A healthcare professional will check your personal details, explain the procedure and ask you a few routine questions. They will want to know about any previous endoscopies, medical conditions and medication you are taking.

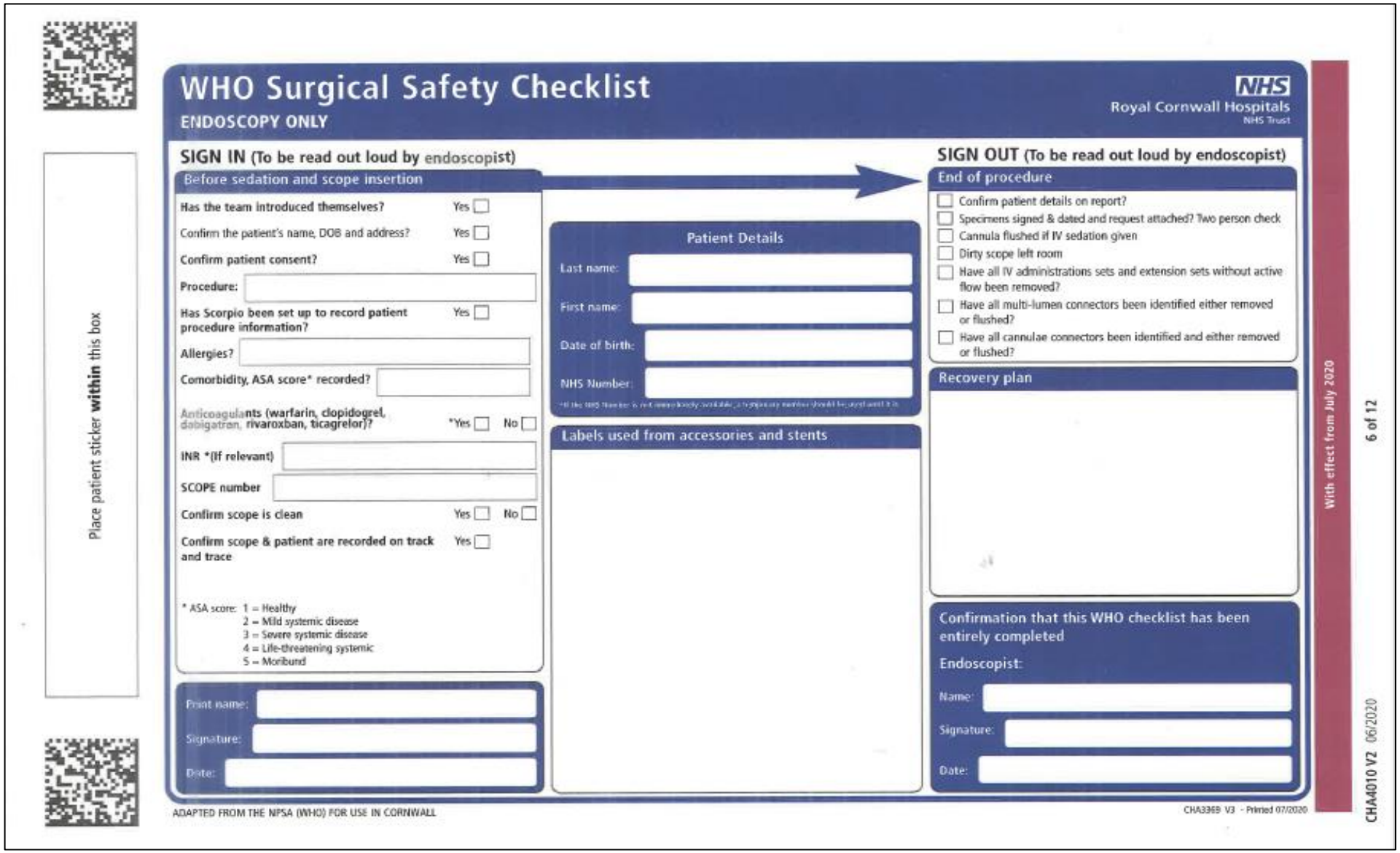
CHAXXXX V1
Printed 10/2023 Review due 10/2026

Appendix 5. NEWS Chart

Documentation of Patient Monitoring.



Appendix 6. WHO Surgical Safety Checklist [WHO Surgical Safety Checklist Link]



WHO Surgical Safety Checklist

ENDOSCOPY ONLY

NHS Royal Cornwall Hospitals NHS Trust

Place patient sticker **within** this box

SIGN IN (To be read out loud by endoscopist)

Before sedation and scope insertion

- Has the team introduced themselves? Yes ☐
- Confirm the patient's name, DOB and address? Yes ☐
- Confirm patient consent? Yes ☐
- Procedure:
- Has Scorpio been set up to record patient procedure information? Yes ☐
- Allergies?
- Comorbidity, ASA score* recorded?
- Anticoagulants (warfarin, clopidogrel, dabigatran, rivaroxban, ticagrelor)? *Yes ☐ No ☐
- INR *(If relevant)
- SCOPE number
- Confirm scope is clean Yes ☐ No ☐
- Confirm scope & patient are recorded on track and trace Yes ☐

* ASA score: 1 = Healthy
2 = Mild systemic disease
3 = Severe systemic disease
4 = Life-threatening systemic
5 = Moribund

Print name:
Signature:
Date:

Patient Details

Last name:
First name:
Date of birth:
NHS Number:

Labels used from accessories and stents

SIGN OUT (To be read out loud by endoscopist)

End of procedure

- ☐ Confirm patient details on report?
- ☐ Specimens signed & dated and request attached? Two person check
- ☐ Cannula flushed if IV sedation given
- ☐ Dirty scope left room
- ☐ Have all IV administrations sets and extension sets without active flow been removed?
- ☐ Have all multi-lumen connectors been identified either removed or flushed?
- ☐ Have all cannulae connectors been identified and either removed or flushed?

Recovery plan

Confirmation that this WHO checklist has been entirely completed

Endoscopist:

Name:
Signature:
Date:

With effect from July 2020

6 of 12

CHA4010 V2 06/2020

ADAPTED FROM THE NPSA (WHO) FOR USE IN CORNWALL

CHA3369 V3 - Printed 07/2020

Appendix 7. Equipment List

List of standard **sundry equipment** required for TNE Service.

Item	Quantity
50ml Syringes.	20.
Bag Valve mask.	1.
Biopsy Forceps.	3 full boxes.
Biopsy Squares.	40.
Blue Trays.	1 x large. 2 x small.
Blunt Needles.	1 full box.
CLO Tests.	20.
Dental Bibs.	20.
Dustpan and Brush.	1.
Endo smart cap.	2.
Eyewash kit.	1.
Full PPE.	FFP3 Masks 60. Gowns 60. Gloves 1 box of each (S, M, L). Respirator 1. Formalin filters for respirator x1. Hair Nets. Eye Protection. 3
Green Gauze.	2 packs.
Inco pads.	10.
KY Jelly.	2.
Laptop.	1.
Nasal Specs.	2.
Non-Rebreathe oxygen mask.	2.
Oral Syringe 5ml.	25.
Oral Syringe 50ml.	20.
Paper cups.	25.

Item	Quantity
Paper Roll	1.
Pillow	1.
TNE Scopes	17.
Small Mouthguards	20.
Spare Disposable Scope Buttons	4 sets.
Specimen Bags	40.
Specimen Pots	2 trays.
Spill Kit	2.
Sterile Water (Bottles)	6.
Suction Tubing	1 full roll.
Suction Unit (depending on availability at site)	2.
Throat spray nozzles	20.
Yankeurs	10.

List of standard **medications** required for TNE Service.

Item	Quantity
Infacol	10.
Xylocaine (lidocaine) 10mg Spray	1.
Adrenaline	2.
Lidocaine Hydrochloride 5% w/v and Phenylephrine 0.5% w/v Topical Solution (nasal Spray)	20.

List of standard emergency equipment required for TNE Service.

Item	Quantity
Gastroscope	1.
Clips Size 11	5.
Clips Size 16	5.
Upper GI Needles	2.
Haemospray	1.
Epistaxis Kit	1.

List of standard Epistaxis Kit required for TNE Service.

Item	Quantity
Thudicum Nasal Speculum Size 2 .	2.
Thudicum Nasal Speculum Size 5.	2.
NosePore.	1 box of 8.
Rapid Rhino.	2.
10ml Syringe.	2.

List of standard ***Epistaxis Medication*** required for TNE Service.

Item	Quantity
Avoca Caustic Applicator 75% w/w Cutaneous Stick (Silver Nitrate).	2 packets.
Naseptin Nasal cream.	2.

List of standard Paperwork required for TNE Service.

Item	Quantity
Patient profile.	20.
News 2 Chart.	5.
Discharge Leaflet.	20.
Consent form.	20.
Consent form 4.	4.
Prescription chart.	5.
Pre-list Brief .	5.

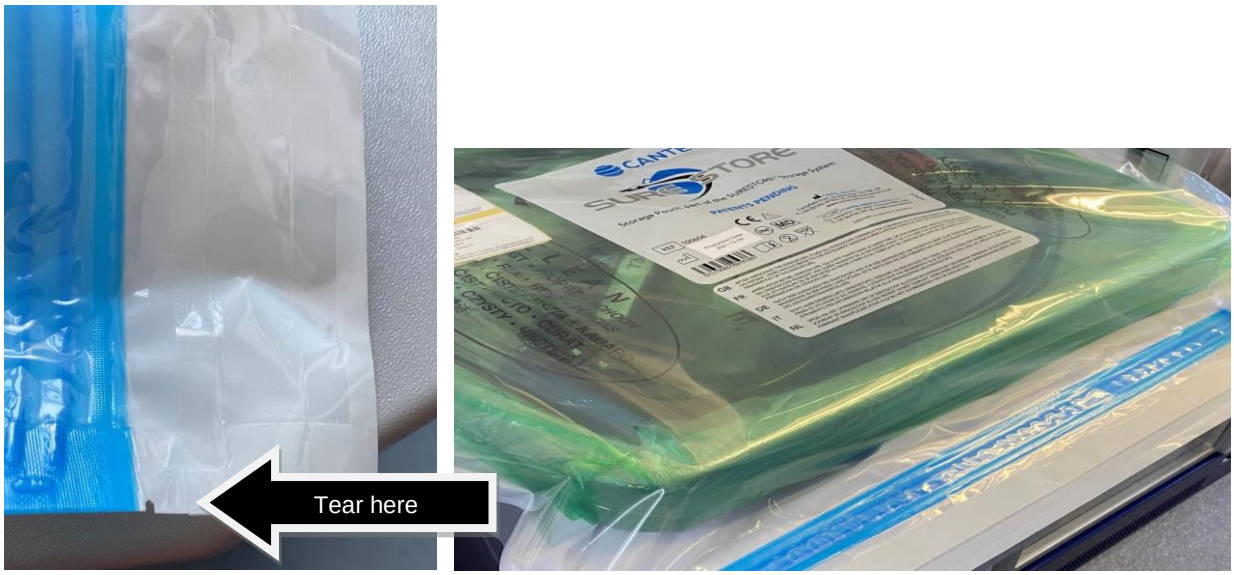
Appendix 8. Endoscope Preparation

Staff must wear the appropriate PPE (apron, gloves).

The scope will be placed on a secure clean flat surface.

Locate the tab and tear along the whole length of the scope tray pouch.

Pull apart the blue grip sealing strip of the outer pouch.



Remove the scope tray from the plastic outer pouch.

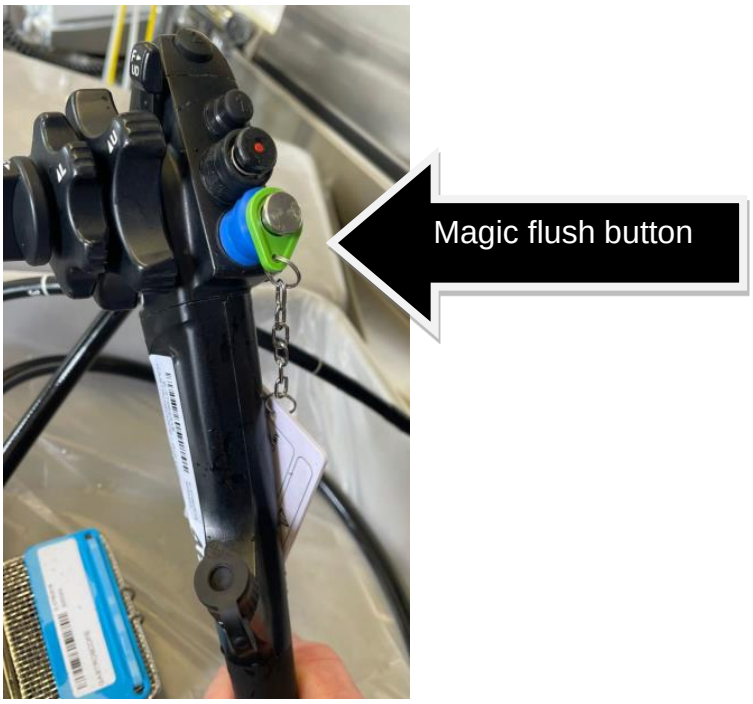
Remove the patient label from the green cover on the scope, check the number on the label matches the serial number of the scope to be used and then stick this label in the patient profile.

Locate the barcode label on the front of the outer plastic pouch, peel off one barcode label and stick this in the patient profile also (there are 4 labels all the same, so it doesn't matter which one you peel off)

Discard the outer pouch in the general waste bin.

Place the red scope button into the red button port of the scope.

Place the ‘magic’ flush button into the blue button port of the scope.



Hang the scope as normal.

Place the distal tip of the scope into a bowl of sterile water and flush the scope through.

IMPORTANT!!

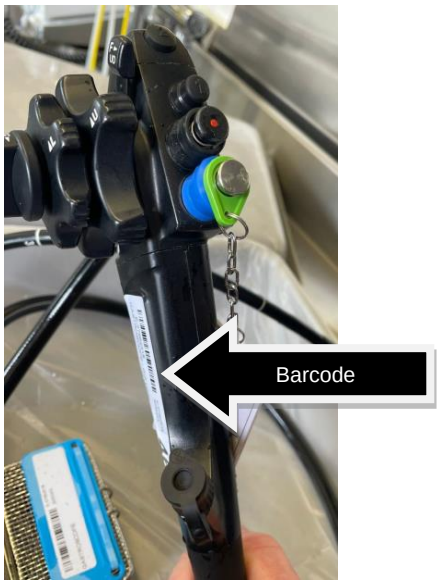
The scope must now be fully flushed for 30 seconds to flush any remains of hydrogen peroxide with sterile water.

Once this has been carried out:

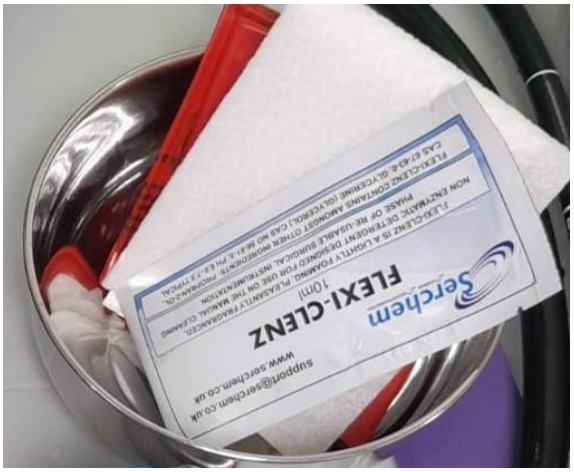
Remove the magic button and place the blue button in the blue port of the scope.

The scope is now ready for use.

The scope must be scanned to the patient on HESA, this is carried out by scanning the long barcode on the scope.



Once the procedure has finished, commence the bedside clean on the scope.

- 

Open the sachet of detergent and put into the bowl and fill the bowl to the 500ml mark with sterile water.

Wipe the entire length of the scope with the sponge provided.

DO NOT THROW THIS SPONGE AWAY.

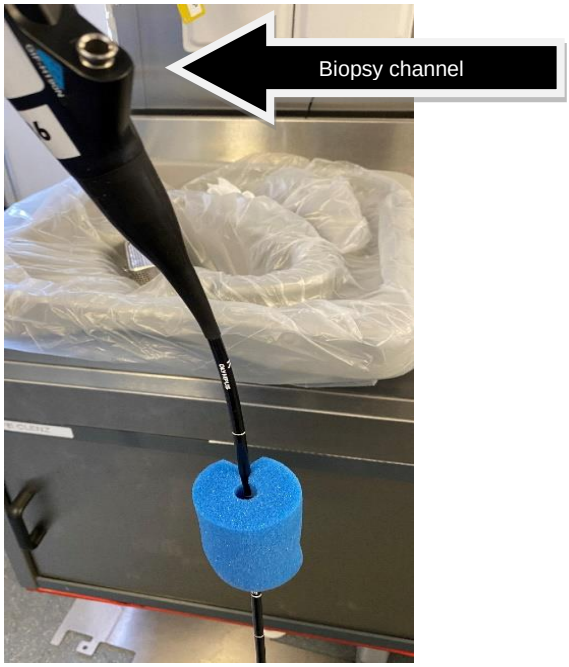
Remove the blue button from the blue port of the scope and insert the magic flush button into the blue port, leave the red button in place.

Flush the scope through in the usual way.

Once the bedside clean has been completed:

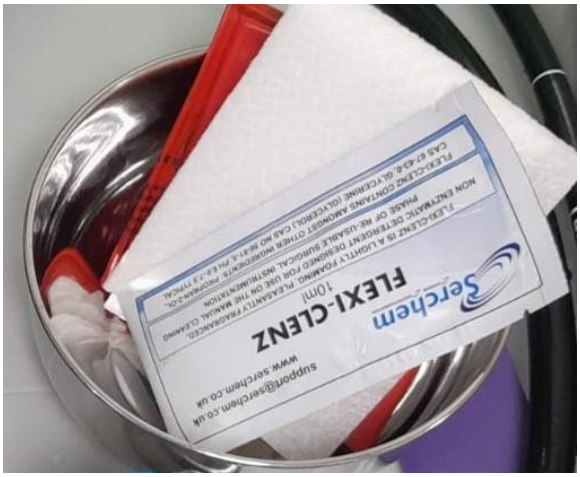
- Place the scope back into the tray.
- Locate the PREPZYME XF foam as shown below.

- Place the straw type nozzle inside the biopsy channel of the scope and spray the foam through this channel.



Place the sponge inside the tray with the scope and cover securely with the red cover This will help to keep the scope moist whilst awaiting processing.

Ensure the ‘bedside clean’ box on HESA has been ticked.



The scope must then be placed inside the lockable ‘dirty’ transportation trolley.

Once the list has finished – all used or unused scopes must be placed inside the transportation trolley, locked, and returned to decon to process regardless of whether they are ‘clean’ or ‘dirty’.

The ‘holding stack’ must be thoroughly wiped down on return with detergent wipes.

The transportation trolley containing the dirty scopes will be wheeled to the decontamination unit.

The scopes will be removed, leak tests and full manual washes will take place before processing in an AER.

The transportation trolley will be thoroughly cleaned down with detergent wipes before moving to the clean side to receive processed shore stored scopes ready for the next day.

Appendix 9. The Administration of Nasal Anaesthetic Spray

Procedure for The Administration of Nasal Anaesthetic Spray:

Equipment:

- One 2.5ml Lidocaine Hydrochloride 5% and Phenylephrine Hydrochloride 0.5% Topical solution spray.
- Box of tissues.
- Gloves.
- Patient sitting in assessment area due to have Trans Nasal Endoscopy.

1. Wash your hands and put on gloves.
2. Prime the spray before use.
    a) Remove the cap and assemble the pump onto the small glass vial. Attach the elongated nozzle onto the top of the pump.
    b) Activate the device with either your thumb or index finger on the nozzle. Press the nozzle repeatedly until the solution is emitted as a fine spray. This may take up to 1-2 depressions.
    c) Do not prime too many times – this is a single use of up to 10 sprays, 2 sprays required for each nostril, then repeat making 4 sprays in total per nostril.
3. Cleanse the nose before using the spray. Ask the patient to blow their nose and offer them some tissues for this. Manual cleansing may also be required as the drug needs to come into contact with the nasal mucosa. Explain this to the patient.
4. Ask the patient to sit upright with the head slightly forward and, using a forefinger, gently close a nostril.
5. Insert the nozzle into the open nostril, pointing centrally, or slightly to the outer wall. - Avoid spraying directly onto the medial septal wall as the mucosa here is much thinner and liable to break down resulting in epistaxis. In extreme cases septal perforation may occur - this seems to be more common in young women. Some authorities advocate using the left hand for the right nostril and vice versa as this helps avoid over-deposition of drug on the medial septal wall, remember aim for the outside mucosal passages not the septum.
6. Ask the patient to gently inhale through the nostril being treated, while depressing the collar of the device. - It is vital to avoid ‘over-zealous sniffing’ as this will lead to the drug being inhaled away from the nose and into the posterior cavity, where it will trickle down the pharynx, leading to an unpleasant taste. This, coupled with the resulting lack of effect, may lead to non-adherence, and poor anaesthetic cover. This often leads to making the patients eyes water.
7. Repeat this again with the same nostril for a second dosage - as the drug is delivered in a fine spray, ‘run off’ is minimal, but if the patient feels the need to sniff, this should be a gentle one.

8. Now complete the same procedure with the other nostril.

9. For a trans-nasal Endoscopy, 4 doses are needed in total for each nostril. No more than 2 sprays at a time because more than 2 sprays is too much for the nasal passage to absorb the anaesthetic spray. 2 Left, 2 right, 2 left, 2 right is the best method of administration, trying 4 at once will not be as effective for the patient.

10. The patient is now ready to wait to enter the procedure room and will go on to have throat spray in the normal way if converting to an oral approach.

11. Record on the patient record that the dosage has been administered. Dispose of the single use nasal spray immediately afterwards to avoid re-use.

Appendix 10. The Administration of Infacol (Simeticone 40mg/ml)

Governance

Training and competency of Registered Healthcare Professionals:

	Requirements of registered health professionals working under this SOP
Qualifications and professional registration	Registered Level 1 Nurse working within the Endoscopy Department has received training or update in the recognition of anaphylaxis within the past 12 months. Knowledge of the interaction of Simeticone 40mg/ml with other medication. Has undertaken appropriate training to carry out assessment of patient leading to administration of medication prior to planned procedure.
Competency assessment	Successful completion of generic PGD training. Log of anaphylaxis training.
Ongoing training and competency	The administering nurse should be aware of any change to the recommendations for the medication listed. It is the responsibility of the individual to keep up to date with continued professional development and to work within the limitations of the individual scope of practice.

Clinical Condition:

Clinical condition or situation to which this applies	Patients attending for a diagnostic trans-nasal Endoscopy.
Inclusion criteria	All adult patients triaged as suitable for trans-nasal Endoscopy.
Exclusion criteria	Nil.
Cautions (including any relevant action to be taken)	Nil.
Arrangements for referral for medical advice	Allergic reaction (very rare) refers to ED.
Action to be taken if patient excluded	N/A.
Action to be taken if patient declines treatment	Advise patient of limitations of views and increased chance of missed pathology requiring potential need to repeat procedure.

Procedure for the Administration of Infacol (Simeticone 40mg/ml).

Pre-medication Drink.

Equipment:

- Infacol (Simeticone 40mg/ml).
- 1 litre bottle of Sterile water.
- Disposable cup.
- Oral syringe.
- Gloves.
- Blue medication tray.
- Patient sitting in assessment area due to have trans-nasal Endoscopy.

1. Wash your hands.
2. Put on gloves.
3. Open Infacol (Simeticone) and write date of opening on bottle when opening new bottle.
4. Prepare the pre-med drink on a blue medication tray.
    a) Dispense 45mls of sterile water into a disposable cup using a 50ml syringe.
    b) Using an oral syringe dispense 5mls of Infacol (Simeticone 40mg/ml) into the disposable cup containing 45ml of sterile water.
    c) Give the prepared pre-med solution to patient to drink.
    d) Dispose of the cup, remove PPE, and wash hands.
    e) The patient is now ready to undergo the remaining preparation for the procedure.

Procedure for The Administration of Infacol (Simeticone 40mg/ml).

To Flush Endoscope.

Equipment:

- Infacol (Simeticone 40mg/ml).
- 1 litre bottle of Sterile water.
- Gloves.
- Oral syringe.
- 50ml syringe.
- Silver bowl from scope tray.
- Blue medication tray.

1. Wash your hands.
2. Put on gloves.
3. Open Infacol (Simeticone) and write date of opening on bottle when opening new bottle.
4. Prepare the Flush solution on a blue medication tray.
    a) Open 1 litre bottle of sterile water.
    b) Dispense 22mls of Infacol (Simeticone 40mg/ml) into the bottle.
    c) Replace the cap and gentle agitate the bottle.
        1. Pour approx. 200ml of solution into the bowl provided in the scope tray.
        2. Draw up solution into 50ml (44mg Simeticone) syringe ready for flush through scope to be used as necessary to improve mucosal views.
        3. The maximum of up to 150ml (132mg Simeticone) can be given as flush.

Appendix 11. Management of Epistaxis during Trans-nasal Endoscopy in the Community

If your patient starts to bleed, this guide will help you to stop the bleeding.

- Stop the procedure.
- Sit the patient upright (do not lie down).
- Ask the patient to apply compression by pinching with their thumb and index finger to the soft part of the nose just above the nostrils **continuously** for 20 minutes. Do not stop to see if the bleeding has stopped until the 20 minutes have passed.
- Advise the patient to lean forward and breathe through their mouth.
- Do not blow your nose or swallow any blood, spit it out.
- Once stopped, do not blow the nose or touch it for at least 2 hours.
- Avoid hot drinks during this period.

If the nosebleed has not stopped within 30 minutes, follow the following procedure:

ONGOING ANTERIOR BLEEDING* DESPITE THE ABOVE MEASURES.

*Means bleeding that comes from the front of the nose not swallowed to the back.

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Try to look and visualize for a possible bleeding point ideally after spraying the nose again with the blue spray (Lidocaine with phenylephrine).

↓

If a bleeding point can be seen, use silver nitrates stick to cauterize the bleeding point or use dissolvable nasal pack (Nasopore) if the bleeding is too heavy or nil seen.

(If you cauterized the bleeding point, use Naseptin cream to cover the cauterized area immediately and advise the patient to carry on using Naseptin cream four times daily for 10 days).

↓

Ongoing bleeding despite the above measures or the bleeding is mainly posteriorly*, then use **Unilateral** non-absorbable nasal packing (e.g., Rapid Rhino).

*Posteriorly means more from the back of the nose to the mouth rather than the nose.

Bleeding continues:

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Bilateral antero-posterior 7.5cm Rapid Rhino packs.

If bleeding continues despite all the above measures, please refer to ED to be seen by ENT.

Note: Naseptin covered by PGD (END-13).

Resource: Patient Information Leaflet: Following your nosebleed RCHT011.

Appendix 12. The Administration of Throat Spray

Governance:

Training and competency of Registered Healthcare Professionals:

Training	**Requirements of registered health professionals working under this SOP**
Qualifications and professional registration.	Registered Level 1 Nurse working within the Endoscopy Department. Has received training or update in the recognition of anaphylaxis within the past 12 months. Knowledge of the interaction of Topical Xylocaine (lidocaine hydrochloride 10%) with other medication. Has undertaken appropriate training to carry out assessment of patient leading to administration of medication prior to planned Procedure.
Competency assessment.	Successful completion of generic PGD training. Successful completion of local training on the administration of throat spray. Log of anaphylaxis training.
Ongoing training and competency.	The administering nurse should be aware of any change to the recommendations for the medication listed. It is the responsibility of the individual to keep up to date with continued professional development and to work within the limitations of the individual scope of practice.

Clinical Condition:

Clinical condition or situation to which this applies.	Patients attending for a diagnostic trans-nasal. Endoscopy requiring conversion to Gastroscopy.
Inclusion criteria.	All adult patients triaged as suitable for trans-nasal. Endoscopy requires conversion to Gastroscopy.
Exclusion criteria.	Patients under 16 years of age. Known allergies to local anesthetics. History of epilepsy. Patients with Bradycardia, Porphyria, Glaucoma and urinary retention. Patients on warfarin with INR greater than 3. Pregnancy or breast feeding. Taking monoamine oxidase inhibitors.
Cautions (including any relevant action to be taken).	History of allergy. Patient must remain nil by mouth for 60 minutes to prevent risk of choking. Maximum of 20 doses/200mg (BNF).
Arrangements for referral for medical advice.	Allergic reaction (very rare contains antihistamine decongestant) refer to ENT for advice.
Action to be taken if patient excluded.	Referral for Gastroscopy under sedation at main hospital site.
Action to be taken if patient declines treatment.	If declines test with sedation, refer back to referrer. Follow consent to treatment policy.

Procedure for The Administration of Throat Anaesthetic Spray:

Equipment:

- Xylocaine (lidocaine hydrochloride 10%)10mg per 1 actuation topical anaesthetic pump spray.
- Gloves.
- Blue medication tray.
- Patient sitting in assessment area due to have trans-nasal Endoscopy.

1. Wash your hands and put on gloves.
2. Prime the spray before use.
    a) Remove the cap and assemble the pump onto the small glass vial. Attach the elongated nozzle onto the top of the pump.
    b) Activate the device with either your thumb or index finger on the nozzle.
    c) Press the nozzle repeatedly until the solution is emitted as a fine spray. This may take up to 1-2 depressions.
3. Ask the patient to remove dentures if present.
4. Ask the patient to sit upright with their head slightly bent backwards and their mouth wide open.
5. Insert the nozzle into the patient's mouth pointing down towards the back of their throat. Ask the patient to hold their breath and apply 5 sprays to the back of the throat.
6. Remove the nozzle and ask the patient to swallow.
7. Insert the nozzle into the patient's mouth pointing down towards the back of their throat so you can get apply the spray at a more distal point. Ask the patient to hold their breath and apply a further 5 sprays.
8. Remove the nozzle and ask the patient to swallow, they will have had 10 sprays/100mgs in total.
9. Dispose of the single use nozzle to avoid reuse, remove PPE and wash hands. Clean the Xylocaine pump spray and put away.
10. The patient is now ready to be positioned on the trolley to undergo a gastroscopy.
11. Record on the patient record that the dosage has been administered.