AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

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Colonoscopy Clinical Care Standard

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Before starting bowel preparation, a patient receives comprehensive consumer-appropriate information about bowel preparation, the colonoscopy and sedation or anaesthesia. They have an opportunity to discuss the reason for the colonoscopy, its benefits, risks, 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, co-morbidities, 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 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 medication, and arrangements for medical follow-up. The patient is discharged into the care of a responsible adult when it is safe to do so.

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, and documents this in the facility records. Recommendations for surveillance colonoscopy, if required, are consistent with national evidence-based guidelines. If more immediate treatment or follow-up is needed, appropriate arrangements are made by the colonoscopist.

About the clinical care standards

Clinical care standards aim to support the delivery of appropriate evidence-based clinical care, and promote shared decision making between patients, carers and clinicians.

A clinical care standard is a small number of quality statements that describe the clinical care a patient should be offered for a specific clinical condition. The quality statements are linked to a number of indicators that can be used by health service organisations to monitor how well they are implementing the care recommended in the clinical care standard. A clinical care standard differs from a clinical practice guideline; rather than describing all the components of care for managing a clinical condition, the quality statements address priority areas for improvement.

Each clinical care standard intends to support key groups of people in the healthcare system in the following ways:

- The public will have a better understanding of what care should be offered by the healthcare system, and will be better able to make informed treatment decisions in partnership with their clinician
- Clinicians will be better able to make decisions about appropriate care
- Health services will be better able to examine the performance of their organisation and make improvements in the care they provide.

This clinical care standard was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) following consultation and development of a national safety and quality model for colonoscopy (the safety and quality model).The development of a clinical care standard was an integral component of the safety and quality model.The Commission collaborated and consulted with consumers, clinicians, researchers and health organisations during the development of the safety and quality model and many of these groups were represented on the Colonoscopy Clinical Care Standard Topic Working Group. The clinical care standard complements existing efforts that support care of patients undergoing colonoscopy for screening and diagnostic purposes, including state and territory-based initiatives.

For more information about the development of this clinical care standard and the indicators, visit: www.safetyandquality.gov.au/ccs.

Introduction

Context

Colonoscopy refers to the examination of the entire large bowel using a camera on a flexible tube, or colonoscope. It is a complex task that requires the colonoscopist to manipulate the colonoscope effectively in order to visualise the bowel, while performing therapeutic interventions such as removing polyps or 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 as indicated by a positive screening test, previous pathology, or family history or genetic conditions. It may also be used to help diagnose the cause of symptoms in conditions such as inflammatory bowel disease.

Bowel cancer is the second most common cancer diagnosed in both men and women in Australia, which has one of the highest rates of bowel cancer in the world.[1] Evidence-based guidelines describe when colonoscopy should be used and how frequently testing should occur, according to the patient's presenting symptoms, history and risk.

In Australia, most screening for bowel cancer involves a faecal occult blood test (FOBT), which occurs either through the National Bowel Cancer Screening Program (NBCSP) or when the test is requested as a Medicare-subsidised test by a clinician. For people whose personal and/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 (NBCSP) is a government funded, population based screening program which aims to reduce illness and death from bowel cancer through early detection or prevention of the disease. Eligible Australians aged 50 to 74 are sent a free FOBT kit 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. 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 (adenomas).

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 can also identify those who require regular colonoscopy surveillance due to having an increased risk of bowel cancer.

The NBCSP has been shown to reduce illness and mortality from bowel cancer in Australia.[2] Planned expansion of the NBCSP means that by 2020, all eligible Australians aged between 50 and 74 will be invited to screen every two years, with an associated increase in the number of diagnostic colonoscopies.[3]

The NBCSP Register records details of participants and 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.

The risk of serious complications following colonoscopy is estimated to be 2.8 per 1,000 examinations[4] with an estimated mortality rate of 0.007%.[5] The quality of colonoscopy is

important for minimising the risk of complications from the procedure. Complications associated with colonoscopy include:

- Risks of the procedure itself such as perforation and bleeding
- Risks associated with bowel preparation including dehydration and electrolyte imbalances which can be serious.[6]
- Complications arising from sedation or anaesthesia.

While the risk of complication is relatively small, a large number of people undergo colonoscopy, many of whom are not diagnosed with any disease.

More than 900,000 colonoscopies are performed in Australia annually. Despite the large number of procedures performed annually, there is considerable geographic variation in diagnostic colonoscopy, with up to a 30-fold variation in rates of MBS funded colonoscopies across Australia.[7]

Between 20% and 25% of colonoscopies are performed in public hospitals, with the remainder performed in private hospitals and day procedure centres. A relatively small proportion (4.7% in 2015)[*] is performed on people with a positive FOBT through the NBCSP.

In 2016-17, a safety and quality model for colonoscopy was developed by the Commission through national consultation and agreement with the public and private hospital sectors, clinical colleges and societies, and consumers. Its development was funded by the Australian Government Department of Health. The safety and quality model comprises three elements:

- A Colonoscopy Clinical Care Standard (this document)
- Initial certification, and periodic re-certification of colonoscopists' performance, in accordance with defined quality indicators and performance targets determined by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, a national body comprising representatives of the Royal Australasian College of Physicians (RACP), the Gastroenterological Society of Australia (GESA), and the Royal Australasian College of Surgeons (RACS)
- Implementation of the Colonoscopy Clinical Care Standard in public and private hospitals and day procedure services.

This clinical care standard supports the delivery of high quality colonoscopy in terms of:

- Processes to support a high quality procedure including bowel preparation, sedation, colonoscopy and recovery
- Clinical skills and ongoing competence required to deliver all aspects of care
- Appropriate use of colonoscopy according to evidence-based guidelines
- The information provided to consumers before and after a colonoscopy and their participation in shared decision-making
- Clinical communication during referral, reporting and follow-up.

Goal

The goal of the 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.

[*] Medicare data, Australian Government Department of Health

Scope

The Colonoscopy Clinical Care Standard relates to the care of adult patients undergoing colonoscopy for screening, diagnosis, surveillance, or treatment. It covers the period from when a patient is referred for consideration of colonoscopy through to discharge including planning for follow-up care. The Colonoscopy Clinical Care Standard is relevant to the care provided in primary and acute healthcare settings including general practice, and public and private hospitals including day procedure services.

Using the clinical care standard

Related standards and guidelines

Implementation of the Colonoscopy Clinical Care Standard should be undertaken within the context and requirements of the National Safety and Quality Health Service (NSQHS) Standards and other relevant standards and guidelines for health service organisations and clinicians providing colonoscopy services.

Key guidelines

Key evidence sources referred to in the development of this clinical care standard are the Cancer Council Australia Guidelines including:

- *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*. [8]
  Accessed at: http://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer
- *Clinical Practice Guidelines for Surveillance Colonoscopy*[9] [Note: Currently being updated, with an expected release in 2018].

The clinical care standard supports the use of current Australian and New Zealand College of Anaesthetists guidelines for sedation and anaesthesia including:

- *Guidelines for the perioperative care of patients selected for day stay procedures (PS 15)*[10]
- *Guidelines on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures (PS 09)*[11].

The National Safety and Quality Health Service (NSQHS) Standards

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, state and territory governments, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

The National Safety and Quality Health Service (NSQHS) Standards (first edition)[12] has been used to assess health service organisations since January 2013. The National Safety and Quality Health Service (NSQHS) Standards (second edition) was released in November 2017, and health service organisations will be assessed to the new standards from January 2019.

In the NSQHS Standards (2nd ed.), the Clinical Governance for Health Service Organisation Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all health service organisations.

The Clinical Governance for Health Service Organisation Standard aims to ensure that there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care.

The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care.

It is expected that colonoscopy will be provided by a health service organisation that has been assessed to the NSQHS Standards.

Under the NSQHS Standards (2nd ed.), health service organisations providing colonoscopy will be expected to support clinicians to use the best available evidence, including the Colonoscopy Clinical Care Standard (action 1.27b in the NSQHS Standards 2nd edition).

Health service organisations are expected to implement the NSQHS Standards in a manner that suits the services provided and their associated risks. Individual standards within the the NSQHS Standards (2nd ed.) that are particularly relevant to the safety and quality of colonoscopy services, and their associated actions, are as follows:

- The Clinical Governance for Health Service Organisations Standard, including actions related to:
  - governance, leadership and culture (for example, action 1.1)
  - safety and quality monitoring, including incident reporting systems
  - policies and procedures (for example 1.7)
  - credentialing and scope of clinical practice (1.23 and 1.24)
  - evidence-based care (1.27)
  - variation in clinical practice and health outcomes (1.28)
  - safe environment (1.29) including for Aboriginal and Torres Strait Islander people (1.33)
- The Partnering with Consumers Standard, including actions related to:
  - informed consent (2.4)
  - information for consumers (2.9) and communication of clinical information (2.10)
- The Preventing and Controlling Healthcare associated Infection Standard, including actions related to:
  - infection prevention and control systems (3.5–3.13)
  - reprocessing of reusable medical devices (3.14)
- The Communicating for Safety Standard, including actions related to:
  - communication of critical information
  - documentation of information
- The Recognising and Responding to Acute Deterioration Standard, including actions related to:
  - responding to deterioration.

Competencies and service capability

This clinical care standard recognises that safety and quality of care may be at risk if the workforce does not have the appropriate skills or experience.[13] The medical, nursing, procedural, and sedation/anaesthetic competencies required for high-quality and safe colonoscopy should be considered as part of health service organisations clinical services planning.[12, 14] For colonoscopy, health service organisations should take into account the

work of the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) – a national body comprising representatives of the Royal Australasian College of Physicians (RACP), the Gastroenterological Society of Australia (GESA), and the Royal Australasian College of Surgeons (RACS) – as well as the requirements of individual professional organisations.

Credentialing, certification and re-certification of colonoscopists

The CCRTGE has offered a program for recognising training in endoscopy and colonoscopy for some years.

Recently, GESA introduced a voluntary triennial re-certification program in colonoscopy, designed to support practitioners to:

- Maintain their expertise in colonoscopy
- Continue to develop their skills through subsidised training opportunities
- Increase safety standards and the quality of care being delivered to patients.

In May 2017, the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) endorsed the GESA voluntary recertification program for its members. The standards and quality indicators supported by the GESA and CSSANZ are expected to form the basis of the specifications for the re-certification of medical colonoscopists.

Indicators to support local monitoring

The Commission has identified a set of indicators to support healthcare providers and local health service organisations to monitor how well they implement the care described in the clinical care standard. The indicators are a tool to support local clinical quality improvement and may be relevant to other quality assurance and peer review activities.

The indicators described in this clinical care standard are intended to align with the safety and quality model and the performance indicators for certification and recertification indicators being developed by the CCRTGE.

The process to develop the indicators specified in this document comprised:

- An environmental scan of existing local and international indicators
- Prioritisation, review and refinement of the indicators with the Colonoscopy Clinical Care Standard Topic Working Group.

Measuring and monitoring patient experience

Systematic routine monitoring of patients' experiences of healthcare is an important way to ensure that service improvements and patient-centeredness are driven by the patients' perspective. This is the case in all health service organisations, including those performing colonoscopy.

While there are no indicators in this standard specific to patient experience measurement, the Commission strongly encourages health service organisations to adopt the Australian Hospital Patient Experience Question Set (AHPEQS). The AHPEQS is a short 12 question generic patient experience survey which has been tested and found reliable and valid for both day-only and admitted hospital patients across a wide variety of clinical settings. The instrument is available free of charge to both private and public sector health service organisations. The Commission's website contains more information about this tool.

Where to find the indicator specifications

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading *Indicators for local monitoring*. Full specifications of the *Colonoscopy Clinical Care Standard* indicators can be found in the Metadata Online Registry (METeOR) at {URL to be confirmed}

METeOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare (AIHW), METeOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

Supporting documents

The following supporting information for this clinical care standard is available on the Commission's website at www.safetyandquality.gov.au/ccs:

- A consumer fact sheet
- A clinician fact sheet.

Quality statement 1 – Initial assessment and referral

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

Purpose

To ensure that communication of information from referring clinicians to colonoscopy clinics 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 persons 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 doctor or health service organisation that you are referred to has the right information about you and your medical history to help them decide if a colonoscopy is likely to help you. Your current and past medical conditions, your age, your family medical and cancer history, current medicines and the results of previous tests, imaging and colonoscopies should all be included in the referral document. In some health service organisations, the referral is also used to decide how soon to book your appointment.
The doctor who writes the referral will explain what you need to do next, how soon you need the appointment and what to do if you are not given an appointment within that time.

For clinicians. When referring patients for consideration of colonoscopy, provide a comprehensive referral to prevent delays and enable accurate assessment of the patient's suitability for colonoscopy. Standard (electronic) templates can help, for example those included in local health pathways. The referral should include:

- The indication for the referral including presenting symptoms and the preliminary diagnosis
- All relevant medical and family history, including of bowel and other cancers, known genetic predispositions
- Current medicines and other medical conditions.
- Previous relevant treatment
- Results of previous investigations, including of FOBT (indicating whether this was through the NBCSP), colonoscopies and histopathology.

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* [8],*and Clinical Practice Guidelines for Surveillance Colonoscopy)*[9], the patient's co-morbidities and the patient's willingness to proceed. Advise the patient that the specialist receiving the referral will assess them individually before undertaking the colonoscopy. 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.

For clinicians receiving referrals, ensure that there are processes for allocating appointments according to clinical need.

For health service organisations. For health service organisations that refer patients, use consistent processes for referring patients for colonoscopy to ensure that referrals are comprehensive and accurate. For health service organisations receiving, allocating or prioritising referrals for clinical assessment or colonoscopy (including open access services) ensure that clear referral guidelines are available for referring clinicians, identifying the type and format of clinical information required. Use of this information will support the provision of services according to patient's clinical priority. Using agreed, standardised templates can assist the communication of important information between referring clinicians and colonoscopy services; which may be in electronic format.

Quality statement 2 – Appropriate and timely colonoscopy

A patient is offered timely colonoscopy when appropriate for screening, surveillance, or the investigation of signs or symptoms of bowel disease, 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 alternate recommended management.

Purpose

To ensure colonoscopy is offered to patients who are most likely to benefit from the procedure and within a timeframe concordant with their risk, in a manner consistent with current national evidence-based guidelines.

What the quality statement means

For patients. Colonoscopy is used when doctors 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 FOBT) or your family history. 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, the sedation and the colonoscopy all have some risks. Your doctor or nurse 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 doctor may suggest an alternative test.

For clinicians. Consider whether colonoscopy is indicated for the patient according to national evidence-based guidelines and the epidemiology of colonic disease. Assess the likely benefits to the patient, as well as the risks associated with the bowel preparation, sedation, the procedure itself, and the risks associated with not having the procedure.

- For people with symptoms suggestive of bowel cancer or a positive immunochemical FOBT, refer to Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer* [8], and the recommended triage criteria to ensure prompt scheduling for patients.
- For people requiring surveillance colonoscopy, refer to the current version of Cancer Council Australia's *Clinical Practice Guidelines for Surveillance Colonoscopy*[9] regarding the frequency and surveillance intervals for colonoscopy in high-risk individuals.

If colonoscopy is not appropriate, advise the patient and their referring clinician about recommended alternative diagnostic strategies or management.

For health service organisations. 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 C*linical practice guidelines for the prevention, early detection and management of colorectal cancer*, and current *Clinical Practice Guidelines for Surveillance Colonoscopy* [8, 9]
- Supporting and encouraging clinician participation in quality improvement and peer-review processes.

For health service organisations that receive referrals, reflect guideline recommendations from the Cancer Council Australia in policies and procedures for triage and scheduling colonoscopy appointments.

Quality statement 3 – Informed decision making and consent

Before starting bowel preparation, a patient receives comprehensive consumer-appropriate information about bowel preparation, the colonoscopy, and sedation or anaesthesia. They have an opportunity to discuss the reason for the colonoscopy, its benefits, risks, 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 the risks and benefits of colonoscopy before providing informed consent prior to starting bowel preparation or any other aspect of the procedure.

What the quality statement means

For patients. If your doctor recommends that you have a colonoscopy, you will need to decide whether to go ahead with it. 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, and that you agree to have the colonoscopy. To help you make your decision, you will be informed about all the parts of the process 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.

The discussion will include:

- Why the doctor is suggesting a colonoscopy
- Benefits to your health
- Risks of the bowel preparation, sedation and the colonoscopy
- Risks of not having the colonoscopy
- Any out-of-pocket costs
- Any alternatives to colonoscopy.

It is important that you understand this information before giving consent and 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, 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 including the bowel preparation, sedation (or anaesthesia) the colonoscopy and any therapeutic interventions, using language that they can understand. Arrange an interpreter if required. Tell the patient the reason for the colonoscopy, its benefits and potential adverse events including those related to the bowel preparation or sedation, perforation, bleeding (immediate and delayed) and missed pathology. Provide information about the financial costs and the alternatives to having the colonoscopy, including any risks of not having the colonoscopy. 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 health service organisations. Ensure that clear, written information is available to patients for all aspects of the colonoscopy for which the health service organisation is responsible, which may include 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 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.[15-17]

Quality statement 4 – Bowel preparation

A patient booked for colonoscopy receives a bowel preparation product and dosing regimen individualised to their needs, co-morbidities, 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 told what (and what not) to eat and drink, including when to drink extra fluids to stop you from getting dehydrated. You will be 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 doctor or nurse 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 or medicines to prevent blood clots. You may need to change the way you take your other medicines or follow special instructions in the days before your colonoscopy. Your doctor will discuss with you any changes you may need to make. Some people may need extra personal or health support during bowel preparation 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 doctor 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, taking into account individual risks, co-morbidities, current medicines, and the patient's previous experience with bowel-cleansing medicines.[6] 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.

A split-dose regimen is recommended as this 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.[18] Typically this involves splitting the standard dose of the bowel preparation between the day before and the morning of the colonoscopy (3-6 hours before the planned start of the procedure).[18]

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. Consider whether a patient with relevant co-morbidities needs specific health or personal support whilst undergoing bowel preparation, for example, overnight admission for patients who are unlikely to manage bowel preparation independently.

For health service organisations. Ensure that policies and procedures support best practice for bowel preparation. Support patients by enabling access to information about bowel preparation. For health service organisations with responsibility for providing bowel preparation and advice, provide clear, written patient information about the bowel preparation procedure and a telephone number for any inquiries they may have as the bowel preparation proceeds; ensure interpreter services or translated materials are available. Ensure patient information is approved and periodically reviewed by clinical staff. Where relevant to the facility, ensure policies support the provision of extra assistance to patients who are unlikely to manage bowel preparation independently, including overnight admission if needed.

Indicator for local monitoring

Bowel preparation

Indicator: Proportion of patients scheduled for a colonoscopy whose bowel preparation was adequate.

METeOR link: http://meteor.aihw.gov.au/content/index.phtml/itemId/691696

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 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 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. During your colonoscopy you will be given medicines to minimise your pain or discomfort (sedation). Before the colonoscopy, a doctor or nurse will check whether there are any particular risks for you when you are having the sedation. They will ask about your health, other 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 doctor. Your sedation will be given according to current professional recommendations, guidelines and taking into account your risks. Your sedation may sometimes be given by a specialist anaesthetist but this is not always required.

For clinicians. Ensure that the patient's suitability for sedation and any increased risks such as cardiovascular, respiratory or airway compromise are assessed in advance of the colonoscopy by a clinician who is appropriately trained to make such an assessment. Ensure that the facility is appropriate for the patient taking into account their clinical requirements and co-morbidities, as described in ANZCA *Guidelines for the Perioperative Care of Patients Selected for Day Stay Procedures.*[10] If an increased risk is identified, an anaesthetist, or other trained and credentialed medical practitioner within his/her scope of practice, should assess the patient and be present during the colonoscopy to care for the patient. 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, and that this in turn depends on the scope of practice of the clinician providing the sedation. Sedation must be administered by a credentialed practitioner working within their scope of practice. Provide sedation as described in current Australian and New Zealand College of Anaesthetists guidelines such as the *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures (PS09),* 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.

For health service organisations. Sedation should be provided in accordance with current ANZCA recommendations such as the *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*[11] and *Guidelines for the Perioperative Care of Patients Selected for Day Stay Procedures*.[10] Ensure that systems 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, in order to identify patients who are not suitable for intravenous sedation in the absence of an anaesthetist, and to plan for sedation accordingly. Ensure that clinicians who administer sedation or anaesthesia for colonoscopy are credentialed by the health service organisation and operating within their defined scope of clinical practice and that they maintain their skills by participating in ongoing professional development and review of performance. Implement and ensure compliance with policies and procedures for the safe supervision of trainees, where relevant to the facility.

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 is provided by skilled clinicians at a high level of safety and quality.

What the quality statement means

For patients. When you have a colonoscopy you can expect to be cared for by qualified doctors and nurses who have met necessary health service organisation and professional requirements and standards. This includes those 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, 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.

For health service organisations. 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 manager and practitioners*[14]. 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. Ensure non-anaesthetist practitioners who provide sedation meet a defined standard of competency for sedation.{ANZCA Ps09} Support participation by clinicians in peer review activities. Monitor and periodically review individual and service performance against accepted quality indicators and ensure under-performance is addressed promptly and effectively. Where relevant to the health service organisation, implement and ensure compliance with policies and procedures for the safe supervision of trainees.

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, to minimise adverse outcomes for all patients who undergo colonoscopy, and to 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 problems that may have occurred, which you can ask to see if you want to.

For clinicians. To maximize adenoma detection, intubate the caecum or terminal ileum and allow adequate time for mucosal inspection whenever performing colonoscopy.[19] In people with previous resection, examine the remaining bowel thoroughly. Document the quality of the bowel preparation, whether caecal intubation was achieved (with photo-documentation if feasible), withdrawal time, clinical findings, the details of polyps removed, how they were removed and whether they were retrieved. Ensure all polyps that are removed are retrieved where possible and are sent for histopathology examination. Clearly identify histology samples generated through participation in the NBCSP to enable pathologists to complete data collection on screening outcomes recommended by the NBCSP. 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 these have occurred and their management.

For health service organisations. 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. Provide systems that require and support colonoscopists to maintain accurate records of the colonoscopy including the adequacy of bowel preparation, biopsies taken, polyps removed and retrieved, all diagnostic and therapeutic interventions, procedure duration and details of any adverse events. Ensure complications or adverse events of colonoscopy are reported in the health service organisation's incident management system, monitored and reviewed as part of quality monitoring and clinical quality improvement activities (such as morbidity and mortality reviews).

Indicators for local monitoring

Indicator: Caecal intubation

Proportion of patients undergoing a colonoscopy who have their entire colon examined
METeOR link: http://meteor.aihw.gov.au/content/index.phtml/itemId/691703

Indicator: Adenoma Detection Rate (ADR)

Proportion of patients who had a colonoscopy that detected one or more adenoma(s)
METeOR link: http://meteor.aihw.gov.au/content/index.phtml/itemId/691715

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 discharged into the care of a responsible adult when it is safe to do so.

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 was 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 be able to go home once your doctor or nurse is satisfied that you have recovered from the sedation. You should not drive and will need 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 doctor 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, 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, once satisfactory discharge criteria are met. 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 if they are to be discharged without adequate adult support at home, or who is otherwise not suitable for discharge.

For health service organisations. Ensure that policies and procedures for monitoring, supervising and discharging patients align with current recommendations for post-operative care following anaesthesia (for example ANZCA guidelines for perioperative care [PS15][10]). Ensure that procedures are in place for discharging patients into the care of a responsible

adult, and that written instructions are provided 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, and that the discharge information includes specific health service contact details after hours. Policies should allow for 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).

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, and documents this in the facility records. Recommendations for surveillance colonoscopy, if required, are consistent with national evidence-based guidelines. If more immediate treatment or follow-up is needed, appropriate arrangements are made by the colonoscopist.

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

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 letter or report will say why you had the colonoscopy, and 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 this 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. Provide follow-up recommendations to the patient, general practitioner and other relevant clinician based on the colonoscopy findings and final histology results, which are consistent with national evidence-based guidelines. Include the reason for the colonoscopy in the report, and 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* [8] ,*and Clinical Practice Guidelines for Surveillance Colonoscopy*.[9] 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. For NBCSP participants, provide colonoscopy outcomes, results and adverse events to the NBCSP Register.

For health service organisations. Ensure that policies and procedures for information management and communication support the complete reporting of colonoscopy and histology outcomes to referring clinicians, other relevant clinicians and the patient, and that responsibilities are clearly delineated. These should include arrangements for the reporting of all histology results if any tissue was removed, regardless of the histological findings. Ensure systems are in place for the prompt communication and management of histologically-confirmed colorectal cancer or high-risk lesions as appropriate for the type of facility. Support and promote clinicians' use of national evidence-based guidelines on surveillance colonoscopy, such as the Cancer Council Australia's *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer,* [8] *and Clinical Practice Guidelines for Surveillance Colonoscopy*[9], when making recommendations for future surveillance and follow-up. Support reporting to the NBSCP for patients referred through participation in this program.

Glossary

Adenoma	A benign (non-cancerous) growth which has specific characteristics that can be seen using pathology testing techniques (proliferation of neoplastic epithelial cells). Adenomas may be protuberant, flat or depressed. Some adenomas may change over time and develop into malignant growths (cancers).
Benign growth (tumour)	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.
Bowel	Part of the digestive tract extending from the stomach to the anus. It has two main sections – the small and large bowel (also known as the small and large intestine). 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. The large bowel is made up of the colon and rectum. The rectum joins up with the anus.
Bowel cancer	Cancer of the large bowel; also known as colorectal cancer, colon cancer or rectal cancer. [8]
Bowel preparation	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.
Caecum	The first part of the ascending colon of the large bowel. This is one of the important landmarks when performing a colonoscopy, to ensure the procedure has examined the whole bowel.
Clinician	A qualified and trained health professional who provides direct patient care (that is, the diagnosis and/or treatment of patients including recommending preventative action). In this document it may refer to a doctor, nurse or nurse practitioner, depending on the care that is being described and the individual's scope of professional practice.[20, 21]
Colon	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. [8]
Colonoscopist	A clinician with the necessary qualifications and training who performs the colonoscopy. This may be a physician, surgeon, general practitioner or nurse. In a health 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.

Colonoscopy	An examination of the entire large bowel using a camera on a flexible tube, which is passed through the anus.[8] Colonoscopy can be performed to establish if there is something wrong in the bowel (diagnostic) or to treat a known bowel problem (therapeutic). (See also Flexible Sigmoidoscopy)
Colorectal	Referring to the large bowel, comprising the colon and rectum.[8]
Credentialing	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. [14]
Dehydration	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.
Faecal occult blood test (FOBT)	A test that can detect microscopic amounts of blood in stools. Types of FOBT 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.[8] The NBCSP sends a free Faecal Occult Blood Test (FOBT) to eligible Australians aged 50 to 74 to screen for bowel cancer, every two years.
Family history	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.
Familial syndromes	Genetic disorders in which inherited genetic mutations in one or more genes predispose a person to developing cancer, particularly at an early age. [8]
First presentation	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 in the NBCSP or symptoms.
Flexible sigmoidoscopy	A procedure used by doctors to examine the inner lining of the rectum and sigmoid colon (unlike a colonoscopy, in which the entire colon is examined). [8]

General anaesthesia	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.[22] 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.[11] See also 'Sedation'.
iFOBT	Immunochemical Faecal Occult Blood Test (see entry for Faecal occult blood test)
Informed consent	Informed consent is a person's voluntary decision about health care that is made with knowledge and understanding of the benefits and risks involved.[23]
Inflammatory bowel disease	A group of inflammatory conditions of the colon and small intestine, including Crohn's disease and ulcerative colitis. [24]
Laxative	A medicine used to stimulate the bowel and clean it of faecal matter. Laxatives are important as part of preparation of the bowel prior to colonoscopy so the lining of the bowel can be seen clearly.
Malignant tumour	A growth that is able to spread into nearby normal tissue and travel to other parts of the body.[24] A malignant growth is a cancer.
National Bowel Cancer Screening Program (NBCSP)	A national program available to people ≥50 years of age which aims to decrease bowel cancer and illness and death related to it. In Australia, government-funded, population-based bowel cancer screening is available through the National Bowel Cancer Screening Program (NBCSP). The NBCSP started in 2006 and is managed by the Department of Health in partnership with state and territory governments. The Program sends a free Faecal Occult Blood Test (FOBT) to eligible Australians aged 50 to 74 to screen for bowel cancer every two years. 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. The NBCSP Register maintains records of participants and the outcomes of screening, using information provided by clinicians.
Polyp	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).

Rectum	The final section of the large bowel, ending at the anus.
Referring clinician	The doctor or nurse practitioner who refers the patient for a specialist consultation. In most cases this is the general practitioner.
Scope of clinical practice	As defined by health service organisations, follows on from credentialing and involves delineating the extent (scope) of an individual practitioner's clinical practice within a particular organisation based on: • the individual's credentials, competence, performance and professional suitability • the needs of the organisation and its capability to support the practitioner's scope of clinical practice. A practitioner's scope of clinical practice can be separated into: • 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 • Scope of clinical practice requiring specific credentialing (specific scope of clinical practice) based on additional training, the introduction of new clinical procedures, equipment or where any other significant change in practice occurs.
Screening	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 in whom further tests are usually needed to exclude or detect the disease being screened for. For bowel cancer screening in Australia, those ≥50 years are invited to undertake a faecal occult blood test (FOBT) through the national screening program. If the test is positive, a colonoscopy is usually recommended.
Screening colonoscopy	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.

Sedation	Sedation refers to the use of medicines to allow a person to tolerate uncomfortable or painful procedures. Sedation is a form of anaesthesia. Sedation occurs along a continuum, which can range from 'conscious sedation' through to 'deep sedation' and 'general anaesthesia'. While different medicines are used for sedation and general anaesthesia, people can respond differently to the same medicines. Conscious sedation refers to depression of consciousness during which patients are able to respond to verbal commands or light touch. Conscious sedation may be achieved by a wide variety of drugs including propofol, and may accompany local anaesthesia. All conscious 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.[11] Deeper 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. It is associated with loss of the ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function, and has similar risks to general anaesthesia, requiring an equivalent level of care.[11]
Sigmoid colon	The last section of the colon before it connects to the rectum.[8]
Surveillance colonoscopy	A colonoscopy performed in: • 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) • Someone who currently has disease to see if it has progressed (for example, inflammatory bowel disease). Surveillance intervals are recommended in the Cancer Council Australia guidelines.
Terminal ileum	The end of the small bowel (intestine) where it joins the large bowel (intestine).

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