NURSE-ASSISTED INJECTION

A Path to Equity in Supervised Consumption Services

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DISCLAIMER

The scope of this report is limited to the province of British Columbia (Canada). The information contained in the report cannot be used as a substitute for legal or professional advice. You can contact a lawyer to get up-to-date legal information and legal advice. You can also consult **Provider-Assisted Injection in Ontario's Supervised Consumption Services: Frequently Asked Questions**, a resource developed by the HIV Legal Network for Ontario providers. While this resource is Ontario-specific, some of the content may be transferable to other Canadian jurisdictions. For questions about professional practice standards, always consult your nursing regulatory body. For questions about workplace policies and procedures, consult your practice leads and employer.

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BACKGROUND

In April 2016, British Columbia declared a public health emergency due to rising overdoses and overdose deaths caused by a toxic drug supply. Since then, we have seen a sharp increase in the number of supervised consumption services[1], including dozens of low-threshold supervised consumption services called overdose prevention sites (OPS), and a broadening of overdose prevention services to include episodic services in health care settings (e-OPS[2]) and safe supply programs[3].

In addition to reducing harms and preventing overdoses and overdose deaths, supervised consumption services act as a point of service for people who use substances to access health care and social support. Depending on the care and support offered, staffing models can include peer workers, nurses (including registered nurses, registered psychiatric nurses, licensed practical nurses, and nurse practitioners), harm reduction workers, and/or social workers.

The benefits of supervised consumption services for people who use substances are well documented[4]. However, for clients who need help injecting, barriers to accessing these services remain because staff are currently not allowed to provide injection assistance.

DEFINITION

In this report, we define assisted injection (or injection assistance) as the hands-on assistance provided with the injection itself. We distinguish two types of injection assistance that are relevant to nurses:

- Assistance with venous access
- Assistance with administration

Assisted injection does not include any injection support that nurses currently provide, such as handling harm reduction material, cleaning the injection site, helping a client apply a tourniquet, and stabilizing the syringe, nor does it include safer injection education and coaching.

Nurses who work in supervised consumption services do not currently provide hands-on assistance with the injection itself. Clients who access supervised consumption service are expected to have the knowledge, skills, and ability to inject without help from staff. In reality, this expectation creates barriers to access, prevents nurses from meeting clients where they are at, and runs counter to the goals of supervised consumption services, which are to save lives, improve health, and increase access to care and services[5].

The research consulted for this report (see Appendix C) cites several reasons why someone might need help, including but not limited to, poor venous access, withdrawal symptoms, limited mobility, dexterity or vision, lack of knowledge and/or skills, and reliance on getting injected by a partner, "hit doctor", or friend. It also notes that women, youth, people with disabilities, people who experience homelessness, and people who use rapid-acting substances such as rapid-acting opiates (e.g., fentanyl) and stimulants are more likely to require injection assistance.

In Canadian studies, the prevalence of clients requiring assisted injection varies between 14% to 49%[6]. However, because assisted injection is often defined broadly (e.g., including any help from preparation to consumption), it can be difficult to know exactly what percentage of clients need hands-on assistance with the injection itself (as defined above).

In 2018, Health Canada introduced a pilot project to allow peers to provide injection assistance to other peers[7]. In 2020, it added peer assistance to its list of authorized services, making it possible for applicants seeking or renewing an exemption under section 56.1 of the *Controlled Drugs and Substances Act* to include this service. Health Canada defines peer assistance[8] as "one person providing assistance to another in the course of preparing and consuming drugs". That person can be a friend or another client, but not an employee of the supervised consumption service.

Notably, in British Columbia, clients who visit peer-run overdose prevention sites can access assisted injection if a peer is willing to help on site. However, clients accessing supervised consumption services staffed by nurses do not currently have access to assisted injection. This creates barriers to accessing supervised consumption services *and* nursing care, both of which contribute to health inequities for clients who cannot self-inject.

> *"They won't assist me and I told them about that. I said, "You're probably excluding 25 percent of the [injection drug-using] population here with that rule".*
>
> *"Oh, I'll assist you. We'll show you how to do it." [the nurses]*
>
> *"Well, what about a blind person? How do you assist them?"*
>
> *[Participant #8, Male, Caucasian]*
> *McNeil et al., (2014) p.477*

AIDS Behav (2014) 18:473–485
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ORIGINAL PAPER

"People Knew They Could Come Here to Get Help": An Ethnographic Study of Assisted Injection Practices at a Peer-Run 'Unsanctioned' Supervised Drug Consumption Room in a Canadian Setting

Ryan McNeil · Will Small · Hugh Lampkin · Kate Shannon · Thomas Kerr

Published online: 25 June 2013

Abstract People who require help injecting are disproportionately vulnerable to drug-related harm, including HIV transmission. North America's only sanctioned SIF operates in Vancouver, Canada under an exemption to federal drug laws, which imposes operating regulations prohibiting assisted injections. In response, the Vancouver Area Network of Drug Users (VANDU) launched a peer-run unsanctioned SIF in which trained peer volunteers provide assisted injections to increase the coverage of supervised injection services and minimize drug-related harm. We undertook qualitative interviews ($n = 23$) and ethnographic observation (50 h) to explore how this facility shaped assisted injection practices. Findings indicated that VANDU reshaped the social, structural, and spatial contexts of assisted injection practices in a manner that minimized HIV and other health risks, while allowing people who require help injecting to escape drug scene violence. Findings underscore the need for changes to regulatory frameworks governing SIFs to ensure that they accommodate people who require help injecting.

Keywords Drug users · Harm reduction · HIV risk behaviors · Supervised injecting facilities · Peer-based interventions · Risk environments · Ethnography

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Introduction

In Canada and internationally, injection drug use is associated with high levels of preventable morbidity and mortality [1–3], and in particular is a major driver of the global HIV/AIDS and hepatitis C (HCV) epidemics [4, 5]. Over the past decade, increased attention to social determinants of health has led to a greater recognition that these health harms are produced by social, structural, and environmental factors [6–9]. In this regard, people who use drugs may be understood to be structurally vulnerable to drug-related harm [10], in that the social arrangements embedded in the organization of our society render them vulnerable to harm [11]. Central to the emerging social ecology of injection drug use has been the development of the "risk environment" framework as a heuristic for delineating the social-structural production of vulnerability among people who inject drugs (IDU) [6–8].

In the broadest sense, risk environments are conceived as social or physical spaces in which all factors exogenous to the individual (i.e., social situations, structures, and places) interact to produce or reduce drug and health harms [7, 8]. The risk environment framework conceptualizes risk and harm as the product of the *interplay* between types of environments (i.e., social, physical, economic, and political) operating at differing levels of environmental influence (i.e., micro-, meso- and macro-environmental levels) [6–8].

PURPOSE

The purpose of this report is to describe why assisted injection matters, what philosophy guides nursing practice, and how nurse-assisted injection could unfold in British Columbia. It seeks to draw a path forward and offer considerations for policy change.

In preparation for this report, we conducted a literature review (see Appendix C for a list of the research articles consulted for this report), partnered with the HIV Legal Network to complete a policy and legal review, invited harm reduction nurses to provide input using an online survey, and held consultations with four groups of stakeholders: researchers, people with lived and living experience, leaders in relevant clinical or policy positions, and nursing organizations in the province (i.e., union, regulatory body, and association). This work was supported by a Convening and Collaborating (C2) grant from Michael Smith Health Research BC.

VISION

To promote an equity-informed and rights-based approach to supervised consumption services and nursing practice by removing barriers to access and improving health outcomes.

WHY ASSISTED INJECTION MATTERS

Supervised consumption services provide a designated space for clients to inject[9] – a safer alternative to injecting alone or in a setting that poses risks to health and safety. It is not the only reason clients use supervised consumption services, but it is an important one.

Nurses who work in these services encounter clients who need/request injection education and support every day, multiple times a day. Injection education includes information about how to inject, where to inject, what issues to look for and how to prevent them, and so forth. Injection support also includes help with steps leading to the injection, such as help locating a vein.

When working with clients who live with a disability, clients who experience withdrawal symptoms or have a history of injection-related anxiety, and clients with difficult or limited access to veins, nurses encounter situations in which not being able to provide direct assistance with the injection itself results in the client having to leave to seek help somewhere else.

We know, anecdotally, that nurses experience moral distress when they cannot provide this form of direct assistance because clients leaving means greater risks to their health and safety, including the risk of overdosing and dying alone. Nurses also report an increased workload associated with lengthy periods of injection support (for example, spending an hour in a booth with someone who cannot inject and is dopesick) resulting in less time to care for other clients.

Reasons why assisted injection matters include:

1 IT IS CONSISTENT WITH A HARM REDUCTION APPROACH

It is consistent with the principle of "meeting the client where they are at". It seeks to reduce the harms associated with repeated puncturing of veins, injecting/being injected in a central vein, or injecting in the muscle. It also reduces the likelihood of syringe and equipment sharing.

2 IT CONTRIBUTES TO HEALTH PROMOTION

It reduces further damage to veins in clients who have challenging venous access and it can contribute to safer injection practices by providing an opportunity for health teaching, skin and vein assessment, and when appropriate, treatment and/or referral.

3 IT PREVENTS COMPLICATIONS AND INFECTIONS

It decreases the likelihood of vein and tissue injury, prevents needle-sharing and re-using of injection equipment, averts exposure to HIV and Hepatitis C, and prevents serious infections such as endocarditis and complications such as sepsis.

4 IT IS CLIENT-CENTERED

It meets the client where they are at and contributes to building trust and rapport (including setting boundaries about injection assistance). It can also create opportunities for greater client engagement, autonomy, and decision-making.

5 IT REMOVES DISCRIMINATORY BARRIERS

It removes barriers that disproportionately impact clients based on gender, age, and disability, which are prohibited grounds of discrimination. As such, it is part of an equity-informed and rights-based approach to supervised consumption services that seeks to broaden access for clients who need help injecting.

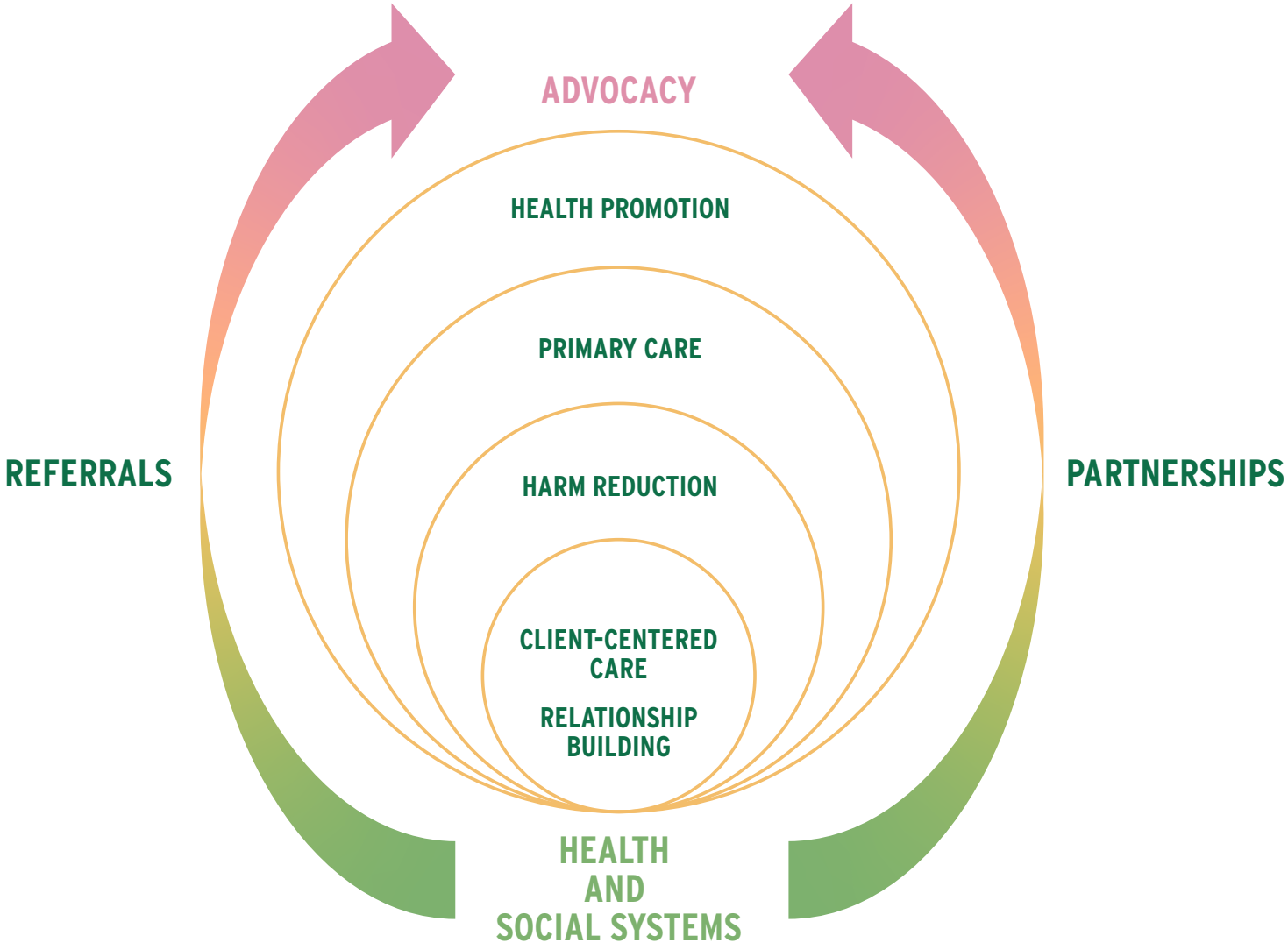
6 IT ADDRESSES POWER IMBALANCES AND RISKS TO SAFETY

It prevents clients from leaving and seeking help elsewhere. More specifically, it addresses documented power imbalances (e.g., street-based and intimate partner violence) and risks associated with unsafe injection practices and unwitnessed overdoses.

PHILOSOPHY OF CARE

As stated in the *International Consensus Statement on the Role of Nurses in Supervised Consumption Sites*[10], nursing practice in supervised consumption services is informed by a broad philosophy of care that encompasses harm reduction, health equity, cultural safety, relational care, social justice, and anti-oppression.

In their day-to-day work, nurses keep client-centred care and relationship-building at the core of their practice. In addition to overdose prevention and management, nurses work across health promotion, harm reduction, and primary care to deliver safe, ethical, compassionate, and competent care per their professional standards and code of ethics.



Framework adapted from Lightfoot et al. (2009), taken from Gagnon et al. (2019)

NURSE-ASSISTED INJECTION

To create a path to equity in supervised consumption services, nurse-assisted injection should be implemented alongside peer-assisted injection. Nurse-assisted injection is not a replacement for peer-assisted injection nor is it inherently better. It is one more tool in the harm reduction toolbox and a way to ensure greater access and continuity across supervised consumption services.

In the BC context, where staffing models vary, nurse-assisted injection would be limited to where nurses work and already provide care to clients who inject in supervised consumption services, including episodic services in health care settings (i.e., e-OPS) and safe supply programs. Nurse-assisted injection would be subject to standards outlined by the British Columbia College of Nurses and Midwives (BCCNM), contingent upon readiness and ability to provide assistance, completion of training (see Appendix A), and organizational support in the form of clear policies and procedures (see Appendix B).

All nursing interventions stem from rigorous assessment and planning. Nurse-assisted injection is no different. It would require an assessment of the client and the situation as well as the appropriateness of assisted injection. It would also require proper documentation and evaluation, including any adverse events and steps taken following an adverse event. As with other nursing interventions, education, support, and assistance would be provided in a way that promotes autonomy, decision-making, and client-centred care.

In the current context, two types of injection assistance are relevant to nurses:

ASSISTANCE WITH VENOUS ACCESS

This form of assistance applies to situations in which nurses help secure access to a vein. We propose two types of assistance: 1) puncturing a peripheral vein and 2) installing a saline lock in a peripheral vein. Each type of assistance would be subject to the professional standards, practice standards, and scope of practice standards outlined by BCCNM. Implementation would also require explicit organizational support in the form of clear policies and procedures that are consistent with standards, limits, and conditions set out by BCCNM.

1. Puncturing a peripheral vein		
Nurse practitioner	Yes	
Registered nurse	Yes	
Registered psychiatric nurse	Yes, with limits/ conditions:	- additional education - short peripheral venous access devices
Licensed practical nurse	Yes, with limits/ conditions:	- client-specific order - additional education - short peripheral venous access devices
2. Installing a saline lock in a peripheral vein		
Nurse practitioner	Yes	
Registered nurse	Yes	
Registered psychiatric nurse	Yes, with limits/ conditions:	- additional education - short peripheral venous access devices
Licensed practical nurse	Yes, with limits/ conditions:	- client-specific order - additional education - short peripheral venous access devices

A note about prescribed safe supply medications

Prescribed safe supply medications are not different from other medications. If the prescription indicates that the medications should or can be administered intravenously, assisting with venous access would be appropriate. This is important to highlight because we know, anecdotally, that safe supply medications prescribed IM/IV are often administered IM. This can pose problems, because the volume of medication to be injected is often high, resulting in the need for multiple IM injections. There is also a potential risk of reduced therapeutic effects and outcomes. If IV administration is indicated on the prescription (i.e., the medication prescribed is intended for IV injection) and preferred by the client, injection assistance should be provided in accordance with standards, limits, and conditions set out by BCCNM.

ASSISTANCE WITH ADMINISTRATION

This form of assistance applies to situations in which nurses help administer the substance (i.e., push the plunger of the syringe). Under the current legal and regulatory framework, this form of assistance is limited to prescribed safe supply medications and does not currently extend to unregulated substances (i.e., substances purchased and brought in by clients). This presents important limits that we discuss below.

We propose three types of assistance: 1) administering via venipuncture of a peripheral vein, 2) administering via a saline lock installed in a peripheral vein, and 3) administering via a central line. Each type of assistance would be subject to the professional standards, practice standards, and scope of practice standards outlined by BCCNM. Implementation would also require explicit organizational support in the form of clear policies and procedures that are consistent with standards, limits, and conditions set out by BCCNM.

ADMINISTERING PRESCRIBED SAFE SUPPLY MEDICATIONS		
1. Via venipuncture of a peripheral vein		
Nurse practitioner	If prescribed by the same NP: yes	
	If prescribed by another NP or MD: yes, with limits/conditions:	- client-specific order
Registered nurse	Yes, with limits/conditions:	- client-specific order
Registered psychiatric nurse	Yes, with limits/conditions:	- client-specific order - additional education - short peripheral venous access devices
Licensed practical nurse	Yes, with limits/conditions:	- client-specific order - additional education - short peripheral venous access devices
2. Via a saline lock installed in a peripheral vein		
Nurse practitioner	If prescribed by the same NP: yes	
	If prescribed by another NP or MD: yes, with limits/conditions:	- client-specific order
Registered nurse	Yes, with limits/conditions:	- client-specific order
Registered psychiatric nurse	Yes, with limits/conditions:	- client-specific order - additional education - short peripheral venous access devices
Licensed practical nurse	Yes, with limits/conditions:	- client-specific order - additional education - short peripheral venous access devices
3. Via a central line		
Nurse practitioner	If prescribed by the same NP: yes	
	If prescribed by another NP or MD: yes, with limits/conditions:	- client-specific order
Registered nurse	Yes, with limits/conditions:	- client-specific order
Registered psychiatric nurse	Yes, with limits/conditions:	- client-specific order - additional education
Licensed practical nurse	No	

A note about limits placed on the administration of an unregulated substance* (i.e., pushing the plunger on a syringe containing an unregulated substance purchased and prepared by a client)

In the current context, limits exist in assisting with the administration of an unregulated substance. These limits arise from professional and practice standards set out by BCCNM, which are upheld by health care settings and organizations (including supervised consumption services), and existing drug laws, including the regulatory framework under which exemptions are granted to supervised consumption services. We believe that there is a strong ethical rationale for allowing nurses to provide assistance with the administration of an unregulated substance, but this practice is not permissible under the existing regulatory framework and questions related to criminal, civil, and professional liability remain (see **Provider-Assisted Injection in Ontario's Supervised Consumption Services: Frequently Asked Questions**). We also recognize that practice standards, such as the *Medication practice standard*, are difficult to work with when providing care to clients who inject unregulated substances and face significant health risks that nurses are in a position to mitigate by providing assistance (e.g., unwitnessed fatal overdose or adverse events such as anaphylaxis, myocardial infarction, etc.). This report reinforces the need to continue advocating for this practice to be permitted and for barriers to be removed to ensure that no client is turned away or put in harm's way because they cannot access the help they need at a supervised consumption service.

A note about flushing

If a client wishes to use a central line to self-administer an unregulated substance*, education should be provided about the risks of using the central line and ways of reducing such risks, including how to properly flush the line before and after. Flushing before and after the client has self-administered the unregulated substance is difficult to separate from the act of administration because it clears the line and pushes the unregulated substance into the bloodstream. For this reason, it constitutes a form of administration and the limits outlined above are likely to apply to this practice. To a lesser extent, the same could be said about flushing an existing saline lock before the client self-administers an unregulated substance (i.e., a client coming in with an already inserted saline lock). However, saline locks do not allow for the same amount of residual volume to stay in the line and do not pose the same risk as central lines.

** For ease of reading, we refer to "unregulated substance" (singular) but in practice, multiple substances can be contained in one sample (e.g., opioids, benzodiazephines, and adulterating cutting agents).*

CONSIDERATIONS FOR POLICY CHANGE

At the provincial level, nurses have voiced the need for explicit and consistent policies and procedures to help them move toward the implementation of assisted injection. They have also flagged limits being placed on the practice by employers even in situations where nurses perform activities that fall clearly within their scope of practice, such as administering safe supply medications prescribed to a client. There is no doubt that support from BCCNM and NNPBC in guiding practice and policy will be important to move this practice forward and ensure consistency across healthcare settings and organizations.

At the federal level, changes to the exemption process would go a long way to support the full implementation of nurse-assisted injection. By allowing peer-to-peer assistance, Health Canada signalled in 2018 and 2020 that it understood the need for assistance in supervised consumption services. Expanding the scope of the exemption to include protections for *employed* peer workers and nurses to provide assisted injection, including assistance with the administration of an unregulated substance in situations that warrant such assistance (for example, clients living with a disability that prevents them from pushing the plunger) is needed to ensure that clients who need the most help are not turned away from life-saving services.

CONCLUSION

Supervised consumption services are an essential part of health care and community services for people who use substances in BC. These services are particularly important for people who inject because they offer a safer place to inject and an opportunity to access harm reduction supplies, connect with resources, and receive care and support if needed – including emergency care in the event of an overdose or other acute health issues. Removing barriers to accessing supervised consumption services should be a priority given the number of lives lost to the poisoned drug supply crisis. Making access contingent upon the ability to self-inject not only generates deadly inequities but creates a two-tier access system that is discriminatory in nature. This report paves the way for change, but barriers remain for clients who cannot self-inject and clients who cannot currently access supervised consumption services (e.g., youth who inject). We hope this report ignites a bold and courageous response, and a commitment to address remaining barriers related to age, gender, and disability as well as barriers related to administration assistance.

Endnotes

1 For up-to-date maps (and number of supervised consumption services), consult Health Canada's map here: https://health.canada.ca/en/health-canada/services/drugs-medication/opioids/responding-canada-opioid-crisis/map.html or Pivot Legal Society's map here: https://www.pivotlegal.org/scs_ops_map.

2 Ministry of Health and BCCDC (June, 2020). COVID-19: Provincial episodic overdose prevention service (e-OPS) protocol. Available here: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_EpisodicOPSProtocolGuidelines.pdf.

3 Ministry of Mental Health and Addiction and Ministy of Health (July, 2021). Access to prescribed safer supply in British Columbia: Policy direction. Available here: https://www2.gov.bc.ca/assets/gov/overdose-awareness/prescribed_safer_supply_in_bc.pdf.

4 Kennedy, M.C., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. *Current HIV/AIDS Reports, 14*, 161–183.

5 Kerr, T., Mitra, S., Kennedy, M.C., & McNeil, R. (2017). Supervised injection facilities in Canada: Past, present, and future. *Harm Reduction Journal, 14*, 28.

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8 Health Canada (October, 2022). Supervised consumption sites: Status of applications. Available here: https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html.

9 Supervised consumption services are not limited to injection. Snorting and injesting are also allowed in many supervised consumption services. Smoking is not typically permitted unless the space is designed to accommodate this mode of consumption. For more information, see Gehring, N.D., Speed, K.A., Launier, K., O'Brien, D., Campbell, S., & Hyshka, E. (2022). The state of science on including inhalation within supervised consumption services: A scoping review of academic and grey literature. *International Journal of Drug Policy, 102*, 103589.

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APPENDIX A. TRAINING REQUIREMENTS

Training should be required before nurses can undertake any form of assisted injection. This training should not be cumbersome or rigid because this will generate barriers to the practice. One option would be to develop an online module that can be completed on the PHSA Learning Hub and offer support/mentorship via existing communities of practices.

Training should be co-developed with peers who practice assisted injection and focus on:

- Harm reduction principles
- Injection 101
  - Veins and venous access
  - Injection use in the context of regulated and unregulated substances
    - Considerations in the context of regulated substances (i.e., safe supply)
    - Considerations in the context of unregulated substances (i.e., illicit drugs)
  - Common issues associated with injection drug use
    - Potential adverse events
      - Assessment
      - Interventions
      - Evaluation
  - Safer injection education and support
  - Assessing needs and limitations
- Assisted injection
  - When to offer assistance: situations, approaches, and best practices to foster trust, autonomy, boundaries, and safety
  - What injection assistance entails and scope of practice considerations
    - Assistance with venous access
    - Assitance with administration
  - How to provide assistance in a respectful, ethical, competent, and person-centred approach
- Overview of policy, legal, and ethical considerations

APPENDIX B. POLICY TEMPLATE

Background
- What is nurse-assisted injection
- Situations in which assistance is needed

Objectives
- Provide equity-informed care
- Reduce harms
- Promote health
- Prevent disease
- Provide client-centred care

Risks when providing assistance with injection
- Overall risks
  - Overdose, infection, infiltration, embolism, etc.
- Risks associated with each type of assistance:
  - Risks associated with venous access assistance
    - Risks associated venipuncture
    - Risks associated with saline lock
    - Risks associated with central line
  - Risks associated with administration assistance (including the risks associated with denying this assistance)

Scope of practice considerations (including client-specific order and training requirement)

Core principles
- Fostering trust and a non-judgmental approach
- Communicating process and clarifying boundaries when necessary
- Ensuring the safety of the client, nurse, and other staff
- Respecting and supporting decision-making
- Providing information needed for informed consent and decision-making
- Providing safer injection education and coaching
- Maximizing benefits for the client and minimizing risks

Staff procedure
- Assessment
  - Assessing the client
  - Assessing the situation
- Planning
  - Based on the assessment and in discussion with the client, decide which assistance is appropriate
  - Gather supplies needed for that particular type of assistance
  - Make a plan for the client that includes education and coaching, prevention of adverse events, etc.
- Intervention
  - Explain the limits of the assistance (i.e., may not be successful) and potential adverse events
  - Provide the type of assistance needed and possible in consultation with the client
- Evaluation
  - Evaluate the assistance itself, the site, and the line
  - Evaluate the client's response and condition
  - Document process (including in the event of an adverse event)

Supplies needed (list supplies needed)

When to notify a physician or refer a client to the hospital/clinic (include examples of situations requiring notification and process to follow based on the organization, staffing, etc.)

APPENDIX C. RESEARCH CONSULTED

Bluthenthal, R. N., Wenger, L., Chu, D., Quinn, B., Thing, J., & Kral, A. H. (2014). Factors associated with initiating someone into illicit drug injection. *Drug and Alcohol Dependence*, 144, 186-192. https://doi.org/10.1016/j.drugalcdep.2014.09.008.

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