TE WAIORA Nelson Marlborough Health

DHB Office
Braemar Campus

Private Bag 18
Nelson, New Zealand

14 March 2022

Andrew McGregor
Via Email: fyi-request-17710-041d40b1@requests.fyi.org.nz

Response to a request for official information

Dear Andrew

Thank you for your request for official information as transferred from the Ministry of Health and received 9 December 2021 by Nelson Marlborough Health (NMH)[1], followed by the necessary extension of time 27 January 2022 and notice of decision 16 February 2022, where you seek the following information:

1. ***Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation***

NMH response: Please see attached NMH Clinical guideline *Constipation management.*

2. ***Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR)***

NMH response: Please see attached NMH Pathway *Urinary Retention.*

3. ***Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain***

NMH response: Please see attached NMH Outline *Post-Surgical Pain.*

4. ***Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation***

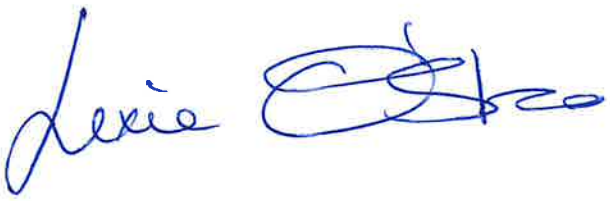
NMH response: We subscribe to national Guidelines in the first instance, and there are processes are in place for people who attempt suicide or have suicidal ideation.

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602. If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz

[1] Nelson Marlborough District Health Board

I trust this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely



Lexie O'Shea
Chief Executive

ATTACHMENT 1: *Constipation management* clinical guideline (7 pages)
ATTACHMENT 2: *Urinary retention* pathway (1 pages
ATTACHMENT 3: *Post-surgical pain* outline (2 pages)

Constipation Management in Adults

Contents

Definition

Constipation is the infrequent or difficult passing of a bowel motion. For the purposes of management, it has been defined as the absence of a bowel motion for a period of three days accompanied by other signs and symptoms as per the criteria below.

Scope

This guideline has been developed for clinical staff working with adult patients within NMH. It is particularly important for those post-surgery receiving opiates for analgesia and for patients vulnerable to constipation as a result of immobility e.g. stroke patients.

Statement

It is essential to identify patients with constipation and follow a management plan in order for them to achieve and maintain good bowel function and habits through timely, appropriate and individualized intervention strategies.

Criteria

Adult patients with the following signs or symptoms can be considered for this management strategy:-

- Less than 3 bowel motions within a week
- Change in stool frequency and consistency
- Excessively dry, lumpy, hard stools which are painful and/or difficult to pass (Types 1 and 2 Bristol Stool Chart)
- Breath-holding, straining or bearing down to pass a motion

- Leaning back/rocking from side to side and or pulling in / supporting the tummy muscles
- Sense of fullness, obstruction or incomplete emptying of the bowel
- Using the hand to help empty the bowel
- Abdominal pain and/or distension
- Nausea and/ or decreased appetite
- Review the patient's medical record for a history underlying medical conditions or surgical procedures that could increase the risk for constipation and discuss with medical team the potential for bowel obstruction

Procedure

1. Identify patients with constipation problems using the above definition and criteria
2. Document bowel habit in bowel chart (see appendix 1) and/or use 'bowel stamp' on each shift in clinical notes.
3. Follow the constipation model of assessment, intervention and treatment plan (flow chart - appendix 4)

   Ensure adequate dietary fibre and fluid intake. Encourage regular exercise (within current capabilities)
4. Encourage and facilitate the use of the gastro-colic reflex[1]
5. Ensure correct seating position for bowel emptying[2] unless this is contra-indicated by medical condition or recent surgery
6. Ensure patient privacy

   Review the patient's medications. Check for medications that affect bowel activity, such as analgesics, antibiotics, some anticholinergics, antiparkinsonian agents, aluminium hydroxide, calcium carbonate antacids, diuretics, iron preparations, opiates, phenothiazines, sedatives, and tricyclic antidepressants. In consultation with the medical team increase the use of laxatives (see appendix 3 relating to opiate use).
7. Encourage increased fibre and fluids to achieve a good bowel habit.
8. Ensure laxatives are prescribed as per 'assessment, treatment and intervention' flowchart (appendix 4) and administer as recommended.
9. Provide patient and/or their family member with the patient pamphlet '*Constipation: a guide for patients and their whanau*' and develop an individualised plan with them which is written on their pamphlet. Answer questions and provide further education as required
10. Document all interventions

Associated Documents

- NMDHB Medication Administration Policy
- '*Constipation: A Guide for Patients and their Whanau*' pamphlet

[1] The Gastro-Colic Reflex occurs 15-20 minutes after a meal, when peristaltic waves move the bowel contents from the colon to the rectum. The nerve endings are activated providing a sense of fullness with the desire and urge to empty the bowel. Constant delay contributes to constipation.

[2] Knees should be higher than the hips and slightly apart with the feet raised (e.g. on a footstool) if appropriate. Encourage patient to lean forward at the hips, keeping the back straight, gently bulging the abdomen forward, working with the urge to go.

References

Continence Foundation of Australia. *Bristol Stool Chart.* https://www.continence.org.au/pages/bristol-stool-chart.html Retrieved 25/7/2017

Grainger, M., Castledine G., Wood, N. and Dilley, C. (2007) Management of constipation in long-term care settings: research study. Part 1. *Br J Nursing* 16(18): 1128-31

Grainger, M., Castledine G., Wood, N. and Dilley, C. (2007) Management of constipation in long-term care settings: research study. Part 2. Br J Nursing 16(19): 1212-17

Hawkes Bay DHB *'Constipation: A Guide for Patients and their whanau'* leaflet

Lippincott Procedures: *'Bowel Training'* https://nm.healthpathways.org.nz/index.htm

Nelson Marlborough Health Pathways: *'Constipation in Adults'* https://nm.healthpathways.org.nz/index.htm Retrieved 25/7/2017

Waitemata DHB constipation pamphlet downloaded from http://www.waitematadhb.govt.nz/Portals/0/Documents/Health%20Professionals/RN-Care-Guides/P10_11_GastroIntestinalConstipationGuidelines2012.pdf

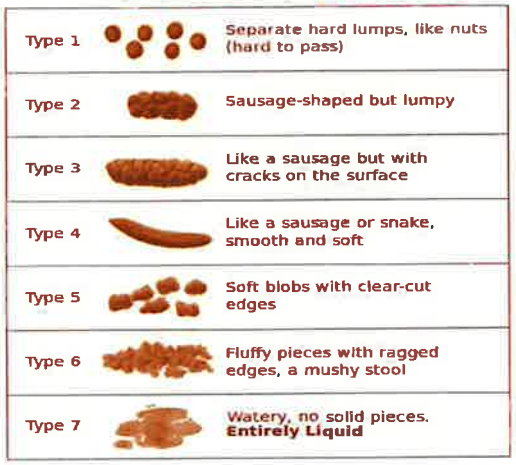
Appendix 3: BOWEL CHART

Patient Label

Date of last bowel motion prior to admission:

_____

Bristol Stool Chart



Bowel Motion				**Document type (1,2,3 etc and size S,M or L)**
Date	**A**	**P**	**N**	Interventions e.g. laxatives, foods - kiwifruit

Appendix 2: DRUGS OVERVIEW

Types of drugs used for constipation:

1. **Bulking agents: e.g. psyllium (Konsyl D[3]),**

- Good for maintenance.
- Must have adequate fluid intake at the time of administration (1 full glass of water).
- These agents require 2-3 days to exert their effect and are not suitable for acute relief.
- Avoid if peristalsis is impaired, such as for late stage Parkinson's Disease, Stroke or Spinal Injury and existing faecal impaction or bowel obstruction.

2. **Osmotic Agents: e.g.lactulose, e.g.Lax Sachet** - maintain fluid content in the stool.

- Often the first choice for constipation because they are gentle with few side effects.

3. **Stimulants: e.g. senna, e.g. bisacodyl** - stimulate intestinal movement.

- Use sparingly, these can result in electrolyte imbalance and abdominal pain.
- Prolonged use can precipitate lack of colon muscle tone and hypokalaemia.
- Contraindicated in suspected intestinal blockages.

4. **Softener and Stimulant: e.g. docusate and sennosides (laxsol)**

Suppositories: Medicated suppositories should be inserted blunt end first. Lubricant suppositories should be inserted pointed end first.

a. **Lubricant (glycerine)** - lubricate anorectum and have a stimulant effect. Should be inserted into the faecal mass to aid softening of the mass. No significant side effects.

b. **Stimulant (glycerol, bisacodyl)** - must be inserted against the mucous membrane of the rectum, and not into the faecal mass

c. **Osmotic (rectal phosphates)**

Enemas: follow instructions on the product.

a. **Micolette (sodium citrate)**
b. **Fleet enema (sodium phosphate)**

[3] Trade names as per New Zealand Drug Formulary

APPENDIX: 3 OPIATES – LAXATIVE PRESCRIPTION LADDER

- Preventative measures such as ensuring privacy and comfort, encouraging activity and increasing fluid intake and good diet should be ongoing during care
- Rectal intervention should be avoided where possible, but may be necessary where oral medication has been unsuccessful
- Since opioids reduce peristalsis, causing hard faeces to form, the most useful laxatives are those that increase peristalsis and soften the stool. Bulking agents are not recommended.
- During the therapy with laxatives it is recommended to drink sufficient amounts of fluids (1.5–2 litres, equal to 6-8 glasses) during the day
- Lactulose - Several days (2-3 days) of treatment may be needed before treatment effect occurs. Avoid if poor fluid intake.
- Rectal laxatives may be used for faecal impaction or if there is insufficient response to oral laxatives.
- Timely recording and documentation is crucial
- USE THE STAMP!

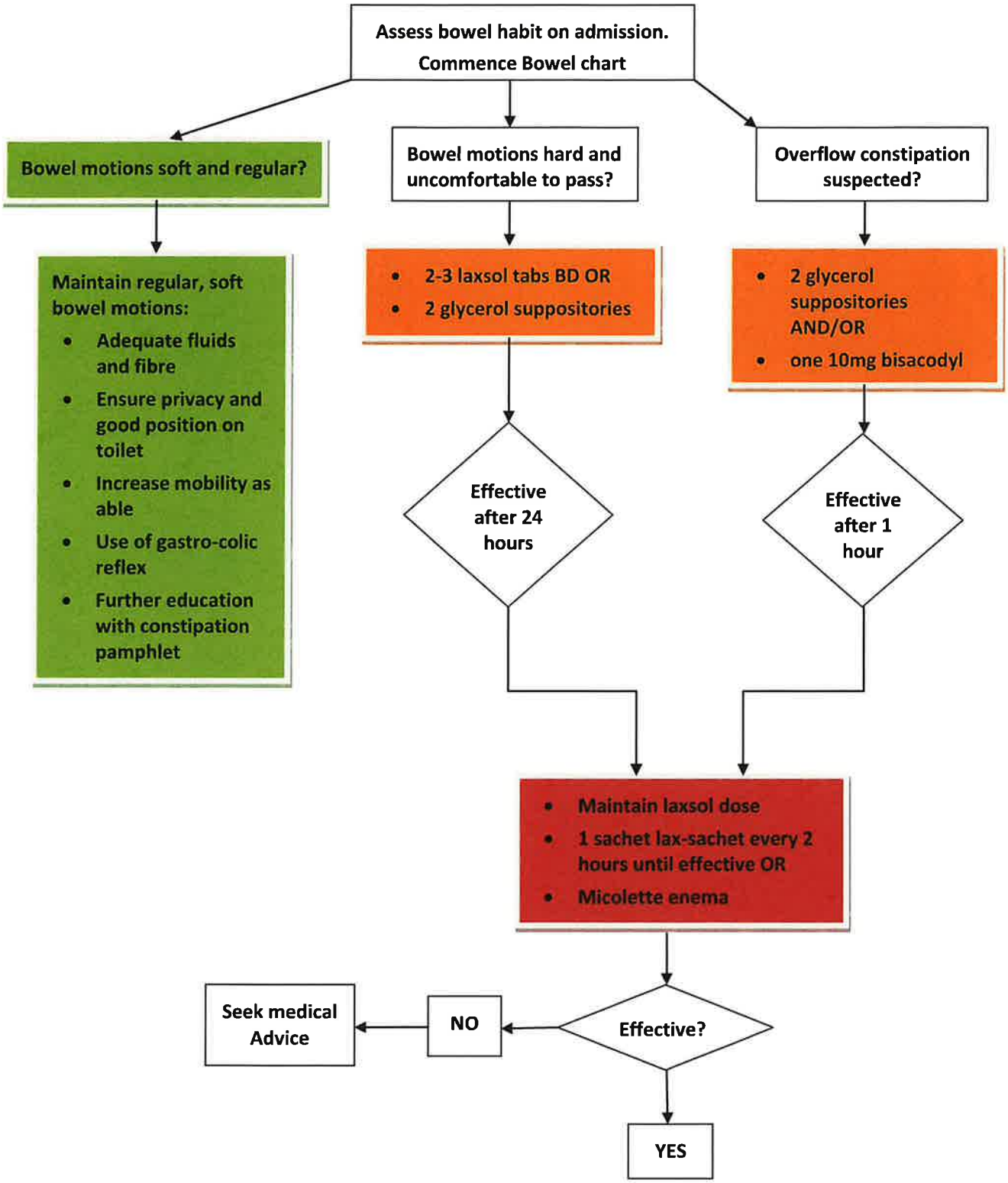
Step 1	Prescribed Opioids	Docusate/Senna Tablets 50/8mg (Laxsol) Regular 2 Tablets BD	
Step 2	BNO for 1-2 Days	Continue regular Docusate/Senna 50/8mg Tablets AND Add regular Lactulose 20-30ml BD	
Step 3	BNO for 3 Days+	Continue regular Docusate/ Senna Tablets & Lactulose Add Lax-sachet 2 stat. Consider rectal route –suppository/micro-enema	
Step 4	BNO for 5 days+	Continue Docusate and Senna Tablets Add regular Lax-sachet 2 BD Consider rectal route – suppository or micro-enema	

Hard or soft faeces?

Hard faeces - use osmotic laxative (Lax-sachet or lactulose)
Soft faeces – use stimulant laxatives (laxsol or bisacodyl)
Or try Glycerol 3.6G suppositories into hard faeces and bisocodyl 10mg suppositories against side wall of rectum for soft faeces

Developed by the Safer Opioids Group, NMDHB, January 2016.

APPENDIX 4: Flowchart of assessment, treatment and intervention



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Emergency Departments – NMDHB

Emergency Department Pathway for Urinary Retention

Take blood to check renal function (creatinine, eGFR) and prostate specific antigen (PSA)

Place indwelling catheter (IDC) and document volume drained. In general a 14F is a reasonable starting point, size up if necessary

- Ensure to discuss post-radical prostatectomy patients and patients with artificial urinary devices with the Urologist on call prior to inserting IDC

In the event of catheter failure discuss with Urologist on call {they will elect to try again/use introducer/flexible cystoscope or in some cases may recommend a suprapubic catheter (SPC)}

SPC should rarely be required and should be preceded by an ultrasound scan to identify the bladder

No ED doctors will be expected to place an SPC unless they feel comfortable/experienced with both ultrasound and SPC insertion. Call for help from the Urologist if required

A Bonanno catheter would be the first choice in the ED

Discuss with ED SMO and consider admission for management of possible post-obstructive diuresis

Otherwise patient sent home with IDC in situ with patient education as per usual

Refer to district nursing and provide patient with catheter take-home pack

Start all males on escalating dose of Doxazosin if they are without symptoms of postural hypotension

- 1mg PO nocte for 3 days, 2mg PO nocte for 3 days, 4mg PO nocte thereafter

Follow Up: (Nelson only)

- Fill out a yellow Outpatient Referral form and send to UROLOGY Secretaries Level 7, stating ''Urinary retention TROC in one week" and any relevant details. The Urology Secretaries will then book the TROC in the Day Stay Unit and notify the patient of the day/time. If the TROC is unsuccessful, the DSU Nurses will notify the Urology Secretary who will give the referral to the Urologist for triaging.

Date initiated:	Author: C Abbott, R Windish, S Beuker, B McLaughlin	Distributed to:
Date approved:	Signature:	Emergency Department
Date for review:	Position: Emergency Physician	

"Please provide Guidelines/procedure for the management/prevention of persistent Post-surgical Pain"

NMH response

The International Classification of Diseases (ICD-11), defines Chronic post-surgical or post-traumatic pain as; chronic pain that develops or increases in intensity after a surgical procedure or a tissue injury and persists beyond the healing process, ie, at least 3 months after the surgery or tissue trauma. The International Association for the Study of Pain Factsheet; *Prevention of Chronic Post-Surgical Pain (1)*, provides a concise overview of the complexity of this area of pain management.

Strategies to **prevent** the development of persistent post surgical pain are part of routine practice in Anaesthesia. The Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine publication *Acute Pain Management: Scientific Evidence (2)* gives a clear overview of the evidence and recommended practice in this area. They describe pre-operative, Intraoperative and postoperative risk factors for persistent pain, some of which may be modifiable. The approach taken in practice is therefore individualised to each patient to reflect their circumstances. Particular emphasis is placed on the effective management of acute post operative pain including the use of multimodal analgesic regimes. Regional anaesthetic techniques, local anaesthetic infusions, ketamine infusions and patient controlled opioid analgesia are all commonly used as part of acute pain management in NMH.

Management strategies for established persistent post-surgical pain after 3 months are usually initiated by surgical specialists and general practitioners. Multidisciplinary persistent pain services in the community for adults are coordinated by the Primary Health Organisations. Referral to these services can be made by general practitioners and hospital specialists.

Risk Factors for the development of Post-surgical pain

Preoperative factors

Pain, moderate to severe, lasting >1 mth
Repeat surgery
Psychological vulnerability (eg catastrophising)
Preoperative anxiety
Female sex
Younger age (adults)
Workers 'compensation
Genetic predisposition
Inefficient diffuse noxious inhibitory control Opioid use (particularly if ineffective)

Intraoperative factors

Surgical approach with risk of nerve damage

Postoperative factors

Pain (acute, moderate to severe and subacute)
Radiation therapy to area
Neurotoxic chemotherapy
Depression
Psychological vulnerability Neuroticism
Anxiety
Pain and anxiety trajectories

1) International Association for the Study of Pain Factsheet; Prevention of Chronic Post-Surgical Pain. *https://www.iasp-pain.org/resources/fact-sheets/prevention-of-chronic-post-surgical-pain/*

2) Schug SA, Palmer GM, Scott DA, Alcock M, Halliwell R, Mott JF; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2020), Acute Pain Management: Scientific Evidence (5th edition), ANZCA & FPM, Melbourne.