

Overdose Prevention Site Manual

2016

Overdose Prevention Sites (OPS) opened as part of the provincial response to the opioid overdose (OD) emergency on December 8, 2016 as ordered by the BC Minister of Health. OPS are fixed sites to which VCH provides clinical protocols, training and supplies to enable teams of peers, lay staff and in some instances clinical providers, to observe injections in a room that is integrated into an already existing social services setting. The primary goal is to provide a space for people to inject their previously obtained illicit substances, with sterile equipment, in a setting where trained OPS staff can observe and intervene in overdoses as needed. The OPS will last for the duration of the public health emergency.

Table of Contents

1. Introduction	5
Health Issues Related to Injection Drug Use	5
Overdose Prevention Site Objectives	5
<i>Vision</i>	5
<i>OPS objectives</i>	5
<i>OPS core services</i>	5
Goals & Guiding Principals	6
2. Staff Guidelines	7
Introduction (PHS, 2016)	7
Confidentiality	7
Professionalism	8
Key Staff Responsibilities	8
Data Collection	8
3. Service Delivery Guidelines and Protocols	9
Occupancy Numbers	9
Entering OPS / Reception	9
<i>1. Eligibility Criteria</i>	9
<i>2. Participant Profile</i>	9
<i>3. Needle Distribution</i>	10
<i>4. OPS Flow</i>	10
<i>5. Self (Safer)-Injecting Education</i>	10
<i>6. Disposal of Injection Equipment</i>	10
Post-Injection, Leaving the OPS	10
Code of Conduct	11
Opioid and Stimulant Overdose Information	11
Rescue Breathing	11
Naloxone Hydrochloride (Narcan)	11
Secondary Health Problems Related to Injection Drug Use (PHS, 2016)	11
PICC Lines	12
Jugular Self Injection (Jugging)	12
Unknown Substance Left Behind	12
Refusal of Service to OPS	12
4. Operational Guidelines and Protocol	13
Washroom Monitoring	13
Leaving the OPS to Provide Overdose Assistance	13
Death Protocol	13
5. Occupational Health & Safety (OH&S)	14
Needle Stick Injuries/Exposure to Blood and Body Fluids	14
Fire Evacuation Procedures	14
Earthquake Procedures	15
Management of Escalating Aggressive Behaviours	15
Management of Observable Behaviours	16
6. Works Cited	22

APPENDICES.....	23
APPENDIX A (Insite, 2016).....	24
Responsible Person in Charge (RPIC) Responsibilities.....	24
Alternate Responsible Person In Charge (ARPIC) Responsibilities	24
APPENDIX B.....	25
Code of Conduct (Insite, 2016)	25
APPENDIX C.....	26
Opioid and Stimulant Overdose	26
APPENDIX D	29
Participants in Particular Circumstances (Insite, 2016):	29
a) First Time Persons Who Inject Drugs	29
b) Pregnant Persons Who Inject Drugs	29
c) Youth	29
d) Non-Self-Injectors.....	30
e) Overly Intoxicated Participants	30
APPENDIX E.....	32
Reasons for Refusal to OPS (Insite, 2016)	32
Prohibited from Using the Site:	32
APPENDIX F.....	34
Needle Stick Injuries/Exposure to Blood and Body Fluids (Insite, 2016)	34
APPENDIX G	36
Rescue Breathing (VCH, 2016)	36
APPENDIX H	38
Procedure for Supervised Injection Education into the Jugular Vein (Insite, 2009)	38
APPENDIX I.....	40
Self (Safer) Injection Protocol (Insite, 2016).....	40
APPENDIX J	45
Responding to a Suspected Overdose in a Community Setting	45
APPENDIX K.....	54
Cleaning Booths (Insite, 2016).....	54
Overdose Prevention Site	56
APPENDIX L	57
Unknown Substances Left Behind Policy	57
APPENDIX M	61
Forms.....	61

Thanks to the BC Centre for Disease Control and The Portland Hotel Society (PHS) for the documentation that contributed to the assembly of this manual. The text in this document was adapted from Insite's (a project of both Vancouver Coastal Health (VCH) and the [PHS]) 2016 Policy and Procedure Manual unless otherwise indicated. The policies referenced in the appendixes are from either Insite (2016) or from VCH.

1. Introduction

Health Issues Related to Injection Drug Use

Injection drug use can be associated with an array of severe health and social consequences for persons who injects drugs (PWID), their families, and their communities. Rates of overdose, disease, death, and the accompanying costs are distressing indicators of drug-related harms experienced within our society.

The primary goal is to provide a space for people to inject their previously obtained illicit substances, with sterile equipment, in a setting where OPS staff can observe and intervene in overdoses as needed.

Abstinence may or may not be a goal for participants of the Overdose Prevention Site (OPS). There are many goals that a person may have that are not abstinence, including safety and avoiding infection. The OPS supports the integration of harm reduction practices into every aspect of programming, as a means to reduce the spread of HIV, Hepatitis C, and to decrease or eliminate the need for sharing syringes, or any other injection equipment. Harm reduction has the potential to address many of the social, cultural and structural factors that contribute to overdose, improve the health status of PWID, and support the civil rights of participants living with addiction and poverty. When non-judgmental harm reduction is practiced, it profoundly changes the living environment to one that values and includes PWID alongside everyone in the community. A safe community for all is the goal of harm reduction at the OPS (PHS, 2016).

Overdose Prevention Site Objectives

Vision

As part of a temporary emergency response offered by Vancouver Coastal Health (VCH), the Overdose Prevention Site (OPS) is a unique health care setting where PWID inject under supervision of peers, lay staff and in some instances clinical providers. The service was initiated due to increasing mortality from illicit drug overdoses in the province of British Columbia, Canada.

The OPS is a *welcoming, safe, and supportive* environment for PWID.

OPS objectives

- To provide space for people who inject drugs (PWID) under supervision of staff trained to intervene in overdose
- To improve the overall health of PWID
- To reduce the harm associated with illicit drug use (e.g., crime, discarded needles, public drug use) that affects communities
- To increase appropriate use of health and social services by PWID
- To reduce health, social, legal, and incarceration costs associated with drug use
- To create opportunities to work with PWID to facilitate stabilizing their lives

OPS core services

- Supervision of injections and intervention in drug overdoses
- Harm reduction teaching and counselling
- Distribution of needles, condoms and other harm reduction supplies

Goals & Guiding Principals

Goals

The OPS will reduce the harms associated with injection drug use and promote the health of PWIDs by:

- Reducing the number of overdose fatalities
- Providing a supervised and hygienic facility for PWIDs
- Increasing access to low barrier services
- Reducing the transmission of blood borne pathogens including HIV and hepatitis C
- Reducing the incidence of potentially serious infections leading to conditions such as endocarditis and osteomyelitis requiring hospitalization
- Reducing the incidence of soft tissue injuries, including abscesses and cellulitis
- Providing access to needle distribution and injecting equipment
- Providing referrals to other health and service providers in the area
- Connecting participants with peer support services and increased opportunities for healthy social networking

Guiding Principles

- Improve population health through increased access to health care
- Follow a harm reduction model, encouraging people to reduce high-risk behaviors while respecting choices they make
- Equal support and services offered to all participants
- Work with other community organizations to provide a continuum of care and ensure participants have support and access to services as needed

2. Staff Guidelines

Introduction (PHS, 2016)

Many participants develop trusting relationships, seek support, accept advice, discuss referrals and even follow rules, not because they are expected to do so, but because the pre-conditions are made possible by staff attitudes and behavior in a safe, health-focused and respectful environment. It is the job of the staff team to make sure these conditions are present at all times.

We do not take an institutionalized, 'one size fits all' approach to participant care, but, rather, tailor our approach to each individual, based on what we have found works best. Tailoring our approach to fit each individual does not mean that we are creating different sets of rules for different people; it is our way of 'leveling the playing field' so that a wide variety of vulnerable and challenging people can maintain access to our service.

Ultimately, this work is about building trust, founded on healthy professional relationships that recognize and respect the fundamental humanity in all of us. This is the most challenging, but also the most rewarding aspect of our work at the OPS.

Relationship-building is an on-going process that cannot be effectively summarized here. These attributes on the part of staff may help:

- A sensitive working knowledge and understanding of the client population, the local community and the history of the site
- A capacity to accept and respect people in this population
- Self-awareness, an open mind and an ability and willingness to reflect on one's own triggers and boundaries
- An ability to accept that all people make progress in their own way and at their own time
- A capacity for forgiveness and empathy
- An ability to 'back-off' and disengage should an intervention not be successful or welcomed
- A willingness to work as a team, and to try something different if current approaches are not working
- A sense of humor
- Good personal support networks and habits of self-care

(PHS, 2016)

Confidentiality

(See Appendix L)

All staff must sign a confidentiality agreement. All participant information that is obtained by staff while working at the OPS is confidential. Any information discussed on site, in staff meetings, during debriefing or in the communication systems must remain confidential.

Information on participants can only be shared outside of the OPS when:

- An emergency involving EHS or VPD has occurred.
- Statistical information will be shared within Vancouver Coastal Health; individual names will be kept confidential.

Staff should always seek advice from management if unclear on any aspect of confidentiality.

Professionalism

Staff working in the OPS are role models for the participants of the OPS and are representatives of the OPS to the community at large. It is the expectation that all staff conduct themselves in a professional and respectful manner at work.

Discrimination or harassment in any form will not be tolerated.

Staff are encouraged to work out conflict between themselves in a professional and respectful manner. If staff are not able to come to an agreed upon solution, they should seek support from their management representative.

Key Staff Responsibilities

During shift the role of every OPS staff member to:

- Be punctual
- Check overdose response and harm reduction supplies inventory with the supply form **(site specific)**
- Review overdoses from last shift
- Initiate communication with OPS participants
- Role model respectful behaviour
- Be attentive to participants who are presenting interest in or need for further information/support such as social, mental Health or addiction services
- Provide life support in medical emergencies
- Offer education on safer injection techniques
- Controls flow and numbers of participants into and out of each area in site, in accordance with established staff: participant ratios
- Ensure the safety of resting participants. Resting participants must be checked for response at least every 20 minutes, more often if they are at risk
- Monitor participant activity and enforce the OPS Code of Conduct as necessary. **(See Appendix B)**
- Apply workplace guidelines for verbal de-escalation and consequences for aggressive behavior, as outlined in the Occupational Health and Safety Section of this manual
- Build a sense of ownership and shared responsibility in the facility among participants of the OPS
- Debrief work-related issues at the end of each shift and following any critical incident
- Work collaboratively with other staff team members
- Help to orient new staff members and participants
- Maintain documentation and data collection as required
- Bring any concerns about possible breaches of the OPS policy and procedure guidelines and protocols to the RPIC/Alternative Responsible Person in Charge (ARPIC) as soon as possible
- Maintain a structured, healthy and clean worksite
- Supervises the disposal of used equipment in accordance with established protocols
- Cleans OPS tables after each use in accordance with established protocols **(See Appendix K)**
- Regularly monitor the area outside of the site. Sweep and clean as needed throughout the day
- Refer all media inquiries or public presentation opportunities to the Vancouver Coastal Health Communications Department (business hours line 604-708-5273 or after hours 604.202.2012) **(site specific)**
- Engage in personal phone calls, internet use and other personal communications at designated break times only

Data Collection

Comprehensive, quality data is essential for the OPS evaluation research project. OPS staff are responsible for collecting data on these suggested forms **(site specific): (See Appendix L)**

- 1) User Agreement (1st visit)
- 2) Release Form (1st visit)
- 3) Visit and Overdose Log
- 4) Youth form (with every youth intake)

3. Service Delivery Guidelines and Protocols

Occupancy Numbers

Staff: Participant Ratio

- 1 staff person for every 2 participants (minimally 2 staff on shift)
- Maximum number of participants in the OPS at one time is determined by number of tables for injection and staff on site

Entering OPS / Reception

- Staff will greet participant
- All participants need to be assessed for eligibility by reception staff (See **Eligibility Criteria** below)
- Participants will sign the User Agreement, Release and Consent form prior to first accessing the OPS (**site specific**)
- All participants need to be registered in the visit log before each visit. Participants will only need to provide their established identifier for subsequent visits, preferably the identifier used at Insite and other OPS locations. (**site specific**)

1. Eligibility Criteria

Participants must meet the following criteria in order to be eligible to access the OPS:

- Be willing to sign the User Agreement, Release (**site specific**)
- Be willing to adhere to the OPS Code of Conduct (**site specific**)
- Not be exhibiting overly aggressive behavior
- Not be accompanied by children (see below text for "Protocol for Participants Accompanied by Children")
- Not be previously prohibited

Participants assessed as ineligible to use the OPS for any of the above reasons will be asked to leave the OPS. To ensure the safety of all in the OPS, staff retains the authority to refuse entry and to ask ineligible participants to leave. Upon request, participants will have access to information to initiate the OPS appeals process (**site specific**).

Participants in Particular Circumstances:

(See Appendix D):

Review the following list and protocol (**Appendix D**) on how to engage these identified participants:

- a) Pregnant PWID
- b) Youth
- c) Overly intoxicated individuals
- d) Non-self-injectors
- e) New PWID

2. Participant Profile

Participant anonymity ensures low barrier service provision. For this reason participants will not be required to verify personal identification at reception, and they will not be required to submit to an assessment, other than the basic eligibility assessment described above. The OPS participant will choose or be given a unique identifier. No personal contact details will be recorded.

Participant confidentiality will be maintained at all times. However, with respect to youth at risk, the Child, Family and Community Services Act supersedes participant confidentiality.

3. Needle Distribution

Staff will encourage all participants to stay and inject at the OPS, but in the event that participants are ineligible to do so, or wish to leave and go elsewhere, needle distribution will be provided.

4. OPS Flow

- Staff will try to ensure that the OPS is a quiet and safe place for both participants and staff
- Participants will only self-inject in the OPS
- When an injection table becomes available, eligible participants will be directed by staff into the OPS order in which they arrived
- Each participant entering the OPS will be provided with all necessary injection equipment, such as a tray, a syringe, an alcohol swab, filters, sterile water, a disposable cooker, matches, a tourniquet, a 2X2 gauze and a spot band aid
- The participant will be directed to a table to inject drugs
- Participant must remain at their booth to complete their injection, no walking around with uncapped needles
- Participants will be encouraged to inject only one dose per visit. Some participants may choose to inject part of their dose first to test it, and then finish it a few minutes later, or inject two different substances separately. These practices are permitted
- If participants are observed to be injecting multiple doses, staff will ask them to leave and come back again
- Participants will only inject with needles and syringes provided at the OPS
- In the event of a participant nodding off, tweaking, or otherwise staff will continue to monitor until participant can safely be discharged to the street or chill-out space (discharge location determined by site)

5. Self (Safer)-Injecting Education

(See Appendix I)

- The OPS staff will seek out opportunities to educate participants about venous access and safer injection practices
- Participants must self-inject only. Staff are not permitted to perform the venipuncture or administer the drug to the participant

6. Disposal of Injection Equipment

- After injecting, each participant will dispose of their used injection supplies in the sharps container, which is readily accessible at each injecting station or in the main sharps bin located near the injection room exit. **Participants will be encouraged to not bend or break off needles before disposal.** OPS staff will supervise the disposal process.
- If staff need to pick up a needle they must do so with tongs provided
- The disposal containers will be a puncture resistant plastic not filled to more than three-quarter capacity. The sharps disposal container will be sealed.
- The filled containers will be removed and placed in a large cardboard bin provided by the hazard waste pick-up company
- All full sharps containers will be in a locked non-service area
- The hazard waste pick-up company currently used is Steri-Cycle at 604-552-1011 (**site specific**)
- Needle disposal/pick-up will be arranged by the RPIC

Post-Injection, Leaving the OPS

- Participants will be encouraged to remain in the OPS for 10-15 minutes for observation post injection especially if no chill space is available
- Staff ensure that participants are stable before they leave the OPS unless additional space onsite available where participants can rest with staff supervision (**See Appendix C**)
- Prior to leaving the OPS, staff will attempt to discuss with the participant harm reduction strategies for the rest of the day and encourage the participant to return to the OPS for future observed injecting as needed
- Prior to leaving the OPS participant identified concerns have been addressed
- Staff will attempt to ensure that high-risk participants, such as youth and women, feel safe in leaving the OPS

Code of Conduct

(Site specific, See Appendix B)

New participants will be provided with the OPS Code of Conduct ("Rights and Responsibilities").

A copy of OPS Code of Conduct will be kept on hand in all work areas and made available when required. If participants are denied access related to inability to adhere to the OPS Code of Conduct or do not meet eligibility criteria, they will have the right to seek redress with the RPIC (or their designate) and, failing that, to file a complaint or request an appeal.

Opioid and Stimulant Overdose Information (BCCDC, 2016; PHS,2016; Insite, 2016)

(See Appendix C)

The purpose of this protocol is to assist **all OPS staff** with identifying and managing participants with opioid and stimulant overdose.

Rescue Breathing

(See Appendix G)

In a witnessed overdose, it is likely that the client's heart is still beating. Towards the Heart (BCCDC) recommends prioritizing giving breaths because the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 5 seconds while preparing to administer naloxone.

Naloxone Hydrochloride (Narcan)

Naloxone, also known by the brand name Narcan, is a safe and highly effective antidote to opioid overdose. It is an opioid antagonist. Naloxone has a much higher affinity (attraction) for the same receptors in the brain that heroin and other opiates bind to. For this reason, naloxone displaces and prevents any opioids from working at the receptor. It has no effect on non-opioid drugs. It has no potential for abuse. Naloxone is an important part of managing an opioid overdose. If there are two first-responders, one can administer naloxone while the other manages airway, breathing, and circulation. Once the naloxone is administered, both responders can perform airway, breathing, and circulation interventions. Naloxone has a short half-life: 15 to 30 minutes. This is much shorter than most opioids, so it is important to monitor a person after an overdose for 30 minutes or more. This is best done at the hospital.

Secondary Health Problems Related to Injection Drug Use (PHS, 2016)

This section is for information purposes only. If participants express any of the following health concerns refer to a community clinic or emergency room for evaluation.

Abscesses and Cellulitis

- An abscess is an enclosed collection of purulent liquid, known as "pus". It can form in skin, muscle, or other soft tissue in the body.
- Cellulitis is an infection of skin or soft tissue.
- Bacteria cause abscesses and cellulitis. For intravenous drug users, bacteria are often introduced because the skin is not cleaned properly prior to the injection of drugs.
- There are four signs of inflammation/ infection:
 - Heat
 - Swelling
 - Redness
 - Pain
- Residents with an abscess should be encouraged to seek medical attention as soon as possible, as their infection may need antibiotics and may need to be drained. Abscesses may also benefit from frequent application of clean hot compresses, hot tap water in a nitrile glove is a simple and cost effective intervention.
- Call 911 if the resident exhibits any signs and symptoms of sepsis, Endocarditis and/or Osteomyelitis. People exhibiting these symptoms should be sent to hospital. Treatment includes hospitalization and intravenous antibiotics.
 - Sepsis a blood infection that can occur when the content of an abscess leaks into the body's general circulation. It can result in organ damage and death.
 - Symptoms include chills, fever, aching, and general discomfort.

- Endocarditis is a bacterial infection inside the heart chambers or heart valves. For intravenous drug users bacteria are often introduced because the skin is not cleaned properly prior to the injection of drugs, allowing bacteria to gain access to the blood stream and heart. Injection drug use is a common cause of endocarditis.
 - Symptoms include: chills, sweating, fatigue, fever, joint pain, muscle aches, night sweats, paleness, shortness of breath, swelling of feet, legs, abdomen, weakness, and weight loss.
- Osteomyelitis is a painful infection of bone. It can cause extensive damage to the bone and surrounding soft tissue. Injection drug use is a common cause of osteomyelitis.
 - Symptoms include: pain, fever, general discomfort, swelling, redness, warmth, chills, sweating, and low back pain.

(PHS, 2016)

PICC Lines

A PICC Line is a Peripherally Inserted Central Catheter which is inserted, to maintain direct intravenous access for short term IV therapy. If a participant presents to the OPS and is trying to inject into their PICC line make every effort to refer participant to Insite. This practice is not encouraged due to high risk of medical complications, and should be supervised by medical staff if possible.

Jugular Self Injection (Jugging)

(See Appendix H)

Jugular veins pose high risk of medical complications. If a participant insists on using this site to inject and will not go to Insite, support the participant with the harm reduction education outlined in the protocol.

Unknown Substance Left Behind

(See Appendix L)

Any controlled or unknown substances left on site will immediately brought to the attention of the RPIC/ARPIC who will place the substance in an envelope, which is then sealed, dated and initialed by the RPIC/ARPIC staff member. The envelope will be placed in a locked safe in the staff-only area. The envelope will be logged into a record-keeping book, by the RPIC/ARPIC. The Vancouver Police Department (VPD) will be contacted and a VPD staff member will log out the envelope(s). In the event of theft the VPD will be notified.

Refusal of Service to OPS

(Site specific, see Appendix E)

Reasons for Refusal to OPS

The OPS policy is to remain as accessible as possible to all PWID all the time. However, there are a few circumstances in which we may refuse someone entry to the site.

4. Operational Guidelines and Protocol

Washroom Monitoring

(Site Specific)

Washrooms need to be accessible in case of emergency, even if locked from the inside. Staff need to be responsible for monitoring participant washroom use and initiating an appropriate response to any occurrence, per OPS protocol.

Leaving the OPS to Provide Overdose Assistance

OPS Staff may, on occasion, see a person outside the facility who requires immediate assistance **(site specific)**.

Guidelines:

- Vancouver Coastal Health-Vancouver Community does not require or request staff to leave the facility to provide care
- Staff may decide to do so to provide care only if the safety of participants and other staff inside the OPS is ensured
- Staff primary responsibility is to provide their service within the OPS and to ensure the safety of participants and staff on-site

Staff who choose to leave the facility to provide care may do so only under the following circumstances:

- The situation is life threatening and cannot wait until Emergency Health Services or police arrive
- The situation does not present a risk to staff safety or health
- Emergency services (911) have been called
- A second person accompanies them or is able to observe them from inside the OPS
- It is the individual staff member's decision to leave the facility to provide service/support. No worker is expected to leave the facility to provide this service and no worker is to be pressured to do so

Death Protocol

(site specific)

- As with all medical emergencies, contact Emergency Health Services ambulance (911) to request immediate assistance.
- Secure the immediate area around the individual, providing privacy and prohibiting access to area by other participants
- Place all of the individual's belongings in a plastic bag with their name on it and secure them in the RPIC office
- Call the RPIC. If you cannot reach the RPIC, please call the VCH Administrator on Call (604-632-7448) and if they cannot be reached call through the list of all ARPICs/Managers/Coordinators/Directors until you reach someone.
- Check in with your team members to see if they need to debrief the incident. If you need backup, let the RPIC know.

5. Occupational Health & Safety (OH&S)

Needle Stick Injuries/Exposure to Blood and Body Fluids

- Cleanse the area/puncture site thoroughly with warm water and soap, or a suitable antiseptic soap. . In the event of an eye splash, flush the eye with tap water for 10-15 minutes.
- Report to your supervisor immediately, or leave a message if unable to speak directly.
- Go directly to St. Paul's Emergency, 1081 Burrard Street, Vancouver. You should be assessed for risk of exposure to blood-borne pathogens at the emergency department as soon as possible, preferably within two hours of the incident.
- If you know the source/person of the blood or body fluid, ask the person, (or parent/guardian) if he/she consents to have blood testing as well. They can go to emergency with you.
- Ask your supervisor or designate to complete Worker's Compensation Board form -Employers Report of Injury or Industrial Disease.

(See Appendix F)

Fire Evacuation Procedures

If You See a Fire:

- Leave area immediately and close the door behind you if possible.
- Pull the fire alarm nearest you and call 9-911 and report the fire at OPS address (**site specific**).
- If you are trained to use a fire extinguisher and the fire is small enough, attempt to control and extinguish the fire.

Do not fight a fire if the following conditions exist:

- You don't know what's burning
- The fire is spreading rapidly
- You don't have the proper equipment
- You can't do so with your back to an exit
- The fire might block your means of escape
- You might inhale toxic smoke
- Your instincts tell you not to do so
- If the first attempts to put out the fire do not succeed, evacuate the building immediately by using the nearest exit
- Meet in emergency meeting area

If You Hear an Alarm:

- All alarms are to be considered real. No one is to remain in the building unless they are prevented from exiting by fire and/or smoke
- Always check the doors for heat (use the back of your hand) and the halls for smoke before exiting
- Evacuate the building by using the nearest exit
- Meet in designated emergency meeting area
- Under no circumstances leave the emergency meeting area or go home until you are instructed; under no circumstances re-enter the building without authorization by the fire department

RPIC/ARPIC Role:

(site specific)

If You Cannot Evacuate:

- Close the doors between you and the fire
- If possible call 911 and advise the fire department of your situation

Fire Evacuation:

- Use a building telephone to call the fire department only if it is a safe distance from the fire
- While exiting always walk, never run and proceed in a quiet and orderly manner. Shut all doors behind you and assist those who have difficulty exiting. High-heeled shoes are hazardous and it is advisable to remove them before entering a stairwell. Do not push or jostle
- If you must use an escape route where there is smoke, stay as low as possible. Crawling lets you breathe the cleaner air near the floor as you move toward the exit
- Before you open a closed door, feel it with the back of your hand. If it is hot, leave it closed and use your alternate escape route. If it feels normal, brace your body against the door and open it a crack
- Note: be prepared to slam it shut if heat or smoke starts to rush in
- If all exits are blocked by fire or smoke, enter a room preferably with an exterior window, and seal the cracks in the door with available materials to prevent smoke from entering the room
- Attract the attention of someone outside the building by any possible means
- When you have reached the outside of the building, move away from the exit allowing others behind you to exit
- Do not attempt to drive your vehicle from the parking area

Earthquake Procedures

During Shaking:

- Never run out of a building.
- Always stay calm.
- Duck or drop down to the floor.
- Take cover under a solid structure if possible or seek cover next to an interior wall and protect your head and neck with your arms.
- If you have taken cover under something, hold onto it, and hold your position until the shaking stops.

After the shaking has stopped:

- Do not attempt to move anyone with serious injuries unless there is a danger of further injury.
- Assess yourself, others and the condition of your area.
- Note and report hazards and your assessments to officials when you are able.
- Help others and evacuate the building with extreme caution.
- Bring any first aid supplies that you can find.
- Meet at your designated emergency area meeting area.

Management of Escalating Aggressive Behaviours

Assessment for Potential Aggression:

1. Assess the participant's potential for aggression on admission using the risk indicators outlined below.
2. Assess own personal self-awareness as to thoughts, attitudes, feelings and actions towards people who are aggressive or have the potential to be.
3. Assess environment for overall activity, e.g. a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Risk Factors:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment
- Psychosis
- Delirium/dementia
- Lack of inhibition
- Labile mood
- Suicide intent, plan, thoughts or history
- Psychological factors, poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief
- Loss of central love interest, family member
- Loss of housing
- Loss of income
- Loss of health
- Feelings of powerlessness, anger, fear and failure
- Socio-economic indicators
- Low-income households
- High residential mobility
- Marital status (single)
- Education/IQ (low)
- Demographic indicators
- Age (20-4- years)
- Gender (male)

Management of Observable Behaviours

Anxiety:

Anxiety is an observable increase of change in behaviour. Mild anxiety can be good; it motivates us, heightens our awareness and can stimulate problem solving. Moderate to severe anxiety can cripple our ability to perceive, think and conceptualize - in other words, our ability to cope with the situation that faces us. Stimulant use can increase anxiety.

Anxiety Behaviours:

- Eye contact- loss of soft focus eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.
- Verbal contact- talkative, quiet, laughing, crying, joking, talking faster.
- Physical- rocking, restless, pacing, sitting very still, a need for more personal space, holding their breath.
- Hands- wringing hands, drumming fingers, opening and closing hands.
- Others- asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions), very poor short term memory, procrastination.

Staff Response to Anxiety:

- A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours in 95% of the population.

Staff Intervention to Anxiety:

- Be respectful of the participant's belongings and personal space (do not touch the participant without their permission).
- Actively listen to the participant, to have an understanding from their point of view and what is driving the behaviour.
- Answer questions to give the participant back a sense of control and reassurance.
- If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain to them it is a question to which there is no answer (do not ignore the question or need).
- Focus on what you can do for the participant and how it will benefit them, not what you cannot do (e.g. "How can I help?").
- Assist the participant to verbalize feelings in their own words, avoid using leading questions.
- Re-direct participant's energy into safe activities.

Verbal Aggression:

As verbal aggression escalates from the lowest to highest,

1. Challenging behaviours;
2. Refusing behaviours;
3. Loud behaviours; and
4. Threatening behaviours,

The person acting out will lose rational control and the ability to process information and think clearly. Eye contact will become focused and intensify as the level of verbal aggression escalates. Personal space will shrink and the acting out person will move closer to you, crowding your personal space.

1. Challenging Behaviour (First Level of Verbal Aggression)

- Relentless questions, with no satisfaction with the answers to these questions or they really do not care what the answer is
- Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction
- Rhetorical questions which are a form of distraction
- Demanding/instant gratification
- No respect for rules or regulations - challenge and test staff.

If this line of questioning continues, it could become very personal and the individual might challenge you on your credibility, skill or knowledge. If they are not satisfied with the answers that you give, this behaviour usually turns out to be a refusal in disguise, which is the next level of verbal aggression.

Staff Response to Challenging Behaviour:

- Staff have to acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression. This acknowledgement is key for staff to match their response to the level of verbal aggression.

Staff Intervention to Challenging Behaviours:

- Remain calm.
- Do not argue; focus on a common goal.
- Redirect them back to the issue at hand.
- Ask them a question to distract them (e.g. "Can I ask you something?").
- Give a positive directive that will assist them in getting their needs met.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.
- Use time and space.

2. Refusing Behaviour (Second Level of Verbal Aggression)

- Disagreeable
- Refusing
- Silence
- Walk away
- Verbally (this can be done in a calm or aggressive manner)
- Distracting behaviours (refusal in disguise)
- Repeated complaints
- Repeated requests
- Repeated demands
- Blaming others
- Exaggerated response of annoyance

Staff Response to Refusing Behaviours:

Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.

Staff Intervention:

- Remain calm.
- Verify that they are refusing.
- Verify the reason for the refusal.
- Give a positive directive.
- Give the individual reasonable choices or consequences- positive first, and a specified time to decide.

3. Loud Behaviour (Third Level of Verbal Aggression)

- Button pushing
- Yelling, shouting

Staff Response to Loud Behaviours:

At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.

Staff Intervention to Loud Behaviours:

- FIRST PRIORITY IS SAFETY FOR STAFF AND PARTICIPANT.
- Remain calm.
- Isolate the acting out person if safe to do so, and either move them or clear the area of on-lookers (people play to a crowd).
- Give a directive to the participant that puts your safety first (e.g. "Please leave the building").
- Time and space.
- Assess the need for additional staff to be present, or call police.

4. Threatening Behaviour (Fourth Level of Verbal Aggression)

Verbal threats are intolerable behaviour and will be managed as intolerable behaviour.

Staff Intervention to Loud Behaviours:

The following behaviours have been identified as intolerable to the OPS. All staff must follow this list to present a consistent approach to participants. The key to the successful use of behaviour modification techniques is a consistent approach by all staff. When a staff member asks a participant to leave and restricts access to the service or site, all staff must respect that staff member's decision to enforce limits on the participant's behaviours.

1. Verbal Aggression

Verbal threats that are:

- A direct threat of physical harm to a staff member, participant or family member.
- A direct threat to damage the physical environment or the service or building.
- A threat of a weapon (imaginary or real).

Verbal comments that are:

- Intended to dehumanize a staff member, participant or family member.
- Intended to demoralize a staff member, participant or family member.
- Intended to insult a staff member, participant or family member.
- Intended to sexually exploit a staff member, participant or family member.
- Intended to frighten and verbally control a staff member, participant or family member.
- Intended to start a fight in the facility.

2. Physical Aggression

- Sexual touching.
- Physical touching with the intent to harm a person or damage the facility.
- Throwing objects with the intent to harm a person or damage the facility.
- Punching or slapping a staff member or another participant.
- Kicking with the intent to harm a person or damage the facility.
- Spitting that is directed at a staff member or another participant.
- Fighting in the facility.
- Defacing the facility.
- Damaging equipment in the facility.
- Setting fire to the facility.
- Walking around with an uncapped needle.

3. Challenge of Facility Rules

- Refusing to stop drinking alcohol in the facility.
- Stealing.
- Refusing to stop any behaviour that facility staff have requested the participant to stop.

Staff Response to Intolerable Behaviours:

- Staff safety always comes first. If you have any concerns regarding another staff member's behaviour in dealing with the participant, this is not a safe or appropriate time to question or challenge another staff member. These concerns should be brought up in the informal briefing.
- Be aware of your own limitations and the volatility of the situation.
- Assess the need for more staff to be present when asking the participant to leave the facility, or whether it is necessary to contact the police. If more staff is required or the situation is volatile, remove yourself from the situation until appropriate support can be put in place.
- Know what you can and cannot do ahead of time, so that you are always prepared for the unexpected:
- Who is available to assist you?
- What are your options and choices at this time?
- When are you going to request the participant to return to the OPS for follow-up?
- Where are your exits?
- What is your past history with the participant, and do you have a rapport with them?

Staff Intervention to Intolerable Behaviours:

In a calm, clear, matter-of-fact manner

- State why you are asking the participant to leave the facility.
- Direct the participant to leave the facility.
- State when the participant may return to the facility (e.g. after meeting with RPIC, after 24 hours, etc.).

Intervention for Staff Member Being Assaulted:

A staff member that is being physically assaulted is to:

- Call for help.
- Trigger an emergency call if available.
- Protect the vulnerable areas of the body (e.g. face, neck,
- Move to an area occupied by other staff
- Ensure that help is on the way.

Staff intervention to physical aggression:

- Quickly assess the situation
 - Call 911
 - Assess if weapons present
 - Clear exits for staff
 - Remove bystanders from the area
- One staff responder is to give direction to the staff member being assaulted to assist them in protecting themselves and removing themselves from the attacker. They need to clearly identify themselves to the staff member being assaulted as the one voice to concentrate on, so more than one person talking to them does not confuse the person being assaulted.
- Call 911 (or ensure 911 has been called).
- A second staff responder will be the responder who directs the participant to stop the attack and leave the facility. The responder can attempt to distract the attacker (e.g. flicking the lights on and off or throwing ice water on the attacker), this can give the victim a window of opportunity to escape.
- Clear bystanders from the area.
- Remove any potential weapons from the area.

Evacuation

Evacuation of staff and participants from the OPS could be necessary in the following situations:

- Fire
- Violent/potentially violent incident which staff cannot contain
- Earthquake
- Bio-chemical hazard

In the above situations, safety of staff and participants is the primary concern. Should an exit be blocked for any reason (e.g. fire, violence or threat of violence, etc.) the staff person in charge of their area is responsible for leading everyone in their area to the next closest safe exit. **There are ___ exits at the OPS: (List) (site specific)**

1)
2)
3)
4)

The RPIC/ARPIC will coordinate the evacuation and ensure that all staff and participants have left the building. The RPIC/ARPIC is also responsible for ensuring that 911 is called. Generally, the closest staff member not directly involved with the incident will call 911. Advise the dispatcher that there may be sharps and bio-hazardous material in the site.

Should the building need to be evacuated because of violence in a room, staff will ensure that all people not involved in the incident vacate the building. Staff not taking charge of evacuating their areas should attend the incident and provide any assistance they can without putting their safety at risk. When evacuating the building, staff will close and lock all doors if possible.

Overdose Prevention Site

The OPS staff in the Injection Room will take charge of ensuring all participants in the Injection Room cease their injections, place all their equipment on the top of their table, and exit in a safe and orderly manner. The OPS staff will not leave the room until everyone has vacated and the room is secured (if securing the room does not jeopardize their safety).

Off-Site Meeting Area

In the event of evacuation, staff will meet in front of [REDACTED]. The RPIC/ARPIC is responsible for ensuring that all staff is present and accounted for, and for deciding when staff can re-enter the site.

Debriefing (site specific)

After an evacuation, staff will meet on site to debrief, and will re-open the site only after this occurs. A critical incident form will be completed, and both the OPS and Vancouver Coastal Health management team will be notified immediately.

- Vancouver Coastal Health contact: Miranda Compton 604-862-1210
- OPS contact: (site specific)

6. Works Cited

Portland Hotel Society Community Services Society (PHS), Harm Reduction and Overdose Management Policy and Procedures, 2016.

BCCDC (2016, November) Retrieved December, 12, 2016, from [http://towardtheheart.com/naloxone/news/program-modules, Sample Protocol, \(Editable\).](http://towardtheheart.com/naloxone/news/program-modules, Sample Protocol, (Editable).)

APPENDICES

APPENDIX A (Insite, 2016)

Responsible Person in Charge (RPIC) Responsibilities

Job summary: **(site specific) – some suggested text below**

- The RPIC is responsible for the planning, delivery and evaluation of OPS as well as maintaining overall operational responsibility. The RPIC is responsible for ensuring the operation of the OPS complies with the Vancouver Coastal Health OPS policies and procedures.
- Ensures feedback from participants.
- Evaluates the effectiveness and appropriateness of the services according to quality indicators in collaboration with the community partners (host agency), community, consumers, other program managers and staff.
- Acts as a liaison with site and community partners, media and police in consultation with Management Team.
- Supervises, coordinates scheduling, leads team meetings, coordinates internal communication and decision making among team members,
- Oversees the gathering of statistical information and record keeping, as per established evaluation format.
- Coordinates staff training, orientation and on-going professional development with the Vancouver Coastal Health Project Leader.
- Orders supplies.
- Orients new staff.

Alternate Responsible Person In Charge (ARPIC) Responsibilities

See RPIC **(site specific)**

APPENDIX B

Code of Conduct (Insite, 2016)

Rights and Responsibilities of Overdose Prevention Site Participants

Rights

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by Insite staff.
- To be in a clean environment.
- To receive appropriate support and attention.
- To access services even while under the influence of drugs or alcohol.
- To have a voice in the operations and functioning of the site, in conflict resolution processes and in regards to complaints or concerns.

Responsibilities

- To respect others while on site.
- To help create and maintain a safe place.
- To not cause physical harm to other participants or staff.
- To use the site for self-administration only; no “doctoring.”
- To not deal, exchange, share or pass drugs to anyone else on-site.
- To not use alcohol, smoke or ingest drugs other than by injection while on-site.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money on-site.
- To not bring outside conflicts into the site.
- To not engage in solicitation of any kind on site.
- To respect the property and privacy of others in the site.
- To follow the reasonable directions of OPS staff.
- To bring concerns or complaints to the attention of RPICs.

APPENDIX C

Opioid and Stimulant Overdose (BCCDC, 2016; PHS,2016; Insite, 2016)

The purpose of this protocol is to assist **all OPS staff** with identifying and managing participants with opioid overdose.

a) Opioid Overdose

Background

The opiate class includes:

- Substances directly derived from the opium poppy (such as opium, morphine, and codeine),
- The semi-synthetic opioids (such as heroin), and
- The purely synthetic opioids (such as methadone and fentanyl).

The opiate affects the mu, kappa and delta types of central nervous system receptors. The mu receptors' pharmacological effects include sedation, respiratory depression and analgesia as well as intoxication and withdrawal. The time to peak serum concentration and the half-life depends on the specific opiate in question and will affect the length of time to intoxication.

Commonly misused/abused opioids:

- Codeine
- Heroin
- Morphine
- Demerol
- Amileridine (Leritine)
- Methadone
- Hydromorphone (Dilaudid)
- Fentanyl
- Opium
- Pentayocine (Talwin)
- Percocet (Percodan)

Opiate intoxication symptoms include:

- Depressed level of consciousness (LOC)
- Constricted pupils
- Decreased respiration,
- Gurgling, snoring
- Body is limp
- No response to noise or knuckles being rubbed firmly on the sternum
- Skin looks pale or blue, and feels cold
- Slow or no pulse
- Person cannot stay awake
- Pinpoint pupils
- Cannot talk or walk
-

Opiate withdrawal symptoms include:

- Anxiety, irritability
- Dilated pupils
- Sweating
- Nausea/vomiting

Opioid intoxication is a continuum of four stages based on LOC including:

1. Drowsiness
2. Nodding (intermittently falling asleep)
3. Nodding with respiratory rate less than ten breaths per minute
4. Unresponsive

In this situation, OPS staff will:

- Remain calm
- Attempt to wake up participant
- Shake and talk to participant
- Get participant to open eyes
- Get participant to talk
- If responsive, assist to walk around
- If above steps are unsuccessful, initiate the **Opioid Overdose Protocol**

Opioid Overdose Protocol (BCCDC, 2016)**Identify**

- Before approaching MAKE SURE AREA IS SAFE- clear away any needles and put on gloves
- UNRESPONSIVE (doesn't respond to verbal stimulation (shout their name) or pain (Tell them what you are going to do: nudge/touch them, then do sternal rub/pinch ear lobe/finger webbing)
- SLOW BREATHING (less than 1 breath every 5 seconds), may be snoring/gurgling
- Skin (may be pale or blue, especially lips and nail beds; may be cool or sweaty)
- Eyes (pinpoint (i.e. very small) pupils)

Take Charge

- DELEGATE Tasks (examples below, some can be done by 1 person, some may not be needed)
- (1) Phone 911 (2) Rescue breathing (3) Meet emergency responders and direct them to the OD (4) Get overdose response supplies (5) Give naloxone (6) Crowd control (7) Read these instructions

Call 911

- PHONE 911
- Say it is a medical emergency (not responsive not breathing) make sure ambulance is dispatched
- Give the address to the dispatchers
- Send someone to meet emergency responders at main entrance or street and direct them to the site of the overdose

Rescue Breathing

- Clear mouth/airway & tilt head back
- You can use a breathing mask as a barrier
- PINCH NOSE and give 2 breaths
- Continue to give 1 BREATH EVERY 5 SECONDS (even after giving naloxone, until the person regains consciousness or paramedics arrive)

Give Naloxone

- If the person has not regained consciousness with rescue breathing...
- Swirl the ampoule, then snap the top off the ampoule (away from your body)
- Draw up all of the naloxone in the ampoule (1 mL) into the vanishpoint syringe
- Inject entire dose at 90° STRAIGHT INTO A MUSCLE (THIGH, upper arm, butt) can inject through clothes

Evaluate

- WAIT 3-5 MINUTES to see if the person regains consciousness
- Don't forget to CONTINUE RESCUE BREATHING 1 breath every 5 seconds until the person is breathing on their own
- You should give 40-50 breaths before deciding to give an additional dose of naloxone

More Naloxone

- If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
- WAIT 3-5 MINUTES - about 40 breaths (CONTINUE TO GIVE RESCUE BREATHS)
- Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive

Document and Debrief

- Tell paramedics about all emergency care provided (including # naloxone injections given)
- Fill out your organization's Critical Incident form and any other required paperwork
- Talk to your coworkers and/or site coordinator and/or site manager and/or access support through your employer

(BCCDC, 2016)

b) Stimulant Overdose (PHS, 2016)

Stimulants can cause increased heart rate, blood pressure, and body temperature. A stimulant overdose can cause cardiac or respiratory arrest as well as seizure. Patients may report chest pain, shortness of breath, disorientation, or panic. These symptoms require medical attention, and the person should be supported to attend hospital via ambulance.

Commonly used stimulants include:

- Cocaine
- Crack cocaine
- Amphetamines
- Ritalin
- Adderall

Responding to a Stimulant Overdose

Stimulant overdose has a variety of presentations and can be precipitated by lack of sleep. Signs that a person may have taken too much of a stimulant drug includes agitation, shaking or chest pain and a high level of anxiety. The person should be monitored, kept safe and encouraged to attend hospital.

A stimulant overdose can lead to seizure, heart attack, or stroke as a result of elevated body temperature, heart rate, blood pressure, as well as dehydration.

If the person is having a seizure:

- Don't restrict their movement
- Don't put anything in their mouth
- Protect their head (place a pillow underneath their head)
- Place the person in the recovery position.
- Call 911

Additional steps you can take in the event of a stimulant overdose:

- Apply cool cloth to back of person's neck or to forehead
- Limit stimulation by moving the person to a quiet location with low light
- Encourage person to take slow, deep breathes
- If person becomes unconscious or has chest pain call 911. Perform assessment and intervention to maintain
- airway, breathing, and circulation

(PHS, 2016)

APPENDIX D

Participants in Particular Circumstances (Insite, 2016):

a) First Time Persons Who Inject Drugs

People who use drugs who may be transitioning into injection drug use present both a potential opportunity to provide them appropriate harm reduction information, while at the same time may represent an opportunity to deter them from initiating a potentially high risk behaviour. In most circumstances these would be alienated, vulnerable youth who may be at a crossroads between increasingly high-risk behaviours and an opportunity to transition away from a street-entrenched lifestyle. It is unlikely that a participant would present to the OPS as a first-time user.

Protocol

Access is granted to the OPS after staff member assessment.

- Potential first-time PWID may be deterred from transitioning to injection drug use.
- However, participants who are willing to present themselves to the OPS as a first-time user may have already made the decision to begin injection drug use, and would not be denied the benefits of OPS harm reduction services.
- For these participants the negative health consequences of denial of access would be potentially mitigated; participants who have never used injection drugs are not denied access.
- A concerted attempt to refer the first-time user to Insite will be made.
- In the event that first-time participants are determined to begin injecting drugs in the OPS, they will be granted access to the Injection Room and then encouraged to have their next injection at Insite where they can access nursing support.

b) Pregnant Persons Who Inject Drugs

Background and Protocol

There are inherent risks to both the mother and fetus associated with the lifestyle of injection drug use.

- Pregnant PWID are both shamed by their use and traumatized by the harm that they may be causing to their fetus, making them less likely to access health care services.
- This sub-group of PWID may be amenable to interventions to reduce harm, or even access treatment services if low-threshold services are provided.
- By engaging these participants in the OPS activities, it may be possible to assist them in moving towards safer drug-using behaviours or recovery and prenatal care services.
- Denying access to pregnant women is unlikely to result in their abstinence from drug injection.

c) Youth

Background

Youth represent the highest risk group for contracting hepatitis C and HIV through injection drug use.

- Research has shown that younger PWID engage in high-risk behaviours to a greater extent than established PWID, including sharing needles and other drug equipment, engaging in sex trade work and using condoms inconsistently, increasing their vulnerability to blood-borne disease.
- There is real potential to reduce the harm associated with ongoing injection drug use in this group, given the rapid acquisition of hepatitis C and HIV infection following initiation into use of intravenous drugs and their increased risk of drug overdose due to their relative inexperience with injection drugs.

Conditions for Access to the Overdose Prevention Site

Persons aged 16 and over who meet the assessment criteria can access an Overdose Prevention Site.

The following groups are restricted from accessing the Overdose Prevention Site:

- Persons under the age of 16.
- Youth under the age of 19 who are obvious first time PWID, do not have a history of injection drug use and who do not meet the assessment criteria as:

- Supervised injection facilities are generally seen as an intensive intervention along the continuum of harm reduction services for an extremely marginalized population. Youth who do not have a history of injection drug use should access resources that can more appropriately address their level of need.
- Individuals accompanied by children, as:
 - restricting access is consistent with the principles of the Child, Family and Community Service Act, which identifies the need for parents to address the safety needs of their children by making appropriate alternative care arrangements
 - Adults will be impaired in their abilities to parent the child after injecting their drugs and it would be questionable whether the adult can adequately care for and protect their child once they have left the facilities.

Assessment Procedure for Access of Youth Between the ages of 16 and 19 to the Overdose Prevention Site

Youth under the age of 19 will access the OPS only when the youth shows obvious signs of physical addiction to injectable narcotics. When a youth presents at the OPS the RPIC performs an assessment using the following criteria:

- The assessment determines that the youth has a history of injection drug use and has previously bought injectable narcotics with the intention of self-use, and
- The assessment provides appropriate and expedited referrals to primary health care, addictions care, shelter and/or mental health services as indicated by information gathered, demonstrated symptoms, and/or desire to access appropriate addictions care.

For those youth under the age of 19 who request access to the Overdose Prevention Site but do not meet the above criteria, as well as those youth under 19 who are at immediate risk other than that associated with their physical addiction to injectable narcotics, the RPIC/ARPIC:

- Refers them to Insite to access services

d) Non-Self-Injectors

Background

There are many PWIDs who are unable to injection themselves and rely on others to perform this challenging procedure. Some have never learned how to inject themselves; others cannot because of a physical disability such as blindness or paraplegia. This is an important population to engage as research has demonstrated a significantly heightened risk for HIV infection associated with this practice. This issue is one rife with power issues and most often it is women that rely on a man to inject them. Often, on the street, this service is provided in exchange for money, drugs or sexual favours.

Only self-injection is permitted in the OPS. No staff person, nor participant may administer an injection.

Protocol

Non-self-injectors will be identified and assessed whether the barrier to self-injection is education or a physical disability.

- If the barrier is education, the OPS staff will attempt to provide education to support the participant to self-inject in a safer manner.
- If the barrier is physical disability, the OPS staff will determine whether any physical supports, not directly related to the provision of the injection, might assist in self-injection.
- If education or physical assistance do not result in self-injection, the participant will be respectfully asked to seek assistance elsewhere.
- All efforts will be made to connect non-self-injectors with safe support including addiction treatment services.

e) Overly Intoxicated Participants

Background:

Intoxicated persons present unique problems due to the likelihood of even higher risk than usual of needle-sharing, fatal overdose, assault or otherwise unsafely injecting if they are denied access to clean equipment and a safe location with on-site supervision. However, allowing intoxicated individuals to inject when they are clearly at greater risk for overdose also presents certain problems.

Protocol:

- May increase the likelihood of a participant overdosing on site, however, the likelihood of a positive outcome after this episode is greater than if it occurred outside the OPS.
- Staff will identify those participants who are overtly intoxicated and provide them with extra teaching about the risks associated with injection drug use at this time.
- The participant will be discouraged from using the injection room and encouraged to proceed to Insite or to walk around outside the OPS before considering injecting again.
- Access to the injection room would be granted by the RPIC/ARPIC only if convinced that the participant would likely inject drugs outside the OPS if denied access.

APPENDIX E

Reasons for Refusal to OPS (Insite, 2016)

People may be politely denied admittance if:

- They refuse to sign a waiver or to give reception their OPS handle
- They have a medical condition which needs emergency attention
- They have no intention of injecting drugs on the premises
- They have a child with them
- They are under 16 years of age (note: see youth policy for details on access for 16-19 yr olds)
- They are currently on the temporarily prohibited list
- The site is full (note: see policy on staff: participant ratios)

Prohibited from Using the Site:

There are 3 levels of prohibited access to the site:

1. Prohibited from using the site for the rest of the shift/day:

- Participant's behavior that is extremely difficult to control or refusing to follow staff direction

2. Prohibited from using the site for 24 hours, and access again only after speaking

with RPIC:

- Threats or violence directed against staff or participants, or dealing on site

3. Prohibited from using the site for a period over 24 hours, and access again only after conferring with staff and arranging a meeting with 2 RPICs or an RPIC and Manager:

- Repeated or serious threats or violence
- 2-RPIC prohibitions are requested by staff (via email to explain the incident in more detail than the alert flag note) and set by RPICs

Participants can be prohibited from using the site for the day by any staff, due to:

- Uttering threats of violence or carrying out violence against anyone on the premises.
- Attempting to deal, purchase or share drugs on the premises.
- Periods of prohibition of more than one day will be set by the RPIC if they determine that the circumstances are severe enough to warrant it.

Readmission after Being Prohibited from Using the Site

Readmission After Being Prohibited from Using the Site:

- Barred participants must meet with the RPIC/ARPIC. They will be readmitted after RPIC/ARPIC is assured that the behaviour will not continue.

The Steps for Staff/Participation Safety

1. The first step is to avoid triggering conflict (e.g. communicate openly and respectfully with participants, do not get angry or demanding).
2. The second step is de-escalating conflict when it arises. This includes backing up co-workers by appropriately intervening in conflict in ways that do not make the participants more defensive and by giving the parties to a conflict an easy way out.
3. The final step, when a situation cannot be de-escalated, is to call the police. In any situation involving violence, when staff or participants feel unsafe, the police should be called.

Documentation of Prohibition from Using the Site

- Staff must communicate with RPIC/ARPIC as soon as a prohibition occurs.
- The RPIC/ARPIC is responsible for making the decision to place a person on 2 RPIC prohibition after a review of the documented events.
- The prohibition list will be kept current at the Reception desk. Reason for refusal will be clearly documented.

- If a prohibited participant engages in the Vancouver Coastal Health Complaint Management process, the Refusal protocols set out here will always take precedence.

APPENDIX F

Needle Stick Injuries/Exposure to Blood and Body Fluids (Insite, 2016)

Staff

- Cleanse the area/puncture site thoroughly with warm water and soap, or a suitable antiseptic soap such as Hibitane or Salvodil. In the event of an eye splash, flush the eye with tap water for
- 10-15 minutes.
- Report to your supervisor immediately, or leave a message if unable to speak directly.
- Go directly to St. Paul's Emergency, 1081 Burrard Street, Vancouver.. You should be assessed for risk of exposure to blood-borne pathogens at the emergency department as soon as possible, preferably within two hours of the incident.
- If you know the source/person of the blood or body fluid, ask the person, (or parent/guardian)
- if he/she consents to have blood testing as well. They can go to emergency with you.
- Ask your supervisor or designate to complete Worker's Compensation Board form -Employers Report of Injury or Industrial Disease.

Adults

- Should be routed to St. Paul's Emergency, 1081 Burrard Street, Vancouver, if it does not cause a delay as they have appropriate medication or vaccine readily available.

Children

- Should be routed to Children's Hospital Emergency, as they have anti-retrovirals in the pediatric liquid formulation. These are not readily available at any other Emergency Department.
- If you know the source/person of the blood or body fluid, ask the person,(or parent/guardian) if he/she consents to have blood testing as well. They can go to emergency with you.

Safe Disposal of Sharps Including Sharps Containers

- The main cause of HIV infection in occupational settings is via percutaneous (e.g. needle-stick) injury resulting in exposure from infected blood. Research suggests that HIV infection is rare after a needle-stick injury, however infection of hepatitis B & C is much more easily transmitted through a needle. Whether the risk of infection after a needle-stick injury is common or uncommon, this is still understandably an area of considerable concern for many of our staff.
- To ensure those Vancouver Coastal Health employees who are required to handle or accidentally come in contact with sharps are aware of the risks.
- To use the procedure laid out here to minimize their chances of an accident related to needle-stick injury.
- Employees that could come in contact with sharps are all VANDU staff.

Participant Education

- Participant education can help to reduce Vancouver Coastal Health staff exposure at the source.
- Participants should put needles in appropriate containers.
- Employees have a role in educating and advising participants about the kind of containers they can and should use that are safe.
- All participants using sharps containers where a health care provider is involved in the procedure should have a container provided by the health center.
- Participants who use sharps, but do not have ongoing health care involvement are to be instructed to put sharps in a heavy plastic or metal container with a secure lid.
- Participants are to be encouraged to ask their pharmacist if used needles/syringes can be returned for disposal at the pharmacy.

Containers

- Sharps containers should be located as close as practical to the work area.
- Different sharps containers are required for different purposes and worksites.
- Replace containers when they are 75% full.
- Sharps container should be maintained upright throughout use.

Transportation of Sharps

- Internal transportation of sharps containers should be kept to a minimum (examine at local worksite).
- When transporting sharps in vehicles, ideally sharps containers should be placed inside a secondary form of containment with a secure lid and always be transported in the trunks of vehicles.
- Lay sharps container on its side if tipping over is a concern.

How to Handle Garbage Safely

- Consider not having garbage in the OPS to avoid sharps being disposed here.
- Physical handling of garbage in the OPS should be kept to a minimum.
- Use waterproof garbage bags.
- Be Alert! If possible look for sharps protruding from garbage bag, and listen for broken glass when moving the bag.
- Don't compress garbage or reach into garbage containers with your hands or feet.
- Don't use bare hands when handling garbage. Wear puncture resistant and liquid resistant gloves or use other tools designed for picking up garbage.
- Don't let garbage get too full. Leave enough free space at the top of the bag, so that when you grab it, you grab the top of the bag only.
- You may have to change bags more often to prevent them from getting too full. This will also make them lighter - and thus easier to hold away from your body.
- Hold the garbage bag by the top of the bag, away from your body. Don't hold garbage against your body.
- Don't place one hand under the bag to support it.
- Picking up Sharps
- Use tongs to pick up needles.
- If no tongs are available, use a gloved hand to carefully pick up the needle/s and dispose of gloves and WASH HANDS after needle contact.
- Hold needle tip away from you.
- Put needle/s in a puncture resistant can or jar.

APPENDIX G

Rescue Breathing (VCH, 2016)

Should you give breaths or compressions?

In a witnessed overdose, it is likely that the client's heart is still beating. Towards the Heart (BCCDC) recommends prioritizing giving breaths because the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 5 seconds while preparing to administer naloxone.

If you come across someone who is unresponsive and suspect overdose:

- Check the scene for safety, clear uncapped rigs or other hazards
- Confirm level of consciousness with a firm trapezoid pinch or by rubbing your knuckles on their sternum
- Check for breathing and carotid pulse (10 seconds max) while looking for signs of cyanosis or insufficient blood oxygen, like bluishness around the lips and eyes
- In addition to breaths, if the person has been oxygen deprived for a long or unknown amount of time and you are CPR trained, give chest compressions in addition to breaths while preparing to administer naloxone

Simple Face Shield or Bag-Valve Mask (BVM)?

- A face shield with a one-way valve is easy to use and recommended by the BCCDC for those trained in the SAVE ME steps to respond to an overdose
- Management of ventilations with a BVM is a high-skilled intervention that should only be use by trained professionals. Problems that can arise from improperly using a BVM are:
 - Inadequate ventilations due to improper seal
 - Over-ventilating
 - Difficulty maintaining airway while using the BVM
 - Complications arising from forcing air down the esophagus (vomiting)

Would you give rescue breaths, chest compressions, or both, in the following scenarios?

a. Clients observed their friend overdosing and come find you immediately	Rescue Breaths
b. You are doing a room check and come across a resident who is unconscious and not breathing	Both
c. You watch a client slump over and stop breathing	Rescue Breathing
d. On your scheduled bathroom check you find a client unconscious but gurgling and taking shallow breaths	Rescue Breathing

*Although liability related to administering naloxone is a common concern, there are no known legal action cases. Bystanders are protected under the BC Good Samaritan Act.

References:

Pozner, C. M. (2016, April) Basic life support (BLS) in adults. Retrieved December 12th from https://www.uptodate.com/contents/basic-life-support-bls-in-adults?source=search_result&search=basic%20life%20support%20in%20adult%20bls&selectedTitle=1~40

Wittels, A. K. (2016, January) Basic airway management in adults. Retrieved December 12th from https://www.uptodate.com/contents/basic-airway-management-in-adults?source=search_result&search=basic%20airway%20management%20in%20adults&selectedTitle=3~150

BCCDC (2016, November) Retrieved December 12th from http://towardtheheart.com/assets/uploads/THN%20Training%20Manual%20Final_2016.11.30.pdf

APPENDIX H

Procedure for Supervised Injection Education into the Jugular Vein (Insite, 2009)

PROCEDURE FOR SUPERVISED INJECTION EDUCATION INTO THE JUGULAR VEIN

BACKGROUND: Those who use and inject illicit drugs are at high risk for soft tissue infections, and more serious infections such as endocarditis. These infections and other serious medical problems can occur from injection at into any vein. The jugular veins pose higher risk for the following reasons.

- The anatomical location of the jugular is very close to large blood vessels (including arteries), nerves, the trachea and the esophagus
- An abscess in close proximity to these structures could cause compression of nerves, and vessels supplying blood to the brain
- A large abscess on the jugular line could potentially cause compression or narrowing of the airway
- Jugular infection could travel easily to the brain or heart
- Air embolus can easily enter the blood stream from jugular injection and travel into the heart and coronary arteries (heart attack) or the brain (stroke) or to the lungs (pulmonary embolism). Air is more likely to enter through injection into the Jugular vein because of the lack of valves and because of the negative pressure in the jugular, associated with inspiration

It is part of the role of the Insite nurse to provide injection education in the context of harm reduction, with regards to injecting into the Jugular vein

NURSE PROCEDURE

- It is the role of all Insite staff, including nurses to build a trusting and therapeutic relationship with Insite participants
- Nurses and program staff are to be constantly scanning the room and IR booths for both overdose and opportunities for education, while performing daily tasks
- Nurses to approach participants who are noted to be injecting into the jugular, and offer education
- Nurse to determine the following:
 - i) Participant's rationale for using the jugular, and participant's knowledge of risks of injecting into the jugular
 - ii) Whether the participant has any visible or palpable venous access other than the jugular
 - iii) Whether or not the participant is able to inject their drugs intramuscularly

Then, based on the above assessment the RN should do the following, in priority sequence:

1. Educate the participant to self-inject into a different vein
2. Educate the participant to self-inject intramuscularly
3. Educate the participant on the risks involved with injecting into the jugular
4. Educate the participant to safely self-inject into their Jugular vein, IF and only IF participant determined to do so. Nurses are ethically obligated to provide proper and adequate education as outlined in the CNA Code of Ethics "Promoting and Respecting Informed Decision-Making" and the CRNBC Practice Standard "duty to Provide Care" This includes:
 - Education on the risks involved (clot or obstruction, embolus, infection, overdose, heart attack/stroke, embolus, compression of vital structures in the neck)
 - How to minimize these risks (Harm Reduction Education)
 - How to landmark the vein for injection and other safe-injection education
5. Document appropriately and accurately on the Insite database

Prepared by Bethany Jeal RN Clinical Coordinator December 2009

Revised 29th July 2010

APPENDIX I

Self (Safer) Injection Protocol (Insite, 2016)

Self-Injection Protocol (Insite,2016)

This protocol applies to the Injection Room at Insite. Drug use is not permitted elsewhere on the premises.

Under Health Canada guidelines, injection room staff are expected to educate participants about venous access and safer injecting techniques.

Staff are to use the following guidelines to minimize the risk of needle stick injury and to educate the participant to safely prepare to inject, and then self-inject. Staff role is to verbally educate and demonstrate with mock-injection as necessary.

Unsafe injection of illegal substances is associated with:

Blood-borne pathogens such as HIV and Hepatitis C¹

Injection related infections¹

Death due to overdose¹

Risk of potential harms are reduced through:

Health teaching and care by trained staff¹

Application of harm reduction philosophy and core principles of health promotion through staff teaching and care¹

Promoting participant empowerment and independence, especial in their injection practice

Staff are not permitted to perform venipuncture or administer the drug to a participant.

Before entering booth to provide assistance:

Assess safety

Assess participant's ability to follow simple directions

Assess participant's current state of mind

Is participant currently prone to sudden or erratic movements?

Ask participant to dispose of all used needles (reduce risk of needle stick injury)

Ask participant to place rig that is to be used on the table

Ask participant what they need help with (eg. Vein location, cooking, verbal direction, stabilization of rig, etc)

Consider location of sharps container in booth in relation to your location in booth (you may be in the path to the sharps container post injection)

*If there is concern regarding safety based on the above assessment staff can choose to not engage booth assistance, especially "hazardous activities" listed on the next page. Communicate safety concern with staff team.

If participant is lucid and stable → make a verbal agreement with them:

Ask participant to give verbal notice if, in the process of receiving injection support, they are going to move their rig (ie: re-landmark).

While the participant adjusts the syringe, staff will remove themselves from booth.

When directly supervising injections in IR booths:

Self-injection shall take place only in the participant's assigned booth with participant seated in chair

This minimizes risk of needle-stick injury related to:

Participant and/or staff positioning

Unpredictability of participant movements

Stand/sit on the side of the participant that is furthest from the hand holding the syringe.

Authorized Activities – Trained Staff only:

Verbally explain all steps in safer injection process (Harm Reduction Education).

Palpate participant's arm for veins – land marking is an important part of vein care.

Identify potential injection sites, including physically guiding participant's hand to the appropriate injection area.

Encourage hand washing as a measure to prevent infection.

Swab participant's arm with alcohol swab to reduce infection from unclean injection practices.

Tie off participant's arm.

Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection only).

Hazardous Activities – Trained Staff only

*Undertake with extreme caution and only when other options have been exhausted.

Removing tourniquet after participant injects to prevent vein damage and blood leakage from the injection site (risk of needle stick injury to staff).

Stabilizing syringe or vein while syringe in body (risk of needle stick injury to staff).

Priority is to educate participants to self-anchor their veins and syringes.

Adjusting angle of syringe while syringe in body (risk of needle stick injury to staff).

Cooking/prepping participant's drugs (risk of spillage and blame)

This includes changing syringes.

Removing syringe from body in emergency situations (risk of needle stick injury)

NOTE: In the absence of the SIS, IDU's who cannot prepare their own substances are likely to seek "doctoring" from another IDU, increasing the potential for unsafe injection, and transmission of Blood Borne Pathogens. Handling of participant substances to be done only by trained staff, and only for participants who are unable to do so themselves.

When participating in "Hazardous Activities" staff should:

Always keep hands behind the syringe, never in front of the syringe tip/needle

For anchoring:

Place their hands behind and below the syringe, on the opposite side of the limb, away from the syringe

Use a tongue depressor to gain further distance between staff hands and the syringe

*The best way to anchor a vein is to educate participant to self-anchor

Unauthorized Activities: **

Inserting the syringe into the body or vein

Flagging/aspirating (checking needle placement in vein)

Depressing the plunger

**NOTE: These are assisted injection practices and are not part of the Insite staff role

Removing syringe from body, except in emergency situations and only by trained SIS staff

Staff Training:

All regular SIS staff are expected to attend the mandatory in-house training on safer injection and harm reduction education prior to engaging in any of the above activities

All SIS staff must have current certification in Level C CPR

Documentation:

All staff are to document Harm Reduction and self-injection education in participant files on the SIS database.

References:

Lightfoot, B., Panessa, C., Hayden, S., Thumath, M., Goldstone, I., Pauly, B. (2009). Gaining insite: harm reduction in nursing practice. *Canadian Nurse*. 105(4) 16-22

APPENDIX J

Responding to a Suspected Overdose in a Community Setting

Responding to Suspected Opioid Overdoses in Community Settings (for LPN, OT, PT, RT, SW, and unregulated care providers)

Site Applicability

VCH Community Sites where opioid overdoses may be encountered by staff (where supported by managers)

Practice Level

- LPN, OT, PT, RT, SW
- Unregulated care providers (such as harm reduction workers, peer workers)

Advanced Skill – Overdose Prevention and Naloxone Training for VCH Staff is required before performing this skill. A training course is available through VCH Harm Reduction and on [CCRS](#).

A First Aid Course with rescue breathing and CPR is also recommended but optional.

Remaining Competent – If you cannot recall how to perform all parts of this skill properly, or have not used this skill for 6 months, re-read this guideline. If you have not used this skill in 1 year, re-take the Overdose Prevention and Naloxone Training for VCH Staff course.

Policy Statement

A British Columbia-wide health emergency has been called by the provincial health officer to recognize the current opioid overdose crisis in BC.

On Oct. 14, 2016, the *Health Professions General Regulation under the Health Professions Act* was amended to enable any person in a community setting to administer naloxone and first aid to another person if they suspect that person is suffering from an opioid overdose.

VCH supports all staff who work with people at risk for opioid overdose to administer naloxone and first aid in cases of suspected opioid overdose.

Need to Know

Opioids are substances (drugs) used to treat pain and addiction, to produce euphoria, or to manage withdrawal symptoms. Opioids include codeine, hydrocodone, hydromorphone (dilaudid), methadone, fentanyl and carfentanil, among others. Opioids bind to receptors in the brain, and cause sleepiness and slowing of body functions.

Opioid overdose that is not identified and treated in a timely manner leads to brain damage or death. This is caused by a decrease or lack of breathing, which results in a lack of oxygen to the brain and heart.

Opioid overdose symptoms:

- Decrease or lack of breathing (fewer than one breath every 5 seconds)
- Gurgling or snoring sounds
- Difficult to wake up or keep awake
- Tiny pupils
- Slow or no heart rate
- Vomiting

- Cold and clammy skin
- Bluish colour around the lips in people with lighter skin; grayish or ashen around the lips in people with darker skin

Naloxone is a safe treatment that should be used in conjunction with rescue breaths to reverse symptoms of opioids and help prevent brain damage or death. Rescue breaths provide oxygen while waiting for naloxone to take effect and will reduce risk of brain damage.

Naloxone displaces previously ingested opioids from the receptors in the brain, temporarily reducing the opioids effect on the body. **The goal of naloxone administration is to:**

- Increase breathing rate
- Open airway
- Increase alertness

NOTE: There are many reasons why a person may lose consciousness and be unresponsive (e.g. head injury, heart attack, stroke, seizures, low blood sugars in a diabetic, blood loss, etc.). If you suspect opioid overdose, treat as per this guideline, as giving naloxone to someone who has not taken opioids will not harm them. However, it is essential to call 911 immediately to ensure the person is transported to hospital quickly for diagnosis and treatment.

If a person is 'high', they may appear drowsy. They will respond to shouting or sternal rub. This is not an overdose and does not require treatment. However, drowsiness may be a sign that an overdose is coming. If possible, watch them or have someone (who has access to naloxone and a means to call 911) watch them to ensure their symptoms do not worsen.

Because naloxone wears off before opioids do, anyone who receives naloxone is at risk of re-overdosing. All people treated with naloxone should be encouraged to be monitored in a health care setting with access to oxygen and naloxone (e.g. hospital). If they decline this monitoring, encourage the person to remain with others who could re-administer naloxone and call for help for at least 2 hours.

Advise the person not to use other substances, especially opioids, alcohol or other 'downers' because they are at higher risk of overdosing again.

All people who use opioids or any substances purchased illicitly (because they may be contaminated with fentanyl) should be considered as candidates for receiving a *Take Home Naloxone* kit and training.

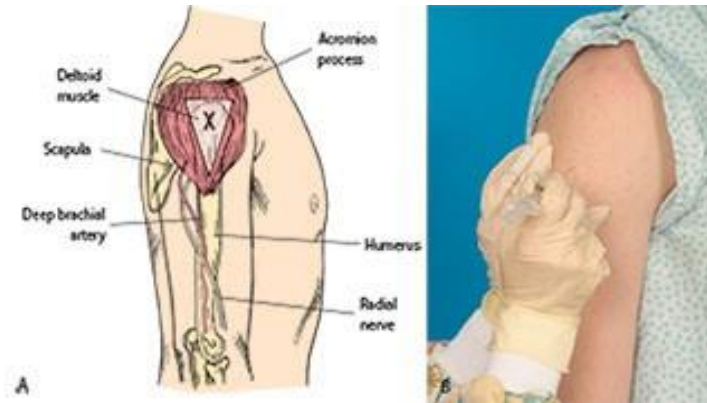
Too much naloxone can cause a person to experience severe **acute withdrawal symptoms**. This may include:

- Anxiety, irritability, aggression
- Dilated (large) pupils
- Sweating
- Nausea, vomiting, diarrhea
- Stomach cramps
- Fast pounding heart rate
- Tremors or shaking

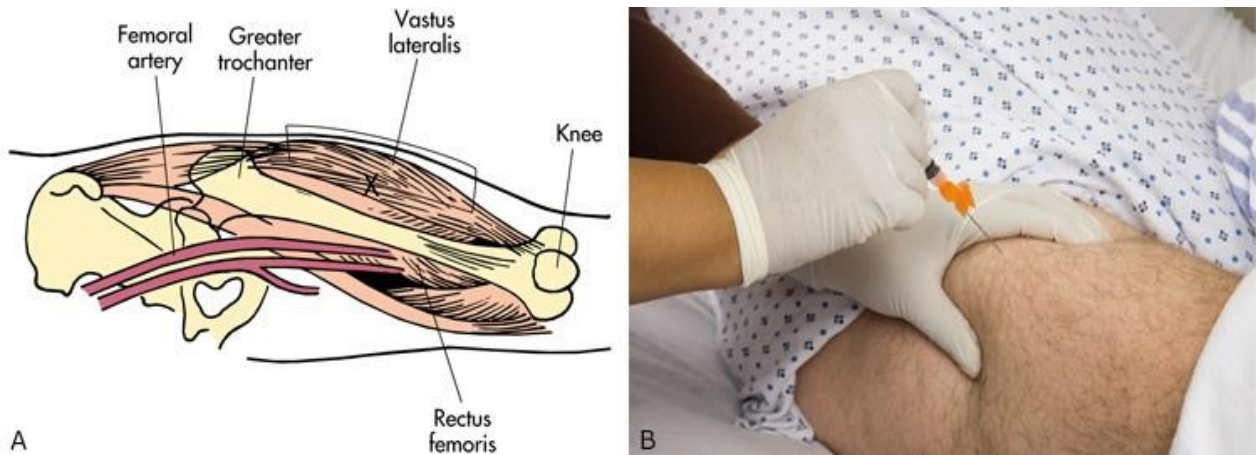
Therefore, the goal of naloxone administration is to administer enough to increase alertness and breathing, but not place them into withdrawal.

Landmarking for injections: If possible, use the upper arm or thigh rather than the butt. These sites are generally easier to access and it is more likely naloxone will correctly end up in the muscle rather than other tissues. The butt (dorsogluteal) also carries a risk of damage to the sciatic nerve if not landmarked correctly.

- **Upper arm:** inject into the meaty part of the muscle on the upper arm as shown in below pictures.



Thigh: inject into the meaty part of the thigh muscle as shown in below pictures.



Alcohol swabs should be used before injections (circular motion, allow to dry) to prevent infection if there is time. But if breathing is very slow or absent, alcohol swabbing may be skipped to allow quick administration of naloxone. In emergencies, injections can be done through clothing.

How to perform rescue breaths:

- Rescue breathing is easiest performed with the client/patient on their back
- Open the airway and mouth
- Check for any foreign bodies or blockages which may include needle caps, gum, food, or vomit.
 - Do not put your fingers inside the person's mouth
 - Turn the head and/or use an object such as the end of a syringe to remove objects if easy to do so.
- Open the airway by doing a head-tilt chin-lift, or by putting the patients head in the "sniffing" position (see image)
- Keeping airway open, place the plastic face shield over the patients face using the directions drawn on the mask
- Pinch the nose
- Give two breaths over no more than one second
- Continue giving one breath every 5 to 6 seconds for the rest of the intervention, or until the patient rouses or breathes effectively on their own (1 breath every 5 to 6 seconds)

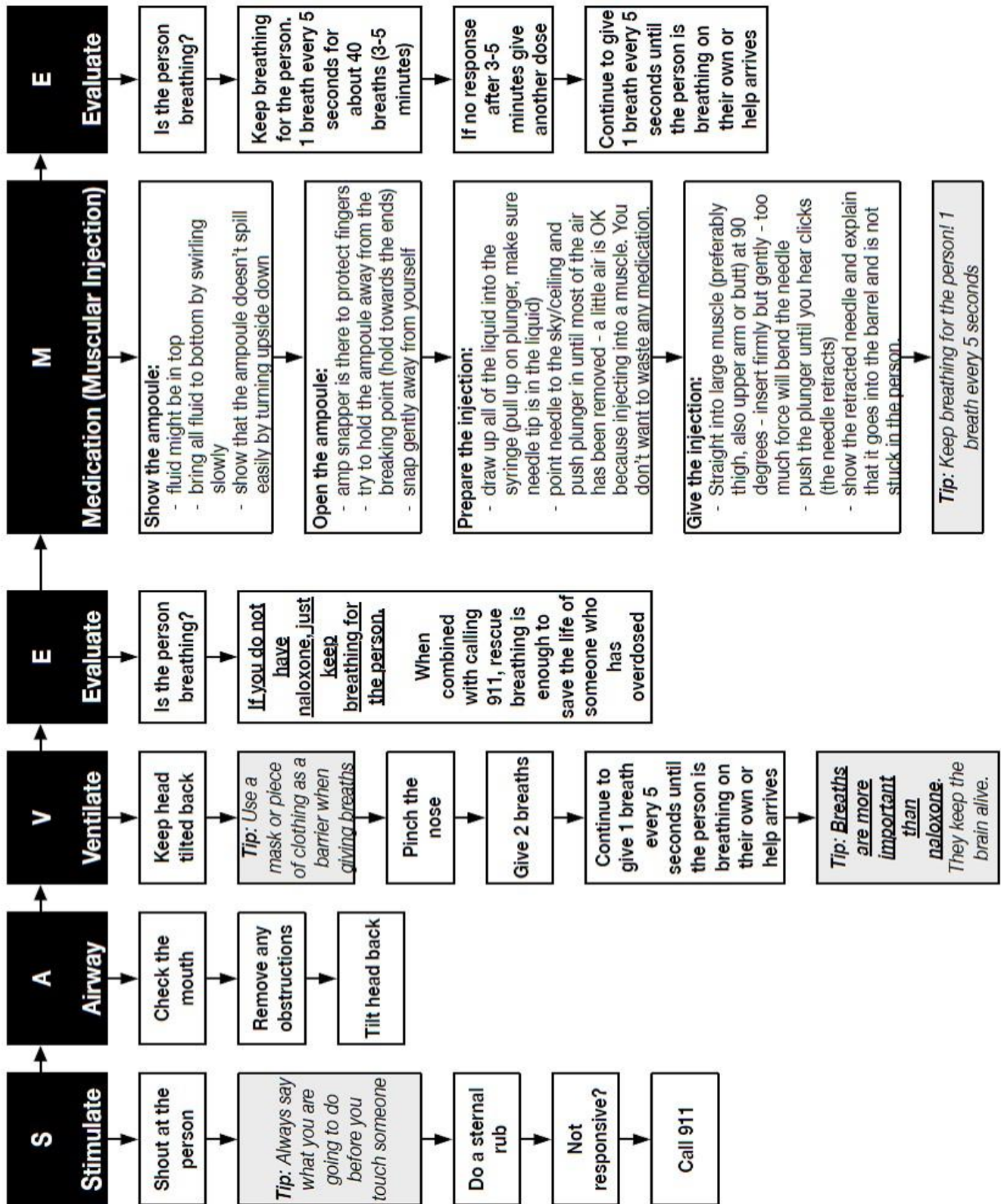


Note: Breaths oxygenate the brain and vital organs and are therefore more important than naloxone alone.

Equipment & Supplies

- Naloxone 0.4mg per 1 mL X 3 ampoules with ampoule snappers for protection
- 3mL 25G 1" syringes with safety needles X 3 (safety needles required by Worksafe BC)
- Alcohol swabs
- Face mask or face shield
- Gloves

Procedure: BCCDC Take Home Naloxone Program SAVE ME Steps



Note: This is a controlled document for VCH internal use. Any documents appearing in paper form should always be checked against the electronic version prior to use. The electronic version is always the current version.

Expected Patient/Client/Resident Outcomes

- Increase breathing
- Increase alertness
- Prevent brain damage
- Prevent death

Patient/Client/Resident Education

- Advise them naloxone wears off (20 to 90 minutes) before opioids do. It is important to stay with others who have access to naloxone for at least 2 hours in case of re-overdose.
- If the person experiences withdrawal symptoms from naloxone, these symptoms will subside when naloxone wears off (20 to 90 minutes)
- Advise them not to take more opioids, alcohol or other 'downers' following naloxone administration because they will not feel the effects of those substances and put them at increased risk for re-overdose.
- Provide information on accessing a Take Home Naloxone kit
- Give harm reduction information as needed, e.g.:
 - After a period of abstinence tolerance is reduced and overdose risk increases
 - Consider using less
 - Change route of administration from higher overdose risk (IV) to lower overdose risk (oral/nasal)
- Do not mix drugs and alcohol because they increase the effect of the other. Using more than one type of substance at a time increases overdose risk.
- Use with others if at all possible
 - Leave your door unlocked
 - Tell someone to check on you
- Do 'testers' to check the strength of the drugs you are using
 - Try a small portion first
 - Use less
 - Pace yourself
- Ask if they would consider incorporating family or friends into safety plan and educating those identified about overdose prevention, identifying and responding to overdose

Documentation

- If medications are within your scope of practice, document on medication administration record and in case note / encounter note.
- Otherwise, document all details including medication administration in a case note / encounter note.
- If you do not have access to an electronic medical record, document on paper.

Related Documents

- [VCH-N-0030: Naloxone HCL \(Narcan\) Administration on the Management of Suspected Opioid Overdose in Community Settings \(Adults & Youth\)](#)
- [VCH-N-0035: Dispensing Naloxone Kits to Client at Risk of Opioid Overdose \(Adults & Youth\)](#)
- BCCDC: [Decision Support Tool for the use of naloxone HCL \(Narcan\) in the management of suspected opioid overdose in outreach and harm reduction settings](#)
- [Toward the Heart Training Manual](#)

References

British Columbia Centre for Disease Control (2016). Decision Support Tool (DST) for the use of naloxone HCL (Narcan) in the management of suspected opioid overdose in outreach and harm reduction settings. Accessed December 1st, 2016 at: <http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/NaloxoneDSTUseforRN.pdf>

Perry, A.G., Potter, P.A., Ostendorf, W.R. (2014). Clinical nursing skills & techniques [8th ed.]. St. Louis: Mosby. Accessed Dec. 2nd, 2016 at: http://lms.elsevierperformancemanager.com/ContentArea/NursingSkills/GetNursingSkillsDetails?skillid=GN_21_5&skillkeyid=376&searchTerm=intramuscular%20injection&searchContext=nursingskills

Province of British Columbia Ministry of Health. Health Professions Act: Health Professions General Regulation (2016). Accessed December 1st, 2016 at: http://www.bclaws.ca/civix/document/id/lc/statreg/275_2008

Sanders, M.J. (2012). Mosby's paramedic textbook [4th ed.]. St. Louis: Mosby JEMS. Accessed Dec. 2nd, 2016 at: http://lms.elsevierperformancemanager.com/ContentArea/NursingSkills/GetNursingSkillsDetails?skillid=EN_003&skillkeyid=156&searchTerm=airway&searchContext=nursingskills

Developed by

CPD Developer Lead(s):

Danielle Cousineau, (Interim) Clinical Practice Leader, Primary Care, Vancouver Community
Sally Kupp, Clinical Educator, Community Health, Prevention, Vancouver Community
Sara Kathryn Young, Harm Reduction Coordinator, Mental Health & Substance Use, Vancouver Community
Lindsay Bendickson, Practice Initiatives Lead, Professional Practice, Vancouver Community

Endorsed by

VCH Scope of Practice & Regulations Review Committee

Barb Lawrie, Vice President Professional Practice and Chief Clinical Information Officer, VCH

Final Sign-off & Approval for Posting by

Barb Lawrie, Vice President Professional Practice and Chief Clinical Information Officer, VCH

Date of Approval/Review/Revision

Approved: December 7, 2016

Posted: December 7, 2016

APPENDIX K

Cleaning Booths (Insite, 2016)

CLEANING BOOTHS (Insite, 2016)

Avoid Needle Stick Injuries

- Always sweep debris off a booth with a **broom and dustpan**
- **Never use your hands** to take garbage off a booth
- Wear thick, **black rubber gloves** for booth cleaning
- **Encourage participants to clean** debris off their own booths
- Don't let yourself get **distracted** when cleaning

If you get stuck with a needle:

- Immediately go to Vancouver General Hospital (using SIS taxi acct)
- Alert the RPIC on duty
- Ascertain whose needle it was
- Get release of information from participant to access blood test results
- Complete WCB forms and "Unusual Incident Report"

Cleaning Check list for OPS (Insite, 2016)

All table/ booth surfaces need to be cleaned with a clinical grade disinfectant after each use. In addition, The following is a log of the areas that need regular cleaning maintenance in the OPS.

<u>Overdose Prevention Site</u>													
Doors													
Floor mopped													
Counters													
Sinks													
Phones													
Garbage out													
Restock towel													
Cupboard doors													
Clean mirrors													
Phones													
Walls													

APPENDIX L

Unknown Substances Left Behind Policy

Unknown Substances Left Behind Policy (VCH, 2016)

(Includes fillable form and log, Insite, 2016)

Any controlled or unknown substances left on site will immediately be brought to the attention of the RPIC/ARPIC. The substance may be a variety of forms:

Solid: powder/crystals/resin etc. and contained in an envelope, flap or other wrapping. Use a gloved hand to transfer contained substance into an envelope which is then sealed, dated and initialed by the RPIC/ARPIC staff member. The envelope will be placed in a locked safe in the SIS staff-only area. Fill out form and log sheet for 'Unknown Substance Left Behind' and place in locked safe by the RPIC/ARPIC. The Vancouver Police Department (VPD) will be contacted on the same day to collect the substance and a VPD officer must sign the form when removing substance from the premises.

Liquid: in a used/unused syringe. Use a gloved hand to handle tongs, which will be used to transfer syringe to a sharps container. Fill out form for 'Unusual Substance Left Behind' with a witness, logging incident on log sheet and accessing locked safe not necessary for a liquid form.

Site Specific: Describe any physical security measures that restrict access to and protect the controlled substances and precursors, that are currently or will be in place (for example: safe, locked cabinet, locked room, security monitoring, access keypads, swipe cards, door contact protection, video surveillance, etc).

Store all documentation in "Unknown Substances Left Behind" Binder.

Theft

In the event of theft from the locked safe, VPD will be notified. There is no other controlled substances and precursors for controlled substances stored onsite.

UNKNOWN SUBSTANCE LEFT BEHIND

Any member of staff or client who finds an amount of 'unknown substance' in the facility that is not upon a client's person, must complete this form and report the incident to the RPIC/ARPIC.

Date of report: _____

Reported by: _____ **Position:** _____

WHERE SUBSTANCE FOUND

- Washroom
- Reception/waiting area
- Injection room
- Chillout Lounge
- Other

LOG IN

If substance found was in:

- 1) Solid form, place in envelope and numbered according to next # on log sheet:
_____ and sign form with witness.

Sealed, numbered and put in safe by: _____ (print name)

- 2) Liquid form in syringe, dispose in sharps container and sign form with witness (log form not necessary).

Witnessed by: _____ (print name)

Witness signature: _____

LOG OUT

Date VPD called for pick up: _____

Date VPD removed from SIS: _____

VPD name: _____

VPD signature: _____

Witnessed by: _____ Witness signature: _____

APPENDIX M
Forms



VCH Harm Reduction Leader Contractor

CONFIDENTIALITY UNDERTAKING

In consideration of my contract placement at Vancouver Coastal Health Authority (VCH), I acknowledge and agree as follows:

1. I will adhere to the VCH Information Privacy and Confidentiality Policy and related policies as amended from time to time, concerning the collection, use and disclosure of information obtained in the course of my service with VCH;
2. I understand that all personal information concerning staff and clients that receive services from VCH (including medical records relating to patients and residents) is confidential and may not be communicated to anyone in any manner, except as authorized by VCH or applicable policies;
3. I understand and acknowledge that all information regarding the affairs of VCH, including corporate, financial and administrative records is confidential and may not be communicated or released to anyone in any manner except as authorized by VCH or applicable policies;
4. I will not copy, alter, interfere with, destroy or remove any confidential information or records except as authorized by VCH and in accordance with established policies; and
5. I understand that compliance with confidentiality is a condition of my placement with VCH and that failure to comply may result in immediate termination of my placement, in addition to legal action by VCH and others.

Print Name _____

Signature _____ Dated (mm/dd/yr) _____



User Agreement, Release and Consent Form: Overdose Prevention Site (OPS) LOGO

Prior to using the OPS, I agree to the following:

- I have injected drugs in the past, am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health.
- I will follow the direction of OPS staff and any Code of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize OPS staff to provide emergency medical services if necessary.
- I am aware of the harmful effects of drug use and accept full responsibility for all risks to myself, including my death, and on behalf of myself and my heirs, hereby release the Overdose Prevention Site, Vancouver Coastal Health Authority, Portland Hotel Society, and/or VANDU and their employees, partners and agents from any and all liability for any loss, injury or damage I may suffer as a result of my use of this facility.

I understand the above and am able to give consent.

Name: _____ (must include first & last initials)

Date of Birth: _____ (D/M/Y)

Completed by: _____

Date: _____ (D/M/Y)

Handle or Identifier:
(Name, nickname, or #,
Ideally same as at Insite)

Revised December 7th, 2016



Overdose Prevention Site: Release responsibility Waiver LOGO

Purpose: To waive responsibility of OD Prevention Site staff and volunteers upon a participant leaving the site against medical advice.

Participant Name/Handle: _____

I _____ have had the risks of leaving the OD prevention site against medical advice explained to me and I release all staff from all responsibility if my safety/life is compromised because of leaving this facility AMA. I am solely responsible for my own life/safety once I leave the OD Prevention Site.

Participant Signature: _____ Date/Time: _____

Staff Witness: _____ Date/Time: _____

OR

Participant left OD Prevention Site AMA, with knowledge of the risks involved, but without signing waiver.

Staff signature: _____ Date/Time: _____

Witness: _____ Date/Time: _____

Revised December 7th, 2016



SIS Youth Registration & Assessment



Name: _____ Date: _____ Handle: _____
DOB: _____ Verified with ID? [Y] [N] ID Type: _____
If <16 yrs old, MCFD Notified? [Y] [N]

Reasons for wanting to access SIS:

Drug History: Substances, routes, duration, frequency

Injection sites visualized? [Y] [N] [N/A] Congruence between history and presentation? [Y] [N]
Notes: _____

Understanding of risks related to IVDU: [OD] [Tolerance] [Addiction] [Infectious Disease] [Emboli]
[Vasc/Nerv Damage] [Injecting Unknown Substances] [Scarring/tracks] [Access to HR Supplies]
Notes: _____

Does youth present with need for immediate IR access? [Y] [N] IR Access Granted? [Y] [N]
Notes: _____

Harm Reduction Education
[OD Prevention] [Not Using Alone] [Hand Washing] [ETOH Swab] [VC/location]
[Flagging] [Disease Prevention] [Drug preparation] [Equipment] [Alt routes of ingestion]
[Take Home Naloxone (if opiate use in drug hx)]
Notes: _____

Table with 6 columns and 7 rows listing referral services under categories: Detox, Case Management, Housing, Income Assistance, Primary Care & Addictions, Mental Health.

Sexual Health/Gender † PRISM † BCCDC † Opt Clinic † CW Holman † Qmunity

† Other: _____ Transport Offered? † Y † N

Additional resources in Youth Health & Wellness Services pamphlet. <http://vch.eduhealth.ca>

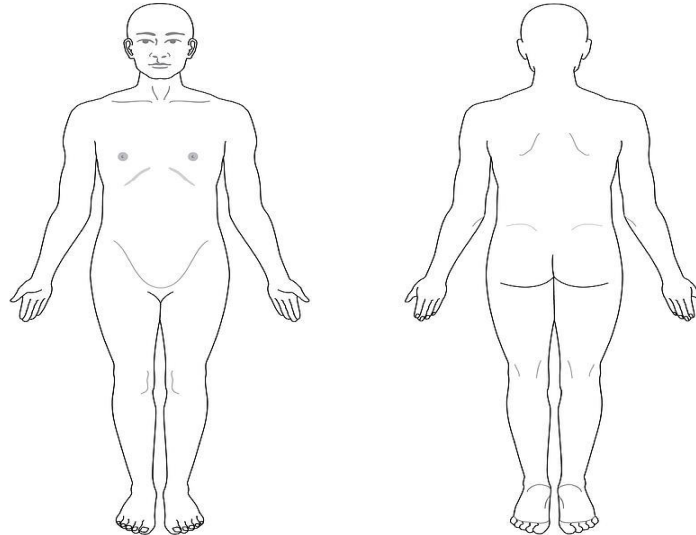


Figure 1. Visualized Injection Sites

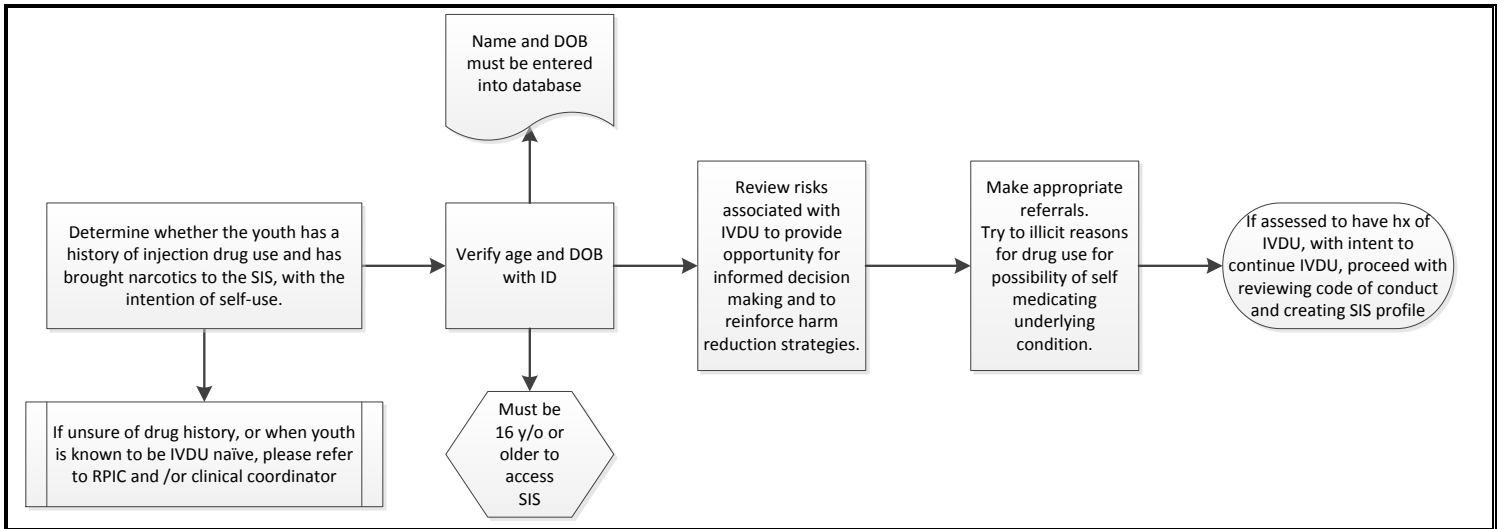
Background

Youth represent the highest risk group for contracting HCV and HIV through IVDU, and research has shown that they engage in high-risk behaviours to a greater extent than established users. As such, there is real potential to reduce the harms associated with ongoing injection drug use among this group. Supervised Injection Facilities are generally seen as an intensive intervention along the continuum of harm reduction services, for an extremely marginalized population already entrenched in IV drug use (IVDU)¹. Accordingly, youth who do not have a history of IVDU should access addiction resources that can more appropriately address their level of need and prevent initiation to IVDU. Prompt referrals to addiction treatment programs is an evidence-based strategy at preventing initiation to IVDU².

Youth Intake Process for Senior RN & Senior Program Staff

¹ SIS Policy and Procedure Manual. (2014). 2.3.2.8 Youth. pp 37-38

² Werb, D. et al. (2013). Interventions to prevent initiation to IVDU: A systematic review. *Drug and Alcohol Dependence*. (133)2. pp 669-676



Program Staff Sign: _____

Please fill out one row in the table for **each visit** to the Overdose Prevention Site.

Please use a new sheet at the start of each day.

	Time of visit (include time of day and circle am or pm)	Did the person overdose? (Yes/No)	If the client overdosed, answer these questions as well:					
			Was naloxone given?			Was the person taken by ambulance to an emergency department?		
1.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
2.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
3.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
4.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
5.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
6.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
7.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
8.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
9.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
10.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
11.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
12.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
13.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
14.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown
15.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unknown

Contact info for receiving extra forms and arranging pick up of completed forms: Shannon.riley@vch.ca Phone: 604-875-4111 ext. 69773 Fax: 604-875-5229

