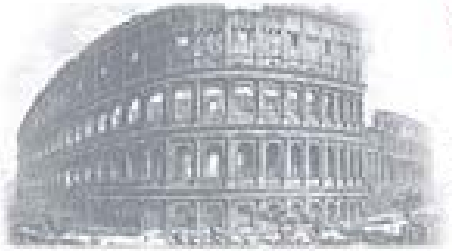


VIII CONGRESSO NAZIONALE GISCoR

WORKSHOP SCREENING CCR REGIONE LAZIO

ROMA, 3 E 4 OTTOBRE 2013

Auditorium Antonianum, Viale Manzoni 1

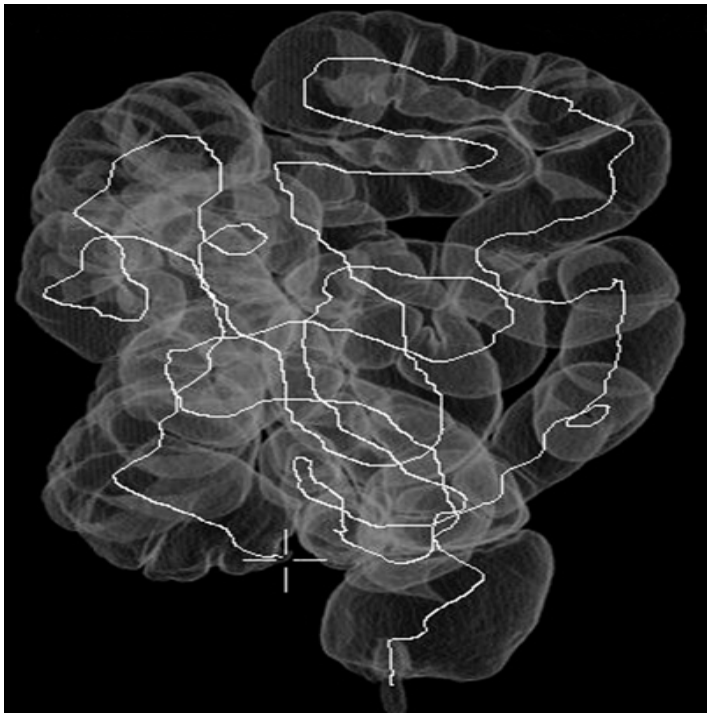
Miglioramento continuo della qualità: il protocollo diagnostico-terapeutico ed il re-training degli Endoscopisti

Lucio Petruzziello

Policlinico A. Gemelli

EETC - Roma

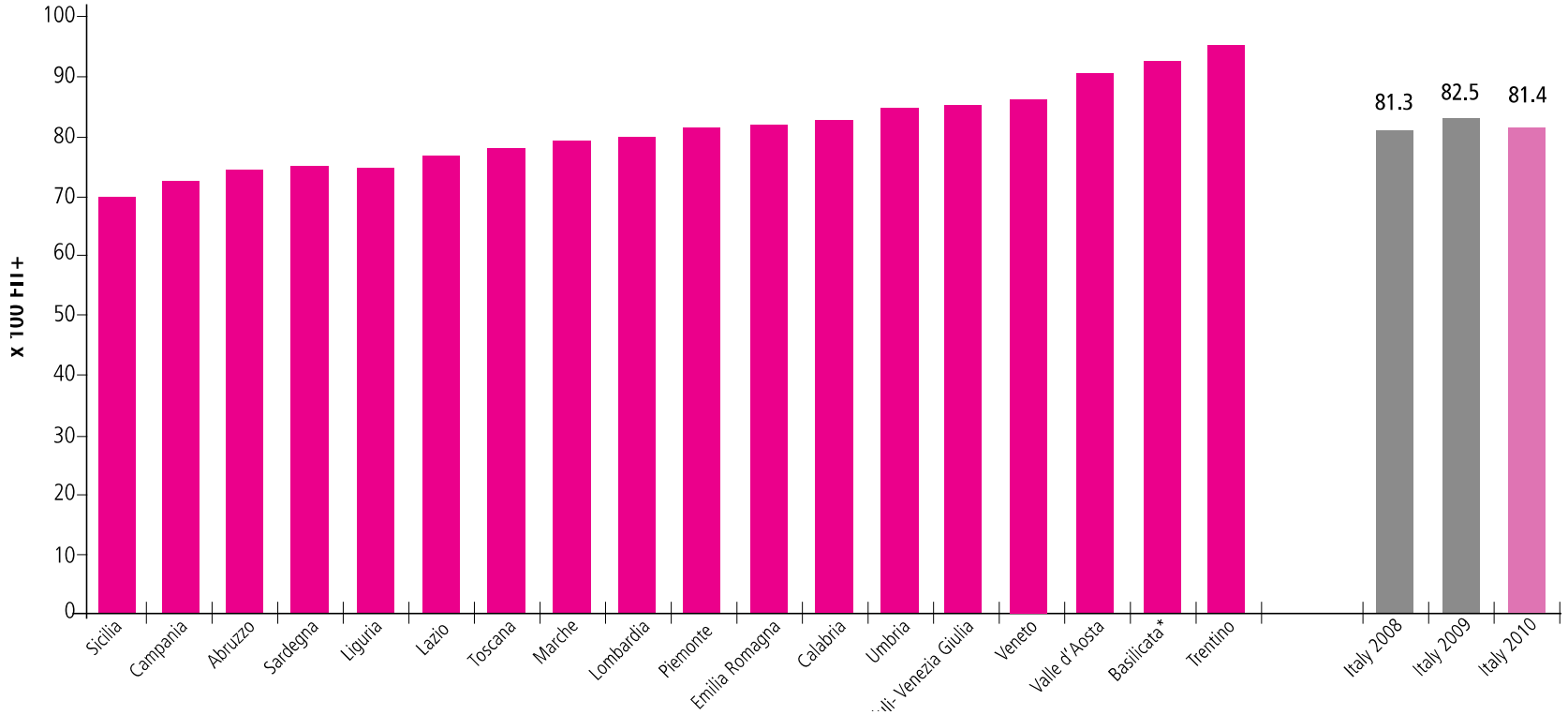
Colonoscopy:
a “complex” procedure …



Italian CRC Screening:
II Level Quality Indicators

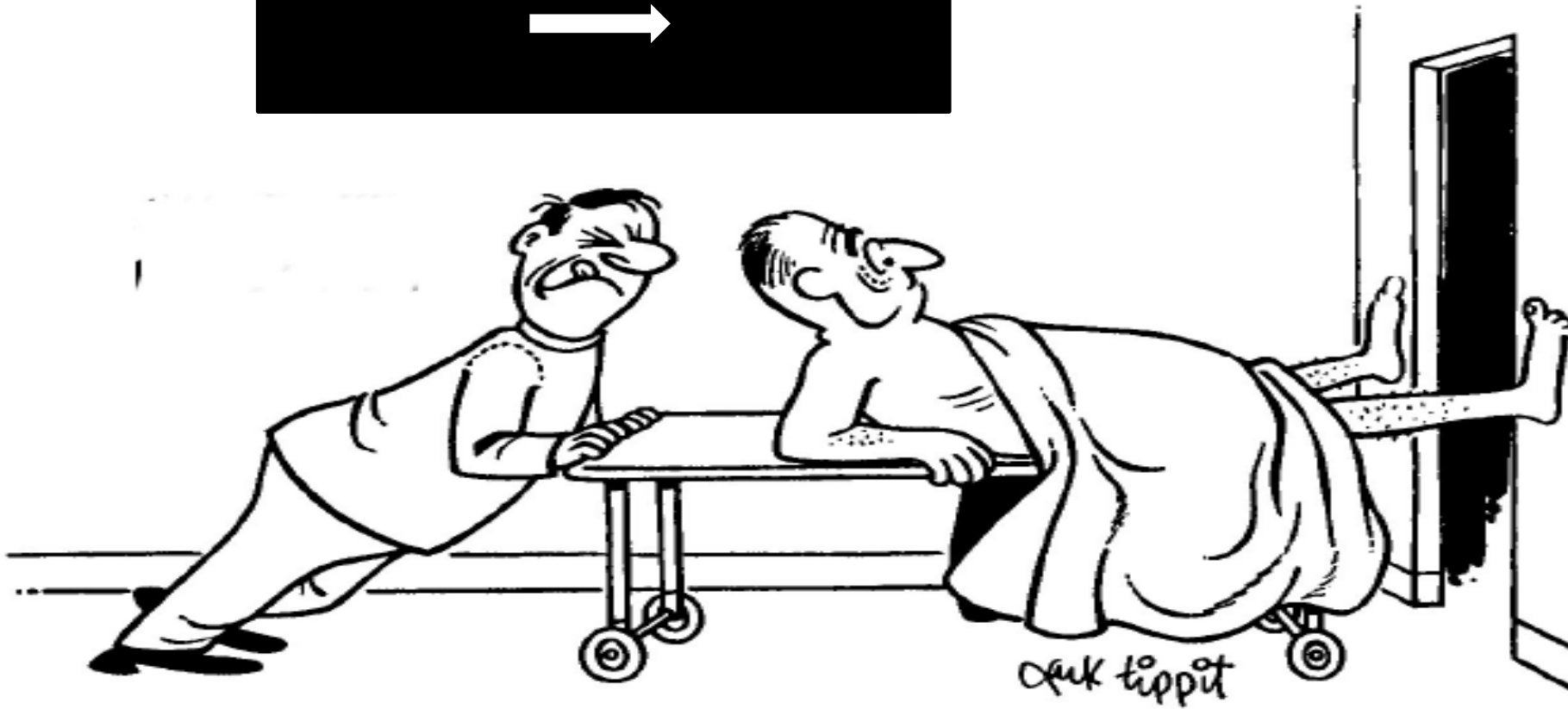
proporzione aderenti al II livello	**> 85%**	**> 90%**
proporzione di colonscopie complete	**> 85%**	**> 90%**
proporzione di polipectomie non contestuali	**< 10%**	
tasso di identificazione (carcinoma)		
primi esami	**> 2.0 per mille**	**> 2.5 per mille**
esami successivi	**> 1.0 per mille**	**> 1.5 per mille**
tasso di identificazione (adenoma avanzato)		
primi esami	**> 7,5 per mille**	**> 10,0 per mille**
esami successivi	**> 5,0 per mille**	**> 7,5 per mille**
VPP del FOBT alla colonscopia per AA o K		
primi esami	**> 25%**	**> 30%**
esami successivi	**> 15%**	**> 20%**

CRC Screening in Italy (2010)
Adhesion to Colonoscopy for FOBT+



Zorzi M. Lo screening colorettale in Italia: survey 2010

COLONSCOPIA



Continuous Quality Improvement (CQI)

Screening Colonoscopy Standards in Italy

- Completion Rate > 85% (acceptable) or > 90% (desirable)
- Withdrawal time (6'-10')
- Good to Excellent bowel prep
- Adenomas yeld in > 15% of asymptomatic pts
- Complications Registry
- Patient's satisfaction questionnaire
- Immediate polypectomy for polyps at low risk for complications (< 2 cm?)
- Biopsy (?) and delayed polypectomy for other polyps

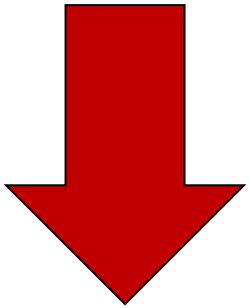
Source: Italian Ministry of Health. 2005-2006

Credentialing & Certification

Formazione operatori dedicati allo screening

- Personale medico fornito di specializzazione in endoscopia o almeno 10 anni di attività in centri di endoscopia
- Ogni medico dedicato deve aver eseguito, nell'anno precedente, almeno 300 colonscopie
- Ogni medico dedicato deve essere incorso, nei due anni precedenti, in meno del 2‰ di complicazioni maggiori

How to support
the Endoscopists
who do not achieve
the Standards ?



Retraining

Keyword

Retraining

↓

Rieducazione, Riqualificazione

↓

Miglioramento /
*Perfezionamento di Competenze e Performanc**es***

↓

Nuovo Training

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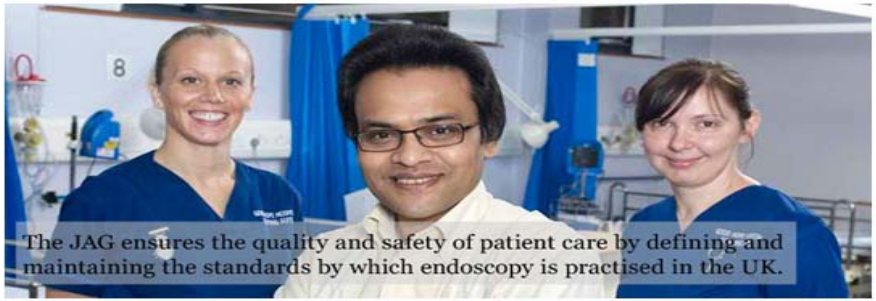

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Basic Skills in Colonoscopy

Jun 11

08 Jun	Torbay	Fully Booked
08 Jun	Wolverhampton	Fully Booked
14 Jun	Liverpool	Fully Booked
21 Jun	Sheffield	Only 1 place left
27 Jun	Yorkshire	Fully Booked

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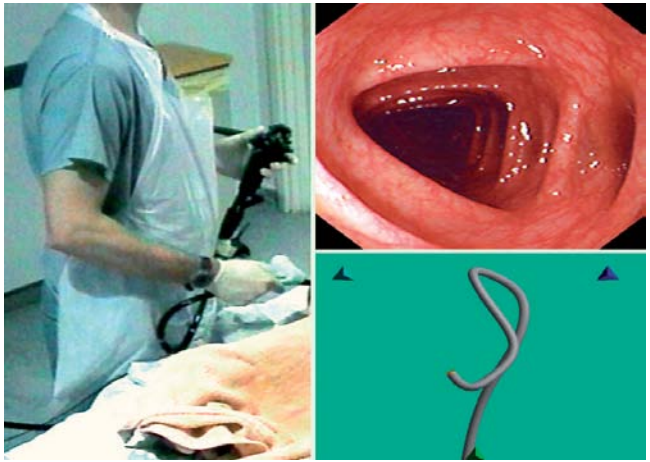
GRS Global Rating Scale

gin gastrointestinal endoscopy for nurses

e-LfH e-Learning for Healthcare

Intensive training over 5 days improves colonoscopy skills long–term



Training and assessments within Accelerated Colonoscopy Training Week (ACTW)

Timetable for ACTW

Day 1:
Assessments & live case training

Days 2 & 3:
Simulator & and live case training

Day 4:
Live case training & assessments

Day 5:
Simulator training & assessment

Pre-training Assessments

MCQ

Simulator test cases

DOPS: Live case assessment
Tri-split video assessment

Post-training Assessments

MCQ

Simulator test cases

DOPS: Live case assessment
Tri-split video assessment

Training and assessments at follow up

Practice at base hospital – 9 months (5 – 13)

Follow-up (1 – 2 days)

Live case training & assessments

Follow-up Assessments

MCQ

Simulator test cases

DOPS: Live case assessment
Tri-split video assessment

S. Thomas–Gibson, Endoscopy 2007

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- Independent Endoscopists
- Endoscopy Trainers
- DOPS Forms
- Curriculum
- Training Centres
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Training for Endoscopists

The JAG provides a robust quality and training framework for endoscopy professionals

Certification

Information on training, assessment and JAG certification

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Courses

Training for all endoscopy modalities

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e-Portfolio

Supporting endoscopy training and certification

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Screening Colonoscopists

A support tool for accreditation

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NHS Cancer Screening Programmes

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SAAS

Screening Assessment and Accreditation System

ACCREDIT your ability

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Introduction

The NHS Bowel Cancer Screening Programme (NHS BCSP) is being implemented over a 3 year period and the aim is to recruit expert colonoscopists to carry out the 30,000 extra colonoscopies required to fulfil the programme. Given the known variability in colonoscopic skills, strict criteria for the accreditation of screening endoscopists have been developed to minimise the risks of complications and inaccurate and incomplete examinations.

There are several advantages of this accreditation process, both to the unit and the individual endoscopists involved. Accreditation is an essential part of the preparations for the implementation of screening locally. It also provides an opportunity to demonstrate high level colonoscopic skills, and to improve the local endoscopy service. In addition it will help those clinicians who wish to teach colonoscopy, locally or on courses.

To find out more about the accreditation process see the Guidelines section.

Italian CRC Screening Program

2008

Colonoscopy Retraining Working Group

G. Costamagna, MD

P. D'Argenio, MD

A. Federici, MD

E. Di Giulio, MD

G. Minoli, MD

L. Petruzziello, MD

M.E. Pirola, MD

C. Senore, MD

M. Zappa, MD

Italian CRC Screening Program

Colonoscopy “Retraining Program”

- Held by Italian Ministry of Health
- Managed by National Screening Observatory (ONS)
- Region-based
- 1-2 Trainers from each Region
- National “Train-the-Trainers” Course
- Regional “Retraining Courses”

Screening Colonoscopy

Colonoscopy Retraining Targets

- Colonoscopy Technique
- Safe Sedation
- Better diagnostic accuracy
- Immediate therapy (polypectomy-EMR)

Italian CRC Screening Program
Colonoscopy
"Train the Trainers" Course

- In collaboration with the 3 Gastroenterological Societies (AIGO, SIED, SIGE) and with the Italian Group for CRC Screening (GISCoR)
- 2 Eds (Rome, EETC, Sept. 2007 – Campobasso, Oct. 2007)
- 23 Trainers
- 1 Master Colonoscopist (CB Williams)
- 10 Experts (epidemiology, quality, screening principles, sedation, etc.)

Italian CRC Screening Program

Colonoscopy

“Train the Trainers” Course

Lectures

Simulator Training

Hands-on

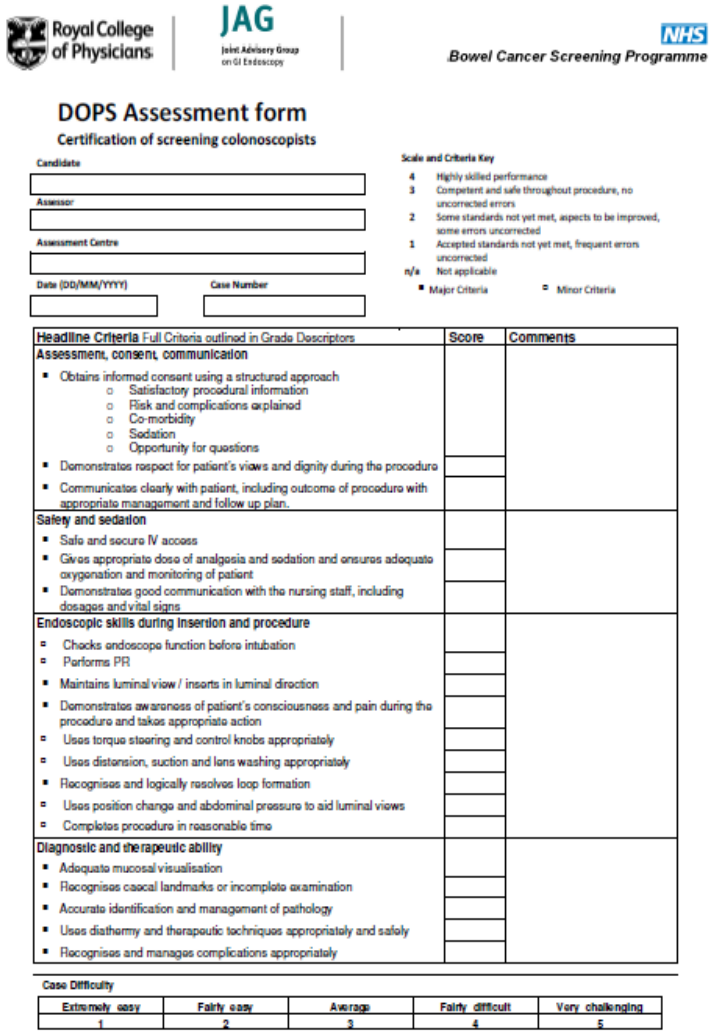
Italian CRC Screening Program Retraining Courses

- Hands-On One-to-Master
  (Lazio, 2005)

2007: National "Train the Trainers Course"

- Observational
  (Lombardia, 2008)
- Hands-On Peer-to-Peer
  (Emilia Romagna, 2009)
- Hands-On One-to-Master
  (Veneto, 2010)
- Hands-On One-to-Master
  (Lazio, 2012)

Assessment of Technical Skill



Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy | NHS Bowel Cancer Screening Programme

DOPS Assessment form

Certification of screening colonoscopists

Candidate

Assessor

Assessment Centre

Date (DD/MM/YYYY) Case Number

Scale and Criteria Key

4 Highly skilled performance
3 Competent and safe throughout procedure, no uncorrected errors
2 Some standards not yet met, aspects to be improved, some errors uncorrected
1 Accepted standards not yet met, frequent errors uncorrected
n/a Not applicable

▪ Major Criteria ▫ Minor Criteria

Headline Criteria Full Criteria outlined in Grade Descriptors	Score	Comments
Assessment, consent, communication		
▪ Obtains informed consent using a structured approach o Satisfactory procedural information o Risk and complications explained o Co-morbidity o Sedation o Opportunity for questions		
▪ Demonstrates respect for patient's views and dignity during the procedure		
▪ Communicates clearly with patient, including outcome of procedure with appropriate management and follow up plan.		
Safety and sedation		
▪ Safe and secure IV access		
▪ Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and monitoring of patient		
▪ Demonstrates good communication with the nursing staff, including dosages and vital signs		
Endoscopic skills during insertion and procedure		
▫ Checks endoscope function before intubation		
▫ Performs PR		
▪ Maintains luminal view / inserts in luminal direction		
▪ Demonstrates awareness of patient's consciousness and pain during the procedure and takes appropriate action		
▫ Uses torque steering and control knobs appropriately		
▫ Uses distension, suction and lens washing appropriately		
▪ Recognises and logically resolves loop formation		
▫ Uses position change and abdominal pressure to aid luminal views		
▫ Completes procedure in reasonable time		
Diagnostic and therapeutic ability		
▪ Adequate mucosal visualisation		
▪ Recognises caecal landmarks or incomplete examination		
▪ Accurate identification and management of pathology		
▪ Uses diathermy and therapeutic techniques appropriately and safely		
▪ Recognises and manages complications appropriately		

Case Difficulty

Extremely easy	Fairly easy	Average	Fairly difficult	Very challenging
1	2	3	4	5

CB Williams Comments

A: A skilled colonoscopist, successfully intubating a difficult and partially-fixed colon, although the medication given initially proved to be insufficient. The quality of the examination phase could be improved by using slower and precisely-directed steering movements (not 'rock & roll'!).

B : A skilled endoscopist with fairly vigorous technique. Consider:

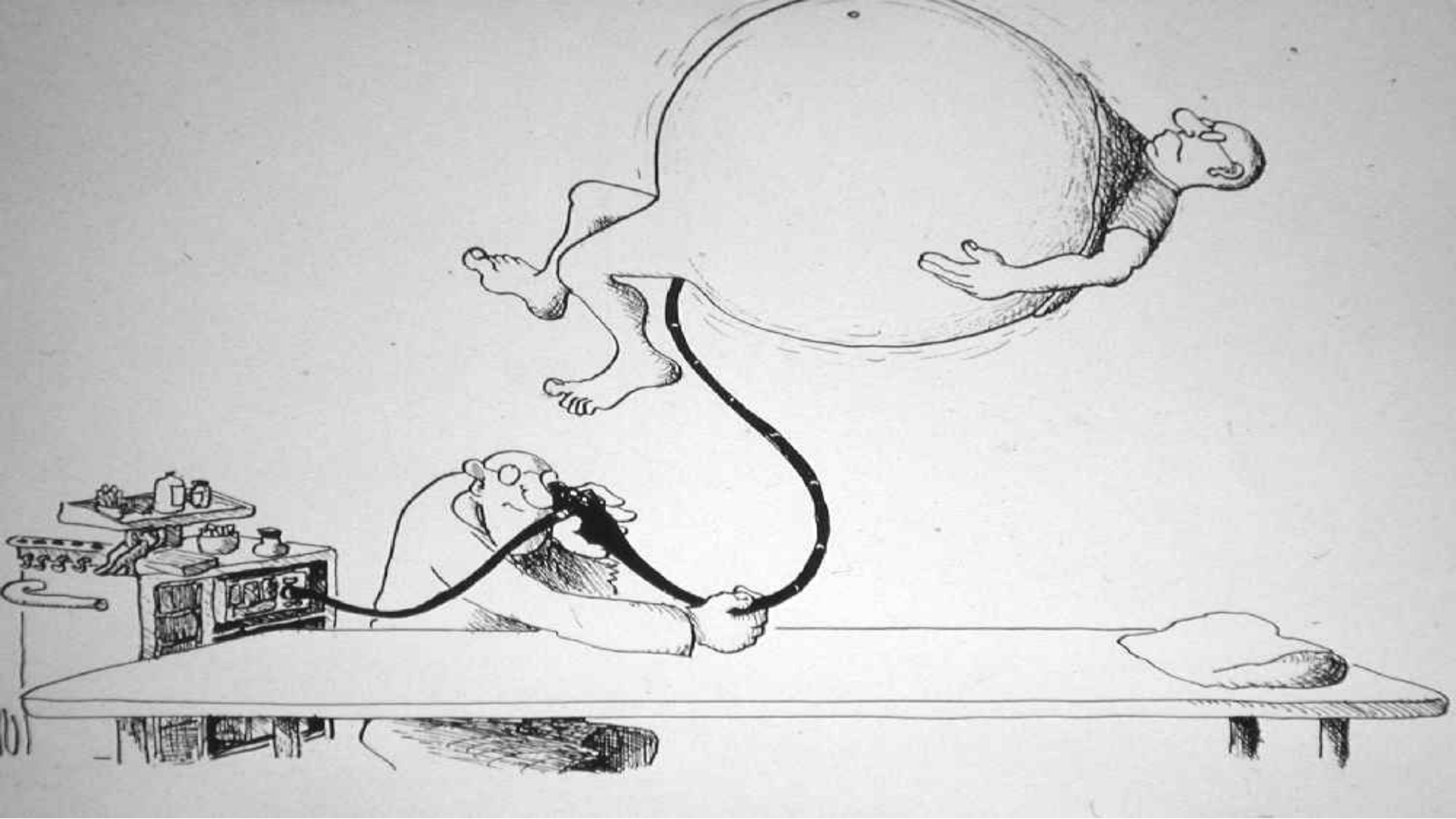
- Use of position change to optimise endoscopic view when necessary (at Splenic Flexure)
- Instrument rotation to place fluid (or polyp) at the bottom of the view for efficient suction (or targeting)
- Care in avoiding unnecessary re-looping of the sigmoid colon in passing the Splenic Flexure

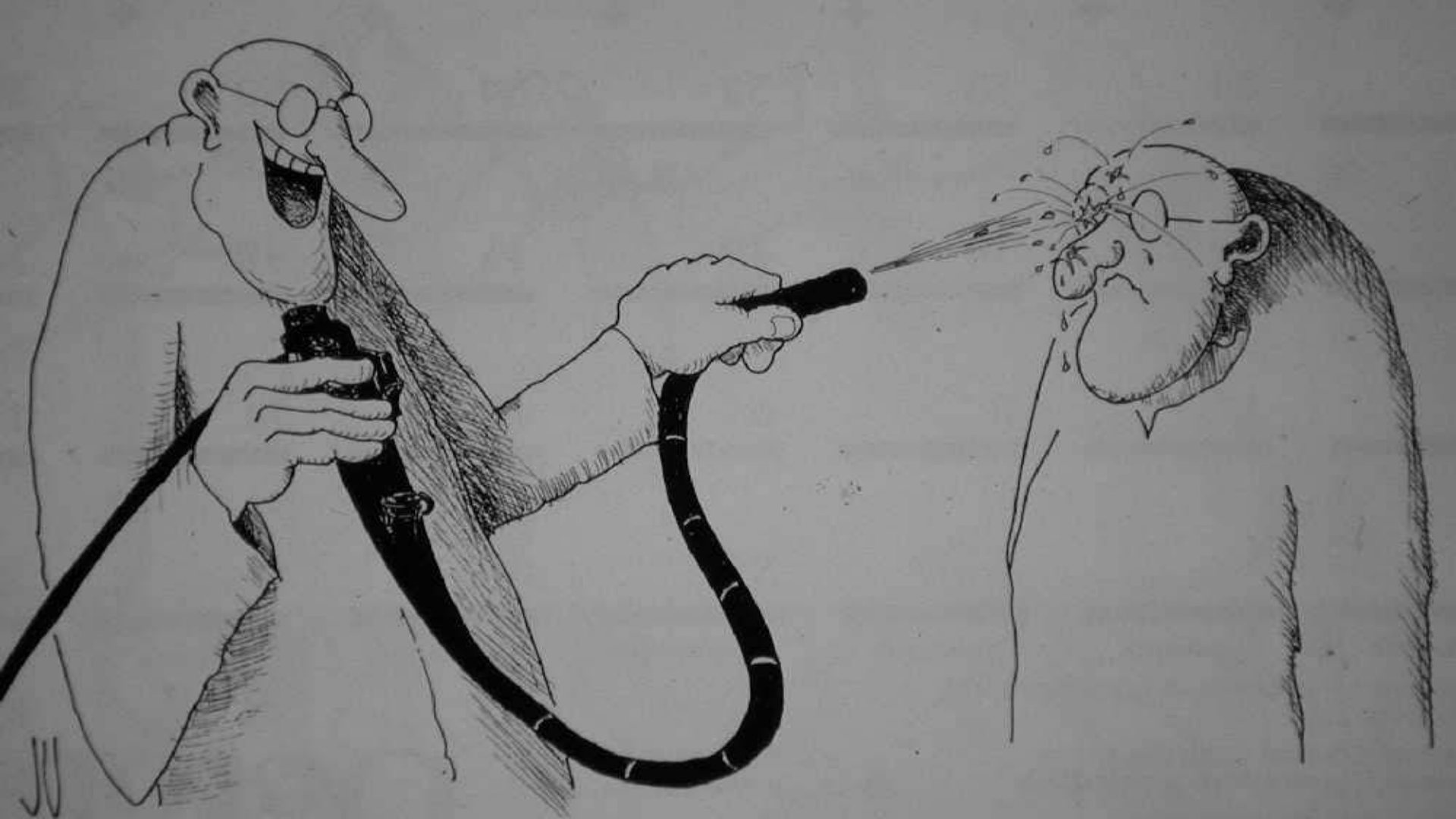
Colonscopies in FIT+ - Lazio

Anni	Colon Eseguite	Colon Complete	Colon complete %
2006	154	127	82%
2007	75	62	83%
2008	629	547	87%
2009	1208	1061	88%
2010	1008	913	91%
2011	1860	1710	92%
2012	1651	1480	90%
Totale	6585	5900	90%

Pediatric vs Standard Colonoscopes

CO_2





Water Jet Pump

Polypectomy / EMR

- Adequate skill to remove polyps or NPL (flat lesions) up to 2 cm (ESD skills not required)
- Knowledge of Guidelines on Anticoagulation and Antiplatelet Therapy management
- Exhaustive knowledge of management of adenomas with invasive carcinoma (pathologic criteria)

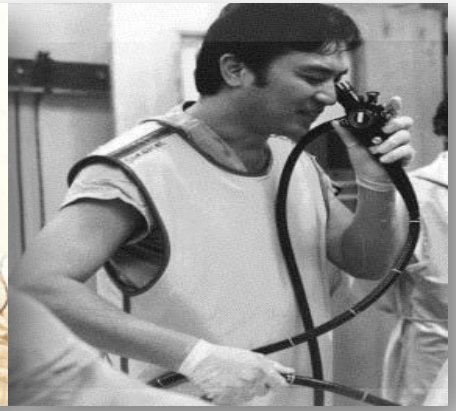
Lesions sent to surgery - Lazio

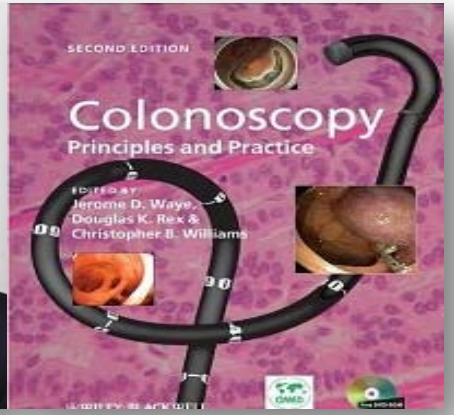
anni	Invio ad Intervento	Neoplasie	Adeno-Carcinoma	Adenoma Avanzato	Adenoma Iniziale	Benigni	Negativi	No Istologia
2005	9	0	8	1	0	0	0	0
2006	12	1	8	3	0	0	0	0
2007	4	0	3	1	0	0	0	0
2008	46	4	33	4	0	0	1	4
2009	88	4	69	5	3	1	2	4
2010	77	5	51	15	1	0	4	1
2011	153	17	107	23	1	1	3	1
2012	122	22	64	28	5	0	2	1
Totale	511	53	343	80	10	2	12	11

“T” of lesions sent to surgery - Lazio

anni	N.D.	TX	T0	TIS	T1	T2	T3	T4
2005	7	0	2	0	0	0	0	0
2006	8	0	1	1	0	0	2	0
2007	4	0	0	0	0	0	0	0
2008	8	0	0	3	3	3	4	0
2009	5	0	3	7	2	11	10	0
2010	12	0	5	8	4	10	7	0
2011	19	0	11	15	6	15	35	9
2012	33	1	4	4	7	10	27	1
Totale	96	1	26	38	22	49	85	10

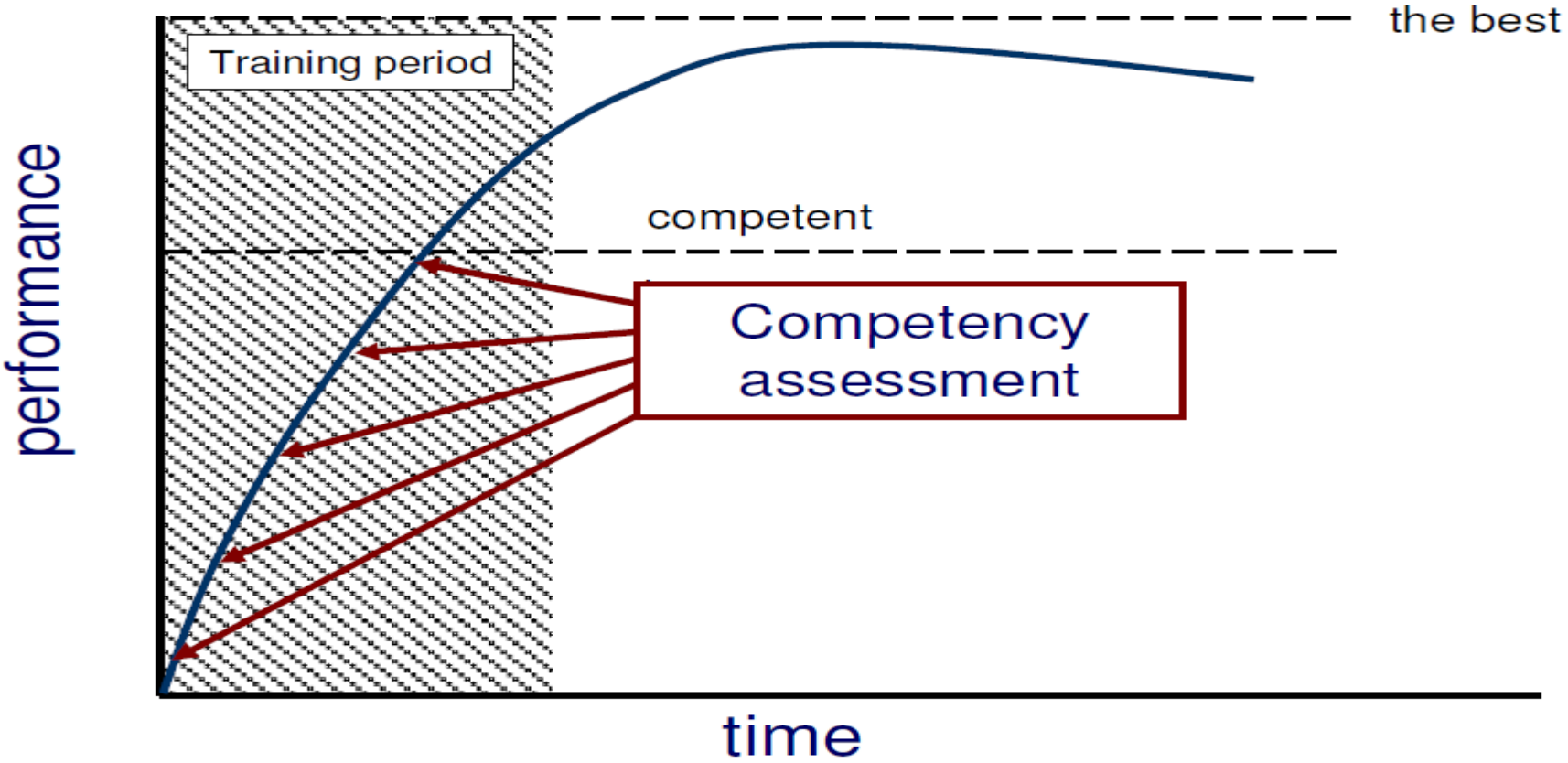
Why Training for Endoscopic Resections ?



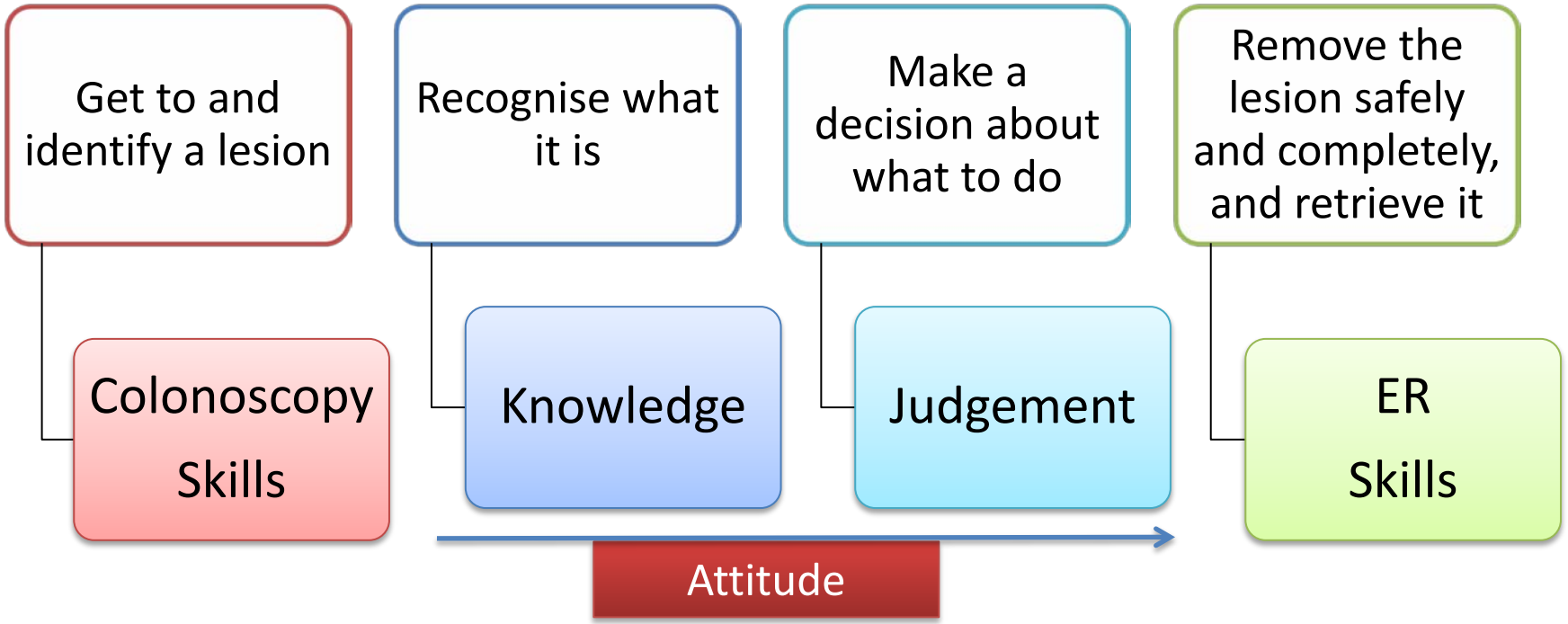


- Removing colonic polyps can be dangerous.
  - The risk of perforation approximately doubles with polypectomy and the risk of bleeding increases to between 1:100 - 1:30
- The larger the polyp, the greater the risks

Endoscopic Resections Training



Competency in Endoscopic Resections



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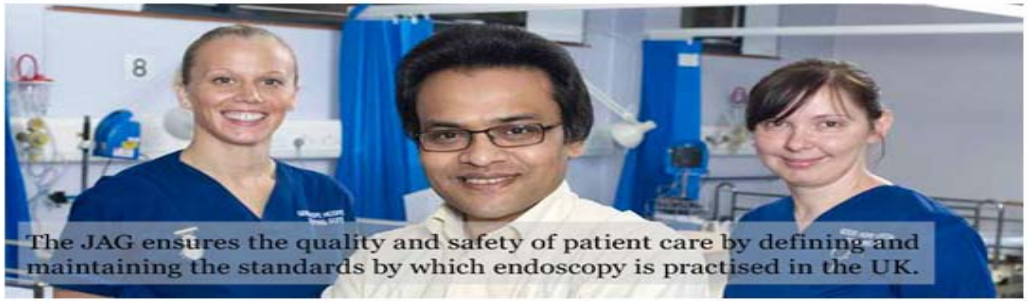

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Jun 11

08 Jun	Torbay	Fully Booked
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14 Jun	Liverpool	Fully Booked
21 Jun	Sheffield	Only 1 place left
27 Jun	Yorkshire	Fully Booked

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gin gastrointestinal endoscopy for nurses

e-LfH e-Learning for Healthcare

ER: Key performance indicators

- Appropriate removal technique
- Completeness of excision
- Recovery rate
- Proper use of the tattoo
- Complications
- Appropriate surveillance intervals
- *Cancer rates in patients under surveillance*
- Correct selection of procedures/techniques
- Non-technical skills

Direct Observation of Polypectomy Skills

Validation of a novel method for assessing competency in polypectomy

Sachin Gupta, MBBS, MRCP,[1] Paul Bassett, MSc,[2] Ripple Man, BSc,[1] Noriko Suzuki, PhD,[1] Margaret E. Vance, MSc,[1] Siwan Thomas-Gibson, MD[1]

London, Amersham, United Kingdom

- 59 videos scored
- Majority of the assessors agreed for the global assessment scale in 98% of polyps
- Analysis suggested that DOPyS is a reliable assessment tool, provided that it is used:
  - by 2 assessors
  - to score 5 polypectomy videos all performed by 1 endoscopist.
- DOPyS scores reflect the endoscopist's competence

GIE 2011

Direct Observation of Polypectomy Skills (DOPyS)

DOPyS domains

- Generic skills
- Stalked polyps
- Sessile polyps/EMR
- Post-polypectomy

Direct Observation of Polypectomy Skills (DOPyS)

Colonoscopist: …… Case ID:…… Date ……/……/…… Assessor……

Polyp site: C / AC / HF / TC / SF / DC / SC / R

Scale:
- **4** - **Highly skilled performance**
- **3** - **Competent & safe throughout procedure, no uncorrected errors**
- **2** - **Some standards not yet met, aspects to be improved, some errors uncorrected**
- **1** - **Accepted standards not yet met, frequent errors uncorrected**
- **N/A** - **Not applicable/Not assessable**

The underlined parameters can only be assessed during 'live' polypectomy

Generic	Score	Comments
Optimising view of / access to the polyp:		
1. Optimises polyp position		
2. Optimises view by aspiration/insufflation/wash		
3. Optimises visualization of full extent of polyp		
4. Determines full extent of lesion (+/- use of adjunctive techniques e.g. bubble breaker, NBI, dye spray etc) if appropriate		
5. Adjusts/stabilizes scope position		
6. Uses appropriate polypectomy technique (e.g. taking into account site in colon)		
7. Checks all polypectomy equipment (forceps,snare,clips,loops) available		
8. Checks (or asks assistant to) snare closure prior to introduction into the scope		
9. Clear instructions to, and utilisation of endoscopy staff		
10. Checks diathermy settings are appropriate		
11. Photo-documents pre and post polypectomy		
Stalked polyps: Generic, then		
12. Pre-injects stalk/applies endo-loop/clips prophylactically if appropriate		
13. Selects appropriate snare size		
14. Directs snare accurately over polyp head		
15. Correctly selects en-bloc or piecemeal removal depending on size		
16. Advances snare sheath towards stalk as snare closed		
17. Places snare at appropriate position on the stalk		
18. Mobilises polyp to ensure appropriate amount of tissue is trapped within snare		
19. Applies appropriate degree of diathermy		
Small sessile lesions / Endoscopic mucosal resection: Generic, then		
20. Adequate submucosal injection using appropriate injection technique, maintaining views		
21. Only proceeds if the lesion lifts adequately		
22. Directs snare accurately over the lesion head		
23. Correctly selects en-bloc or piecemeal removal depending on size		
24. Appropriate positioning of snare over lesion as snare closed		
25. Ensures appropriate amount of tissue is trapped within snare		
26. Tents lesion gently away from the mucosa		
27. Uses cold snare technique or applies appropriate diathermy, as applicable		
28. Ensures adequate haemostasis prior to further resection		
Post polypectomy		
29. Examines remnant stalk/polyp base		
30. Identifies and appropriately treats residual polyp		
31. Identifies bleeding and performs adequate endoscopic hemostasis if appropriate		
32. Retrieves, or attempts retrieval of polyp		
33. Checks for retrieval of polyp		
34. Places tattoo if appropriate		

Overall Competency at polypectomy:	4	3	2	1
Polyp Level	4	3	2	1
Was it appropriate to remove this polyp at index colonoscopy (i.e. on standard BCS consent)	YES	NO	**Polyp size**	……mm

Future perspectives - Principles

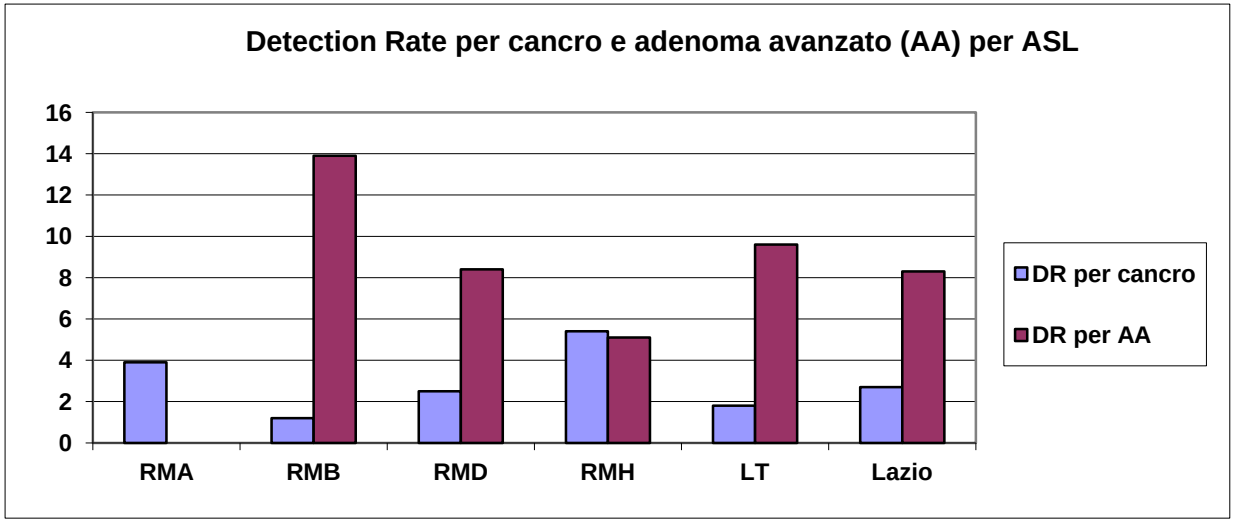
- Create a culture in which individuals are willing to improve their skills
- Provide opportunities for better training
- Recognize and reward those who perform well

Future Perspectives - Actions

- Not all endoscopists should be involved in a Screening Program
- A voluntary-based selection should be made by self-certification
- The selected trainees should attend a Retraining Course, followed by annual assessment of skills and performances
- Specific Retraining will then be appropriate for those not complying


Thank You
for your Kind Attention

VPP del FIT alla colonscopia:
Detection Rate per Cancro e per Adenoma Avanzato



Livello desiderabile DR cancro:>2,5‰

Livello accettabile DR cancro:>2‰

Livello desiderabile DR AA:>10‰

Livello accettabile DR AA:>7,5‰