

**Topic:** Adequacy of Bowel Preparation

### Sample A

Over the past three years, [the unit] has used several different bowel preps in order to achieve the best possible colonoscopy for our patients. The cleansing quality is a critical factor in determining the quality, ease, speed, and completeness the colonoscopy. Our facility has used [Prep A], [Prep B], and [Prep C] over the past two years with varying results.

Our facility was originally using [Prep A] bowel prep. Our staff found a significant amount of patients could not tolerate the large volume of prep. Most patients would not drink the entire solution because of the nausea, vomiting, and bloating. This would result in poor bowel preps. In addition, older patients were also having issues being able to follow the prep directions. After chart reviews and patient interviews, our physician change to [Prep B].

[Prep B] is a lower volume bowel prep. Patients like the [Prep B] prep because of the smaller prep solution, but a large volume of patients did not follow the prep directions properly. The directions stated that a light breakfast was allowed. A “light breakfast” was not defined in the instructions. Our patients were eating large, complex meals and not drinking enough clear liquids with their bowel prep. This was giving the patients very poor prep results. After chart reviews and patient interviews, we changed to [Prep C].

Our staff has noticed a significant improvement in prep quality. After doing Quality Assessment on 50 consecutive cases, the prep quality was good in 92% using [Prep C].

By changing to the [Prep C] bowel prep, we have achieved better outcomes for our patients and staff. We have been successful in achieving better visualization of the entire mucosal surface and decreased the need to reschedule procedures due to poor preps.

### Sample B

[Our unit] chose to compare two preps we currently used on a routine basis. We looked at the quality and cost of the two preps.

The unit’s goal as a practice is to provide a quality and cost effective exam for our patients. Some physicians felt like [Prep A] was providing a better quality prep than [Prep B]. However, we frequently received calls from patients complaining that [Prep A] was too expensive. We felt like the best way to evaluate this was to do a blind study. We polled each patient on arrival to see how much the prep had cost them.

The physicians collaborated to come up with prep definitions to score the preps appropriately and consistently. The scores ranged from excellent, good, fair, poor, and inadequate. A copy of the prep definitions was posted in each procedure room so it would be easily accessible. We then devised a form for staff to document the required information. Staff was notified about the form and information we were looking to collect. We alternated preps distributed on a daily basis and tracked this information for three months to assure we would get a good sample of both preps. Our initial goal was to have the endoscopists reporting that 50% of patients were presenting with good to excellent prep regardless of the prep they received and to keep the average cost to the patient around \$20-30.

At the end of three months, results were tallied. 73% of patients taking [Prep A] presented with good to excellent preps and 72% of patients taking [Prep B] presented with good to excellent preps. The data also showed the average cost of [Prep A] to patients was \$52 and the average cost of [Prep B] to patients was \$20. Therefore, with both preps providing a quality prep more than 50% of the time and [Prep A] on average costing patients \$30 more than [Prep B], [Prep B] was obviously the best choice to

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maintain our goal of providing a quality and cost effective prep. After sharing the results with our physicians, [Prep B] was chosen as our primary prep unless contraindicated. We had a meeting with staff to share the results and make them aware of our decision to use [Prep B] as our primary prep. There was no need for repeat measurement at this time.