South Canterbury
District Health Board

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23 December 2021

Andrew McGregor

By email: fyi-request-17707-d45ba096@requests.fyi.org.nz; fyi-request-17708-188654ed@requests.fyi.org.nz; fyi-request-17709-192f1f95@requests.fyi.org.nz; fyi-request-17710-041d40b1@requests.fyi.org.nz;

Dear Andrew,

Re: Official Information Act Request

I refer to your Official Information Act request received on 8th December 2021 in which you specifically requested the following:

1. **Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR).**
   SCDHB's response: Please refer to appendix A as attached.

2. **Please provide Guidelines/procedures for the management/prevention of persistent Postsurgical Pain.**
   SCDHB's response: Please refer to appendix B & C as attached.

3. **Please provide Guidelines/procedures in the treatment of patients after a suicide attempt and/or suicidal ideation.**
   SCDHB's response: Please refer to appendix D as attached.

4. **Please provide Guidelines/procedures differentiating subtypes of primary (idiopathic) constipation.**
   SCDHB's response: South Canterbury DHB does not have guidelines/procedures differentiating subtypes of primary (idiopathic) constipation; therefore, we decline your request under section 18(g) of the OIA because the information is not held.

You have the right to seek an investigation and review of our decision by the Ombudsman. The Ombudsman's Office can be contacted on 0800 802 602 or on-line at http://www.ombudsman.parliament.nz/

If you wish to discuss this decision with us, please feel free to get in touch.

Kind regards

Sophie Lyons
SLT Administrator
South Canterbury DHB

Appendix A:

South Canterbury District Health Board

UROLOGY SERVICES PROTOCOL

Urinary Retention

Introduction:

- Patients requiring catheterisation do not always require urological follow-up.
- Urinary retention associated with renal failure can lead to a post-obstructive diuresis, a potentially life-threatening scenario.

1. Initial diagnosis of urinary retention

1.1 Confirm diagnosis (palpation of distended bladder or bladder scan).
1.2 Collect blood for creatinine.

2. Management of urinary retention

2.1 If retention has been preceded by gross haematuria, manage as per SCDHB Urology Protocol Number 2: Haematuria Management.
2.2 Place 16 G Fr urethral catheter.
2.3 Allow bladder to empty and record volume drained.
2.4 Send urine for microscopy, culture and sensitivities.
2.5 If creatinine is less than 200, discharge (see below).
2.6 If creatinine is >200, observe patient for two hours:
  2.6.1 if urine output, after initial drainage, is > 200 mL per hour, commence treatment for post-obstructive diuresis – see 3 below
  2.6.2 if urine output, after initial drainage, is < 200 mL per hour, encourage oral fluid intake, discharge patient and arrange repeat creatinine in 2 to 3 days with GP

3. Management of post-obstructive diuresis

3.1 Prescribe intravenous fluid replacement at a rate of 50% of urine output per hour.
3.2 Urine needs hourly measurement and the iv fluid rate adjusted accordingly by nursing staff.
3.3 Use alternate one litre bags of Normal Saline and Dextrose 4% Saline.
3.4 The patient will require admission to hospital.

4. Admission

4.1 Patients in urinary retention can usually be discharged, unless they develop a post-obstructive diuresis.
4.2 Discussions around acute management and admission are to be discussed with the on call Urologist in Christchurch.
4.3 Patient to be admitted under the On Call SCDHB General Surgeon.
4.4 If patient haemodynamically unstable, consider ICU involvement.
4.5 On week days Urology Nurse to be notified of admission, and in weekend, the on call house surgeon.
4.6 On the week days Urology Nurse (and in weekends the house surgeon) to discuss patient with the Christchurch on call Urologist, after daily ward round.

5. Discharging a patient who is catheterised

5.1 Supply patient with night bag and give catheter education.
5.2 Prescribe doxazosin 4 mg daily for male patients if they are likely to tolerate this and are not currently on any therapy for benign prostatic hyperplasia.
5.3 Complete District Nursing referral: a District Nurse should attend the next day.
5.4 Refer to Urology Nurse for outpatient review: a decision will be made and the patient contacted regarding a trial of void if that is thought appropriate.

Protocol:

1. Initial diagnosis and management as per 1 and 2 above.
2. The vast majority of patients will be discharged home.
3. Complete referrals and prescribe doxazosin as outlined in 5 above.
4. Patients who develop a post-obstructive diuresis will need admission and discussion with the on call Urologist in Christchurch, or if it has not been possible to place a catheter.

TERTIARY REFERRAL TO CDHB:

No improvement after 3 days should prompt tertiary referral to the CDHB. This should be done through the Christchurch Urologist on-call.

Appendix B:

South Canterbury District Health Board

Patient Label

ACUTE PAIN SERVICE REFERRAL FORM

Email and scan referral to acutepain@scdhb.health.nz

File form in ward referal clear file

Referral Date:	**Patient Location:** Ward Room Number	**Referrer:** Name Designation Contact Number
Admission Date:		
Planned Discharge Date:		

Indication for Referral

☐ Pain not responding to standard treatment **

☐ Uncontrolled Nausea / Vomitting **

☐ Complex Pain Past History

☐ Trauma _____

_____

☐ Surgery _____

_____

☐ Caesarean Section (day one)

☐ In-situ Intervention (eg PCA, Pain Buster, T34)

☐ Other _____

**** Call Acute Pain CNS and complete Referral Form**

After hours: House Officer to contact Duty Anaesthetist

Current Interventions - tick all which apply

☐ PO /IV Analgesia - charted and given? **Y / N**

☐ PCA ☐ Intrathecal

☐ Epidural ☐ Regional Infusion

☐ On-Q Pain Buster ☐ Local Anaesthetic

☐ Opioid infusion ☐ Ketamine infusion

☐ IV Sedation ☐ T34 Niki Pump

Co-morbidities

☐ IHD / Cardiac Failure ☐ History of PONV

☐ Respiratory Issue ☐ Gastric Ulcer

☐ Renal Impairment ☐ Chronic Pain

☐ Liver Impairment ☐ Anxiety

☐ Diabetes ☐ Substance Abuse

☐ Other _____

1. **Patients with invasive pain adjuncts or complex analgesic medication needs will be seen daily**
2. **Please ensure charted analgesia has been given prior to submitting Acute Pain Service Referral**
3. **Please ensure Antiemetics, Break through analgesia and Constipation medications are charted**

Pain Score 1-10: _____ rest: _____ activity	**Function Activity Score:** A ☐ B ☐ C ☐	
Dermatome Level:	**Bromage Scale:** 0 ☐ 1 ☐ 2 ☐ 3 ☐	**Sedation Score:**
OFFICE ONLY Date Received:	**First Seen:**	**CNS**

ACUTE PAIN SERVICE REFERRAL PATHWAY	**Bromage Score**

South Canterbury District Health Board

UNCONTROLLED PAIN

Contact Acute Pain CNS by **mobile phone**
(See Anaesthetist roster)
Clinical hours
Morning hours: 830-1130
Afternoon hours: 1300-1530

After hours: House Officer to contact Duty Anaesthetist
Complete referral and email to painsec@scdhb.health.nz

POSTOPERATIVE - DAY ONE

TRAUMA

YES

COMPLETE REFERRAL FORM

PATIENT WILL BE REVIEWED
AM WARD ROUND

NO

COMPLETE REFERRAL FORM

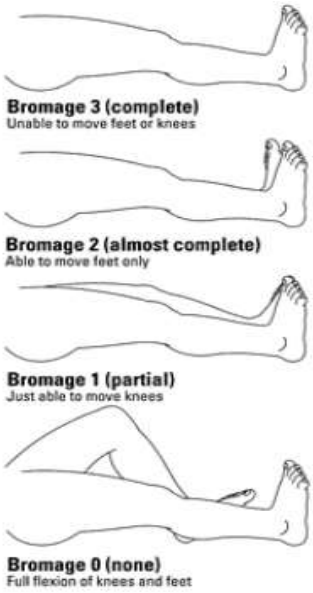
PATIENT WILL BE REVIEWED
PM WARD ROUND

IMPORTANT POINTS TO CONSIDER

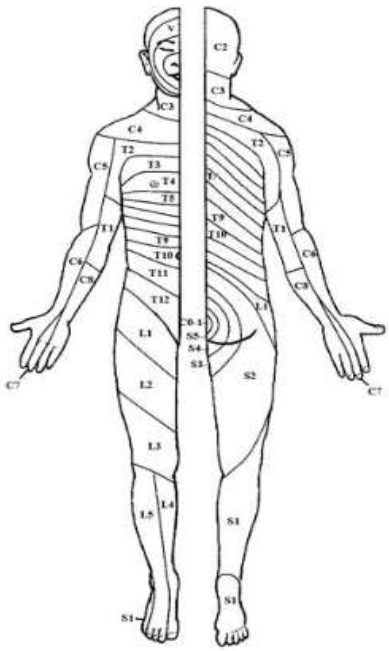
- Has the patient had regular analgesia?
- Has the patient had PRN analgesia?
- Is bowel function documented?
- Have laxatives been charted?

PALLIATIVE RESOURCES

IHUB ⇨ Knowledge Base ⇨ Palliative Care
Please refer to Palliative Care Team
03 6872421 or after hours Palliative SMO



Dermatome Map



Function Activity Score

A = no limitation of activity due to pain

B = mild limitation of acticity due to pain

C = unable to compelte activity due to pain

Appendix C:

Minimum Observations Guide- Acute Pain Patients

Post-Operative Observations- if stable

	Pulse, BP, Resp rate, SPO2 & Temperature	Pain Score, Nausea, and Sedation score
First 4 hours once returned to the ward from PACU	On arrival, then 30min for 2hrs, hourly for 2hrs	On arrival, then 30min for 2hrs, hourly for 2 hrs if stable
If stable after first 4 hours	2 Hourly	2 Hourly
If stable after first 8 hours	4 Hourly	4 Hourly

Patient Controlled Analgesia (PCA)-if stable

	Pulse, BP, Resp. rate, SPO2, Temperature	Pain Score, Nausea, and Sedation score	Insert Site & Infusion pump check
First 12 hours since commencement of infusion	Commencement of infusion, Then 1 hourly	Commencement of infusion, Then1 hourly	Insertion site 4 hourly Programme check every shift change
If Stable after first 12 hours since commencement of infusion	4 Hourly	4 Hourly	Insertion site checked minimum 4 hourly Programme check every shift change
After Clinician Bolus injection	Every 5 minutes for 15 minutes	Every 5 minutes for 15 minutes	Insertion site and Programme check after bolus

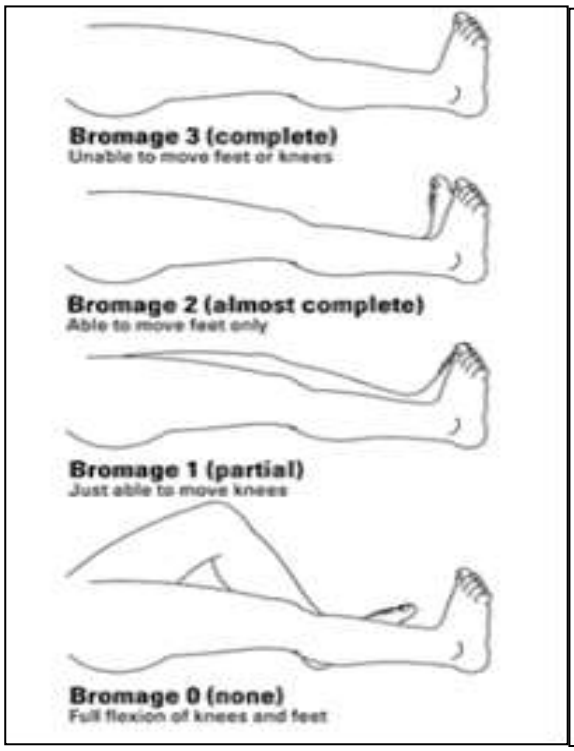
Epidural Analgesia- If Analgesia is inadequate, motor block is excessive or patient is hypotensive then identify sensory block and degree of motor block.

	Pulse, BP, Resp. rate, SPO2, Temperature	Pain Score, Nausea, and Sedation score	Level of Sensory block	Degree of motor block	Insert Site & Infusion pump check
Inpatient first 6 hours	Every 15 mins for 2 Hours Every 30 mins for 4 hours	Every 15 mins for 2 Hours Every 30 mins for 4 hours	4 hourly	4 hourly	Insertion site checked minimum 4 hourly Programme check every shift change
If stable after 6 hours	Hourly for 4 hours (if remains stable) 4 hourly	Hourly for 4 hours (if remains stable) 4 hourly	4 hourly	4 hourly	Programme check every shift change
Starting infusion or After Bolus injection	Every 5 minutes for 20 minutes	Every 5 minutes for 20 minutes	Before bolus 30 minutes and 1 hour after	Before bolus 30 minutes and 1 hour after	Programme check after bolus

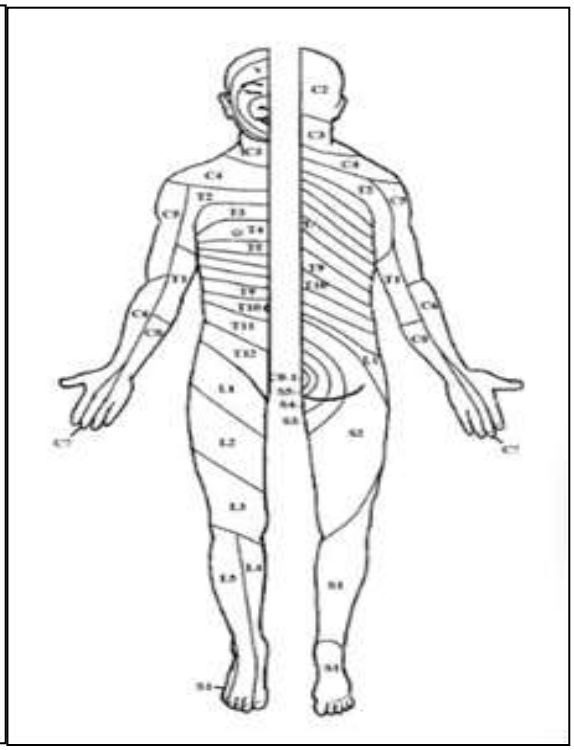
Intrathecal/Epidural Morphine for Acute Pain Management

	Temperature	Pulse, BP, Resp. rate, SPO2	Pain Score, Nausea, and Sedation score	Height of Sensory block
Inpatient first 24 Hours	2 Hourly	2 Hourly	2 Hourly	2 Hourly

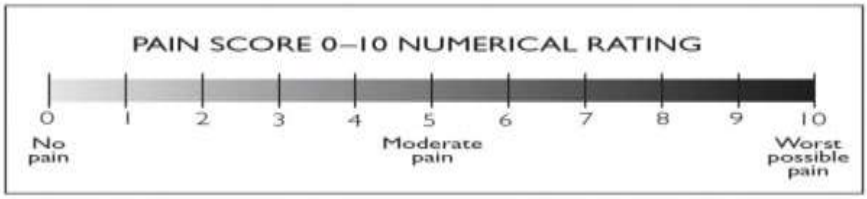
Bromage Score (motor test)



Dermatome Map (sensory test)



Sedation Score	
0	**No sedation/ alert**
1	**Mild, occasionally drowsy, eay to rouse**
2	**Moderate, frequently drowsy, easy to rouse**
3	**Severe, somnolent, difficult to rouse**
S	**Asleep but easily roused**



Appendix D:

South Canterbury District Health Board

MENTAL HEALTH SERVICE PROCEDURE

Management of Suicidal People

Objective:

To provide a guide to staff in the appropriate assessment and management of people who are at risk of suicide.

Responsibility:

All staff working with people who are at risk of suicide must follow the guidelines set out within this policy and refer to other relevant Procedures/Protocols.

Client Group:

All people entering the South Canterbury District Health Board (SCDHB) Mental Health & Addictions Service.

Associated Documents:

- Memorandum of Understanding with NZ Police
- Involving Families Procedure
- Clinical Documentation Guidelines - Mental Health Service

Important Information

- Staff will actively seek assistance from and give information to family/whānau/caregivers throughout the assessment, crisis management and subsequent recovery process of their family member.
- A staff member may override a suicidal client's refusal to involve family/whanau/caregivers following consultation with the on call psychiatrist or the Multi-Disciplinary Team (MDT).
- Clients who are not presenting with risk to self or others have the right to refuse to have family/whanau/caregivers involved and the right to refuse treatment.
- Clients who are under the Mental Health Act do not have the right to refuse to have family/whanau/caregivers involved and do not have the right to refuse treatment.
- Risk should be reviewed at every contact and documented in the progress notes.
- Clients at risk of suicide should be discussed frequently in the MDT.

Referrals

- All calls regarding threats of suicide, suicide attempts or deliberate self harm must be regarded as a psychiatric emergency.
- The person receiving the call is responsible for ensuring the caller is linked to the appropriate staff member. That is, within working hours to their case manager or after hours to the TACT team.
- All calls regarding suicide risk or intent or deliberate self harm must, as well as action(s) taken, must be recorded on a Triage Form or in the Progress Notes (if already known to MHAS).

Assessment of New Clients

A full risk assessment, which involves a comprehensive psychiatric assessment and collateral information from family/whanau/friends will be carried out by the case manager or TACT team and documented on the respective forms as per Service Framework Process.

Information is to be obtained from the National Health Index (NHI), HCS and Ajexus regarding any previous admissions to psychiatric services. If there is a file locally this must be retrieved and reviewed in terms of past diagnosis and previous risk patterns.

If suicide risk is identified, the assessment must be presented to the MDT or on-call psychiatrist for the formulation of a safety plan. One of the options available to manage the risk is to admit to the inpatient unit and if required, use of the Mental Health Act.

The Safety Plan (Crisis Plan) must be written up and discussed with the client. It will also be discussed with family/whānau/caregivers wherever possible. If not available for discussion this must be documented and future attempts made to discuss the Safety Plan with them.

If the client is to remain an outpatient, the case manager or TACT must discuss a comprehensive Safety Plan with the family/whānau/caregivers and provide them with appropriate written information about managing suicide risk e.g. being aware of treatment details of the underlying mental illness, details of early warning symptoms, relevant contact details for health personnel if the risk increases. This must include a conversation about when to use the Police and the reasons for approaching the Police intervention e.g. in the event of any immanency to safety, if there are any physical harm concerns etc.

The client's assessment and management plan must be presented at the next MDT. If this occurs over a weekend or public holiday the plan must be discussed with the on call psychiatrist then to the MDT.

Counselling regarding restricting access to means:
Counselling about access to lethal means is a standard part of patient Safety Plans. However, staff often advocate for removal of means without warning families of the risk of substitution of other methods. We recommend that staff should be reminded that if they advocate restriction of access to a preferred method of suicide, families and friends of the at-risk patient should routinely be warned that removal of access to the preferred method may mean that some patients may substitute other, more lethal methods, and that access to these methods should also be monitored.

Consider the client's occupation and place of residence which may indicate obvious access to lethal means.

Document what you have advised the client and/or family/whānau/caregivers to do to promote safety and to restrict access to lethal means.

During subsequent phone calls/visits to the client continue to check access to means and that specific items of concern have been removed.

Firearms
Ask all clients and their family/whanau/caregivers about access to firearms.

Advise families/whanau/caregivers to remove potential weapons, in particular, firearms. The safest option is for the family to contact the police and request that firearms are removed. If an emergency Tact should contact the police directly.

Medications and poisons and other means of suicide.

<u>Advise</u> the family/whanau/caregivers of the following:

1. Ensure medications are accounted for and that medications (including paracetamol) are locked away after they have been used.

Any prescription medications should be of a minimum amount. Check on HCS the current medications being prescribed by the GP and request that they are close controlled.

Remove all medications that are lethal.

Clean out the medicine cabinet and dispose of all unused, out-of-date-medications.

2. Ensure poisons, pesticides and, if applicable, agricultural chemicals are locked away. Dispose of all unwanted poisons, pesticides and agricultural chemicals.

3. Remove dangerous knives like machetes, and crossbows. If the person has fashioned a hose for carbon monoxide poisoning or has fashioned a noose, remove these too.

Please note: staff are not expected to remove anything from a person's property. They are to advise family and/or the police.

Follow up
The suicidal client must be reviewed face-to-face and via telephone as often as directed by the MDT and / or on-call psychiatrist until the period of risk has passed.

The client can remain under the care of the TACT in the acute phase then referred for case management to the CMHT. Care is formally handed over at the time of the Partnership Appointment.

If the client does not attend for a scheduled appointment the TACT/case manager must make telephone contact as soon as possible and if no answer, should phone family/whānau/caregivers detailed on the Consent Form.

If no contact is made within 2 hours and there is serious concern about risk to self or others the Police will be contacted and a Welfare Check requested.

Child and Adolescents
If a child or adolescent presents after hours and there is concern about serious suicide risk, they will be assessed by the TACT with discussion with the on-call Adult Psychiatrist. The assessment and management plan will then be discussed with the most appropriate iCAMHS staff the following day and arrangements made for the client to be reviewed by the Child and Adolescent Psychiatrist as soon as possible.

In the event an adolescent is unwilling to engage, the case manager or Tact Team will meet or make phone contact with the family/whanau/caregivers to develop a clear Safety Plan (Crisis Plan

If the risk is at a lower level it may be prudent to discuss the situation with the child's family/whānau/caregivers by phone (including the child if of appropriate age) and to formulate a Safety Plan for overnight. The duty ICAMHS worker or case manager will then see them the following day.

Assessment of Intoxicated People
People who present expressing suicidal ideation or following a suicide attempt whilst grossly intoxicated are likely to be detained in the police cells or in a 'health facility' (ED or the Kensington Centre) for the prevention of suicide. The decision as to where the person should be seen will be made by the police and Tact Team. They can only be held at the cells for a maximum of 6 hours. Following this they will be assessed by the TACT Team and a Safety Plan developed as for any other client. This includes family/whānau/caregivers involvement. Assessment should focus on their immediate risk and a management plan formulated to address this

Those presenting with suicidal ideation whilst intoxicated, but not requiring police detention, will have a Safety Plan developed jointly with the family, Tact Team and police if they are involved (ie: called to the home due to a dispute) with arrangements made for the person to be contacted by Tact the following day.

Safety Plan (Crisis Plan)
All clients must have a Safety Plan which is reviewed and updated at each appointment.

The purpose of the Safety Plan:
- To minimise the risk and maximise the safety of the client.
- To establish an effective therapeutic partnership with the client and family/whānau/caregivers.
- To institute an effective management plan in keeping with the principles of recovery and good clinical practice.

As part of the Safety Plan the client and family/whanau/caregivers must be given contact phone numbers to call for advice in a mental health emergency or suicide crisis.

At a minimum, the following numbers should be provided:
- Need to Talk? - 1737 (phone call or text)
- SCDHB Mental Health Tact Team number 0800277997
- In an emergency, Police contact 111.

Emergency Department
A copy of the Safety Plan is to be sent to the Emergency Department (ED) for those people who have a history of suicidal ideation, suicide attempts and/or self-harm. This is to be kept up to date and is the responsibility of the case manager.

When clients present to the ED, staff are to check on Ajexus to see if the client is or has been involved with the SCDHB MHAS and contact their case manager.

These clients are discussed at the quarterly ED/Mental Health Interface Meeting to ensure that the Safety Plan is current and that the client still needs to be on this list.

Cultural Issues
Cultural contacts and beliefs must be considered in the assessment of clients.

This includes issues of identity, protocol within their culture, beliefs about suicide, culturally determined preferences for methods of suicide, use of interpreters and the involvement of family and specialist cultural workers.