Royal College of Physicians

JAG
Joint Advisory Group
on GI Endoscopy

JAG Global Rating Scale (GRS)

Version for public services in Ireland

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Contents

Introduction

The Global Rating Scale (GRS) is a quality improvement tool designed to support endoscopy services to implement quality improvement and to meet the JAG quality assurance standards. This version has been developed to be specific to public endoscopy services in the Republic of Ireland and is based on the GRS for UK services. The GRS is maintained by JAG and this version has been developed in conjunction with the Health Service Executive (HSE) National Endoscopy Programme.

The GRS is made up of 19 standards, divided into four domains. Each standard has a number of measures which underpin it, which is assigned a level from D to A (described in the 'Levels' section below). Services are asked to answer 'yes' or 'no' to each measure using the webtool (www.thejag.org.uk). The measure answers then generate a score for the service for each standard.

A resource pack has been developed to support services and contains further guidance and templates. The resource pack is available for download from the JAG website.

Domain

Each domain refers to a broad aspect of care. There are four domains: clinical quality (quality and safety), quality of patient experience (customer care), workforce and training of endoscopists. All services are asked to complete the clinical quality, quality of patient experience and workforce domains. Only those offering endoscopy training are required to complete the training domain.

Standards

The standards within each domain provide a more detailed picture of what the domain consists of. The standards are qualitatively different and therefore no standard is more or less important than another.

Measures

Measures are statements that are intended to be unambiguous. To assist services in answering appropriately, guidance statements have been added where necessary.

Levels

Levels create a more complete picture of the service by describing the different levels of achievement for a standard. These levels range from basic (D) to excellent (A). While scoring a standard with levels gives an accurate picture of performance, the scoring process can be subject to bias. To minimise bias measures are underpinned by national policy, guidelines and/or best practice guidance.

Services are required to score a Level B in all standards to apply for and maintain JAG accreditation.

Level	Summary	Description
A	Aspirational	service is 'outward looking' with excellent adherence to requirements
B	Audit	service is proactive to changes with a good adherence to requirements
C	Process	service is reactive to changes with basic adherence to requirements
D	Policy	service shows generally inadequate levels of adherence to requirements

Clinical quality

Standard 1: leadership and organisation

The purpose of this standard is to ensure that the service achieves an integrated and patient-focused endoscopy service. A service requires a clear structure for leadership, management and accountability. This standard ensures that the basic components of this structure are in place. Without these it will be impossible to deliver the standards in a cost-effective manner.

No	Measure	Lvl	Guidance
1.1	There is a designated clinical lead for the endoscopy service and Endoscopy Clinical Lead for the Hospital Group.	D	Each service has a designated clinical lead for endoscopy and a Hospital Group Clinical Lead for Endoscopy. These post holders are responsible for ensuring effective clinical governance in line with Hospital Group governance structures. They also contribute to effective clinical and strategic planning for the service.
1.2	There is a leadership team comprising clinical, nursing and managerial lead roles, each with defined responsibilities.	D	There is a clear structure and clear lines of accountability within the medical, nursing, clerical and management sections of the team, and outside it to the organisation's senior management team. The endoscopy leadership team is usually described as a triumvirate and should include at least medical, nursing and managerial/operational lead.
1.3	Clear information is available about the range of endoscopy procedures provided at this site and at all associated sites.	D	The service description should be available in written or electronic format for patients and their carers and healthcare professionals.
1.4	There is a defined governance structure for the endoscopy service with clear lines of accountability.	D	The governance structure should clearly describe whether patients may be referred to other organisations. This should also include outsourcing and insourcing arrangements.
1.5	There is an annual audit plan for the service with named leads and timescales for completion	D	This would normally be the Endoscopy Users Group (EUG) or a recognised/alternative governance group. The timetable should include the clinical audits (see RCPI guidelines[1]) and other audits, including those of patient experience and staff satisfaction. See resource pack for audit plan template.
1.6	There is effective communication within the service which supports the organisation and delivery of the service (eg operational, nursing and governance meetings).	C	The endoscopy service should have clear and effective communication structures and processes, e.g. operational, nursing and governance meetings, which show how alerts, changes and decisions are communicated. The service should hold an EUG meeting at least quarterly with medical, nursing and managerial representatives. Outcomes from EUG meetings should be documented clearly to show how alerts, changes and decisions are communicated.
1.7	The leadership team have protected time in their job plans and/or roles to lead and manage the service.	C	This specifically applies to clinical, training and nurse leads.

1.8	There are defined processes and timescales to review and maintain all policies and standard operating procedures.	C	All service policies and operating procedures are reviewed on an annual basis.
1.9	The leadership team have the managerial, administrative and technical support (such as information technology (IT)) to organise and deliver the service effectively.	B	Outcomes and recommendations from the EUG are escalated to senior management level in the hospital/hospital group.
1.10	The leadership team have access to timely and appropriate information on which to base operational and planning decisions.	B	The leadership team have access to HSE waiting list data, specifically the urgent colonoscopy figures, National Treatment Purchase Fund (NTPF) waiting lists for routine and planned procedures and the National Screening Service (NSS) expected monthly procedures lists (where applicable). This information should be used to plan and structure work and development decisions.
1.11	The leadership team review and set the service's strategic objectives on an annual basis and develop plans to achieve these objectives.	B	Leaders develop annual operational plans within their area of responsibility, which are aligned to the organisation's objectives.
1.12	The leadership team engage in sharing good practice with other endoscopy services locally, regionally and/or nationally.	A	Sharing good practice could mean a number of approaches such as attendance at learning events, visiting other services, sharing methodology or providing access to guidance documents.
1.13	There are systems in place to ensure that the leadership team seek and receive feedback about their performance on an annual basis.	A	Team leaders should invite feedback from staff to assess the degree to which their leadership and management of the service is effective. This feedback can be at an individual level or for the leadership team. The staff survey could ask specific questions about the leadership of the service. All sources of feedback, including trainee and nurse feedback, should contribute to the review of leadership effectiveness.
1.14	There is an annual process in place to consider and plan resources for new service developments.	A	An endoscopy service is encouraged to consider new developments and innovation annually; however, the impact of any new innovations must be carefully considered and planned for.

Standard 2: safety

The purpose of this standard is to ensure that the service has processes in place to identify, respond to and learn from expected and unexpected adverse events.

No	Measure	Lvl	Guidance
2.1	Systems are in place for monitoring adverse events. Key safety indicators and auditable outcomes as defined by the conjoint board RCPI and RCSI are available in written and electronic form for procedures carried out in the service.	D	Key performance indicators for endoscopy have been defined and described in 'Guidelines for the Implementation of a National Quality Improvement Programme in GI Endoscopy'. The service should adhere to the guidelines fully for the procedures performed in the service[1]. The service uses the agreed hospital adverse events management system. It is usual to see a hospital-wide adverse events management system and an endoscopy service is not only expected to use this but also to show how near misses and adverse events are managed and learned from.
2.2	There is routine use of a pre-, peri-, and post-procedure safety checklist.	D	Safety checklists allow complex pathways of care to function with high reliability by giving users the opportunity to pause and take stock of their actions before proceeding to the next step. The World Health Organization (WHO) safety checklist and others have improved reliability and helped to standardise care for thousands of individuals globally[2]. A template for developing a service safety checklist is included in the resource pack.
2.3	There are local policies or protocols for the management of diabetes, anticoagulation, antiplatelet use, antibiotic and implantable devices in patients undergoing endoscopy.	D	Anticoagulation use, antibiotics policy and planned procedure follow up should adhere to the 'Guidelines for the Implementation of a National Quality Improvement Programme in GI Endoscopy'[1]. Diabetes should be managed in accordance with local endocrine and diabetes policy.
2.4	The endoscopy service leadership team review adverse events at least every 3 months.	D	It is usual to see a hospital-wide adverse events management system. The service should use this and also show how near misses and adverse events are managed and learned from.

2.5	The endoscopist and the endoscopy nurses meet before each list to identify any potential problems, including high-risk patients or procedures, and to anticipate the need for equipment or accessories.	C	Endoscopy teams meet before each list to identify potential problems including high-risk patients or procedures, staffing issues, requirements for equipment and accessories, and coordinating with endoscopy teams in parallel rooms. This is usually called a team briefing and ideally should include all core staff involved with endoscopy on that day. High-risk patients are identified as those: • with an American Society of Anesthesiologists (ASA) score of 3 or greater[3] • Where an underlying clinical condition or medications may make them more likely during the endoscopy to have a complication eg severe diverticulosis, patients on anticoagulants and patients having general anaesthesia[4] • Where Health Information and Quality Authority (HIQA) instructions exist for the management of patients' safety. For example, the HSE Standards and Recommended Practices for Facility Design and Equipping of Endoscope Decontamination Units QPSD-D-022-1[5] Examples of high-risk procedures include therapeutic oesophagogastroduodenoscopy (OGD), percutaneous endoscopic gastrostomy (PEG), endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic mucosal resection (EMR)[4]. The assessment process allows individual patient and procedure risks to be identified and managed.
2.6	Over 50% of patients admitted with acute upper gastrointestinal bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission	C	While no standards for the management of acute upper GI bleeding are in place in Ireland, the future development of quality standards will likely follow the Scottish Intercollegiate Guidelines Network (SIGN) clinical guideline for the management of acute upper and lower gastrointestinal bleeding. The National Institute for Health and Care Excellence (NICE) has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard. The quality standard defines clinical best practice for acute upper gastrointestinal bleeding. The NICE guidance should be read in full and used as best practice in the interim[6, 7]
2.7	Patients with acute upper gastrointestinal bleeding undergo a risk assessment using a validated risk scoring system.	C	NICE has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard[6,7]. The quality standard defines clinical best practice for acute upper gastrointestinal bleeding and should be read in full.

2.8	A process is in place for identifying and reviewing all deaths occurring within 30 days of an endoscopic procedure and all unplanned admissions within 8 days of an endoscopic procedure.	B	The endoscopy service is expected to review all safety matters including 30-day mortality and 8-day readmissions at agreed intervals (monthly, quarterly). It is equally important to show how identified issues are managed and learned from and how the duty of candour is discharged.
2.9	Reviews of 30-day mortality include an assessment of the appropriateness of the procedure and any contribution of the procedure itself to the cause of death. Outcomes of reviews are reported through agreed hospital governance structures.	B	The endoscopy service is expected to review all safety matters, including 30-day mortality and 8-day readmissions, at agreed intervals (monthly, quarterly). It is equally important to show how identified issues are managed and learned from and how the duty of candour is discharged.
2.10	Actions required in response to learning from adverse events are implemented within 3 months of being reported.	B	It is usual to see a hospital-wide adverse events management system. The service should use this and also show how near misses and adverse events are managed and learned from.
2.11	Over 75% of patients admitted with acute upper gastrointestinal bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission.	A	NICE has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard. The quality standard defines clinical best practice for acute upper gastrointestinal bleeding and should be read in full[7].
2.12	The service is compliant with over 50% of the quality measures in the 2013 NICE guidelines for acute upper gastrointestinal bleeding.	A	NICE has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard. The quality standard defines clinical best practice for acute upper gastrointestinal bleeding and should be read in full[7,8].
2.13	The service has an action plan to address areas where it is unable to currently meet the quality measures in the 2013 NICE guidelines for acute upper gastrointestinal bleeding.	A	NICE has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard. The quality standard defines clinical best practice for acute upper gastrointestinal bleeding and should be read in full[7,8].

Standard 3: comfort

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that the comfort of patients is supported and respected throughout their contact with the endoscopy service.

No	Measure	Lvl	Guidance
3.1	Patients receive information ahead of time which provides a realistic description of the level of discomfort to be expected during the procedure.	D	Patient satisfaction or dissatisfaction with an endoscopy depends on the gap between what they expect and what they experience. If they experience an acceptable level of discomfort but have been led to believe that the procedure would be painless, then they could be more likely to be dissatisfied. Hence the importance of giving patients realistic expectations of what they might expect.
3.2	Nurses monitor and routinely record patient pain and discomfort during and after the procedure using a validated scoring scale.	C	A comfort assessment should cover all procedures, irrespective of sedation level. It is the endoscopy nurse's responsibility to tend to the needs of the patient during the procedure and, in particular, to monitor their comfort. Because the endoscopist's attention is focused on the procedure, it is believed that the endoscopy nurse is the best judge of the level of discomfort. Furthermore they have the benefit of knowing what discomfort other patients experience having the same procedure done by different operators. Sedation may also affect patients' perception of discomfort. The process involves the nurse and consultant agreeing the score before the end of the procedure, allowing the endoscopist to enter the mutually agreed score on the system.
3.3	Patient comfort scores are reviewed at least two times per year by the endoscopy leadership team and data are fed back to individual endoscopists.	C	Patient comfort scores are routinely reviewed at EUG meetings.
3.4	If an endoscopist's patient comfort scores fall below agreed levels, the endoscopist is required to take remedial action and scores are reviewed again within 6 months.	B	Feedback of comfort levels to endoscopists is important to reassure those who are causing relatively little discomfort, and to make those causing more discomfort aware that they might be able to improve their technique or sedation practice.
3.5	If patient comfort levels do not reach acceptable levels after a remedial period, that individual's endoscopy practice is reviewed by the service's clinical lead and/or provider governance committee.	B	A judgement must be made by the service clinical lead and Hospital Group Clinical Lead for Endoscopy if an operator is consistently causing more discomfort to their patients than others. A professional development plan should be agreed and the operator should be reassessed at three months.
3.6	The service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy. This should include access to general anaesthesia if required. Anaesthesia should be administered under the supervision of an anaesthetic doctor.	A	Local guidance on sedation should be in line with the 'Guidelines for the Implementation of a National Quality Improvement Programme in GI Endoscopy'[1].

Standard 4: quality

The purpose of this standard is to ensure that the service implements and monitors systems to ensure the clinical and technical quality of all procedures.

No	Measure	Lvl	Guidance
4.1	Key quality indicators and auditable outcomes defined by the Conjoint Board RCSI/RCPI for the procedures performed in the service are available in the department in accessible form.	D	The specific key performance indicated that require continuous monitoring are defined in 'Guidelines for the Implementation of a National Quality Improvement Programme in GI Endoscopy'[1].
4.2	Individual endoscopists are given feedback on their procedure KPIs at least two times per year.	C	Feedback is provided in line with Gastrointestinal Endoscopy National Quality Improvement Programme guidance.
4.3	Individual endoscopists are given feedback on their late outcomes (30-day mortality and 8-day unplanned admissions) at least once per year.	C	All unplanned admissions and mortality are reviewed and discussed if necessary at EUG meeting and fed back to individual endoscopists.
4.4	The service has clear guidance on managing endoscopist performance and the action required if levels are not achieved and maintained.	C	There are many reasons why an endoscopists' KPIs may not reach national standards occasionally during their career. The service should establish clear guidance which identifies a process of review and discussion of such periods, within a clear framework of decisions, action and escalation, which protects the safety and quality of the patients' endoscopy experience. It is the responsibility of the service clinical lead and Hospital Group Clinical Lead to review performance and action in line with the organisation's and national guidance in a timely manner.
4.5	There is an endoscopy reporting system (ERS) in place to capture immediate procedural and performance data	C	All services must have an endoscopy reporting system.
4.6	The ERS has been configured to record data required by the National Quality Assurance Improvement System (NQAIS) and to be able to upload data into NQAIS.	C	The ERS upload to NQAIS central database will facilitate quality assurance and benchmarking at a national level. Individual users and services will be able to access their own performance data.
4.7	Actions taken in response to suboptimal performance by an endoscopist are reviewed within agreed timescales.	B	Where poor or suboptimal performance is identified following clinical audits or appraisal, action should be planned in a timely manner with the endoscopist. This action should be with defined timescale and next steps should be identified.
4.8	If an endoscopists performance does not reach acceptable levels after an agreed development period, the service's clinical lead and provider governance committee reviews that individual's endoscopy practising rights.	B	Following a period of development (eg skills enhancement course or increased numbers), should an endoscopist's performance not meet the accepted standard, the Hospital Group Clinical Lead for Endoscopy and Hospital Group Clinical Director (if required) should undertake a review. This should establish whether further action is appropriate or whether the endoscopists practising right for the modality should be withdrawn.

4.9	The service collects separate data for inpatients who undergo endoscopy. This is used to assess the indication, waiting times, Conjoint Board RCSI/RCPI auditable outcomes and quality standards.	B	Inpatients should be afforded a timely, appropriate and high-quality endoscopy service. They may have significant comorbidity which incurs a greater risk during endoscopy while others may not need the procedure or could be discharged to have it as an outpatient e.g. some colonoscopies.
4.10	The service collects details of all 'off unit' gastrointestinal endoscopy that occurs in the organisation. This is audited and action plans are formulated.	B	Endoscopy is performed in a number of settings outside of the endoscopy service e.g. main theatres, intensive care unit (ICU) etc. This can be both emergency and elective work. This is not always captured on the ERS and is therefore not subject to audit processes. The service should setup systems to identify all these patients and assess their indications and outcomes against Gastrointestinal Endoscopy National Quality Improvement Programme auditable outcomes and quality indicators[7].
4.11	All endoscopy procedures which take place outside the endoscopy service (e.g. in the theatre or intensive care unit (ICU)) are captured on the ERS.	A	If the endoscopy procedure is not captured then this should be considered a reportable event.

Standard 5: appropriateness

The purpose of this standard is to ensure that the service implements and monitors systems to ensure appropriate and safe referrals for all procedures.

No	Measure	Lvl	Guidance
5.1	There are referral guidelines available for all diagnostic procedures in an accessible form.	D	It is recommended that all endoscopists agree guidelines for endoscopy and that these are recorded in an operational policy for the service.
5.2	There is a local policy for vetting referrals.	D	It is helpful when constructing a guideline to have one or more auditable outcomes against which adherence to the guideline can be measured. This policy should include who does the vetting and which requests are vetted. A timeliness outcome might be that 90% of inpatient referrals will be reviewed within 24 hours of receipt of referral. It is recommended that all endoscopists agree the vetting policy for endoscopy and are recorded in an operational policy for the service.
5.3	Endoscopy referral forms have sufficient clinical information to permit vetting of the appropriateness of the referral against guidelines.	D	Referral forms can be paper or electronic.
5.4	Referral guidelines for direct access procedures have been agreed with representatives from primary care.	C	Primary care should be involved in the writing and reviewing of guidance.
5.5	Referral guidelines for other procedures have been agreed by all who perform those procedures.	C	Compliance with a guideline will be easier to enforce if the guideline has the agreement of all who use it.
5.6	All referrals from non-endoscopists within primary and secondary care are vetted by an endoscopist who performs that procedure, unless agreed 'straight to test' protocols exist.	C	Agreed 'straight to test' protocols will usually include a direct referral form with tick boxes that can be assessed by a suitably trained person.
5.7	Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.	B	Vetting of urgent inpatient requests should be carried out daily for acute services to prioritise the most urgent cases and reduce length of inpatient stay. Such vetting will include good two-way communication between the referring teams and the endoscopists, particularly for emergency cases.
5.8	All surveillance procedures are validated clerically and clinically according to the current national guidance at least 2 months prior to the due date.	B	Patients should be advised that in several years' time there may be a very good reason why their procedure has been cancelled or deferred for a longer period (eg new surveillance interval guidelines).
5.9	An audit of the vetting process is undertaken once per year and action plans are created if problems are identified.	A	

Standard 6: results

The purpose of this standard is to ensure that the service implements and monitors systems to ensure the clinical and technical quality of the interpretation of test results, and their reporting and communication.

No	Measure	Lvl	Guidance
6.1	All endoscopy reports are completed on the day of the procedure and include follow-up details.	D	
6.2	Endoscopy reports for all inpatients are placed in the patient record before the patient leaves the department.	D	
6.3	There is a process for referring patients with a suspected or definite cancer diagnosis to the appropriate multidisciplinary team (MDT).	C	Referral process should be in line with local colorectal and upper GI cancer MDT guidelines.
6.4	Endoscopy reports are sent to the patient's GP and also to the referring clinician (if different) within 24 hours of the procedure.	C	There are systems in place to ensure communication of reports to referrers and MDT meetings within specified timescales. Reports should be dispatched to the referrer as agreed.
6.5	The service has a robust process to track suspected and unexpected malignant histology and to ensure prompt referral for staging and treatment.	B	There is a documented structure and process in place to inform the appropriate local cancer team as soon as is practicable after diagnosis. This should not be reliant on an individual endoscopist. For most endoscopy services the histology report goes to the referring clinician who is ultimately responsible for taking the appropriate action. Prompt referral to the cancer MDT or equivalent, usually facilitated by a clinical nurse specialist or equivalent.
6.6	There are local processes in place to identify who endorses pathology reports when received by the service.	B	Electronic systems and processes to identify and endorse pathology are acceptable but must be verified or approved by a clinician.
6.7	If it is necessary for the referrer to receive additional information (e.g. pathology reports), this information is dispatched to the referrer within 5 working days of receipt of the report.	B	There must be a process in place for determining at the time of endoscopy whether a referrer should be sent additional information. For most endoscopy services the histology report goes to the referring clinician who is ultimately responsible for taking the appropriate action. Clearly, if the patient has a planned outpatient appointment to review the endoscopy and the pathology report, then this case would fall outside this measure. The information dispatched to the referrer may not be a copy of the report (indeed most GPs prefer not to receive this – they prefer an interpretation of the report).
6.8	Pathology reports are actioned within 5 working days of receipt of the report.	B	Electronic systems and processes to identify and endorse pathology are acceptable but must be verified or approved. For most endoscopy services the histology report goes to the referring clinician who is ultimately responsible for taking appropriate action.

6.9	If a cancer is suspected at the procedure, the patient is referred to the relevant cancer clinical nurse specialist (CNS) who contacts the patient either before discharge from the service or within 1 working day.	B	
6.10	All endoscopy reports are communicated electronically on the day of the procedure.	A	

Quality of patient experience domain

Standard 7: respect and dignity

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that the privacy, dignity and security of all patients are respected throughout their contact with the service

No	Measure	Lvl	Guidance
7.1	The service has a respect, dignity and security policy, which includes the care of all adults accessing the service.	D	The service should demonstrate its commitment to ensuring that patients are treated in clean and pleasant hospital surroundings and that the staff will do all that they can to protect privacy and dignity. Treating people as individuals, whatever their differences or values, and ensuring that their particular needs are met, must be central to an endoscopy service's philosophy of ensuring the very highest levels of privacy, dignity and respect. The National Healthcare Charter 'You and Your Health Service' is a statement of commitment by the HSE describing what patients can expect when using health services in Ireland[9]. **Examples of how a culture of dignity and respect might be applied in practice include:** staff introductions, name badges, interpretation and translation policy in place (to ensure that patients and carers whose first language is not English get the same level of service as others), communication books on wards and departments including pictures and sign language, universal accessible signs across hospitals for toilets and bathrooms, privacy curtains in toilets and bathrooms and some examination rooms, privacy clips on curtains, side-tying gowns, larger size wheelchairs available, flashing vibrating devices to alert patients who may be hard of hearing, and communications boxes on the wards and departments to aid people who have sight, hearing or communication problems. The Quality Improvement Division was established in 2015 to support the development of a culture that ensures improvement of quality of care is at the heart of all services that the HSE delivers. Information about Quality Improvement Division initiatives and programmes as well as publications and resources for healthcare staff are available[10].
7.2	There are policies for safeguarding adults and children within the department.	D	There should be a specific description of how vulnerable patients are cared for within the service and this ideally should be contained within the service's operational policy.

7.3	There is a nominated Dignity Champion within the service.	D	A Dignity Champion challenges disrespectful behaviour and acts as a role model by treating other people with respect, particularly those who are vulnerable; speaks up about dignity to improve the way that services are organised and delivered; influences and informs colleagues; and listens to and understands the views and experiences of patients.
7.4	There are processes to identify the personal needs of all patients (background, culture and including vulnerable adults).	C	The National Healthcare Charter, which is titled You and Your Health Service is based on eight principles which underpin high quality, people-centred care[9].
7.5	There is a range of communication methods and materials to ensure that patients are appropriately informed about what they should expect from the service.	C	Communication methods and approaches will be different for each service and therefore must reflect both the needs of patients and the service, eg website, written information and specialised communication such as pictures.
7.6	There are processes and training systems in place to ensure that all staff act with discretion and respect towards all patients and carers.	C	Training for staff may be organisation wide or bespoke for the service.
7.7	There are systems in place for any clinical conversations to be held in private.	C	See the Medical Council of Ireland (2016), Guide to Professional Conduct and Ethics for Registered Medical Practitioners 8th Edition[11].
7.8	The use of family and friends as interpreters is discouraged unless it is the patient's choice. If the patient exercises this choice it is documented in their file.	C	The reason the use of family or friends as interpreters is discouraged is because of the difficulty of being certain that the information transmitted to, or received from, the patient is complete and correct. It is the patient's choice if they wish to use their family or friends as interpreters. If it is confirmed by an interpreter (usually by phone) then this should be documented in the patient's file.
7.9	Patient-identifiable material is not openly displayed in areas accessible to other patients, relatives or carers.	B	See the Medical Council of Ireland (2016), Guide to Professional Conduct and Ethics for Registered Medical Practitioners 8th Edition[11].
7.10	Patients' privacy and dignity is adequately protected at each stage of their pathway supported by clear processes and staff understanding.	B	
7.11	The presence of relatives in clinical areas is not permitted unless the clinical team determines it to be in the patient's best interest to do so (eg if the patient is a vulnerable adult or a child).	B	A record of the decision should be made in the patient notes.
7.12	There is separation by gender for patients who need to change	A	All new build endoscopy services should work towards gender separation. Existing services should strive towards this is feasible within existing infrastructure.
7.13	Gender separation and pre- and post-procedure separation is provided routinely from the admissions stage onwards in the patient journey, including the recovery area.	A	Gender separation rules and the environment are nation specific and reflect national polices relating to gender separation. All new build endoscopy services should work towards gender separation. Existing services should strive towards this, if this is feasible within existing infrastructure.

Standard 8: consent process including patient information

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that informed patient consent is obtained for each procedure.

No	Measure	Lvl	Guidance
8.1	There is a published patient information sheet for all procedures (diagnostic and therapeutic) performed in the service.	D	It is recommended that basic standards are set for the development of patient information leaflets in endoscopy.
8.2	There is accessible guidance within the service for consent including withdrawal of consent during an endoscopic procedure for all adults (includes vulnerable adults).	D	Guidance should be developed in line with the HSE National Consent policy (2017)[12].
8.3	The service requires a patient's fitness for oral bowel cleansing agents to be documented by the requesting clinician prior to bowel preparation being dispensed.	D	The referrer needs to verify that their patient is fit enough to undergo the procedure. This includes being able to take bowel preparation, to lay flat and move for colonoscopy. In services where non-PEG based laxatives are used, protocols need to be in place to ensure renal function has recently been assessed with appropriate advice given.
8.4	Signatures are obtained on a consent form for all patients who are able to sign the form and there are procedures in place for those who cannot sign.	C	
8.5	All patients are given sufficient time to ask questions about the procedure before consent is agreed and before entering the procedure room on the day.	C	
8.6	'High-risk' patients and patients scheduled for 'high-risk' procedures are informed of the additional risk by the endoscopist carrying out the procedure, and there is a process to document this.	C	High-risk patients are identified as those: • With an ASA score of 3 or greater[3] • Where an underlying clinical condition or medications may make them more likely during the endoscopy to have a complication eg severe diverticulosis, patients on anticoagulants and patients having general anaesthesia[4] • Where National Patient Safety Agency instructions exist for the management of patients' safety eg the use of oral bowel cleansing agents.[14] • High-risk procedures eg therapeutic OGD, PEG, ERCP, EMR are defined by the BSG[4]. The assessment process allows individual patient and procedure risks to be identified and managed.
8.7	High-risk groups, defined by the service, are assessed before the date of the procedure to prepare them properly for procedures (and to avoid late cancellations).	C	High-risk patients are identified as per the guidance for measure 8.6.

8.8	The consent process for inpatients scheduled to have therapeutic procedures is commenced on the ward, either by the provision of procedure-specific information or by pre-assessment by the endoscopist or an appropriately trained member of staff.	B	
8.9	Non-compliance of any consent issue is recorded as an adverse event.	B	
8.10	Two-stage consent is performed for all high-risk patients and patients scheduled for 'high-risk' procedures, over a time period, including explanation of risks of and alternatives to the procedure, and where applicable the risk of bowel preparation.	B	See note for measure 8.6 for a definition of high risk patients. In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This is usually on one occasion in outpatients, or it might be over a whole series of consultations with a number of different health professionals (nurses and anaesthetist). The consent process will therefore have at least two stages, i.e. the information stage and the confirmation stage on the day of the procedure. High-risk procedures e.g. therapeutic OGD, PEG, ERCP, EMR are outlined within the following BSG documents[18,19] The assessment process allows individual patient and procedure risks to be identified and managed.
8.11	There is a process to review and update (as required) all patient information annually to reflect patient feedback and changes in practice or risks (covers website, printed information and other).	B	
8.12	Consent for all inpatients is taken on the ward or as a minimum outside the procedure room.	A	
8.13	Appropriate patients are routinely pre-assessed, either by telephone or in person.	A	The service should define the appropriate groups of patients for a routine pre-assessment service. It may include all patients or target-specific procedures such as colonoscopy and ERCP.

Standard 9: patient environment and equipment

The purpose of this standard is to ensure that adequate resources are provided and used effectively to provide a safe, efficient, comfortable and accessible service. This is achieved through appropriate and adequate facilities (rooms and equipment) and the integration of sound business planning principles within the service.

No	Measure	Lvl	Guidance
9.1	There is a description of the facilities (outpatient and inpatient) available for patients and referrers.	D	The service is advised to review the separate environment guidance document, available on the JAG website.
9.2	Guidelines for endoscope decontamination are available in the service in written and/or electronic form	D	Decontamination equipment and associated machinery includes endoscope washer disinfectors (EWDs) reverse osmosis plants, endoscope storage cupboards etc. Testing and validation should be in line with the HSE Standards and Recommended Practices[14]. Testing and validation of the Automatic Endoscope Reprocessors (AER) are carried out in line with current standards and recommended practices set out by the HSE Decontamination of Reusable Invasive Medical Devices Programme, and action is taken if necessary on results which fall outside the acceptable parameters[5].
9.3	There is a service policy that describes access to the facilities and restrictions where appropriate.	D	There are systems in place to ensure that all areas used by the service meet the specific needs of the patient population (including children and those with particular needs) and staff, and comply with national rules (eg vulnerable adults, single sex accommodation etc).
9.4	There are systems in place to ensure that all areas used by the service meet the specific needs of the patients undergoing endoscopy (including children and those with particular needs) and staff.	C	The service is advised to review the separate environment supporting checklist.
9.5	The service implements and monitors systems to ensure that the facilities and environment support delivery of the endoscopy service. This includes annual completion of the endoscopy environment checklist.	C	Mandatory decontamination assessment and audit by the authorised engineer (AED) within 1 year of an accreditation assessment, and yearly audits and actions for all other years is required.
9.6	There is a Decontamination Lead appointed by the Hospital who has overall responsibility for Endoscopy Decontamination Practice	C	The management lead for decontamination within endoscopy must fulfil the role and requirements as identified in the respective national guidance. Where decontamination is undertaken outside endoscopy, the nominated person must show how this links to the staff using the equipment within the endoscopy service.
9.7	There is an endoscopy management lead responsible for the procurement and management of all endoscopy equipment and consumables (includes decontamination).	C	Where decontamination is overseen outside the service, or by another authorised manager, procurement and management may fall within the remit of two people.

9.8	There is an annual authorised engineer report for decontamination.	C	Mandatory decontamination assessment and audit by AED within 1 year of an accreditation assessment, and yearly audits and actions for all other years is required.
9.9	There are systems in place to ensure that all areas within the endoscopy environment are well maintained and support efficient patient flow to facilitate ergonomic and effective working (includes decontamination).	B	There should be high standards of operational practice in all areas where endoscopy procedures are undertaken eg main unit, radiology for ERCP and day surgery footprint for shared areas.
9.10	There are systems in place to ensure that access to particular areas is restricted where appropriate (includes decontamination).	B	This should define the clinical environment from reception and decontamination facilities.
9.11	There are systems in place to ensure equipment is appropriate and available for patients, staff, children and those with particular needs.	B	For example, hoists and bariatric beds or paediatric endoscopy equipment.
9.12	There are systems in place to ensure the management and control of environmental conditions (includes decontamination).	B	For example, temperature or ventilation control.
9.13	There are systems in place to ensure the maintenance and quality assurance of all equipment with corresponding records (includes decontamination).	B	
9.14	The annual authorised engineer report for decontamination is actioned and approved by the organisation.	B	
9.15	There are systems in place to ensure that equipment replacement is planned (includes decontamination).	B	The clinical lead and service nurse manager highlight capital equipment needs for the service as part of annual service planning.

Standard 10: access and booking

The purpose of this standard is to ensure that the service is accessible, timely and patient centred. The service should be fully compliant with the booking and scheduling within the Endoscopy Department as outlined in the National Inpatient, Day Case, Planned Procedure (IDPP) Waiting List Management Protocol[16].

No	Measure	Lvl	Guidance
10.1	The service has agreed standard operating procedures to support endoscopy waiting list management, booking and scheduling practices.	D	The service should define an operational policy including a section on: access for new patients; patient tracking list (PTL) management and validation; booking and scheduling rules; vetting; pooling; surveillance; operational meetings; and escalation processes.
10.2	The service has defined, documented roles and responsibilities for endoscopy waiting list management, booking and scheduling management that meet the needs of the service.	D	The roles and responsibilities should include who is responsible for day-to-day administration of waiting lists, scheduling and capacity management.
10.3	The service has a supported waiting list management system that records new and recall (planned/surveillance) patients.	C	A supported system means having electronic tracking of waits for waiting and surveillance lists. An endoscopy service should be able to produce up-to-date waiting list and surveillance information through electronic systems.
10.4	There is an agreed process for determining and monitoring the capacity of each endoscopy list. The most usual method is by allocating procedures 'points' of time.	C	The capacity of each list must reflect the competence of each endoscopist. Training lists will have reduced capacity.
10.5	The service has a process for identifying patients at risk of breaching waiting times and these are escalated and offered appropriate dates for admission.	C	
10.6	There is sufficient pooling of referrals to ensure that patients are booked in turn (unless there is a clinical reason why a patient should not be on a pooled list).	C	Pooling of lists helps to deliver a patient centred service. The pooling of endoscopy lists to reduce the risk of breaches occurring. There should be an appropriate level of pooling occurring for more common procedures. It is appreciated that some cases and high-risk procedures must be done by a specific endoscopist. Services should agree their pooling policy and this should include all specialities involved in the delivery of endoscopy.
10.7	All appropriately vetted inpatient procedures are performed within 48 hours.	B	Inpatients should be afforded a timely, appropriate and high-quality endoscopy service. The timescales allow for the preparation of patients for urgent colonoscopy. Patients may not need the procedure in this timescale and could be discharged to have it as an outpatient eg some colonoscopies.
10.8	The service adheres to national waiting time criteria for routine, urgent cancer waits and non-cancer urgent waits.	B	The service should reflect national and local recommended waiting list practices. Appointment times should be equitable for all patients.

10.9	The service adheres to waiting times criteria for surveillance waits.	B	The service should reflect any national and local recommended surveillance times and these should be equitable for all patients. JAG has a mandatory template and notes to support surveillance time reporting as part of evidence submissions.
10.10	All appropriately vetted urgent upper gastrointestinal and ERCP inpatient procedures are performed within 24 hours and colonoscopy within 48 hours.	A	Inpatients should be afforded a timely, appropriate and high-quality endoscopy service. The timescales allow for the preparation of patients for urgent colonoscopy. It is important to have robust vetting and patient assessment processes in place to ensure that only those patients that need the procedure in this timescale are treated.
10.11	There is an electronic scheduling system that facilitates efficient booking and scheduling.	A	

Standard 11: productivity and planning

The purpose of this standard is to ensure that resources and capacity are used effectively to provide a safe, efficient service. This is supported by sound business planning principles within the service.

No	Measure	Lvl	Guidance
11.1	Productivity metrics are agreed and documented in the service operational policy.	D	The service should consider including the minimum following performance and productivity dataset: overall/individual utilisation of lists; start and finish times audit; room turnaround audit; and did not attend (DNA) and cancellation rates.
11.2	There is a review every two weeks of waits, demand, capacity and scheduling with key service leads.	C	The service team needs to have access to accurate waits and capacity information to deliver and plan services effectively. The review meeting will typically takes 30 minutes with key service leads. The aim of the review is to ensure lists are planned in accordance with real-time demand on the service.
11.3	There is active backfilling of vacant lists, the frequency of unfilled lists is reviewed during the review meeting every two weeks and there is sufficient flexibility in the job plans of endoscopists to enable backfilling of funded (ie staffed) capacity.	C	
11.4	The service offers an administrative and nursing (if appropriate) pre-check for all patients before the date of the procedure to identify issues and to avoid late cancellations	C	An administrative pre-check or telephone pre-assessment is performed by booking/administrative staff to ensure that the service has the most up-to-date information about the patient's condition. Nurses may further support this. In some cases this check is led by nurses and this is down to local policy
11.5	Booking efficiency is monitored (through DNA and cancellation monitoring) at least monthly and is fed back to endoscopy staff.	C	
11.6	Room utilisation data (such as start and finish times and room turnaround times) is collected, collated, reviewed and acted upon. There is an agreed room utilisation performance target.	B	The service should consider including as a minimum the following performance and productivity dataset: overall/individual utilisation of lists; start and finish times audit; room turnaround audit; DNA and cancellation rates.
11.7	There is an annual planning and productivity report for the service with an action plan.	A	
11.8	Demand, capacity and utilisation data is used to inform short and long term business planning to ensure sufficient capacity, and the service has an agreed business plan if shortfalls are identified.	A	
11.9	There is, on an annual basis, a measurement of the demand for endoscopy to support service planning.	A	

Standard 12: aftercare

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that patients are prepared for discharge and understand what the plan of care is thereafter.

No	Measure	Lvl	Guidance
12.1	There are procedure-specific aftercare patient information sheets for all procedures performed in the service.	D	
12.2	There is a 24-hour hospital-based contact number for patients who have questions and experience problems, and the contact is aware of the protocol to advise and manage patients.	C	Patients must have a contact number and be able to discuss problems with someone who knows about endoscopy. This might include nursing staff on a gastroenterology ward or gastrointestinal bleed unit; the nursing staff on an endoscopy on- call rota; and the ED (if it has been agreed beforehand). A call-back system is a suitable alternative whereby the patient calls the ED or switchboard and is called back by a member of the endoscopy team if their problem cannot be dealt with in any other way.
12.3	All patients are told if they are suspected of having a malignancy on the same day as the procedure unless it is considered to be in the patient's best interest not to do so.	C	
12.4	There is a process to provide a written explanation to patients about their ongoing care follow-up appointments.	C	
12.5	All patients are told the outcome of the endoscopic procedure or next steps prior to discharge.	B	Patients and carers (if the patient agrees) are told the outcome of the procedure and given a copy of their report.
12.6	All patients are told if further information from pathological specimens will be available, from whom and when.	B	
12.7	All patients are offered a copy of the endoscopy report or a patient-centred version of it. If this is deemed inappropriate, the reason is recorded in the file.	A	Patients may be advised that they will be followed up or to return to their GP.

Standard 13: patient involvement

The purpose of this standard is to ensure that the service implements and manages systems to ensure that patients are able to feed back on their experience of the service and that the feedback is acted upon.

No	Measure	Lvl	Guidance
13.1	The endoscopy service complaints procedure is documented and is clearly available for patients, relatives and carers to access.	D	The hospital complaints policy is clearly documented in the service and in the patient pre and post procedure literature.
13.2	There are defined roles and responsibilities for obtaining and managing feedback from patients, carers and relatives.	D	Patient and relatives feedback is included in the audit schedule for the service.
13.3	There are systems in place to ensure that patients and carers are able to give feedback in a variety of formats and in confidence.	C	This could include verbal, written and web-based feedback.
13.4	There are processes in place to ensure that complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon.	C	
13.5	Patient feedback and agreed actions are disseminated and discussed at Endoscopy User Group (EUG) or equivalent and nurse meetings to ensure learning.	C	
13.6	There are a number of processes to invite and learn from patient feedback consistently (eg focus groups, patient forums, questionnaires or invited comments).	C	A service should consider a number of approaches including questionnaires, social media or invited comments: it is up to the service to define what is best for their type of service.
13.7	The service conducts an annual patient feedback survey on the patients' experience in endoscopy.	C	
13.8	An executive summary of patient feedback and actions is available and accessible within the department for patients to view.	B	
13.9	Actions for annual patient feedback are reviewed within 6months to ensure the service has dealt with the problems identified.	B	
13.10	Details of changes made in response to patient feedback are reported to patients and carers who attend the service (eg 'you said, we did').	B	Patients and carers are much more willing to participate in satisfaction surveys if they know that change has occurred as a result of the survey.
13.11	Patients participate in planning and evaluating services.	A	

Workforce domain

Standard 14: teamwork

The purpose of this standard is to ensure that the service implements and monitors systems for effective teamwork within the service.

No	Measure	Lvl	Guidance
14.1	The endoscopy team has a documented policy, outlining the ethos, culture, professionalism and discipline of how the team works together.	D	This guidance should be agreed and signed by all endoscopists, nursing and administrative workforce members. This includes a process for visiting or temporary staff eg agency staff, insourcing teams.
14.2	There is a clear description of the members of the team, and the responsibilities of both the core and wider team, in the running and development of the service.	D	This should cover medical, nursing, administrative and management staff. The core team is identified as staff with day-to-day roles and responsibilities for the service. The wider team is staff who support the service, undertake only part of the patient journey, or are temporary staff to the service.
14.3	The service has a documented matrix of staff competencies for all procedures undertaken. This should be clearly visible within the service, to ensure safe patient care.	D	The matrix should include all endoscopist competencies, and those of supporting clinical staff within the endoscopy service. It should be regularly updated, and include comments where procedural exposure is required to prevent loss of competence.
14.4	There are systems in place to ensure that all staff are involved in the development of the service and the implications within their area of responsibility.	C	This should be evidenced through interviews during the appraisal process and meeting minutes.
14.5	The service has structured handovers for briefing and debriefing at each list to ensure safe efficient practices and learning.	C	At the beginning and end of each list the endoscopist, supporting clinical staff and trainees must participate in the process and a written record made[16].
14.6	There are processes in place that actively encourage both core and wider team members to provide informal feedback about patient care, team functioning or the way the service is delivered, and to suggest ways these things could be improved.	C	This should cover medical, nursing, administrative and management staff. The core team is identified as staff with day-to-day roles and responsibilities for the service. The wider team is staff who support the service, undertake only part of the patient journey, or are temporary staff to the department.
14.7	There are systems in place to ensure that staff are able to feedback in confidence on issues related to the service, including the team or team members.	C	
14.8	Time is allocated in job plans and the establishment to allow safety checks and equipment calibration to be performed.	C	Systems should be established for safety checking and calibration, which may be part of maintenance or everyday practice.

14.9	There is an annual review of the documented policy, outlining the ethos, culture, professionalism and discipline of how the team works together.	B	This review should be agreed by the endoscopists, nursing and administrative workforce members. This includes a process for sharing and feedback from visiting or temporary staff eg agency staff, insourcing teams.
14.10	There are processes in place for staff leaving or joining the clinical team part way through a procedure or activity, to ensure patient safety.	B	This includes any stage in the patient pathway from admission to discharge/handover from the service.
14.11	The endoscopy team and users of the service are surveyed at least once per year about their perceptions on patient care, team leadership, team working and communication with patients and other professionals, and for ideas of how the service could be improved.	B	The service should build an appropriate feedback survey that should include the core team, other internal departments who use the service eg secretaries, wards and external services eg GP referrers, referrers to tertiary care centres.
14.12	There are processes in place to review feedback and team surveys, and to create quality improvement plans.	B	Feedback and ideas should be collated to a service quality improvement plan.
14.13	Quality improvement plans are reviewed 6-monthly to review progress and ensure that they are being acted upon.	B	There should be a process to ensure quality improvement plans are acted upon, and mark progress. Where this cannot be achieved, this is escalated to the appropriate directorate team.
14.14	There are processes in place for recognising and rewarding the achievements of the team and individual members for outstanding performance.	B	The organisation should determine methods for reward eg outstanding service awards, bonus payments, participation in HSE staff awards
14.15	The team networks with other endoscopy teams in other areas – both regionally and nationally – to share best practice and to help resolve service challenges.	A	Networking may be undertaken by visiting other services, regional groups, speaking at meetings, online forums, writing for journals, attendance at the GI QI Programme workshop, Hospital Group forums (organised by the Hospital Group Clinical Lead/management team) etc.
14.16	The Endoscopy Team should meet annually to review their processes and support services for quality improvement	A	The core clinical, nursing, administrative and managerial team take at least 1 day out together from normal service to undertake the review. This may be held internally or at an external location, and should not be part of a general EUG or governance meeting.

Standard 15: workforce delivery

This standard ensures that the service has the appropriate workforce and that recruitment processes meet the needs of the service.

No	Measure	Lvl	Guidance
15.1	There are policies and systems in place to ensure that there are sufficient competent staff within the service with an appropriate mix of skills to enable delivery of the service.	D	This should include a process describing staffing allocation for each list, including risk management of substantive and non-substantive staff. There should be a policy and escalation process for patient activity if staffing and skill mix do not meet the established agreed levels.
15.2	The service rosters staff according to service activity and the competency level required to support it. Allocation of the workforce must be based on the expected duration of the service activity.	D	Modelling of the day and activity is undertaken as part of productivity and safety. Allocation of the workforce must support the expected duration of all service activity eg inpatient activity, safety checks, handover etc.
15.3	A workforce skill mix review is completed on at least an annual basis for all functions of the service and an impact assessment of the gaps is made and objectives are agreed on how these will be addressed in the immediate year.	C	This includes the management, medical, nursing and administrative team members.
15.4	There are polices and systems in place to meet the induction requirements of the endoscopy team, including any additional service specific education and training.	C	This includes all visiting and non-substantive staff to a service such as agency staff, staff from other areas, insourcing teams, and should be based round national and professional guidance. For example, HSE Induction Guidelines and Checklists provide the employer and the employee with detailed and relevant information on the Induction process[18]. Roles and responsibilities are clearly defined. Timeframes for the completion of each stage of induction are set out in the supporting documentation. The checklists have been designed for all stages of the Induction process. They are designed to give employees and their line managers a guide to a logical and comprehensive procedure. The checklists also provide the employer with a record of the employee's induction
15.5	There is a training needs analysis for all new staff that supports the needs of the service.	C	A training needs analysis tool is used to identify transferable and required skills for all staff.
15.6	There is a training needs analysis for substantive staff, which is agreed by the appropriate senior manager responsible for each workforce group.	C	This should be undertaken when there is a change or adoption of practice, when team members leave, during succession planning or at least yearly.
15.7	The impact of recruitment processes for new or replacement senior or essential core staff do not adversely affect the running of the service.	B	There should be processes and escalations to provide continuity of service without safety or quality being compromised.

15.8	There are monitored processes to ensure the recruitment of suitable staff in a timely manner.	B	It is expected that the recruitment of new staff does not negatively impact upon the service.
15.9	As a result of the workforce skill mix review an action plan is created and acted upon in a timely fashion.	B	It is expected that the workforce skill mix review is actioned so that it does not negatively impact upon the service.
15.10	There is an induction programme and training plan that meets the needs of new staff that is implemented in a timely and efficient way to minimise disruption to the service.	B	The induction training programme should meet nationally agreed profiles and should be implemented in a structured, modular way to build on learning and skills progression. HSE induction guidelines and checklists are available[17].
15.11	The service-specific induction programme for all new staff is modified on the basis of feedback.	B	
15.12	Workforce development plans are in place in anticipation of future demands in the volume and type of future demand, for the next 2–5 years.	B	A needs analysis and development plan should be developed around service provision for the medical, nursing and administrative workforce.
15.13	There is a process for the recruitment and induction of senior staff, which allows a handover period prior to replacement.	A	There should be processes and escalations to provide continuity of service without safety or quality being compromised.

Standard 16: professional development

The purpose of this standard is to assess the degree to which the service monitors and supports the development of the professionals working within it.

No	Measure	Lvl	Guidance
16.1	There are polices and systems in place to ensure that the workforce are properly trained and competent, including any additional service-specific education and training.	D	The training should cover medical, nursing and administrative workforces. The training programmes should meet national agreed profiles and should be implemented in a structured, modular way to build on learning and skills progression. This includes all visiting and non-substantive staff to a service such as agency staff, staff from other areas and insourcing teams, and should be based around national and professional guidance eg NMBI approved nursing postgraduate courses and medical training courses endorsed by the National Endoscopy Training Committee.
16.2	Where the wider team supports the patient, the training and competence of staff is equal to that of the core team.	D	The wider team may include day surgery assessment and recovery staff, out-of-hours theatre teams and ward staff where recovery is undertaken.
16.3	There is a nominated mentor/trainer supervising each team member until identified competencies have been achieved for them to undertake their role independently.	C	The nominated trainer should have nationally agreed proficiencies eg mentor course / Train the Trainer (TTT). There should be clear competency sign off at each stage of their development and final sign off. This should follow nationally agreed training profiles.
16.4	There is an effective appraisal system in place for all professionals in the service, which identifies learning needs, and changes in behaviour and practice required on the basis of performance metrics and other relevant information.	C	The appraisal for all staff should include the professionally agreed template, and the addition of other relevant information eg patient and staff complaints, 360-degree feedback, training needs analysis etc.
16.5	There is a system in place for providing all professionals in the service with individual performance data sufficient to reliably inform their appraisal and revalidation requirements.	C	There should be processes and feedback mechanisms to provide medical and nursing staff with evidence to support the revalidation cycle eg 360-degree appraisal, KPIs, training needs review.
16.6	The appraisals identify what learning needs require interventions outside the organisation and how these will be resourced.	C	There should be a needs analysis which includes external providers to support learning opportunities, and an agreement between the workforce and the management about how these will be obtained and achieved.
16.7	There are systems and processes to allow staff to meet the requirements of professional revalidation.	C	There should be processes and feedback mechanisms to provide medical and nursing staff with evidence to support the revalidation process eg 360-degree appraisal, KPIs, training needs review.
16.8	The professionals in the service have sufficient time and resource to meet their learning needs and revalidation requirements.	C	Where the service requires specific learning to be undertaken eg new starters, new procedural skills etc, this should be clearly identified in jobs plans with outcomes and support required. Revalidation requirements should be clearly identified and resourced within yearly appraisals.

16.9	There are processes to assess the competencies of non-substantive team members who support the team.	B	This should include assessment and updates of temporary staff, outsourcing service level agreements, training needs analysis and self-disclosure for all clinical and administrative staff.
16.10	There are processes for all staff to receive training and achieve competence when new or replacement equipment is introduced.	B	Where new processes or equipment is introduced, there should be a clear training plan with identification of competencies met for all the workforce, eg new diathermy unit, change in ERS.
16.11	There are processes for the responsibility and supervision of students, trainees and observers within the service.	B	This applies to medical and nursing staff, industry representatives, and professional and lay observers.
16.12	Ongoing review of individual performance metrics identifies areas for development.	B	All staff performance should be reviewed including assessment and updates of temporary staff, training needs analysis and any outsourcing or service level agreements. It is expected that reviews include self-disclosure for all clinical and administrative staff.
16.13	There are robust processes to address performance through the Hospital Group Clinical Leads for Endoscopy and Hospital Group clinical governance system. Issues so that patients and the viability of the service are not put at risk.	B	This should link to the EUG and governance meetings through the organisation.
16.14	There is a process to recognise or address performance issues or concerns.	B	All professionals should be provided with individual performance data sufficient to reliably inform their appraisal and revalidation requirements. Where poor performance has been identified, staff members should be supported through further training and education. If the staff member is still performing poorly, despite being given the necessary training and support, they should be managed through an agreed human resources process.
16.15	The service identifies ways of improving the efficiency of professional development such as joint learning events, helping professionals learn more efficiently and inviting external expertise to support in-house training.	A	
16.16	The service provides professionally accredited endoscopy-specific study days or courses.	A	
16.17	There are educational facilitators attached to the team to support learning and development.	A	Examples of these are a professional development nurse or clinical facilitator.

Training of endoscopists domain

Standard 17: environment, training, opportunity and resources

The purpose of this standard is to ensure that trainees receive the optimal training environment that provides them with the correct orientation and training opportunities.

No	Measure	Lvl	Guidance
17.1	There is a trainee endoscopy induction document.	D	This document, which should be available in electronic format, needs to include: details of key endoscopy staff and contact numbers, local induction process, appraisal, organisation of local training and training lead, JAG certification requirements, rules for independent practice and other useful training information and simulation resources.
17.2	All local protocols and policies are available within the endoscopy service.	D	These should be available in electronic format and should be updated on a regular basis.
17.3	All trainees have access to an ERS capable of generating key audit data.	D	
17.4	Weekly dedicated training lists are factored into the 2-weekly service planning meeting.	D	
17.5	There is a formal endoscopy induction programme for at least some of the new endoscopy trainees.	D	See resource pack for further guidance.
17.6	There is a formal endoscopy induction programme for all new endoscopy trainees to the service.	C	
17.7	There is a dedicated member of staff coordinating training lists.	C	
17.8	Feedback is obtained from all endoscopy trainees on the availability of training support service and the quality of the training environment.	C	
17.9	There is a process in place that ensures that endoscopy trainees' exposure to emergency and urgent endoscopic procedures is maximised.	B	Trainees identified as 'training in gastrointestinal haemostasis' will require evidence. This should be linked to an updated register in the endoscopy room of trainees actively training in specific therapeutic procedure types.

17.10	There is a process for reviewing the delivery of endoscopy training, incorporating trainee feedback and an annual service training survey, with a linked action plan and evidence of implementation of agreed actions.	B	
17.11	All endoscopy trainees have a dedicated appropriately supervised training list (at an annual rate of *at least* 20 lists per year) in addition to ad hoc training opportunities.	B	Training surveys and data on learning curves support the link between dedicated training lists and improved training outcomes. A dedicated training list is defined as 'a pre-planned list, adjusted to a trainee's learning needs and supervised by an appropriately trained endoscopy trainer'. It is recognised that ad hoc training lists can add valuable additional training experience. The minimum number of 20 dedicated lists has been agreed by the JAG, medical and surgical specialist advisory committees (SACs) as realistic and deliverable within the current service environment. The system monitors training list activity and trainee feedback allowing review of performance against this standard.
17.12	There is a process in place for training lists to be identified and planned at least 6 weeks in advance.	B	
17.13	The content of the induction programme is reviewed each year and modified according to need.	A	
17.14	Processes are in place to ensure that actions taken in response to trainee feedback are effective.	A	
17.15	There is evidence of regular trainee representation at endoscopy users' group meetings, and related governance, audit review / service evaluation or management meetings.	A	
17.16	The service is able to support accelerated training for endoscopy trainees with access to dedicated appropriately supervised training lists at an annual rate of *at least* 40 lists per year, in addition to ad hoc training opportunities.	A	Accelerated training programmes require local provision of an increased intensity of training lists. It is recognised that not all services are currently able to support this type of training.

Standard 18: trainer allocation and skills

The purpose of this standard is to ensure that trainees working within an endoscopy service have nominated trainers who demonstrate both acceptable performance in their clinical roles and who have received appropriate training as trainers. Its purpose is also for trainers to remain up to date in training techniques, have assessments of their performance and respond to trainee feedback.

No	Measure	Lvl	Guidance
18.1	There is a nominated trainer for each endoscopy trainee.	D	
18.2	All endoscopy trainers are registered.	D	
18.3	There is a nominated local training lead with overall responsibility for ensuring the induction and appraisal of trainees (with recognised sessional time in their job plan to support this role).	D	A description of the role of a local endoscopy training lead and requirements for sessional time to support the role are available in the KMS.
18.4	The local training lead has attended a JAG-approved TTT course and has maintained and updated trainer skills relevant to the procedures for which they act as a trainer within the revalidation cycle.	D	JAG-approved TTT courses include generic endoscopy trainer courses or procedure-specific courses – it is not expected that a full TTT course needs to be repeated every revalidation cycle. Maintenance of training skill can be evidenced by satisfactory trainee feedback. Updating of trainer skills can be via: acting as faculty trainer on a JAG-approved course; attending an additional procedure-specific TTT course; or enrolment on a formal medical education course (PCME, Diploma, MSc, PhD).
18.5	Trainees regularly provide feedback to endoscopy trainers (as an agreed action of participation in training lists).	C	Trainers review their trainees' performance and review their own training experience (eg number of dedicated training list, anonymous feedback etc). The training lead can use this feedback to support appraisal of training.
18.6	The performance of all endoscopy trainers is regularly reviewed and meets the standards of the Conjoint Board of the RCPI & RCSI quality and safety indicators.	C	This standard relates to the endoscopic skills (audited KPIs) for all trainers (ie providing training on dedicated or ad hoc lists).
18.7	All trainers supervising dedicated training lists have attended (or are supported to attend) a TTT course and have maintained and updated trainer skills relevant to the procedures for which they act as a trainer.	B	This standard supports the principle that all trainers should maintain and develop their training skills.
18.8	All trainers undergo an evaluation of their KPIs and training expertise at least once per year (based on KPIs, and annual service training survey).	B	It is recommended that this standard is incorporated into an annual ETR. A template ETR document is available in the KMS.

18.9	There are recommendations for trainer development in response to evaluations of their training expertise (based on KPIs, and annual service training survey).	B	It is recommended that this standard is incorporated into an annual ETR. A template ETR document is available in the KMS.
18.10	There is an annual direct observation of training skills assessment for all endoscopy trainers (based on Direct Observation of Trainer Skills (DOTS) and Long-term Endoscopy Trainer Skills (LETS) assessment tools).	A	DOTS and LETS tools are available.
18.11	There is a process in place for ensuring that the actions taken following review of trainer evaluations are acted upon and effective.	A	Local training leads should provide recommendations to JAG regional training centre leads to support the development of individual trainers and augment regional training faculty.
18.12	At least one trainer from the service participates as training faculty on a JAG-approved training course at an approved JAG regional training centre each year.	A	

Standard 19: assessment and appraisal

The purpose of this standard is to ensure that trainees have access to all tools required to make an assessment of their performance, are released for training linked to learning needs and are supported in providing evidence for certification of competence. The standard ensures regular appraisal of trainees' progress against training goals and assessment, and monitoring of their independent practice.

No	Measure	Lvl	Guidance
19.1	All endoscopy trainees are registered with the relevant college and linked to the current training service as part of induction into the endoscopy service.	D	
19.2	All endoscopy trainees who have not completed mandatory basic skills courses have booked a date for an appropriate course.	D	
19.3	All endoscopy trainee activity is recorded. .	D	
19.4	There is a formal baseline appraisal completed for all trainees to identify their training needs.	C	
19.5	There is a formal assessment of endoscopic skills conducted by the local training lead (or nominated deputy) for all trainees seeking to perform independent procedures.	C	A JAG-approved Direct Observation of Procedure or Skills (DOPS) can be used as the main tool of trainee assessment. These can be filled in during any training list. Learning objectives can be set during completion of the DOPS forms – these then populate the trainee's personal development plan.
19.6	There is a policy within the department for defining and monitoring independent practice of trainees.	C	
19.7	There is a visible updated register within each procedure room of trainees allowed to perform specified procedures independently.	C	
19.8	Trainees are assessed regularly using DOPS (in accordance with JAG certification requirements for the procedure for which they are training).	C	Trainees require a minimum of 10 DOPS forms for basic Upper GI or Lower GI certification. It is recognised that there may be an increased need for DOPS at both the start of training and as a trainee approaches summative sign off. For therapeutic training due to the lower frequency of training opportunities it is recommended that the related DOPS form is used at least once per training list.
19.9	The KPIs of trainees practising independently are regularly monitored and reviewed by the local training lead, with evidence of action according to local clinical governance policy if KPIs are below acceptable standards.	B	Progression of training is documented. This record is transferable from hospital to hospital. It is helpful to all trainers involved in the training process for documentation of appraisal meetings to be complete. This allows for review of the training goals that have been set and progress made against these targets. This is important for continuity of training and maintenance of training standards.

19.10	If an endoscopy trainee who is not on the independent register performs a procedure unsupervised, an adverse event is registered.	B	The local training lead would be expected to report such an adverse event to the trainee's regional training programme director (or line manager for a non-medical endoscopist).
19.11	All endoscopy trainees have an appraisal with their trainer completed and documented	B	Guidance on completing appraisal is available.
19.12	The local training lead ensures that local arrangements for summative DOPS required for the JAG certification support the sign off process.	B	Details on the requirements of JAG certification and the summative sign-off process are available on the JAG website.
19.13	The local training lead regularly reviews the number and quality of DOPS assessments performed by trainers to ensure supportive training.	A	It is recommended that this standard is incorporated into an annual ETR.
19.14	There is evidence of intermediate appraisal at least every 6 months (appropriate to the duration of a trainee's attachment) with adjustment of training goals.	A	
19.15	There is evidence of training lists being actively modified and action plans documented on DOPS assessments in response to the training needs.	A	

Terms and definitions

For the purposes of this document, the following terms and definitions apply.

Accreditation	The evaluation of an organisation's systems, processes or product that investigates whether defined standards and minimum requirements are satisfied
Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change; clinical audits are central to effective clinical governance as a measure of clinical effectiveness
BSG	British Society of Gastroenterology
Clinical governance	A system through which healthcare providers and partners are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish
Clinical service leader	A named individual of a clinical service leadership team with responsibility for leading the clinical service
Clinical service strategy	An overarching approach of a clinical service that encompasses all plans, procedures and policies
Competence	Having the expertise, knowledge and/or skills, and in a clinical role the clinical and technical knowledge, required to carry out the role
DNA	Did not attend
Endoscopy service	A dedicated area where medical procedures are performed with endoscopes, which are cameras used to visualise structures within the body, such as the digestive tract and genitourinary system; endoscopy services may be located within a hospital, incorporated within other care centres, or may be stand-alone.
JAG	The Joint Advisory Group on GI Endoscopy
KPI	Key performance indicator
Lead clinician	A named clinical staff member for a clinical specialty with a remit for leading the clinical staff within a clinical service *Note*: The lead clinician might have a non-medical role, eg a nurse or other registered professional
Leadership team	Clinical and managerial staff members with responsibility for leading a clinical service
Organisation	A legal, regulated body and location where clinical care is governed and provided or coordinated

Patient centred	Providing *care* and support that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that *patient* values guide all clinical and support decisions
Policy	A document that states, in writing, a course or principles of action adopted by a provider and/or clinical service
Procedure	A specified way to carry out an activity or a process (ISO 14971:2007, 2.12)
Quality	Quality is used in this document to denote a degree of excellence
Quality improvement plan	A document, or several documents, that together specify quality requirements, practices, resources, specifications, measurable objectives, timescales and the sequence of activities that are relevant to a particular clinical service or project to achieve the objectives within the timescales given
Risk assessment	A process used to determine risk management priorities for clinical service delivery, user treatment and/or care by evaluating and comparing the level of risk against healthcare provider standards, predetermined target risk levels or other criteria
Roster	A list or plan showing turns of duty or leave for individuals or groups in an organisation, clinical service or pathway
Skill mix	A combination of different types of staff members who are employed in a clinical service who have the required skills and competencies to carry out the work of the clinical service and deliver the pathway
Staff (workforce)	A person (clinically or non-clinically trained) working in the endoscopy service including those who are: • employed, clinical eg nurses, doctors, healthcare assistants and technicians other • non-clinical eg administrative staff • agency/bank/voluntary
Service user	A person who receives treatment and/or care from the endoscopy service and the defined population for whom that endoscopy service takes responsibility: examples of endoscopy service users are patients, carers and advocates
Trainee	A trainee is an individual taking part in a trainee programme (eg medical or nursing) or who is an official employee of endoscopy service that is being trained to the job he/she was originally hired for: literally an employee in training

References

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JAG Global Rating Scale (GRS): version for public services in Ireland

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