Overdose Prevention Site (OPS) at St. Paul's Hospital: Operating Procedures

Site Applicability

PHC: SPH Overdose Prevention Site (OPS)

Practice Level

Practice Level	RN, RPN and LPN
Advanced Skill *(requiring additional education)*	*Provincial Violence Prevention for Medium and High Risk Departments Certification* • LearningHub Online • LearningHub Classroom The following activities may be performed as ***Nurse Independent Activities*** following completion of the LearningHub Course - **Understanding Autonomous Practice & Nurse Independent Activities (NIA) / Nurse-Initiated Protocols (NIP)** and naloxone administration education provided by Nurse Educator: **1) Administer naloxone to treat suspected opioid overdose in acute care** **Note:** LPNs administer via subcutaneous and intramuscular routes only **2) Administer oxygen to manage hypoxia following the DST** Oxygen Therapy: Acute Care **3) Dispense naloxone kits to treat suspected opioid overdose** to clients at risk of opioid overdose Train the trainer education from Nurse Educator AND LearningHub Course: BCCDC - Naloxone Administration OR equivalent previous training (as determined by Nurse Educator)
Basic Skill (with completed OPS orientation)	*Remainder of SOP*

Need to Know

- The purpose of the SPH OPS is to provide patients who inject drugs a safe space to use their substances under supervision of staff trained to reduce harms associated with injection drug use and able to respond in the event of an overdose.
- Staff are not permitted to perform venipuncture or administer patients' substances to them. If patients require assistance from a friend/family member, they should identify this on arrival. Otherwise patients are to inject themselves.

- If patients are wanting to share/split substances with each other, they should notify staff of this plan on arrival. There can be no cash exchange in the site.
- For the site to operate, there must be two staff in the OPS at all times. This includes during breaks. This may necessitate closing the OPS temporarily for breaks.
- LPNs work in a team nursing approach and must always have access to an RN for clinical support. The Urban Health leadership team will connect with OPS staff each shift to notify them who will be the clinical support that day.
- Staff are responsible for ongoing communication and collaboration with each other to ensure completeness of all duties.
- For any significant event involving an inpatient (e.g., Code White, Code Blue, naloxone administration), the home unit must be notified and verbal handover provided.
- Nurses working at the OPS are expected to orient new staff and patients to the site.

Protocol

- Staff are to sign in on the flowsheet located in the Rapid Access Addiction Clinic (RAAC).
- Shift time and site hours are between 10:00 to 20:00. Last patient visit for the purpose of injection is 45 minutes prior to closing (19:15).

Room Preparation: Start of Shift
Safety check. This includes: • Use inventory list found in the supply cupboard to check that all harm reduction supplies and emergency response equipment/supplies are stocked and functioning. • Ensure at least two portable oxygen tanks are available and moderately full. They must be stored in the designated, marked oxygen tank area in order to maintain 6 feet from any open flame. Obtain new tanks from the 8th floor, near the elevators. • Check the public washrooms by the OPS for anyone in distress or needing assistance. • Read through the communication book and restrictions binder for awareness of any recent safety events. **Room set up. This includes:** • Ensure sharps bins are empty and replace them as needed. • Set up and wipe down injection booths and chairs. • Ensure computers and phones are functioning. • Check that other supplies are stocked. If low on supplies, contact the Urban Health Program Support staff or CNL (phone numbers are available in a staff resource binder).

Arrival of Patient: Prior to Injection

Documentation:

- Sign-in the patient using the *OPS Data Collection Form* (Appendix A).
- Fill out the *User Agreement, Release and Consent Form* (Appendix B) with the patient. This only needs to be completed upon first visit. Completed forms are kept in the locked cupboard in the OPS.
- Search the patient in Cerner to confirm primary care location, code status, check for violence alerts, and note the admitting team/Most Responsible Physician (MRP) if applicable.

Patient education/orientation:

- Offer drug testing.
- Offer harm reduction supplies and education.
- Ensure patient is aware of OPS emergency procedures. In the event of an overdose, staff may call a Code Blue and necessary medical information will be provided to the code team. Necessary information will also be communicated to health care providers in the care area where the patient is registered.
- On first visit, review *Rights & Responsibilities* with patient (located on the wall; Appendix C).
- Instruct patient which booth to use and that they should remain at this booth for the duration of injection.
- Notify patient that they should remain at the OPS for 10 to 15 minutes post injection for observation.

During Injection

Monitoring:

- Monitor for signs of overdose or other medical emergencies.
  - *Early signs/symptoms of OD include, but are not limited to:* decreased level of consciousness, slow or erratic breathing or pulse, vomiting, cool or clammy skin, blue-tinged fingernails or lips, limp body, and/or small or pinpoint pupils
  - *Late signs/symptoms of OD include, but are not limited to:* unresponsive to painful stimuli, seizures, no breathing and/or no pulse

  ***Patients may demonstrate early or late signs and symptoms at any time during an overdose episode.**

Booth Support:

- Ongoing provision of supplies and education

Post-Injection
Monitoring: • Monitor patient for minimum 10 to 15 minutes post-injection for signs or symptoms of overdose or other adverse events.

Overdose Response
Witnessed Suspected Overdose: 1. Attempt to rouse the patient using verbal, physical, then painful stimuli, and encourage to take deep breaths. 2. Provide oxygen support per DST *Oxygen Therapy, Acute Care.* 3. If respiratory depression (below 8 breath/min) and decreased SpO_2 (below 92%) continues despite oxygen support, administer 0.1 to 0.4 mg of naloxone (LPNs: IM/SC only, RN/RPNs: IV/IM/SC). 4. Once naloxone has been administered, reassess for increased level of consciousness (LOC), improved quality of breathing and respiratory rate (RR). Naloxone has an onset of action within 1 to 2 minutes following IV administration and up to 5 minutes following subcutaneous or IM administration. 5. After 3 to 5 minutes if LOC, quality of breathing and RR have not significantly improved, administer 2nd dose of naloxone 0.1 to 0.4 mg. 6. If symptoms persist, may administer 3rd dose of naloxone 0.4 mg (3rd dose should be 0.4 mg) and wait for 3 to 5 minutes for onset of effect prior to initiating Code Blue, as long as vitals remain stable, and patient is maintaining airway (no significant desaturations, no cyanosis, no respiratory distress). 7. **If no improvement** after 3 to 5 minutes, call a Code Blue **(DIAL 7111)** and administer additional doses of naloxone according to DST *Naloxone Administration in the Management of Suspected Opioid Overdose in Acute Care without a Provider Order.* ****If at any point the patient becomes pulseless, apneic, is seizing, vomiting with decreased LOC, or cannot maintain their airway (desaturation despite oxygen administration, cyanosis) activate Code Blue immediately, then proceed with emergency interventions**

Unwitnessed Suspected Overdose:

If the suspected overdose was not witnessed (e.g., person found in bathroom):

1. Call a Code Blue **(DIAL 7111)** immediately if unable to rouse and/or oxygen support and/or naloxone are required to maintain SpO_2 above 92% and RR above 8/min.
2. Administer oxygen per DST. *Oxygen Therapy, Acute Care.*
3. Administer naloxone per DST *Naloxone Administration in the Management of Suspected Opioid Overdose in Acute Care without a Provider Order.*

Other Medical Emergencies:

Initiate code blue **(DIAL 7111)** and direct the emergency response until code team arrives.

Crowd Control and Safety During an Overdose Event:

- Ask other patients in the OPS to refrain from injecting during an overdose at the site.
- If possible, clear the room of other patients, especially during a Code Blue due to space limitations within the OPS.
- Assist patients to move to the designated waiting area in the hallway during a code. Once the code team arrives, one OPS staff can attend to patients in the hallway to provide ongoing monitoring, while the other assists the Code Blue Team.

Communication for Inpatients:

Code Blue:

- Once the Code Blue Team arrives, an OPS nurse or member of the Code Blue Team, will call the MRP/on-call physician (if after hours) to notify them that a code response is in progress and request their presence at the OPS.
- Call the home unit after MRP is notified and inform the MRN that a code is in progress. The MRN is not expected to come down to the OPS at that time.

No Code:

- Once the patient is stable, inform the MRN of the overdose event and all interventions provided by OPS staff by verbal handover either on the phone or in person. In handover, inform the MRN that you have NOT notified MRP at this time.

Ongoing Duties

Safety:

- Complete hourly safety checks of the public bathroom to ensure no one is in distress or requires assistance.

Education:

- Provide harm reduction education as needed or requested (see "Patient Education" section below).

Crowd Control:

- Organize flow in and out of the OPS. Rotate patients to designated monitoring area if people are waiting for an injection booth.
- Periodically check outside doors to ensure no one is waiting to come in or loitering outside for long periods. Call security if assistance required to clear the area (non-urgent DIAL 4777).

Cleaning:

- Ensure sharps bins are not full and replace as needed.
- Maintain room tidiness.
- Wipe down booth/chair after each patient using Accel Rescue wipes. Ensure proper PPE is worn if there is potential for drug and/or blood and bodily fluid exposure.
- Call Housekeeping (1-844-372-1959) for additional cleaning needs (e.g., mopping, sweeping).

End of Shift Duties

- Final wipe down of injection booths and chairs.
- Place chairs up on tables so housekeeping can clean floor.
- Ensure space is clean and free of garbage and clutter.
- Check supply inventory. Restock if possible and if not, make note of missing items on the inventory list for staff coming in the following day.
- Turn off all computers and wipe down work stations.
- Perform final public bathroom check. Call Security (4777) if anyone is remaining in the area or bathroom when you are leaving.
- Ensure the room is closed and door is locked at night.

***Housekeeping will do a terminal clean at end of day.**

Transportation:

- Inpatients that have experienced an overdose, but are stable to return to the home unit, will always be escorted by a nurse back to the home unit and verbal report given to the MRN.
- Outpatients who have experienced an overdose will be escorted to the Emergency Department (ED) by a nurse for ongoing monitoring.
- If the Code Blue Team responded, they will assist with transport and handover to the home unit or ED, if the patient is agreeable to go.
- **Bring naloxone, portable pulse oximeter, and oxygen for patient transportation**
- To assist with patient transportation to ED (outpatient) or an inpatient unit, OPS staff may:
  1. Call OPS Nurse Educator/CNL/Addiction Assessment Nurse (AAN) or AMCT Liaison Nurse to support 7 days/week until 18:00. After 18:00 (or if no one is able to support the transfer), proceed to steps 2 and 3.
  2. OPS nurses will close the OPS temporarily to transport the patient to the home unit/ED.
  3. If unable to close the OPS (e.g. if other patients are still inside and need monitoring), call the inpatient unit to request assistance with transferring the patient back to the ward.

If the patient requires transport to ED (outpatient) after 18:00, this will need to wait until the OPS can be safely closed to facilitate transfer by OPS nurses.

Documentation

*** Use two patient identifiers to confirm correct patient prior to documentation (use patient armband if available)***

Document visit information on appropriate forms:

- Record patient visit information on the SPH *OPS Data Collection Form* (Appendix A)

Document all interventions provided:

- Document a *Nursing Narrative Note* titled "Overdose" or "Code Blue – Overdose" all information related to an overdose in the patient chart, including everyone who was informed about the event.
- Document any other significant findings in a *Nursing Narrative Note* (e.g. Code White)ocument vital signs in *Interactive View and I&O*
- Document naloxone given on the MAR.
  - Record naloxone dosage, route, time.
- Document dispensing Take Home Naloxone on the *Take Home Naloxone: Distribution Record*.

Patient Education

- Offer education on safer substance use and harm reduction including, but not limited to:
  - Vein finding and vein care as needed

- Take Home Naloxone
- Providing information on safer injecting if patients interested. See: https://vch.eduhealth.ca/PDFs/DB/DB.500.S34.pdf
- Offering additional resources related to opioid Overdose & Prevention

***If naloxone was administered during an overdose, the following information must be provided to the patient:**

- Explanation of events leading to the decision to administer naloxone.
- Explain that the effects of naloxone start wearing off after 20 to 90 minutes while most opioids last much longer, emphasizing the importance of not taking more opioids because overdose can return and encouraging them to remain where they can be safely monitored, and have naloxone available, for a minimum of 90 minutes.
- If patient is opioid dependent and is experiencing withdrawal from the naloxone administration, let them know when naloxone wears off, withdrawal symptoms will subside.

Staff Safety

General:

- For the OPS to remain open, there must be a minimum of two staff on shift and inside the OPS at all times.
- All OPS staff have a hospital ID which will allow for swipe access to the emergency egress door inside OPS.
- OPS cell phones are provided for safety and to ensure easier communication with the OPS leadership team and other staff.
- For any safety concerns leaving the OPS at the end of the shift, call Security (4777) for a *Safe Walk* out of the building.
- Report patient safety incidents or near misses through the Patient Safety Learning System (PSLS) portal on PHC connect.
- Report staff safety incidences and near misses through the Workplace Health Call Centre. Staff safety events include but are not limited to: psychological trauma, musculoskeletal injury, blood and bodily fluid exposure, needle stick injuries, environmental exposures.
- Call Security for first aid as needed, for any staff injury and notify shift supervisor or Manager.

Security/Code White Procedures:

- Call security for standby assistance as needed. Use either routine line (4777) or urgent line (5800) depending on risk assessment and urgency of the needed response.
- Initiate a Code White by calling **7111** and state “Code White OPS, 4th floor Providence Building” or pressing the Personal Protective Device (PPD). Pressing the PPD will automatically call a Code White overhead.

- Nurses must be prepared to provide clinical direction to security on arrival.

Occupational Health & Safety – minimizing potential exposure risks

- Report any exposure concerns to substances and/or Blood and Bodily Fluid through WorkPlace Health Contact Centre and notify your shift supervisor or manager immediately.
- Patients cannot inhale/smoke any substances inside. If staff have concerns of patients smoking inside, they can remove themselves from the area, and call Security for assistance if needed to clear the area.
- For tasks that may cause dermal exposure to substances (e.g. drug testing, cleaning up booth after use), staff are to wear the following Personal Protective Equipment (PPE):
    - Double glove using two pairs of powder-free nitrile disposable gloves
    - Reusable Level 2 Isolation Gown
    - Surgical mask (change to N95 if surface has clear drug residue/powder when cleaning)
    - Safety Goggles (if splash risk)
- Nurses check Cerner for isolation precautions and complete a Point of Care Risk Assessment prior to any patient support or task, to determine risk and PPE needs.

Related Documents

1. B-00-11-10125 - Philosophy of Care for Patients and Residents Who Use Substances
2. BCD-11-11-40001 - Nurse Independent Activities (NIA) and Nurse-Initiated Protocols (NIP)
3. B-00-04-10001 - Nurse Independent Activities (NIA)/Nurse Initiated Protocols (NIP) Approved at PHC
4. PDTM - Monograph for naloxone
5. B-00-13-10179 - Naloxone Administration in the Management of Suspected Opioid Overdose in Acute Care
6. B-00-07-10060 - Cardiac Arrest (Code Blue): Initiating and Responding (SPH & MSJ)
7. B-00-13-10019 - Oxygen Therapy, Acute Care
8. B-00-13-10167 - Dispensing Medications (Nurses)
9. B-00-13-10175 - Dispensing Naloxone Kits to Clients at Risk of Opioid Overdose (Adults & Youth)
10. BCCNM Dispensing Medications Standard for RNs, RPNs, and LPNs

References

1. Vancouver Coastal Health (VCH). (2017). Overdose prevention site manual. Retrieved from: http://www.vch.ca/Documents/Overdose-Prevention-Site-OPS-Manual.pdf

2. Alberta Health Services (AHS). (2018). Suspected Opioid Overdose Protocol.

Appendix A: PHC Overdose Prevention Site Data Collection Form

Vancouver Coastal Health | Providence Health Care

VCH/PHC Overdose Prevention Site Data Collection Form

Site: SPH (In-hospital) **Date:** _____ **Page #:** _____

- Please fill out one row in the table for **each visit** to the Overdose Prevention Site.
- Use a **new sheet** at the start of each day
- Insert "✓" if applicable
- Online Reporting: https://vchhealthsurvey.phsa.ca/opsdata.survey

	Client Name	Care Area /Unit	Gender M - male F - Female T - Trans O - Other	Booth #	Time In 00:00	Time Out 00:00	Substance Involved (Fill the letter to represent the substance involved) H - heroin F - fentanyl D - DILAUDID M - morphine C - cocaine CM - crystal meth DE – Depressant P - Psychedelic O - Down (Unknown Opioid) S - Side (Unknown Stimulant) PU - Pick up supplies OT - Other	Fentanyl Check Result +/–	Did the client overdose?		If the client overdosed, answer these questions: Was naloxone given?		Was code blue called?	
									Yes	No	Yes	No	Yes	No
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														

Depressant includes: benzodiazepines (XANAX, etizolam or clonazePAM), GHB and other
Psychedelic includes: 2C-B, 2C-E, DMT, ketamine, MDMA, mushroom extract, MXE, cannabinoids and other

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Appendix B: User Agreement, Release and Consent Form

Providence HEALTH CARE

ST. PAUL'S HOSPITAL
OVERDOSE PREVENTION SITE

USER AGREEMENT, RELEASE AND CONSENT

Prior to using the Overdose Prevention Site (OPS), I agree to the following:

- I have injected drugs in the past.
- I 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 Rights & Responsibilities of the OPS (signage posted on wall).
- 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, Providence Health Care 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 risks of leaving the OPS against medical advice, and I release all staff from responsibility if I choose to leave against medical advice and/or if I leave prior to the designated monitoring period of 10 to 15 minutes post injection.

I understand the information above and am able to give consent.

Client Name: _____
(must include first name, last name and initials)

Client Signature: _____

Date of Birth: (dd/mmm/yyyy) _____

Reviewed with: (staff name) _____

Date: (dd/mmm/yyyy) _____

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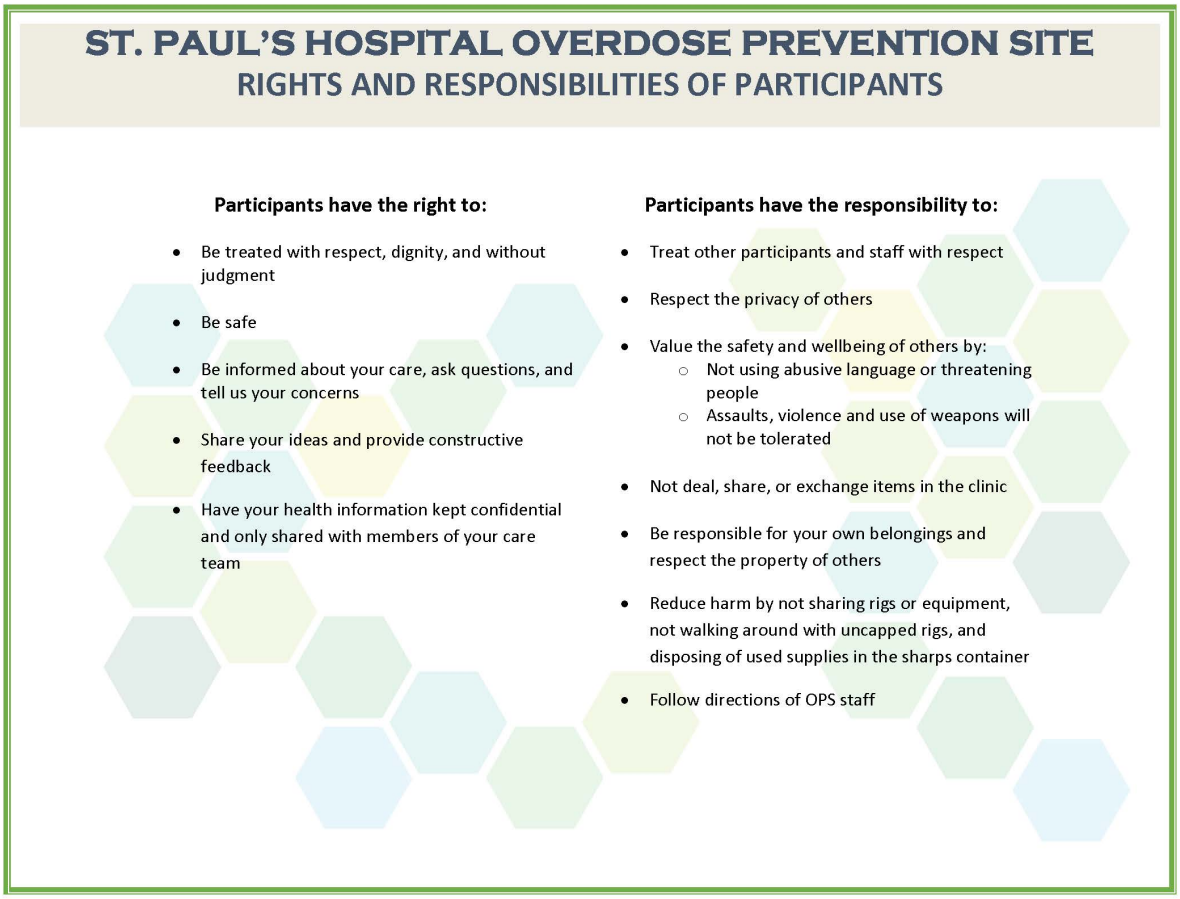
Appendix C: Right & Responsibilities of Patients Using the OPS



ST. PAUL'S HOSPITAL OVERDOSE PREVENTION SITE
RIGHTS AND RESPONSIBILITIES OF PARTICIPANTS

Participants have the right to:

- Be treated with respect, dignity, and without judgment
- Be safe
- Be informed about your care, ask questions, and tell us your concerns
- Share your ideas and provide constructive feedback
- Have your health information kept confidential and only shared with members of your care team

Participants have the responsibility to:

- Treat other participants and staff with respect
- Respect the privacy of others
- Value the safety and wellbeing of others by:
  - Not using abusive language or threatening people
  - Assaults, violence and use of weapons will not be tolerated
- Not deal, share, or exchange items in the clinic
- Be responsible for your own belongings and respect the property of others
- Reduce harm by not sharing rigs or equipment, not walking around with uncapped rigs, and disposing of used supplies in the sharps container
- Follow directions of OPS staff

Persons/Groups Consulted:

Patient Care Manager, Urban Health Program

Director, Urban Health & VCH/PHC Substance Use Service Integration

Clinical Nurse Leader, Rapid Access Addiction Clinic & SPH OPS

Clinical Nurse Educator, ICU

Occupational Health and Safety, Hygienist

Developed By:

Nurse Educator, Urban Health, SPH

Nurse Educator, Substance Use, PHC

Initial Effective Date:	01/FEB/2021
Posted Date:	18/JUL/2023
Last Revised:	18/JUL/2023
Last Reviewed	18/JUL/2023
Approved By:	PHC
	Professional Practice Standards Committee, Program Director
Owners:	PHC
	St. Paul's Hospital Overdose Prevention Site (SPH OPS)