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BC Overdose Prevention Services Guide

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1.0 ACKNOWLEDGMENTS

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2.0 INTRODUCTION

2.1 Overview of OPS Protocol and Resources

This guideline is intended for service providers and Public Health practitioners offering overdose prevention services (OPS) in the community. OPS were initiated by the BC Minister of Health in Dec. 2016 due to increasing mortality from illicit drug overdoses. While this document provides guidance for the majority of circumstances service providers and practitioners may encounter, knowledge and practice are always evolving and you are encouraged to connect regularly with your local Harm Reduction Program leads and Medical Health Officers. Although there may be overlap between OPS and Supervised Injection/Consumption Services (SIS/SCS), a separate provincial guideline has been produced and should be referred to by SIS/SCS sites approved by Health Canada.

The guidance in this document primarily concerns and references injection drug use, however the authors recognize that clients may prefer to use drugs in other ways. Consequently, the guideline may also be applied to clients who ingest their drugs orally (i.e. swallow) or nasally (i.e. snort).

The guideline does not cover opioid smoking. Although law enforcement follows trends in the chemical composition of illicit drugs and their cutting agents, very little is known about what chemical by-products are produced when these drugs are burned, or their effects on health. Also, unlike injecting, swallowing or snorting, smoking illicit drugs will release these unknown chemicals into the air. In non-emergency situations where clients are smoking drugs inside, it is recommended to do so with open windows and staff to allow the room to clear of smoke before entering.

OPS provide designated spaces for the purpose of monitoring people who use drugs for signs of an overdose. This permits rapid intervention if an overdose occurs to prevent brain injury and death. For an overview of OPS protocols and service recommendations, see Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (Vancouver Coastal Health and Fraser Health, 2016). For guidelines and resources for OPS within supportive housing and homeless shelters, see Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response.

2.2 Key Elements in Overdose Prevention

Key elements in preventing deaths from overdose are:

- (1) using drugs with other people;
- (2) calling for assistance in the event of an overdose;
- (3) ensuring that naloxone and other life-saving first aid (e.g. breathers) are available quickly.

Key elements in preventing deaths from overdose may be achieved by:

- encouraging people residing in shelters and housing to ask staff or peers to periodically check in on them;
- training staff, and possibly interested peers (persons with past or present experience with injection drug use) and/or volunteers, to monitor a designated space and respond to an overdose;
- providing harm reduction and first aid supplies, including naloxone, in designated spaces and anywhere else there may need to be access to them;
- providing residents with a designated space within the shelter or housing facility where they can be monitored while using drugs
- providing education, upon request, to residents and clients about overdose risk and how to reduce it;
- arranging for visits by health care providers to provide supplies and support to staff and residents.
- providing referrals to health and social supports, including treatment options and primary care.

3.0 PURPOSE

This document outlines principles, protocols, training and related supplies to enable harm reduction workers to provide a space designated for overdose (OD) prevention. Such a designated space may be integrated into an already existing social service or health care setting or may be in a newly established location.

4.0 BACKGROUND

4.1 Epidemiology

British Columbia is in the midst of a drug overdose crisis due to illicit opioids. According to the BC Coroners Service, there were more than 930 apparent illicit drug overdose deaths in BC from Jan. 1 to Dec. 31, 2016. This compares to 518 in 2015, an increase of 79.2%. In December 2016, there were 142 illicit drug overdose deaths: the highest monthly mortality number in provincial history and more than double the average monthly number since 2015 (59).

89.9% of illicit drug overdoses in 2016 occurred inside (61.3% private residences, 28.7% other inside locations), 9.2% occurred outside in vehicles, sidewalks, streets, parks, etc., and 0.9% had an unknown injury location (BC Coroners Service – Illicit Drug Overdose Deaths in BC, January 1, 2007 - December 31, 2016).

4.2 Legislation and Regulation

On April 14, 2016, the BC Provincial Health Officer declared a Public Health emergency under the *Public Health Act* in response to increasing overdoses and overdose deaths.

Health Canada revised the Federal Prescription Drug List on March 22, 2016 to make naloxone more accessible to Canadians in support of efforts to address the growing number of opioid overdoses. In September 2016, the College of Pharmacists of British Columbia changed the scheduling of emergency use naloxone from Schedule II to unscheduled to increase accessibility. Consequently, naloxone can be made available for sale/purchase anywhere. Consequently, the *Health Professions General Regulation* under the *Health Professions Act* was amended to enable any person in a community or acute care setting to administer naloxone and first aid to another person if they suspect that person is suffering from an opioid overdose.

On December 8, 2016 Overdose Prevention Services (OPS) opened as part of the provincial response to the opioid overdose (OD) emergency as ordered by the BC Minister of Health. The Health Minister of British Columbia enacted the ministerial order under the *Health Emergency Services Act* and *Health Authorities Act* to support the development of overdose prevention services. The minister has the authority to take such measures in the face of a public health emergency. The order was enacted on the advice of provincial health officer and will last for the duration of the Public Health emergency. The order gives BC Emergency Health Services and regional health authorities the ability to provide overdose prevention services as necessary on an emergency basis. It is the responsibility of each individual health authority to assess the need in their region and provide such emergency services in a manner consistent with federal legislation.

4.3 Health and Social Issues

This guideline supports low barrier service for people who inject drugs (PWID) who often have experienced significant and intersecting discrimination, oppression, marginalization and stigma due to drug use and structural violence. Stigmatizing and/or criminalizing PWID contributes to the crisis by pushing people into more isolated situations where they are more likely to experience overdose.

High rates of overdose, disease, and death in PWID are critical and concerning indicators of drug-related harms in society. Providing services to help deal with the underlying traumas and challenges facing PWID is an important part of the provincial response.

5.0 GOALS, OBJECTIVES AND PRINCIPLES

5.1 Goals and Objectives

Aside from drug overdose, harms associated with injection drug use may include skin abscesses, transmission of HIV and hepatitis C, blood-borne infections (BBI), excess morbidity and mortality for PWID, stigmatization of PWID and exacerbated mental wellness.

Goal. The primary goal of OPS is to provide a space for people to use previously obtained drugs with sterile equipment (in the case of injection drug use), in a setting where trained staff are present and able to respond to overdoses as needed.

Objectives. The following objectives support OPS in attaining the overall goal of reducing harms associated with injection drug use:

- Provide space for PWID under the supervision of trained staff to intervene in overdose
- Reduce health, social, legal, and incarceration harms associated with drug use
- Support networks of people with lived experience, and peer workforce as integral to crisis intervention
- Create opportunities to work with PWID to build trusting relationships
- Optimize on the use of health and social services by PWID

5.2 Principles

5.2.1 Harm Reduction

Harm reduction is based on a strong commitment to public health and human rights with a primary aim of reducing the adverse health, social, economic and cultural consequences of using illicit drugs. OPS aim to reduce harms associated with injection drug use and promote health for PWID through:

- Increased opportunity for peer support networks and peer participation
- Reducing the number of overdose deaths
- Provision of Harm Reduction supplies to reduce transmission of blood-borne infections, endocarditis, and sepsis
- Increased access to low barrier services for PWID
- Increased referral pathways to local services

5.2.2 Improved Population Health

OPS improves overall population health through increased community capacity to adequately respond to the current overdose crisis in BC and through providing a point of access to harm reduction services, primary care and/or referral to treatment options based services for PWID, as determined by those accessing OPS services.

5.2.3 Integrated Services

OPS are uniquely positioned as a low barrier point of entry into health and or social services for drug users.

6.0 CORE SERVICES

Overdose prevention services (OPS) are generally seen as an intensive intervention along the continuum of harm reduction services for marginalized populations. OPS should be low barrier, person-centered and offer a trauma- and violence informed, culturally safe and supportive environment. Abstinence may or may not be a goal for participants accessing the service. Aside from overdose prevention, OPS can also provide referral pathways for participants who wish to access services related to opioid use and/or other health or related social issues.

Core services of OPS Include:

- Provision of a designated monitored space for injection drug use
- Intervention for drug overdoses
- Provision of Harm Reduction supplies (e.g. sterile needles, filters, cookers, condoms, etc.)
- Harm reduction teaching, training and referral services as requested by participants

7.0 SERVICE PROVIDERS

7.1 Guiding Principles for Service Providers

OPS models will vary across BC depending on the environment and context. An institutionalized, 'one size fits all' approach is not appropriate for participant-centered, trauma-and-violence informed and culturally responsive services, and a tailored approach is required to enable a wide variety of people who may experience overdose and other harms to access services.

In some regions, service providers have found that minimizing signage and rules typically found within established supervised injection sites has improved access to overdose prevention. Providers have also found that by allowing people who use drugs to contribute to rules and culture of the OPS, they experience better relationships than in more formal health care settings.

7.1.1 Relationship Building

Relationship building and connection has been the centre of harm reduction work for many years. The following qualities in OPS staff can significantly contribute to building trust with clients:

- Capacity to accept and respect people
- Self-awareness, an open mind and heart, and willingness to reflect on one's responses and boundaries
- Sensitivity and a working knowledge and understanding of the local community context
- Accept that all people are on their own journeys, and do it in their own way at their own pace
- Pro-Choice and ability to step back as an action; respecting choice even if it's not what was recommended
- A willingness to work as a team, and try different approaches when current ones are not working
- A sense of humor and humility
- Support networks and ways to care for yourself that help to sustain longevity in the work

7.1.2 Confidentiality

It is recommended that people working in harm reduction receive basic training in confidentiality and sign a confidentiality agreement (See Appendix C: *Service Provider Confidentiality Agreement Template*). The following are fundamental aspects of maintaining confidentiality when providing OPS:

- All participant information obtained by while working at the OPS is confidential.
- Because many OPS are often set up as a "one room" model, there may not be a separate area to have sensitive discussions. Take extra precaution to maintain participant confidentiality.
- Any information discussed on site, in staff meetings, during debriefing or in communication systems must remain confidential.

7.1.3 Responsibility/Accountability

Harm reduction workers and employers are responsible for ensuring appropriate training and/or professional designation, in relation to the duties they may be carrying out (e.g. proper training for rescue breathing supported by bag/valve masks and oxygen, if available, vs. general rescue breathing with face masks, Assisted injection, etc.). See Appendix D: Key Responsibilities for OPS Service Providers.

7.2 Documentation/Data Collection

Documentation is a crucial component for all OPS in BC in order to: 1) evaluate the impact and effectiveness of these programs; and 2) to meet regulatory standards for documentation and professional accountability. See Appendix E: *Required Documentation and OPS Intake Templates*:

- User Agreement/Release Form (1st visit only)

- OPS: Release of Responsibility Waiver (1st visit only)
- Visit and Overdose Log
- Youth Registration and Assessment
- Overdose Prevention Sites Core Data Elements for Overdose Incident

7.3 Support for OPS Service Providers

Provision of OPS requires particular attention to the wellness of staff. Attendance to repeated overdoses, sometimes several during the same shift, can be traumatic. This is especially true for people with lived experience as they are often working within their own community, and often witnessing high overdose and mortality rates among friends and family. See Appendix F: Support for Peers Providing Overdose Prevention and Response Services

8.0 SERVICE DELIVERY

The recommended service provider to participant ratio is 1:2. The maximum number of participants in the OPS at one time is determined by the number of tables for injection and service providers onsite. Staffing should take into consideration allowances for service providers' time to debrief and take breaks during their shift if required or when indicated. Ideally participants can be monitored post injection in a nearby location.

For an overview of the recommended training, protocols, prevention and follow up for OPS, See Appendix A: *Overdose Prevention & Response Protocol Recommendations for Service Providers* ([VCH] & [FHA], 2016).

Local Law Enforcement

Criminalization of drug use is inconsistent with the goals of OPS since OPS focuses on drug use as a health issue. The key is to ensure that people feel safe to access OPS and are not targeted or subjected to increased criminalization by police or security because of using services. This creates distrust and increases mortality by forcing people to use in hidden spaces and alone. Public order outside of OPS sites can be maintained without use of enforcement or increased security measures. Staff, particularly peer staff, should be seen as a priority in hiring as a means to provide optimal services delivery. See Appendix Q for additional information.

8.1 Participant Profile

In order to maintain low-barrier service provision, personal information including contact information is not required for access to OPS. OPS participants may choose or be given a unique identifier and confidentiality will be maintained at all times.

8.1.1 Participant Codes of Conduct

Statements of participant rights, responsibilities and codes of conduct should be clearly outlined and posted so they are visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct*).

8.1.2 Management of Specific Behaviors

- An appropriate service provider response requires de-escalation skills in a caring and respectful manner, and access to a quiet space when possible.
- Appropriate decision making around temporarily or permanently barring someone. Access to services can be lifesaving for people.
- Participant perception of judgemental behavior or strict rule enforcement may incite aggressive behavior.
- Service providers who have lived experience (Peers), the availability of food, drink and a warm dry place to relax post injection offers extra comfort which can minimize the potential for aggression.
- Participant rights, responsibilities and codes of conduct should be made available/visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct* [INSITE, 2016]).
- Aggressive behavior can result from agitation, frustration, or anxiety related to the physical and mental side effects of illicit drug use, and/or experiences of homelessness, poverty, criminalization, and marginalization.

For further recommendations see Appendix H *Management of Specific Participant Behaviors*)

8.1.3 Eligibility for OPS Access

To ensure the safety of everyone in the OPS, service providers must retain the authority to refuse entry and request ineligible participants to leave. It is recommended that staff consult with participant first, then management before initiating a longer-term participant ban. Any use of bans should be appropriate to the behavior and employed beginning with least restrictive means. Service providers should be particularly sensitive that bans which restrict use of OPS should be avoided to prevent deaths. For example, use of substances in other agency locations such as washrooms

should not result in ban from agency but rather redirecting people to appropriate sites for use. A goal of the OPS should always be to protect access for all people (See Appendix I: *Prohibition from Accessing OPS*). **Eligible: The following criteria indicate participants as *eligible* to access OPS when they are:**

- Willing to sign the User Agreements and Waiver Release (site specific)
- Willing to adhere to the OPS Code of Conduct • Not exhibiting overly aggressive behavior
- Not previously prohibited from entering the site
- Aged at least 16 years or over, or a mature minor capable of providing informed consent to their own health care as per the *Infants Act*
- Not using injection drugs for the first time and between the ages of 16-19 years

Ineligible: The following criteria indicate participants as *ineligible* to access OPS when they are:

- Mature minor unable to consent to their own health care (*Infants Act*)
- Under the age of 19 and no previous history of injection drug use (IDU). Overdose prevention services are generally seen as an intensive intervention along the continuum of harm reduction services for extremely marginalized populations. Youth who do not have a history of IDU should access resources that can more appropriately address their level of need.

Participants assessed as *ineligible* to use the OPS will be asked respectfully to leave the OPS.

Reasons for Service Refusal to Eligible Participants.

People may be politely denied admittance even when eligible if they have no intention of using drugs on the premises or the site is full

8.2 Reasons for Service Refusal from OPS

Service refusal occurs when participants are declined access for an identified amount of time and should occur as a last resort. Service providers should be aware that service refusal from OPS may cause more harm to the person, and should be considered in the decision-making process. The decision to deny a participant from accessing OPS lies with the site supervisor and is often specific and temporary. (See Appendix I: *Prohibition from Accessing OPS*).

8.3 OPS Access for Participants with Special Circumstances

The following individuals are considered as requiring specific considerations when seeking access to OPS.

- Youth
- Overly intoxicated
- First time using injection drugs
- Pregnant
- Non-Self Injectors

See Appendix J: Participants with Special Circumstances: Access to OPS.

8.4 Injection Services

8.4.1 Key Concepts

This section outlines key concepts to minimize the risk of needle stick injury, to safely prepare and then self-inject.

1. **Participants should self-inject where possible.**

2. Service providers who are under a regulatory body are not permitted to perform the venipuncture or administer the drug to the participant; however, peer to peer injection may be permissible under certain circumstances (see 8.4.4.4).

3. Injection of illicit substances is associated with:

- a. Blood-borne infections such as HIV and hepatitis C
- b. Injection related infections
- c. Death due to overdose

4. Potential harms can be reduced through:

- a. Application of harm reduction philosophy and core principles of health promotion
- b. Promoting participant agency and autonomy, especially in their wellness and injection practices
- c. Health teaching and care as determined by participants by trained staff

5. Safe disposal of sharps including sharps containers is critical because:

- a. The main cause of HIV infection in occupational settings is via percutaneous (e.g. needle-stick) injury resulting in exposure to blood with higher viral loads of HIV.
- b. Research suggests that HIV infection is rare after a needle-stick injury, however infection of hepatitis B & C is much more easily transmitted through a needle. It is recommended that people working in OPS settings have Hepatitis B vaccinations.
- c. Use procedures laid out in this section to minimize chances of an accident related to needle-stick injury.

8.4.2 Physical Space

The space for drug consumption may vary depending on the size of the population being served and the resources of the organization. The following are recommended space attributes and equipment:

- The space should be warm and well-lit
- Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy. In most cases, one window or open door is sufficient for ventilation purposes. Please see Appendix K for further details on the standard.
- Mirrors may be strategically placed to facilitate monitoring and self-injection; or the site should provide portable mirrors for clients on request
- Sharps disposals should be easily accessible for each client and in washrooms
- Table and chairs should have non-permeable, non-flammable surfaces, which can be easily cleaned with hospital grade cleaning supplies.
- Chairs may be positioned facing a wall to optimize privacy but is still accessible and able to be periodically monitored.
- There should be adequate space for staff or volunteers to perform naloxone administration and artificial respiration if necessary.
- The area should have a clear and open pathway to the entrance/exit should medical transport by emergency health services be required.

8.4.3 Equipment

Provide disposable trays for participants to collect equipment prior to proceeding to an injection booth. The following equipment should be available:

- Tourniquet
- 1cc and 0.5cc syringes/rigs. Choice in size varies and is a matter of personal preference.
- Sterile water for cooking
- Sterile cookers and filters (such as cotton) to filter the substance and reduce the amounts of harmful contaminants
- Alcohol swabs
- Gauze
- Band-Aids
- Ascorbic Acid (for breaking down crack cocaine)
- Sharps containers
- Cleaning supplies
- Fire extinguisher if available

Disposal systems for both bio hazardous waste and sharps should be easily accessible. Encourage participants to dispose of their own equipment.

8.4.4 Safer Injection

The following practices significantly reduce the risk of needle stick injury to staff, participants or visitors to the OPS.

- Participants dispose of needles in appropriate containers supplied by OPS
- Participant knowledge re: safe handling of injection equipment.
- Participants who use sharps outside of the OPS environment are instructed to put sharps in a heavy plastic or metal container with a secure lid.

OPS staff trained in safer injection techniques may offer education/guidance for participants upon request. These activities are undertaken with extreme caution and carried out by trained staff. (See Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*).

8.4.4.1 Pre-Injection Assessment

Before the participant accesses the injection area:

- assess for participant safety
- assess the participant's ability to follow simple directions
- consider the participant's current state of mind
- assess whether the participant is currently prone to sudden or erratic movements
- request that the participant dispose of all used needles (reduce risk of needle stick injury)
- request that the participant places the rig to be used on the table
- offer the participant hand sanitizer or the option to wash their hands
- consider location of sharps container in booth in relation to your location in booth (you may be in the path to the sharps container post injection)

*If there is concern regarding safety based on the above assessment staff can inform supervisor and may choose to not engage in booth assistance, especially for activities listed in Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*.

8.4.4.2 Authorized Activities

Authorized Activities - Booth assistance by *trained* staff **if requested**:

- Encourage hand washing as a measure to prevent infection;
- explain steps in safer injection process (Harm Reduction Education);
- Palpate and locate veins – land marking is an important part of vein care;
- Identify potential injection sites, including physically guiding participant's hand to appropriate injection area;
- Swab injection site with alcohol swab to reduce infection;
- Tie off participant's arm;
- Physically demonstrate all steps in safer injection process using separate set of sterile equipment and own body (mock injection only).

Participants with substantive history of injection drug-use may not require booth assistance and often serve as a valuable resource for safer injection practices for other OPS users, these folks may also be able to assist non-selfinjectors if necessary.

8.4.4.3 Jugular Self Injection (Jugging)

Jugular veins pose high risk of medical complications. If a participant insists on using this site to inject support the participant with the harm reduction education outlined in the protocol. (See Appendix M: *Injection into the Jugular Vein [Jugging]*).

8.4.4.4 Assisted Injection

While self-injection is preferred, non-self-injectors (people who are unable to self-inject) may seek peer to peer assisted injection if neither education of the person to self-inject, nor the provision of physical supports, will address the person's immediate need to be protected from harm. (See Appendix J, part D: *Non-Self-Injectors*.)

The public health rationale for permitting assisted injection by peers is to reduce the risks of injection for highly vulnerable persons who are unable to self-inject. Like those who do self-inject, they are at risk of overdose death, but in addition they are highly vulnerable to the transmission of HIV and HCV infection.

It is important to note that under the current legal framework it remains possible that providing assisted injections could result in serious criminal liability for those who assist; thus the person assisting should make an informed choice when providing assisted injections.

8.5 Disposal of Injection Equipment

- After injecting, each participant disposes of their used injection supplies in the sharps container, which is readily accessible at each injecting station. Participants are asked to not bend or break off needles before disposal.
- OPS staff will supervise the disposal process.
- If needle pick-up is required – use tongs if available; if using hands wear industrial gloves (black rubber)
- The disposal containers should be puncture resistant plastic and not filled to more than three-quarter capacity.
- When three quarters full, the sharps disposal container should be sealed.

- The filled containers should be removed and placed in a large cardboard bin provided by a hazardous waste company (where available)
- All full sharps containers should be stored in a locked, non-service area.
- Needle disposal/pick-up should be arranged by the site supervisor
- Agencies are responsible for hazardous waste pick up: consult with the regional health authority.

8.6 Needle Distribution

Service providers should encourage all participants to stay and inject at the OPS; however, if participants intend to inject elsewhere, needle distribution should be provided. Needle distribution services include:

- Distribution of all supplies (e.g. cookers, sterile water) including syringes
- Education on safe disposal of injection equipment
- Extending access to whoever needs them, regardless of the person's age, substance-using status or choice of substance used. (see Appendix J: *Participants with Special Circumstances; Access to OPS* [re: Youth])
- Individuals should receive enough supplies (injection equipment) to enable a clean needle for each injection.

8.7 Secondary Health Harms Associated with Injection Drug Use

For information on common secondary health harms associated with injection drug use See Appendix N: *Secondary Health Problems Associated with Injection Drug Use*.

8.7.1 Referral for Substance Use Treatment Including Opioid Agonist Therapy

- Long term opioid agonist therapy including iOAT, methadone, buprenorphine and other alternatives are an evidence based overdose prevention strategy for people with opioid use disorder.
- OPS staff should familiarize themselves with local addiction treatment services and be able to refer clients to primary care and treatment supports as requested.

9.0 OVERDOSE

This section outlines information for recognition and response to drug overdose for both stimulants and opioids. All OPS staff should be trained to respond to an overdose.

9.1 Opioids: Background and stages of Intoxication

Background Information

Opioid drug class includes:

- Substances directly derived from the opium poppy (such as opium, morphine, and codeine),
- The semi-synthetic opioids (such as heroin), and
- The purely synthetic opioids (such as methadone and fentanyl).

Opioids affect central nervous system receptors. The pharmacological effects include sedation, respiratory depression and analgesia as well as intoxication and withdrawal. The time to peak blood concentration and half-life depends on the specific opioid in question and will affect the length of time to intoxication.

Commonly used opioids:

- Codeine
- Heroin
- Morphine
- Demerol
- Amileridine (Leritine)
- Methadone
- Hydromorphone (Dilaudid)
- Fentanyl
- Opium
- Pentayocine (Talwin)
- Percocet (Percodan)
-
-

Opioid intoxication symptoms:

- Depressed level of consciousness (LOC)
- Constricted pupils
- Decreased respiration,
- Gurgling, snoring
- Body is limp
- No response to noise or knuckles being rubbed firmly on the sternum
- Skin looks pale or blue, and feels cold
- Slow or no pulse
- Person cannot stay awake
- Pinpoint pupils
- Cannot talk or walk
-

Opioid withdrawal symptoms:

- Anxiety, irritability
- Dilated pupils
- Sweating
- Nausea/vomiting

Atypical Opioid Overdose Symptoms

- Muscle rigidity
- Unusual movements of the arms and legs
- Seizures
- Delirium
- Staring gaze
- Walking or awake
- Decorticate posturing
- Slowed or irregular heartrate
- Vomiting

Stages of Opioid intoxication:

Stage	Services Provider Response
One: Drowsy	<ul style="list-style-type: none"> • Monitor Closely
Two: Nodding (intermittently falling asleep)	<ul style="list-style-type: none"> • Remain calm, monitor – paying attention to respiratory rate/minute • May verbally check in with the participant – being mindful not to disrupt their experience
Three: Nodding with respiratory rate less than ten breaths per minute	<ul style="list-style-type: none"> • Remain calm, attempt to wake participant • Gently shake and talk to participant • Get participant to open eyes • Get participant to talk • If responsive, assist to walk around • If available, may require oxygen
Four: Unresponsive	Initiate Opioid Overdose Protocol

9.1.1 Opioid Overdose Protocol (BCCDC, 2016)

Note: If oxygen or bag valve masks are available in your facility see Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks.*

1 Identify

- Before approaching MAKE SURE AREA IS SAFE- clear away any needles and put on gloves
- UNRESPONSIVE (doesn't respond to verbal stimulation [shouting their name] or pain. Tell them what you are going to do: nudge/touch them, then do sternal rub/pinch ear lobe/finger webbing)
- SLOW BREATHING (less than 1 breath every 5 seconds), may be snoring/gurgling
- Skin (may be pale or blue, especially lips and nail beds; may be cool or sweaty)
- Eyes (pinpoint (i.e. very small) pupils)

2 Take Charge

DELEGATE the following Tasks (examples below, some can be done by 1 person, some may not be needed):

- (1) Phone 911
- (2) Rescue breathing
- (3) Meet emergency responders and direct them to the OD
- (4) Get overdose response supplies
- (5) Give naloxone
- (6) Crowd control

3 Call 911

PHONE 911

- Say it is a medical emergency (not responsive not breathing) make sure ambulance is dispatched
- Give the address to the dispatchers
- Send someone to meet emergency responders at main entrance or street and direct them to the site of the overdose

4 Rescue Breathing

- Head tilt, chin lift - Clear mouth/airway & tilt head back
- You can use a breathing mask as a barrier – ensure the barrier is sealed around the mouth to maximize breaths
- PINCH NOSE and give 2 breaths
- Continue to give 1 BREATH EVERY 5 SECONDS (even after giving naloxone, until the person regains consciousness or paramedics arrive)

5 Give Naloxone: If the person has not regained consciousness with rescue breathing.

- Swirl the ampoule, then snap the top off the ampoule (away from your body)
- Draw up all the naloxone in the ampoule (1 mL) into the VanishPoint syringe
- Inject entire dose at 90° STRAIGHT INTO A MUSCLE (THIGH, upper arm, butt) - can inject through clothes

6 Evaluate

- WAIT 3-5 MINUTES to see if the person regains consciousness
- Don't forget to CONTINUE RESCUE BREATHING 1 breath every 5 seconds until the person is breathing on their own
- Give 40-50 breaths before deciding to give an additional dose of naloxone

7 More Naloxone

- If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
- WAIT 3-5 MINUTES - about 40 breaths (CONTINUE TO GIVE RESCUE BREATHS)
- Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive

8 Document and Debrief

- Tell paramedics about all emergency care provided (including # naloxone injections given)
- Fill out your organization's Critical Incident form and any other required paperwork
- Talk to your coworkers and/or site coordinator and/or site manager and/or access support through your employer (BCCDC, 2016)

9.1.2 Rescue breathing

The greatest harm from opioid overdose is brain damage due to lack of oxygen. Rescue breathing is a critical component of an opioid overdose response.

In a witnessed overdose, it is very likely that the client's heart is still beating. **Prioritizing giving breaths:** the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 3-5 seconds while preparing to administer naloxone AND approximately 30-40 breaths should be given between each injection of naloxone.

9.1.3 Oxygen Therapy and Bag Valve Masks (BVM)

Some OPS programs may have access to oxygen tanks or BVM supplies. For sites that do wish to provide oxygen the following guidance is offered. See Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks*.

Background

- There is minimal published literature on oxygen use by laypeople in the outpatient setting and no known published studies on its utility in opioid overdoses in the community.
- Expert opinion, as outlined in the 2016 *Canadian Consensus Guidelines on First Aid and CPR*, allows for oxygen (O₂) administration by trained first responders.
- There is expert agreement that provision of O₂ by lay people within the OPS context is appropriate. Some OPS have portable tanks of oxygen available for use in an emergency.
- Oxygen should only be used on people who are unconscious and whose oxygen saturation is less than 90%. This is to prevent the potential harm that oxygen can cause when given to someone who has an underlying respiratory illness.
- A person who is unconscious and showing a depressed respiration rate would benefit more from BVM with supplemental oxygen if used by someone trained and competent in its use.
- Sites that plan to have O₂ should also procure oxygen saturation machines and BVM. Staff must have received training on the safe use of the equipment as well as safe storage and maintenance of oxygen tanks and ensure supplies are maintained.

Definitions

- Oxygen therapy is the administration of oxygen as a medical intervention, which can be for a variety of purposes in both chronic and acute patient care. Oxygen is essential for cell metabolism, and in turn, tissue oxygenation is essential for all normal physiological functions.
- Bag Valve Masks (BVM) is an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs mechanically by squeezing a reservoir of oxygen.
- Oxygen saturation refers to the extent to which hemoglobin is saturated with oxygen. Hemoglobin is an element in the blood that binds with oxygen to carry it through the bloodstream to the organs, tissues and cells of the body. Normal oxygen saturation is usually between 96% and 98%.
- Pulse oximeter: a device, usually attached to the earlobe or fingertip that measures the oxygen saturation of arterial blood by sensing and recording capillary pulsations.

9.1.4 Naloxone

Naloxone is a safe and *highly effective* antidote to opioid overdose. Naloxone is an opioid antagonist and has a much higher affinity (attraction) for the same receptors in the brain as heroin and other opioids.

Naloxone displaces and prevents opioids from working at receptor sites in the brain. It has no effect on non-opioid drugs and no potential for abuse. If there are two first-responders, one can administer naloxone while the other manages airway, breathing, and circulation.

Once naloxone is administered, responders continue to perform airway, breathing, and circulation interventions. Naloxone has a short half-life: 15 to 30 minutes. This is much shorter than most opioids, so it is important to monitor a person after an overdose for 30 minutes or more. This is best done at the hospital.

9.2 Stimulants: Background and Stages of Intoxication

Background Information

Stimulants can cause increased heart rate, blood pressure, and body temperature. A stimulant overdose can cause cardiac or respiratory arrest as well as seizure. Patients may report chest pain, shortness of breath, disorientation, or panic. These symptoms require medical attention, and the person should be supported to attend hospital via ambulance.

Commonly used stimulants include:

- Cocaine
- Crack cocaine
- Amphetamines
- Ritalin
- Adderall

Stimulant overdoses symptoms may include:

- agitation, shaking
- chest pain
- high level of anxiety
- seizure

9.2.1 Stimulant Overdose Protocol

Stimulant overdose has a variety of presentations and can be precipitated by lack of sleep. The person should be monitored, kept safe and encouraged to attend hospital.

A stimulant overdose can lead to seizure, heart attack, or stroke as a result of elevated body temperature, heart rate, blood pressure, as well as dehydration.

Additional steps in the event of a stimulant overdose:

- Apply cool cloth to back of person's neck or to forehead
- Limit stimulation by moving the person to a quiet location with low light
- Encourage person to take slow, deep breathes
- If person becomes unconscious or has chest pain call 911.
- Perform assessment/intervention to maintain airway, breathing, and circulation (PHS, 2016)

If the person is having a seizure:

- Don't restrict their movement
- Don't put anything in their mouth
- Protect their head (place a pillow underneath their head)
- Place the person in the recovery position.
- Call 911

10.0 OPERATIONAL PROTOCOLS

10.1 Cleaning the facility and Disposal of Equipment

To guard against infection and contamination, the OPS sites should be kept as clean and tidy as possible at all times. Keeping the site tidy also shows respect for the participants. When service providers' clean booths, take out garbage or tidy up the OPS space - the main focus is to avoid needlestick injuries through:

- Paying close attention – do not get distracted when cleaning debris off the booth or floor
- Never using hands to take garbage off a booth – use a small dustpan and brush.
- Ensure good lighting in the workspace

See Appendix P: *Cleaning Checklist Template for OPS Space* as an example template for cleaning recommendations at OPS.

Cleaning Booths/Floors – Reminders:

- Don't get distracted
- Never use hands to remove garbage from an injection booth or the floor
- Wear gloves whenever cleaning
- Use a dustpan and small brush to remove debris from the booth.
- Use a dustpan and large broom to remove debris from the floor
- Encourage participants to clean debris off their own booths
- Wearing gloves, wipe down booths/mirrors with industrial disinfectant wipes such as CaviWipes or other hospital grade cleaners.

Refer to Section 7.0: *Service Delivery*

- *Safer Injection*
- *Disposal of Injection Equipment*
- *Equipment Disposal*

10.2 OPS Flow

10.2.1 Admission into OPS/Reception

- Reception staff greet each participant
- Reception staff assesses each participant for eligibility to access the service (See Section 7.0 *Service Delivery: Eligibility to Access OPS*)
- Participants sign the following forms as per site policies (See Appendix E – *Required Documentation and OPS Intake Templates*):
 - Adults:
 - *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS)* – (Signed on the 1st visit only).
 - *Overdose Prevention Services (OPS): Release of Responsibility Waiver* – (Signed on the 1st visit only).
 - Youth:

- *Youth Registration and Assessment* - (To be completed for each visit)

- All participants are registered in the *Overdose Prevention Services (OPS): Visit and Overdose Log* (Appendix E) before each visit.
- Participants will only need to provide their alias for subsequent visits.

10.2.2 Leaving the OPS to Provide Overdose Assistance (site specific).

OPS Staff may, on occasion, see a person outside the facility who requires immediate assistance.

Guidelines:

- Depending on agency/regional health authority protocols, service providers may or may not be required staff to leave the facility to provide care.
- For some OPS, there may be an associated chill out area located outside or adjacent to the OPS area. If overdose occurs in this area, staff may be required to respond.
- Staff may respond to an overdose outside of the designated OPS space to provide care only if the safety of participants and other staff inside the OPS is ensured.
- The primary responsibility is to provide service within the OPS and to ensure the safety of participants and staff on-site.

Staff may choose to leave the facility to respond to an overdose when:

- The situation is life threatening and cannot wait until Emergency Health Services or police arrive.
- The situation does not present a risk to staff safety or health.
- Emergency services (911) have been called.
- A second person accompanies them or can observe them from inside the OPS.
- It is the individual staff member's decision to leave the facility to provide service/support.

10.2.3 Washroom Monitoring (Site Specific)

Staff may be required to access the washroom in case of emergency, even if locked from the inside. Monitoring participant washroom use and initiating an appropriate response to any occurrence should be part of OPS protocol.

It may be beneficial to alert participants that staff will “check in” if the washroom is occupied for longer than usual (e.g. approx. 5 minutes). Indoor overdoses often occur in facility washrooms.

10.3 Death Protocol (site specific)

- Clear away any crowds that have gathered.
- As with all medical emergencies, contact Emergency Health Services ambulance (911) to request immediate assistance.
- Secure the immediate area around the individual, providing privacy and prohibiting access to area by other participants.
- Place all the individual's belongings in a plastic bag with their name on it and secure them in an office or space separate from the OPS space.
- Call the supervisor immediately and/or the regional health authority or agency Administrator on call.
- Check in with team members to see if they need to debrief the incident.

11.0 OCCUPATIONAL HEALTH AND SAFETY (OCHS)

11.1 OPS Space Requirements

For OPS space requirements please refer to the following sections:

- Appendix K: *Physical Space and Ventilation Requirements*
- Section 7.0: Service Delivery:
 - *Physical Space*
 - *Equipment*

11.2 Equipment

The following equipment is recommended for cleaning purposes:

- Industrial black gloves
- Cavi-Wipes (Industrial cleaning product for wiping down booths– wear gloves)
- Dust pan and brooms:
 - Large for floors
 - Small for removing debris from tables
- Sharps Containers
 - Sharps containers should be located as close as practical to the work area.
 - Different sharps containers are required for different purposes and worksites.
 - Replace containers when they are 75% full.
 - Sharps container should be maintained upright throughout use.

11.3 Personal Protective Equipment (PPE)

- The risk of unintended fentanyl exposures to staff treating overdose victims is extremely low. Fentanyl citrate and fentanyl HCl crystals in powders intended for street use are too large to become airborne or easily inhaled.
- In BC, there have been no reported cases of secondary exposures of fentanyl to first responders, health care workers or private citizens administering naloxone, despite thousands of overdose reversals in the field and in health care facilities.
- No additional Personal Protective Equipment is required when attending patients with drug exposures unless there is a risk of respiratory and/or bodily fluid exposure.
- Routine practices such as gloves and additional precautions should continue to be used when there is a risk of respiratory and/or bodily fluid exposure. The additional practices and/or elevated levels of PPE used in other professions are not required at this time.

11.4 Equipment Disposal and Transportation of Sharps

Equipment Disposal

Service providers must be familiar with safety and handling guidelines: post these guidelines in disposal areas and janitorial closets.

Transportation of Sharps

- Internal transportation of sharps containers should be kept to a minimum (examine at local worksite).
- When transporting sharps in vehicles, ideally sharps containers should be placed inside a secondary form of containment with a secure lid and always be transported in the trunks of vehicles.
- Lay sharps container on its side if tipping over is a concern.

How to Handle Garbage Safely

- Consider removing garbage just outside of the OPS regularly to avoid sharps being disposed here.
- Physical handling of garbage in the OPS should be kept to a minimum.
- Use waterproof garbage bags.
- Be Alert! If possible look for sharps protruding from garbage bag, and listen for broken glass when moving the bag.
- Don't compress garbage or reach into garbage containers with your hands or feet.
- Don't use bare hands when handling garbage. If available wear puncture resistant and liquid resistant gloves, polyurethane gloves, or use other tools designed for picking up garbage.
- Don't let garbage get too full. Leave enough free space at the top of the bag, so the top of the bag is easily handled.
- Change bags often to prevent over-filling. This allows for a lighter, less full back and makes it easier to hold away from the body when transporting.
- Hold the garbage bag by the top of the bag, away from the body – never hold the bag against the body.
- Do not place one hand under the bag to support it.
- Use tongs to pick up sharps.
- If tongs are not available, use a gloved hand to carefully pick up the needle. Dispose of gloves and WASH HANDS after needle contact.
- Hold needle tip away from the body.
- Put needle/s in a puncture resistant can or jar.

11.5 Needle Stick Injuries/Exposure to Blood and Body Fluids (Insite, 2016)

In the event of a needle stick injury:

- Cleanse the area/puncture site thoroughly with warm water and soap, or a suitable antiseptic soap such as Hibitane or Salvodil.
- In the event of an eye splash, flush the eye with tap water for 10-15 minutes.
- Report to the supervisor immediately.
- Go directly to the local emergency department to be assessed for risk of exposure to blood-borne infection as soon as possible: preferably within two hours of the incident.
- If the source/person of the blood or body fluid is known, request (or parent/guardian) their consent to have blood testing as well. They can go to emergency as well – preferably at the same time.
- Request or designate the site supervisor to complete Worker's Compensation Board form -Employers Report of Injury or Industrial Disease (WorkSafe BC).

11.6 Unknown Substance Left Behind

For any controlled or unknown substances left on site:

- Immediately bring to the attention of the site supervisor
- The site supervisor will place the substance in an envelope, which is then sealed, dated and initialed by the supervisor.
- The envelope should be placed in a locked safe in the staff-only area.
- The envelope will be logged into a record-keeping book, by supervisor.
- Contact the local police department
- A member of the local police department will log out the envelope

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13.0 APPENDICES

Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (VCH & FHA, 2016)

OVERDOSE PREVENTION & RESPONSE PROTOCOL RECOMMENDATIONS FOR SERVICE PROVIDERS



PURPOSE

Provide guidance for service providers to develop overdose (OD) prevention and response policies and protocols.

OD PREVENTION & RESPONSE: FIRST AID & HARM REDUCTION TRAINING

Does your staff have:

- OD prevention and response training? Provincial training resources and a [Training Manual](#) can be found at [TowardTheHeart.com](#). Contact your local health authority for training support.
- First Aid Training that includes responding to overdoses? This is essential for unregulated care providers working where overdose risk is high.
- Harm Reduction Training? Knowledge of harm reduction practices is fundamental for staff who work with people who use substances. Harm reduction addresses: safer use of drugs and alcohol; appropriate use of harm reduction equipment; access to health care; personal and cultural safety practices; and mechanisms for dealing with critical incidents. Contact your local health authority for training opportunities. Access the online [Harm Reduction Training](#) from the Course Catalogue Registration System (CCRS).

SUBSTANCE USE PROTOCOL

Does your agency:

- Have a substance use protocol (examples found [here](#))? Policies that force drug use off site (or to be hidden) increase risk of undetected ODs, and greatly diminish your staff's ability to intervene effectively.
- Have punitive sanctions or a Residential Tenancy Agreement that states that "any drug-related criminal activity" is a reason for end of tenancy? This will likely inhibit communication about drug use and overdoses.
- Have a substance use protocol known by all clients? Share it with clients in casual conversations or posters.

OVERDOSE PREVENTION

Does your agency:

- Recommend that all staff who have contact with clients receive the training referenced above?
- Have a protocol addressing both onsite and offsite ODs?
- Track staff training? Does training happen yearly?
- Have an agency staff trainer (or an external resource)? This will help with timely new staff and client trainings.
- Have OD response drills at regular intervals at each facility in your agency?
- Identify quiet corners where clients and their guests might use substances and be at risk for OD? e.g. bathrooms, stairwells and develop a system for regularly checking these spaces.
- Have a public bathroom? If so, does this space have its own protocol to prevent ODs that includes:
 - Regular safety checks?
 - Secured, tamper resistant sharps containers?
 - Locks that can be opened from the outside?
 - Posted bathroom protocol for clients to see?
- Have regular site assessments? This will ensure a review of all OD prevention and response measures.

Does your agency have signage that includes:

- List of staff who are trained in OD response (particularly if not all staff are trained)?
- List of clients who are trained in OD response (voluntary)?

*All underlined text is connected to a hyperlink

Version 2, 2016

- [SAVE ME](#) signs? Cue people on OD response steps (including those with low literacy).
- Door [signs](#) for clients who have naloxone and are trained in opioid OD interventions (voluntary)?
- A naloxone sign at the front desk? To inform clients and guests that staff are trained to respond with naloxone.

Does your agency have client-focused OD prevention such as:

- How to determine which clients are at risk of OD? OD risk should be assessed at intake and on an ongoing basis. Clients can be at higher OD risk at different times. A resource for this is: [Housing Opioid OD Risk Assessment Tool](#).
- Developing care plans in collaboration with clients during known times of OD risk. Can include but not limited to:
 - How to facilitate supporting clients to use alone more safely in their rooms:
 - Encourage clients to inform staff when using substances (with OD potential) in their room to facilitate a follow-up room check (may be via: in-person, phone call, intercom, baby monitor).
 - Timing for room checks should be based on route of administration, time of use, and ease of use.
 - Support client to be trained in opioid OD prevention and response.
 - Discuss with client when to call 911.
- Addressing stigma in your agency? Is stigma about substance use preventing clients from accessing services?
 - Vertical stigma – staff to peer. Lateral stigma – peer to peer. Self-stigma – self-judgment.
- OD prevention as a standing item on all client advisory groups and staff meetings? This will ensure continued evaluation, input and feedback from both groups.

OVERDOSE RESPONSE

Does your agency:

- Allow trained staff to administer naloxone to clients in the event of an overdose? Is there a protocol describing this intervention? Is staff trained yearly? Does your agency have naloxone onsite?
- Have a shift change checklist that:
 - Details overdose responses that occurred on that shift. Identifies clients with new or increased OD risk.
 - Requires a communication log review. Include inventory checks of naloxone kit and emergency supplies.
 - Establishes roles and responsibilities of each person on shift in case of an OD (including volunteers/students).
- Have a means of emergency communication? e.g. cell phones, walkie-talkies, panic buttons.
- Provide clients with access to phone, 24/7?
- Have a system to ensure staff is always reachable? e.g. posted phone number and/or staff location.

POST OVERDOSE INCIDENT FOLLOW-UP

Does your agency:

- Debrief with staff and clients following an OD?
- Have post-OD intervention duties? e.g. restocking supplies, reporting: critical incident form, naloxone usage log, naloxone administration, OD response information form?
- Make alert posters to notify clients? After how many ODs? Is a template used? When are posters removed?
- Alert extended community after OD incidents? After how many ODs? Who is information shared with (managers, health authority, other non-profit organizations)?
- Have a [guide to promote staff resiliency and prevent distress](#) after an OD reversal?

CLIENT INVOLVEMENT

Does your agency:

- Encourage clients to get training including acquiring their own naloxone kit?
- Have accessible venues to solicit client feedback? A variety of options can be used together such as: monthly client peer meetings, annual anonymous surveys, a suggestion/complaint box.
- Have paid client peer trainers? Peer trainers are an asset to both client and staff trainings.

*All underlined text is connected to a hyperlink

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Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

February 15, 2017

Purpose

The purposes of these guidelines are to provide management and staff of supportive housing and homeless shelters with best practice advice and resources on prevention, recognition and response to overdoses.

Background

Overdoses are unpredictable, can happen in any setting, and a quick response can prevent significant disability or death. People who use drugs may reside in any setting, and due to the illegality of drug possession their drug use may not be apparent to staff and tenants/clients at supportive housing and homeless shelters. As such, staff and management may need to take steps to prevent, recognize and be prepared to respond to overdoses should they occur.

Key elements in preventing deaths from overdose are (1) educating and encouraging people not to use drugs alone, (2) utilizing the actions below to reduce the stigma that encourages isolation and (3) ensuring that naloxone and other life-saving first aid is available quickly in the event of an overdose. These goals may be achieved by:

- providing education to tenants/clients about overdose risk and how to reduce it;
- ensuring that tenants/residents will not be evicted for disclosing drug use;
- allocating space within the shelter or housing facility where those who use drugs may do so in the company of others;
- provision of harm reduction and first aid supplies, including naloxone kits and sharps disposal containers, in allocated spaces and anywhere else there may need to be access to them;
- training of staff, and interested tenants/clients, peers and/or volunteers, to monitor allocated spaces and respond to an overdose;
- managing access to the space so that tenants/clients use is not impeded by guests, but also ensuring that guests do not use drugs unsupervised such as in bathrooms and stairwells.
- discouraging drug use alone; and for tenants/clients who choose to use alone, encouraging them to work with staff to establish a plan for room checking to reduce risk based on when a tenant/client is likely to be using drugs;
- arranging for visits by health authority community health nurses, or by community paramedics, to provide advice, advise on supplies, and provide support to staff and tenants/clients.

Guidelines

Given the diversity of supportive housing and homeless shelters in BC the following may or may not apply to specific circumstances, and should be adapted accordingly.

1. Develop an overdose prevention, recognition and response protocol for your organization. This may include information on:
 - a. First aid and harm reduction training
 - b. A substance use protocol
 - c. Overdose prevention, recognition and response
 - d. Post overdose incident follow-up
 - e. Tenant/client involvement
 - f. Incident debriefing and psychosocial support for staff
 - g. Evaluation, with tenants/clients, of the effectiveness of the protocol.

Details on what should be considered under these headings may be found in the *Overdose Prevention & Response Protocol Recommendations for Service Providers* by Fraser Health and Vancouver Coastal Health (Resource # 1).

For non-profit community organizations which serve a population in a facility at risk of overdose, the BC Centre for Disease Control (BCCDC) may be able to provide supplies at no cost containing naloxone and other emergency overdose response supplies through the BC Facility Overdose Response Box Program (<http://towardtheheart.com/naloxone/forb/>). An expectation of this program is that information about overdose responses will be provided to BCCDC.

In addition information on planning tools i.e. sample protocols, policies and check sheets are available to any organization at <http://towardtheheart.com/naloxone/forb/program-modules>.

For more information about the Take Home Naloxone Program, which provides overdose prevention and response training, as well as naloxone kits to eligible individuals, visit <http://towardtheheart.com/naloxone/>.

2. Involve staff, volunteers, and tenants/clients in developing an overdose plan. People with lived experience can provide a rich perspective on what may and may not work in your facility. To learn more about how to involve people who use drugs in developing a plan see resource #2.
3. Determine who is at risk of overdose and level of risk (see resource #3)
4. Develop step-by-step instructions on how to recognize and respond to overdoses, including the importance of call 911 for all overdoses (see resource #4).
5. Review and practice your overdose response protocol regularly.

6. Ensure that facility policies are not a barrier for people who are prescribed opioid-assisted treatment medications such as buprenorphine/naloxone (e.g. Suboxone) or methadone to treat their opioid use disorder, as these medications are internationally recognized as a best practice in treating opioid use disorder.
7. Anticipate the psychological impacts of overdose events and the need for providing or referring staff and tenants/clients to psychosocial support services (see resource #6).

Resources

1. *Overdose Prevention & Response Protocol Recommendations For Service Providers*
(http://www.fraserhealth.ca/media/Overdose_Prevention_Response_Protocol_Recommendations_Service_Providers.pdf)



Overdose Prevention
Checklist V3.pdf

2. *How to Involve People Who Use Drugs*
(http://towardtheheart.com/assets/resources/how-to-involve-people-who-use-drugs-20140227posted_7.pdf)



how-to-involve-people-who-use-drugs.pdf

3. *How to determine who is at risk of overdose, and the level of risk*
(<http://www.drugsandhousing.co.uk/hoorat4colour.pdf>)



hoorat4colour.pdf

4. *How to recognize and respond to overdoses*

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/recognizing-an-overdose/>

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/responding-to-overdose/>



RECOGNIZING AN
OVERDOSE.pdf



RESPONDING TO AN
OVERDOSE.pdf

5. See additional resources compiled by Fraser Health at:

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/overdose-planning-organization/overdose-planning-for-your-organization>

or contact the Portland Hotel Society for their “Harm Reduction and Overdose Management Policy and Procedures” (604 683 0073) .

6. *Incident debriefing and psycho-social support resources*

- Take Home Naloxone: A Guide to Promote Staff Resiliency & Prevent Distress After an Overdose Reversal

http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final_185.pdf



Naloxone-staff-resilie
ncy-BCCDC Dec 23 20:

- Healthcare Resiliency During Prolonged Response by Health Emergency Management BC



HEMBC Staff
Resiliency.pdf

- In addition see resources available from the Public Health Agency of Canada at <http://www.phac-aspc.gc.ca/publicat/oes-bsu-02/index-eng.php> and listed below:
[Taking Care of Ourselves, Our Families and Our Communities](#)

[Helping Children Cope](#)

[Helping Teens Cope](#)

[Self-Care for Caregivers](#)

- Additional information may be found in "*Opioid Overdose in Supportive Housing, How to Keep People Safe.*" by Shannon Riley RN, BSN, MPP, Project Manager, Illicit Drug Overdose Response, Prevention, Vancouver Coastal Health Authority
(<http://summit.sfu.ca/item/16417>)

[Appendix – Ministerial Order with respect to Overdose Prevention Services](#)



Appendix C: Service Provider Confidentiality Agreement Template

CONFIDENTIALITY UNDERTAKING FOR OVERDOSE PREVENTION SERVICES SERVICE PROVIDERS

In consideration of my contract placement at _(indicate regional health authority [RHA]/agency)___; I acknowledge and agree to the following:

1. I will adhere to the Information Privacy and Confidentiality Policy and related policies and subsequent amendments, concerning the collection, use and disclosure of information obtained in the course of my service with *(indicate RHA/agency)*;
2. I understand that all personal information concerning staff and the people who receive services (including medical records) is confidential and may not be communicated to anyone in any manner, except as authorized by *(indicate RHA/agency)* or applicable policies;
3. I understand and acknowledge that all information regarding the affairs of *(indicate RHA/agency)*, including corporate, financial and administrative records is confidential and may not be communicated or released to anyone in any manner except as authorized by *(indicate RHA/agency)* or applicable policies;
4. I will not copy, alter, interfere with, destroy or remove any confidential information or records except as authorized by *(indicate RHA/agency)* and in accordance with established policies; and
5. I understand that compliance with confidentiality is a condition of my placement with *(indicate RHA/agency)* and that failure to comply may result in immediate termination of my placement, in addition to legal action by *(indicate RHA/agency)* and others.

Print Name _____

Signature _____ Dated (mm/dd/yr) _____

Appendix D: Key Responsibilities for OPS Service Providers

- Check the overdose response and harm reduction supplies inventory.
- Review overdoses from last shift – ensure proper paperwork has been submitted
- Initiate communication with OPS participants
- Role model respectful behavior
- Be responsive to participants requesting further information/ support (e.g. social, mental health or addiction services)
- Provide overdose response and life support
- Offer education on safer injection techniques
- Control the flow and numbers of participants into and out of each area in accordance with established staff to participant ratios
- Ensure the safety of resting participants; checking in for a response at least every 20 minutes, more often if they are at risk
- Monitor participant activity - enforce the OPS Code of Conduct as necessary.
- Apply guidelines for verbal de-escalation and consequences for aggressive behavior, as outlined in the Occupational Health and Safety Section of this manual
- Build a sense of ownership/shared responsibility among participants of the OPS
- Debrief work-related issues at the end of each shift *and* following any critical incident
- Work collaboratively with other team members and help to orient new staff and participants
- Maintain documentation and data collection as required
- Address concerns regarding breaches of the OPS policy/protocols to the responsible person in charge or alternate.

- Maintain a structured, healthy and clean worksite
- Dispose of used equipment in accordance with established protocols • Clean OPS tables after each use in accordance with established protocols
- Regularly monitor the area outside of the site.
- Refer all media inquiries or public presentation opportunities to the supervisor or RHA/agency Communications Department

Appendix E: Required Documentation and OPS Intake Templates

Form 1: *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS) – (Signed on the 1st visit only).*

Prior to using the OPS, I agree to the following:

- I have injected drugs in the past, 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 direction of OPS staff and Codes of Conduct.
- 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, (*Indicate Regional Health Authority/Agency*) 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 above and am able to give consent.

Name: _____ (must include first & last initials)

Date of Birth: _____ (D/M/Y)

Completed by: _____

Date: _____ (D/M/Y)

Handle or Identifier:
(Name, nickname, or #,)

Revised February 4th, 2017

Form 2: Overdose Prevention Services (OPS): Release of Responsibility Waiver – (Signed on the 1st visit only).

Purpose: To waive responsibility of OD Prevention Services staff and volunteers upon a participant leaving the site against medical advice (AMA).

Participant Name/Handle: _____

I _____ have had the risks of leaving the OD prevention service AMA explained to me and I release all staff from all responsibility if my safety/life is compromised because of leaving this facility AMA. I am solely responsible for my own life/safety once I leave the OD Prevention Site.

Participant Signature: _____ Date/Time: _____

Staff Witness: _____ Date/Time: _____

OR _____

Participant left OD Prevention Service AMA, with knowledge of the risks involved, but without signing waiver.

Staff signature: _____ Date/Time: _____

Witness: _____ Date/Time: _____

Revised February 4th 2017

Form 3: Overdose Prevention Services (OPS): Visit and Overdose Log

Please fill out one row in the table for **each visit** and use a new sheet at the start of each day.

Identifier/Handle (if given)	Time of visit (include time of day and circle am or pm)	Did the person overdose? (Yes/No)	If the client overdosed, answer these questions as well:	
			Was naloxone given?	Was the person taken by ambulance to an emergency department?
1.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
2.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
3.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
4.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
5.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
6.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
7.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
8.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
9.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
10.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
11.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
12.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
13.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
14.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
15.	am / pm	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown

Form 4: Youth Registration and Assessment - (To be completed for each visit by Senior Staff Member)

Background

Youth represent the highest risk group for acquiring HCV and HIV through IVDU. Research indicates that they engage in high-risk behaviours to a greater extent than adults with established intravenous drug use. Youth who do not have a history of IVDU should access substance use resources that can more appropriately address their level of need and prevent initiation to IVDU. Prompt referrals to treatment options is an evidence-based strategy at preventing initiation to IVDU.

Name: _____ Date: _____ Handle: _____
DOB: _____ Verified with ID? []Y []N ID Type: _____

Reasons for wanting to access OPS:

Drug History: Substances, routes, duration, frequency

Injection sites visualized? []Y []N []N/A Congruence between history and presentation? []Y []N

Notes: _____

Understanding of risks related to IVDU:

- [] OD [] Tolerance [] Addiction [] Infectious Disease [] Emboli
[] Vasc/Nerv Damage [] Injecting Unknown Substances [] Scarring/tracks [] Access to HR Supplies

Notes: _____

Does youth present with need for immediate OPS access? []Y []N OPS Access Granted? []Y []N

Notes:

Are there any adult contacts identified by the youth: Y N

If yes, please complete the following:

Contact's Name: _____ Relationship to youth: _____
Phone/Cell# _____

Harm Reduction Education

- OD Prevention
- Not Using Alone
- Hand Washing
- ETOH Swab
- VC/location
- Flagging
- Disease Prevention
- Drug preparation
- Equipment
- Alt routes of ingestion
- Take Home Naloxone (if opiate use in drug hx)

Notes: _____

Referrals Provided? Y N If yes – where and was transport offered?: _____

Form 5: Overdose Prevention Sites Core Data Elements for Overdose Incident (Complete for every OD incident)

Contact:

margot.kuo@bccdc.ca Last

Revised: January 3rd, 2017

Background: On Dec. 8th, BC enacted a ministerial order to create overdose prevention sites. To support the decision making of the BC Health System Steering Committee on Overdose Response some basic metrics on the sites at a provincial level are needed.

Objectives of Surveillance: 1) To capture overdose events that may not otherwise be captured by existing surveillance
2) To monitor overdose events related to Overdose Prevention Sites.

Focus of Data Collection: Overdose Prevention Sites in BC operate on different models in a variety of settings. The focus is to provide no barrier venues for persons who use drugs to be in a safer environment with a person with naloxone available nearby in case of overdose. In keeping with this, data collection must not pose barriers while collecting minimum core elements from all sites with a focus on information that is readily available to any person, with or without medical training responding to an event.

This core data tool was developed collaboratively with Northern, Island, Vancouver Coastal, Fraser, BCCDC, and Interior Health Epidemiologists. Implementation will depend on settings and models.

CORE DATA ELEMENTS

Person

Core Data Element (as it would ideally appear on a data collection tool)	Definition and Other Information
Gender (if known): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown	The gender of the person experiencing the overdose. Data collection tools to include at minimum male, female, unknown.
Age Group: <input type="checkbox"/> under 19 <input type="checkbox"/> 19-39 <input type="checkbox"/> 40 or older <input type="checkbox"/> Unknown	The estimated age group of the person experiencing the overdose. Broad age categories are used to allow estimation by first responders.

Place

Overdose Prevention Site or Response Group Name/Code:	Name or Code of the Overdose Site (e.g. Powell St. Getaway). A list of overdose prevention sites by name and code with an address and Response Groups/Names with an affiliated site or area is required to interpret this field.
Overdose Occurred: <input type="checkbox"/> Inside <input type="checkbox"/> Outside	Indoors or Outdoors as best describes where the person experiencing the overdose was seen to overdose or was found.

Time	
Date: DD/MM/YYYY	The date of the overdose event
Time of Overdose: ____:____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. HH MM	The time that most closely approximates when the person showed observable signs of overdose or was found unresponsive.
Event/Intervention	
Was 911 Called: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whether or not 911 was phoned.
Was Naloxone Given: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whether or not Naloxone was given (any form but injectable is assumed for most settings)
How many injections of Naloxone were given: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> more than 5	The number of naloxone injections given as a part of this overdose response. The underlying assumption is that the 0.4 mg vials are standard in community kits and Overdose Prevention Sites. Only count injections prior to a paramedic taking over.
Was rescue breathing performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Whether or not breaths were given or observed to be given by <u>anyone</u> as a part of the overdose response.
What was the outcome? <input type="checkbox"/> Client Left <input type="checkbox"/> Client Transported to the ED <input type="checkbox"/> Client Died	The outcome of the event as best described by one of the three options. May also include unknown but this has been excluded from example format to encourage a usable answer.
Additional Summary Statistics Required Weekly:	
1. Estimated number of visits/interactions per site per week	
2. Estimated number of ODs per site per week (should equal report numbers)	

Appendix F: Support for Peers Providing Overdose Prevention and Response Services

The experience of witnessing and/or responding to an overdose is often stressful and overwhelming. The impact on health care providers responding in emergency situations is well recognized and acknowledged in the health care system; with resources such as critical incident debriefing and counseling available through employers. As part of the overdose response, it is important to have resources available for all of those providing overdose prevention and response services. Experiences such as these, if unresolved, may interfere with performing one’s daily life and work commitments, and trigger further trauma, grief and loss.

Unlike most health care professionals, Peers (a person who has both lived experience with drug use (either past or present), and uses that lived experience to inform their professional work) may be in a position where they lack the institutional support systems for immediate and ongoing emotional/mental health and well-being, thus often left to cope with the psychological impact of overdoses on their own.

A critical step in mitigating some of these impacts lies in the support and provision of regular and standardized services for Peers. These initiatives can be implemented at three levels: Peer-to-Peer, organization/agency for

Peer, and community initiatives. They should all provide relevant, appropriate, and timely Peer supports. Peer-to-Peer

Peers themselves are best positioned to empathize and intimately understand the lived experiences of other Peers. Peer-to-Peer support cultivates a setting whereby Peers can both look to other individuals who may have lived similar experiences for support, whilst other Peers can share their knowledge and expertise.

One potential Peer-to-Peer initiative whereby this may occur includes the formation of a Peer support team specifically oriented to people with lived experience, who are working as Peer workers at Overdose Prevention Sites.

This team could:

- work with Peers to develop active Peer support practices within teams through training and education;
- offer support and debriefing to all Peer workers at Overdose Prevention Sites;
- nurture self-care and self-assessment among Peer workers; and,
- triage to other services if needed and available.

Peers can encourage self-care for themselves and each other by:

- being patient and understanding with themselves;
- taking time to relax and take breaks (ex. go for a 15-minute walk during a lunch or coffee break. Do something enjoyable);
- taking timeout from media reports (including social media) and breaks from thinking and talking about overdose events;
- taking breaks from work and/or limiting the number of hours worked in a day or week;
- negotiating or asking to do other types of work or trading off with work;
- ensuring a good night's sleep;
- taking time to practice self-care and reflection;
- encouraging communicating or stating needs with others they trust;
- normalizing expectations – talking about what does stress, anxiety, being overwhelmed look and feel like
- recognizing that the work you do is saving lives.

Know and respect your limits. Commit to regularly scheduled time off. If you feel exhausted and need extra time-take it. If, at any time, you feel overwhelmed and unable to cope, consider who is a safe person for you to talk with and debrief. Identify someone you trust and feel safe talking to, it could be: another Peer worker, harm reduction worker, or community worker for example.

Organization/Agency for Peer

Organizations can enhance Peer staff resiliency by creating a supportive work environment and promoting self-care as a regular and worthwhile practice.

Actions to achieve this may include:

- openly acknowledge and value Peers and Peer work that is saving lives daily. Respect, and acknowledge the expertise and work being done by Peers in unusually stressful situations;
- Peers have important experiential knowledge about how best to provide services. Recognize and utilize that expertise in the development and operation of services;
- designate time and resources for Peer-to-Peer support including education and training for Peers to support each other;
- provide relief on short notice and on an as-needed basis to Peer workers;
- ensure that Peer workers have scheduled breaks and are encouraged to take them;

- prioritize and allow Peer staff to debrief following critical incidents - if they feel it would be helpful. If they prefer not to debrief, give staff a few moments (or whatever time they need) to recover from the adrenaline rush of reversing an overdose – they may need to take a walk, buy a coffee or make a phone call to a friend or family member;
- normalize the need to debrief and encourage taking time for oneself to manage stress, grief, loss and vicarious trauma;
- provide opportunities for regular debriefing with and among Peer workers including discussing how overdoses were managed ("what went well and what could be improved");
- provide a safe physical space where people can gather to discuss their experiences or seek respite;
- allow and encourage individuals to communicate when they feel stressed or overwhelmed. Further support this by encouraging and demonstrating non-judgemental responses or behaviour.
- obtain or secure support from community or leisure centres for streamlined access to passes.

In addition, the following resources outline suggestions as to how better to include Peers at a decision-making table or engagement process:

- [Peer Engagement Principles and Best Practices](#);
- [Peerology](#).
- [A Guide to Promote Staff Resiliency & Prevent Distress after and Overdose Reversal](#) further outlines management strategies to address the risk factors that may lead to staff distress.

Community Initiatives for Peer Support Services

Community initiatives that bring people together to give them the power or opportunity to act may include:

- information meetings about overdose events going on in your neighbourhood;
- memorials, candlelight vigils;
- regular acknowledgement of those who have died. For example, practice a moment of silence to recognize lives that have been lost next time you have a group gathering (ex. VANDU includes this practice at their meetings);
- Grief and Loss Support Groups - look for one in your neighbourhood, or consider starting one through existing Agencies.

Finally, a Provincial initiative (approved by the Ministry of Health and under the auspices of the Provincial Health Authority), not noted above, involves a current project that is underway for the rapid development and implementation of a [Mobile Response Team \(MRT\)](#). The MRT is a provisional team created in response to the recognition of the psychosocial impact that the opioid overdose public health emergency has on frontline workers.

The purpose of the MRT is to offer psychosocial supports to staff and volunteers of community-based organizations working within the opioid overdose public health emergency. This includes individuals who have been impacted by the effects of critical incidents such as multiple overdoses and/or deaths.

The activities and services the MRT are to provide include to:

- provide education and crisis response services;
- mobilize to designated sites across the province as a health resource for front line workers;
- provide psychoeducational materials;
- introduce Peer support tools to individuals and groups; • assess and respond to province-wide critical incidents.

Team members will be deployed to areas experiencing high rates of overdoses and overdose deaths (i.e. the Lower Mainland, Surrey, and Downtown Eastside) before expanding to Vancouver Island, the Interior, and Northern BC.

More information can be obtained from: mrt@phsa.ca

Appendix G: Participant Rights/Responsibilities and Code of Conduct (Insite, 2016)

Rights and Responsibilities of Overdose Prevention Site Participants

The rights and responsibilities offered below are not exhaustive. Ideally, OPS rights and responsibilities are developed to reflect the local context and in collaborative with PWID.

Rights

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by staff.
- To be in a clean environment.
- To receive appropriate support and attention.
- To access services even while under the influence of drugs or alcohol.
- To have a voice in the operations and functioning of the site, in conflict resolution processes and in regards to complaints or concerns.

Responsibilities

- To respect others while on site.
- To help create and maintain a safe place.
- To not cause physical harm to other participants or staff.
- To use the site for self-administration
- To not deal, exchange, share or pass drugs to anyone else on-site.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money on-site.
- To not bring outside conflicts into the site.
- To not engage in solicitation of any kind on site.
- To respect the property and privacy of others in the site.
- To follow the reasonable directions of OPS staff.
- To bring concerns or complaints to the attention of RPICs.

Appendix H: Responding to Specific Participant Behaviors

A) Management of Observable Behaviors Anxiety

Anxiety is an observable change in behavior and can increase through stimulant use. Mild anxiety can be beneficial for motivation and heightened awareness for problem solving. Moderate to severe anxiety can cripple the ability to perceive, think and conceptualize and the ability to cope with a situation.

Table 1: Management of Behaviors that Indicate Anxiety

Behaviours	Service Provider Response	Interventions
<ul style="list-style-type: none"> • Eye contact: loss of eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning. • Verbal contact: talkative, quiet, laughing, crying, joking, talking faster. • Physical Signs e.g.: <ul style="list-style-type: none"> ○ rocking, restless, pacing, ○ sitting very still, ○ a need for more personal space, ○ holding their breath. ○ wringing hands, drumming fingers, opening and closing hands. • Other signs: <ul style="list-style-type: none"> ○ asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions) ○ very poor short term memory ○ procrastination. 	<ul style="list-style-type: none"> • A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours in 95% of the population. 	<ul style="list-style-type: none"> • Be respectful of the participant's belongings/ personal space (do not touch the participant without their permission). • Actively listen to gain understanding from their point of view and what may be driving the behaviour. • Answer questions to give the participant back a sense of control and reassurance. • If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain there may not be an answer (do not ignore the question or need). • Focus on what you can do for the participant not what you cannot do (e.g. "How can I help?"). • Assist the participant to verbalize feelings in their own words, avoid using leading questions. • Re-direct participant's energy into safe activities.

B) Management of Aggressive Behavior

Depending on the stage of escalation, not all behavior perceived as aggressive requires participant eviction from the site. There are several techniques that can effectively dissipate aggression and restore a calmer environment. Service providers should understand how to assess for potential aggression and experiences or circumstances that can increase the likelihood of aggressive behaviors. It is important for service providers to present a consistent approach to participants. The key to the successful use of behavior modification techniques is a consistent approach by all staff.

Assessment for Potential Aggression:

- Assess the participant's potential for aggression on admission considering the indicators outlined below.
- Self-awareness; e.g. understand personal thoughts/attitudes, and actions towards people who are aggressive or have potential to become aggressive.
- Assess the environment for overall activity, e.g. a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Experiences/Circumstances that may contribute to a greater likelihood of participant demonstration of aggression:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment, lack of inhibition, labile moods
- Psychosis/Delirium/dementia
- Suicide intent, plan, thoughts or history
- Poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief (e.g. loss of central love interest, family member, housing, income, health)
- Feelings of powerlessness, anger, fear and failure
- Socio-economic indicators (e.g. poverty, low-income households)
- High residential mobility
- Demographic indicators (e.g. aggression is more likely within the age range of 20-24 years and in males)

Verbal Aggression

Verbal aggression can range from challenging (lowest form of verbal aggression) to threatening (highest form of verbal aggression). Lower stages of verbal aggression can often be managed through specific techniques and approaches. Threatening in the form of verbal aggression is intolerable and requires the participant to be directed to leave the OPS.

Table 2: Management of Lower Stages of Verbal Aggression

Stages of Verbal Aggression	Service Provider Response	Intervention
<p>Stage One: Challenging Behaviors</p> <ul style="list-style-type: none"> • Relentless questions, with no satisfaction - do not care what the answer is • Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction • Rhetorical questions - a form of distraction • Demanding/instant gratification • No respect for rules or regulations - challenge and test staff. 	<ul style="list-style-type: none"> • If this line of questioning continues, it could become very personal and the service provider's credibility, skill or knowledge. • Acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression 	<ul style="list-style-type: none"> • Remain calm. • Do not argue; focus on a common goal. • Redirect them back to the issue at hand. • Ask them a question to distract them (e.g. "Can I ask you something?"). • Give a positive directive to assist them in getting their needs met. • Give the individual reasonable choices or consequences - positive first, and a specified time to decide. • Use time and space.
<p>Stage Two: Refusing Behaviors</p> <ul style="list-style-type: none"> • Disagreeable • Refusing • Silence • Walk away • Verbally (calm or aggressive manner) • Distracting behaviours (refusal in disguise) • Repeated complaints, requests and demands • Blaming others • Exaggerated response of annoyance 	<ul style="list-style-type: none"> • Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make. 	<ul style="list-style-type: none"> • Remain calm. • Verify that they are refusing. • Verify the reason for the refusal. • Give a positive directive. • Give the individual reasonable choices or consequences- positive first, and a specified time to decide.
<p>Stage Three: Loud Behaviors</p> <ul style="list-style-type: none"> • Button pushing • Yelling, shouting 	<ul style="list-style-type: none"> • At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself. 	<ul style="list-style-type: none"> • FIRST PRIORITY: SAFETY FOR STAFF AND PARTICIPANT. • Remain calm - isolate the person if safe to do so, and either move them or clear the area of on-lookers • Give a directive to the participant that puts your safety first (e.g. "Please leave the building"). • Provide time and space and assess the need for additional staff to be present, or call police.

Stage four: Threatening Behaviors	<ul style="list-style-type: none"> • See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS 	<ul style="list-style-type: none"> • See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS
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Table 3: Physical/Verbal Aggression and/or Behavior that Challenges OPS Rules Requiring Direction for Participants to Leave the OPS*

Behavior	Service Provider Response	Interventions
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<p>Verbal aggression (stage four)</p> <ul style="list-style-type: none"> • Verbal threats are intolerable behaviour and will be managed as intolerable behaviour. <p>Physical aggression</p> <ul style="list-style-type: none"> • Sexual touching. • Physical touching with the intent to harm a person • Throwing objects with the intent to harm a person or damage the facility. • Punching or slapping a staff member or another participant. • Kicking with the intent to harm a person or damage the facility. • Spitting that is directed at a staff member or another participant. • Fighting in the facility. • Defacing the facility. • Damaging equipment Setting fire to the facility. • Walking around with an uncapped needle. <p>Challenge of Facility Rules</p> <ul style="list-style-type: none"> • Stealing. • Refusing to stop any behaviour that facility staff have requested the participant to stop. 	<ul style="list-style-type: none"> • Staff Safety always comes first • Consider past history with the participant, and whether or not a specific service provider has rapport with them. • Be aware of your own limitations and the volatility of the situation. • When asking the participant to leave the facility, assess the need for more staff to be present and/or whether it is necessary to contact the police. • If the situation is volatile, remove yourself from until appropriate support arrives • Be familiar with the course of action you need to take -know what you can and cannot do ahead of time • Prepare for the unexpected: • Be aware at all times re: who is available to assist you? • Request the participant to return to the OPS for follow-up with the supervisor to negotiate when they may be able to return? • Know your exits 	<p>For all Behaviours:</p> <p>In a calm, clear, matter-of-fact manner</p> <ul style="list-style-type: none"> • State the reason for asking the participant to leave • Direct the participant to leave the facility. • State when the participant may return <p>1. Intervention: Physical Aggression/Assault:</p> <ul style="list-style-type: none"> • Quickly assess the situation <ul style="list-style-type: none"> ○ Call 911 ○ Assess if weapons present ○ Clear exits for staff ○ Remove bystanders from the area • Immediately have two staff members attend the incident while waiting for police: <ul style="list-style-type: none"> ○ One to give direction to the person being assaulted re: protecting themselves/removing themselves from the attacker. The victim should have only one voice to concentrate on, so as not to cause further confusion. ○ A second staff member directs the participant to stop the attack and leave the facility. Attempts to distract the attacker can offer the victim a window of opportunity to escape. • Clear bystanders from the area. • Remove any potential weapons from the area. <p>2. Staff Experience of Physical Assault:</p> <ul style="list-style-type: none"> • Call for help. • Trigger an emergency call if available. • Protect the vulnerable areas of the body (e.g. face, neck, • Move to an area occupied by other staff • Ensure that help is on the way.
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*The above behaviors have been identified as intolerable to the OPS. When a staff member asks a participant to leave and restricts access to the service, all staff must respect that staff member's decision in order to enforce limits behaviors.

Evacuation

Should the building need to be evacuated because of violence in a room, staff will ensure that all people not involved in the incident vacate the building. Staff not taking charge of evacuating their areas should attend the incident and provide any assistance they can without putting their safety at risk. The closest staff

member not directly involved with the incident will call 911. Advise the dispatcher that there may be sharps and bio-hazardous material in the site. When evacuating the building, staff will close and lock all doors if possible.

Evacuation of staff and participants from the OPS could be necessary in the following situations:

- Fire
- Violent/potentially violent incident which staff cannot contain
- Earthquake
- Bio-chemical hazard

In the above situations, safety of staff and participants is the primary concern. Should an exit be blocked for any reason (e.g. fire, violence or threat of violence, etc.) the staff person in charge of their area is responsible for leading everyone in their area to the next closest safe exit. The site supervisor checks that 911 has been called, coordinates the evacuation and ensures that all staff and participants have left the building.

Appendix I: Prohibition from Accessing OPS

Participants can be prohibited from using the site for the day by any staff, due to:

- Uttering threats of violence or carrying out violence against anyone on the premises.
- Attempting to deal, purchase or share drugs on the premises.
- Periods of prohibition of more than one day will be set by the RPIC if they determine that the circumstances are severe enough to warrant it.

The following are recommended time frames for prohibition according to the circumstance:

1. Prohibited from using the site for the rest of the shift/day when a participant's behavior that is extremely difficult to control or there is refusal to follow staff direction
2. Prohibited from using the site for up to 24 hours. Access is reinstated only after speaking with the site supervisor. 24-hour prohibition is appropriate for circumstances where the participant has threatened violence directed toward a service provide or other participants, and/or a participant is dealing drugs on site
3. Prohibited from using the site for a period over 24 hours. Access is reinstated once consensus is reached with all services providers, including a supervisor and a manager. This may be reasonable for participants demonstrating:
 - Repeated or serious threats or violence
 - More than one prohibition has already been requested by service providers

Readmission after Being Prohibited from Using the Site

Barred participants must meet with the site supervisor/manager. They will be readmitted after assurances are made that the behavior will not continue.

The Steps for Service Provider/Participant Safety if Prohibition is Assigned to a Participant

1. The first step is to avoid triggering conflict (e.g. communicate openly, respectfully and calmly; do not demonstrate aggression or become demanding).
2. The second step is de-escalating the conflict. This includes backing up co-workers by appropriately intervening in conflict in ways that do not make the participants more defensive and by giving the parties to a conflict an easy way out.
3. The final step, when a situation cannot be de-escalated, is to call the police. In any situation involving violence, when staff or participants feel unsafe, the police should be called.

Documentation of Prohibition from Using the Site

- Service providers must communicate with supervisors as soon as a prohibition occurs.
- The supervisor is responsible for making the decision to place a person on further prohibition after a review of the documented events.
- The prohibition list will be kept current at the sign-in. Reason for refusal will be clearly documented.

Appendix J: Access to Overdose Prevention Services for Special Circumstances and Priority Populations

September 1, 2023

In BC, some groups of people—including Indigenous (i.e., First Nations, Inuit, and Métis) peoples, people who are made vulnerable by poverty, and people experiencing mental illness—experience disproportionate harms related to substance use and face significant barriers to accessing appropriate drug poisoning prevention services. There are also certain circumstances that may prompt ethical or legal considerations for providers supporting people seeking drug poisoning prevention services, such as first time injection substance use, people who are unable to self-inject, people who are pregnant or parenting, and youth. This document describes considerations to better support equity-deserving groups and people with special circumstances seeking drug poisoning prevention services.

Sites operated by nonregulated health and social service providers, such as peer run overdose prevention sites, should consider developing connections with their health authority for clinical support from regulated healthcare providers (such as RN, NP, paramedic or MD) or a primary care team to discuss emerging issues and additional supports to link clients to programs and services.

A) First Time Injection Substance Use

People who are injecting substances for the first time may pose an ethical challenge for drug poisoning prevention service providers. People who may be transitioning into injection substance use present an opportunity to offer harm reduction and health promotion education in addition to appropriate referrals and supports.

Participants who present for first-time injection substance use have often already made the decision to begin injection substance use and are seeking services to reduce harm. It is critical that people who are injecting substances for the first time have access to safe, ethical, and appropriate harm reduction services. Service providers should consider the consequences of refusing access to lifesaving information or drug poisoning prevention and response services for people who are injecting substances for the first time.

Protocol

- Provider initiates discussion and assessment with person wishing to inject substances for the first time.

- Provider explores reasons for injection substance use and identifies alternative modes of consumption, if appropriate and with consent.
- Provider offers harm reduction education about injection substance use with a non-judgemental and trauma informed approach.
- Provider offers referral to a primary care team or healthcare provider for additional supports.
- Provider offers debriefing to identify needs and supports after injection substance use.

B) People who are Pregnant or Parenting

People who are pregnant or parenting experience significant barriers to accessing drug poisoning prevention services due to stigma, fear of child welfare involvement, child separation, punitive policies, and substance use surveillance, combined with a lack of appropriate harm reduction services.

To improve access to drug poisoning prevention and response services, providers should meet people where they are at with dignity and trust with the goal of providing non-judgmental support and family togetherness. Providers should use non-stigmatizing language, avoid assumptions about substance use and family goals, and adapt services to meet the needs of families. Use a harm reduction approach, support individuals and use discussions and relationship as an opportunity for engagement. Use a trauma and violence informed approach to promote safety and establish a relational space to discuss responsibilities.

Building rapport and trust with someone who is pregnant, or parenting is necessary to create safety and access to services. Providers should recognize their position of power and consider how people who are pregnant or parenting and using substances experience significant vulnerabilities from substance use stigma and judgement when interacting with the healthcare system.

Protocol:

- Providers should refer to the [BCCDC MMHA Provincial Episodic Overdose Prevention Services \(eOPS\) Protocol](#) for further information on delivering overdose prevention services for people who are pregnant or parenting.

Child welfare considerations for people who are pregnant and seeking drug poisoning prevention services:

- Providers should note that BC's child welfare mandate and duty to report guidelines pertain to living children and do not include a fetus.
- There is no duty to report safety concerns for a fetus.

- This means, providers should not share information about any individual, including pregnant persons who use substances, to agencies or individuals without the pregnant persons' consent, as doing so would be a breach of confidentiality.

Child welfare considerations for people who are parenting and seeking drug poisoning prevention services:

- Not all substance use affects a person's ability to provide safer care to child(ren). Substance use, without indication or concerns of *immediate* risks for harm to child(ren), should not be reported to the Ministry of Children and Family Development (MCFD)/ Indigenous Child and Family Serving Agencies (ICFSA).
 - This means that substance use alone—whether the substances are regulated (e.g. alcohol) or unregulated substances (e.g. illegal fentanyl), used rarely or daily, consumed by any mode including inhalation, injection etc.—should not be reported to MCFD/ICFSA.
- Providers have a duty to report to the MCFD/ICFSA if there are *immediate* concerns the parent or family are unable to provide safer care to child(ren) due to significant impairment in judgement, behaviour, or level of consciousness and has not made adequate arrangements for the child's care.
 - This means that providers should not make a report to MCFD/ICFSA if the parent or family does not have the child in their care or has made adequate arrangements for the child's care while they are unable to provide safer care due to significant impairments.
- Referral to MCFD/ICFSA supports is voluntary. If the pregnant or parenting person is seeking services, providers can offer information and referral for voluntary supports.
- Providers should refer to decision support tools to guide information sharing and collaborative care for people who are pregnant or parenting: [Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director and the Ministry of Health](#).

C) Youth

Youth, also called “minors” in legal terms, refers to anyone under 19 years old. Youth who use substances are a highly underserved population that need access to harm reduction services, including drug poisoning prevention and response services.

Youth face many barriers to accessing harm reduction and drug poisoning prevention and response services. These barriers are even greater for Indigenous youth, youth who experience poverty or are unhoused, youth in and from care, and 2SLGBTQ+ youth.

Often, providers are unsure if youth are allowed to access harm reduction services on their own or if the youth needs a parent or guardian's consent. This confusion creates unnecessary barriers for youth and distress for providers.

Protocol:

- Providers should refer to the [BCCDC MMHA Provincial Episodic Overdose Prevention Services \(eOPS\) Protocol](#) for information on delivering overdose prevention services for youth.

Basic services for youth:

- Youth can access drug poisoning prevention services without a parent or guardian's consent and without a formal capacity assessment.
- Providers can witness the youth's substance use, provide safer substance use education, provide assistance to clean the skin before substance use, and support safer substance use practices without a formal capacity assessment or parent or guardian consent.
- Youth can also access other basic harm reduction services without a formal capacity assessment or parent or guardian consent, including accessing harm reduction supplies, training and giving out take home naloxone kits, providing drug checking services and education, providing emergency response (including naloxone) during drug poisoning, etc.
- Any person competent in drug poisoning response and adequately equipped to respond (e.g. Take Home Naloxone kit) can provide basic harm reduction services to a youth to prevent and respond to drug poisoning without a formal assessment by a regulated health care provider.
- If a youth has experienced drug poisoning and is unconscious, the common law provides that no consent is necessary in order to provide emergency treatment.

Advanced services for youth:

Advanced practices in harm reduction and drug poisoning prevention are considered health care under the Infants Act and require formal capacity assessment (also referred to as "mature minor consent") by a regulated healthcare provider, and in accordance with the provider's professional standards of practice.

Advanced practices in harm reduction and drug poisoning prevention and response:

- Only a regulated health care provider (e.g. nurse, physician, social worker, etc.) can provide advanced practices in harm reduction and drug poisoning prevention and response. Advanced services are considered healthcare interventions that go beyond basic harm reduction and drug poisoning prevention and response and can only be performed by a regulated healthcare provider.

- Advanced practices include inserting an intravenous line, inserting a nasopharyngeal airway, prescribing safer supply, prescribing opioid agonist therapy (OAT), etc.
- Additional Advanced practices include interventions provided during witnessed consumption that can only be carried out by a regulated healthcare provider, such as writing a prescription for prescribed safer supply, providing hands-on assistance with venipuncture (injection into the vein), medication administration of injectable opioid agonist treatment (iOAT), etc.

Duty to report and youth accessing drug poisoning prevention services:

- According to [Section 14 of the Child, Family and Community Service Act](#) (CFCSA), if a provider believes a youth under 19 years of age is being abused or neglected, there is a legal duty to report their concerns to MCFD or ICFSA. They are available 24 hours a day, 7 days a week.
- Substance use, accessing harm reduction supplies or Take Home Naloxone does not mean there is immediate risk of harm. These are not appropriate reasons to report. This means there is no duty to report youth based on substance use, access to harm reduction, or Take Home Naloxone.
- Reporting to authorities such as police or MCFD/ICFSA should be considered carefully and with caution. A mature youth has a reasonable expectation of privacy and confidentiality when accessing health services. Making a premature or inappropriate report could damage any trusting and therapeutic relationship developed with the youth and impact their decisions on accessing health or social services in the future.
- If there are additional concerns for a youth, including lack of food, shelter, clothing, or medical care, discuss with the youth about making a report or requesting support services to an MCFD or ICFSA. Communicate and ensure transparency with the youth about what information will and will not be shared with MCFD or ICFSA.
- There may be circumstances where a provider has significant concerns about a youth in care's well-being and safety. In collaboration with the youth, consider sharing, discussing or planning with their social worker at MCFD/ICFSA. If the youth does not provide consent to share with their MCFD or ICFSA social worker, contact may still be necessary to ensure the youth's safety and well-being.

D) People Unable to Self-Inject

Background

For a variety of reasons, some people are unable to self-inject and rely on others to assist with injection. This is an important population to engage as research has demonstrated a significantly heightened risk for

HIV infection. This is a complex issue that involves power differentials, gender based violence, and increased risk for harms.

Sites should consider the local context and aim not to turn away clients who are requesting support from another participant for injection purposes. Recognizing the vulnerability of people unable to self inject, providers should explore supports for self-injection and identify what is needed to reduce harms.

Protocol

- Providers should engage people who are unable to self-inject to identify barriers to self-injection (e.g. education, disability, etc.).
 - Address barriers by providing appropriate supports (e.g. physical supports, education, props, etc.).
 - Providers may discuss alternatives to self-injection, where possible. This may include access to prescribed safer supply and injection by a regulated healthcare provider or other methods of consumption (e.g. inhalation, intramuscular injection, rectal use, etc.).
- Providers should attempt to connect non-self-injectors with support services.

E) People Experiencing Excessive Intoxication

Background

People experiencing excessive intoxication may have a higher risk of needle-sharing, fatal drug poisoning, assault and other poor outcomes.

Denying access to drug poisoning prevention services to people who appear to be experiencing excessive intoxication compounds the risk for harms. Yet, providers may face challenges providing services.

Sometimes people who appear intoxicated may be experiencing other symptoms or medical conditions that require urgent medical treatment.

Protocol

- Organizations are encouraged to develop discretionary protocols to monitor and promote the safety of the person seeking services and other service users.

Appendix K: Physical Space for Injecting and Ventilation Requirements

Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy (see below).

Ventilation

9.41 (1) Each personal service room and food preparation area shall be ventilated to provide at least two changes of air per hour

- (a) by mechanical means, where the room is normally used by 10 or more employees at any one time; or
- (b) by mechanical means or natural ventilation through a window or similar opening, where the room is used by fewer than 10 employees if
 - (i) the window or similar opening is located on an outside wall of the room, and
 - (ii) not less than 0.2 m² of unobstructed ventilation is provided for each of the employees who normally use the room at any one time.

(2) Where an employer provides ventilation by mechanical means in accordance with paragraph (1)(a), the amount of air provided for a type of room set out in Column I of an item of the schedule to this Part shall be not less than that set out in Column II of that item.

(3) Where an employer provides for the ventilation of a food preparation area or a lunch room by mechanical means in accordance with paragraph (1)(a), the rate of change of air shall be not less than nine litres per second for each employee who is normally employed in the food preparation area at any one time or for each employee who uses the lunch room at any one time.

SOR/88-632, s. 38(F).

Appendix L: Activities that Require Extreme Caution: Supporting Safer Injection

Undertake with caution, by trained staff only and when other options have been exhausted The

following are considered activities that require extreme caution:

- Removing tourniquet after participant injects to prevent vein damage and blood leakage from the injection site (risk of needle stick injury to staff).
- Supporting the participant to stabilize the syringe or vein while injecting (risk of needle stick injury to staff)
- Directing the participant to adjust the angle of the syringe while the syringe in body (risk of needle stick injury to staff).
- Supporting the participant to cook/prep drugs (risk of spillage)
- This includes changing syringes
- Supporting removal of the syringe from the body in emergency situations (risk of needle stick injury)

When participating in these activities staff should:

- Always keep their hands behind the syringe, never in front of the syringe tip/needle
- For support in anchoring the vein:
 - Place hands behind and below the syringe, on the opposite side of the limb, away from the syringe
 - Use a tongue depressor to gain further distance between staff hands and the syringe
 - *The best way to anchor a vein is to educate the participant in vein anchoring techniques

If participant is able to, request that they:

- give verbal notice if, in the process of receiving injection support, they are going to move their rig (i.e.: relandmark)
- While the participant adjusts the syringe, staff will remove themselves from booth

When directly supervising injections:

- Self-injection should take place in the participant's assigned booth with participant seated in chair
- This minimizes risk of needle-stick injury related to:
 - Participant and/or staff positioning
 - Unpredictability of participant movements
 - Stand/sit on the side of the participant that is furthest from the hand holding the syringe.

Authorized Activities – By Trained Staff only:

- Verbally explain all steps in safer injection process (Harm Reduction Education)
- Educate participants to self-anchor their veins and syringes.
- Palpate participant's arm for veins to assist land marking. This is an important part of vein care
- Identify potential injection sites, including physically guiding participant's hand to the appropriate injection area
- Encourage hand washing as a measure to prevent infection

- Swab participant's arm with alcohol swab to reduce infection from unclean injection practices
- Demonstrate how to tie off the participant's arm
- Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection only)

Appendix M: Injecting into the Jugular Vein (Jugging)

BACKGROUND: Those who use and inject illicit drugs are at high risk for soft tissue infections, and more serious infections such as endocarditis. These infections and other serious medical problems can occur from injection at into any vein. The jugular veins pose higher risk for the following reasons.

- The anatomical location of the jugular is very close to large blood vessels (including arteries), nerves, the trachea and the esophagus
- An abscess in close proximity to these structures could cause compression of nerves, and vessels supplying blood to the brain
- A large abscess on the jugular line could potentially cause compression or narrowing of the airway
- Jugular infection could travel easily to the brain or heart
- Air embolus can easily enter the blood stream from jugular injection and travel into the heart and coronary arteries (heart attack) or the brain (stroke) or to the lungs (pulmonary embolism). Air is more likely to enter through injection into the Jugular vein because of the lack of valves and because of the negative pressure in the jugular, associated with inspiration

Trained OPS staff can provide injection education in the context of harm reduction, with regards to injecting into the jugular vein.

- Constantly monitoring the OPS space for both overdose **and** opportunities for education, while performing daily tasks
- OPS staff may offer participants who are noted to be injecting into the jugular education. If the participant indicates they require support - determine the following:
 - i) Participant's rationale for using the jugular, and participant's knowledge of risks of injecting into the jugular
 - ii) Whether the participant has any visible or palpable venous access other than the jugular
 - iii) Whether the participant can inject their drugs intramuscularly

Based on the above assessment, in priority sequence:

1. Explore with the participant, the possibility of self-injecting into a different vein
2. Educate the participant regarding other alternatives, e.g. "muscling" (self-inject intramuscularly)
3. Educate the participant on the risks involved with injecting into the jugular
4. Educate the participant to safely self-inject into their Jugular vein, IF and only IF participant determined to do so
5. Document appropriately and accurately on the database.

OPS RN Staff: Nurses are ethically obligated to provide proper and adequate education as outlined in the CNA Code of Ethics "Promoting and Respecting Informed Decision-Making" and the CRNBC Practice Standard "duty to Provide Care" This includes:

- Education on the risks involved (clot or obstruction, embolus, infection, overdose, heart attack/stroke, embolus, compression of vital structures in the neck)
- How to minimize these risks (Harm Reduction Education)

- How to landmark the vein for injection and other safer-injection education

Appendix N: Management of abscesses and cellulitis related to injection drug use (PHS, 2016)

This section is for information purposes only. If participants express or present with any of the following health concerns refer to a primary care or emergency room for evaluation.

Abscesses and Cellulitis

- An **abscess** is an enclosed collection of purulent liquid, known as “pus”. It can form in skin, muscle, or other soft tissue in the body.
- **Cellulitis** is an infection of skin or soft tissue.
- Bacteria cause abscesses and cellulitis. Bacteria are often introduced because the skin is not cleaned properly prior to the injection of drugs.
- There are four signs of inflammation / infection:
 - Heat
 - Swelling
 - Redness
 - Pain
- Participants with an abscess should be encouraged to seek medical attention as soon as possible. Their infection may need antibiotics and/or need to be drained. Abscesses may also benefit from frequent application of clean hot compresses, hot tap water in a nitrile glove is a simple and cost effective intervention.

Appendix O: Protocol for providing Oxygen Therapy and Use of Bag Valve Masks

Use of Oxygen: Principles

- Oxygen is only to be used in response to an overdose.
- Do not give oxygen unless the person is unconscious.
- Oxygen saturation should be checked before administration of oxygen, if possible. If the layperson is not familiar with pulse oximeters or one is not available, the person should receive assisted ventilation or O2 until a higher level of care arrives.
- In an emergency in which a person is unconscious and experiencing respiratory collapse (not breathing, low oxygen saturation, blue skin) use a bag-valve mask (ambu bag) with high-flow oxygen at 15 litres/min which will deliver approximately 75-100% oxygen.
- The mask should be held firmly over their face using a C-hold to ensure a good seal.
- Continuously monitor the person's oxygen saturation level with a pulse oximeter.

- In cases of suspected cardiac arrest that CPR with rescue breathing should be commenced. There is reasonable consensus it will cause no harm even if the patient has intrinsic low flow cardiac output.
- When 911 is activated the rescuer will be given instructions over the phone by the 911 call taker to ventilate and if appropriate perform CPR in suspected cardiac arrest.

For patients with chronic conditions such as COPD, a high concentration of oxygen is usually contraindicated. However, if the person is unconscious from an opioid overdose, oxygen is indicated to keep their saturation above 90% until paramedics arrive. In an acute respiratory arrest or OD situation there is no harm in applying O₂ to patients with COPD while they are assisted and until they are breathing on their own. Once the paramedics arrive a reassessment can then be done to determine the need for continued supplemental oxygen. Overdose Response Procedure if Oxygen Therapy Available:

1. Call 911
2. Insert the oral airway or head tilt and chin lift
3. Set the O₂ at 15L/min and provide ventilation at 1 breath every 5 seconds
4. If available, follow BVM procedure outlined below
5. Administer naloxone (as described above)
6. Evaluate, (continue to provide breaths, 1 every 5 seconds) while waiting 3-5 minutes before giving another dose of naloxone.
7. Provide continuous oxygen.
8. If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
9. Wait 3-5 min, continue to give oxygen and breaths
10. Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive
11. Document and Debrief
12. Restock crash kit and oxygen supplies

BVM Procedure:

Use of a bag valve mask is recommended when two people are available to respond to an overdose. Using a bag valve mask takes practice. It is important to learn to skillfully seal the mask to the face of the patient without crushing it onto the face. The patient's face should be pulled up.

1. Gather your equipment (if available): a pulse oximeter, oxygen source, bag-valve mask device, cushioned rim mask, airways (if available and trained)
2. Head tilt-chin lift is done by using one hand to apply downward pressure on the forehead, while the other hand lifts the chin.
3. If oxygen is available, the bag-valve mask unit should be attached to high-flow oxygen at 15 liters per minute, at which a typical device delivers about 75% oxygen.
4. If trained and available, insert airway
5. Obtain an adequate seal using the 'EC' hand position using the thumb and index finger holding the mask and the upper and lower mask borders, respectively. The other three fingers hold the jaw while performing the jaw thrust. If using the two-provider technique, one person should hold the mask with both hands, while the other

provider bags the patient. A common location of air leak is located around the nasal bridge, which should be detected when attempting ventilation.

6. Once the position and seal are obtained, "bagging" can commence. The rate of ventilation for an adult is 10-12 breaths per minute or, approximately 1 bag squeeze every 5-6 seconds.
7. The bag should be depressed for a full 1-2 seconds and then released. Chest rise should be seen.

Appropriate oxygenation and ventilation should be reflected by pulse oximetry readings.

Common pitfalls of BVM ventilation include inadequate positioning, improper mask holding, and failure to use an oral or nasal airway. Providers tend to hyperventilate patients. The emergency medicine literature has demonstrated that hyperventilation can be harmful by increasing intra-thoracic pressure, which decreases venous blood to the heart and subsequently decreases cerebral and coronary perfusion.

Appendix P: Law Enforcement and OPS Sites

Adapted from Harm Reduction: a British Columbia community guide. British Columbia Ministry of Health. www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf

Public Health and law enforcement are both concerned with reducing drug-related harms. While the contexts and mandates may differ, both sectors are responsible for public safety and there is considerable overlap and mutual benefit in working together. Both Public Health and law enforcement should recognize the possible positive and negative ramifications of their operations may have on a community: Police enforcement activities may influence health harms such as overdoses and the spread of blood-borne diseases; and Public Health programs may influence crime and public nuisance complaints. Mutual understanding of each other's mandates, jurisdictions, operations and legal and organizational limitations is essential to optimizing access and outcomes for OPS clients and ensuring support from local communities and governments.

Policing practices in many jurisdictions have changed over the past few decades. They have become less reactive and more proactive, intelligence driven, and concerned with implementing best practice. This has required a greater understanding and use of crime prevention strategies, which is a similar approach to health promotion and protection. Harm reduction based approaches to law enforcement complement public health efforts by seeking to reduce the net harm experienced by drug users and the community. Examples of these enforcement practices include greater use of discretion by police, provision of harm reduction training for police and partnerships between police and health agencies. The use of discretion in attending overdoses (e.g. police not attending non-fatal overdoses) is well established and has reduced the reluctance of drug users to call ambulances, resulting in fewer deaths. Other accepted discretionary practices are the use of warnings or cautioning and the use of referrals to appropriate health and social services as alternatives to arrest and confiscation of injection equipment.

Health care providers should recognize that laws change and evolve to reflect societal values. The royal assent of the Good Samaritan Drug Overdose Act in May 2017 provides an exemption from charges of drug possession for people who call 911 for themselves or another person suffering an overdose, as well as anyone who is at the scene. While this act codified an existing discretionary police practice to reduce barriers to emergency care, others legal barriers may be slower to change or may persist indefinitely, and law enforcement may have less discretionary power in some cases.

While police as first responders may frequently be involved with overdose resuscitation efforts, there is evidence that police can reduce harm by maintaining adequate distance from health services used by drug users, so as not to deter access, and by not interacting with drug users during the injection process. According to a report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), supervised consumption site staff and neighbourhood committees are working in partnership with local police to minimize public nuisance and increase the efficacy of overdose prevention strategies. The Vancouver Police Department was a partner in establishing Insite and supports the facility as part of the four-pillar integrated approach to substance use in Vancouver. Police have reported public order benefits in the wake of the opening Insite.

The Canadian Centre on Substance Use and Addictions (CCSA)'s guideline on the role of police in harm reduction suggests:

- Police should avoid unnecessary visits and enter only with permission from operators unless they are in active pursuit of a suspect
- Police Services should be actively involved with the planning and development of overdose prevention sites and be supportive of the role it plays as a public health initiative.
- Police services should actively refer drug users who are injecting in public to local overdose prevention sites and supervised consumption services along with treatment and support.

OPS staff should recognize that police officers may need to enter facilities to perform law enforcement duties and should make every effort to cooperate. Health care workers and Public Health officials involved in OPS activities are encouraged to proactively engage local law enforcement in all stages of planning and operations and to maintain ongoing dialogue with local detachments to address client and community issues.

Appendix Q: Cleaning Check List Template for OPS Space

Overdose Prevention Site													
Doors													
Floor mopped													
Counters													
Sinks													
Phones													
Garbage out													
Restock towel													
Cupboard doors													
Clean mirrors													
Phones													
Walls													

Appendix R: Recommendations for Outdoor Inhalation Overdose Prevention Services (OPS)

From the BCCDC 2018 Harm Reduction Client Survey, more than half of participants identified smoking or inhalation as their preferred method of drug use compared to injection and other methods of consumption.¹ Outdoor inhalation OPS promote safer use of opioids through direct observation and reduce the risks associated with using alone. In addition, people who use stimulants are more likely to smoke or inhale rather than inject and may be opioid naïve, meaning these populations are not supported at OPS/SCS that do not provide inhalation services.

This document is intended to provide some guidance and best practice recommendations for outdoor inhalation OPS and has been reviewed by WorkSafe BC.

Checklist

Workplace Health and Safety

- Inhalation OPS sites have a responsibility under the Workers Compensation Act and Occupational Health and Safety Regulation for ensuring health and safety of workers.
 - In most situations, a peer support worker being paid a regular wage for time worked is considered a worker under the Workers Compensation Act. If there are questions about whether a peer worker qualifies as a worker, contact the WorkSafeBC Employer Service at 1-888-922-2768 for assistance.
 - Inhalation OPS sites are expected to follow general employer OHS policies and regulations that may need to be adapted for inhalation OPS sites.
 - Assess the risks associated with the outdoor inhalation site with consideration of:
 - Layout of the facility – degree of confinement, proximity to other public areas, businesses, etc.
 - Identify work activities that require entry into the facility (i.e., type of work, duration, frequency) and those that can be done from the outside.
 - Information about the type of products that will be smoked including current information about contamination.
 - Duration of time that clients are smoking inside.
 - Available PPE and training.
 - Consideration of routes of exposure – inhalation, skin, inadvertent ingestion, etc.
 - Employers are expected to identify, assess, and ensure adequate procedures are in place to eliminate or minimize risks, including:
 - [Workplace violence](#)

- [Working alone or in isolation](#)
- [Ergonomics](#)
- Indoor air quality - [tobacco and e-cigarettes](#)
- [Chemical and biological agents](#)
- [Personal protective equipment](#) o Refer to the WorkSafeBC Feedback on Inhalation OPS Checklist document and the [hierarchy of controls](#) for more information
- o [WorkSafeBC Claims Call Centre \(for reporting a workplace injury or disease\)](#):
 - Phone: 1-888-967-5377
 - Hours of Operation: Monday to Friday, 8 a.m. to 6 p.m.
- o WorkSafeBC Prevention Information Line for health and safety assistance:
 - Phone: 1-888-621-7233
 - Hours of Operation: Monday to Friday, 8:05 a.m. to 4:30 p.m.

Ventilation

- The inhalation OPS must allow for natural ventilation as much as possible – if using a tent ensure three ends/flaps of the tent are open.
- A fan can be used to exhaust air out of the tent away from clients, workers, and the public.
- Other options that require further assessment – a possible option might be the use of portable extractors similar to those used in nail salons and for small scale hot work (i.e., soldering).
- The inhalation space must remain 6 meters from any air intake, door, or window as per the [Safe Tobacco Act](#).

Heating

- If heating equipment is used to warm the tent, ensure proper fire safety practices are followed:
 - Do not use open flame or gas/propane to heat tents. Use electric heaters instead.
 - When using electric heating equipment, ensure compliance with manufacturer's instructions for placement away from combustible material, such as furnishings and tent fabric.
 - Ensure tent fabric is rated as flame resistant as required by the BC Building Code (contact local building official).
 - Ensure fire extinguishers are accessible and workers are trained in their use.
 - Keep furniture and other combustible material in or near tent away from open flame devices (e.g. lighters or butane torches) and electric heaters.
 - Provide an adequate number of non-combustible ash trays.

Layout

- Layout should maximize natural ventilation and minimize stagnant spaces
- It is strongly recommended to set up the inhalation spaces in a booth style and in a circular arrangement when possible to build community. Have somewhere for people to sit, put their drugs down, prepare, and use.
 - Having a booth style service considers the importance of privacy and may help to reduce sharing of materials, forced/coerced sharing of substances and considers the vulnerability of some clients in these settings (e.g. Women).
- Have a 'chill out' area in a separate tent or area to reduce smoke exposure
- Have staff conduct tasks such as paper work, questionnaires, and other outreach activities outside of the inhalation OPS area to reduce smoke exposure

Observation/Sight Lines

- These sites are required to be monitored in a similar way to injection OPS spaces. Agencies must consider sight lines and who will be monitoring this space for overdoses or other related harms. Clear roles and responsibilities need to be defined at the agency level (e.g. peer monitoring, staff, video, etc.).
- Remote observation from outside the tent (via transparent curtains or video cameras) reduces smoke exposure to workers.

Personal Protective Equipment

- For protection from inhalation exposure, a worker should wear an appropriately sized filtering facepiece respirator (such as an N95 respirator) if they need to enter for a short duration when second hand smoke is present. This is not the PPE requirement for first responders as their requirements are different.
- Workers required to wear a filtering facepiece respirator (such as an N95 respirator) need to be fit tested for that respirator to ensure an adequate seal to the face for protection. Workers must be clean-shaven for the seal to be effective.
- When performing tasks where workers may have contact the interior surfaces of the tent, the employer must provide and workers must wear the appropriate skin protection based on the assessment of the risks (e.g. Nitrile gloves).

Overdose/Emergency Response

- If there are instances when the worker/individual must enter the tent to respond to a client emergency (e.g. overdose), they must follow safe work procedures to minimize exposure to

second hand smoke as much as possible. These procedures may include enhanced ventilation and the use of personal protective equipment to minimize the inhalation exposure to the worker. [See COVID-19 resource on responding to opioid ODs in OPS/SCS for more information.](#)

- If there are instances when a worker/individual must enter the tent to respond to an employee or staff emergency, the worker must follow [OFAA protocols](#).

Cleaning Surfaces

- Due to the nature of the activity taking place, inhalation tents have the potential for a higher risk of surface contamination than other Overdose Prevention Services/Supervised Consumption Sites (OPS/SCS). As substances are smoked, particles settle on surfaces (e.g. walls, tables, ceiling, and furniture) and need to be safely cleaned to reduce the risk of exposure.
- Fentanyl is not easily absorbed by the skin; however, there are other potential routes of exposure (via inhalation, mucosal contact (via finger in the nose or eyes), accidental ingestion) if surfaces are contaminated
- Employers must ensure that workers follow safe work procedures if there is a risk of exposure from contact with surfaces contaminated with residue from the smoke (e.g., cleaning the tent and interior surfaces).
- Select a tent, table and other furnishings made from non-porous materials to facilitate the necessary cleaning/decontamination of surfaces.
- Gloves (heavy duty nitrile) should be worn for all cleaning activities. Eye protection and additional skin protection, as well as emergency washing facilities, will likely be required if concentrated cleaning chemicals are handled/diluted prior to use. If the substance is on the gloves, there is still a risk for ingesting the substance or mucosal exposure (via finger in the nose or eyes)
- Provide instructions for the client to clean any debris and wipe down surfaces afterwards. Then, a worker will clean and wipe down surfaces again. Where practicable, avoid dry sweeping to minimize the potential for aerosolization of residues.
- Surfaces such as tables and other furnishings should be cleaned regularly. Industrial disinfectant wipes (e.g. CaviWipes) or other hospital grade cleaners may be used to clean surfaces where fentanyl and analogues may be present
- Follow safe work procedures for cleaning surfaces outlined in the [BCCDC OPS Guide](#)

Signage

- Consider posting signage that acknowledges the space as an inhalation OPS. It is also recommended to engage service users of the space in developing common ground rules and posting these as well.
 - Suggested language for signage *“This outdoor structure is intended to operate as an inhalation Overdose Prevention Site in accordance with BC’s Overdose Public Health Emergency and the Ministerial Order M488. This location is monitored for the safety of people who are using substances within.”*

Supports

- Consider providing drug checking services. Talk to your [Regional Harm Reduction Coordinator\(s\)](#) for more information.
- Have Take Home Naloxone onsite to provide training and distribution to individuals who need kits.

Supplies

- Safer smoking supplies, such as straight glass tubes, meth bowls, mouth pieces, screens, and push sticks can be ordered through the BCCDC Harm Reduction Supply Program. Connect with your [Regional Harm Reduction Coordinator\(s\)](#) for more information on ordering.

Training

- All staff in the agency must have received adequate training in overdose recognition and response, including the administration of naloxone. If eligible, the agency must be registered with the BCCDC [Facility Overdose Response Box Program](#).
 - Note: community-based non-profits are eligible for FORB, not government or for-profit agencies. Government and for-profit agencies can access staff naloxone through their employer and can access harm reduction supplies and Take Home Naloxone through the BCCDC Harm Reduction And Naloxone Programs.
- All staff in the agency must have received training on safe work procedures for working at an outdoor inhalation OPS. Workers who require fit testing for filtering facepiece respirators (such as N95 respirators) must be fit tested and trained in how to put them on, take them off, check the seal, care/maintain respirators, and understand their limitations (e.g what they do and do not provide protection from)

Considerations for Housing Locations

- For housing locations – an inhalation OPS **must not be** the only smoking area available to residents (i.e. people who smoke tobacco must be offered a place where there is not illicit drug use also happening).

Policies and Procedures

- The operating agency will follow the approved Regional Health Authority Manual where applicable:
 - Interior Health: [Overdose Prevention Services Site Manual](#)
 - Fraser Health: [Overdose Prevention Site Manual](#)
 - Vancouver Coastal Health: [Overdose Prevention Site Manual](#)
- The operating agency has reviewed provincial BCCDC [Guide to Overdose Prevention Sites](#) or Vancouver Coastal Health [Housing Overdose Prevention Site Manual](#) and agrees to utilize as a guiding document in service provision.
- The operating agency is aware of the data collection requirements and agreeable to completing reporting to Regional Health Authorities (RHAs) as required.

Appendix S: Template: Medical Health Officer Overdose Prevention Services Designation Letter

Date:

To:

[Designated Person's Name]

[Agency]

[Address of agency]

Re: Designation of Overdose Prevention Services

On behalf of the Minister of Health, and in keeping with the public health emergency declared by the Provincial Health Officer on April 14th 2016 under section 52 (2) of the *Public Health Act* S.B.C. 2008, Chapter 28, AND in keeping with Ministerial Order M488 under section 5.2 of the *Emergency Health Services Act* and section 7.1 of the *Health Authorities Act*, I am satisfied that the terms and conditions set out by the BC Ministry of Health are understood and will be met by [Agency] to provide observed consumption as an overdose prevention service at:

Site Name:

Organization:

Address:

[Date and time if relevant]:

Observed consumption refers to the provision of a space for people to consume pre-obtained substances under the supervision of people trained in overdose recognition and response for the purpose of reducing harms such as overdose and death.

In order to maintain this designation, the [Agency] is required to:

- [Insert Regional Health Authority specific requirements]
- Employ staff with training in overdose prevention, recognition, and response.
- Provide harm reduction supplies including Take Home Naloxone kits and training.
- Carry out services in accordance with the BCCDC Overdose Prevention Services Guide.

This designation is only in place for the duration of the public health emergency and at the location specified above, unless modified, extended, or terminated by a Medical Health Officer.

Yours sincerely,

Dr. [first] [last]

Medical Health Officer

[Health Authority]

¹ <http://www.bccdc.ca/health-professionals/data-reports/harm-reduction-and-substance-use>

This document is based on the Interior Health Recommendations for Sites Offering Inhalation OPS document

Appendix T: Requirements for Indoor Inhalation Overdose Prevention Services (OPS)

A qualified industrial hygienist (e.g. Certified Industrial Hygienist, Registered Occupational Hygienist, and Canadian Registered Safety Professional) and qualified ventilation engineer should be engaged at the beginning of any indoor inhalation OPS development process.

Purpose

This document is intended to provide high-level guidance and best practice recommendations for indoor inhalation OPS. Workplace health and safety is the responsibility of the employer. This broad guidance will likely need to be tailored to your specific space and setting. It is strongly recommended that sites work with a qualified ventilation engineer and qualified industrial hygienist or similar persons to develop engineering controls while a site is being designed and before it is opened. WorkSafeBC (WSBC) was consulted as part of the preparation of this document.

Background

From the BCCDC 2018 Harm Reduction Client Survey, more than half of participants identified smoking or inhalation as their preferred method of drug use compared to injection and other methods of consumption¹.

Indoor inhalation OPS may increase service utilization among people who inhale substances compared to outdoor inhalation OPS, especially in areas with seasonally low temperatures and/or inclement weather where outdoor inhalation OPS may not be preferred by clients.

Elimination of smoke, vapour, and residue exposure is not possible at indoor inhalation OPS due to the nature of the activity taking place. Engineering controls, administrative controls, and personal protective equipment provide layers of protection to reduce the risks to workers and volunteers associated with smoke, vapour, and residue exposure. Indoor inhalation OPS are an essential intervention to reduce overdose deaths due to toxic drug supply, as long as they do not pose undue risk to workers.

Note: The Tobacco and Vaping Products Control Regulation prohibits the use of tobacco and vaping products in any indoor area, including an indoor inhalation OPS. Tobacco and cannabis cannot be used in indoor inhalation OPS spaces.

For any questions about this guidance, please contact harmreduction@bccdc.ca

¹ <http://www.bccdc.ca/health-professionals/data-reports/harm-reduction-client-survey>
BC Overdose Prevention Services Guide 2019

Overall Workplace Health and Safety Considerations

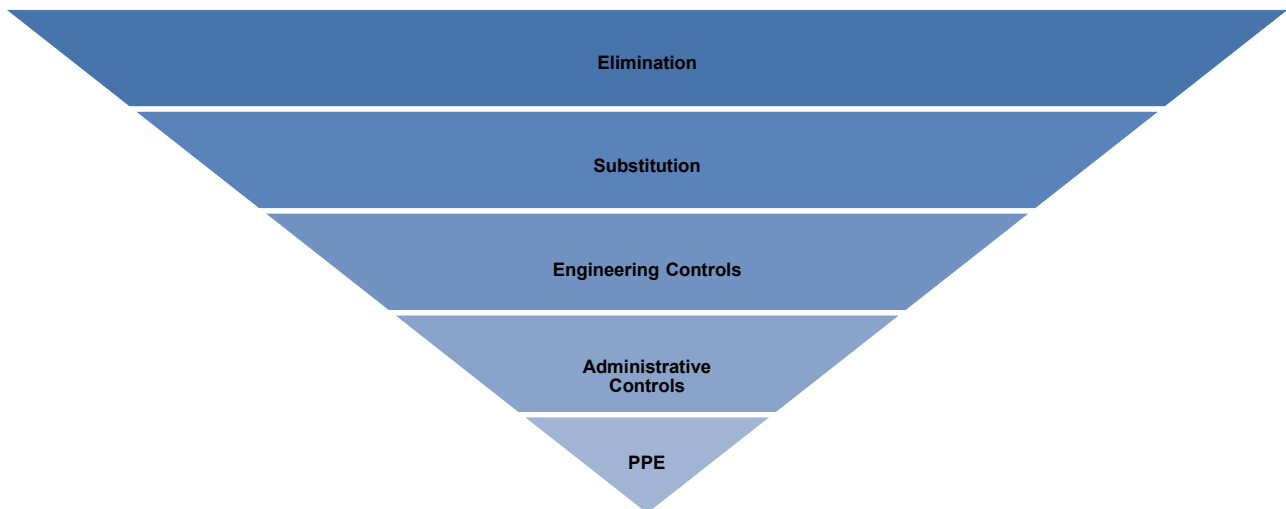
Inhalation OPS sites have a responsibility under the Workers Compensation Act and Occupational Health and Safety Regulation for ensuring health and safety of workers. Under BC's OHS regulation, "all work must be carried out without undue risk of injury or occupational disease to any person." The recommendations and resources listed below are not an exhaustive list of employer responsibilities.

- o Ensure all people working or volunteering at the indoor inhalation OPS are provided with appropriate training, fit testing, and personal protective equipment to carry out their duties safely
- o Workers and volunteers with lived and living experience of substance use are integral to the operation of an OPS. In most situations, a peer support worker being paid a regular wage for time worked is considered a worker under the Workers Compensation Act. If there are questions about whether a peer worker qualifies as a worker, contact the WorkSafeBC Employer Service at 1-888-922-2768 for assistance. For additional information, consider contacting the Employers' Advisers Office at 1-800-925-2233.
- o When assess the risks associated with an indoor inhalation site, consider:
 - The layout of the facility – degree of confinement, proximity to other public areas, businesses, etc.
 - Identifying work activities that require entry into the designated inhalation space (i.e., type of work, duration, frequency) and those that can be done from the outside.
 - Information about the type of products that will be inhaled including current information about contamination.
 - How long clients are using designated inhalation space and duration of time workers are exposed to contaminants inside designated inhalation space.
 - Available Personal Protective Equipment and training (defined in further detail in guidance).
 - Routes of exposure – inhalation, skin/mucous membrane absorption, ingestion, etc.
 - Potential concentration of contaminants in the air, determined through testing or estimated from data at similar sites.
- o Employers are expected to identify, assess, and ensure adequate procedures are in place to eliminate or minimize risks, including:
 - [Workplace violence](#)
 - [Working alone or in isolation](#)

- [Ergonomics](#)
 - Indoor air quality - [tobacco and e-cigarettes](#)
 - [Chemical and biological agents](#)
 - [Personal protective equipment](#)
 - Emergency washing facilities
- o Refer to the WSBC information on the [hierarchy of controls](#)
 - o Follow employer workplace injury or disease reporting process and when required utilize [WorkSafeBC Claims Call Centre \(for reporting a workplace injury or disease\)](#):
 - Phone: 1-888-967-5377
 - Hours of Operation: Monday to Friday, 8 a.m. to 6 p.m.
 - o WorkSafeBC Prevention Information Line for health and safety assistance:
 - Phone: 1-888-621-7233
 - Hours of Operation: Monday to Friday, 8:05 a.m. to 4:30 p.m.

Recommendations and requirements to reduce exposure concerns

Control measures include: 1) elimination, 2) substitution, 3) engineering controls, 4) administrative controls, and 5) Personal Protective Equipment (PPE). Each indoor inhalation OPS site can be unique. The controls utilized to mitigate the risks associated with smoke, vapor, and residue exposure may be different. It is important to employ adequate and effective measures at each step of the hierarchy of controls (a method of determining which actions will best control exposure concerns) to reduce the risks posed to workers at these sites. Because exposure cannot be entirely eliminated, sites must demonstrate that there is no undue risk. Understanding these exposures can be complicated. In collaboration with a qualified person, you can utilize these recommendations and requirements to design and develop the site.



1) Elimination and Substitution

Indoor Inhalation OPS provides a space for people who smoke/inhale substances to be observed for the purposes of identifying and responding to overdose. Risk of exposure to smoke, vapours, and residues from substances used at these sites cannot be eliminated or substituted, but risks can be mitigated through other levels within the hierarchy of controls.

2) Engineering Controls

Location considerations

- New-build or purpose-built sites (e.g. using renovated metal shipping containers) are much easier to engineer for indoor inhalation OPS ventilation than retrofitting existing buildings.
- Assess whether the inhalation area can be retrofitted with a ventilation system that does not allow for cross-contamination of OPS air with air that moves through other parts of the building, and that moves air out of the room and away from clients, workers, and the public.
- Choose an area with a transparent interior window or door, or install a transparent interior window or door through which workers can observe clients and respond quickly to overdose.
- Pass-through boxes and interior windows that slide open/close can be used to pass harm reduction supplies or quickly converse with clients. When using pass-throughs, room pressurization is an important consideration; employee areas should be positively pressurized to prevent the entry of smoke into the observation space.
- Locate the indoor inhalation space separately from observation space to minimize worker exposure to smoke, vapours, and residues.
- For supportive housing locations where indoor inhalation OPS are located – an indoor inhalation OPS **must not be** the only smoking area available to residents (i.e. designate a separate location for smoking/vaping tobacco and cannabis).

Ventilation

Ventilation at the indoor inhalation OPS site will be dependent on use, location, and needs. A qualified industrial hygienist and ventilation engineer is recommended to be retained at the design stage.

- Design considerations
 - There is limited research on what chemicals are released when drugs are heated/burned, and the only drug with an industry Occupational Exposure Limit (OEL) is fentanyl. Exposures should be kept ALARA (as low as reasonably achievable) as a result.
 - Ventilation systems should be designed to keep airborne fentanyl exposure as low as reasonably achievable (ALARA). Samples taken on workers for airborne fentanyl must be less than 50% of the pharmaceutical occupational exposure limit (0.1 µg/m³). Consider other appropriate exposure guidelines. More information on sampling can be found in the section on testing for fentanyl exposure.

- o Additional controls should be put in place in the inhalation space to keep exposure to smoke/vapour and residues as low as reasonably achievable.
- o Doorways and pathways can impact ventilation performance.
- o Ductwork should be designed to reduce the accumulation of residues and need for cleaning.
- o Standards that can be used to develop an effective ventilation systems include, but are not limited to, those developed by the Canadian Standards Association (CSA), American National Standards Institute (ANSI), and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE).

Table 1.1: Ventilation Design Options

Below is a list of ventilation design options for indoor inhalation OPS sites. Please note: these advantages and disadvantages are general and for illustrative purposes only. This is an incomplete list of solutions. The best ventilation system is the one that works for your specific site needs. Consult with a qualified professional (e.g. a qualified ventilation engineer) before making decisions.

Type of ventilation	Description	Advantages	Disadvantages
Dilution	<ul style="list-style-type: none"> - Dilution ventilation supplies clean air in and exhausts contaminated air out of the area or building. This usually involves large exhaust fans placed in the walls or roof of a building. - Best for: <ul style="list-style-type: none"> o Small quantities of contaminant and uniform rates of exposure o Low hazard contaminants o Sites that provide a large distance between worker and contaminant (to allow for dilution) 	<ul style="list-style-type: none"> - Can be quick and easy to implement - Allows for more client movement within the room (when compared to downdraft or local exhaust) 	<ul style="list-style-type: none"> - Large volumes of air are needed which can lead to client discomfort - Employee exposure can be difficult to control near the source of the exposure

Local exhaust ventilation	<ul style="list-style-type: none"> - Contaminated air is captured and exhausted out of the work environment 	<ul style="list-style-type: none"> - Removes the contaminant from the source - Require less airflow than dilution 	<ul style="list-style-type: none"> - Requires special consideration on placement and design of hoods/pickup points - Clients would need to be seated in specific places for maximum efficiency
Downdraft system	<ul style="list-style-type: none"> - Air flows down towards a capture hood to pull the contaminant down - Can be part of the ventilation system, through a downdraft table 	<ul style="list-style-type: none"> - Require less airflow than dilution - Keeps the contaminant lower than most breathing zones 	<ul style="list-style-type: none"> - Air grilles can be blocked by large items or people - Require special considerations on placements and design of pickup points/grilles - Clients would need to be seated in specific places for maximum efficiency

- Emergency purge function
 - Consider installing a ventilation system with a switch to increase ventilation in the inhalation space during a health emergency. This will allow the air to evacuate quickly during emergency response.
- Ventilation for office areas and adjacent non-inhalation spaces
 - Ventilation system for office should be separate from ventilation for the observation room and should be purpose-built or retrofitted by an engineer to keep exposure to substances as low as reasonable achievable (ALARA). Indoor air quality should be comparable to indoor air quality elsewhere in the facility or building.
- Communicating with people in the inhalation space and passing supplies

- Microphones, pass-through boxes, small interior windows that slide open/close can be used to pass harm reduction supplies or quickly converse with clients. Maintaining appropriate room pressurization is an important consideration with windows and pass-throughs.
- Doorways and vestibules
 - Vestibules (channels or chambers separating rooms) are recommended to reduce worker exposure to smoke, vapours, and residues in the observation space. Air pressurization is an important consideration for doorways and vestibules.
- Exhaust
 - Air from the inhalation space must be exhausted outside through a smokestack in accordance with applicable local bylaws (if any exist). Consider the amount of vapour/smoke being dispelled and the impact on surrounding area, which may require responding to community concerns around exhaust. Dispersion can be used to dispel air from inhalation space. Point of exhaust testing may be warranted to validate dilution/environmental impact. A filter system is recommended – ensure it is properly installed and regularly cleaned to prevent accumulation of residues.
- Noise
 - When purchasing ventilation system, ensure noise output in both the inhalation and observation spaces will be within acceptable limits defined by WorkSafe BC. Noise impacts the client experience and ability to converse in the space. Keep in mind that with increased ventilation, the noise level will increase and need to be monitored.
- Testing for worker exposure to fentanyl
 - Sampling conducted to evaluate worker exposure to fentanyl at Indoor Inhalation OPS should be performed by a qualified person². Sampling and analysis should utilize an approved standard method at an accredited laboratory if possible. As of writing, there is currently no validated method. Therefore, the method used in the NIOSH Health Hazard Evaluation Program may be used. Sampling should use an inhalable fraction particulate sampler.

² WorkSafeBC accepts that a certified industrial hygienist (CIH), a registered occupational hygienist (ROH), and a registered occupational hygiene technologist (ROHT) are trained and experienced to perform occupational hygiene sample collection and interpretation of results. Guidelines - Part 5 - Controlling Exposure. "G5.53-4 Occupational hygiene methods acceptable to WorkSafeBC." <https://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-guidelines/guidelines-part-05>

- o The pharmaceutical industry's Occupational Exposure Limit (OEL) is commonly used as a guidance limit in the absence of a regulatory exposure limit. The OEL used by the pharmaceutical industry for airborne fentanyl exposure (0.1 µg/m³).
- o More information can be found on the password-protected section of Toward the Heart. Email harmreduction@bccdc.ca for access.
- Maintenance
 - o Post maintenance schedule and use maintenance logs to ensure ventilation system is running to specifications, ensure protocol is in place for service if ventilation system fails, and schedule regular cleaning to prevent accumulation of residues within the ventilation system.
 - o Ductwork will need to be monitored for dust/lint/contaminant build up and cleaned routinely using PPE and safe work practices.
 - o Consider installing real-time continuous particulate monitors in the inhalation areas and employee areas; monitor these levels with the safety team. Changes in particulate matter concentrations may indicate problems with the ventilation performance or other controls (such as pressurization).

3) Administrative Controls

Layout

- Layout should minimize stagnant spaces with no or little air flow.
- Layout should support routine cleaning.
- Consult with local community of people who use substances to determine appropriate layout.
- Have somewhere for people to sit, put their drugs down, prepare, and use.
 - Individual booth style - considers the importance of privacy and may help to reduce but not eliminate attempts to share materials, force/coerce sharing of substances and considers people who are more likely to experience harm and violence in these settings (e.g. women).
 - Larger shared table style - may be preferred in some communities as it replicates non-medicalized environments where substance use takes place and supports people to maintain community.

- Have a 'chill out' or extended monitoring area in a separate room or area where clients can reduce their smoke exposure and they can be monitored for signs and symptoms of overdose. There may be an increased need for an extended monitoring space with the presence of benzodiazepines in the toxic drug supply.
- Have staff conduct tasks such as paper work, questionnaires, and other outreach activities outside of the inhalation OPS area to reduce smoke, vapour, and residue exposure and maximize client visits to the inhalation OPS space.
- Consider providing secure storage for belongings that cannot be brought into indoor inhalation OPS area – this may not be possible in all locations.
- Staff should have two options to exit the space (e.g. to return to the observation space or exit out of the inhalation space).

Observation/Sight Lines

- These sites are required to be monitored in a similar way to injection OPS spaces. Agencies must consider sight lines and who will be monitoring this space for overdoses or other related harms. Clear roles and responsibilities need to be defined at the agency level related to monitoring and overdose response protocols. Monitoring options include peer monitoring, staff monitoring, remote/video monitoring etc.
- Remote observation from outside the room (via interior window, sliding glass doors, or video cameras) reduces smoke exposure to workers.

Fire safety

- Ensure fire extinguishers are accessible and workers are trained to use them
- Choose non-combustible furniture and keep combustible material in the room away from open flame devices (e.g. lighters or butane torches) as much as possible.
- Ensure oxygen is safely stored away from open flame devices, combustible furniture, and materials.
- Smoke and heat detectors are required in the observation area but are not required in the smoking area.
- A walk-through with local fire safety workers is recommended.

Training

- All paid and unpaid staff in the agency must receive adequate training in overdose recognition and response, including the administration of naloxone. If eligible, the agency must be registered

with the BCCDC [Facility Overdose Response Box \(FORB\) Program](#). The FORB program provides overdose response boxes for employees of community-based organizations. They include the opioid antidote, naloxone.

- Note: community-based non-profits are eligible for FORB, not government or for-profit agencies. Government and for-profit agencies can access staff naloxone through their employer and can access harm reduction supplies and Take Home Naloxone (for client use) through the BCCDC Harm Reduction and Naloxone Programs.
- All staff and volunteers in the agency must have received training on safe work procedures for working at an indoor inhalation OPS. Workers who require fit testing for respirators must be fit tested and trained in how to put them on, take them off, check the seal, care and maintain respirators, and understand their limitations (e.g. what they do and do not provide protection from).

Policies and Procedures

- The operating agency must follow the approved Regional Health Authority Manual on Overdose Prevention Sites where applicable:
 - Interior Health: [Overdose Prevention Services Site Manual](#)
 - Fraser Health: [Overdose Prevention Site Manual](#)
 - Vancouver Coastal Health: [Overdose Prevention Site Manual](#)
- The operating agency must review the provincial BCCDC [Guide to Overdose Prevention Sites](#) or the Vancouver Coastal Health [Housing Overdose Prevention Site Manual](#) and must agree to utilize it as a guiding document in service provision.
- The operating agency must be aware of the data collection requirements and must agree to complete reporting to Regional Health Authorities (RHAs) as required.
- Sites must develop site specific Code White or Emergency Response to Violence and Aggressive Behavior Procedures.

4) Personal Protective Equipment (PPE)

General guidance on PPE

- There are a number of potential routes for exposure: inhalation (breathing in); mucosal contact (touching the nose or eyes); accidental ingestion (swallowing); and dermal exposure

(skin contact). Alcohol-based hand sanitizer can increase absorption of substances through the skin.

- Accidental or incidental dermal fentanyl exposure during health emergency response does not present a risk. Ensure workers wear one pair of nitrile gloves when responding to reduce the likelihood of workers touching their eyes, nose, and mouth through which exposure can occur. Although accidental or incidental dermal fentanyl exposure does not present a risk for drug poisoning, other substances may be present. Repeated, long-term exposure to fentanyl and other substances remains a concern.
- In poorly ventilated areas, airborne fentanyl may be present in the immediate vicinity of individuals who are inhaling drugs. Therefore, a qualified person³ must conduct a risk assessment to assess the need for respiratory protection from vapours and particulates when working around people inhaling drugs. The risk assessment should consider conditions such as the number of people using drugs, how they are consuming their drugs, the size of the space, the ventilation rate, drug poisoning response procedures, and other control measures in place (see hierarchy of controls for examples), as well as any available air sampling data.
- Dedicated first responders (fire, ambulance, and police) should bring their own PPE and follow their occupational health and safety requirements when responding to overdoses.
- Workers required to wear a respirator need to be fit tested for that respirator to ensure an adequate seal to the face for protection. Workers must be clean-shaven for the seal to be effective.
- Employers must provide workers with appropriate skin protection. When performing tasks where workers may have contact with the interior surfaces of the room, workers must wear the appropriate skin protection based on the assessment of the risks (e.g. one pair of nitrile gloves). The mucous membranes in the eyes, nose, and mouth are a potential route of exposure and gloves. Although accidental or incidental dermal fentanyl exposure does not present a risk for drug poisoning, other substances may be present. Repeated, long-term exposure to fentanyl and other substances remains a concern. Gloves reduce the likelihood that workers touch their eyes, nose, and mouth through which exposure to substances present in the inhalation space may occur. Perform hand hygiene after removing gloves. Avoid touching eyes, nose, and mouth with gloves on before washing hands. Avoid using alcohol-based hand sanitizer to clean hands because this can increase absorption of substances through the skin.

³ WorkSafeBC accepts that a certified industrial hygienist (CIH), a registered occupational hygienist (ROH), or a registered occupational hygiene technologist (ROHT) are trained and experienced to conduct a risk assessment in the context of an indoor inhalation OPS.

Cleaning Surfaces

As substances are smoked, particles settle on surfaces (e.g. walls, tables, ceiling, and furniture) and need to be safely cleaned to reduce the risk of exposure.

- There are a number of potential routes for exposure to substances: inhalation (breathing in); mucosal contact (touching the nose or eyes); accidental ingestion (swallowing); and dermal exposure (skin contact). Alcohol-based hand sanitizer can increase absorption of substances through the skin. Accidental or incidental dermal fentanyl exposure during health emergency response does not present a significant risk.
- Select tables and other furnishings made from non-porous materials that are easy to clean and decontaminate that are easy to clean and decontaminate (e.g. stainless steel or IPAC countertops).
- Ensure wall hangings are not constructed out of fabric and note that contaminants may collect behind wall hangings, which may be difficult to clean regularly. Ensure papers posted on walls or boards are changed frequently.
- One pair of nitrile gloves should be worn for all cleaning activities. Eye protection and additional skin protection, as well as emergency washing facilities, will likely be required if concentrated cleaning chemicals are handled/diluted prior to use. If the substance is on the gloves, there is still a risk for ingesting the substance or mucosal exposure (via finger in the nose, eyes, or mouth).
- Provide instructions and materials for the client to clean any debris and wipe down surfaces afterwards. Workers should clean surfaces of site at the end of each work day. Where possible, avoid dry sweeping to minimize the potential for particles to become suspended in the air.
- Surfaces such as tables and other furnishings should be cleaned regularly. A 2-stage cleaning approach is recommended for cleaning surfaces, using 1) hydrogen peroxide wipes (1-5% hydrogen peroxide) and 2) an alcohol-based wipe or solution. If a surface wipe is available that contains 1-5% hydrogen peroxide and alcohol, then one product may be used. Clients may be requested to clean tables after use. Surfaces are recommended to be cleaned by workers at the end of each day of operations.
- Ductwork should be designed to reduce the accumulation of contaminants and need for cleaning. Ductwork will need to be monitored for dust/lint/contaminant build up and cleaned routinely using PPE and safe work practices.
- Follow additional safe work procedures for cleaning surfaces and waste management outlined in the [BCCDC OPS Guide](#)

Harm Reduction and Overdose Emergency Response

Providing harm reduction and overdose prevention services is essential within an indoor inhalation OPS. This section details drug poisoning response protocols, providing drug checking services and the availability of harm reduction supplies at indoor inhalation overdose prevention services. More details can be found in the larger [BCCDC Overdose Prevention Services Guide](#) and [BCCDC OD Toolkit](#).

Response Protocol

- If there are instances when the worker/individual must enter the room to respond to a client emergency (e.g. overdose), they must follow safe work procedures to minimize exposure to smoke, vapour, and residues much as possible. These procedures may include enhanced ventilation and the use of personal protective equipment to minimize possible worker exposures. Refer to regional health authority or employer policies and procedures.
- If there are instances when a worker/individual must enter the room to respond to an employee or staff emergency, the worker must follow [OFA protocols](#).
- Engagement with first responders is recommended.

Drug Checking

- Consider providing drug checking services. Talk to your [Regional Harm Reduction Coordinator\(s\)](#) for more information.

Harm Reduction Supplies

- In addition to safer injection and safer sex supplies, safer smoking supplies, such as straight glass tubes, bubble pipes, mouth pieces, foils, screens, and push sticks can be ordered through the BCCDC Harm Reduction Supply Program. Minimize staff exposure to vapour/smoke and residues by making supplies available before clients enter the inhalation space. Connect with your [Regional Harm Reduction Coordinator\(s\)](#) for more information on ordering.
- Individuals are to be provided with supplies to minimize sharing, provide harm reduction options for individuals who may share (e.g. tubing, alcohol wipes, hand sanitizer).
- Have Take Home Naloxone kits onsite to provide training and distribution to individuals who need kits.
- Provide safe and secure disposal options for used and broken equipment. Staff should be provided clear guidance on disposal and handling protocol for left or forgotten substances as well as direction in the event that someone wants to dispose of substances.

Requirements before site is operational:

- Review the BCCDC Overdose Prevention Services Guide and, if applicable, corresponding health authority guidance to ensure alignment.
- Ventilation systems should be designed by a ventilation engineer so that occupational samples (samples taken on workers) for fentanyl show that exposure is kept as low as reasonably achievable (ALARA). Airborne fentanyl samples taken on workers must be less than 50% of the pharmaceutical occupational exposure limit. Consider implementing other appropriate exposure controls within the hierarchy of controls as well to keep exposure ALARA. Samples can be sent to the UBC Occupational and Environmental Health Laboratory. [UBC Occupational and Environmental Health Laboratory](#).
- In poorly ventilated areas, airborne fentanyl may be present in the immediate vicinity of individuals who are inhaling drugs. Therefore, a qualified person⁴ must conduct a risk assessment to assess the need for respiratory protection from vapours and particulates when working around people inhaling drugs. The risk assessment should consider conditions such as the number of people using drugs, how they are consuming their drugs, the size of the space, the ventilation rate, drug poisoning response procedures, and other control measures in place (see hierarchy of controls for examples), as well as any available air sampling data.
- Conduct air flow testing to ensure air flow is adequate within the inhalation space and minimization of stagnant air space.
- Commissioning testing should be performed once before the site is operational to confirm controls are working effectively and once after the site is operational. Additional commissioning testing should be performed if there are changes to layout, ventilation, administrative procedures (e.g. changes to occupancy limit), or substantial shifts in the drug supply.
- Sites are encouraged, but not required, to send site specifications and testing results to BCCDC for quality improvement of this guidance. Email harmreduction@bccdc.ca

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