Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy

JAG accreditation

Guide to achieving a JAG compliant endoscopy environment

Version for UK services

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Contents

Foreword

This guidance has been designed to assist endoscopy services in their preparation for a JAG accreditation assessment. It defines the essential components required to demonstrate a high quality, safe and patient focused environment including the equipment necessary to run a modern endoscopy service.

The guide reflects best practice for ALL services whether stand-alone facilities, those within day case or theatre environments, purpose built or adapted, existing or proposed new builds, and in the acute or non-acute sector. The guidance recognises and incorporates any differences between acute and non-acute sector facilities, the public and independent sector, adult and paediatric services and between different nations of the UK. This guidance does not cover services in the Republic of Ireland.

A high performing service will comply with the standards or have achievable action plans to meet them. It will have all pathways reflected in local policies and evidence of an annual review of strategic objectives with clear business plans to support any environmental developments. There should be Standard Operating Procedures (SOPs) for any part of the patient journey that has to be managed differently due to limitations imposed by the environment.

JAG aligns its standards to national policies across each of the devolved nations where they exist.

This guidance must be followed to achieve JAG accreditation. It has been noted where guidance is aspirational, but which is not required for accreditation (described as ‘best practice’).

The guidance is applicable to children undergoing endoscopy and this is referred to throughout the guidance.

General principles

The following principles apply to all areas within endoscopy and at all stages of the patient pathway.

- Patient's privacy, dignity and respect should be maintained at all times, including where services are undertaken outside of the endoscopy unit e.g. out of hours theatres, TNE, ERCP, pre assessment.
- There should be clear signage and signposting leading to the endoscopy service from the main hospital entrance and within each area of the unit.
- The flow through the facility should progress the patient without unnecessary looping back. If this is not achievable, information should be provided to patients, which defines the expected pathway.
- There should be suitable facilities to support patients with disabilities (defined as any physical or mental condition that limits a person's movements, senses or activities). All facilities should comply with the requirements of the Equality Act (2010)
- The environment should be calm with noise levels kept to a minimum.
- Entry into all clinical areas should be secured against unauthorized access. Effective restrictions should be in place to prevent the unit being used as a general thoroughfare or shortcut to other areas such as wards or offices.
- Views into clinical areas through glass panelled doors or windows should be appropriately restricted within fire regulations.
- The environment should be welcoming, clean, organized and uncluttered. The décor should be well maintained.
- All notice boards within clinical and non-clinical areas should display up to date, relevant and appropriate information to the target audience.
- Floors should be hardwearing, in good repair and with no carpets in clinical areas.
- Ventilation and temperature should be appropriately regulated throughout the unit to provide a comfortable environment and safely eliminate any noxious chemicals or fumes.
- Equipment including consumables in clinical areas should be restricted to that necessary to that area at that time, with additional storage facilities provided for unused, unnecessary or excessive stocks.
- Provision should be made for the safe storage of patient's belongings and valuables.
- Endoscopy used as an escalation/ inpatient area: It is recognised that in extreme circumstances inpatients may occupy endoscopy recovery areas. All instances should be recorded and made available to JAG if requested including any gender segregation breaches. Organisational leads should be made aware of the JAG position on this and the potential consequences (see Further resources section).
- In England: Gender segregation is required routinely from admission through to recovery wherever patients are required to undress and/or have received sedation or associated drugs. Where genders cannot be segregated single sex lists should be undertaken. Gender segregation applies to all GI and non-GI procedures undertaken within the facility and to procedures where the unit is within a shared day case facility. All gender segregation breaches should be recorded and available to JAG if requested.
- In Wales, Scotland and Northern Ireland: There should be routine separation of patients' pre-and post-procedure throughout the pathway.

- **Paediatrics**: As best practice children should not be admitted or treated alongside adult patients but on a separate and dedicated list. The pathway should be child friendly and support family centred care throughout.

Booking and administrative areas

Booking and administration teams are responsible for receiving referrals and ensuring that they are dealt with appropriately to ensure lists are booked to capacity.

Regardless of where booking and administrative functions are undertaken:

- Booking and administrative functions should be undertaken in a physical space separate to the reception area.
- The office space should comply with the relevant workplace regulations and Health building notes to ensure that there is sufficient floor area, height, and space for purposes of health, safety and welfare.
- Within the office space there should be facilities that support the size of the service including:
- Lockable storage for clinical and patient identifiable information
- Local secure printing facilities
- Sufficient IT to support electronic booking and administrative functions
- Sufficient telephone access with answer machines to allow both outgoing and incoming calls to be captured
- The office space should support confidential conversations with patients.

Reception and waiting areas

Reception is the front face of a service and as such should provide a welcoming environment that exemplifies the service.

Regardless of whether it is a dedicated or a shared reception and waiting area:

- There should be adequate and appropriate seating which, prioritises patients over relatives and carers. Seating for those with disabilities including bariatric seating should be available, and there should be space for wheelchair users.
- The reception desk should have low-level access area for wheelchair users and a hearing loop system available.
- The reception desk should be staffed during operating hours. If the reception area is left unstaffed for any reason, then there should be appropriate signage for patients, relatives and carers to follow.
- Privacy, confidentiality and security should be maintained at all times when retrieving verbal or storing written patient identifiable data. Locked storage cabinets or cupboards for patient notes are essential and staff should log out of computer screens when left unattended.
- Booking functions should not be undertaken at the reception area unless there is a soundproofed screen or separate area/ office.
- Toilet facilities should be available within or nearby the waiting areas, but outside of the clinical area.

If it is a dedicated reception/waiting area:

- Up to date, patient friendly material that illustrates the service and the resources available should be displayed.
- As best practice there should be a secondary entrance for inpatients, linked to the hospital corridor.
- **Paediatrics:** Children should be cared for pre- and post-procedure in child friendly areas that can be clearly segregated from adult patients. Best practice therefore would be for children to be pre-assessed and admitted directly from a paediatric facility.

Patient assessment and preparation areas

Whether dedicated private rooms, pods, cubicles or general pre-assessment areas are used they must all be suitable for the intended use. All areas should have:

- Curtains or doors with appropriate signage to restrict access when the area is occupied
- Sufficient space to allow access of staff including resuscitation teams in the event of an emergency
- Patient trolleys should be height adjustable (ideally hydraulically), allowing the head of the trolley to be moved up or down. Composition of all materials should facilitate easy cleaning between patients
- Adequate soundproofing to ensure confidential discussion
- Pulse oximetry, blood pressure monitoring and access to a glucose testing device and INR testing machine
- Emergency call bells in all areas where a patient is left unattended
- Handwashing equipment within or just outside the area if clinical activities including delivery of enemas or intravenous cannulation are undertaken
- Adequate toilet facilities including assisted and accessible access for those with disabilities
- Patients' respect and dignity should be considered when these are accessed outside of a gender segregated area i.e. across a corridor.

Where patients are allocated a private room, pod or cubicle that they will occupy throughout their stay and that protects their privacy and dignity:

- There must be a system in place to ensure that patients can be visually observed by staff at all times. This may include the use of electronic monitoring systems or one way glass
- Private rooms or pods (i.e. that have toilet facilities) can be used for pre-assessment and preparation including the delivery of enemas
- Private rooms or cubicles (i.e. that have no toilet facilities) can be used for pre-assessment and preparation. Patients requiring enema preparation should be allocated an adjacent toilet dedicated solely for their use.

Where patients are not allocated a private room, pod or cubicle that they will occupy throughout:

- There should be separate rooms to undertake patient pre-assessment that allow confidential discussion and preparation such as cannulation. One pre-assessment room per procedure room will reduce bottlenecks.
- Where clinical activities are undertaken there should be a trolley or reclining chair in the event of a syncope or other emergency.
- In England: Where a patient is required to undress into a gown, there should be gender segregation from the pre-assessment stage onwards i.e. changing areas onwards. Corridors are considered to be gender-neutral zones but patients' dignity should be maintained when accessing these areas when they are not wearing day clothes i.e. into gowns
- In Wales, Scotland and Northern Ireland: It is best practice to separate patients waiting for the procedure from those post procedure. Although gender segregation is not required deference to respect, and dignity should be demonstrated

- **Paediatrics:** Best practice is for children to be pre-assessed in a paediatric facility. If pre-assessed within the endoscopy unit, there should be clear separation from adults; registered children's nurses and play specialists should be available; and the environment should be child-friendly and support the family.

For gender segregated shared pre-assessment and recovery areas:

- Where patients of the same gender are pre-assessed within the recovery area, attention must be given to ensuring that confidentiality, respect and dignity are maintained at all times and that there is appropriate separation of patients awaiting their procedure from those who have had their procedure (i.e. curtains, screens).
- The presence of relatives and carers should not compromise the respect and dignity of other patients, and so it is best practice that their presence in these areas is discouraged. Best practice in circumstances where the presence of relatives or carers is required would be for patients to occupy a single room or to be pre-assessed and admitted from a ward.
- **Paediatrics:** Children must not occupy a recovery area at the same time as adult patients.

The procedure room

Regardless of whether endoscopy is carried out in a dedicated procedure room, designated theatre or in the case of off-unit endoscopy:

- Procedure rooms should have enough free space to allow people to get to and from workstations and to move within the room with ease. There should be enough room to accommodate an emergency team and resuscitation equipment if needed.
- Room ventilation should comply with HTM 01 03 (see further resource section). Annual ventilation audits for each room must be undertaken.
- There should be handwashing facilities in each procedure room.
- Personnel in the procedure room should be limited to those staff necessary to undertake the procedure or support the patient. There should be effective restriction to non-essential staff entering the room during procedures.
- All work surfaces should be of a medical grade, wipeable and uncluttered.
- All consumables should be kept in clinical grade storage, and equipment on work surfaces should be limited to that required for the immediate procedure. There should be sufficient storage of consumables to equip a list, including emergency therapeutic equipment, without the need to restock during a procedure.
- Cables and leads where possible should be suspended from the ceiling. If not, feasible they should be risk assessed as a 'trip' hazard.
- All signage and notices should be kept to a minimum, be of relevance and laminated or within a wipeable folder.
- The following ancillary equipment should be present in each procedure room.
    - √ Pulse oximetry
    - √ Blood pressure monitoring
    - √ Suction for both patient and endoscope.
    - √ Medical gases, ideally wall mounted, including oxygen, nitrous oxide and carbon dioxide for insufflation.
    - √ ECG monitoring is not required routinely but should be available.
    - √ Emergency drugs for immediate life support.
    - √ Electrosurgical unit/diathermy
    - √ Water irrigation device
    - √ Full range of endoscope consumables dependent on procedural activity but, including a range of therapeutic equipment to deal with intra procedural emergencies. All consumables should support the latest diagnostic and therapeutic capability.
- There should be a complete range of modern endoscopic equipment available, appropriate to the procedures performed on the unit. Light sources and video processors and high-resolution monitors should support the endoscopes in use. Endoscopes should have high-definition capability with enough endoscopes to provide a seamless service from reprocessing to use. Magnetic imaging guides enhance patient comfort and facilitate training and should be available in each procedure room.
- Equipment should be stored safely and securely when not in use.

- There should be maintenance contracts in place for all essential equipment and a replacement programme that enables the service to keep up with technological advances to maintain high standards of service provision and diagnostic capability.
- There should be an NED compliant endoscopy reporting system with a secure printing facility.
- Best practice is to ensure that where there are multiple procedure rooms the equipment layout is the same in each to enable staff to familiarize themselves with the location of essential and in particular emergency equipment.
- Where x-ray guided procedures are undertaken staff exposure to radiation should be reduced to well within the regulated permitted exposure levels (see Further resources section). Rooms should be appropriately lead lined and staff working within the room suitably protected (lead aprons, glasses, thyroid collars, film badges).

Recovery and discharge

Patient recovery usually comprises of first and second stage. These areas may be separate or combined as first and second stage or male and female recovery. There should be a dedicated base for patient records and general communications, ensuring that patients can be safely monitored at all times.

First stage: Is required for patients who have been sedated or need to recover on a trolley post procedure.

- Each recovery space should have an oxygen and suction supply and clinical monitor providing pulse, blood pressure and oxygen saturation monitoring. ECG monitoring should be readily available if required. Where patients are allocated a private room, pod or cubicle there should be safe methods of monitoring individuals when occupying these rooms.
- There should be sufficient space between each trolley to allow access for resuscitation equipment and an emergency team if required.
- There should be gender segregated toilets (one in each gender segregated area and two in a shared area). If external to the recovery area i.e. across a corridor, care must be taken to protect respect and dignity when accessing toilets. There should be access to an assisted and accessible toilet for those with disabilities.
- Where private rooms, pods or cubicles are allocated to patients during recovery, care should be taken to ensure that respect and dignity are maintained throughout their stay. Curtains or doors should be used to restrict access when the area is occupied.
- Where trans patients are cared for in an endoscopy setting, care should be taken to meet their needs for respect and dignity. Patient placement should be based on both asking the patient for their preference, and on gender presentation. The NHS, GMC and RCN have clear guidance on caring for trans patients. It is of utmost importance that the local organisation policy is followed. Within endoscopy it is common practice to be pre-assessed and recovered in a single room or to be schedule first or last on the scoping list. This provides the best opportunities to care for them in a respectful and dignified way.
- In England: there should be gender segregation within recovery. Optimally this will comprise of two distinct areas each with their own toilet and washing facility. Where screens or room dividers are used to separate a single room into two areas, these should be fixed at wall and floor to the building structure and high enough to make the patients feel that they are in their own room. There should be a separate entrance/exit into each gender area and patients should not have to walk through an opposite gender area to reach facilities such as toilets or the second stage recovery area.
- Non-acute sector in England: Where endoscopic procedures are carried out in theatres, e.g. within the independent sector, theatre first stage recovery may be used but only until patients are medically fit to go back to their allocated rooms. First stage theatre recovery is not required to be gender segregated.
- In Wales, Scotland and Northern Ireland: Although gender segregation is not a requirement step should be taken to address any patient feedback around respect and dignity. There should be appropriate separation of patients awaiting their procedure from those who have had their procedure.
- Paediatrics: Children should be recovered and discharged on a paediatric facility or in a single room on the unit separated from the adult pathway. Children should not be recovered alongside adult patients.

Second stage: This is a communal seated area for use prior to discharge, either as a step down from first stage or for patients immediately post procedure that are not sedated.

- Patients in second stage are dressed and can be gender mixed as long as the facility is not within an otherwise gender-segregated area.
- Second stage recovery should be clearly separated from first stage. If room dividers are used these should be fixed to the building structure at the wall and floor and high enough to make the patients feel as though they are in a separate room.
- Toilet facilities including assisted and accessible access should be available within or just outside of the second stage recovery area. They should be gender segregated where necessary and accessible without having to pass through an area of the opposite gender.
- Where refreshments are served, crockery should be disposable or washed in an organisation-approved dishwasher. Where food is offered this should be distributed according to the organisation's food and hygiene policy with suitable refrigeration. There should be restricted access to kitchen/pantry areas.
- Once the patient is ready for discharge, there should be a separate room available for private discussion of their clinical care. An area that allows the presence of a relative or friend without compromising the privacy or dignity of other patients or breaching gender segregation requirements is best practice.

The decontamination environment

Reprocessing of endoscopic equipment may take place within the unit, elsewhere within the organisation or off site. In all instances dedicated decontamination facilities are required and must demonstrate robust communication and governance links with the endoscopy services that they support.

- Whether occupying a single room or two rooms there should be a clear separation of dirty and clean equipment and processes.
- Where single rooms are in operation care should be taken to avoid splash contamination between clean and dirty areas.
- All areas should securely restrict access to all but essential staff.
- All areas should be adequately equipped with medical grade wipeable surfaces and storage, and areas uncluttered.
- All signage and notices should be kept to a minimum, be of relevance and laminated or within a wipeable folder.
- Ventilation and extraction to these areas should ensure that staff are protected from exposure to fumes from hazardous chemicals and demonstrate full compliance with the relevant standards.
- Personal protective equipment, spillage kit and first aid kit (eye wash) should be accessible at all times.
- Chemicals should be stored in accordance with their product sheets and the storage area clearly labelled to indicate the content. Chemical product sheets should be on display outside of the storage room in the event of fire and the storage area clearly signed to indicate the chemical hazard.
- There should be a separate hand washing sink in addition to the endoscope cleaning sinks. Dedicated clean areas should also have accessible hand washing facilities, which may be in the clean room or just outside.
- The numbers of sinks needed for manual cleaning of equipment will depend on the size of the unit. However, there should be a minimum of one double sink with double drainer which should be of adequate height to prevent back-related injuries. Evidence should be demonstrated of appropriate risk assessment.
- Adequate and appropriate equipment to perform manual cleaning processes should be readily available and protected from splash contamination around sink areas.
- All endoscope reprocessing should be automated. All EWDs must be in good working order and HTM compliant as assessed by an AED.
- Following reprocessing, endoscopes that are not to be used within 3 hours should be stored in a medical grade storage unit to be reprocessed prior to next use or in an endoscope drying/storage cabinet according to manufacturer's instruction with maximum storage periods validated by the unit. Lockable endoscope storage must be in a dedicated clean area.
- Storage should be available for any dirty equipment awaiting transfer to sterile services.
- Annual IHEEM and infection prevention (IPS) audits should be undertaken and action plans put in place to address identified issues.

Other areas

Resuscitation area

- A dedicated area within the unit should be identified to house the resuscitation trolley, oxygen, suction and emergency drug box. This should be accessible to all areas in endoscopy and comply with the organisation's own resuscitation services practice.
- The number of resuscitation trollies required should be decided in conjunction with the resuscitation team and based on the number of procedure rooms and then environmental footprint to ensure speedy access to all areas of the unit in the event of an emergency.

Stock room, storage and disposal area

- When not in use large pieces of endoscopic equipment should be stored safely and securely. They should not block emergency access within corridors or to rooms.
- When not in use medical gas cylinders should be kept in a purpose-built lockable cylinder store or locked cage. Storage should allow the cylinders to be kept dry and in a clean condition, away from extreme sources of heat or flammable liquids. There should be appropriate warning signs on storage areas. Industry guidelines on use and storage of each type of gas cylinder should be followed and safety Data sheets (SDS)/Medical Gas data sheets (MGDS) should be readily available.
- There should be readily accessible stock room(s) for the storage of major supplies such as endoscopic accessories, linen etc.
- As an infection prevention measure all linen should be stored in a cupboard or covered trolley.
- There should be a dedicated area nearby for the safe disposal of general and hazardous waste.

Staff changing and staff room

- Staff should have access to a dedicated changing area with secure property storage and toilet facilities
- Larger units may have access to dedicated staff room.

Additional facilities

- Larger units or those with a focus on providing high level or regional training should have access to a seminar room with a video link to the endoscopy unit.

Off unit endoscopy services

- Facilities supporting any part of the endoscopy pathway, including pre-assessment, should provide the same level of patient privacy, dignity and respect as if undertaken on the unit
- Light sources and video processors and high-resolution monitors should support the endoscopes in use. There should be enough endoscopes to provide a seamless service from reprocessing to use
- There should be a full range of endoscope consumables dependent on procedural activity but, including a range of therapeutic equipment to deal with intra procedural emergencies. All consumables should support the latest diagnostic and therapeutic capability.

- Provision should be in place to support the deteriorating patient and recovery facilities should be available to all patients requiring them.
- There should be access to an endoscopy reporting system to allow the contemporaneous recording of endoscopic procedures.
- The decontamination pathway should support all stages of the decontamination process including the bedside clean.

Further resources

There are a number of resources that provide additional information and support when planning any changes within the environment. Some will be nation specific, and organisations should check the relevance to their service.

The following Health building notes (HBN) and Health Technical Memorandum (HTM) provide additional guidance on the core elements required within the endoscopy environment in England. These can be accessed from www.gov.uk/government/collections/health-building-notes-core-elements.

- HBN 00-10 – Part A. Design for flooring, walls, ceiling, sanitary ware and windows
- HBN 10 – 02 – Day surgery units
- HBN 23 – Hospital accommodation for children
- HBN 00-03 Clinical and clinical support services
- HTM 03 – 01 Heating and ventilation systems: Specialised ventilation for healthcare premises.

The following Health Building note (HBN) provides additional guidance on the core elements required within the endoscopy environment in Wales and can be accessed from www.wales.nhs.uk

- HBN 52 – Accommodation for day care, medical investigation and treatment unit.

Other useful guidance and resources include:

- Department of Health (2002) Enhancing privacy and Dignity: Achieving single sex accommodation. NHS Estates, HMSO.
- Royal College of Nursing: Fair care for trans people. file:///C:/Users/Computer/Documents/JAG/005575.pdf
- Health and Safety Executive (2018). Dose monitoring assessment and recording. www.hse.gov.uk/radiation/ionising/doses
- JAG (2018) JAG briefing: Endoscopy as an inpatient area. www.thejag.org.uk/CMS/Page.aspx?PageId=82
- A guide to the endoscopy suite at Chesterfield Royal Hospital: www.youtube.com/watch?v=HCy6MRfHJyY
- The Equality Act (2010) https://www.gov.uk/guidance/equality-act-2010-guidance
- Safe Use of Oxygen Cylinders NHSE (Jan 2023) https://www.england.nhs.uk/wp-content/uploads/2023/01/Official-sensitive-Oxygen-Cylinder-Comms-FINAL-v2.pdf
- Regulation 10 of the Workplace, (Health Safety and Welfare) Regulations (1992) https://www.hse.gov.uk/contact/faqs/roomspace.htm

The following documents provide additional guidance on the core elements required within the endoscopy environment in Northern Ireland:

- https://www.hse.ie/eng/about/who/nqpsd/qps-improvement/hse-standard-for-decontamination.html Part 1: HSE Standards and Recommended Practices for Facility Design and Equipping of Endoscope Decontamination units, V.1, QPSD-D-022-1 (2019)

- Infection Control Guiding Principles for Buildings Acute Hospitals and Community Settings –August 2020
  https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Infection%20Control%20Guiding%20Principles%20for%20Building.pdf
- Radiation Protection
  https://www.hse.ie/eng/about/who/acute-hospitals-division/radiation-protection/
- The National Healthcare Charter: You and Your Health Service. Accessible services section. HSE National Guidelines on Accessible and Social Care Services
  https://www.hse.ie/eng/services/yourhealthservice/access/natguideaccessibleservices/part1.html
- Equal Status Act (2015)
  https://www.ihrec.ie/guides-and-tools/human-rights-and-equality-in-the-provision-of-good-and-services/what-does-the-law-say/equal-status-acts/

Further information

For further information, please see www.thejag.org.uk/support.

In Northern Ireland further support is available from HSE Endoscopy Programme
https://www.hse.ie/eng/about/who/acute-hospitals-division/clinical-programmes/endoscopy-programme/

Further information regarding this document may be obtained from the JAG office at the Royal College of Physicians.

JAG office
Accreditation Unit
Care Quality Improvement Department
Royal College of Physicians
11 St Andrews Place
London
NW1 4LE

0203 075 1620
askjag@rcp.ac.uk
www.thejag.org.uk

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