Crosstown Clinic: Client Flow and Assessment

Site Applicability

PHC Crosstown Clinic

Practice Level

Basic Skill: RN/RPN, LPN, Clinic Assistant Support Worker

Need to know

- This document describes the steps in the client's flow through the clinic from arrival to discharge and the care provided at each step.
- Clients, who are intoxicated, have other sedatives or stimulants in their systems may need to have a dose held or reduction in dose amount.
- Clients might not tolerate their prescribed dose if they have other substances in their system, are feeling unwell or are experiencing an exacerbation of underlying medical conditions
- To receive dose clients must be awake, able to respond verbally, and able to ambulate (per their baseline mobility).
- Intoxication refers to psychomotor delay (unsteady gait), dyskinesia (uncoordinated movements), confusion, disorientation and sedation (based on the POSS scale) (**Appendix A**). This may be caused by treatment medication alone or in combination with other substances the client is also taking (prescription or illicit).
- Injection room staffing ratio should be maintained at 1:4 staff to client ratio.

Equipment & Supplies:

- Dynamap
- Naloxone kit
- Supplemental Oxygen/Ambu bag
- Suction

Procedure

Admission to the Clinic

- Upon arrival at the clinic, clients will be identified by use of an exterior camera with a security monitor located at the reception desk.
- The client will be allowed into the vestibule of the clinic and after the exterior door has closed, they will be allowed in to the waiting room of the clinic.

- The client will report to the reception desk where their attendance will be noted by the Clinic Assistant Support Worker by scanning that clients' picture ID/bar code into the database. CASW will use the OAT legend iOAT PR if the client is only wanting to access a prescriber. This will begin the pre-injection period.

Pre-injection Assessment

1. The five (5) minute pre-assessment starts once the client is in the clinic and "arrived" in the Opiate Assisted Treatment (OAT) database.
2. The assessment nurse is responsible for assessing the clients in this five (5) minute time frame.
3. Any staff who are concerned about a client's ability to tolerate their injectable treatment must communicate this observation to the assessment nurse prior to injection treatment
4. Clients are assessed for intoxication of alcohol, stimulants and sedatives, as well as their health status in terms of their ability to tolerate their injectable dose.
5. Assessment is done by observing the clients for the following signs or symptoms:
    - Severely anxious or agitated
    - Dyskinetic
    - Overly sedated (use the POSS scale - **Appendix A**)
    - Slurred speech
    - Smells of alcohol/signs and symptoms of alcohol intoxication
6. If the client displays one or more of the above signs or symptoms, further assessment or intervention may be warranted and the client may be asked to sit quietly and wait or refrain from using and come back later (at least one hour), or nursing will call the MD for a dose reduction.
7. Check client visit history in OAT database to ensure there is no absence beyond 96 hours and no new titration orders which would appear as a pop up in the OAT database. Dose directions will be found in EMR
    - **If the client has been absent greater than 96 hours,** the nurses follow the pre-printed orders for Missed Dose Protocol (Must look up in EMR).
8. During the 5 minute assessment period clients must remain in the waiting area. Clients are responsible for the order in which they walk into the injection room. During this time clients may ask the pre assessment nurse to reduce their dose. This nurse talks to the client about the reason for the reduction, communicates this to the provision nurse and documents the dose in EMR. They will then task the MRP, task the pharmacist, note the change on the communication sheet, and on the shift report. A dose decrease TMU entry will need to be made. If this is the third consecutive dose reduction, nurse to task prescriber to discuss a script change with the client.

Drug Preparation and Provision

Once the pre-injection assessment is completed, clients proceed to the injection room (IR) to collect a pre-filled syringe with their prescribed dose from the designated provision nurse.

1. Nursing checks:

Before client is in IR

a. Check the client's chart for pop ups in the OAT database, and refer to EMR for the specific prescription information.

b. Pulls the syringes from the client specific bags and sorts them either by order on the clinic visit screen on the Opiate Assisted Treatment (OAT) database or alphabetically

With clients in IR

c. Uses **two client identifiers** (Full name, Date of Birth, Facial recognition, Current photograph, Know the client, PHN)

   i. Know the client – staff must work a total of 66 shifts after orientation to have enough time to get to know the client to use this as an identifier.

d. Provision nurse will scan the syringe to cross reference with the database to ensure the correct dose is being provided for self-administration to the correct client.

e. Syringe containing the required amount of drug will be handed to the client via the opening in the window

2. This begins the post-injection assessment, where clients remain in the clinic for a minimum of 5 minutes. Clients start with a 15 minutes post-injection assessment time. Once clients are on a stable maintenance dose with no tolerance concerns, nursing can task prescriber to reduce the post assessment time. If at any time a client shows signs of decompensation, nursing has the discretion to request the client stay longer. Similarly if a client is escalated, clients may leave before the post assessment period is complete.

Injection of Provided Drug

1. Clients will be asked to leave belongings such as big jackets, backpacks etc. on the hooks on the wall provided in the injection room, clinic or waiting room area.
2. Clients will be offered supplies (alcohol swabs, syringe tips, tourniquets) to safely inject.
3. At this time a staff member will be available in the injection room to offer advice for safer injection practices and assistance, within scope, if requested. If the IR room is staffed by only clinic assistants, they will need to call available nurse to help clients with land marking, vein finding or to administer the medication intramuscularly.
4. In case of a bent or damaged needle, clients can ask for a new needle from the staff and can attach the needle to the syringe themselves. Staff will ensure used needles will be collected and disposed appropriately.
5. After an approximate time frame of 20 minutes clients who are unable to inject themselves will have the option to inject themselves IM or have nursing inject them (IM only). Upper extremities are the preferred site however clients insisting on using lower extremities will need to do so independently.
6. The staff will supervise this operation to ensure that the drug is self-administered as per protocol, (watching for diversion and safety) and that the injection technique is clean and safe.
7. Once the injection is completed, clients must recap the needle tip and deposit the used syringe down the provision room chute.

8. The provision nurse will visually check to see if the syringe is fully used or has a post waste amount remaining and will confirm with the client if that was the intent. The provision nurse will open the cage out tab then use the client's clinic ID number to confirm dose provisioned. A TMU entry will be made for all dose decreases.

Post-Injection Assessment

- Post assessment time period (5 to 15 minutes) begins once the client's syringe has been provisioned.
- After the client has injected, it is preferred that they return to the waiting area for the remainder of their assessment time.
- The Assessment Nurse is responsible for the assessments post injection.
- Any staff who are concerned about a client's tolerance of their injectable treatment must communicate this observation to the team (nurses and clinic assistants) via walkie-talkie prior to the client leaving the clinic as nursing assessment/intervention will be warranted.
- Assessment is done by nursing assessing the clients for the following signs and symptoms (**Appendix B**):
    - Severely anxious or agitated
    - Dyskinetic
    - Overly sedated (use the POSS scale **Appendix A**)
    - Slurred speech
    - Smells of alcohol/signs and symptoms of alcohol intoxication
- At 5 to 15 minutes mark, if client displays one or more of the above symptoms, we request that the client remain in the clinic for their safety until all of the above symptoms have resolved.
- The post-injection assessment should be recorded in the OAT database. The client will be regularly monitored until symptom resolution or patient is transferred for medical intervention elsewhere.
- If the client has become agitated or dyskinetic or appears to have signs and symptoms of respiratory distress or depression, or is sedated then further assessment is warranted, which includes level of consciousness and full vital signs.
- Follow up with the client's MRP or on call physician for possible dose adjustment.
- Refer to B-00-13-40094- Opioid Overdose (Suspected): Management, Including Naloxone Administration without a Provider Order
- Once the client has met the criteria to leave the clinic, the client will be let out of the clinic and departed in the OAT database system by the Clinic Assistant Support Worker.

Documentation:

- Pre and post assessment forms are documented in the OAT database under the "pre assessment" and "post assessment" tabs (**Appendix B**)
- When a dose is held:
    - The nurse documents the assessment and interventions in the EMR using the typing

template "ITCI"

- Notify prescriber on site, MRP preferable, or call on call prescriber if no one on site about withheld dose

- When a dose is not tolerated:
  - Document the assessment and intervention in the EMR using the typing template "ITCD"
  - Notify prescriber on site, MRP preferable, or call on call prescriber if no one on site about client's dose intolerance

Related Documents

1. POSS Scale
2. B-00-13-10206 - Crosstown Clinic: Missed Days Protocol
3. BCD-11-11-40002 – Patient-Client-Resident Identification
4. B-00-13-10209 - Crosstown: Care for Clients who use Alcohol
5. BD-00-13-40094- Opioid Overdose (Suspected): Management, Including Naloxone Administration without a Provider Order

References

Pasero C, McCaffery M. Pain Assessment and Pharmacologic Management, p. 510. St. Louis, Mosby/Elsevier, 2011

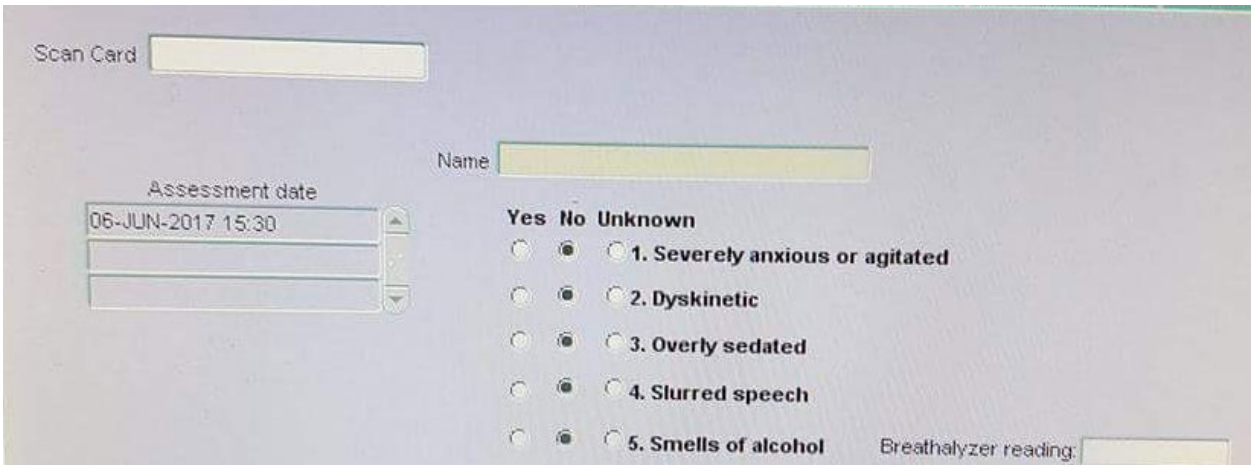
Appendices

Appendix A – Modified Pasero Sedation Scale (POSS)
Appendix B – Pre and Post Assessment in OAT Database

APPENDIX A: Modified Pasero Sedation Scale (POSS)

Score	Meaning of Score	
S	Sleep, easy to rouse	**Acceptable**: no action necessary; may increase opioid dose if needed
1	Awake and alert	**Acceptable**: no action necessary
2	Slightly drowsy, easily roused	**Acceptable**: no action necessary
3	Frequently drowsy, rousable, drifts off to sleep during conversation	**Unacceptable:** client does not meet the criteria for pre- or post-assessment and requires further medical assessment/interventions
4	Somnolent, minimal or no response to verbal and physical stimulation	**Unacceptable:** Consider administering naloxone and call 911. Call prescriber for dose adjustment for next visit

APPENDIX B: Pre and Post Assessment in OAT Database



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