Crosstown Clinic: Care for Clients Who are Unable to Inject Independently

Site Applicability

Crosstown Clinic

Skill Level:

Basic: Registered Nurse (RN), Registered Psychiatric Nurse (RPN), Licensed Practical Nurse (LPN)

Need to Know:

- Patients are prescribed individual doses of diacetylmorphine or HYDROmorphone according to their tolerance and opioid needs.
- Most patients self-administer their medication at Crosstown clinic and are monitored by a nursing team for adverse reactions or overdose.
- When clients of Crosstown clinic are physically unable to regularly inject themselves, a specific care plan will be created in collaboration with the client, the Crosstown nursing and physician teams. The care plan may include the option of having a Crosstown nurse provide an intramuscular injection (IM) of the client's prescribed dose of undiluted injectable diacetylmorphine or HYDROmorphone.
- High concentration injectable HYDROmorphone (50 mg/mL) and injectable diacetylmorphine 100 mg/mL is supplied by the Crosstown pharmacy as a patient specific medication.
- Prior to administration, an Independent Double Check must be conducted, that includes the medication, its concentration, and the dose with a second nurse.
- It is important to assess the client prior to giving diacetylmorphine or HYDROmorphone to ensure they are not exhibiting a decreased Level of Consciousness (LOC)as per the Pasero Opioid Sedation Score (Modified) [POSS] score of 3 or 4 see Appendix A).
    - If the patient shows signs of decreased LOC hold the dose and notify the on-call physician.

Protocol

Initial Assessment:

Prior to IM administration of HYDROmorphone or diacetylmorphine doses:

- Refer to the client specific care plan
- Ensure the client has met the pre-assessment criteria

- Let the client know the plan for administration of injectable treatment and ask them to remain in the waiting area
- Collaborate with the provision nurse to obtain the client's pre-filled syringe
- Complete 7 Rights of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.
- Make sure the pre-filled syringe is the accurate amount and the syringe corresponds to the current session (as indicated in the OAT database).
- Ask the provision nurse for an Independent Double Check.
- Attach a safety needle to the syringe.
- Check Electronic Medical Records (EMR) for previous IM injection site; rotate administration sites with each injection.
- Possible sites for IM administration include the ventrogluteal area, the upper outer quadrant of the gluteal area, the vastus lateralis, and the deltoid
- If possible, follow the **A**rm, **A**rm, **H**ip / **H**ip, **H**ip **T**high (AAH / HHT) rotation
- When repeated doses are given, the site of injection should be alternated and be recorded in the EMR
- Collect a client label and bring into Injection Room to check 2 identifiers with the client prior to injection

Administration:

- Use injectable undiluted diacetylmorphine 100 mg/mL or HYDROmorphone 50 mg/mL concentration for all IMs.
- Perform hand hygiene before patient contact.
- Introduce yourself to the patient and verify the correct patient using two identifiers.
- Assess the patient for specific allergies and contraindications to receiving IM injections such as muscle atrophy, reduced blood flow, skin condition, and circulatory shock.
- Verify the prescriber's order.
- Explain the procedure to the client and ensure that they agree to treatment.
- Ensure the seven rights of medication safety: right patient, right drug, right dose, right time, right route, right indication and right documentation.
- Select the appropriate site for injection and locate the injection site again using anatomic landmarks.
- Cleanse the site with an alcohol swab.
- Hold a clean swab or dry gauze between the third and fourth fingers of the non-dominant hand.
- Remove the needle cap by pulling it straight off.
- Hold the syringe between the thumb and forefinger of the dominant hand as if holding a dart, palm down.
- Administer the injection using the Z-track method.

  - Position the ulnar side of the non-dominant hand just below the site and pull the skin laterally.
  - With the dominant hand, inject the needle quickly into the muscle at a 90-degree angle using a steady and smooth motion.
  - After the needle pierces the skin, use the thumb and forefinger of the non-dominant hand to hold the syringe barrel while still pulling on the skin. Move the dominant hand to the end of the plunger. Avoid moving the syringe.
  - Using your other hand, pull back slightly on the plunger to see if any blood enters the syringe. If there is blood, do not inject the medicine. Remove the needle and start over with a new needle and syringe
  - Inject the medication.
  - Smoothly, quickly, and steadily withdraw the needle and release the skin.
  - Apply a dry cotton ball or gauze with light pressure for several seconds over the site. Do NOT massage. Apply a Band-Aid if needed.
- Discard the needle enclosed in safety shield and attached syringe into sharps container.
- Monitor the patient for adverse and allergic reactions to the medication.
- Discard supplies, remove gloves, and perform hand hygiene.
- Document the procedure in the client's record.

Post- injection assessment:

1. Monitor for signs and symptoms of opioid overdose, or adverse reaction
2. Ensure patient has met the post-assessment criteria

Interventions:

1. Hold diacetylmorphine or HYDROmorphone if patient is drowsy, and not easily rousable (POSS score of 3 or 4 see Appendix A).
2. If diacetylmorphine or HYDROmorphone is held or missed for any reason, contact the on-call physician

Related Documents and Resources:

1. B-00-13-10176 -Naloxone Administration in the Management of Suspected Opioid Overdose in Community Settings (Adults & Youth)
2. B-00-13-10210 - Crosstown Clinic: Client Flow and Assessment
3. Parenteral Drug Therapy Manual (PDTM)

References:

Perry, A.G., Potter, P.A., Ostendorf, W.R. (Eds.). (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis: Elsevier.

Persons/Groups Consulted

Medication Safety Team, Professional Practice

Pharmacy

Crosstown Nurses

Revised By

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Initial Effective Date:	29-JAN-2019
Posted Date:	25-JAN-2023
Last Revised:	25-JAN-2023
Last Reviewed:	25-JAN-2023
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Urban Health

APPENDIX A: Modified Pasero Sedation Scale

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