Harm Reduction and Managing Substance Use – Acute Care

Site Applicability

St. Paul's Hospital (SPH) and Mount Saint Joseph Hospital (MSJ) Acute Care, including Emergency Departments

Practice Level

RN, RPN, LPN

Need to Know

- In April of 2016, a public health emergency was declared in British Columbia in response to the rise in drug overdose deaths. Providence Health Care (PHC) endorses and expects that a harm reduction approach be offered to individuals, families and communities who are at risk of harms related to substance use. PHC's Philosophy of Care for Patients and Residents Who Use Substances supports a spectrum of care for patients who have a history of or are currently using substances.
- It can be difficult for individuals who use substances to abstain from using while admitted to hospital, which can be a period of increased stress and/or pain. Harm reduction neither condones nor condemns substance use, but instead intends to reduce harms associated with substance use.
- Rather than requiring patients to stop using substances to access care or services, care options can be offered to meet patients' individual needs.
- A harm reduction approach does not mean that patients may freely engage in challenging, disruptive or unsafe behaviours whether related to the use/effect of substances or not (e.g., verbal or physical violence, uncapped needles). Harm reduction does not intend to transfer the risk from one person to another person within the shared care environment.
- PHC is committed to providing a safe and healthy working environment for all staff working within PHC facilities. All staff share the responsibility for the achievement of a safe and healthy work environment.
- Patients who use substances often report feeling stigmatized in the health-care system. Negative encounters and unmanaged pain and withdrawal can lead to patient-initiated discharge before medical care is complete. Stigma can also drive people to hide their substance use and avoid health care altogether (see Appendix A for more information on stigma).
- Point-of-care encounters provide opportunities for providers to offer life-saving care options, engage patients in treatment for their substance use disorder, and help them remain in hospital to receive treatment for their acute medical issue(s). Abstinence may not be a realistic or desirable goal for all patients but PHC can offer options to keep patients safe while admitted to our services.
- The Addiction Medicine Consult Team (AMCT) provides clinical support for these care options.
- SPH has an Overdose Prevention Site (OPS) on site.
- Patients are asked not to use substances in hospital, other than at the SPH OPS, for their safety (e.g., risk of unwitnessed overdose) as well as the safety of staff and other patients and visitors.

- Health care providers work collaboratively with patients to help them understand the risks and possible harms that they are accepting by using substances in an unsafe manner. Patients need to be informed that hospital staff cannot be responsible for effects nor guarantee safety if they use substances outside or unsupervised; however, OPS services are available at SPH as well as education to reduce harms and prevent overdose.
- Health care providers are not responsible for the autonomous decisions made by a capable patient. Health care providers are also not responsible for preventing patients from using substances, even when patients decline staff requests for them to use at the OPS or offsite (see "Active Substance Use").
- Harm reduction and overdose prevention education and supplies are offered to minimize potential harms. The care options and patient and family education provided is documented in the patient's chart.

Quick Links:

Guideline

1.0 Goals of Care

1. The AMCT or other specialized supports will be involved early in admission.
2. Pain, cravings, and withdrawal management will be assessed and treated to improve patient comfort and engagement.
3. Physical, emotional, mental, social, psychological, and spiritual health care needs of patients will be met through an interdisciplinary team approach with patients and families encouraged and supported to be active participants in their care.
4. Harm reduction education and care options will be offered by members of the interdisciplinary care team.

2.0 Assessment of Substance Use and Withdrawal

2.1 Screen all patients on admission for substance use (including alcohol and tobacco) and assess for ongoing use throughout their hospital stay.

- The CAGE-AID tool is used to screen for substance use as part of the admission forms in CST-Cerner PowerChart for the medicine/general inpatient areas (see Appendix B). If the patient answers "yes" to two or more questions:
  - Cerner will generate an order and nursing task to complete the CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, revised) assessment, and
  - Consider asking the Most Responsible Physician (MRP) to assess need for an AMCT consult (if not already ordered).

If the patient has been seen by the AMCT, there may be an AMCT consult note which outlines the patient's known use of substances and treatment plan.

2.2 Encourage patients to engage with health-care staff regarding their substance use and tell us if they are experiencing pain, cravings, or withdrawal so that the health care team can assist in treating their pain, cravings, or withdrawal and work with them toward their substance use goals.

Recognize however, that not everyone will be forthcoming about their substance use because of shame, stigma, past experiences in hospital, or fear of being perceived as drug seeking.

Patients may be more willing to disclose substance use patterns if permission is asked and the information is requested in a non-judgmental manner, in a private setting and the value of the information is explained (e.g., useful in predicting and treating withdrawal or determining starting doses for pain control agents).

The **sample script** below may be a helpful tool for clinicians initiating a conversation.

"I want to make sure that you feel safe and comfortable so that you can stay here in hospital and receive the medical treatment that you need. I'd like to ask you a few questions that will help me provide you with better medical care and make sure you are getting the

right treatment. I'll ask you about drug use—but only to better offer treatment and adequately manage your pain, cravings, or withdrawal. Is that okay?"

Patients have the right to determine whether or not to disclose this information so respect their privacy if they choose not to engage.

2.3 Ask patient about use of substances including nicotine, alcohol, opioids, stimulants (e.g., cocaine, MDMA, methamphetamine), benzodiazepines, cannabis, GHB, hallucinogens, and inhalants and assess for withdrawal accordingly.

- Ask what their substance use goals are (e.g., abstinence, reduce use, to be safe while using).
- Patients' substance use goals may not align with the goals of the health care team. Patients may face challenging treatment choices, and discussion about what is important to them promotes good decision-making and patient-centered care. Consult Ethics for navigating challenging situations on a case-by-case basis.

2.3.1 *Assessment of alcohol withdrawal*

Determine when the patient's last drink was to anticipate when initial manifestations of acute withdrawal may be expected and assess progression.

- **CIWA-Ar Scale:** includes both subjective and objective signs and symptoms of withdrawal. See Alcohol Withdrawal Protocol.
  Note: Nurses can independently initiate the CIWA-Ar assessment and monitor the patient if the patient's last drink of alcohol was less than 7 days ago and the patient scored 2 or more positive responses related to alcohol use on the CAGE-AID questionnaire (see Appendix B).
  - The "Alcohol Withdrawal Management (CIWA-Ar)" PowerPlan, which includes medications to treat withdrawal symptoms and bloodwork, must be ordered by a provider but nurses can identify the need for treatment of alcohol withdrawal and inform the provider.

- **Objective Alcohol Withdrawal Scale (OAWS):** includes only objective signs of withdrawal and may be used for individuals who cannot report symptoms, for example, patients with cognitive impairment, mechanical barrier (e.g., intubation), or language barrier that cannot be bridged.
  Note: Assessment and treatment of a patient using the OAWS may only be ordered by an AMCT provider.

CIWA-Ar and OAWS are not interchangeable and are not to be used at the same time. This may increase the risk of overmedication. CIWA monitoring orders are standardized across patients, however, OAWS orders are individualized (i.e., patient specific) and vary from patient to patient.

2.3.2 *Assessment of opiate withdrawal*

- **COWS (Clinical Opiate Withdrawal Scale):** used to assess signs and symptoms of opiate withdrawal and determine stage/severity of withdrawal; sometimes used for

buprenorphine-naloxone (SUBOXONE) inductions *(located in CST-Cerner PowerChart in "Interactive View and I&O" under "Adult Systems Assessment")*.

3.0 Collaborating with the Addiction Medicine Consult Team (AMCT)

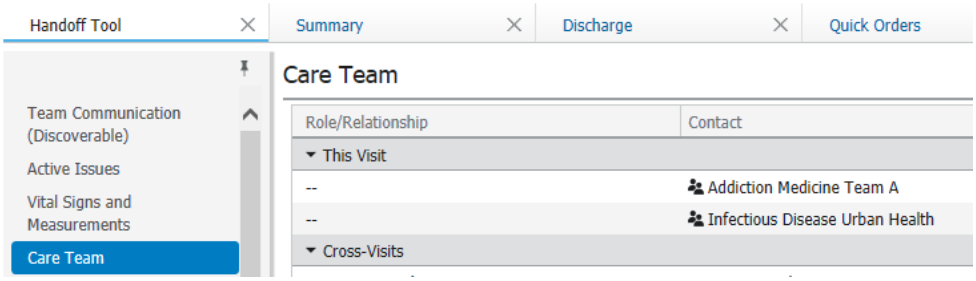
The AMCT is a consulting service that follows patients for all types of substance use disorders and can prescribe medications and support other management approaches (e.g., referral to psychosocial interventions).

Referrals to the AMCT can be made by Physicians, Nurse Practitioners and Clinical Nurse Leaders (CNLs) and can occur at any point during hospitalization.

3.1 At SPH:

- Referrals are made in CST-Cerner by placing the order "Consult to Addiction Medicine" (or in ED, "ED Consult to Addiction Medicine").
- The AMCT provides support 7 days per week, with a provider on site between 0800 and 1700 and available on-call overnight through the MRP or on call provider.
- There are four AMCT teams that follow inpatients at SPH. Once consulted, nurses can view the patient's chart and click on "Patient Summary" and under "Handoff Tool" -> click "Care Team" to see which team is following the patient (A, B, C or D) and call the attending physician from that team through switchboard for review or concerns between 0800 and 1700.

For example, this patient is being followed by AMCT Team A:



3.2 At MSJ:

- One AMCT physician provides coverage Monday to Friday between 0800 and 1700 and can be accessed through switchboard.

  Note: Do not submit a "Consult to Addiction Medicine" order in CST-Cerner for MSJ patients. There is no process for the physician to be notified other than by phone.

  - When patients who are followed by the AMCT are transferred from SPH to MSJ, inform the MSJ AMCT provider (or AMCT on-call if after hours/weekends) by phone. There is no process to automatically transition patients followed by the AMCT to this physician upon transfer from SPH to MSJ.

- Weekend and overnight support is provided by the AMCT on-call, accessed through switchboard by MRP.

3.3 Overnight management for SPH and MSJ:

Between the hours of 1700 and 0800, the AMCT on-call provider may be accessed **by providers (and medical students) only** through switchboard for guidance on new patients or when the clinical team has attempted all available strategies and substance use issues are still unmanaged.

Exception: If the patient's MRP/admitting physician is an AMCT provider, the provider is to provide nurses with a contact number so that nurses can access support directly overnight (likely AMCT on-call).

Nurses can advocate for MRP or on-call physician coverage (e.g., clinical associate or cross-coverage) to call the AMCT for unmanaged issues including, but not limited to:

- Order clarification for medications ordered by the AMCT (try to call before 2200 and ideally for orders that cannot wait until the following morning to be clarified),
- Uncontrolled opioid withdrawal (perform a pain assessment and a COWS score - *located in CST-Cerner PowerChart in "Interactive View and I&O" under "Adult Systems Assessment"* - prior to calling). Do not ask MRP to call the AMCT for *pain alone* as this may indicate another acute medical issue. If there is worsening pain or new onset pain, call MRP who can assess and liaise with the AMCT as needed,
- Complications such as withdrawal or intoxication for patients on the Managed Alcohol Program, and
- Uncontrolled withdrawal for patients on the Objective Alcohol Withdrawal (OAW) PowerPlan.

If nurses feel that they were unable to access support that was needed overnight, notify the CNL in the morning who can inform the AMCT Liaison Nurse to follow up.

3.4 AMCT Liaison Nurse, Pharmacist, Social Work, and Peers:

The **AMCT Liaison Nurse** is available to provide clinical support for nursing staff caring for inpatients at SPH who are followed by AMCT 7 days a week between 0800 and 1600 (call switchboard). They can assist with case guidance and complex care planning, in the moment education related to medication administration, assessments, or any questions related to substance use and substance use disorder care and treatment. Some examples include, but are not limited to:

- Missed or held doses of opioid agonist treatment (OAT),
- Patients on the Objective Alcohol Withdrawal Scale (OAWS),
- Buprenorphine-naloxone (SUBOXONE) inductions,
- Questions about medications or orders that you are unfamiliar with or that require clarification,
- Active substance use on (or off) the unit, and
- Concerns about decreased respiratory rate or level of consciousness and when or if to hold a dose of opioids, or when to administer naloxone.

There is also an **AMCT Clinical Pharmacy Specialist** whose role encompasses medication management, patient education and health promotion, seamless care, and program support and development.

Two **AMCT Social Workers**, one in Psychiatry and another who covers all of the other inpatient units at SPH, can support patients with a number of things, including connecting patients to resources in community, including group support (e.g., Alcoholics Anonymous), referral to detox, and completing and submitting application forms for residential treatment upon discharge.

Peer support workers are also part of the AMCT and are people who have lived/living experience with a mental health, substance use, or trauma issue who are able to use their experience and engage in mutually supportive relationships with patients in the midst of struggling with a similar issue. Peer support workers and services can be accessed through the AMCT Liaison Nurse.

4.0 Approaches to Care and Management of Substance Use Disorders

4.1 Opioid Use Disorder (OUD)

Patients with OUD often experience very uncomfortable withdrawal symptoms when they stop using opioids (e.g., diaphoresis, body aches, chills, nausea/vomiting, anxiety/panic attacks, diarrhea, piloerection of the skin).

Due to the high tolerance many people with OUD have, they often require very high doses of opioids to relieve their symptoms of withdrawal.

Therefore, many individuals with OUD will continue to use substances (e.g., heroin, fentanyl) in addition to the opioids prescribed and administered in hospital, especially during titration phases of opioid agonist treatment (OAT).

Interventions

- Administer prescribed doses of OAT as ordered and *notify prescriber if any doses are held or missed.*
  - Regularly scheduled doses of methadone and injectable opioid agonist treatment (iOAT) that are missed (e.g., patient was off unit) can be rescheduled up until midnight on the same day without necessitating a call to AMCT and according to certain parameters depending on the medication. See links to SHOP documents below that outline these parameters:
    - Information regarding dose rescheduling for methadone can be found here and iOAT here.
  - Patients can go into withdrawal if they do not receive their OAT. All doses should be administered provided that the patient isn't too sedated according to the Pasero Opioid-induced Sedation Scale (POSS; see Appendix C).
  - Wake patient up for all regular doses and administer if the patient is not too sedated as above.
  - **If a patient uses non-prescribed substances while receiving OAT, it is still safe to give them their dose if their POSS score is less than 3** (see Appendix C).
- Assess and offer PRN medication for pain, cravings, or withdrawal routinely and *proactively (i.e., don't wait for patient to have to ask if possible)*.

- Sometimes patients are reluctant to ask for PRNs due to fears of stigma and discrimination and being labelled a "drug-seeker".
- Inform patients when and how often they can have PRN medication.
- If a patient has PRN doses of OAT ordered, in addition to a regular dose, the AMCT may be trying to titrate the patient to a higher regular dose. If patients receive and tolerate the PRN doses, the prescriber may consolidate/add the PRN doses to the scheduled dose. The AMCT note in the "Documentation" section of the chart should outline treatment plan.
  - In hospital, patients can be titrated much more quickly to therapeutic doses of OAT because nurses are able to monitor for sedation at peak blood levels to ensure patient is tolerating doses.

OUD and pain management

Treating acute pain in patients with pre-existing, active OUD can be challenging given high opioid tolerance. It is a misconception that administering opioids will contribute to or exacerbate OUD. Undertreated acute pain is a greater risk factor for relapse or return to substance use or to contribute to ongoing use (see Appendix D).

- Administer or offer non-opioid pharmacotherapies such as acetaminophen, nonsteroidal anti-inflammatories, and anticonvulsants for neuropathic pain as ordered.
- In cases of severe acute pain or significant traumatic injury, opioid analgesics are likely going to be required.
  - Patients in recovery may not want to take opioid analgesics and have apprehension related to the possibility of relapse, coupled with fears about unrelieved pain. In these cases, a discussion with the care team around alternative therapies or a proactive approach to prevent relapse, and a patient-centered care plan to reduce or eliminate use of opioids can be developed in collaboration with the patient.
- OAT does not treat acute pain and should be used in conjunction with analgesia for pain.

  However, patients on methadone maintenance therapy, while they will get no analgesic effect from their regular dose, may experience benefit from a split dose or higher dose. The analgesic effects of opioids are shorter than their effect on withdrawal and cravings, which is why BID or TID dosing may be used.
- Patients with high opioid tolerance may benefit from a consult to Acute Pain Service (APS) for consideration of interventions such as nerve blocks or ketamine infusions.

4.2 Alcohol Use Disorder (AUD)

Alcohol withdrawal is commonly managed with use of symptom-triggered benzodiazepine administration according to the Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar). At SPH, the Objective Alcohol Withdrawal Scale (OAWS) may be used as an alternative method to assess and manage withdrawal when ordered by the AMCT for patients for whom CIWA-Ar is deemed not appropriate.

Managed Alcohol Program (MAP) may be ordered for patients who are on a program in community or those who regularly consume unsafe quantities of alcohol or non-beverage alcohol (e.g., hand sanitizer, rubbing alcohol) and require a harm reduction approach to avoid withdrawal and support completion of medical treatment in hospital.

Interventions

- Managed Alcohol doses are ordered PRN. Assess patients who are on MAP regularly for signs and symptoms of withdrawal using CIWA-Ar BID and offer alcohol when indicated to avoid them going into more severe withdrawal.

4.3 Stimulant Use Disorder

Stimulants include substances such as cocaine (injected or snorted), crack (a form of cocaine that is smoked, injected or snorted) and amphetamines, including crystal methamphetamine. Stimulants may also contain fentanyl or other contaminants, which can cause overdose or death. Stimulant users should consider testing their drugs as they may be at increased risk of adverse effects in the absence of opioid tolerance.

Stimulants can cause elevated behaviour (e.g., agitation), delusions and sometimes psychosis as well as abnormal vital signs (e.g., elevated temperature and heart rate) which can constitute a medical emergency and result in long-term cardiac complications (e.g., increased risk of myocardial infarction).

Interventions

- Advocate for low-stimulation environment (e.g., private or semi-private room, cluster care to limit interactions, decrease lighting).
- Currently, there are no evidence-based pharmacotherapies to treat stimulant use disorder, but other medications may be ordered and administered to temporarily manage agitation or psychosis related to acute intoxication (e.g., loxapine).
  - If you observe early signs of agitation, or escalation of behaviour(s), offer the appropriate PRN medications that are available for this and/or call the MRP and/or AMCT to assess the need for such treatment.
  - Prescribed stimulants (e.g., dextroamphetamine) as replacement therapy is used in some cases to reduce risk of withdrawal, exposure to COVID-19 and the contaminated drug supply for risk mitigation.
- Stimulant psychosis could require a psychiatry consult to assist in care management as requested by the MRP and/or AMCT.
- Provide snacks and fluids (as appropriate) as individuals withdrawing from stimulants can experience increased appetite and dehydration.

4.4 Tobacco Use Disorder

Advise patients that PHC sites are smoke and vape-free premises. All patients should be screened for tobacco use and offered nicotine replacement therapy (NRT), which can be ordered by RNs and RPNs as a Nurse Independent Activity (NIA) with orders that will last for 24 hours.

Interventions

- Offer PRNs liberally (nicotine lozenges, gum, inhaler) particularly for patients who are unable to leave the unit to go outside to smoke.

4.5 Cannabis Use

Screen patients for cannabis use.

- It is uncommon for cessation of cannabis use to cause acute withdrawal syndromes, but patients may experience cravings and some heavy users will demonstrate withdrawal symptoms (e.g., nausea, anxiety).

4.6 Harm Reduction

Abstinence may not be a realistic or desirable goal for all patients. Harm reduction neither condones nor condemns substance use, but instead intends to reduce harms associated with substance use. Evidence has shown that harm reduction-oriented practice can reduce the transmission of blood-borne illnesses and other injection-related infections and prevent fatal overdose.

Interventions

4.6.1. **Offer a naloxone kit** to all patients who use substances, have a history of substance use and those on opioid agonist therapy. This does not have to wait until discharge and should be offered at any time during admission to hospital (unless patient is admitted to inpatient psychiatry or certified under the Mental Health Act).

4.6.2 **Offer safer use supplies.** Harm reduction supplies include, but are not limited to, syringes (0.5 or 1 mL), alcohol swabs, tourniquets, sterile water, cookers, filters, Vitamin C, safer smoking supplies (e.g., pipes, foils, mouth pieces, push sticks), and personal sharps containers (see harm reduction supply lists that provide item descriptions and what they are used for).

- **At SPH**, the Urban Health unit (8A) and the ED have sterile injection/inhalation supplies available for patients upon request; the Medicine units, the Rapid Access Addiction Clinic (RAAC; see Appendix E) and the SPH Overdose Prevention Site (OPS) can also provide patients with both safer injecting and smoking/inhalation supplies.
- **MSJ** stocks harm reduction supplies - contact the nurse educator for Medicine.

Other care areas can provide patients with the supplies listed above as available. Care areas that would like to obtain a stock of additional harm reduction supplies can contact the Nurse Educator for Substance Use.

4.6.3 **Inform and refer patients who use substances to Overdose Prevention Sites (OPSs) and Supervised Consumption Sites (SCSs) in the area** (see VCH map or search your area).

- **SPH has an OPS located inside the hospital *for patients only*** (including outpatient clinics and ED). Patients are able to use their own substances under

supervision of staff who provide overdose prevention and response and harm reduction education and supplies (see Appendix F for details and map).
If patients require assistance to get to the SPH OPS (e.g., patients with limited mobility), contact CNL who can discuss options for providing assistance to get to the site with the AMCT Liaison Nurse or Nurse Educator, Substance Use.

4.6.4 **If a patient is noted or suspected to be using their intravenous line to inject substances, refer to the decision support tool on SHOP:** PICC/PIV and Substance Use: Patients Who May be Using Their IV Line to Inject Substances.

- Patients can also be referred to the SPH OPS (see Appendix F). Staff there are trained to provide harm reduction education around IV line use and sterile supplies.

4.6.5 **Provide harm reduction education to patients and families.**

Overdose prevention:

- **Do not use alone.** Alternative options include: *use at an OPS/SCS, or use with someone else (if both individuals will be using substances, stagger use to avoid overdosing at the same time); if using alone, have someone on the phone who can call 911 if the person becomes unresponsive or use life-saving digital apps such as Lifeguard or Brave if the patient has a smartphone.*
- **Consider sampling or checking substances** (partial dose) to see how the drug affects them. The SPH OPS has test strips for fentanyl and benzodiazepines that patients can use to check their substances.
- **Do not mix drugs**, especially those with sedating effects (e.g., alcohol and opiates).

For people who inject substances:

- Perform hand hygiene and use sterile supplies and a new needle each time, inserted with the bevel facing up.
- Clean the site with an alcohol swab.
- Do not touch the inside of the sterile cooker to avoid contamination and draw up substances using a filter.
- Rotate sites and save one vein for medical emergencies (ideally in the arm).
- **Whenever possible, avoid injecting into high-risk sites: the neck** (*easier to overdose, close to large blood vessels, nerves, trachea and esophagus - abscesses in this area are dangerous and could cause compression of these structures, risk of air emboli, infection could travel easily to brain or heart)*, **the groin** *(could hit an artery and cause bleeding or loss of limb)*, and **inside of the wrist** *(many arteries and nerves that are close to the veins)*.

For people who smoke substances:

- Use sterile supplies (available at SPH OPS [see Appendix F], SPH Acute Medicine Units and RAAC [see Appendix E]).
- Don’t share pipes or mouth pieces.

- Advise patient to conduct activities outside as outlined in PHC's Smoke and Vape-Free Premises policy. Do not enter the space when patient actively inhaling.

Dispose of all sharps and supplies safely.

See 'Patient Resources' section for additional patient teaching material.

5.0 Establish a Safe Care Environment

Being in hospital can be a traumatic and overwhelming experience for patients and result in a loss of control. Our goal is to provide a safe environment for all patients, families, visitors and staff. Patients may escalate behaviorally when they feel scared or that their needs are not being met. Most individuals do not have any intention to harm others and can be receptive to a conversation, free of stigma and judgment, regarding safety issues.

5.1 Create Expectations

- Establishing and maintaining clear and consistent boundaries (e.g., personal, team, unit and hospital) in a respectful way is a healthy and essential component of harm reduction.
- If staff can demonstrate that patients are welcome and supported in hospital, they may be more receptive to behaviour expectations (e.g., *"How can I support you right now? What is it that you need?"*).
- Acknowledge how they feel and try to validate the emotions and experience of the patient (e.g., *"I can see you're feeling angry right now,"*) while gently and firmly outlining expectations (e.g., *"but you cannot continue to yell in this space."*).
- When patient is settled, inform them if their behaviour made others feel unsafe, even if it was not their intention and ask them how we can support them to feel less frustrated going forward (e.g., *"Please tell me more about what happened so I can better understand how to help you."*).
- Staff should not put themselves at risk by enforcing unit rules. Site security can be called proactively for standby or if staff feel that they are in immediate danger. See also: Violence Prevention in the Workplace.
- Provide culturally safe care that includes access to Spiritual Health Practitioners and the Indigenous Wellness and Reconciliation Team who can provide access to traditional medicines, talking circles, and bedside ceremonies.

Discuss safety issues as a team to determine the best approach to maintain a safe and healthy working environment. Consult unit Nurse Educator, Nurse Educator or Clinical Nurse Specialist for Substance Use, and/or Occupational Health and Safety and Violence Prevention Advisor (where applicable) for support and direction.

5.2 Respond to Overdose

- In the case of suspected opioid overdose (patient or visitor) naloxone can be administered with or without a provider order.
- If someone who is not a patient overdoses, call the code blue team for assistance as these individuals cannot be monitored in an ongoing way on the units.
- Fill out a Patient Safety & Learning System (PSLS) report for all patient overdoses.

NOTE: There have been unusual and atypical clinical presentations of opioid overdose such as dyskinesia (flailing), muscle rigidity (chest wall, clenched jaw), or individuals who appear to be standing, walking or awake while experiencing an overdose (see pages 27 to 30 of this document).
Given the complex nature of patients in acute care settings, other causes contributing to a patient's altered level of consciousness or respiratory depression should be considered when responding to a suspected opioid overdose.

5.3 Support Recovery

Patients who wish to remain abstinent should be supported to do so. This may necessitate room and/or unit changes (where possible) if the behaviors of other patients are triggering.

Staff can submit a referral to the Addiction Medicine Social Worker for additional support, including:

- Counseling patients,
- Assisting with referrals to residential outpatient treatment/recovery programs, and
- Directing patients to mutual self-help groups available in hospital and/or community.

Peer support, Indigenous Health and Wellness Team and Spiritual Health Services referrals may also be offered to the patient.

5.4 Support Patients to Complete Medical Treatment

Patients with substance use disorders may face multiple competing priorities in addition to their medical concerns (e.g., risk of eviction, legal matters, caring for pets or family members), which may impact their ability to participate in care (e.g., missed treatments, leaving the unit, initiating discharge).

They often do care about their health and want to get better but need to address these urgent and competing concerns first.

- Ask patients about their priorities and liaise with the interdisciplinary team to determine how to support the patient (e.g., involving Social Work).
- To support continuity and engagement in care, include the patient and other resources such as social work, Indigenous Wellness and Reconciliation Team, peer supports and community health teams in care planning.

5.5 Plan for Discharge

Patients should not be discharged until the AMCT has completed the discharge prescription and arranged follow-up care.

The **Rapid Access Addiction Clinic (RAAC) at SPH** can provide short-term follow-up care for patients with substance use disorders and assist in connecting them to ongoing care in community. The clinic is open 7 days/week from 0900 to 1600 (see Appendix E) and there is access to social work and peer support (individuals with lived/living experience with substance use disorders).

The VCH Overdose Outreach Team can also provide connections to substance use care and support for people who recently overdosed and/or are at high risk for opioid overdose and who are not connected to community supports.

6.0 Active Substance Use

While the goal is to manage and treat patients' withdrawal and cravings, it is possible that patients will continue to use substances while admitted to hospital. It is best to engage the patient in conversation around substance use early and respectfully without conveying judgment or stigma to prevent the situation from escalating.

6.1 When active substance use is encountered:

1. **Take a moment to assess safety** *(e.g., use of flames, overdose, signs of behavioural escalation, risk to other patients, visitors or staff)*.

2. **Do not try to physically stop the patient from using substances, take a confrontational approach, or immediately intervene unless there is an imminent safety risk** *(e.g., open flames close to an oxygen source)*.
   - Patients may be defensive or reactive if confronted in that moment. Potential risks include, but are not limited to, violence, blood or body fluid exposure and exposure to second-hand smoke or fumes.

3. **Acknowledge them and return in five minutes to assess for safety and talk to the patient.** For example, *"Okay. I see that you are in the process of using. I am going to come back in five minutes to check on you and make sure that you are safe and we can talk."*
   - It is best **not to** have a conversation when someone is in the process of using.

4. **When appropriate (i.e., when patient is not acutely intoxicated or sedated), respectfully remind the patient that they are expected not to use on the unit as it unsafe** for them *(e.g., risk of unwitnessed overdose)*, and potentially for other patients, visitors and staff. Explain that oxygen is a fire accelerant/catalyst (another reason why it is unsafe to use in the room).
   - It can be helpful to frame staff concerns related to substance use around safety and in a way that communicates to the patient that *"it is because we care about you and your safety as well as the safety of other patients and staff"* as opposed to *"it is because it is disruptive to other patients".*
   - Inform them of overdose prevention services available or nearby.

- When patients are unable to access the SPH OPS *(e.g., patients certified under the Mental Health Act, patients in critical care settings and patients at MSJ)*, the AMCT Liaison Nurse and the AMCT, and Nurse Educator and Clinical Nurse Specialist for Substance Use may be contacted to work with the patient and the care team to ensure appropriate care management.

Example approaches:
"Hey, I just noticed some syringes around here. Are you feeling some pain or withdrawal that we can help with?"

"I can provide you with some sterile supplies and let you know about our overdose prevention site that is in hospital (or nearby) where people can use safely (provide information including hours and location). Patients are not able to use in their beds or bathrooms for safety reasons. We want to prevent unwitnessed overdoses."

5. **Explain that we would like to support not using on the unit and ask them if there are ways that we can work with them to manage their pain, cravings, and withdrawal.**
   - Ask the patient in a nonjudgmental way what needs are not being met currently (i.e., why they may be using? – *e.g., unmanaged pain, stress, anxiety?*).

6. **Offer harm reduction strategies and education as opposed to a punitive response where possible** (e.g., *"How can we keep you (and others) safe while you're here?"*).

7. **Inform the AMCT Liaison Nurse and the AMCT of ongoing substance use and work with the team and the patient to optimize medications and pain, cravings, and withdrawal management.**

Additional considerations:

- Address ongoing substance use on the unit or unsafe behaviours *(e.g., uncapped needles, substances left unattended, verbal or physical aggression while intoxicated)* in an ongoing way and involve the patient, nursing leadership, the MRP, the AMCT Liaison Nurse and AMCT, and the interdisciplinary care team to develop and implement a Care and Support Plan (or on-call provider and Clinical Site Coordinator if assistance or guidance is needed overnight).
- Security can always be used for support if needed.
- If the individual using substances is not a patient, they should be informed of overdose prevention services outside the hospital and asked to leave the premises. Staff can call security for assistance.
- If patients or visitors are suspected of selling substances on the unit, inform the CNL, patient care manager (PCM) and the AMCT (if the patient is being followed by them) so that they can have a discussion with the patient/visitor and ask them to remove or dispose of the substances and cease selling (see: illicit (suspected) drugs policy). Site security can be called for assistance in the management of patient or visitor behaviour, or proactively for standby or if staff feel that they are in immediate danger.

6.2 Care Plans and Behaviour Support Plans (BSP)

- Unsafe Sharps Support Plan (in the case of uncapped needles),
- Violence Risk Care Plan,
- Interdisciplinary Care Plan, and/or
- Behaviour Support Plan for ongoing unsafe behaviour(s) (BSP; template available on FormFast Form ID – 4049; see Appendix G for examples).
    - BSPs are written documents developed by CNLs in collaboration with the patient and the attending physician who must agree with enacting the alternative treatment plan if the behaviour(s) continue. Each time the attending physician changes, the BSP should be reviewed and signed off to ensure continuity.
    - Each BSP is tailored to individual patient's circumstances taking all things into consideration *(e.g., acute illness/infection, OUD, other patients and staff safety)*.
    - BSPs should be reassessed with any change in clinical status and upon subsequent admissions.
    - If the BSP is not adhered to but discharge is medically contraindicated, a meeting with ethics can be considered to determine next steps.
    - BSPs are not intended to be punitive, but rather to set clear boundaries and expectations and allow for a trauma-informed approach to managing complex behaviours.

Consult the AMCT Liaison Nurse, Nurse Educator or Clinical Nurse Specialist for Substance Use, and/or Violence Prevention Advisor (where applicable).

6.3 Storage and disposal of non-prescribed substances

Ensure patients are made aware that it is not appropriate or safe for substances to be left out and visible to hospital staff or fellow patients.

Ask patients to securely store their possessions *(e.g., in their bedside locker/cupboard or drawer)*. Health care providers are never expected to store patients' substances for them.

- **At SPH on the Urban Health unit (8A)**, patients have access to locked, bedside safes providing a safe storage option for non-prescribed substances for personal consumption at the SPH OPS.

In order to respect the rights of patients, a patient's belongings and room are **not** searched unless there are reasonable grounds (refer to the policy).

Confiscating and destroying patients' substances can damage the therapeutic relationship, be stigmatizing, and may not stop someone from using, so the patient may be given the opportunity to store and secure them *(e.g., bedside table drawer or cupboard with a lock provided to the patient where available)*.

6.3.1 **If non-prescribed substances are found out in the open:**

1. Remind patient that these items need to be stored securely or disposed of for safety,
2. Inform CNL/charge nurse, including details of your discussion with the patient, and

3. If it occurs again, the CNL/charge nurse may provide a final reminder to store items securely*.

**CNL/charge nurse reserves the right to take immediate action if staff or other patients are at risk of imminent harm due to substances being left out. Action may include initiating a Behaviour Support Plan, disposal of the substance, and/or calling security.*

- If substances must be disposed of, they must be sealed in a tamper-evident container and accompanied by the documentation contained in the illicit (suspected) drugs policy.
- Inform the patient that their substances are being disposed of if they are not able or willing to do this themselves.

6.4 Use of Site Security

Security presence may be considered and requested in some circumstances related to substance use and may be essential if staff or patient safety is at risk.

NOTE: The presence of people in uniform can be triggering for some individuals and the goal of all interactions is violence prevention. In some cases, a discrete security presence may be more appropriate with the guards nearby but not visible to the patient.

- Call 7111 to initiate a Code White response, or 4777 to request security standby.
- Staff are responsible for providing security with clinical direction about what they want security to assist with *(e.g., de-escalation, standby while nurse administers medication)*.
- Security also needs to be informed about the patient, situation, and any safety or infection control precautions for everyone's safety.
- It is **not recommended** for security to use force to enter a bathroom where a patient is suspected to be using unless the patient has become unresponsive.

6.4.1 Patient Watch Officer

Having a patient watch officer (PWO), who remains inside or outside of a patient's room 24/7, may be an appropriate intervention for some patients *(e.g., when the person has history of violence, risk for elopement, or need to monitor for unsafe substance use such as uncapped needles, or selling of substances)*.

NOTE: A PWO is not expected to intervene in isolation without the support of an integrated response from clinical and site security. The role of a PWO is limited to supporting staff and patients in managing behaviours that pose a risk to staff and patients. The PWO always defers to clinical staff in all matters relating to the care, treatment, management, and direction given to the patient that they are assigned to watch.

- A PWO can be arranged by the CNL with PCM approval. On weekends, the charge nurse must notify the CNL and PCM of this decision and rationale by email and can contact the Clinical Site Coordinator for assistance if needed. Site security must also be notified (dial 4777) and they will bring a form to the unit to be completed by the CNL/CN.

7.0 Specialty-Specific Practices

7.1 Mental Health Settings and Certified Patients

Concurrent mental illness and substance use disorders are identified as risk factors related to opioid overdose death and infections, such as hepatitis C, both of which may be mitigated by harm reduction approaches. Patients admitted to locked inpatient mental health units should be counselled on overdose risk and prevention prior to passes or discharge to decrease mortality attributed to loss of opioid tolerance and erroneous judgment of dose when they return to substance use post discharge.

- Take Home Naloxone training and kits may be offered as appropriate when a patient goes on pass or is discharged (because of the syringes contained in the kits).
- Patients can be referred to overdose prevention services with team input.
- **At SPH**, nurses can consult "Addiction Social Work" to support discussions regarding overdose risk and prevention and connect patients to harm reduction services in community.

See the 'Harm Reduction' section above for additional care options and harm reduction education as appropriate.

7.2 Perinatal Substance Use

All pregnant patients should be screened for substance use. Consult the AMCT for all patients who screen positive.

- Withdrawal management is not recommended (i.e., going off all opioids).
- Rooming-in is recommended if there is a parent who can respond to infant cues.
- Breastfeeding is recommended for mothers stable on OAT.

8.0 Documentation

Document:

- All assessments performed in the appropriate CST-Cerner PowerChart "Interactive View and I&O" section(s) or narrative notes in "Documentation",
- All interventions offered, accepted, attempted or declined,
- All medications administered and effectiveness in the Medication Administration Record (MAR),
- Care and support plans using narrative notes or appropriate forms printed from FormFast,
- All patient education provided *(e.g., risks related to substance use, harm reduction strategies)*, and
- Patient Safety & Learning System (PSLS) reports if appropriate *(e.g., overdose)*.

Related Documents

Related Policies

1. B-00-11-10125 - Philosophy of Care for Patients and Residents Who Use Substances
2. B-00-11-10185 - Commitment to a Safe and Healthy Environment
3. B-00-11-10124 - Search of Inpatient Rooms and/or Belongings
4. B-00-11-10182 - Smoke and Vape-Free Premises
5. B-00-11-10190 - Code White Emergency Response
6. B-00-11-10178 - Violence Risk Alert
7. B-00-11-10196 - Violence Prevention in the Workplace
8. B-00-11-10258 – Possession of Controlled Substances for Personal Use

Related Guidelines and Procedures

1. B-00-13-10180 - Methadone for Opioid Use Disorder
2. B-00-13-10183 - Buprenorphine/naloxone (SUBOXONE) for Opioid Use Disorder
3. B-00-13-10232 - Buprenorphine/naloxone 'SUBOXONE To-Go' Patient Kits for Induction Outside of Hospital Setting
4. B-00-12-10126 - Injectable Opioid Agonist Treatment (iOAT) for Opioid Use Disorder and IV fentanyl for Withdrawal Management
5. B-00-13-10013 - Alcohol Withdrawal Protocol
6. B-00-13-10200 - Objective Alcohol Withdrawal Scale (OAWS)
7. B-00-13-10170 - Managed Alcohol (Inpatients)
8. B-00-11-10214 - Cannabis for Non-Medical Purposes
9. BD-00-07-40064 - Tobacco Dependence Management Guideline
10. B-00-07-10092 - PICC/PIV and Substance Use: Patients Who May be Using Their IV Line to Inject Substances
11. BD-00-13-40094 - Opioid Overdose (Suspected): Management, Including Naloxone Administration without a Provider Order
12. B-00-13-10175 - Dispensing Take Home Naloxone Kits to Clients at Risk of Opioid Overdose (Adults and Youth)
13. BD-00-07-41012 - Unsafe Sharps Support Plan
14. B-00-12-10168 - Bedside Safes

Other Documents

1. BCCSU/MOH Guideline for the Clinical Management of Opioid Use Disorder
2. BCCSU/MOH Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder

3. BCCSU Interim Clinical Guidance - Risk Mitigation in the Context of Dual Public Health Emergencies v1.5
4. BCCSU/MOH/Perinatal Services BC - Treatment of Opioid Use Disorder During Pregnancy Guideline Supplement

Patient Resources

- VCH list of Overdose Prevention Sites and Supervised Consumption Sites (www.vch.ca/overdose)
- BCCDC Toward the Heart - Find an Overdose Prevention Site search function
- Lifeguard Digital Health App or Brave App designed to prevent overdoses for people using alone
- VCH Overdose Outreach Team
- VCH Safer Injecting pamphlet
- VCH Safer Smoking pamphlet - Crack and Crystal
- Canada's Low-Risk Alcohol Drinking Guidelines patient pamphlet
- Canada's Lower-Risk Cannabis Use Guidelines and harm reduction patient pamphlet

Additional Education for Health Care Providers

- LearningHub Buprenorphine-naloxone (suboxone) Course
- UBC CPD Addiction Care and Treatment Online Course (free)
- UBC CPD Perinatal Substance Use Online Course (free)
- BCCDC Harm Reduction Resources
- Description of safer injection supplies
- Description of safer inhalation/smoking supplies

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Appendices

Appendix A - Stigma

Appendix B – CAGE-AID Screen

Appendix C – Pasero Opioid-Induced Sedation Scale (POSS)

Appendix D – Opioid Use Disorder and Pain Management Infographic

Appendix E – RAAC Map

Appendix F – SPH Overdose Prevention Site Map

Appendix G – Treatment and Behaviour Contract

Appendix A: Stigma

Stigma is an attribute or quality which significantly discredits an individual in the eyes of others and any attitude, belief or behaviour that discriminates against people. Manifestations of stigma in health-care settings are widely documented and range from denial of care, provision of sub-standard care, physical and verbal abuse, to more subtle forms, such as making people wait longer or passing their care off to a colleague. Patients often can pick up on verbal and non-verbal cues that indicate judgment or disrespect (e.g., lack of eye contact or touch).

It is important for care providers to reflect on their attitudes, beliefs, fears and level of awareness regarding substance use and substance use disorders. Although patients who use substances may exhibit behaviors that can be challenging for staff, we have a duty to treat all patients with respect and dignity. Negative interactions with health-care providers can result in patients self-initiating discharge or avoiding seeking health-care services in the future when they may be at their most vulnerable.

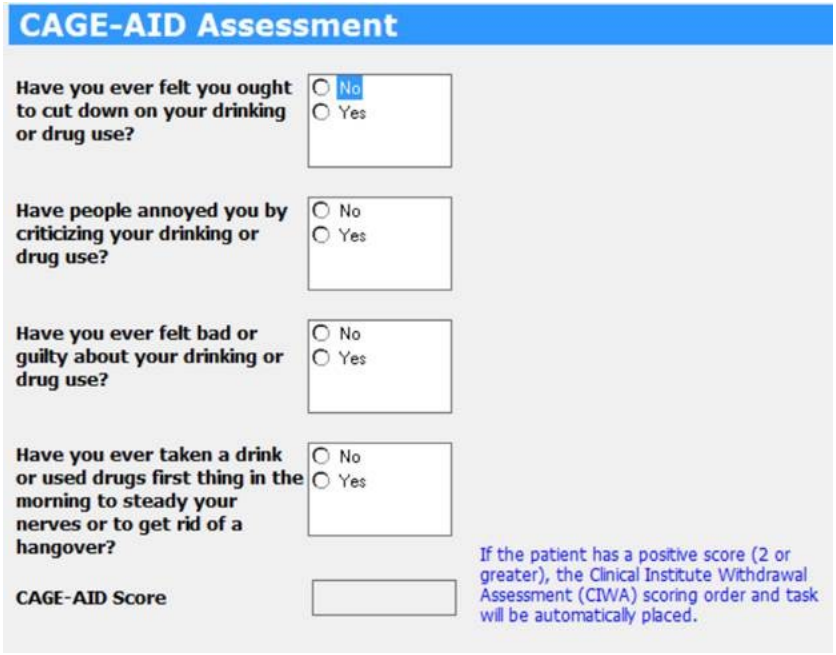
Recognize substance use disorder as a medical condition as opposed to a moral failing or behavioural issue, or lack of willpower. Many patients have complex histories that often include trauma (as a consequence of poverty, abuse, marginalization, racism, residential school experiences, and intergenerational trauma) and added challenges of homelessness, mental illness, HIV/AIDS and hepatitis C. Scientific evidence indicates that addiction is a chronic brain disease with underlying neurologic changes that drive ongoing substance use.

Language is important – using terms such as *"junkie"* or *"drug addict"* continue to perpetuate negative stereotypes. Even more subtle terms have the potential to influence people's perceptions – e.g., to say someone is *"clean"* when in recovery somehow implies that they are *"dirty"* when they were using substances.

- **Use person-first language that describes the person prior to their behavior or condition** (e.g., use *"person with an alcohol-use disorder"* instead of *"alcoholic"* OR *"person who uses drugs"* OR *"person with substance use disorder"*).
- **Use language that supports recovery and emphasizes individual autonomy** (e.g., *"opted not to"* OR *"declined"* as opposed to *"non-compliant"*, *"refused"*, or *"failed"*).

Visit this website for additional information regarding respectful language and stigma regarding people who use substances and other resources.

Appendix B: CAGE-AID Assessment



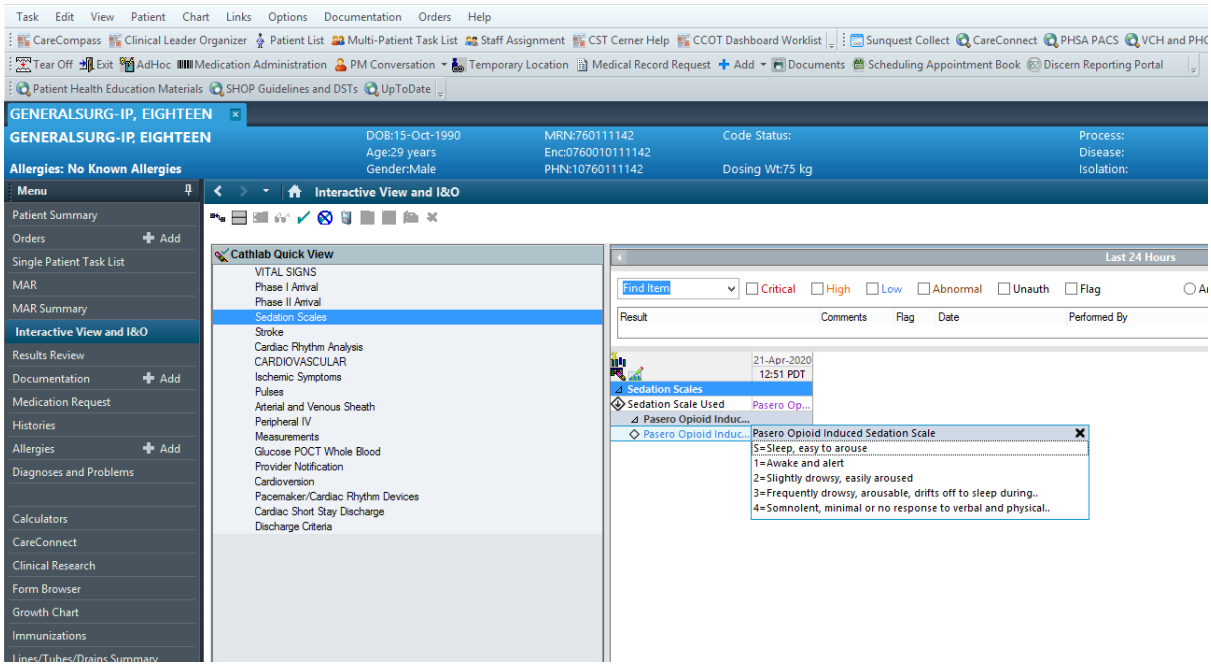
Appendix C: Pasero Opioid-induced Sedation Scale (POSS)

[Modified to include appropriate actions]

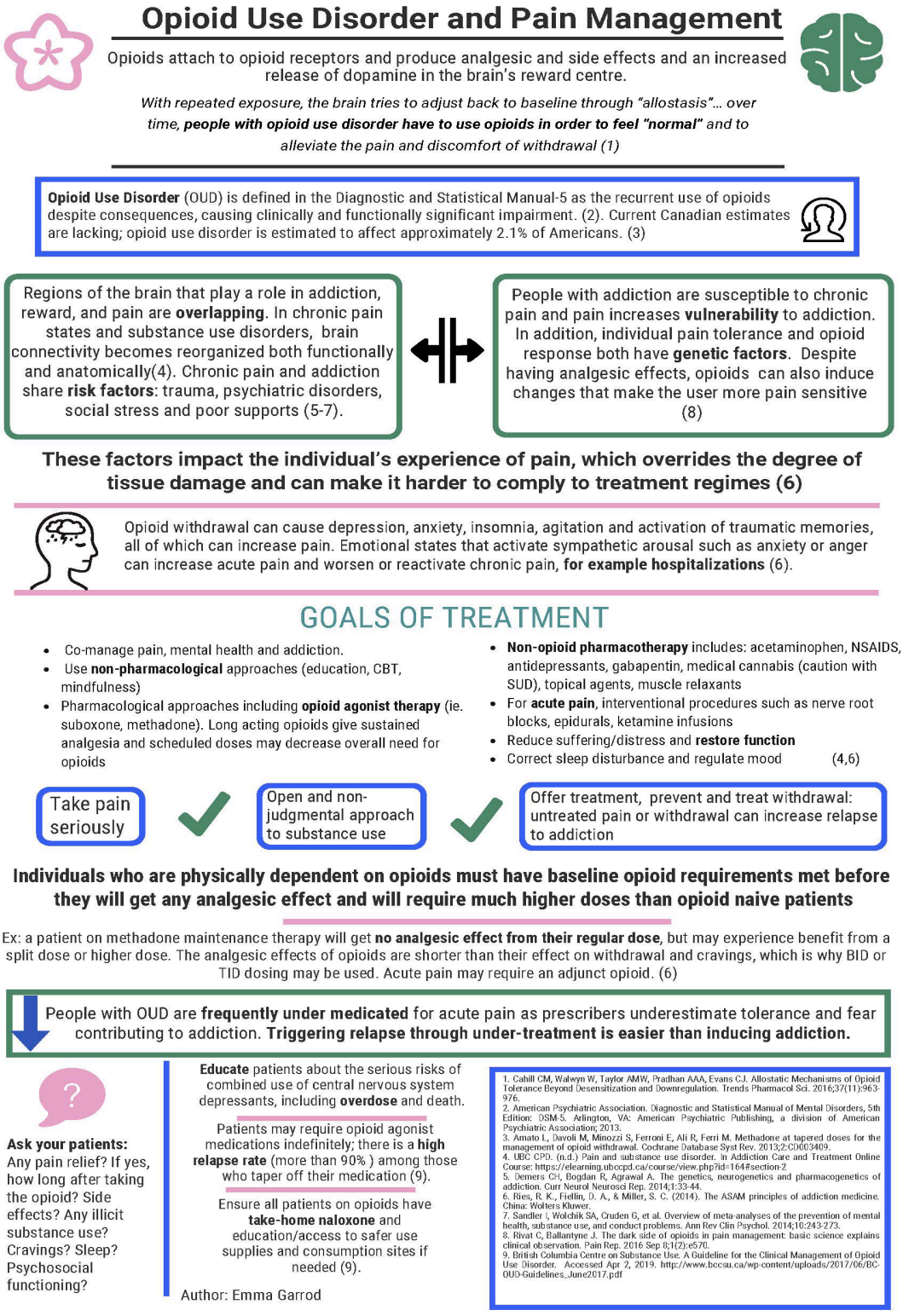
located in CST-Cerner PowerChart in "Interactive View and I&O" under "Sedation Scales" (see below)

Level of Sedation	Appropriate Action
S = Sleep, easy to rouse	Acceptable; no action necessary; may continue with opioid dose
1 = Awake and alert	Acceptable; no action necessary; may continue with opioid dose
2 = Slightly drowsy, easily roused	Acceptable; no action necessary; may continue with opioid dose
3 = Frequently drowsy, rousable, drifts off to sleep during conversation	Unacceptable; hold opioid until improved; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory
4 = Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; hold opioid and notify prescriber; consider administering naloxone; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory

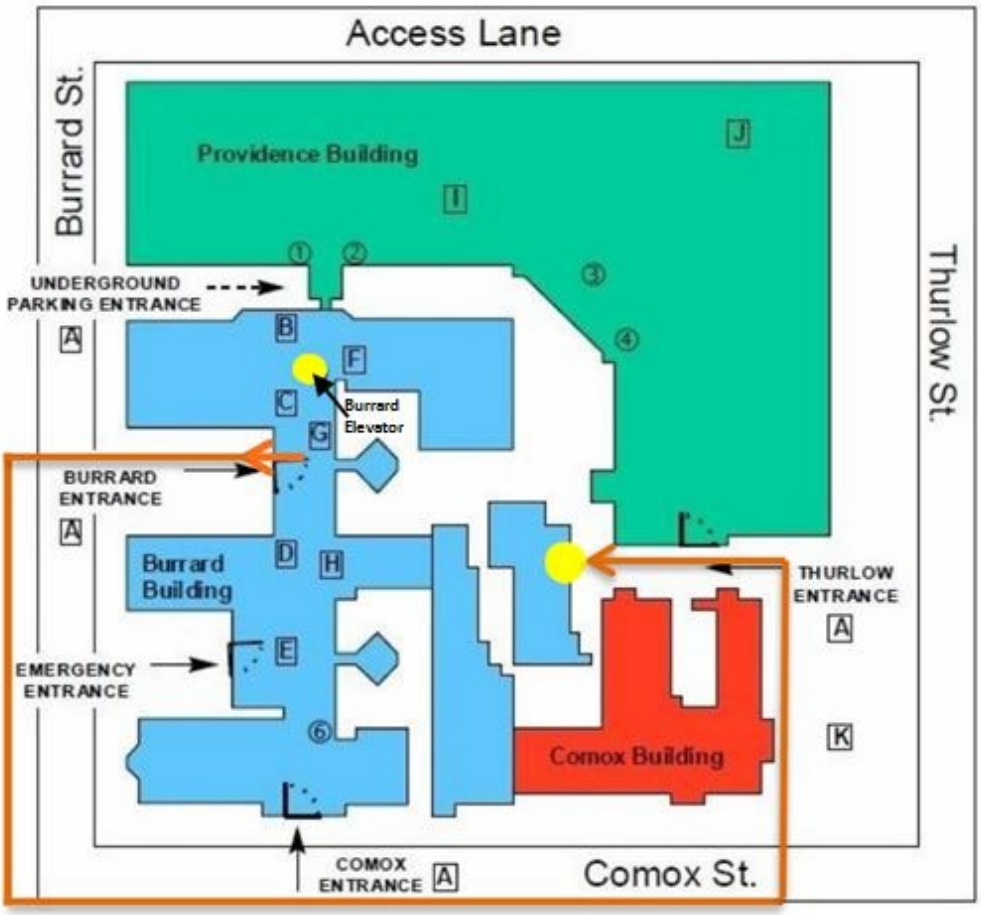
Modified from: Pasero, C., & McCaffery, M. (2002). Monitoring sedation: It's the key to preventing opioid-induced respiratory depression. *American Journal of Nursing, 102*(2), 67-69.



Appendix D: Opioid Use Disorder and Pain Management Infographic



Appendix E: Rapid Access Addiction Clinic (RAAC) Map to access RAAC from Burrard Entrance SPH

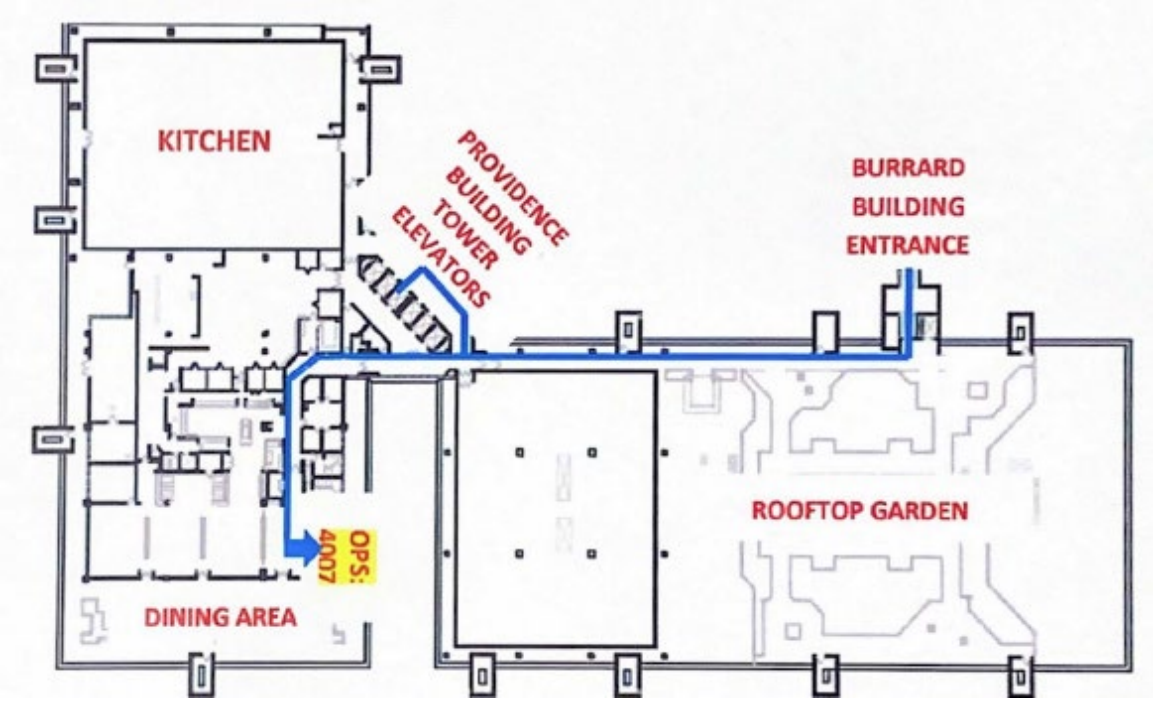


Appendix F: St. Paul's Hospital Overdose Prevention Site (SPH OPS)

WHERE: 4th floor Providence Building by cafeteria

ROUTE: Reach the 4th floor via Tower Elevators

HOURS: **10AM -8PM (closed 2PM-3PM for lunch)** ***last dose 7:30PM***



NOTE: Small postcards/handbills with this information to provide to patients can be obtained from Unit Nurse Educator or Nurse Educator, Substance Use (contacted through switchboard).

Appendix G: Treatment Plan and Behaviour Contract (template available on FormFast)

Providence Health Care | Vancouver Coastal Health

TREATMENT PLAN AND BEHAVIOUR CONTRACT

* 4 0 4 9 *

I have been admitted for:
Endocarditis

BEST TREATMENT PLAN - My current treatment plan is:
IV Antibiotics for 6 weeks
I understand that this is the best treatment plan for my medical condition.

Hospital staff have noticed that I: (See reverse for examples)
have frequent visitors
have overdosed at my bedside after visitors leave with uncapped syringes
I understand that this behaviour is NOT acceptable in the hospital.

EXPECTED BEHAVIOUR INSTRUCTIONS - I understand I must do the following if I want to continue my treatment in the hospital: (See reverse for examples)
- Dispose of all used syringes
- not use substances at bedside, use overdose prevention site instead.

ALTERNATIVE CARE PLAN - I understand that if I cannot follow these expected behaviour instructions I may be putting other patients and staff at risk. This will lead to the following **alternative care plan (include detailed instructions if planning for a discharge):**
A security staff will be posted at my door and no visitors will be allowed.

I understand that my unsafe behaviour limits what health care providers and the hospital can do for me.
I understand that the **alternative care plan** may create risks to my health.
These risks have been explained to me by Dr. _____
I agree to follow the **expected behaviour instructions** in order to continue my **best treatment plan in hospital.**

Patient signature: _____ Date:
Attending physician: _____ Signature: _____ Date:
CNL/PCC/Charge RN: _____ Signature: _____ Date:

By signing below, I acknowledge I have reviewed and agree with this Treatment Plan and Behaviour Contract.		
Attending physician:	Signature:	Date:
Attending physician:	Signature:	Date:
Attending physician:	Signature:	Date:

Form No. PHC-NF435 (R. 28 March 2023) Page 1 of 3

Persons/Groups Consulted:

Director, Urban Health, HIV & Substance Use/ Co-Regional Director, Regional Substance Use & Addictions Program

Patient Care Manager, Crosstown & SPH Medicine & Brief Intervention Clinic

Clinical Nurse Leader, Urban Health Unit

Clinical Nurse Leader, Quality Improvement, SPH ED

Crosstown Clinic Coordinator

AMCT Liaison Nurses

AMCT Social Worker, SPH Psychiatry

Nurse Educator, Substance Use

RAAC Peer Support Workers

Nurse Educator, SPH Acute Medicine & Medical Short Stay Unit

Nurse Educator, SPH & MSJ Access Services

Nurse Educator, Medication Safety & Management

Nurse Educator, MSJ High Acuity Unit

Medical Lead AMCT

Corporate Director Quality, Patient Safety, Risk Management, Patient Relations, Infection Prevention & Control

Medical Director Urban Health Unit

Infectious Diseases / TB Medicine Physician, SPH

General Practitioner, Urban Health Program

Manager, Occupational Health & Safety, PHC

Violence Prevention Advisor, PHC

Coordinator, Protection Operations, VCH/PHC, Lower Mainland Integrated Protection Services

Safe Supply & Drug Policy Consultant, Drug User Activist & Freelance Writer

PHC Ethicist

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Clinical Nurse Specialist Substance Use

Revised by:

Nurse Educator, Substance Use

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