Improving Safety and Quality: The Colonoscopy Clinical Care Standard

GENCA Conference
27 April 2018

Conjoint Professor Anne Duggan
Medical Director Healthcare Variation
Presentation summary

• Overview of Commission’s work
• What is quality in colonoscopy?
• Do we have a problem?
• The Colonoscopy Clinical Care Standard
• Questions
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

STRATEGIC PLAN 2014–2019

SAFETY. QUALITY. EVERY PERSON. EVERYWHERE. EVERY TIME.

1. Patient safety
A health system that is designed to ensure that patients and consumers are kept safe from preventable harm

Success looks like:
- NRC-IC Standards implemented in acute care, community and primary care, and mental health settings
- Implementations of NRC-IC Standards leads to improved outcomes for patients and consumers, including reduction in health care associated infections, falls and incidents of unnecessary medication, tests and treatment
- Improved recognition and care of people with dementia and delirium
- National surveillance systems established for antimicrobial resistance and antibiotic usage
- Framework for action on patient safety improvements in primary care

2. Partnering with patients, consumers and communities
A health system where patients, consumers and members of the community participate with health professionals as partners in all aspects of health care

Success looks like:
- Patients’ rights are respected and partnerships in care are encouraged
- Health services partner with patients and consumers in governance
- Patients, carers and consumers are provided with accurate, consistent and actionable information about health and healthcare
- Communities are involved in addressing health equity
- Open disclosure processes are implemented in healthcare settings
- Carers have rights at the end of life in the same way as people in need of care, support and care

3. Quality, cost and value
A health system that provides the right care, minimises waste, and maximises value and productivity

Success looks like:
- Routine information about healthcare variation is available for informed decision making
- Risk and performance data for selected conditions and procedures
- Increased use of clinical care standards, clinical guidelines and evidence-based practice to enhance appropriateness and improve value of health care delivery
- Tools are available for health professionals, patient and consumer to support self-care
- Health professionals, patients and carers collectively use evidence-based support tools to improve patient outcomes

4. Supporting health professionals to provide safe and high-quality care
A health system that supports safe and quality care through a mix of clinical and sustainable improvement systems

Success looks like:
- Integrated systems of governance and audit to support health professions, services and systems to maintain and continuously improve quality
- Health professionals have access to guidance and tools that support safe clinical practice
- Safety and quality are considered as important aspects of undergraduate and postgraduate education and training
- Patient safety and health care are recognised, reported and analysed, and this information contributes to the improvement of care
- Safe and effective e-health systems are in place that support longitudinal care, communication and decision making for patients

The Australian Commission on Safety and Quality in Health Care leads and coordinates national improvements in the safety and quality of health care based on best available evidence. The Commission works in partnership with patients, consumers, clinicians, managers, policy makers and health care organisations to achieve a sustainable, safe and high-quality health system.
Dimensions of Quality

- Safety
- Effectiveness
- Efficiency
- Appropriateness
- Access (Equitable)
- Patient Centred
Do we have a problem with Colonoscopy?

- Safety
- Effectiveness
- Efficiency
- Appropriateness
- Access (Equitable)
- Patient Centred

- Bowel preparation, procedure
- Missed polyps
- Waiting lists
- Public hospital triage, MBS data
- Atlas of Healthcare Variation
- Health literacy, cultural competence, informed consent
Safety

• Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures (PS09)
• Infection Control in endoscopy guidelines
• Endoscopy - Standards for Endoscopic Facilities and Services (2011)
Effectiveness of colonoscopy: adenoma miss rate

- large multicentre study, same-day back-to-back video colonoscopy by two colonoscopists in randomised order and blinded to results.

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Miss rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyps</td>
<td>28%</td>
</tr>
<tr>
<td>Adenomas</td>
<td>20%</td>
</tr>
<tr>
<td>Polyps &gt;= 5mm</td>
<td>12%</td>
</tr>
<tr>
<td>Adenomas &gt;= 5mm</td>
<td>9%</td>
</tr>
<tr>
<td>Advanced Adenomas</td>
<td>11%</td>
</tr>
</tbody>
</table>

- sessile or flat shape was significantly associated with a higher miss rate

Heresbach 2008
Efficiency

A. “There is nothing so useless as doing efficiently that which should not be done at all.”

Peter Drucker

B. Number of Procedures per list
C. Individual procedure time
D. Withdrawal time 6-8 minutes
Appropriateness

IF YOU HAVE SKIN, YOU’RE AT RISK FOR MELANOMA.

New York Times 12/2/12
Is colonoscopy appropriately used?  
Number of services by year 2003-2015
Growth in colonoscopy over 1, 5 and 10 years

<table>
<thead>
<tr>
<th>Growth period</th>
<th>Colonoscopy item 32090</th>
<th>Colonoscopy item 32093</th>
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<tbody>
<tr>
<td>1 Year Growth, 2013-12 to 2014-15</td>
<td>0.1%</td>
<td>10%</td>
</tr>
<tr>
<td>5 Year Growth, 2009-10 to 2014-15</td>
<td>12%</td>
<td>58%</td>
</tr>
<tr>
<td>10 Year Growth, 2004-05 to 2014-15</td>
<td>51%</td>
<td>177%</td>
</tr>
</tbody>
</table>
Is there equitable access to colonoscopy?

The Australian Atlas of Healthcare Variation series
Colonoscopy

COLONSCOPY
Number of procedures performed

2013-2014
589,748

30x
HIGHER IN SOME AREAS COMPARED TO OTHERS

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

www.safetyandquality.gov.au/atlas
Colonoscopy
Number of MBS-funded colonoscopy services per 100,000 people, age standardised, by local area, 2013–14
Figure 18: Number of MBS-funded services for fibre optic colonoscopy per 100,000 people, age standardised, by local area, 2013–14

For this item, local area refers to an ABS standard geographic region known as a Statistical Area Level 3 (SA3)

The size of each circle represents the number of services in each local area

- 0
- 2,000
- 4,000
- 6,000
- 8,000

<table>
<thead>
<tr>
<th>Local area</th>
<th>State</th>
<th>Rate</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daly - Tiwi - West Arnhem</td>
<td>NT</td>
<td>146</td>
<td>24</td>
</tr>
<tr>
<td>Kimberley</td>
<td>WA</td>
<td>213</td>
<td>68</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>NT</td>
<td>269</td>
<td>102</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>NT</td>
<td>330</td>
<td>43</td>
</tr>
<tr>
<td>Ribans</td>
<td>WA</td>
<td>414</td>
<td>224</td>
</tr>
<tr>
<td>Katherine</td>
<td>NT</td>
<td>420</td>
<td>72</td>
</tr>
<tr>
<td>Goolfield</td>
<td>WA</td>
<td>510</td>
<td>193</td>
</tr>
<tr>
<td>Gascoyne</td>
<td>WA</td>
<td>642</td>
<td>57</td>
</tr>
<tr>
<td>Outback - North and East</td>
<td>SA</td>
<td>681</td>
<td>206</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local area</th>
<th>State</th>
<th>Rate</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Suburbs - North</td>
<td>NSW</td>
<td>4,374</td>
<td>5,966</td>
</tr>
<tr>
<td>Kenmore - Brookfield - Moggil</td>
<td>Qld</td>
<td>3,426</td>
<td>1,936</td>
</tr>
<tr>
<td>Brisbane Inner - West</td>
<td>Qld</td>
<td>3,665</td>
<td>1,845</td>
</tr>
<tr>
<td>Stonnington - East</td>
<td>Vic</td>
<td>3,624</td>
<td>1,594</td>
</tr>
<tr>
<td>Bayeone</td>
<td>Vic</td>
<td>3,607</td>
<td>4,239</td>
</tr>
</tbody>
</table>
Colonoscopy – state & territory

<table>
<thead>
<tr>
<th>State/territory</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest rate</td>
<td>4,374</td>
<td>3,624</td>
<td>3,746</td>
<td>3,266</td>
<td>3,405</td>
<td>2,887</td>
<td>2,073</td>
<td>2,919</td>
</tr>
<tr>
<td>Lowest rate</td>
<td>971</td>
<td>976</td>
<td>972</td>
<td>661</td>
<td>213</td>
<td>989</td>
<td>145</td>
<td>1,785</td>
</tr>
<tr>
<td>No. services</td>
<td>185,985</td>
<td>153,168</td>
<td>132,557</td>
<td>43,432</td>
<td>51,366</td>
<td>13,042</td>
<td>1,845</td>
<td>8,232</td>
</tr>
</tbody>
</table>
 Colonoscopy – remoteness & socioeconomic status

The size of each circle represents the number of services in each local area.
Patient centred care

• Informed – risks, benefits and alternatives
• Shared decision making

Partnering with Consumers Standard National Safety and Quality Health Service Standards

Helping Patients Make Informed Decisions:

Communicating benefits and risks.

Health literacy
Do we need Colonoscopy?

*Is the juice worth the squeeze?*
# Estimated most common cancers diagnosed in 2017

<table>
<thead>
<tr>
<th>Cancer type</th>
<th>New cases 2017</th>
<th>% of all new cancers 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>17,730</td>
<td>13.2</td>
</tr>
<tr>
<td>Breast (among females)</td>
<td>17,586</td>
<td>28.4</td>
</tr>
<tr>
<td>Colorectal (bowel)</td>
<td>16,682</td>
<td>12.4</td>
</tr>
<tr>
<td>Prostate (among males)</td>
<td>16,665</td>
<td>23.1</td>
</tr>
<tr>
<td>Melanoma</td>
<td>13,941</td>
<td>10.4</td>
</tr>
<tr>
<td>Lung</td>
<td>12,434</td>
<td>9.3</td>
</tr>
</tbody>
</table>

AIHW
Estimated age-specific incidence and mortality rates for colorectal cancer, by sex, 2017
Bowel cancer
Population screening for CRC

• earlier stage at diagnosis; better outcomes
• population screening using FOBT reduces CRC mortality by 15–33% (RCTs)

• National Bowel Cancer Screening Program
  – 2,600,000 kits sent out 2014/15
  – by 2020, free biennial screening all 50 - 74 years
  – 39% participation
Background

2002-04 Pilot of the National Bowel Cancer Screening Program (NBCSP)
2005 Australian Health Ministers’ Advisory Council (AHMAC) request work on quality in colonoscopy
2006 Quality working group (QWG) established Membership included ACRRM, RACP, RACGP, GENCA, RACS, Conjoint committee for Recognition of training in GI endoscopy, RANZCA, DOHA, jurisdictions
2006 AHMAC endorse a “Screening framework for Australia”
2009 QWG report “Improving Colonoscopy Services in Australia”
Trialed at 4 sites in SA and Qld confirming feasibility
2015 Department of Health appointed the Australian Commission on Safety and Quality in Health Care (the Commission) to establish a national safety and quality model for colonoscopy services
Draft model incorporates three key elements

- A clinical care standard for the delivery of quality colonoscopy services
- Certification and periodic re-certification of colonoscopist performance
- Collation and review of indicators and performance targets in accordance with a standard national data set
Clinical Care Standards

Clinical Care Standards

• Reflect Clinical Practice Guidelines – actionable and measurable simple statements
• Include statements which would be regarded as standard of care
• Describe what the statements mean for patients and their carers, clinicians and administrators
• Include indicators for local quality improvement, evaluation of implementation or use in registry
Colonoscopy Clinical Care Standard

1. Initial assessment and referral
2. Appropriate and timely colonoscopy
3. Informed decision making and consent
4. Bowel preparation
5. Sedation
6. Clinicians
7. Procedure
8. Discharge
Colonoscopy Clinical Care Standard
Clinician Fact Sheet

Under this clinical care standard

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.

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.

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.
Colonoscopy Clinical Care Standard
Clinician Fact Sheet

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.
Colonoscopy Clinical Care Standard
Clinician Fact Sheet

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.
**Colonoscopy**

Clinical Care Standard Consumer Fact Sheet

9 - Reporting and follow up

**What the standard says**
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.

**What this means for you**
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 by the colonoscopy.
CCS 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
NSQHS Standards (second edition)

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard
Thankyou

Questions?