Waitematā
District Health Board
Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 489 0527

26 January 2022

[redacted]

Dear [redacted]

Re: OIA request – Guidelines and protocols for management of medical conditions

Thank you for your Official Information Act request, transferred to us by the Ministry of Health on 9 December, seeking information from Waitematā District Health Board (DHB) about guidelines and protocols for the treatment and management of patients with a number of medical conditions.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

In response to your request, we are able to provide the following information:

1. **Please provide guidelines/procedures for the management of postoperative urinary retention (POUR).**

Please see our protocol for Post-Operative Urinary Retention – **Attachment 1**.

2. **Please provide guidelines/procedures for the management/prevention of persistent postsurgical pain.**

While our surgical specialties do not have specific policies for the management/prevention of persistent post-surgical pain, we have Enhanced Recovery After Surgery (ERAS) protocols as follows:

- ERAS - Anaesthetic and fluid balance protocol – **Attachment 2**
- ERAS - Rectal & Pelvic Surgery – **Attachment 3**
- ERAS - Small Bowel & Colon Surgery – **Attachment 4**

Patients can also be referred to Waitematā DHB's Pain Management service or our Palliative Care team. Information on these services is available on our website as follows:

https://www.waitematadhb.govt.nz/hospitals-clinics/clinics-services/pain-management-unit/
https://www.waitematadhb.govt.nz/hospitals-clinics/clinics-services/palliative-care-services/
https://www.waitematadhb.govt.nz/health-professionals/medicines/palliative-care-guidelines/

3. Please provide guidelines/procedures in the treatment of patients after a suicide attempt and/or suicidal ideation.

People with suicidal ideation, or those who have attempted suicide, may present to or within any part of the DHB. The immediate priority is to ensure any imminent risk is contained, whether that risk be related to ongoing ideas of self-harm or related to the medical consequences of a suicide attempt.

Referral for specialist psychiatric assessment follows after this immediate risk is addressed. Depending upon where the person is and the nature of the presentation, this assessment will be carried out by the liaison psychiatry service or by the acute community mental health service. Assessment and the subsequent treatment plan is guided by Waitematā DHB Specialist Mental Health and Addiction Service guidelines on risk assessment and safety planning – **Attachment 5**. Ongoing care by the Specialist Mental Health and Addiction Service will be determined by the outcome of the assessment. Considerations include (but are not limited to) hospital inpatient care; acute residential community care; respite care; or acute community care provided in the person's own residential setting.

4. Please provide guidelines/procedures differentiating subtypes of primary (idiopathic) constipation.

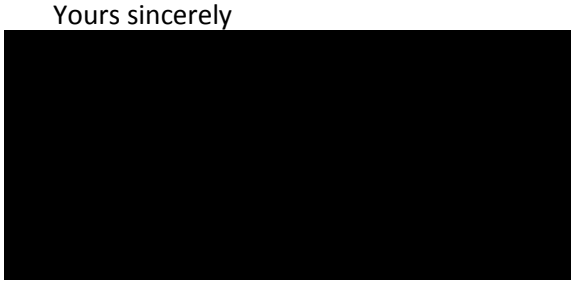
Waitematā DHB has guidelines for managing constipation – **Attachment 6**. However, please note that these do not differentiate between subtypes of primary (idiopathic) constipation.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community 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 consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



Acting Executive Director Hospital Services
Waitematā District Health Board

Post-Operative Urinary Retention

1. Overview

Acute urinary retention postoperatively is not uncommon. This is a protocol outlining the basis of the problem and its management.

1.1 Contributing Factors

Postoperative retention occurs due to a combination of pre-existing problems, perioperative factors and factors specific to certain operations.

Pre-Existing Problems

- BPH – benign prostatic hyperplasia
- Urethral strictures
- Poor bladder function – e.g. following stroke, previous pelvic surgery

Peri-Operative Factors

- Opiate analgesia can impair bladder contractility
- Perioperative fluid loads, or the use of increased perioperative diuretics
- Pain, especially following hernia surgery, perineal operations and anal procedures. This is due to inhibition at sacral reflex level.
- Constipation
- Anti-cholinergic medications

Operations with Specific Risk of Retention

- Abdomino-perineal resection for rectal cancer.
- Wertheim's hysterectomy.

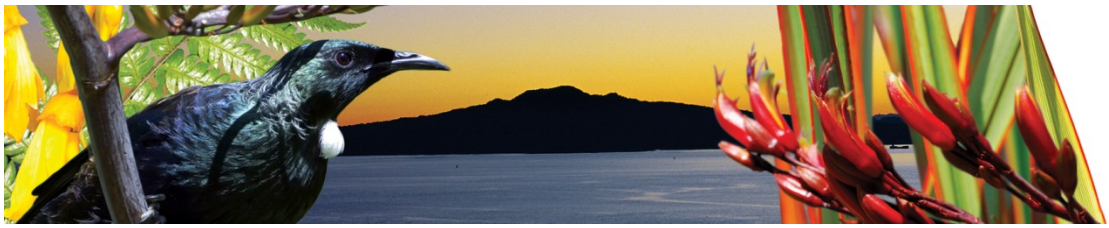
This is due to resection of the pelvic plexus (which enervates the bladder along with the other pelvic viscera).

2. Recommended Actions

Step	Action
1	**CATHETERISE THE PATIENT.** • **Avoid procrastination**, as over distension of the bladder worsens the chance of the patient voiding again. • When the catheter is placed note the volume drained. If you suspect infection send a catheter specimen for culture. • Rectal examination after inserting the catheter is useful to check for constipation as well as to evaluate the prostate. • Take a brief history to establish whether the patient had normal voiding before surgery, or whether they had significant pre-existing prostatic symptoms such as getting up several times at night, a weak or intermittent flow, frequency, urgency etc.
2	**Remove and/treat predisposing factors** Treat constipation, discontinue anticholinergic drugs, treat any local painful stimuli with appropriate analgesics e.g. after haemorrhoid surgery.
3	**Start an alpha-blocker in men over the age of 50** This may be omitted if the patient has absolutely no pre-operative history of any lower urinary tract symptoms or voiding difficulties.

Post-Operative Urinary Retention

Step	Action
	Suggested regime is to start Doxazosin 2mg nocte for 3 days, then 4mg nocte with GP following thereafter. Patient should go home on this medication.
	Notes: • Doxazosin's main side effect is reduction in blood pressure causing postural hypotension. Monitoring of lying/standing blood pressure is recommended when initiating medication regime. If the patient is in hospital when the Doxazosin is commenced, monitoring the blood pressure is not problematic and therefore the usual dose titration can be accelerated. • PSA is NOT useful unless the prostate is clinically malignant on rectal examination.
4	The patient should have **the bladder rested for a few days** and only have the catheter removed when it is appropriate for that patients situation, i.e. when they are mobilising comfortably and the catheter is no longer necessary for monitoring urine output etc. Post void residuals are important to assist in an appropriate trial removal of catheter (TROC) plan. • > 1500ml, patient unlikely to void. Plan for District Nurse to teach ISC at the time of TROC. • < 800 ml, patient has a good chance of successful TROC. • In between volumes, watch closely during TROC. If residual > 400ml, replace catheter.
5	Typically the catheter should be left in situ until the Doxazosin is up to full dose.
6	If the patient is able to only tolerate a lower dose of Doxazosin due to side effects, a trial removal of catheter could still be successful. • If the trial of void is **successful** they can be followed up by their general practitioner. • **Referral to Urology Clinic** If the trial removal of the catheter is **unsuccessful** or the patient had very significant pre-existing prostatic symptoms, then they will need to be referred to the urology service for assessment following discharge.



Waitemata District Health Board

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Attachment 2

Enhancing recovery after surgery

Anaesthetic and fluid balance protocol

Scope: This clinical pathway outlines the standard care for elective open or laparoscopic small bowel, colon and rectal surgery.

Premedication: No routine premedication. Midazolam in highly anxious patients.

Preoperative fluid management:

- Normal diet allowed until six hours before anaesthesia. Clear oral fluids allowed until two hours before anaesthesia. IV fluids not used prior to surgery.
- Most patients will have no oral bowel prep. Most patients will have 400 ml oral carbohydrate solution two hours prior to anaesthesia.

Epidural analgesia (currently used for all cases *including laparoscopic cases*):

- Insertion level T7-9 (all small bowel, colon and rectal surgery).
- Test before induction: 5-10 ml bupivacaine 5 mg/ml, check bilateral block (sensory loss to touch over dermatomes to be affected).
- Intraop block: 5-10 ml/h bupivacaine 0.125% + fentanyl 2 mcg/ml.
- Postop block: bupivacaine 0.125% + fentanyl 2 mcg/ml dosed as below.
- Epidural to be resited – if possible – if analgesia ineffective before 8pm on day of surgery. Otherwise start IV PCA with oxycodone 1mg bolus, 5 min lockout.

Postoperative epidural management for:

Small bowel and colon surgery	Rectal and pelvic surgery
• End of surgery – 8am **POD2**: Basal rate + PCEA (5 ml bolus / 20 mins lockout / 5 ml/hr).	• End of surgery – 8am **POD3**: PCEA + basal rate (5 ml bolus / 20 mins lockout / 5 ml/hr).
• POD2: Stop epidural 8am and start oral multimodal analgesia (see overleaf).	• POD3: Stop epidural 8am and start oral multimodal analgesia (see overleaf).
• Remove epidural at 4pm POD2.	• Remove epidural at 4pm POD3.
• Ensure Clexane is given more than 12 hours prior to removal and not within four hours after removal.	• Ensure Clexane is given more than 12 hours prior to removal and not within four hours after removal.

Induction and maintenance of general anaesthesia:

- TIVA using propofol (2.5-4.5 mcg/ml target range) or desflurane (0.6-1.5 MAC), along with either remifentanil (0.2-0.4 mcg/kg/min) or fentanyl (up to 5 mcg/kg) with BIS or entropy monitoring (target range 20-60 units).

Nasogastric tube:

- Only on indication (gastric distension).
- Pull before extubation.

Active warming: Core temp target >36°C by upper body warming and warm infusions.

Antiemetics: Follow routine hospital protocol.

Intraop maintenance fluid therapy:

- Avoidance of fluid and sodium overload is top priority.
- Give Plasma-Lyte 148 at 4 ml/kg/h + Gelofusin at 4 ml/kg/h.
- *Example:* For a 80-kg patient give 320 ml Plasma-Lyte 148 and 320 ml Gelofusin per hour of surgery.

Postop maintenance fluid therapy and transfusions:

- Start a bag of 500 ml dextrose-saline with 10mmol KCl to run until 8am POD 1, at which time IV fluids are discontinued. (Diabetics on GIK infusion (approximately 80 ml/h) need only their GIK).
- Note that total fluid intake on day of surgery is about 1000 ml PO (PreOp® + postop oral fluids) + 2500 ml IV = 3500 ml in total.
- If Hgb <80, house surgeon to review patient, alert seniors and consider transfusion of 2U RBCs. If Hgb 80-100, aim to transfuse RBCs only if symptomatic or ischaemic heart disease or evidence of ongoing bleeding.

Urine output:

- Target is ≥0.5 ml/kg/h.
- Examples: For 50 kg patient, 25 ml/h; for 80 kg, 40 ml/h; for 110 kg, 55 ml/h.

If urine output <0.5 ml/kg/h, house surgeon follows this management plan:

1. House surgeon to examine patient, review fluid balance and fluid status, and contact patient's anaesthetist and surgeon if any signs or symptoms of hypoperfusion (for example, sepsis or heart failure);
2. Give 500 ml of Plasma-Lyte 148 IV over 15 min;
3. Review urine output over next hour;
4. If urine output still <0.5 ml/kg/h go back to 1) repeating until 2 L Plasma-Lyte 148 has been given;
5. Obtain senior review.

Epidural-related symptomatic hypotension in theatre, PACU, HDU:

1) Metaraminol infusion per protocol; 2) ephedrine IV if bradycardic; 3) noradrenaline infusion.

Epidural-related symptomatic hypotension on ward: Follow the standard institutional Epidural Analgesia Protocol (No. 5.9.008)

All ERAS patients follow the standard institutional North Shore Early Warning System (NEWS) (No. 5.10.008)

Postoperative multimodal analgesia - these are prescribed by patient's anaesthetist on day of surgery in theatre:

Small bowel and colon surgery	Rectal and pelvic surgery
• From surgery – POD 1 8am: paracetamol 1g IV (or PO if tolerated) 6-hrly	• From surgery – POD 1 8am: paracetamol 1g IV (or PO if tolerated) 6-hrly
• From POD 1 8am: paracetamol 1g PO 6-hrly.	• From POD 1 8am: paracetamol 1g PO 6-hrly.
• From POD 2 8am – POD7: etoricoxib 60-90 mg PO OD **unless contraindicated.**	• From POD 3 8am – POD7: etoricoxib 60-90 mg PO OD **unless contraindicated.**
• From POD 2 8am – POD7: tramadol SR 100mg PO 12-hrly.	• From POD 3 8am – POD7: tramadol SR 100mg PO 12-hrly.

Breakthrough pain:

1) Assess epidural function and liaise with patient's anaesthetist;

2) Tramadol 50-100mg 6-hrly PO/IV PRN;

3) Oxycodone sustained release (Oxycontin) PO 5-10 mg BD PRN;

4) Oxycodone 0.5-1mg IV PRN as per DHB Opioid Protocol.

Waitemata District Health Board

Best Care for Everyone

Attachment 3

Enhancing recovery after surgery

Surgical team protocol: Rectal and pelvic surgery

Scope: This clinical pathway outlines the standard care for elective open or laparoscopic rectal and pelvic surgery inferior to the peritoneal reflection (such as low anterior resection, abdominoperineal resection, ileal pouch anal anastomosis and related procedures).

Deviations: Protocol deviations are authorised by the patient's surgeon or anaesthetist, and documented by the nurse on the *Care Plan.*

Length of stay: Expected length of postoperative hospital stay is 5 nights.

Before surgery

- Preoperative patient education 1-2 weeks before surgery.
- Bowel preparation as requested by the surgeon on the yellow waitlist form.
- Same-day admission.
- Normal diet is allowed until 6 hours before anaesthesia. Clear oral fluids are allowed until 2 hours before anaesthesia.
- Preoperative oral carbohydrate treatment 2 hours before anaesthesia. **Exceptions:** patients with insulin-treated diabetes; patients with signs of gastrointestinal obstruction (bloating, nausea).
- Admitting nurse ensures the time that the oral carbohydrate drink (Nutricia PreOp®) is taken is then documented on the *How to take your Nutricia PreOp® Drink* form and the Peri-operative form.

Surgery

- Minimally invasive techniques and short incisions are used.
- Abdominal wound drainage is avoided.

Day of surgery

- After surgery, 500 ml dextrose-saline + 10 mmol KCL is charted to run until 8am POD 1. Diabetics on GIK infusion (approx 80 ml/h) need no other IV fluids.
- Free oral fluids and a sandwich are offered 4 hours after surgery.
- Postoperative oral fluid intake target: 600 ml (including 400 ml Fortisip).
- Postoperative nutritional target: 2 bottles (400 ml) of Fortisip.
- Urine output target is >0.5 ml/kg/h (examples: for 50 kg patient, 25 ml/h; for 80 kg, 40 ml/h; for 110 kg, 55 ml/h). *See Anaesthetic and Fluid Balance Protocol for poor urine output action plan.*
- Mobilisation target: 2 hours out of bed (in chair or walking).
- Ensure paracetamol and Clexane (8pm) are charted.

Postoperative day 1

- IV infusion is stopped at 8am.
- Check the patient's body weight by 10am.
- Standard (not postoperative) diet is commenced.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 bottles (600 ml) of Fortisip. Some cooked food.
- Urine output target is >0.5 ml/kg/h (examples: for 50 kg patient, 25 ml/h; for 80 kg, 40 ml/h; for 110 kg, 55 ml/h). *See Anaesthetic and Fluid Balance Protocol for poor urine output action plan.*
- If the patient has an ileostomy record and consider the output volume.
- If the patient has a colostomy document the bowel functions.
- If the patient has a new ileostomy or colostomy, start daily stoma education.
- Mobilisation target: 8 hours out of bed (in a chair or walking). Four short walks (10 minutes each).

Postoperative day 2

- Check the patient's body weight by 10am.
- Standard diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 bottles (600 ml) of Fortisip. Half a cooked meal.
- Urine output target is >0.5 ml/kg/h (examples: for 50 kg patient, 25 ml/h; for 80 kg, 40 ml/h; for 110 kg, 55 ml/h).

  See Anaesthetic and Fluid Balance Protocol for poor urine output action plan.
- If the patient has an ileostomy record and consider the output volume.
- If the patient has a colostomy document the bowel functions.
- If the patient has a new ileostomy or colostomy, continue daily stoma education.
- Mobilisation target: 8 hours out of bed (in a chair or walking). Four short walks (10 minutes each).

Postoperative day 3 and onwards

- Urinary catheter removed at 8am.
- Make sure the epidural is stopped (and oral etoricoxib and tramadol are started) by 10am.
- Check the patient's body weight by 10am.
- Standard diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 bottles (600 ml) of Fortisip. Half a cooked meal.
- If the patient has an ileostomy record and consider the output volume.
- If the patient has a colostomy document the bowel functions.
- If the patient has a new ileostomy or colostomy, continue daily or twice daily stoma education.
- Mobilisation target: 8 hours out of bed (in chair or walking). Four short walks (10 minutes each).

Postoperative day 4 and onwards

- Standard diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 cartons (600 ml) of Fortisip. Half a cooked meal.
- If the patient has an ileostomy record and consider output volume.
- If the patient has a colostomy document the bowel functions.
- If the patient has a new ileostomy or colostomy, daily or twice daily stoma education.
- Mobilisation target: 8 hours out of bed (in chair or walking). Four short walks (10 minutes each).

Discharge criteria (patient to be discharged when all criteria are fulfilled)

No need for IV fluid infusions or nutrition (able to eat and drink).

No need for epidural or IV analgesia (pain scores ≤4 on oral analgesia).

No need for continued observation: normal temperature and vital signs, resumed bowel function (repeated flatus or stool, through the colostomy if the patient has a stoma).

Ileostomy output is within parameters for safe discharge.

If the patient has a new ileostomy or colostomy the patient is assessed as competent with stoma management.

After discharge

- ERAS nurse specialist (CNS) calls the patient 48 hours after discharge.
- After hours the patient telephones the discharge ward directly during the first 7 days after surgery in case of concerns.

  The telephone triage form is completed by the ward RN and faxed to the ERAS CNS for follow-up.
- Surgical clinic follow-up 4 weeks after surgery (Oncology referral sooner as appropriate).
- Community Ostomy CNS & District Nurse referral on discharge if the patient has a stoma.

Attachment 4

Enhancing recovery after surgery
Surgical team protocol: Small bowel and colon surgery

Scope: This clinical pathway outlines the standard care for elective open or laparoscopic small bowel or colon surgery (including high anterior resection without dissection below peritoneal reflection).

Deviations: Protocol deviations are authorised by the patient's surgeon or anaesthetist, and documented by the nurse on the *Care Plan.*

Length of stay: Expected length of postoperative hospital stay is 4 nights.

Before surgery

- Preoperative patient education 1-2 weeks before surgery.
- Bowel preparation according to Departmental *Bowel Preparation Protocol.*
- Same-day admission.
- Normal diet allowed until 6 hours before anaesthesia. Clear oral fluids allowed until 2 hours before anaesthesia.
- Preoperative oral carbohydrate treatment 2 hours before anaesthesia. **Exceptions:** pts with insulin-treated diabetes; pts with signs of gastrointestinal obstruction (bloating, nausea).
- Admitting nurse ensures that time oral carbohydrate is taken is documented on the *How to take your Nutricia PreOp® Drink* form.

Surgery

- Minimally invasive techniques and short incisions are used.
- Abdominal wound drainage is avoided.

Day of surgery

- After surgery, 500 ml dextrose-saline until 8 am POD 1. Diabetics on GIK infusion (approx 80 ml/h) need no other IV fluids.
- Free oral fluids and a sandwich offered 4 h after surgery.
- Postoperative oral fluid intake target: 600 ml (including 400 ml Fortisip).
- Postoperative nutritional target: 2 cartons (400 ml) of Fortisip.

- Urine output target is >0.5 ml/kg/h (for 50 kg patient, 25 ml/h; for 75 kg, 33 ml/h; for 100 kg, 50 ml/h). *See Anaesthetic Team Protocol for poor urine output action plan.*
- Mobilisation target: 2 hours out of bed (in chair or walking).
- Ensure paracetamol and Clexane (8 pm) charted.

Postoperative day 1

- IV infusion stopped at 8 am.
- Check body weight by 10 am.
- Standard (not postoperative) diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 cartons (600 ml) of Fortisip. Some cooked food.
- Urine output target is >0.5 ml/kg/h (for 50 kg patient, 25 ml/h; for 75 kg, 33 ml/h; for 100 kg, 50 ml/h. *See Anaesthetic Team Protocol for poor urine output action plan.*
- Mobilisation target: 8 hours out of bed (in chair or walking). Four short walks (10 minutes each).

Postoperative day 2

- Urinary catheter removed at 8 am.
- Make sure epidural stopped (and oral etoricoxib and tramadol started) by 10 am.
- Check body weight by 10 am.
- Standard diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 cartons (600 ml) of Fortisip. Half a cooked meal
- Mobilisation target: 8 hours out of bed (in chair or walking). Four short walks (10 minutes each)

Postoperative day 3 and onwards

- Check body weight by 10 am.
- Standard diet.
- Oral fluid intake target: 1500 ml (including 600 ml Fortisip).
- Nutritional target: 3 cartons (600 ml) of Fortisip. Half a cooked meal.
- Mobilisation target: 8 hours out of bed (in chair or walking). Four short walks (10 minutes each).

Discharge criteria (pt to be discharged when all three criteria are fulfilled)

1. No need for IV fluid infusions or nutrition (able to drink and eat).

2. No need for epidural or IV analgesia (pain scores ≤4 on oral analgesia).

3. No need for continued observation: normal temperature and vital signs, resumed bowel function (repeated flatus or stool, through stoma if patient has stoma).

After discharge

- Colorectal nurse specialist calls pt 48 hours after discharge.
- Patient telephones Ward 8 directly during first 7 days after surgery in case of concerns.
- Surgical clinic follow up 4 weeks after surgery (Oncology referral sooner as appropriate).

Waitemata District Health Board
Te Wai Awhina

Risk Assessment and Safety Planning

Contents

Attachment 5

1. Overview

Purpose

The purpose of this policy and procedure document is to communicate the approved structure and processes for risk assessment and safety planning in mental health and addiction services. This will enable a consistency of practice across services and ensure alignment with current international best practice.

Scope

This policy and procedure applies to all clinical staff in Specialist Mental Health and Addiction Services (SMH&AS), **excluding Regional Forensic Psychiatry Services.** This policy also applies to all clinical staff in Mental Health Services for Older Adults.

Risk assessment and safety planning will be implemented throughout a person's engagement with Mental Health and Addiction Services. It is an on-going process, initiated at first point of contact and integrated throughout every person's episode of care. Risk assessment and safety planning cannot predict risk behaviours but can support planning to improve personal safety.

All clinical staff are required to complete the full day Risk Assessment and Safety Planning (RASP) training. This training has been designed to ensure clinicians will be able to implement the approved risk assessment and safety planning processes and tools to assess risk, formulate and communicate risk status and collaboratively develop a safety plan. The training is to be repeated every 3 years. It is expected that junior clinicians will consult with experienced clinicians during risk assessment and safety planning processes.

Identification of an increase in risk carries a duty to act on the information.

Definitions

Term	Definition
Risk	Risk is defined as the likelihood of an adverse event or outcome within a stated period. The purpose of the risk assessment and safety planning process is to work effectively with tangata whai i te ora and their family/whānau to help tangata whai i te ora maintain and promote their personal safety.
Tangata whai i te ora	Literally translates as person seeking wellness. Replaces "consumer", "service user" etc.

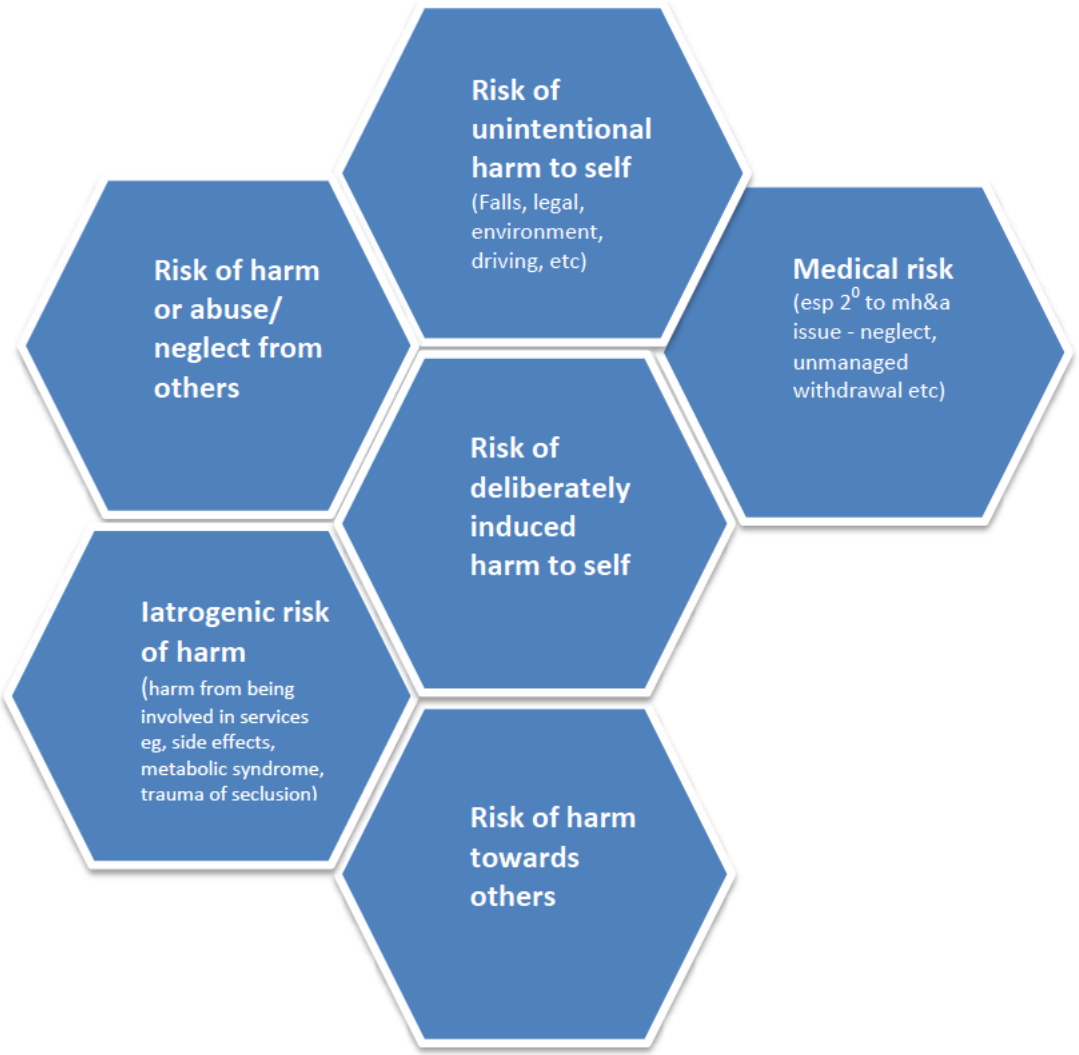
Risk Assessment and Safety Planning

2. Principles

Principle	How the principle is applied
An everyday experience	• Risk is an integral part of everyday life. As such risk factors and risk behaviours are an integral part of a person's journey through the service, and, risk assessment and safety planning cannot be a stand-alone process. • Risk assessment and safety planning is the business of every staff member • Risk assessment and safety planning occurs from the very first moment of contact to the very last contact and is an ongoing process that is woven into clinical practice • To assess risk it is essential to understand the situational and dynamic factors that contribute to the level of risk for an individual • Risk assessment and safety planning highlights where increased attention to a person's needs and treatment planning are required
Collaboration	• Risk assessment and safety planning is based on the principle of tino rangatiratanga or self-determination (ie, led by the tangata whai i te ora), as much as possible • The clinician-tangata whai i te ora relationship is primary and essential for robust information gathering • Family/whānau know the person and their stressors. They should not be asked if they think a person is at risk, but can be asked if they know of anything that might be concerning to their family member, or if they themselves are worried about the person. The term "at risk" is unlikely to be familiar to family/whānau. • **Reports from family/whānau about increased concern** must immediately result in further clinical review or a discussion with the responsible medical staff (including on-call staff out-of-hours). The person should be engaged in a further risk assessment and review of the safety plan should occur. In an inpatient unit the level of observation should be immediately increased and only reduced after medical review • The whole process of risk assessment and safety planning should promote communication amongst teams, and support collaboration with tangata whai i te ora and family/whānau • Supporting resources should be mobilised from the person's community as possible • Risk formulation should be multidisciplinary and not carried out alone
Sensitivity to diversity	• All staff involved must demonstrate awareness of diversity in relation to ethnicity, religion, age, gender, disability status, residency status, and sexual orientation. All staff involved must understand the impact the above factors may have on risk behaviours and safety planning. Cultural safety is required in risk assessment and safety planning processes.
Suicide risk assessment	• The purpose of a risk assessment for suicide is not to attempt to predict suicide but to inform effective treatment planning. The focus is on engaging with tangata whai I te ora and family/whānau to understand their stories and to develop individualised risk formulations that inform a care plan and support safety planning and smooth transitions of care (Pisani et al., 2016).
Tools	• All staff will utilise the tools aligned with the training for the risk assessment and safety planning process • Risk assessment and safety planning documentation is a communication tool, so should be modified to reflect any changes in a persons' circumstances, after discussion with the person and their family/whānau • Standardised assessment and actuarial tools should be considered supplements to the risk assessment and safety planning process, not a replacement for clinical processes

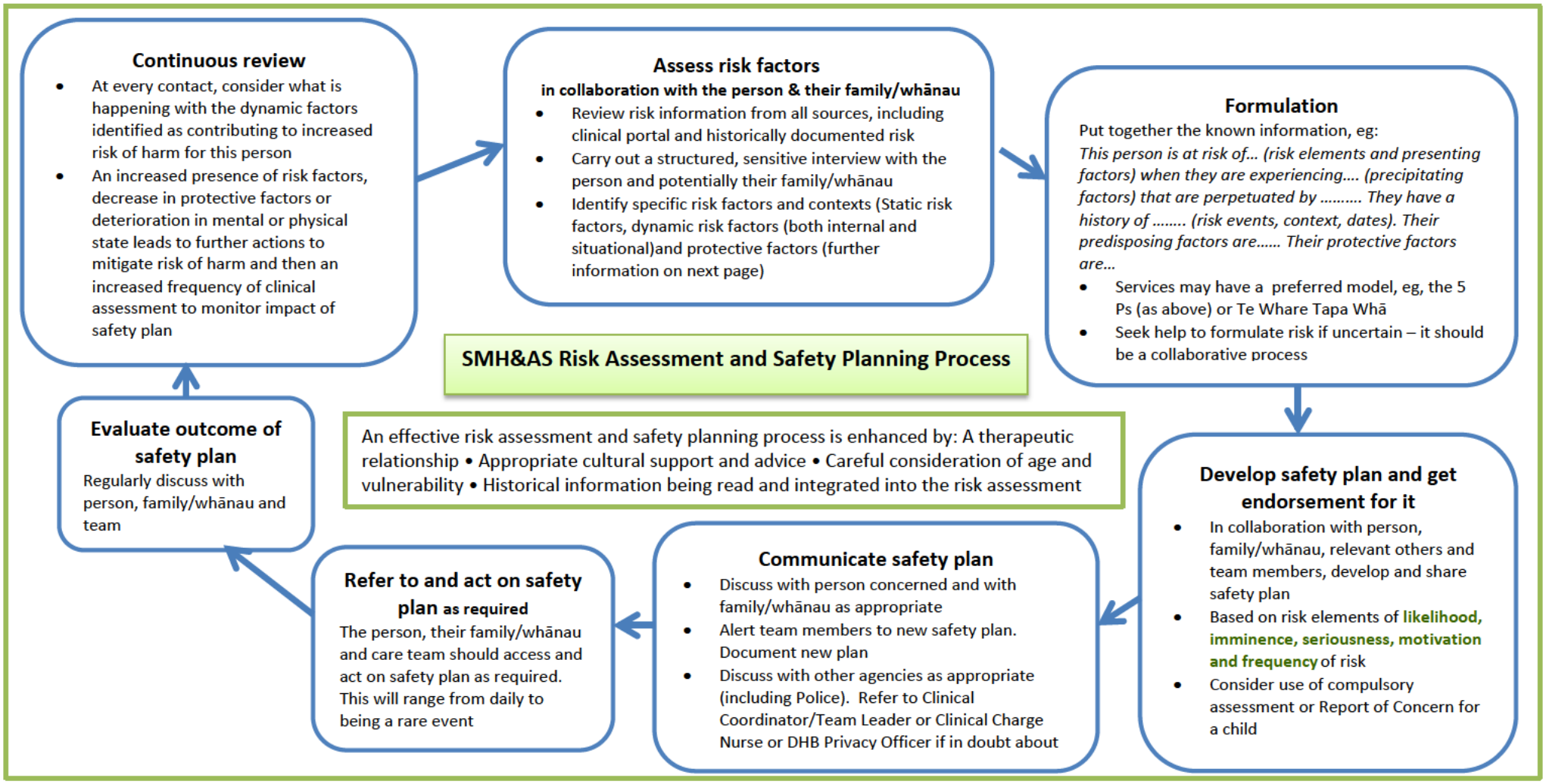
Risk Assessment and Safety Planning

3. Types of risk



Risk Assessment and Safety Planning

4. Risk assessment and safety planning process



Risk Assessment and Safety Planning

4.1 Assessment of risk factors

Static, dynamic, internal, situational and protective factors

Risk factors are the particular features of illness, behaviour or circumstances that in combination lead to lowered or increased risk.

Risk factor type	Description	Examples of risk factors (not exhaustive list)
Static risk factors	Those risk factors and variables which are either unchanging or not subject to change as a result of treatment interventions	• Age • Ethnicity • Previous suicide attempt • Previous convictions • Unresolved childhood trauma
Dynamic risk factors	Dynamic risk factors can be subject to rapid change in seriousness and imminence for some people. Both internal and situational risk factors are subject to change if circumstances, mental state, effective treatment or safety planning change, for example. **Internal** Experienced only by the person; mental state **Situational** Environmental context and influence	**Internal** • Delusions, particularly persecutory or jealous type • Auditory hallucinations, particularly command type • Intense anger or perceived rejection • Cognitive issues/impaired reasoning • Emotional dysregulation • Frantic hopelessness **Situational** • Impulsive alcohol / drug use with housemates • Housing/living situation • Loss of relationship; violent relationship • Access to firearms and other means • Legal issues • Internet use (especially young people). Time spent online can impact sleep and other activities • Intentional self injury • Access to medications
Protective factors (dynamic in nature)	Characteristics, variables and conditions that enhance resiliency and resistance to risk **Don't assume. Protective factors are unique to the person and change over time and with acuity.** Explore what is protective for the person and how this could be enhanced. **Protective factors may not necessarily provide a buffer when acute risk is present,** or when the person feels a burden to people who might ordinarily be protective.	• Connectedness and belonging • Strong family and/or whānau links • Family, whānau, significant others as partners in care and safety planning • Being engaged in treatment • Access to culturally appropriate services • Spirituality / religious beliefs • Resilience and coping skills • Pets • Social supports including peer support • Having a job/routines • Hope • Good physical health • Living with others

Risk Assessment and Safety Planning

Sources of risk assessment information

Risk assessment requires linking historical and current information about illness, behaviours or personal and other characteristics **and** circumstances **to help anticipate future events.**

Risk assessment is best achieved with information from multiple sources, including:

- clinical interview and observation
- other informants such as family/whānau, friends and work colleagues
- previous regional clinical records (ctrl Y view in HCC to see forms and documents)
- Clinical Portal for a snapshot of medical, prescribing and dispensing information
- other health records such as GP files
- Police and Court records.

Family and whānau are an important source of information
Significant weight should be given to information and opinions gained from those who know the person well, as they will be well-positioned to see a change from usual behaviour.

When is risk to be assessed?

The comprehensiveness of risk assessment will always be relevant to the particular presentation and circumstances, and a plan should be developed on that basis. **In the case of a need to create an immediate safety plan, a more comprehensive risk assessment must be completed after the immediate risk period has passed. Note: Prior to new assessment, read available history. Use Ctrl Y on HCC to see regional record.** See the table below for more information.

Comprehensiveness of assessment	When	Documentation
Assessment focused on current presentation	• Acute presentation with acute safety risks	• Assessment/Risk form • Treatment plan • Clinical notes
Comprehensive assessment	• Acute assessment, if appropriate • Comprehensive assessment after acute risk is contained • Any new or renewed contact with service • Inpatient unit admission, leave, discharge • **Contact from family/whānau with concerns** • Compulsory assessment • In an ongoing way for those with high risk behaviours • After serious incidents • Any significant change in circumstances (eg, loss of job/role, relationship, significant anniversary)	• Assessment form (or discharge documentation if one-off assessment/ consult) • Treatment plan • Clinical notes • Regional history form (if used by service)
Review and update	• After situational changes • Prior to transfer or discharge from service – *Planned discharge must be reconsidered if risk assessment shows imminent or short term risks* • Treatment review • Documentation update as required by service	• Regional history form (if used by service) • Treatment review • Document change in safety plan in clinical notes also
Routine screening	• **Every** face to face clinical contact • Phone contacts with tangata whai i te ora or others where risk is discussed *(eg, "no change in known risk factors"), or document the revised formulation and safety plan	• Document in notes that screening has occurred and outcome*

Risk Assessment and Safety Planning

4.2 Formulation

"A process of summary and organisation of the risk data, and identification of the risk factors. It provides the information base for safety planning" (Ministry of Health).

Formulation requires consideration of all known information, and particularly looking for patterns of risk behaviour and related circumstances.

Risk elements and levels

Identifying level of risk requires consideration of the following five elements. Using this terminology consistently helps all people involved have a consistent understanding and builds the context for individual safety planning. Each element should be considered for each risk type. This is the Waitematā DHB and MoH preferred method for estimating and communicating level of risk.

The risk elements to be described in the formulation and considered in safety planning are:

- **Likelihood**
- **Frequency**
- **Seriousness**
- **Imminence**
- **Motivation**

Typically written as:

This person is at risk of… (elements and presenting behaviours) when they are experiencing…. (precipitating) that are perpetuated by ……. . They have a history of …….. (risk events, context, dates). Their predisposing factors are…… Their protective factors are…

Risk formulation statement example 1:

Jack is at likely risk of further physical assaults to his girlfriend and at potential risk of physically assaulting someone from the police - including Officer Andrew Wallis or any male as he is motivated by the thoughts that they may be sleeping with his girlfriend. Jack expresses his thoughts of jealousy more frequently when he is highly aroused, lacking sleep, and experiencing untreated delusions and hallucinations. Jack has a history of physical assaults on a woman and a conviction for rape and has serviced time for illegal possession of a firearm. Jack is predisposed to stopping his prescribed antipsychotic medications however he has a good relationship with his key worker and good family support. Jack hopes to learn a trade one day and sees this as an opportunity to stay out of trouble.

Risk formulation statement example 2:

Melissa is at imminent risk of acting impulsively and aggressively towards figures of authority. She is also at risk of planned violence towards her stepfather, and to a lesser and perhaps more impulsive degree, her mother and brother. Melissa is at serious risk of engaging in dangerous driving whilst intoxicated and illegal driving without a license, having done this several times in the past in the context of youth drinking culture, peer pressure and the rural environment. There is a safety risk to the public road users. Melissa is more likely to engage with risk taking behaviours when she drinks alcohol, engages with her stepfather, experiences loss or rejection (relationship break up/loss of whānau connection) or is triggered by the trauma of growing up with a violent father.

The following act as protective factors:

-Caring, help seeking and somewhat reflective mother who is supported by a partner.

-Mother has initiated referral, assessment and is hopeful for intervention. Is trying to put boundaries around Melissa's recent behaviours.

-Has a history of engagement with a positive adult (rep rugby coach, and past positive peer relationships) who are concerned about her and want to help.

Risk Assessment and Safety Planning

Risk formulation example 3:

Tom is at risk of self harm by overdose of prescribed medications when he is experiencing low mood and drinking alcohol. Tom had a serious suicide attempt in 2019 when he went to his family's isolated bach and took an overdose. This was during an episode of depression in the context of losing his job. The risk of self harm is likely to increase when he self isolates or argues with his partner - arguments are usual triggered by financial pressures. Tom is in full time employment but not in his chosen field which is a cause of great frustration. Tom's lack of motivation prevents him from perusing alternative work opportunities.

Protective factors include weekly dispensing of medications from the pharmacy to avoid stockpiling and having a supportive brother who is currently staying with him and his partner. Tom says that he does enjoy the occasional round of golf with his brother.

Risk Assessment and Safety Planning

4.3 Safety planning

"... aims to minimize the likelihood of adverse events within the context of the overall treatment and recovery processes of an individual, to achieve the best possible outcome, and deliver safe, appropriate and effective care" (Ministry of Health).

Developing the safety plan

In our context **safety plans are part of the overall treatment plan** as the most likely risk mitigation is to develop a comprehensive plan that addresses the relevant psychological/social/cultural/bio-medical issues contributing to increased risk. Not all will be in our domain to address or take responsibility for – but we should be offering advice and direction in respect of those and considering them in our overall treatment plan.

Safety plans should be developed in collaboration with the person concerned as often as possible. When this is not possible safety plans should take into account the person's perspectives and wishes and be developed in consultation with the family/whānau/legal guardians and/or supports. Cultural context and needs should be identified and cultural supports such as a cultural worker, should be accessed where appropriate.

Different combinations of risk elements and potential consequences will lead to different safety plans. Safety plan activities will fall anywhere on the continuum between containment to self-soothing. For example, the imminent likelihood of an event with non-serious consequences (eg,superficial scratching) could have a safety plan where the person uses self-soothing strategies. However, the low frequency event with high seriousness (eg, high potential lethality) and impulsive motivation will have a safety plan, more focused on containment (potentially admission to hospital).

Safety plans often build on existing tangata whai i te ora and family/whānau resources and skills, particularly when working with children and adolescents. For example:

- Where the person is staying tonight and who with
- Which NGO the person will be referred to access secure accommodation
- Family/whānau hold medications and provide support
- Sensory modulation

The safety plan, and any actions already taken to improve safety, should be documented inside the treatment plan in the assessment form and the clinical notes. This must include a plan around safe management of firearms and other weapons when indicated.

Special considerations for safety planning

1. Concerns raised by family/whānau
2. Responsibilities in relation to firearms
3. ED presentation for self-harm
4. Chronic risk of serious self-injury and suicidal behaviours

1. Concerns raised by family/whānau

Inpatient:
When concerns about imminent safety risks are raised by family/whānau (in person or by phone), there will be an immediate increase in the level of therapeutic engagement observation that is currently in place for the tangata whai i te ora. This immediate response of increasing the level of therapeutic engagement observation (eg, from every 15 minutes to special) is then followed up by a full risk assessment to determine the appropriate level of therapeutic engagement observation and other safety planning (eg,

transfer to High Care/ICU). This risk assessment will be discussed with the senior nurse in charge or the responsible clinician to determine the new safety plan (which may result in returning to the level prior to the family/whānau contact).

Community:
When concerns about imminent safety risks are raised by family/whānau immediate further risk assessment and safety planning are to be completed. Safety planning might include initiating a higher level of care, increased support from others and removing access to means, etc.

2. Responsibilities in relation to firearms

Identifying whether a person has access to firearms should be a regular part of asking questions about access to means of harm. If a tangata whai i te ora possesses or has access to firearms clinicians must identify relevant information and safety plan with the view to limiting access to firearms during critical periods.

This may involve notifying police if the clinical judgement is that the person is at an increased risk of suicide or violence as a result of firearms access. It is not adequate to have another member of the household look after access to the firearm/s.

If the threat to any person is imminent and/or serious contact police urgently on 111 or 1-111. Clinicians must also consider notifying police if (1) they have reason to believe the tangata whai i te ora is a firearms license holder, and (2) they consider that in the interests of public safety, the tangata whai i te ora should not be permitted to possess or use a firearm due to a health condition.

Notifications to police must include the opinion, the grounds for the opinion, and whether the health practitioner believes the tangata whai i te ora poses an immediate or imminent danger of self-harm or harm to others. Notification can be online if there is no urgency or via the non-emergency police number 105. Under the Health Information Privacy Code, clinicians can notify police without a tangata whai i te ora's consent if (1) there is a serious threat to public health, safety or life/health of a person, and (2) disclosure is necessary to prevent or lessen that serious threat.

Clinicians should have a low threshold for notifying police. Police will take appropriate action, such as requiring the tangata whai i te ora to undergo an independent assessment, placing conditions, suspending, or revoking the license.

Firearms license status: If Police notify the service that a tangata whai i te ora has a firearms license, or if the tangata whai i te ora discloses they have a firearms license, record firearms license status and expiry date in the HCC pop-up alerts. Status of the alert will need to be reviewed by the current treating team at the license period expiry.

Having a firearm illegally is to be reported to the police. Refer to the DHB's "Reporting Offending to Police" policy.

If in doubt, please contact WDHB Legal for advice.

3. Follow-up post ED presentation for self-harm

Any person who is discharged from ED following a presentation for self harm must be discharged with a detailed follow-up plan, provided to them, their family/whānau and other providers involved in their care. Engagement in follow-up is enhanced by good information about treatment recommendations, follow up plans and details of a contact person (Spirito & Lewander, 2004, in NZGG, 2011).

Risk Assessment and Safety Planning

The first 48 hours after discharge following an ED presentation for self-harm have been identified as a period of elevated risk. For those people not admitted to inpatient care but at continued risk of self-harm and/or suicidal ideation or intent there must be a face to face follow up appointment assessment and planning appointment **within 48 hours of discharge from the ED**, if this is clinically indicated. Any decision not to see the person within 48 hours must be made in conjunction with the regular treating team or on-call consultant.

Ideally the details of the follow up appointment with the relevant community-based team are provided **prior** to ED discharge. Evidence shows that a wait for follow-up care reduces a person's motivation to attend. For adults and older adults, a referral to the acute team may be required to ensure this appointment can happen within the required period.

The follow-up appointment will be used to re-assess risk and further the safety planning (treatment, support, abstinence, distress tolerance etc as appropriate). Ideally family/whānau will be included as much as possible and relevant documentation should be updated.

This appointment is an essential element of post-ED follow up and should be prioritised to be in-person even in Covid lockdown alert levels 3 or 4. Failure to attend the follow-up appointment should result in clinicians making contact with next of kin, other supports and/or GP to support attendance at a rescheduled appointment (see section below on actions to be taken if disclosure to people with whom there is not consent to share information is being considered). If transport is a barrier the clinical team should plan to overcome this.

4. Chronic risk of serious self-injury and suicidal behaviours

Managing the risk associated with chronic suicidality is different from managing risk associated with acute suicidality. In chronically suicidal people, active attempts to prevent suicide, such as hospital admission and close observation, may be unhelpful or even escalate risk. This is particularly the case for tangata whai i te ora that are involved in the DBT Programme, where a '24-hour rule' is agreed as part of the contracting phase.

Careful assessment is needed to identify a change from a chronic to imminent acute risk. An acute risk could be indicated by the appearance of new symptoms, a change in a suicidal behaviours or emergent co-occurring mental illness. This situation may require a change in the usual clinical risk-taking approach to ensure the immediate safety of the tangata whai i te ora. In these circumstances short-term admission to an acute inpatient mental health unit may be appropriate to manage acute risk.

The 24-hour rule: The DBT Program has a "24-hour rule". Tangata whai i te ora are not to have communication with their clinicians (therapist) for a 24-hour period following an instance of self-injury or a suicide attempt. The rationale for this rule is that the availability of the clinician in the time closely following an act of self-injury or a suicide attempt might inadvertently reinforce these behaviours. Contemporary models of self-injury and suicidal behaviour underscore the importance of avoiding such reinforcement. The other important rationale for this rule is to encourage service users to seek support and skills coaching prior to engaging in these behaviours and therefore learning new more adaptive ways of managing stressors/crisis.

Risk Assessment and Safety Planning

4.4 Communicating and carrying out the safety plan

Safety plans should be communicated to relevant people, including other clinicians and agencies involved in care.

All employees are required to be aware of the rules governing privacy and disclosure of health information and how to manage, use and share health information safely. Refer to the following extract from the Waitematā DHB **Privacy – General Guide to Health Information Privacy (Nov 2020**) noting that out of hours consultation should include on-call consultant and DAMHS/Area Director for SACAT:

> ***Staff Actions if Disclosure is Appropriate***
> *Before making such a disclosure, staff should consider the wishes of the client. Even if the client does not agree to disclosure, information can in some cases still be shared to ensure safe and effective treatment or to ensure the safety of the client or others.*
> *Before making a decision to disclose staff should:*
> *• Discuss their decision with the team leader. Consultation with the Clinical Director, Privacy Officer or Legal Services may also be appropriate in difficult cases.*
> *• Consider the following*
> *- The wishes of the client (if known).*
> *- The advantages/disadvantages of disclosing.*
> *- The clinical and therapeutic benefits of involving others in the client's care.*
> *- Any potential risk issues (either to the client or others).*
> *- The seriousness of the risk.*
> *- The likelihood of the risk actually occurring.*
> *- The possible effects of disclosure on the treating relationship.*
> *- Whether other actions can be taken to minimise the risk.*
> *- The views of others involved in the care or treatment of the client.*
> *- Ethical considerations.*
> *- Whether disclosure is required or permitted under any other policy or legislation, such as the Mental Health (Compulsory Assessment and Treatment) Act 1992. (See also the **Privacy - 3rd Party Requests** policy for further exceptions).*
> *- Whether the client has previously given an advance directive permitting involvement of others.*
>
> *All decisions and discussions must be clearly documented.*
> *If a decision is made to disclose certain health information for treatment or safety reasons then only the minimum health information necessary to ensure safe treatment or to reduce risk should be disclosed*.

See the full **Privacy – General Guide to Health Information Privacy (Nov 2020)** policy for further information.

5. Quality monitoring

Regular audits of risk assessment and safety planning documentation will be conducted within each team to ensure practice is consistent and to identify areas where support is needed. The audits will be delegated to a senior clinician by the team manager or clinical lead who will also receive the report and ensure that any corrective actions needed are taken.

Risk Assessment and Safety Planning

Appendix 1: Associated Documents

WDHB Policies	• Duty of Care (2019) • Privacy – General Guide to Health Information Privacy (2020) • Informed Consent (2021) • Child Protection – Organisational Guidelines (2019) • Child Protection – Alert Management (2018) • Reporting Offending to Police (2017)	Staffnet>Policies >Clinical Practice Or Staffnet>Policies >Management> Privacy
SMH&AS Policies	• Therapeutic Engagement Observations (Adult Inpatient) (2019)	Staffnet>Policies >Mental Health and Addictions>SMH&AS
Guidelines	• The Assessment and Management of People at risk of Suicide, MOH 2003 • Assessment and Management of Risk to Others. Guidelines and Development of Training Toolkit (2006). Evans, Humberstone, Maniapoto, McKenna, Simpson, van Altvorst, Wack for MoH. • Arms Act 1983 - Information for Health Practitioners – November 2020 issued by New Zealand Police • Every Life Matters - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand • New Zealand Guidelines Group. Emergency department self-harm presentations clinical audit tool. Wellington: New Zealand Guidelines Group; 2011. • New Zealand Guidelines Group. The assessment and management of people at risk of suicide for emergency departments and mental health services. Wellington: New Zealand Guidelines Group • Pisani AR, Murrie DC, Silverman MM. Reformulating Suicide Risk Formulation: From Prediction to Prevention. Acad Psychiatry. 2016 Aug;40(4):623-9. doi: 10.1007/s40596-015-0434-6. Epub 2015 Dec 14. PMID: 26667005; PMCID: PMC4937078. • Preventing suicide: Guidance for emergency departments. MoH. 2016	
Legislation	• Arms Act 1983 • Care of Children Act 2004 • Children's Act 2014 • Crimes Act 1961 • Health Act 1956 • Health and Disability Sector Standards NZS 8134:2008 • Mental Health (Compulsory Assessment and Treatment) Act 1992 • Oranga Tamariki Act 1989 • Privacy Act 2020 • Substance Addiction (Compulsory Assessment and Treatment) Act 2017 • The Code of Health & Disability Services Consumers' Rights • The Health Information Privacy Code 2020 • Victims' Rights Act 2002	

Attachment 6

Constipation

Assessment

- PR examination
- Treatable causes:
  - Pregnancy
  - Hypothyroidism or
  - Hypercalcaemia
  - Drug-induced
- AXR:

> Radiology will not perform an AXR if constipation is the only clinical indication, but it may be required in some instances to confirm the diagnosis or to exclude bowel obstruction if there is clinical concern of this.

Treatment

- Bulking agents, eg Metamucil

> ⚠ in diabetics, avoid if patient is immobile or on constipating drugs

- Avoid constipating drugs eg opiates, tricyclics, anticholinergics, calcium channel blockers and aluminium hydroxide
- Dietary control, eg fibre, fruit
- Lifestyle, ie regular exercise

If no response then consider

- Lactulose 10-20ml BD (osmotic effect but may cause excess flatulence)
- Faecal softeners, eg Sodium docusate (coloxyl®) 50mg-100mg BD
- Colonic stimulants, eg Bisacodyl, Laxsol® 2 tabs BD

> ⚠ Useful in acute constipation; side effects include cramps, electrolyte imbalance, melanosis coli and "cathartic colon"; should not be used long-term

- Mineral oil, microlax® and phosphate enemas may be helpful
- Movicol® sachets 1-3 daily. If a patient is to be discharged on Movicol, this requires special authority application via Pharmac from any doctor with a New Zealand medical council number
- Glycerine suppositories / manual evacuation for faecal impaction