



Australian  
Commission on  
**Safety and Quality**  
in Health Care

**Clinical Care  
Standards**



# Colonoscopy

Clinical Care Standard

September 2025

[safetyandquality.gov.au](https://safetyandquality.gov.au)

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Published by the Australian Commission on Safety and Quality in Health Care

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ISBN: 978-1-923353-04-6

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Australian Commission on Safety and Quality in Health Care. Colonoscopy Clinical Care Standard. Sydney: ACSQHC; 2025.

First released 2018. Revised 2025.

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The *Colonoscopy Clinical Care Standard* has been endorsed by the following organisations:



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# Quality statements

## 1. Initial assessment and referral

When a patient is referred for consideration of colonoscopy, the referring clinician provides sufficient information for the receiving clinician to assess the appropriateness, risk and urgency of consultation. The receiving clinician or service allocates the patient an appointment according to their clinical needs.

## 2. Appropriate and timely colonoscopy

A patient is offered timely colonoscopy when appropriate for the investigation of signs or symptoms of bowel disease, surveillance or screening, as consistent with national evidence-based guidelines. Decisions are made in the context of the patient's ability to tolerate the bowel preparation and colonoscopy, and their likelihood of benefit. If colonoscopy is not appropriate, the receiving clinician advises the patient and their referring clinician of alternative recommended management.

## 3. Informed decision making and consent

Before starting bowel preparation, a patient receives comprehensive patient-appropriate information about bowel preparation, the colonoscopy, and sedation or anaesthesia. The patient has an opportunity to discuss the reason for the colonoscopy, the risks, benefits, financial costs and alternative options before deciding to proceed. Their understanding is assessed, and the information provided and their consent to sedation, colonoscopy and therapeutic intervention is documented.

## 4. Bowel preparation

A patient booked for colonoscopy receives a bowel preparation product and dosing regimen individualised to their needs, comorbidities, regular medicines and previous response to bowel preparation. The importance of good bowel preparation for a quality colonoscopy is discussed with the patient. They are provided with consumer-appropriate instructions on how to use the bowel preparation product and their understanding is confirmed.

## 5. Sedation

Before colonoscopy, a patient is assessed by an appropriately trained clinician to identify any increased risk, including cardiovascular, respiratory or airway compromise. The use of sedation is planned accordingly. The risks and benefits of sedation are discussed with the patient. Sedation is administered and the patient is monitored throughout the colonoscopy and recovery period in accordance with Australian and New Zealand College of Anaesthetists guidelines.

## 6. Clinicians

A patient's colonoscopy is performed by a credentialed clinician working within their scope of clinical practice, who meets the requirements of an accepted certification and recertification process. Sedation or anaesthesia, and clinical support are provided by credentialed clinicians working within their scope of clinical practice.

## 7. Procedure

When a patient is undergoing colonoscopy their entire colon – including the caecum – is examined carefully and systematically. The adequacy of bowel preparation, clinical findings, biopsies, polyps removed, therapeutic interventions and details of any adverse events are documented. All polyps removed are submitted for histological examination.

## 8. Discharge

Following recovery and before discharge, the patient is advised verbally and in writing about the preliminary outcomes of the colonoscopy, the nature of any therapeutic interventions or adverse events, when to resume regular activities and medicines, and arrangements for medical follow-up. The patient is safely discharged into the care of a responsible adult, in accordance with Australian and New Zealand College of Anaesthetists guidelines.

## 9. Reporting and follow-up

The colonoscopist communicates the reason for the colonoscopy, its findings, any histology results and recommendations for follow-up in writing to the general practitioner, any other relevant clinician and the patient. This information is recorded in the facility records and other electronic shared record management systems to enable accurate follow-up by other clinicians. Recommendations for surveillance colonoscopy, if required, align with national evidence-based guidelines. If more immediate treatment or follow-up is needed, the colonoscopist makes appropriate arrangements.

# Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this Clinical Care Standard. These indicators are intended to support local quality improvement activities.

## Quality statement 2. Appropriate and timely colonoscopy

**Indicator 2a:** Evidence of a locally approved policy that ensures the timely and appropriate provision of colonoscopy.

## Quality statement 7. Procedure

**Indicator 7a:** Proportion of patients who had a colonoscopy whose bowel preparation was adequate using a validated assessment tool.

**Indicator 7b:** Proportion of patients who had a colonoscopy whose entire colon was examined to the caecum and/or terminal ileum.

**Indicator 7c:** Proportion of patients who had a colonoscopy that detected one or more adenoma(s).

**Indicator 7d:** Proportion of patients who had a colonoscopy that detected one or more sessile serrated lesion(s).

## Quality statement 9. Reporting and follow-up

**Indicator 9a:** Evidence of local arrangements to ensure information about a person's colonoscopy is recorded and shared to enable accurate follow-up.

## More information

The definitions required to collect and calculate indicator data are specified online at the Australian Institute of Health and Welfare's Metadata Online Registry (METEOR): [meteor.aihw.gov.au/content/803424](https://meteor.aihw.gov.au/content/803424)

See the Commission's [Colonoscopy Clinical Care Standard](#) webpage for information about indicators and other relevant quality improvement measures.

# Updates

This revised Clinical Care Standard maintains the same goals and scope as the first *Colonoscopy Clinical Care Standard* and incorporates changes in the relevant evidence-based guidelines since 2018.

Key updates in the current version include:

- Amendments to the quality statements and supporting information on
  - initial assessment and referral (Quality statement 1) to delineate the responsibility of the referring clinician and receiving clinician or healthcare service
  - technology and equipment (Quality statement 7), including photodocumentation as a minimum requirement, and artificial intelligence considerations
  - discharge after a colonoscopy (Quality statement 8) to clarify that discharge should occur in accordance with professional guidelines for all patients undergoing sedation, including in relation to post-sedation supervision requirements
  - reporting and follow-up (Quality statement 9) to ensure the recording and transfer of information supports accurate and appropriate follow-up.
- Additional information on
  - expectations in referral for open-access colonoscopy (also referred to as direct-access colonoscopy)
  - considerations for bowel preparation and associated medication management
  - cultural safety and equity considerations throughout the Standard
  - environmental sustainability in colonoscopy in the introductory section.

Key updates to the indicators include:

- Additional indicators to
  - support the timely and appropriate provision of colonoscopy
  - ensure information about a person's colonoscopy is recorded and shared to enable accurate follow-up.

See [Appendix: Updates in the 2025 Colonoscopy Clinical Care Standard](#) for a detailed list of amendments.



# Clinical Care Standards

A Clinical Care Standard describes the care that patients should be offered by clinicians and healthcare services for a specific clinical condition, treatment, procedure or clinical pathway, regardless of where people are treated in Australia. Clinical Care Standards aim to address unwarranted variation in health care or patient outcomes by increasing evidence-based health care for priority aspects of care.

Clinical Care Standards include:

- Quality statements that describe the expected standard for key components of patient care
- Explanations of what each quality statement means for
  - patients – so that people receiving care know what care may be offered and can make informed decisions in partnership with their clinician
  - clinicians – to support decisions about appropriate care
  - healthcare services – to inform them of the policies, procedures, and organisational factors that can enable the delivery of high-quality care
- Indicators to support local quality improvement, allowing clinicians and healthcare services to monitor the care described in the Standard.

Clinical Care Standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission). By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

## Background

The Australian Commission on Safety and Quality in Health Care developed a safety and quality model for colonoscopy in 2016–17, supported by funding from the Australian Government Department of Health and Aged Care. The model comprises three elements:

- A *Colonoscopy Clinical Care Standard* (first published in 2018)
- Implementation of the Standard through the [National Safety and Quality Health Service \(NSQHS\) Standards](#) in public and private hospitals, and day procedure services
- Certification – and periodic recertification – of colonoscopists' performance in accordance with defined quality indicators and performance targets established by the Gastroenterological Society of Australia (GESA), and overseen by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) and the Recertification in Colonoscopy Conjoint Committee (RCCC).

## National Safety and Quality Standards

Colonoscopy must be provided by healthcare services that have been assessed to the NSQHS Standards. The NSQHS Standards require all healthcare services providing colonoscopy services to implement the *Colonoscopy Clinical Care Standard*. These assessment requirements are described in advisory [AS18/12: Implementing the Colonoscopy Clinical Care Standard](#).<sup>1</sup>

Information about the role of Clinical Care Standards for healthcare services accredited to the [NSQHS Standards](#)<sup>2</sup> or the [National Safety and Quality Primary and Community Healthcare Standards \(Primary and Community Healthcare Standards\)](#)<sup>3</sup> can be found online.

See the Commission's [Fact sheet: Applicability of Clinical Care Standards](#) for more information.<sup>4</sup>

### Competencies and service capability

Healthcare services should consider the medical, nursing, procedural, and sedation and anaesthetic competencies required for high-quality and safe colonoscopy as part of clinical services planning. The competencies should meet the requirements of the NSQHS Standards.<sup>2,5</sup>

### ***Credentialing, certification and recertification of colonoscopists***

Certification of training and recertification of ongoing competency in adult colonoscopy (see [Quality statement 6](#)) are mandatory for all colonoscopists working in health service organisations assessed to the NSQHS Standards.

Healthcare services are asked to demonstrate that colonoscopists working in their facility have provided evidence of certification and recertification as part of their accreditation to the NSQHS Standards.

### Medical and surgical endoscopists

- **Certification** – Certification of gastroenterologists, surgeons and general practitioner endoscopists is through the CCRTGE. The CCRTGE is a national body comprising representatives of GESA, the Royal Australasian College of Physicians (RACP), and the Royal Australasian College of Surgeons (RACS) and has existed in its current form since 1990. It sets the minimum standards for training in adult colonoscopy, in line with evidence-based international standards.
- **Recertification** – The Recertification in Colonoscopy program was developed by GESA in 2016 and aligns to international standards to ensure quality in colonoscopy. The program is administered by the RCCC and comprises representatives from GESA, RACP and the RACS. Recertification is designed to support practitioners in<sup>6</sup>
  - maintaining their expertise in colonoscopy
  - continuing to develop their skills through subsidised training opportunities
  - maintaining safety standards and the quality of care delivered to patients.

### Nurse endoscopists

- Nurse endoscopists are certified and recertified through their jurisdiction. The same standards of training in the procedure and the same quality assurance mechanisms are expected to apply as for medical colonoscopists.
- More information is available in the NSQHS Standards' fact sheet [Certification and Recertification of practising adult colonoscopists](#) available from the Commission's website.<sup>7</sup>

# About the Colonoscopy Clinical Care Standard

## Goals

The goal of this Clinical Care Standard is to ensure the safe and appropriate use of colonoscopy and to maximise patients' likelihood of benefit from the procedure while reducing their risk of avoidable harm.

## Scope

The *Colonoscopy Clinical Care Standard* relates to the care of adult patients undergoing colonoscopy for screening, diagnosis, treatment or surveillance. It covers the period from when a patient is referred for consideration of colonoscopy through to discharge, including planning for follow-up care.

## What is not covered

This Clinical Care Standard does not cover care of children or adolescents under the age of 18 who are undergoing colonoscopy.

## Healthcare settings

This Clinical Care Standard applies to care provided in:

- Primary care, including general practice (specifically in regard to referral)
- Other specialists' rooms
- Private hospitals
- Public hospitals
- Day procedure services.

This Standard is particularly relevant to:

- Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander Health Practitioners
- Anaesthetists
- Colorectal and general surgeons performing colonoscopy
- Clinicians undertaking colonoscopy as part of a training program
- Gastroenterologists
- General practitioners (GPs), including rural generalists
- Health service managers
- Non-anaesthetist sedationists
- Nurses and nurse practitioners.

Not all quality statements within this Clinical Care Standard will be applicable to every healthcare service or clinical unit. Healthcare services should consider their individual circumstances in determining how to apply the statement.

When implementing this Clinical Care Standard, healthcare services should consider:

- The context in which care is provided
- Local variation
- Quality improvement priorities of the individual healthcare service.

Healthcare services in rural and remote settings may need different strategies to implement the standard. For example, the use of:

- Hub-and-spoke models integrating larger and smaller health services and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs)
- Telehealth consultations
- Multidisciplinary teams, including GPs and nurses where clinically appropriate.

## Evidence

Key sources that underpin the Standard are current clinical guidelines from:

- Cancer Council Australia, including
  - [Clinical practice guidelines for the prevention, early detection and management of colorectal cancer](#)<sup>8</sup>
  - [Clinical practice guidelines for surveillance colonoscopy](#).<sup>9</sup>
- Australian and New Zealand College of Anaesthetists (ANZCA), including those providing guidance to non-anaesthetist sedationists
  - [Guideline for the perioperative care of patients selected for day stay procedures \(PG15\)](#)<sup>10</sup>
  - [Guideline on procedural sedation \(PG09\)](#).<sup>11</sup>

See the Commission's [Colonoscopy Clinical Care Standard](#) webpage for a full list of the evidence sources that support this Clinical Care Standard.

## Terminology

Key terms used in the context of this Clinical Care Standard are described below. See also the [Glossary](#).

Term	How it is used in this document
<b>patient</b>	<p>The patient is the person receiving care. When the word 'patient' is used in this standard, it may include the person's carer, family member, support person, or substitute decision maker.</p> <p>Only the patient or their substitute decision maker, such as a legal guardian, can give consent for care. However, carers, families and support people who are not substitute decision makers may also support the patient in their decision making and actively participate in their care. These people should be given information and included in discussions when the patient wishes this to occur.</p>
<b>clinicians</b>	<p>Clinicians are all types of healthcare providers who deliver direct clinical care to patients. They include general practitioners, gastroenterologists, colorectal and general surgeons, nurse endoscopists, gastroenterology nurses, sedationists, anaesthetists, nurses, pharmacists, Aboriginal and Torres Strait Islander Health Workers, Aboriginal and Torres Strait Islander Health Practitioners and allied health professionals.</p>
<b>healthcare services</b>	<p>Healthcare services are those responsible for leading and governing the service. They are the organisations responsible for implementing clinical governance, administration and financial management of one or more service units providing health care to patients.</p> <p>Health care is delivered in a wide range of settings. Services may vary in size and organisational structure from single healthcare providers to complex organisations.</p>

## Supporting resources

See the Commission's [Colonoscopy Clinical Care Standard](#) webpage for supporting documents, including:

- [Guide for consumers](#)
- [Information for clinicians](#)
- [Information for healthcare services](#)
- [Self-Assessment Tool](#) for healthcare services
- Links to other implementation resources, templates and information.

## Using indicators

Measurement is a key part of quality improvement. The indicators in this Clinical Care Standard allow clinicians and healthcare services to monitor and improve the care they provide as part of local quality improvement activities.

Before using the indicators, refer to each indicator's specifications as described in METEOR: [Metadata Online Registry](#). These define how to collect and calculate indicator data and describe the applicable healthcare settings.

When using the indicators note that:

- Indicators are listed with the related quality statement; however, not all quality statements will have indicators
- Services may use other relevant measures in addition to, or instead of, these indicators that relate to their needs and the needs of their patients.

See the Commission's website for more information on quality measures, including [patient-reported outcome measures \(PROMs\)](#) and [patient experience measures](#).

The indicators described in this Clinical Care Standard are intended to align with the [Safety and Quality Model for Colonoscopy](#) and the performance indicators for certification and recertification developed by the CCRTGE and GESA.

Consistency in the quality indicators measured at a health service level and an individual level allows quality assurance and improvement at multiple levels. The indicators in this Clinical Care Standard allow for measurement and monitoring for quality improvement at a service level, while the CCRTGE and GESA indicators are for individual performance assessment. While the Commission does not set benchmarks for Clinical Care Standards indicators, the CCRTGE and GESA do set benchmarking criteria for certification and recertification.

## General principles of care

This Clinical Care Standard should be implemented as part of an overall approach to improving safety, quality, and appropriateness of care. Some principles and key actions are described in other Commission standards and guidance and are not reproduced here. These include:

- Effective clinical governance
- Person-centred care
- Shared decision making and informed consent.

For more information, see:

- [NSQHS Standards](#)<sup>2</sup>
- [National Safety and Quality Primary and Community Healthcare Standards](#)<sup>3</sup>
- [User Guide for Reviewing Clinical Variation](#)
- [Clinical Care Standards](#) on the Commission's webpage.

## Cultural safety and equity

Person-centred care recognises and respects differences in individual needs, beliefs, and culture. The Commission:

- Is committed to supporting healthcare services to provide culturally safe and equitable healthcare to all Australians
- Acknowledges that discrimination and inequity are significant barriers to achieving high-quality health outcomes for some patients from culturally and linguistically diverse communities.

Culturally safe service provision and environments are those where the places, people, policies and practices foster mutual respect, shared decision making, and an understanding of cultural, linguistic and spiritual perspectives and differences. Cultural safety is supported by organisations and individuals that recognise cultural power imbalances and actively address them by:

- Ensuring access to and use of interpreter services or cultural translators when this will assist the patient and aligns with their wishes
- Providing visual or written information in a language that the patient, their family and carers will understand
- Providing cultural competency training for all staff
- Encouraging clinicians to review their own beliefs and attitudes when treating and communicating with patients<sup>12</sup>
- Identifying variation in healthcare provision or outcomes for specific patient populations, including those based on ethnicity, and responding accordingly.<sup>13</sup>



## Cultural safety and equity for Aboriginal and Torres Strait Islander peoples

Health outcomes for Aboriginal and Torres Strait Islander peoples can be improved by addressing systemic racism and other root causes that reduce access to care. Historical and current contributing factors include a lack of culturally safe care, culturally appropriate health education and sociocultural determinants such as differences in employment opportunities.

The considerations for improving cultural safety and equity in this Clinical Care Standard focus primarily on overcoming cultural power imbalances and improving outcomes for Aboriginal and Torres Strait Islander people through better access to health care.<sup>14</sup>

Cultural safety and equity recommendations in this document have been developed in consultation with Aboriginal and Torres Strait Islander individuals, clinicians and representative health service organisations. However, it is recognised that cultural safety is determined by the Aboriginal and Torres Strait Islander individuals, families and communities experiencing the care.<sup>15</sup>

## Recommendations

When implementing this Clinical Care Standard, cultural safety can be improved through embedding an organisational approach such as described in the recommendations below. Specific considerations for cultural safety for people undergoing colonoscopy are provided throughout this Standard.

When providing care for Aboriginal and Torres Strait Islander people, particular consideration should be given to the following recommendations.

## Building culturally safe systems

- Ensure systems and processes support people to self-report their Aboriginal and Torres Strait Islander status and to record self-identification.
- Ensure all staff engage regularly in cultural safety training.
- Implement the six actions for Aboriginal and Torres Strait Islander Health from the NSQHS Standards.<sup>12</sup>

## Flexible and connected service delivery

- Provide flexible service delivery to optimise attendance and help develop trust with individual Aboriginal and Torres Strait Islander people and communities.
- Establish robust communication channels and referral pathways with primary healthcare providers (including Aboriginal Community Controlled Health Organisations [ACCHOs]).
- Where possible, provide outreach services close to home, on Country or in collaboration with ACCHOs or other community healthcare providers.

## Communication and person-centred care

- Take a collaborative approach to ensure that interventions are suitably tailored to the individual's personal needs and preferences for care.
- Encourage the inclusion of support people, family and kin or the person's trusted healthcare provider (such as their ACCHO) in all aspects of care, including decision making and planning treatment and management.
- Engage culturally appropriate interpreter services and cultural translators when this will assist the patient.
- Involve Aboriginal and Torres Strait Islander Health Workers or Aboriginal and Torres Strait Islander Health Practitioners as part of a patient's multidisciplinary team and involve Aboriginal and Torres Strait Islander Liaison Officers in hospital settings.
- Use culturally and linguistically appropriate materials to aid in communication and discussion, accounting for varying levels of health literacy.

## Related resources

- [\*NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health\*](#) – a guide to help improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people based on the National Safety and Quality Health Service Standards<sup>12</sup>
- [\*National Agreement on Closing the Gap\*](#) – an agreement built around [four priority reforms](#) for transforming the way governments work with, and for, Aboriginal and Torres Strait Islander peoples to improve outcomes
- [\*Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health\*](#) – a framework that commits the Australian Government and all states and territories to embed cultural respect principles into their health systems<sup>14</sup>
- [\*Clinical Yarning\*](#) – a patient-centred framework to improve communication in Aboriginal health care<sup>16</sup>
- [\*Communicating positively: a guide to appropriate Aboriginal terminology\*](#) – a guide developed by NSW Health to use when working with Aboriginal people and communities, and when developing policy and programs<sup>17</sup>
- [\*Plain English Health Dictionary\*](#) – a resource developed by the Northern Territory Government as a resource for Aboriginal Interpreter Services.<sup>18</sup>



## Environmental sustainability and climate resilience in health care

Health is a fundamental human right that is undermined by climate change.<sup>19</sup> However, healthcare activity generates carbon emissions which contribute to climate change. It is estimated that the health system is responsible, either directly or indirectly, for 5% of Australia's greenhouse gas emissions.<sup>20</sup> Clinical care contributes more than half of these emissions.<sup>20</sup>

The Commission seeks to support clinicians and healthcare services to deliver environmentally sustainable health care that improves patient health outcomes, finds ways to reduce carbon emissions and manages resources effectively. Involving patients and consumers, including Aboriginal and Torres Strait Islander peoples, is an important part of this process.

Actions to improve the appropriateness of care often have a related benefit of improving sustainability and reducing carbon emissions. Sustainable healthcare practices are important for protecting and promoting the health and wellbeing of all Australians, while reducing the environmental impact of the health system.<sup>19</sup>

The Commission, in partnership with the interim Australian Centre for Disease Control and Australian medical colleges, has released a [Joint Statement](#) to signify the shared commitment to work together to achieve sustainable high-quality health care.<sup>20</sup> The statement highlights the need to develop low-emission, climate-resilient and culturally safe models of care that deliver on the three principles of sustainable health care:

- Investing in prevention, to improve health while reducing healthcare demand and associated emissions
- Minimising potentially harmful and wasteful care, which accounts for around 30% of the emissions footprint of clinical care<sup>21</sup>
- Minimising emissions associated with the delivery of high-value care.<sup>19</sup>

The statement aligns with the principles and objectives of Australia's [National Health and Climate Strategy](#).<sup>19</sup>

# Colonoscopy

Colonoscopy refers to the examination of the entire large bowel using a colonoscope – a camera on a flexible tube. It is a complex task that requires the colonoscopist to manipulate the colonoscope effectively to visualise the bowel, while performing therapeutic interventions such as removing polyps or taking tissue samples when required.

Colonoscopy is often performed as a diagnostic intervention to investigate possible bowel cancer, either in people with symptoms and signs of bowel disease or those with an increased risk of bowel cancer. It may also be used to help diagnose the cause of symptoms in conditions such as inflammatory bowel disease.

Australia has one of the highest rates of bowel cancer in the world.<sup>22,23</sup> Bowel cancer was estimated to be the fourth most common cancer diagnosed in both men and women in Australia in 2023.<sup>24</sup>

Evidence-based guidelines describe when colonoscopy should be used and how frequently, according to the patient's presenting symptoms, history and risk.<sup>8,9</sup>

## Screening for bowel cancer

In Australia, most screening for bowel cancer involves an immunochemical faecal occult blood test (iFOBT). For people whose personal or family health history puts them at significantly higher than average risk of bowel cancer, screening is by regular colonoscopy.

The National Bowel Cancer Screening Program (National Screening Program) provides iFOBT test kits to eligible Australians aged 45 to 74 years old. An iFOBT may also be requested by a clinician. The National Screening Program is a government-funded, population-based screening program which aims to reduce illness and death from bowel cancer through early detection and prevention of the disease. The program has been shown to reduce illness and mortality from bowel cancer in Australia.<sup>25,26</sup>

The National Cancer Screening Register records details of participants, their health care, and outcomes related to bowel cancer screening. It relies on the information provided by GPs and colonoscopists to maintain accurate and comprehensive records and to assess the outcomes of the national program.

Participants in the program with a positive screening result, indicated by blood in the stool sample, are advised to consult their primary healthcare provider to discuss further diagnostic assessment – usually a colonoscopy. During the colonoscopy, small growths inside the bowel (polyps) can be removed and examined for signs of cancer. Some polyps have no cancerous cells while others show abnormal changes which may lead to cancer. These abnormal polyps are called adenomas.

## Quality colonoscopy

High-quality colonoscopy is critical to the early detection and treatment of bowel cancer. Removal of polyps and adenomas may prevent bowel cancer developing, while early diagnosis of bowel cancer can improve treatment outcomes and survival. Colonoscopy also identifies people at increased risk of bowel cancer who require regular colonoscopy surveillance.

The quality of colonoscopy is important for minimising the risk of complications from the procedure to the patient. Complications associated with colonoscopy include:

- Risks of the procedure itself such as bleeding, perforation and injury to the spleen
- Risks associated with bowel preparation, including dehydration and electrolyte imbalances, which can be serious<sup>27</sup>
- Complications arising from sedation or anaesthesia.

The risk of serious complications following colonoscopy is approximately 3.1 perforations and 14.6 major bleeding events per 10,000 screening colonoscopies.<sup>27</sup> Risk increases with age, the number of colonoscopies and when polyps are removed.<sup>27</sup> While the risk of complication is relatively small, many people undergo colonoscopy, many of whom are not diagnosed with any disease yet are exposed to risk.

## Colonoscopy rates vary between regions

More than 900,000 colonoscopies are performed in Australia annually. Despite the large number of procedures, there is considerable geographic variation in the delivery of colonoscopy.

The [Atlas Focus Report: Colonoscopy](#) identified a 43-fold difference between the local area with the highest rate and the local area with the lowest rate of MBS-subsidised colonoscopies performed in 2023–24, compared to a 27-fold difference in 2013–14.\* A relatively small proportion (estimated 10–14% in 2019) of MBS-funded colonoscopies is performed on people with a positive iFOBT through the National Screening Program.<sup>28</sup>

## Aboriginal and Torres Strait Islander peoples

Compared to non-Indigenous people, Aboriginal and Torres Strait Islander peoples:

- Are more likely to be diagnosed with and die from bowel cancer<sup>26</sup>
- Have a lower estimated participation rate in the National Bowel Cancer Screening Program yet experience a higher screening positivity rate and a lower follow-up diagnostic rate<sup>26</sup>
- Are less likely to access colonoscopy services. The *Third Australian Atlas of Healthcare Variation* identified a 47% lower rate of hospitalisations for colonoscopy.<sup>23</sup>

This indicates that Aboriginal and Torres Strait Islander people are missing out on appropriate care and access to colonoscopy.

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\* ACSQHC Atlas Focus Report: Colonoscopy. Sydney: ACSQHC; 2025.

## Changes since the first Colonoscopy Clinical Care Standard

Rates of repeat colonoscopies can be one indicator for assessing potentially unwarranted variation. Apart from those required due to poor bowel preparation, repeat colonoscopy should normally be conducted in line with Cancer Council Australia's *Clinical practice guidelines for surveillance colonoscopy*.<sup>9</sup>

The [Atlas Focus Report: Colonoscopy](#) identified an 8% decrease in the national rate of MBS-subsidised repeat colonoscopies (performed within 2 years and 10 months after a previous colonoscopy) between 2013–14 and 2023–24.\* The report identified an 18-fold difference between the local area with the highest rate and the local area with the lowest rate of MBS-subsidised repeat colonoscopies performed in 2023–24, compared to an 11-fold difference in 2013–14.\*

However, other analyses show that between 2016–17 and 2022–23 the national rate of repeat colonoscopies, where the previous colonoscopy did not involve removal of a polyp, decreased by about 18%.† These data indicate that rates of repeat colonoscopies have declined since 2013–14 overall, and particularly since the release of this Clinical Care Standard in 2018.

During this time, there have been multiple system-wide changes to improve safety and quality in colonoscopy. These include:

- The introduction of the *Colonoscopy Clinical Care Standard* in 2018 and its
  - mandatory implementation in public and private hospitals and day procedure services
  - requirement for recertification of adult colonoscopists for credentialling, with 2,221 colonoscopists recertified between the introduction of the Recertification program in 2016 and January 2024‡
- The MBS restructure of colonoscopy item numbers in 2019 to align more closely with the NHMRC-endorsed Cancer Council Australia guidelines for surveillance colonoscopy.<sup>29</sup>

The latest revisions to the *Colonoscopy Clinical Care Standard* complement existing efforts that support care of patients undergoing colonoscopy for diagnostic, surveillance, screening or treatment purposes, including professional and state and territory-based initiatives such as certification and recertification of colonoscopists through the CCTRGE and RCCC and Safer Care Victoria's [Promoting best practice colonoscopy – Recommendations report](#).<sup>30</sup>

For more information about the development and review of this Clinical Care Standard and the indicators, visit the Commission's [Clinical Care Standards](#) website.

## Environmental sustainability in colonoscopy

The clinical practice of endoscopy, inclusive of colonoscopy and gastroscopy, is a significant contributor to both the waste generation and carbon footprint of health care.<sup>31,32</sup> A single endoscopic procedure is estimated to generate between 1.5 kg and 2.1 kg of disposable waste<sup>33,34</sup> and a carbon footprint of 4.8 kg CO<sub>2</sub>.<sup>35</sup> Endoscopy generates the second highest amount of waste per procedure, and the third highest amount of hazardous waste in healthcare facilities.<sup>31,32</sup>

Endoscopy is resource-intensive in nature. There are significant energy and water requirements for both the procedure and reprocessing of equipment, as well as a high volume of single-use devices.<sup>31</sup> The increase in the number of endoscopic procedures performed is accompanied by an increase in the need for histological analysis and accompanying carbon footprint. The processing of three biopsy pots generates carbon emissions equivalent to driving 2 miles (3.2 kilometres) in a car.<sup>36</sup>

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\* ACSQHC Atlas Focus Report: Colonoscopy. Sydney: ACSQHC; 2025.

† ACSQHC analysis of Medicare Benefits Scheme (MBS) claims data, 2016–17 – 2022–23.

‡ Recertification data, the Gastroenterological Society of Australia.

Ensuring that colonoscopy is offered to the right patient, at the right time and for the right reason is an important aspect to improving both patient care and sustainable practice. Reducing unnecessary and low-value colonoscopy procedures serves as the foundation of, and most effective strategy for, sustainable practice in colonoscopy.<sup>32</sup> It is estimated that 20–30% of gastrointestinal endoscopy procedures are inappropriate, exposing patients to avoidable risks without significant benefit and contributing to endoscopy's waste generation.<sup>31</sup> Adhering to evidence-based guidelines is an integral step to ensure clinical appropriateness and to minimise oversurveillance.<sup>31</sup> This is most likely to lead to swift, clinically appropriate and significant reductions in endoscopy-related waste and its carbon footprint. At the same time, appropriate bowel cancer prevention strategies can reduce the need for later interventions such as colonoscopy.<sup>19</sup>

While ensuring high-value colonoscopy is essential, there are other ways to promote environmental sustainability in colonoscopy practice. The principles of reduce, reuse and recycle are integral to sustainable practice in endoscopy.<sup>31,32</sup> Opportunities include:

- Adopting digital patient communications and information resources and electronic documentation and reporting practices where appropriate<sup>31</sup>
- Establishing waste management and triage of contaminated, non-contaminated and recyclable waste in line with local policies<sup>31,32</sup>
- Educating endoscopy staff in waste management and sustainable practices.<sup>32</sup>

# Quality statements

## Quality statement 1

# Initial assessment and referral

When a patient is referred for consideration of colonoscopy, the referring clinician provides sufficient information for the receiving clinician to assess the appropriateness, risk and urgency of consultation. The receiving clinician or service allocates the patient an appointment according to their clinical needs.

### Purpose

To ensure that communication of information from referring clinicians to colonoscopy services and specialists enables the timely and accurate assessment of patients according to clinical urgency and appropriateness.

### What the quality statement means

#### For patients

People might have a colonoscopy for different reasons and every person's situation is different. Just because you are referred to a specialist to consider having a colonoscopy does not mean that it will be the right thing for you.

It is important that the clinician or healthcare service that you are referred to has the right information about you and your medical history. This will help them decide if a colonoscopy is likely to help you. It may also help them decide how soon to book your appointment. The referral document should include:

- Your current and past medical conditions
- Your age
- Your family medical and cancer history
- Current medicines
- The results of previous tests, imaging and colonoscopies.

The clinician who gives you the referral will explain what to expect once the service has received your referral. In most cases, you will have a consultation with the clinician you are referred to before any procedure is booked. However, you may be referred to an open-access colonoscopy service if this is a suitable option for you. Open-access (sometimes called direct-access) means you will be booked for the procedure without having a consultation with the clinician performing your procedure beforehand (see [What is open-access colonoscopy?](#)).

## For clinicians

### Clinicians making referrals

When referring patients for consideration of colonoscopy, provide a comprehensive referral to enable accurate assessment of the patient's suitability for, and urgency of, colonoscopy. Standard (electronic) templates can help. See the Commission's [Colonoscopy Referral Information](#) for further information, and refer to local HealthPathways where relevant. The referral should include:

- The indication for the referral, including presenting symptoms and the clinical concern
- Results and dates of previous investigations, including iFOBT (indicating whether this was through the National Screening Program), colonoscopies and histopathology
- All relevant medical and family history, including of bowel and other cancers and known genetic predispositions
- Current medicines and other medical conditions
- Previous relevant treatment.

Consider the indications and surveillance intervals recommended in current evidence-based guidelines such as the Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*<sup>8</sup>, and *Clinical practice guidelines for surveillance colonoscopy*.<sup>9</sup> Evaluate the likelihood of the patient benefiting from the procedure, considering their overall health, comorbidities, likelihood of benefit from future management, the procedural risk and their willingness to proceed. Discuss with the patient whether the specialist receiving the referral will assess them individually before undertaking the colonoscopy. Give the patient information about what to expect, including whether there are likely to be costs. Provide an opportunity to ask questions and have them answered.

If referral to open-access services is an option, ensure the patient is suitable according to the local service intake guidelines and considering the patient's age, general health, comorbidities and ability to take bowel preparation independently. Provide clear instructions to the patient on what they need to do to act on the referral, the degree of urgency, and what to do if they cannot get an appointment in the recommended timeframe.

### Clinicians receiving referrals

When receiving referrals for colonoscopy, ensure that your protocols and processes allow for reviewing and determining appropriateness for the referral, and for allocating appointments based on clinical need. Clearly communicate the required referral information to referring clinicians, preferably using a standardised template.



## For healthcare services

### Healthcare services supporting referrals

Use consistent processes to ensure that referrals are accurate and comprehensive to enable assessment and prioritisation. Use an appropriate template, preferably electronic. See the Commission's [Colonoscopy Referral Information](#) for further information.

### Healthcare services receiving, allocating or prioritising referrals

Ensure that clear referral guidelines are available for referring clinicians, identifying the type and format of clinical information required. Ensure that processes support the provision of services according to the patient's clinical priority. Using agreed, standardised templates, preferably electronic, can assist the communication of important information between referring clinicians and colonoscopy services.

For open-access services, processes and procedures should ensure adequate consideration of the patient's comorbidities, current medications, risks and suitability for the procedure and:

- Include a process to assess the suitability of the patient for a direct-access procedure
- Include a process to obtain the patient's relevant information, including the dates and findings of previous colonoscopies
- Provide the opportunity for contact between the patient and a suitably trained clinician (including a registered nurse or nurse practitioner) before the day of the procedure to enable the patient to ask questions about the procedure, including about potential risks, benefits, and bowel preparation; this may be via telehealth when appropriate.

### What is open-access colonoscopy?

An open-access (sometimes called direct-access) colonoscopy service is a service which allows clinicians to refer patients for a colonoscopy without a prior consultation with the colonoscopist. Open-access models have been developed to improve access to services for suitable patients (such as following a positive screening iFOBT ['poo test']).



## Cultural safety and equity for Aboriginal and Torres Strait Islander people

Explain the rationale for assessment, tests and interventions to the patient and their family, carer, or support people in a culturally safe way.

Recognise and address potential barriers to people accessing care, such as language differences or being from a remote or disadvantaged community (see [Communication and person-centred care](#) for further information).

Consider actions to help reduce wait times and streamline referrals, such as:

- Ensure processes to capture and to act on identification data
- Ensure referrals and service intake processes provide an opportunity to self-identify
- Provide culturally appropriate and codesigned information resources (in local language as appropriate) and the opportunity to have questions answered with a trusted health professional
- Develop streamlined referral pathways, particularly for those from rural or remote communities, and liaise with primary care clinics including ACCHOs to ensure travel arrangements are in place.

### Related resources

- [Colonoscopy Referral Information](#) – outlines relevant information to support decision making (the Commission)
- [Culturally appropriate bowel screening resources](#) (SA Health).<sup>37</sup>

## Quality statement 2

# Appropriate and timely colonoscopy

A patient is offered timely colonoscopy when appropriate for the investigation of signs or symptoms of bowel disease, surveillance or screening, as consistent with national evidence-based guidelines. Decisions are made in the context of the patient's ability to tolerate the bowel preparation and colonoscopy, and their likelihood of benefit. If colonoscopy is not appropriate, the receiving clinician advises the patient and their referring clinician of alternative recommended management.

### Purpose

To ensure colonoscopy is offered to patients when appropriate to their clinical needs, in a timeframe concordant with their risk and likelihood of benefit, and in a manner consistent with current national evidence-based guidelines.

### What the quality statement means

#### For patients

Colonoscopy is used when clinicians want to look at the inside of the bowel to check for signs of disease. It may be recommended:

- If you are experiencing certain bowel problems
- To follow up a previous bowel condition
- Because of test results (such as a CT scan or iFOBT ['poo test'])
- Because of your family history or having a gene mutation such as Lynch Syndrome.

You should only be offered a colonoscopy if the benefits outweigh any risks of the procedure for you. While most people do not have any complications, the bowel preparation, sedation, and the colonoscopy all have some risks. Additionally, the process may involve time commitments, travel, and associated costs. Your clinician will discuss these risks with you, considering your general health. You should also talk about the risks of not having the colonoscopy. For some people a colonoscopy may need to be carried out as soon as possible, while for other people it may need to be done less urgently. If a colonoscopy is not recommended, then the clinician may suggest an alternative test.

## For clinicians

Consider whether colonoscopy is indicated for the patient according to national evidence-based guidelines, the epidemiology of disease (including bowel cancer and inflammatory bowel disease) and how findings on colonoscopy are likely to influence management. Assess the likely benefits to the patient, as well as the risks associated with the bowel preparation, sedation, the procedure itself, any further management and the risks associated with not having the procedure.

Refer to Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*.<sup>8</sup>

- For people with symptoms suggestive of bowel cancer or a positive iFOBT
- For people who are at markedly higher than average risk for bowel cancer such as those with familial syndromes, where screening colonoscopy is recommended.

For people requiring surveillance colonoscopy (including for inflammatory bowel disease), refer to Cancer Council Australia's *Clinical practice guidelines for surveillance colonoscopy*<sup>9</sup> regarding the frequency and surveillance intervals for colonoscopy in high-risk individuals.

Ensure that colonoscopy is triaged and scheduled according to relevant and locally approved triage criteria, that reflect Cancer Council Australia's guidelines.<sup>8</sup> If colonoscopy is not appropriate, advise the patient and their referring clinician about recommended alternative diagnostic strategies or management.

## For healthcare services

Ensure that policies and processes support the timely and appropriate provision of colonoscopy. This includes:

- Supporting and promoting clinicians' use of national evidence-based guidelines, including Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*<sup>8</sup> and *Clinical practice guidelines for surveillance colonoscopy*<sup>9</sup>
- Supporting and encouraging clinician participation in quality improvement and peer-review processes.

For healthcare services that receive referrals, ensure that policies and procedures for triage and scheduling of colonoscopy appointments for bowel cancer-related indications reflect guideline recommendations from the Cancer Council Australia in regard to timeliness of follow-up or investigation. Consider state and territory-based colonoscopy categorisation criteria, such as NSW Agency for Clinical Innovation's [NSW colonoscopy categorisation](#)<sup>38</sup> and Victoria Department of Health's [Colonoscopy categorisation guidelines](#)<sup>39</sup>, as relevant to the setting.

## Related resources

- [Optimal care pathways: Colorectal cancer](#) – a framework for delivery of high-quality evidence-based care for people with cancer (Cancer Council Victoria and Department of Health Victoria).<sup>40</sup>

### Indicators for local monitoring

**Indicator 2a:** Evidence of a locally approved policy that ensures the timely and appropriate provision of colonoscopy.

The locally approved policy should specify the processes to:

- Ensure that the referring clinicians are informed of the referral process for colonoscopy and the information required in a referral
- Support the provision of colonoscopies according to the patient's clinical priority
- Triage and schedule patients with bowel cancer-related indications in line with national evidence-based guidelines
- Monitor adherence to the locally approved policy.

METEOR link: [meteor.aihw.gov.au/content/803426](https://meteor.aihw.gov.au/content/803426)

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

## Quality statement 3

# Informed decision making and consent

Before starting bowel preparation, a patient receives comprehensive patient-appropriate information about bowel preparation, the colonoscopy, and sedation or anaesthesia. The patient has an opportunity to discuss the reason for the colonoscopy, the risks, benefits, financial costs and alternative options before deciding to proceed. Their understanding is assessed, and the information provided and their consent to sedation, colonoscopy and therapeutic intervention is documented.

### Purpose

To ensure that each patient is provided with adequate information and time to consider their risks and benefits of undergoing a colonoscopy before providing informed consent and before starting bowel preparation or any other aspect of the procedure.

### What the quality statement means

#### For patients

If your clinician recommends that you have a colonoscopy, you will need to decide whether to go ahead with it. To help you make your decision, your clinician will explain all parts of the process to you, including:

- Bowel preparation – the process for clearing your bowel before the colonoscopy using medicines, changing your diet and fasting (not eating for a period of time)
- Sedation – medicines given to minimise discomfort during the colonoscopy
- The colonoscopy procedure – how the colonoscope is used to look at your bowel, and to help remove polyps or tissue samples
- What to expect after the procedure.

The discussion will include:

- Why the clinician is recommending a colonoscopy
- Benefits to your health
- Risks of the bowel preparation, sedation and the colonoscopy
- Risks of not having the colonoscopy
- What happens during a colonoscopy
- Any out-of-pocket costs
- Any alternatives to colonoscopy.

The decision about whether to have a colonoscopy is yours. You can ask for time to make your decision. If you decide to have the colonoscopy, you will be asked to give consent. Giving consent means that you understand what is involved in having the colonoscopy, what the risks and benefits are for you, and that you agree to have the colonoscopy. It is important that you ask questions if you need more information before you make your decision. This should happen before you start the bowel preparation. If you need an interpreter or any other assistance with communication, this can be arranged. If you choose to have the colonoscopy, your consent will be recorded in writing. Even after you have given your consent, you can ask for more information or change your mind about having the colonoscopy at any time before the colonoscopy begins.

## **For clinicians**

Provide the patient (or their responsible decision maker where relevant) with clear and comprehensive information about all aspects of the colonoscopy relevant to the patient's decision and consent. Include information about the bowel preparation, the use of sedation (or anaesthesia), the colonoscopy and any therapeutic interventions. Use language that they can understand. Arrange an interpreter if required.

Inform the patient of:

- The reason for the colonoscopy
- Its likelihood of benefits
- Potential adverse events, including those related to the bowel preparation or sedation, perforation, bleeding (immediate and delayed), splenic injury and missed pathology
- What happens during a colonoscopy
- The financial costs
- The alternatives to having the colonoscopy, including any risks of not having the colonoscopy.

Information on potential adverse events, risks and benefits should be individualised and relevant to the patient. Provide adequate time for the patient to consider the information provided and to ask questions before consenting. Respect the patient's decision and document it and their informed consent in the medical record, with a description of the information discussed and provided to the patient.

## For healthcare services

Ensure that clear, written information is available to patients for all aspects of the colonoscopy for which the health service organisation is responsible. This may include information about bowel preparation, the colonoscopy and associated sedation or anaesthesia.

When consent is being obtained, ensure protocols and procedures enable patients to receive adequate information to inform their decision, are supported to ask questions, and provide consent before the start of bowel preparation. Ensure interpreter services are accessible, and their use is supported. Ensure policies and procedures support the principles and practices of informed consent and appropriate documentation.<sup>41-43</sup>



## Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide written and visual information in a way which reflects the literacy, language, and cultural needs of the individual patient and builds understanding, engagement and empowerment. Written material for Aboriginal and Torres Strait Islander populations should be developed in partnership with the community and people with expertise in Aboriginal and Torres Strait Islander health issues.

Include family, kin, community members or other trusted healthcare providers in discussions, if the patient desires this. Allow time to build rapport and trust. Consider the need for multiple appointments and methods of communication. Explore and address any concerns or stigma associated with the potential diagnosis, such as for cancer.

## Related resources

- [Implementing the Colonoscopy Clinical Care Standard – informed consent](#) – outlines key actions for health service organisations (the Commission)
- [Information about colonoscopy](#) – a fact sheet for patients (Gastroenterological Society of Australia [GESA]).<sup>44</sup>



## Quality statement 4

# Bowel preparation

A patient booked for colonoscopy receives a bowel preparation product and dosing regimen individualised to their needs, comorbidities, regular medicines and previous response to bowel preparation. The importance of good bowel preparation for a quality colonoscopy is discussed with the patient. They are provided with consumer-appropriate instructions on how to use the bowel preparation product and their understanding is confirmed.

### Purpose

To ensure that patients who present for colonoscopy have a clear bowel that enables a thorough examination.

### What the quality statement means

#### For patients

Before you have a colonoscopy, you need to make sure your bowel is as clear as possible. If your bowel is not clear, polyps or even cancers may be missed, or you may need to have the colonoscopy again. This means it is important for you to follow the instructions carefully and ask questions if you do not understand what to do. To get your bowel ready for the colonoscopy, you will be:

- Given instructions about what (and what not) to eat and drink
- Advised when to drink extra fluids to stop you from getting dehydrated
- Given, or asked to buy, medicine to clear out your bowel by causing diarrhoea.

Make sure you understand when to take the medicines, usually starting the day before the colonoscopy. Your clinician will explain how these medicines may affect you. You should tell them about any previous experience you have had with bowel preparation.

Preparation for colonoscopy can also affect your other health conditions or medicines, such as medicines for diabetes, weight loss or to prevent blood clots. You may need to stop or change the way you take your other medicines or follow special instructions in the days before your colonoscopy. Check with your clinician about all your usual medicines. They will discuss any changes you may need to make. During bowel preparation, some people may need extra personal or health support and a few may need an overnight stay in hospital.

If at any time during the bowel preparation you are unsure what to do, ring your clinician or clinic to check.

## **For clinicians**

Provide written and verbal consumer-appropriate information to patients preparing for colonoscopy, using interpreter services where necessary. Select an appropriate bowel preparation agent and ensure the patient knows how to obtain and use it, considering individual risks, comorbidities, current medicines, and the patient's previous experience with bowel-cleansing medicines.<sup>45</sup> Clearly explain the purpose of bowel preparation, the importance of following the prescribed procedure, the regimen and the potential side effects of the bowel preparation products. Allow the patient appropriate time to ask questions and confirm that they understand what to do and its importance. Let the patient know who they can contact if they are unclear about what to do.

A split-dose regimen results in a higher quality colonoscopy examination compared with ingestion of the entire preparation on the day or evening before the colonoscopy and has been associated with increased adenoma detection rates.<sup>46</sup> Typically, this involves splitting the standard dose of the bowel preparation between the day before and the morning of the colonoscopy. Ensure that some of the bowel preparation dose is given on the same day of the procedure (3–6 hours before the planned start of the procedure).<sup>46</sup>

Ensure patients on diabetes medicines, anticoagulants, antiplatelets, or other medicines are provided with individualised instructions about how to adjust their medicines and manage their condition as they undergo bowel preparation. Enquire about the patient's use of medicines to lose weight, due to the potential complications in endoscopic procedures (see [Related resources](#) for further information).<sup>47</sup> Consider whether a patient with relevant comorbidities needs specific health or personal support while undergoing bowel preparation. For example, overnight admission for patients who are unlikely to manage bowel preparation independently.

## **For healthcare services**

Ensure that policies and procedures support best practice for bowel preparation. Support patients by enabling access to information about bowel preparation. Healthcare services with responsibility for providing bowel preparation and advice should ensure processes to:

- Provide clear, written patient information about the bowel preparation procedure
- Provide access to interpreter services or translated materials
- Provide a telephone number for enquiries patients may have during bowel preparation
- Enable clinical staff to periodically review and approve patient information.

Where relevant to the facility, ensure policies support providing extra assistance to patients who are unlikely to manage bowel preparation independently, including overnight admission if needed.



## Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide culturally appropriate written and visual instructions on what to do for bowel preparation before a colonoscopy.

Allow time to yarn about why it is needed and what to expect, and consider any complicating factors (such as living arrangements or the need to travel).

## Related resources

### For patients

- [What you need to know before you have a colonoscopy](#) – a consumer video that provides helpful information, including on bowel preparation (the Commission)
- [Information about bowel preparation](#) – a fact sheet that provides information for patients having a colonoscopy (GESA).<sup>48</sup>

### For clinicians

- [Sodium glucose co-transporter 2 inhibitors | Safety advisory – diabetic ketoacidosis and surgical procedures](#) (Therapeutic Goods Administration [TGA])<sup>49</sup>
- [Periprocedural diabetic ketoacidosis \(DKA\) with SGLT2 inhibitor use in people with diabetes – updated alert](#) (Australian Diabetes Society [ADS])<sup>50</sup>
- [Clinical Practice Recommendations regarding patients taking GLP-1 receptor agonists and dual GLP-1/GIP receptor co-agonists prior to anaesthesia or sedation for surgical and endoscopic procedures](#) (ANZCA, GESA, National Association of Clinical Obesity Services [NACOS], ADS).<sup>47</sup>

## Quality statement 5

# Sedation

Before colonoscopy, a patient is assessed by an appropriately trained clinician to identify any increased risk, including cardiovascular, respiratory or airway compromise. The use of sedation is planned accordingly. The risks and benefits of sedation are discussed with the patient. Sedation is administered and the patient is monitored throughout the colonoscopy and recovery period in accordance with Australian and New Zealand College of Anaesthetists guidelines.

### Purpose

To ensure the safe and appropriate sedation of patients undergoing colonoscopy.

### What the quality statement means

#### For patients

Just before starting your colonoscopy, you will be given medicines to minimise your pain or discomfort (sedation). A doctor or nurse will first check any risks for you about having the sedation. They will ask about your health, medical conditions, medicines and previous experiences with sedation or anaesthesia. This is to make sure that you are given sedation safely. They will also talk with you about the medicines they will use during your sedation, their risks and benefits, and what you can expect to be aware of during the colonoscopy and as you recover. Discuss any concerns or preferences with your clinician, including the option for no sedation.

Your sedation will be given according to current professional recommendations and guidelines and will take into account your risks. Your sedation may be given by a specialist anaesthetist, but this is not always required.

#### For clinicians

Provide patients with the opportunity to discuss the approach to sedation. This may include the option of no sedation where this is the patient's preference and is clinically appropriate.

Ensure that the patient's suitability for sedation is assessed in advance of the colonoscopy by a clinician who is appropriately trained to make such an assessment. This should include assessment of any increased risks such as cardiovascular, respiratory or airway compromise.

Ensure that the facility is appropriate for the patient, taking into account their clinical requirements and comorbidities, as described in ANZCA's *Guideline for the perioperative care of patients selected for day stay procedures (PG15)*.<sup>10</sup> If an increased risk is identified, an anaesthetist, or other trained and credentialed medical practitioner within their scope of practice, should assess the patient and be present during the colonoscopy to care for the patient.

Consider whether the patient is likely to require overnight admission or increased medical support and whether admission to a day procedure unit is appropriate. The sedationist should discuss the risks and benefits with the patient and obtain their informed decision and consent. Ensure that the patient understands that their awareness of the colonoscopy will depend upon the depth of sedation.<sup>51</sup>

Sedation must be administered by a credentialed practitioner working within their scope of practice. Both anaesthetist and non-anaesthetist clinicians should provide sedation as described in current ANZCA guidelines with respect to:

- The number of staff present during the sedation and their level of training, competence and scope of clinical practice
- Facilities, equipment and medicines
- Administration of sedation
- Monitoring of patients during the colonoscopy and in the recovery room.

**Note:** Whilst anaesthetists are specialists in the sedation–anaesthesia continuum, sedation may be administered and managed by clinicians from other clinical disciplines. ANZCA's *Guideline on procedural sedation (PG09)* outlines the requirements for non-anaesthetist sedationists managing minimal or moderate procedural sedation.<sup>11</sup> (See sedationist in the [Glossary](#) for further information). For anaesthetists targeting deep sedation or general anaesthesia, the patient should be managed by a medical practitioner trained and credentialed to provide anaesthesia. Refer to ANZCA's *Guideline for the perioperative care of patients selected for day stay procedures (PG15)* and *Position statement on roles in anaesthesia and perioperative care (PS59[A])*.<sup>11,52</sup>

## For healthcare services

Sedation and anaesthesia should be provided in accordance with current ANZCA recommendations such as the *Guideline on procedural sedation (PG09)*<sup>11</sup>, *Guideline for the perioperative care of patients selected for day stay procedures (PG15)*<sup>10</sup> and *Position statement on informed consent for anaesthesia or sedation (PS26)*.<sup>51</sup>

Ensure that local policies and procedures are in place, and services adequately resourced, to implement the ANZCA guidelines. Policies should ensure that pre-sedation assessment is carried out by appropriately trained clinicians to identify patients who are not suitable for intravenous sedation in the absence of an anaesthetist, and to plan for sedation accordingly. Policies should include arrangements for providing colonoscopy without sedation where the managing colonoscopist has assessed this as clinically appropriate for the patient and it is the patient's preference.

Ensure that clinicians who administer sedation or anaesthesia for colonoscopy are credentialed by the health service organisation and are operating within their defined scope of clinical practice. Ensure that clinicians maintain their skills by participating in ongoing professional development and review of performance. Ensure sedationists achieve the Safe Sedation Competencies as described by ANZCA.<sup>11</sup> Implement and ensure compliance with policies and procedures for the safe supervision of trainees, where relevant to the facility.



## **Cultural safety and equity for Aboriginal and Torres Strait Islander people**

Involve Aboriginal and Torres Strait Islander Liaison Officers or Aboriginal and Torres Strait Islander Health Practitioners and Workers where available to address potential concerns about sedation.

# Quality statement 6

## Clinicians

A patient's colonoscopy is performed by a credentialed clinician working within their scope of clinical practice, who meets the requirements of an accepted certification and recertification process. Sedation or anaesthesia, and clinical support are provided by credentialed clinicians working within their scope of clinical practice.

### Purpose

To ensure all colonoscopies and associated sedation and clinical care are provided by skilled clinicians and are performed safely and at a high level of quality.

### What the quality statement means

#### For patients

When you have a colonoscopy, you can expect to be cared for by qualified clinicians who have met necessary health service organisation and professional requirements and standards. This includes the clinicians providing your nursing care, sedation or anaesthesia, and your colonoscopy. You can expect that the doctor or specialist nurse who carries out the colonoscopy will keep their skills and knowledge up to date.

#### For clinicians

Ensure that your training, skills and experience allow you to provide safe, high-quality care to a patient undergoing colonoscopy, in accordance with expected professional standards. Comply with your health service organisation's policies and procedures regarding your scope of clinical practice. Interact with your peers to ensure your performance, and theirs, meets the accepted requirements for safety and quality (for example, participate in peer-review meetings and quality clinical improvement processes – including the collection of quality indicators and reviews of evidence-based best practice).

If you are a colonoscopist, undergo certification and participate in a recertification process that is accepted by your professional association and employer. Supervise trainees at a level appropriate to their skill and experience.

If you are a clinician providing sedation, ensure you meet the Safe Sedation Competencies as described in ANZCA's *Guideline on procedural sedation (PG09)*.<sup>11</sup>

## For healthcare services

Identify credentials that are required for clinicians to perform colonoscopy or provide sedation or anaesthesia for patients undergoing colonoscopy, and ensure credentialing processes are adequate, as set out in *Credentialing health practitioners and defining the scope of clinical practice: A guide for managers and practitioners*.<sup>53</sup>

For clinicians performing colonoscopy, identify accepted certification and recertification processes according to their clinical speciality and professional body and use this when credentialing clinicians and defining their scope of clinical practice. For trainee colonoscopists working towards certification, implement and ensure compliance with policies and procedures for the safe supervision of trainees. Ensure that non-anaesthetist clinicians who provide sedation fulfil the training and competencies outlined in the Safe Sedation Competencies and are targeting an appropriate level of sedation (minimal to moderate sedation), as described in ANZCA's *Guideline on procedural sedation (PG09)*.<sup>11</sup> Support participation by clinicians in peer-review activities.



## Cultural safety and equity for Aboriginal and Torres Strait Islander people

Ensure clinicians proactively reflect on their assumptions and biases, and provide care that is holistic, culturally safe, and free of discrimination and racism (see recommendations at [Building culturally safe systems](#)).

## Related resources

- [Certification and Re-certification of practising adult colonoscopists](#) – a fact sheet outlining key actions for clinicians (the Commission)
- [Guideline on procedural sedation \(PG09\)](#) – see Appendix IV for guidelines on competencies applicable to clinicians managing procedural sedation (ANZCA).<sup>11</sup>



## Quality statement 7

### Procedure

When a patient is undergoing colonoscopy their entire colon – including the caecum – is examined carefully and systematically. The adequacy of bowel preparation, clinical findings, biopsies, polyps removed, therapeutic interventions and details of any adverse events are documented. All polyps removed are submitted for histological examination.

#### Purpose

To optimise detection and management of disease, minimise adverse outcomes for all patients who undergo colonoscopy, and ensure the colonoscopy is documented adequately in the patient's health record.

#### What the quality statement means

##### For patients

Your colonoscopy will be performed to a high standard. During the colonoscopy, the whole length of your bowel will be carefully examined. This will make it more likely that bowel problems can be found and that growths such as polyps can be seen and removed. If bowel tissue or polyps are removed from your bowel they will be sent to pathology laboratories for examination under a microscope. All the records kept by health service organisations will have information about your colonoscopy, the findings, and any complications that may have occurred during the procedure. You can ask to see this information if you want to.

##### For clinicians

To maximise adenoma detection, intubate the caecum or terminal ileum and allow adequate time for mucosal inspection whenever performing colonoscopy.<sup>54</sup> In people with previous resection, examine the remaining bowel thoroughly. Assess the adequacy of bowel preparation using a validated tool such as the Boston Bowel Preparation Scale, Ottawa Bowel Preparation Scale, or the Aronchick Scale.<sup>55</sup>

Document the quality of the bowel preparation, whether caecal intubation was achieved (with photodocumentation), withdrawal time, clinical findings, the details of polyps removed, how they were removed and whether they were retrieved. Ensure that all polyps removed are retrieved, where possible, and are sent for histopathology examination. For patients referred for colonoscopy due to a positive National Screening Program iFOBT result, reporting to the National Cancer Screening Register should occur as soon as possible.

Record adverse events, including perforation, post-polypectomy bleeding and sedation-related cardio-respiratory compromise in the patient record and relevant quality systems (for example, the facility's incident monitoring system). Inform the patient if adverse events have occurred and how they have been managed.

Equipment used to perform the colonoscopy should be of adequate quality to enable safe and accurate visualisation and photodocumentation of the bowel. Any adjunctive technologies (such as artificial intelligence [AI] polyp detection, foot pump irrigation and narrow band imaging) should be used in an assistive capacity and according to local policy. Clinicians remain accountable for delivering safe and high-quality care regardless of the technology used, and for ensuring their practice meets their professional obligations.<sup>56</sup>

## For healthcare services

Establish procedures to collect and periodically monitor the quality of colonoscopies at the service level, including caecal intubation, adenoma detection rate, sessile serrated lesion detection rate and adequacy of bowel preparation. Review and share organisation and clinician-level data findings with clinicians as part of quality monitoring and clinical quality improvement activities (such as clinical review meetings). Ensure that the number of patients booked on each list enables the colonoscopist to undertake a careful and systematic examination of each patient's colon. Review list sizes periodically as part of procedures to monitor the quality of colonoscopies at the healthcare service. Ensure a process is in place to act promptly and effectively on any results suggesting substandard quality.

Provide systems that require and support colonoscopists to maintain accurate records of the colonoscopy. This includes the adequacy of bowel preparation, biopsies taken, polyps removed and retrieved, all diagnostic and therapeutic interventions, details of any adverse events and procedure duration. Ensure complications and adverse events of colonoscopy are reported and monitored in the organisation's incident management system and other relevant systems and investigated appropriately.

Ensure that the standard of equipment provided for colonoscopy supports safe, high-quality colonoscopy, including for visualisation and photodocumentation. Ensure that organisational policies and procedures support the assessment of technology and equipment used for colonoscopy to identify the benefits and consequences of use, and appropriate clinical governance.

## Artificial intelligence

Governance for safety and quality in the use of artificial intelligence (AI) in health care is rapidly evolving, with guidelines and regulations regarding safety, effectiveness, security and ethical considerations of new AI technologies emerging or under consideration. While some current organisational policies for assessment of new clinical technologies may include assessment of AI, guidance on the requirements for safe and effective use will continue to evolve and health services may need to assess whether policy allows adequate evaluation of AI. Currently, health services and clinicians are advised to consider ethical considerations outlined by relevant organisations (see [Related resources](#)).<sup>57</sup>

## Related resources

- [Colonoscopy Report Template](#) for use by colonoscopists (the Commission)
- [Open Disclosure resources for consumers](#) (the Commission).

Clinicians and healthcare services should refer to the current available advice on artificial intelligence, such as:

- [AI Implementation in Hospitals: Legislation, Policy, Guidelines and Principles, and Evidence about Quality and Safety](#) (the Commission)<sup>57</sup>
- [Position statement on artificial intelligence in healthcare](#) (Australian Medical Society [AMA])<sup>58</sup>
- [Artificial intelligence \(AI\) and healthcare resources](#) (Australian Alliance for Artificial Intelligence in Healthcare)
- [Meeting your professional obligations when using artificial intelligence in healthcare](#) (Australian Health Practitioner Regulation Agency [AHPRA])<sup>56</sup>
- [Artificial intelligence – our work](#) (Royal Australian and New Zealand College of Radiologists [RANZCR]).<sup>59</sup>

### Indicators for local monitoring

**Indicator 7a:** Proportion of patients who had a colonoscopy whose bowel preparation was adequate using a validated assessment tool.

METEOR link: [meteor.aihw.gov.au/content/803428](https://meteor.aihw.gov.au/content/803428)

**Indicator 7b:** Proportion of patients who had a colonoscopy whose entire colon was examined to the caecum and/or terminal ileum.

METEOR link: [meteor.aihw.gov.au/content/803430](https://meteor.aihw.gov.au/content/803430)

**Indicator 7c:** Proportion of patients who had a colonoscopy that detected one or more adenoma(s).

METEOR link: [meteor.aihw.gov.au/content/803432](https://meteor.aihw.gov.au/content/803432)

**Indicator 7d:** Proportion of patients who had a colonoscopy that detected one or more sessile serrated lesion(s).

METEOR link: [meteor.aihw.gov.au/content/803434](https://meteor.aihw.gov.au/content/803434)

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

## Quality statement 8

# Discharge

Following recovery and before discharge, the patient is advised verbally and in writing about the preliminary outcomes of the colonoscopy, the nature of any therapeutic interventions or adverse events, when to resume regular activities and medicines, and arrangements for medical follow-up. The patient is safely discharged into the care of a responsible adult, in accordance with Australian and New Zealand College of Anaesthetists guidelines.

### Purpose

To ensure patients recover and are discharged safely with available information about the outcomes of the colonoscopy and arrangements for follow-up.

### What the quality statement means

#### For patients

After your colonoscopy, you will be cared for while you recover from the sedation. Before you go home, a doctor or nurse will tell you what happened during the colonoscopy, whether any polyps or other tissue were removed and whether there were any problems during the procedure. They will tell you about any arrangements or follow-up appointments you need to make. You may find it difficult to remember this information so it will be also given to you in writing. You will also be provided a copy of your colonoscopy report (see [Quality statement 9 – Reporting and follow-up](#)).

You will be able to go home once your doctor or nurse is satisfied that you have recovered from the sedation. You should not drive and should have an adult to accompany you home. It is also recommended that you have someone stay with you on the night after the colonoscopy. If this is not possible, discuss this with your clinician before you have the colonoscopy.

You will be given written instructions on how to care for yourself when you go home and when to start your regular medicines and diet again. You will be provided with information about what to do if you have any problems after going home, including a phone number that you can call after hours.

## For clinicians

Before discharge, the responsible clinician or their delegate should talk to the patient and briefly describe what happened during the colonoscopy. This includes whether the colonoscopy was completed satisfactorily, initial observations, whether biopsies or polypectomies were performed, and if any adverse events occurred. Advise patients of any arrangements for follow-up medical consultation and when final results and recommendations will be provided to them and their referring clinician.

Ensure patients are discharged by authorised clinical personnel into the care of a responsible adult after satisfactory discharge criteria are met. If, despite all reasonable efforts, a responsible adult is not available, the clinician responsible for managing sedation may exercise their judgement in deciding alternative post-sedation supervision and transport (excluding driving or public transport).<sup>11</sup> Any exception should take into account the nature and duration of the sedation, and the patient's recovery and risk of adverse events, in accordance with ANZCA's *Guideline on procedural sedation (PG09)*.<sup>11</sup> Alternatives, including admission or scheduling of appointments to allow longer periods in recovery, should be explored when scheduling admissions to avoid denying colonoscopy to people due to their social circumstances.

Provide instructions about early post-procedure care and resumption of normal activities, including making legally binding decisions, operating machinery and resuming regular medication. Advise patients of what to do if they experience symptoms suggesting a complication of the colonoscopy and provide them with specific contact details for obtaining appropriate advice. Any information given verbally about the procedure or post-discharge should also be provided in written format. Consider admission for a patient at high risk of an adverse outcome who is otherwise not suitable for discharge.

## For healthcare services

Ensure that policies and procedures for monitoring, supervising and discharging patients align with current recommendations for post-operative care following sedation or anaesthesia (for example, ANZCA's *Guideline for the perioperative care of patients selected for day stay procedures (PG15)*).<sup>10</sup>

Ensure that procedures are in place for discharging patients into the care of a responsible adult. Exceptions to post-sedation supervision by a responsible adult and transport to their discharge destination (excluding driving or public transport) should be based on the clinical judgement of the clinician managing sedation.<sup>11</sup> Exceptions should take into account the depth of sedation and be in accordance with ANZCA guidelines.<sup>11</sup>

Provide written instructions about early post-procedure care and resumption of normal activities, including medicines. Ensure that there is a response plan for patients in the event of problems arising post-discharge. Provide patients with discharge information, including specific health service contact details after hours.

Pre-admission procedures should identify patients who genuinely cannot identify a responsible adult to accompany them home and stay with them overnight and allow for suitable arrangements to be made, according to their risk. Policies should allow for extended recovery periods and overnight admission, if needed, for patients who have comorbidities and cannot be cared for adequately at home in the immediate period post-discharge or who do not meet discharge criteria (as appropriate to the type of facility).



## **Cultural safety and equity for Aboriginal and Torres Strait Islander people**

Ensure that information given to patients is provided in a way that the patient understands and is culturally safe. Allow time for explanation and questions. Use plain language and visual aids where appropriate. Involve family or kin, Aboriginal and Torres Strait Islander Liaison Officers and translators where needed.

## Quality statement 9

# Reporting and follow-up

The colonoscopist communicates the reason for the colonoscopy, its findings, any histology results and recommendations for follow-up in writing to the general practitioner, any other relevant clinician and the patient. This information is recorded in the facility records and other electronic shared record management systems to enable accurate follow-up by other clinicians. Recommendations for surveillance colonoscopy, if required, align with national evidence-based guidelines. If more immediate treatment or follow-up is needed, the colonoscopist makes appropriate arrangements.

### Purpose

To ensure the results of colonoscopy are effectively communicated and that patients are offered follow-up treatment or ongoing surveillance in accordance with evidence-based guidelines.

### What the quality statement means

**Electronic shared record management systems** refers to any systems that support clinicians to accurately manage, follow-up and recall patients, including to support adherence to the evidence-based clinical guidelines for surveillance colonoscopy. This includes My Health Record and the National Cancer Screening Register.

### For patients

The results of your colonoscopy will be given to you, your general practitioner, and any of your other doctors who may need to be informed. The results can also be added to your electronic health record, known as the My Health Record. The letter or report will say why you had the colonoscopy, what was found, whether any tissue or growths (such as polyps) were removed from your bowel and sent for testing, and the results of those tests.

The report will also say whether you need to go and see a doctor for a follow-up visit, have further tests or treatment or another colonoscopy in the future, and when these should happen. These recommendations will be different for each person and will depend on your medical and family history and what was found during the colonoscopy.

## For clinicians

Ensure a colonoscopy report is provided to the patient, their GP and any other relevant clinicians that includes:

- The reason for the colonoscopy
- Findings during the colonoscopy examination
- Histology results where relevant
- Recommendations for follow-up based on national evidence-based guidelines.

Ensure that both positive and negative histology findings are communicated. The need and time interval for future screening and surveillance colonoscopies should be guided by evidence-based guidelines, such as the Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*<sup>8</sup>, and *Clinical practice guidelines for surveillance colonoscopy*.<sup>9</sup> If prompt treatment or investigation is required (such as for histologically confirmed colorectal cancer or high-risk lesions), make the necessary arrangements and ensure these are communicated to the patient and their referring clinician. If presenting symptoms have not been explained by the colonoscopy, advise the patient and refer on if further investigation or treatment is required.

Upload the report and results to the patient's healthcare record and My Health Record (if this capability is available in clinical information systems). For National Screening Program participants, report colonoscopy outcomes, results and adverse events to the National Cancer Screening Register.

## For healthcare services

Ensure that policies and procedures clearly delineate responsibilities for managing patient recall and follow-up for the colonoscopist, the health service and the GP. Ensure that policies and procedures for information management and communication reflect these arrangements. To ensure complete reporting of colonoscopy, policies should:

- Include arrangements for the reporting of all histology results if any tissue was removed, regardless of the histological findings
- Ensure surveillance intervals are updated based on histology results
- Ensure histology results, updated surveillance intervals and other recommendations are uploaded to the facility records and other shared record systems such as the My Health Record
- Ensure the colonoscopy report, histology outcomes and surveillance intervals are provided to referring clinicians (GPs), other relevant clinicians and the patient
- Support reporting to the National Cancer Screening Register for patients referred through participation in the National Screening Program.

Ensure systems are in place for the prompt communication and management of histologically confirmed colorectal cancer or high-risk lesions. Support and promote clinicians' use of national evidence-based guidelines, such as the Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*<sup>8</sup> and *Clinical practice guidelines for surveillance colonoscopy*<sup>9</sup>, when making recommendations for future surveillance and follow-up.





## Cultural safety and equity for Aboriginal and Torres Strait Islander people

Ensure documentation, including results, follow-up and future management, is provided to the referring primary healthcare provider or ACCHO in a timely fashion.

Ensure clinicians have sufficient cultural competence to support Aboriginal and Torres Strait Islander peoples' participation in bowel cancer prevention and treatment and use culturally appropriate materials.

## Related resources

### For patients

- [Bowel Cancer: How to reduce your risk – Fact sheet](#) (the Commission)
- [Check your cancer risk](#) online tool (Cancer Australia)
- [Lifestyle and Risk Reduction](#) webpage for practical tips and information (Cancer Australia).

### For colonoscopists and healthcare services

- [Colonoscopy Report Template](#) (the Commission)
- [Forms for healthcare providers](#) (National Bowel Cancer Screening Program)
- [Healthcare provider portal](#) for health professionals to access and submit screening data for the bowel and cervical screening programs (National Cancer Screening Register)
- [Value In Care – Optimising Surveillance Colonoscopy \[VIC-COL\] multi-component quality improvement strategy tools](#) (Monash University).

## Indicators for local monitoring

**Indicator 9a:** Evidence of local arrangements to ensure information about a person's colonoscopy is recorded and shared to enable accurate follow-up.

The local arrangements should specify the:

- Policy that defines responsibility for managing patient recall and follow-up
- Process to ensure all histology results for any tissue removed, regardless of the histological findings, are recorded in the patient's healthcare record, facility record and other shared electronic record systems, such as My Health Record
- Process to ensure any surveillance intervals and recommendations are revised based on histology results and updated in the patient's healthcare record, facility record and other shared electronic record systems such as My Health Record, to facilitate patient recall
- Process to ensure the colonoscopy report, histology outcomes and surveillance interval are provided to the referring clinician (GP), other relevant clinicians and the patient
- Process to support reporting to the National Cancer Screening Register for patients referred through the National Bowel Cancer Screening Program.

METEOR link: [meteor.aihw.gov.au/content/803436](https://meteor.aihw.gov.au/content/803436)

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

# Appendix:

## Updates in the 2025 Standard

Section	Action	Description
<b>Quality statement 1</b>	Amended	<ul style="list-style-type: none"> <li>Clarification of the responsibilities of the referring clinician and the receiving clinician or healthcare service.</li> <li>Additional information on expectations in referral for open-access colonoscopy (also referred to as direct-access).</li> </ul>
<b>Quality statement 2</b>	Amended	Increased emphasis for the triaging and scheduling of colonoscopies in alignment with evidence-based guidelines.
<b>Quality statement 4</b>	Amended	Additional information on considerations for bowel preparation and associated medication management.
<b>Quality statement 5</b>	Amended	<ul style="list-style-type: none"> <li>Amended to encompass the use of no sedation, where it is the patient's preference and is clinically appropriate.</li> <li>Additional information on competencies that non-anaesthetist sedationists should achieve.</li> </ul>
<b>Quality statement 7</b>	Amended	<ul style="list-style-type: none"> <li>Additional information on the use of equipment and adjunctive technologies, and considerations for the use of artificial intelligence.</li> <li>Addition of photodocumentation as a minimum requirement.</li> </ul>
<b>Quality statement 8</b>	Amended	<ul style="list-style-type: none"> <li>Amended to reflect professional guideline recommendations for post-sedation supervision and discharge requirements.</li> <li>Additional considerations for healthcare services for patients who do not have a responsible adult to accompany them home.</li> </ul>
<b>Quality statement 9</b>	Amended	<ul style="list-style-type: none"> <li>Amended to include the recording of information in other electronic shared record management systems, such as My Health Record and the National Cancer Screening Register, where appropriate.</li> <li>Additional information for healthcare services to support the complete reporting of colonoscopy and communication with relevant clinicians and health services.</li> </ul>

Section	Action	Description
<b>Indicator 2a</b>	New	Evidence of a locally approved policy that ensures the timely and appropriate provision of colonoscopy.
<b>Indicator 4 (now 7a)</b>	Amended	<ul style="list-style-type: none"> <li>Amended wording from 'whose bowel preparation was adequate' to 'whose bowel preparation was assessed as adequate using a validated assessment tool'.</li> <li>Added all adult patients.</li> </ul>
<b>Indicator 7a (now 7b)</b>	Amended	<ul style="list-style-type: none"> <li>Amended wording from 'entire colon was examined' to 'entire colon was examined to the caecum and/or terminal ileum'.</li> <li>Added all adult patients.</li> </ul>
<b>Indicator 7b (now 7c)</b>	Amended	Amended exclusion criteria for inflammatory bowel disease.
<b>Indicator 7c (now 7d)</b>	Amended	<ul style="list-style-type: none"> <li>Amended wording from 'sessile serrated adenoma/polyp' to 'sessile serrated lesion'.</li> <li>Amended exclusion criteria for inflammatory bowel disease.</li> </ul>
<b>Indicator 9a</b>	New	Evidence of local arrangements to ensure information about a person's colonoscopy is recorded and shared to enable accurate follow-up.

# Glossary

Term	Definition
<b>Aboriginal and/or Torres Strait Islander Health Practitioners and Workers</b>	Aboriginal and/or Torres Strait Islander Health Practitioners and Workers are Aboriginal and/or Torres Strait Islander people who provide a range of clinical and non-clinical services, with a focus on culturally safe practice for Aboriginal and Torres Strait Islander people and communities. <sup>60</sup>
<b>adenoma</b>	A non-invasive pre-cancerous growth (of neoplastic epithelial cells). Adenomas may be raised (protuberant), flat, or depressed. Some adenomas of larger size may change over time and develop into malignant growths (cancers).
<b>anaesthetist</b>	<p>An anaesthetist is a registered medical practitioner who provides anaesthesia services within their scope of practice. They include specialist anaesthetists and rural generalist anaesthetists, as defined in ANZCA's <i>CP01 Standard abbreviations and definitions</i> and <i>PS59(A) Position statement on roles in anaesthesia and perioperative care</i>.<sup>52</sup></p> <p>Note: The scope of practice of an anaesthetist is more comprehensive than a non-anaesthetist sedationist. A non-anaesthetist sedationist may not necessarily be a medical practitioner and should only provide minimal to moderate sedation to patients (as defined in ANZCA's <i>PG09 Guideline on procedural sedation</i>).<sup>11</sup></p>
<b>artificial intelligence (AI)</b>	The ability of computer systems to perform tasks or produce outputs that normally require human intelligence. <sup>61</sup>
<b>benign growth (tumour)</b>	A benign growth is one which is not able to spread to other parts of the body. It may also be described as pre-cancerous or pre-malignant.
<b>bowel</b>	<p>Part of the digestive tract extending from the stomach to the anus. It has two main sections – the small bowel and large bowel (also known as small intestine and large intestine).</p> <p>The small bowel continues from the stomach. Its various parts are the duodenum, jejunum, and ileum. The small bowel joins up with the large bowel at the terminal ileum.</p> <p>The large bowel is made up of the colon and rectum. The rectum joins up with the anus.</p>
<b>bowel cancer</b>	Cancer of the large bowel; also known as colorectal cancer, colon cancer or rectal cancer. <sup>8</sup>

Term	Definition
<b>bowel preparation</b>	The use of medicines and changes in the diet to clean out the bowel in preparation for a test, scan, or operation, allowing the lining of the bowel to be seen more clearly.
<b>caecum</b>	The first part of the ascending colon of the large bowel. When performing a colonoscopy, this is one of the important landmarks to ensure the procedure has examined the whole bowel.
<b>clinician</b>	A qualified and trained health professional who provides direct patient care (that is, the diagnosis and treatment of patients, including recommending preventative action). In this document, it may refer to a doctor, nurse, or nurse practitioner, depending on the care described and the individual's scope of professional practice.
<b>colon</b>	The main part of the large bowel, which absorbs water and electrolytes from undigested food (solid waste). Its four parts are the ascending colon, transverse colon, descending colon, and sigmoid colon. <sup>8</sup>
<b>colonoscopist</b>	A clinician with the necessary qualifications and training who performs the colonoscopy. This may be a physician, surgeon, general practitioner, or nurse. In a healthcare service organisation, this person will be credentialed to perform colonoscopy within their scope of practice and have demonstrated suitability to do so in accordance with local requirements and with reference to the requirements of the relevant national professional body.
<b>colonoscopy</b>	An examination of the entire large bowel using a camera on a flexible tube, which is passed through the anus. <sup>8</sup> Colonoscopy can be performed to establish if there is something wrong in the bowel (diagnostic) or to treat a known bowel problem (therapeutic).
<b>colorectal</b>	Referring to the large bowel, comprising the colon and rectum. <sup>8</sup>
<b>credentialing</b>	The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality health services within specific organisational environments. <sup>53</sup>

Term	Definition
<b>cultural safety</b>	<p>Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.</p> <p>In health care, culturally safe practice is the ongoing critical reflection of knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care free of racism.</p> <p>Essential features of cultural safety are individuals and organisations:</p> <ul style="list-style-type: none"> <li>• Acknowledging colonisation and systemic racism, and social, cultural, behavioural and economic factors which impact individual and community health</li> <li>• Acknowledging and addressing individual racism, and their own biases, assumptions, stereotypes and prejudices, and providing care that is holistic, and free of bias and racism</li> <li>• Recognising the importance of self-determined decision making, partnership and collaboration in health care which is driven by the individual, family and community</li> <li>• Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.</li> </ul>
<b>dehydration</b>	<p>Dehydration occurs when the body loses more fluid than it takes in. It can result in problems like feeling dizzy, falls, chemical imbalances and kidney problems. It is important to follow instructions about fluid intake during bowel preparation to prevent dehydration.</p>
<b>faecal occult blood test (FOBT)</b>	<p>A test that can detect microscopic amounts of blood in stools (poo), that can sometimes be a sign of bowel cancer. Types of FOBTs include immunochemical FOBTs (iFOBTs), which directly detect haemoglobin using antibodies specific for the globin moiety of human haemoglobin, and guaiac FOBTs (gFOBTs), which detect peroxidase activity, an indirect method for identification of haemoglobin.<sup>8</sup></p> <p>The National Bowel Cancer Screening Program invites eligible Australians aged 45 to 74 to complete a free iFOBT to screen for bowel cancer every two years.</p>
<b>family history</b>	<p>A family history of cancer is present when there are members of the family who have been diagnosed with cancers. Although bowel cancer is the most important, other cancers such as the uterus, breast and stomach are also relevant. The risk of getting bowel cancer is related to the number of affected relatives and the age at which they were diagnosed with cancer.</p>
<b>familial syndromes</b>	<p>Genetic disorders in which inherited genetic mutations in one or more genes predispose a person to developing cancer, particularly at an early age.<sup>8</sup></p>
<b>first presentation</b>	<p>The first presentation occurs when an individual first seeks advice leading to their first colonoscopy. This may be because of a positive faecal occult blood test or symptoms.</p>
<b>genetic mutation</b>	<p>The process by which a gene undergoes a structural change that produces permanent differences.<sup>62</sup></p>

Term	Definition
<b>general anaesthesia</b>	<p>The use of medicines to bring about a state of controlled unconsciousness, where the person is unaware of pain and has no awareness of what is going on around them.<sup>63</sup></p> <p>A drug-induced state characterised by absence of purposeful response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes.<sup>10</sup></p> <p>See also '<b>sedation</b>'.</p>
<b>iFOBT</b>	<p>Immunochemical faecal occult blood test.</p> <p>See also '<b>faecal occult blood test</b>'.</p>
<b>informed consent</b>	A person's voluntary decision about health care that is made with knowledge and understanding of the benefits and risks involved. <sup>64</sup>
<b>inflammatory bowel disease</b>	A group of inflammatory conditions of the colon and small intestine, including Crohn's disease and ulcerative colitis. <sup>65</sup>
<b>Lynch Syndrome</b>	An inherited cancer predisposition syndrome that increases a person's chance of developing bowel and endometrial cancers, often at a younger age than the general population. <sup>66</sup>
<b>malignant tumour</b>	A growth that is able to spread into nearby normal tissue and travel to other parts of the body. <sup>65</sup> A malignant growth is a cancer.
<b>National Bowel Cancer Screening Program (National Screening Program)</b>	<p>A national program available to people aged 45 to 74 that aims to decrease bowel cancer and related illness and death.</p> <p>In Australia, government-funded, population-based bowel cancer screening is available through the National Bowel Cancer Screening Program. The National Screening Program started in 2006 and is managed by the Department of Health in partnership with state and territory governments. Eligible Australians aged 45 to 74 can access a free immunochemical faecal occult blood test (iFOBT) to complete at home every two years to screen for bowel cancer. Participants with a positive screening result, indicated by blood in the stool sample, are advised to consult their primary health care provider to discuss further diagnostic assessment – in most cases, this will be a colonoscopy.</p> <p>The National Cancer Screening Register maintains records of participants and the outcomes of screening using information provided by clinicians.</p>
<b>open-access colonoscopy</b>	An open-access (sometimes called 'direct-access') colonoscopy service is a service which allows clinicians to refer patients for a colonoscopy without a prior consultation with the colonoscopist. Open-access models have been developed to improve access to services for suitable patients (such as following a positive screening iFOBT ['poo test']).
<b>polyp</b>	A growth of colonic tissue which protrudes into the lumen (space) above the lining of the bowel. Polyps are usually asymptomatic, but sometimes cause visible rectal bleeding and, rarely, other symptoms. Polyps may be neoplastic (for example, adenomas) or non-neoplastic (for example, inflammatory polyps).
<b>rectum</b>	The final section of the large bowel, ending at the anus.



Term	Definition
<b>referring clinician</b>	The doctor or nurse practitioner who refers the patient for a specialist consultation. In most cases this is the general practitioner.
<b>scope of clinical practice</b>	<p>As defined by health service organisations, this follows on from credentialing and involves delineating the extent (scope) of an individual practitioner's clinical practice within a particular organisation based on:</p> <ul style="list-style-type: none"> <li>• The individual's credentials, competence, performance, and professional suitability</li> <li>• The needs of the organisation and its capability to support the practitioner's scope of clinical practice.</li> </ul> <p>A practitioner's scope of clinical practice can be separated into:</p> <ul style="list-style-type: none"> <li>• Routine scope of clinical practice (core scope of clinical practice) based on qualifications, professional awards, and statements of competency from relevant education and training bodies such as a professional college in a speciality or sub-speciality area of practice</li> <li>• Scope of clinical practice requiring specific credentialing (specific scope of clinical practice) based on additional training, the introduction of new clinical procedures or equipment, or where any other significant change in practice occurs.</li> </ul>
<b>screening</b>	<p>Screening is the performance of a test in an individual at average risk of a disease who does not have symptoms. A positive test identifies an individual for whom further tests are usually needed to exclude or detect the disease being screened for.</p> <p>For bowel cancer screening in Australia, those aged 45 to 74 years are invited to undertake an immunochemical faecal occult blood test (iFOBT) through the National Screening Program. If the test is positive, a colonoscopy is usually recommended.</p>
<b>screening colonoscopy</b>	Individuals who are at markedly higher than average risk for bowel cancer are advised to undergo screening colonoscopy, as per NHMRC screening recommendations. This includes those with familial syndromes.

Term	Definition
<b>sedation</b>	<p>Sedation enables a person to tolerate an uncomfortable or painful procedure. Sedation has a range of levels, which occur along a continuum from 'minimal' to 'moderate' through to 'deep sedation' and 'general anaesthesia'.</p> <p>Note: People can respond differently to medicines used for sedation; hence, close individual monitoring and observation is required when intravenous sedation is provided (as described in ANZCA PG09).</p> <p>Minimal sedation refers to a conscious, drug-induced state of diminished anxiety. Moderate sedation refers to a state of depressed consciousness. During minimal and moderate sedation, patients retain the ability to respond purposefully to verbal commands or touch. This may be achieved by a wide variety of drugs, including propofol, and may accompany local anaesthesia. All minimal or moderate sedation techniques should provide a margin of safety that is wide enough to render loss of consciousness unlikely. However, interventions to maintain a patent airway, spontaneous ventilation and/or cardiovascular function may be required in exceptional cases.<sup>11</sup></p> <p>Deep sedation is characterised by depression of consciousness that can readily progress to the point where consciousness is lost and patients respond only to painful stimulation. Deep sedation is associated with an impaired ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. As deep sedation has similar risks to general anaesthesia, accordingly, it requires an equivalent level of care and must be managed by a suitably qualified and credentialed medical practitioner (as described in ANZCA PG09).<sup>11</sup></p>
<b>sedationist</b>	<p>Any clinician registered with their jurisdictional regulatory registration authority, responsible for the administration, management, and conduct of sedation working within their defined clinical scope of practice.<sup>11</sup></p> <p>A sedationist has completed training relevant to sedation and have attained and maintained the Safe Sedation competencies outlined in ANZCA's <i>Guideline on procedural sedation (PG09)</i>.<sup>11</sup></p>
<b>sessile serrated lesion (SSL)</b>	<p>A sessile serrated lesion (SSL) is a flat (or sessile) benign (non-cancerous) growth in the colon with a particular structure (serrated gland architecture). Some may change over time and develop into malignant growths (cancers).</p>
<b>sigmoid colon</b>	<p>The last section of the colon before it connects to the rectum.<sup>8</sup></p>
<b>surveillance colonoscopy</b>	<p>A colonoscopy performed in:</p> <ul style="list-style-type: none"> <li>Someone who has previously had disease to see if it has returned or if new disease is present (for example, after previous bowel cancer or adenoma removal)</li> <li>Someone who currently has disease to see if it has progressed (for example, inflammatory bowel disease).</li> </ul> <p>Surveillance intervals are recommended in the Cancer Council Australia Guidelines.</p>
<b>terminal ileum</b>	<p>The end of the small bowel (intestine) where it joins the large bowel (intestine).</p>

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# Acknowledgements

Many individuals and organisations have freely given their time and expertise in the development of this document. In particular, the Commission wishes to thank the *Colonoscopy Clinical Care Standard* Topic Working Group who advised on the first version of the Standard in 2018, some of whom, with other experts, participated in the 2024 review of the Standard. The involvement and willingness of all concerned to share their experience and expertise is greatly appreciated.

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A number of Commission staff were also involved in the writing and review of this publication, and the Commission wishes to acknowledge:

- Dr Alice Bhasale
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The above artwork used throughout the document was designed by Ms Lani Balzan, a Wiradjuri artist from the south coast of New South Wales. The central symbol is the logo for the Clinical Care Standards program, which began at the Commission in 2013. The outer four circles of the artwork represent the four priority areas of patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care. The outer dots represent growth, healing, change and improvement.



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