

Colon Screening

Direct Observation of Procedural Skills Candidate Resource



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1. Direct Observation of Procedural Skills

Direct Observation of Procedural Skills (DOPS) is an assessment of a colonoscopist's performance of colonoscopy in terms of both technical skill as well as patient and ancillary staff interaction. It has been validated as an assessment tool for trainees and experienced colonoscopists in the United Kingdom. DOPS is one of the quality improvement initiatives in the BC Colon Screening Program; all colonoscopists performing Colon Screening Program colonoscopies are expected to participate in DOPS. DOPS is in line with the BC College of Physicians and Surgeons Physician Enhancement Program and the mission of the BC Patient Safety and Quality Council. The Canadian Medical Protective Agency supports physicians participating in DOPS and other quality improvement initiatives.

The DOPS Assessors are practicing colonoscopists interested in colonoscopy quality improvement. Every Assessor has completed the DOPS Assessor Course, which is an intense two-day course lead by local, national and international experts in colonoscopy quality assurance. The course consists of didactic and interactive small group sessions as well as a "hands-on" assessment. The hands-on assessment involves each Assessor completing a DOPS assessment during a real colonoscopy with the other Assessors and faculty watching live video feed to a conference room. The Assessor provides feedback to the colonoscopist in front of the faculty and other Assessors and then receives feedback from the group, including the colonoscopist assessed. Furthermore, over 90% of the DOPS Assessors have also completed the Canadian Association of Gastroenterology Train the Colonoscopy Trainer Course. There are 24 DOPS Assessors in BC with representation from every Health Authority, rural and urban practice, and the specialties of gastroenterology and general surgery.

The DOPS process involves two assessors simultaneously and independently observing a colonoscopist perform two consecutive colonoscopies resulting in four separate assessments for each colonoscopist. The assessments typically are conducted in the colonoscopist's hospital during their regular endoscopy slate. Ideally, CSP patients will be booked as FIT+ patients are more likely to undergo polypectomy.

The Assessors may provide feedback during the colonoscopy and then following the two procedures. How DOPS results are shared and with whom is outlined in the "Reporting of Direct Observation of Procedural Skills (DOPS) to Colon Screening Program Quality Management Committee", see appendix. DOPS participants will receive a CME credit.

To assess the validity of DOPS in BC, the Colon Screening Program will analyze anonymous results to determine inter-rater variability.

The Canadian Association of Gastroenterology is supporting Skills Enhancement in Endoscopy (SEE), a hands-on course to train experienced colonoscopists in newer colonoscopy techniques. SEE is presently developing faculty across Canada with the intent of having courses on a regular basis. Educational resources are included in this package including information on how to attend a SEE course.

DOPS Assessors

Fraser Health Authority

Scott Cowie, FHA Colonoscopy Lead - scott.cowie@fraserhealth.ca
Daniel Robibo

Interior Health Authority

Carla Nash, IHA Colonoscopy Lead - carla.nash@interiorhealth.ca
Janice Journeau
Taralyn Picton
Mark Sawatzky

Island Health Authority

Denis Petrunia, VIHA Colonoscopy Lead - denis.petrunia@viha.ca
Allen Hayashi
William Orrom
Nathan Schneidereit
Iman Zandieh

Northern Health Authority

Paul Mullins, NHA Colonoscopy Lead - paul.mullins@northernhealth.ca
Warwick Evans

Vancouver Coastal Health Authority

Robert Enns, VCH Colonoscopy Lead - rob.enns@ubc.ca
Carl Brown
Michael Bryne
Nazira Chatur
Fergal Donnellan
James Gray
Ahmer Karimuddin
Adam Meneghetti

How to Arrange a DOPS Assessment in Your Unit

Step One: Submit DOPS Request Form

- List Candidates for DOPS Assessment
 - Identify responsible colonoscopist
 - Minimum 3 colonoscopists per request
 - Maximum 4 colonoscopists per day
- Provide endoscopy unit contact information
- Identify available dates for DOPS Assessment

Check List:

- Contact information for Candidates and their assistants
- Identify Ambulatory Care Unit/GI Clinic Nurse Lead and supply contact information
- Dates allow a lead time of 6 months to facilitate scheduling of DOPS Assessors
- Dates are suitable for all proposed candidates
- Understanding of slate scheduling requirements on the day of DOPS

ACTION: Fax completed DOPS Request Form to 1-604-675-7223

What you can expect:

- The Colon Screening Program will send a confirmation of receipt of DOPS Request Form by email and we will move forward with seeking out DOPS Assessors who are available on the dates you indicated.

Please note DOPS confirmation and communication will be through email. Please ensure email contact information is provided if there are other contacts you would like to be copied on DOPS communication.

Step Two: Confirmation of DOPS Date

Once we have secured a DOPS assessor team to travel to your site to conduct DOPS assessments, we will contact you by email to confirm the date the DOPS assessments will take place and provide your team with a copy of this DOPS Candidate resource.

What you can expect:

- The Colon Screening Program will send a confirmation email with the date selected and introduce the DOPS Assessors. This email will be sent to the DOPS Candidates, DOPS Assessors, your site's GI Clinic Nurse Lead, your Health Authority Lead and Colonoscopy Lead.

Step Three: Slate Scheduling on Day of DOPS

Take the following into consideration for the slate schedule:

- Each Colonoscopist will perform two colonoscopies consecutively
- Allow time for feedback after the two consecutive colonoscopies are performed
- FIT+ patients preferred

Ideally, Colon Screening Program patients will be booked for DOPS assessments as FIT+ patients are more likely to undergo polypectomy.

Checklist for planning the day:

- Remind patients that there will be additional physicians in the room during their procedure.
- DOPS colonoscopies may run a bit longer than usual. We suggest scheduling DOPS colonoscopy slots for 45 minutes.
- To allow adequate time for feedback we suggest scheduling 30 minutes following the two procedures.
- Schedule a lunch break for the DOPS Assessors

ACTION: Once slate scheduling has been confirmed please email to DOPS Assessors and copy Colon Screening Program contact.

Step Four: DOPS Day

Prepare for an informative learning experience with DOPS using the information provided on page 8. This is your opportunity to perfect your technique and learn from others who have already undergone this DOPS assessment.

On rare occasions, weather or travel conditions may hamper the timely arrival of attendees. Should any situations arise that are not in line with the intended schedule for the day, please advise the BC Cancer Colon Screening Program promptly so we can assist you.

Your BC Cancer Colon Screening Contacts:

JK Kim, Colon Screening Program Clerk
(604) 877 6200
colonscreeningquality@bccancer.bc.ca

Dustin Wong, Program Coordinator
(604) 707 6359
colonscreeningquality@bccancer.bc.ca

Step Five: Complete DOPS Assessment Participant Evaluation Form

The program strives to continue to improve DOPS process and the experience for DOPS Candidates. All feedback is much appreciated. Please complete and return the evaluation form.

ACTION: Fax completed DOPS Assessment Participation Evaluation to 1-604-675-7223

Step Six: Claim your Education Credits

The DOPS Assessment program falls under Section 3 (Performance Assessment) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada and is eligible for 6 credits (3 credits per hour). To claim your credits go to Mainport, login and upload the information about this program under Section 3 “Direct Observation”.

ACTION: Claim credits through Mainport using information about this program under Section 3 “Direct Observation”

Resources for Colonoscopy Performance

Skills Enhancement for Endoscopy (SEE)

For a description and scheduled courses: www.cag-acg.org/skill-enhancement-for-endoscopy.

As this is a hands-on course hospital privileges need to be sought well in advance.

There may be a cost for participants.

American Society for Gastrointestinal Endoscopy (ASGE)

For educational on line video “Colonoscopy Technique: Basic and Advanced”: www.asge.org under education. The DVD is available from the ASGE store.

Free and inexpensive resources available include expert presentations on the “Online Learning Center, Recorded Sessions”. CME credits are available.

For example: “Polypectomy: Small to Big”. A review of polypectomy techniques including videos by Dr. Doug Rex.

If you know of other helpful resources on colonoscopy technique, please forward them to Dr. Jennifer Telford at JTelford2@bccancer.bc.ca

DOPS Grade Descriptors: Colonoscopy and Flexible Sigmoidoscopy

Descriptors for each grade in all four domains are given below to improve consistency of grading. The key descriptor level is Grade 3. Grade 4 assumes achievement of all components at Grade 3 level and some achievement above this. The descriptors set expectations for the performance in each domain, but should be used as a guide – colonoscopists do not have to meet all criteria in each descriptor to achieve a grade in that domain.

Assessment, Consent and Communication

Grade 4

Complete and full explanation in clear terms including proportionate risks and consequences with no omissions of significance, and not unnecessarily raising concerns. No jargon. Encourages questions by verbal and non verbal skills and is thoroughly respectful of individual’s views, concerns, and perceptions. Good rapport with patient. Seeks to ensure procedure is carried out with as much dignity and privacy as possible. Clear and appropriate communication throughout procedure and afterwards a thorough explanation of results and management plan.

Grade 3

Good clear explanation with few significant omissions, covering key aspects of the procedure and complications with some quantification of risk. Little jargon, and gives sufficient opportunity for questions. Responds to individual’s perspective. Aware of and acts to maintain individual’s dignity. Appropriate communication during procedure including warning patient of probable discomfort. Satisfactory discussion of results and management plan with adequate detail.

Grade 2

Explains procedure but with several omissions, some of significance. Little or no quantification of risk, or raises occasional unnecessary concerns. Some jargon and limited opportunity for questions or sub-optimal responses. Incomplete acknowledgement of

individual's views and perceptions. A few lapses of dignity only partially or tardily remedied. Occasional communication during the procedure and intermittent warnings of impending discomfort. Barely adequate explanation with some aspects unclear, inaccurate or lacking in detail.

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Grade 1

Incomplete explanation with several significant omissions and inadequate discussion, lacking quantification of risks or raising significant fears. Uses a lot of jargon or technical language; minimal or no opportunity for questions. Fails to acknowledge or respect individual's views or concerns. Procedure lacks dignity and there is minimal or no communication during it. Explanation of results and management is unclear, inaccurate or lacking in detail without opportunity for discussion.

Safety and Sedation

Grade 4

Safe and secure IV access with doses of analgesia and sedation according to patient's age and physiological state, clearly checked and confirmed with nursing staff. Patient very comfortable throughout. Oxygenation and vital signs monitored continually as appropriate, remaining satisfactory throughout or rapid and appropriate action taken if sub-optimal. Clear, relevant and proactive communication with endoscopy staff.

Grade 3

Secure IV access with a standard cannula and appropriate dose of analgesia and sedation within current guidelines, checked and confirmed with nursing staff. Patient reasonably comfortable throughout, some tolerable discomfort may be present. Oxygenation and vital signs regularly monitored and satisfactory throughout, or appropriate action taken. Clear communication with endoscopy staff.

Grade 2

IV access acceptable with just satisfactory analgesia and sedation incompletely confirmed or checked with nursing staff, patient too sedated or too aware and in discomfort. Oxygenation and vital signs monitored but less frequently than appropriate or parameters occasionally unsatisfactory with action taken only after prompting or delay. Intermittent or sub optimal communication with endoscopy staff.

Grade 1

Insecure or absent IV access or butterfly used; inadequate or inaccurate check of analgesia and sedation. Patient significantly under- or over-sedated or needing use of a reversal agent because of inappropriate dosaging. Patient in discomfort much of the time, or significant

periods of severe discomfort. Oxygenation and vital signs rarely or inadequately monitored and mostly ignored even if unsatisfactory. Minimal or significantly flawed communication with endoscopy staff.

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Endoscopic Skills During Insertion and Withdrawal

Grade 4

Excellent luminal views throughout the vast majority of the examination, with judicious use of “slide-by”. Skilled torque steering and well judged use of distension, suction and lens clearing. Rapid recognition and resolution of loops. Quick to use position change or other manoeuvres when appropriate. Immediately aware of patient discomfort with rapid response. Smooth scope manipulation using angulation control knobs and torque steering.

Grade 3

Check scope functions, performs PR. Clear luminal view most of the time or uses slide-by appropriately. Appropriate use of the angulation control knobs. Uses torque steering adequately. Aids progress using distension, suction and lens washing. Recognises most loops quickly and attempts logical resolution. Good use of position changes to negotiate difficulties. Aware of any discomfort to patient and responds with appropriate actions. Timely completion of procedure, not too quickly or too slowly for the circumstances.

Grade 2

Omits scope check or PR. Luminal views lost a little more than desirable or uses slide-by a little too long or frequently. Could torque steer usefully more often or more effectively. Some under or over distension or lack of lens washing. Recognises most loops with reasonable attempts at resolution. Use of position change or other manoeuvres occasionally late or inappropriately. Aware of and responsive to patient but may be slow to do so. Procedure slightly too fast or too slow.

Grade 1

Omits to check scope or rectal examination. Luminal views frequently lost for long periods and pushes on regardless. Little or no use of torque steering. Under- or over-distension of bowel, or fails to attempt lens clearing. Recognises loops late or not at all and little or no structured attempt to resolve them. Inappropriate or no use of position change or other manoeuvres. Barely aware of patient’s status, or very tardy / inappropriate / no response to discomfort. Completes examination too quickly or takes far too long.

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Diagnostic and Therapeutic Ability

Grade 4

Excellent mucosal views throughout the majority of the procedure. Recognition of all caecal landmarks present or rapidly identifies incomplete examination. Faecal pools fully suctioned. Retroflexes in rectum. Thorough assessment and accurate identification of pathology present. Skilled and competent management of diathermy and therapeutic techniques. Rapid recognition and appropriate management of complications.

Grade 3

Adequate mucosal visualisation with only occasional loss or sub-optimal views unless out with control of endoscopist (eg stool, severe diverticular disease). Faecal pools adequately suctioned. Attempts to retroflex in rectum. Correctly identifies caecal landmarks or incomplete examination. Accurately identifies pathology and manages appropriately according to current guidelines. Correct and safe use of diathermy and therapeutic techniques. Rapid recognition of complications with safe management.

Grade 2

Mucosal views intermittently lost for more than desirable periods. Recognises most caecal landmarks present or eventually identifies an incomplete examination. Most pathology identified with occasional missed or mis-identified lesions. Just acceptable use of diathermy and therapeutic tools with some sub optimal use. Delayed or incomplete recognition of complications or suboptimal management.

Grade 1

Frequent or prolonged loss of mucosal views. Incorrect identification of caecal landmarks, or fails to recognise incomplete examination. Misses significant pathology, or inappropriate management that may endanger patient or contravenes guidelines. Unsafe use of diathermy and therapeutic techniques. Fails to recognise or significantly mis-manages complications to the detriment of the patient.

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Endoscopic Non-Technical Skills (ENTS)

Grade 4

Maintains excellent communication between the team and assisting staff. Ensuring the patient is the center of the procedure, emphasizing safety and comfort and providing information to the patient in a clear and thorough fashion. Maintains continuous evaluation of the patient's condition and the procedure is carried out with full respect for privacy and

dignity. Ensures lack of distractions and maintains full concentration. Demonstrates excellent safety and quality skills adhering to current protocols and codes of clinical practice. Maintains fully calm under pressure and utilizes all resources to maintain control of any situation and takes responsibility for patient outcome. Excellent problem solving and decision making techniques. Ability to choose a solution, communicate to assisting team and implement solution confidently. Thorough review of procedure and ability to institute change to improve practice.

Grade 3

Adequate communication between the team and assisting staff. Ensuring the patient is the center of the procedure and able to provide the patient with adequate information. Maintains acceptable evaluation of patient's condition through the procedure. Ensures lack of distraction and maintains adequate concentration. Demonstrates safety and quality skills adhering to most protocols and codes of clinical practice. Maintains calm under pressure and utilizes most resources to remain in control of the situation. Adequate problem solving and decision making techniques. Able to propose a solution, communicate to the team and implement the solution. Reviews the procedure and proposes changes to improve practice.

Grade 2

Minimal communication between the team and assisting staff. Most attention is centered around the patient and provides the patient with minimal information. Slight evaluation of patient's condition throughout the procedure. Slightly distracted and loses concentration. Unable to demonstrate all safety and quality skills and follow protocols and codes of clinical practice. Overwhelmed under pressure and slow to utilize resources to maintain control in the situation. Has difficulty proposing solutions, communicating to the team and implementing solutions. Minimal review of the procedure and proposes insignificant changes to improve practice.

Grade 1

Fails to communicate with team and assisting staff. Lack of attention around the patient and unable to provide clear information to patient. Fails to maintain evaluation of patient's condition throughout the procedure. Easily distracted and loses concentration. Unable to demonstrate safety and quality skills and unable to follow protocols and codes of clinical practice. Unable to perform under pressure. Fails to propose solutions, communicate to the team and implement solutions. Lack of review of the procedures and does not propose changes to improve practice.

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Formative DOPS Assessment Form

Colonoscopy and Flexible Sigmoidoscopy

Adapted from Joint Advisory Group on GI Endoscopy



Colonoscopist

Trainer/Peer

Date (DD/MM/YYYY)

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

Criteria	Scale	Comments
Assessment, consent, communication <ul style="list-style-type: none"> ■ Obtains informed consent using a structured approach <ul style="list-style-type: none"> ○ Satisfactory procedural information ○ Risk and complications explained ○ Co-morbidity ○ Sedation ○ 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. Full endoscopy report. 		
Safety and Sedation <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Adequate mucosal visualisation • Recognises caecal/desc. colon landmarks or incomplete examination • Accurate identification and management of pathology • Uses diathermy and therapeutic techniques appropriately and safely • Recognises and manages complications appropriately 		
ENTS (endoscopic non-technical skills) <ul style="list-style-type: none"> • Communication and teamwork • Situation awareness • Leadership • Judgement and decision making 		

Case Difficulty

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

Learning Objectives for Next Cases

Direct Observation of Procedural Skills (DOPS) Request Form

DOPS is an assessment of colonoscopy skills that was developed by the Joint Advisory Group for Gastrointestinal Endoscopy to ensure high quality colonoscopy. As DOPS is a validated assessment tool, it has been adopted for use by the BC Colon Screening Program.

Proposed Candidates for DOPS Assessment:

Name	MSC#:	Physician Email:	MOA Email:
(1) *Lead Colonoscopist Candidate			
(2)			
(3)			
(4)			

*Lead Colonoscopist Candidate is the designated contact for the group should any changes for the group be requested.

Endoscopy Unit Contact Information

Hospital Name		GI Clinic Hours		GI Clinic Phone Number	
GI Clinic Nurse Lead Name		GI Clinic Nurse Lead Email			
Additional Contact Info					

Available date for DOPS Assessment:

1 st available date	
2 nd available date	
3 rd available date	

Date Specifications:

- Allow a lead time of 6 months to facilitate scheduling of DOPS Assessors
- Ensure all dates are suitable for all proposed candidates
- Dates are identified with an understanding of slate scheduling requirements on the day of DOPS

Please FAX the completed DOPS Request Form to 1-604- .

Accreditation:

This event is an Accredited Group Learning Activity eligible for up to 2.0 Section 1 credits as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada. This program has been reviewed and approved by the UBC Division of Continuing Professional Development.

Accredited by UBC CPD



CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

DOPs Assessment Candidate Evaluation Form

NAME: _____
CITY: _____
EMAIL ADDRESS: _____

PROGRAM: Direct Observation of Procedural Skills (DOPS) Assessment
DATE: _____
LOCATION: _____

Please provide us your feedback, which will help us to plan future CME/CPD events.

Physician
 Please identify specialty: _____

INSTRUCTIONS: Please circle the number that best reflects your assessment of each.

PART 1 – LEARNING & APPLICATION OF KNOWLEDGE **1=Very Little, 5=A Great Deal**

- | | | | | | |
|--|---|---|---|---|---|
| 1. The amount I learned in this program. | 1 | 2 | 3 | 4 | 5 |
| 2. The information I learned will be used in my future practice. | 1 | 2 | 3 | 4 | 5 |
| 3. The key pearls I learned were: | | | | | |

4. Is there anything you plan to do differently as a result of having participated in this program?

PART 2 - PROGRAM **1=Unsatisfactory, 5=Exceptional**

- | | | | | | |
|--|---|---|---|---|---|
| 1. CONTENT
Relevance to my job | 1 | 2 | 3 | 4 | 5 |
| 2. CONTENT
Compatibility with my expectations | 1 | 2 | 3 | 4 | 5 |
| 3. INTERACTIVITY
Adequate opportunities for interaction | 1 | 2 | 3 | 4 | 5 |
| 4. OVERALL RATING OF THIS PROGRAM | 1 | 2 | 3 | 4 | 5 |

Comments: _____

5. What was the most effective part of the program? Why?

6. What was the least effective part of the program? Why?

7. Do you feel that there was any industry bias in the program?

Yes _____

No _____

8. How could this program be improved?

9. Is there anything else you would like to share about your DOPS experience?

PART 3 – ASSESSORS

Assessor: _____

10. Did the assessor provide specific feedback?

- Yes
 No

11. Will you incorporate the assessor's recommendation into your practice?

- Yes
 No

Comments:

Assessor: _____

12. Did the assessor provide specific feedback?

- Yes
 No

13. Will you incorporate the assessor's recommendation into your practice?

- Yes
 No

Comments:

Thank you for completing the evaluation. Please return your completed evaluation form to
colonscreeningquality@bccancer.bc.ca or **604-675-7223** (fax).

Policy Title: Reporting of Direct Observation of Procedural Skills (DOPS) to Colon Screening Program Quality Management Committee	
Section: Quality Management	Reference No.
Effective: 14 Dec 2016	Revision:

1. SCOPE

DOPS Assessors

Colonoscopists participating in the Colon Screening Program

Health Authority appointed Colonoscopy Leads

Colon Screening Program Staff

Medical Director, Colon Screening

2. POLICY

Direct Observation of Procedural Skills (DOPS) is a peer assessment of colonoscopists' performing colonoscopy for the Colon Screening Program. Responsibility for colonoscopists' performance review, privileging and credentialing remains with the Regional Health Authorities

DOPS reviews are conducted under Section 51 of the BC Evidence Act, for the purpose of quality improvement within the Colon Screening Program.

The Colon Screening Program will be transparent about its purpose, collection and handling of information.

For each DOPS review, two trained DOPS Assessors will simultaneously and independently observe a colonoscopist perform two consecutive colonoscopies. For each observation, each DOPS Assessor will complete a validated DOPS assessment. This will result in four written assessments for each DOPS review performed. The assessment form will be faxed to the Colon Screening Program and then given by the DOPS Assessor to the colonoscopist. The assessment form will not be retained by the DOPS Assessor.

DOPS Assessors will provide feedback to colonoscopists undergoing DOPS. The Colon Screening Program and DOPS Assessors will provide information on continuing education opportunities as part of quality improvement to colonoscopists participating in DOPS.

The Colon Screening Program Quality Management Committee will receive and review aggregate data.

DOPS Assessors will report concerns identified in DOPS Assessments to the Health Authority appointed Colonoscopist Lead (CL) in that colonoscopist's Health Authority (HA). The CL will review the concern at the Colon Screening Program Quality Management Committee (QMC).

The recommendations from the QMC will be communicated to the colonoscopist as part of quality improvement. As appropriate, concerns will be reported to the HA senior medical administration.

The College of Physicians and Surgeons of BC should be alerted if a colonoscopist is physically or mentally impaired and unable to perform colonoscopy at the time the DOPS is performed.

The Colon Screening Program will not share results of the DOPS Assessment when reporting concerns to the HA or the College of Physicians and Surgeons of BC. This information will be kept confidential at the BC Cancer Agency Colon Screening Program. It is the colonoscopist's decision to share their DOPS Assessment with their HA.

RELATED POLICIES

N/A

3. RESPONSIBLE PARTY

Medical Director, Colon Screening Program

Screening Operations Director, Colon Screening Program

Approved by Colon Quality Management Committee on December 14, 2016.