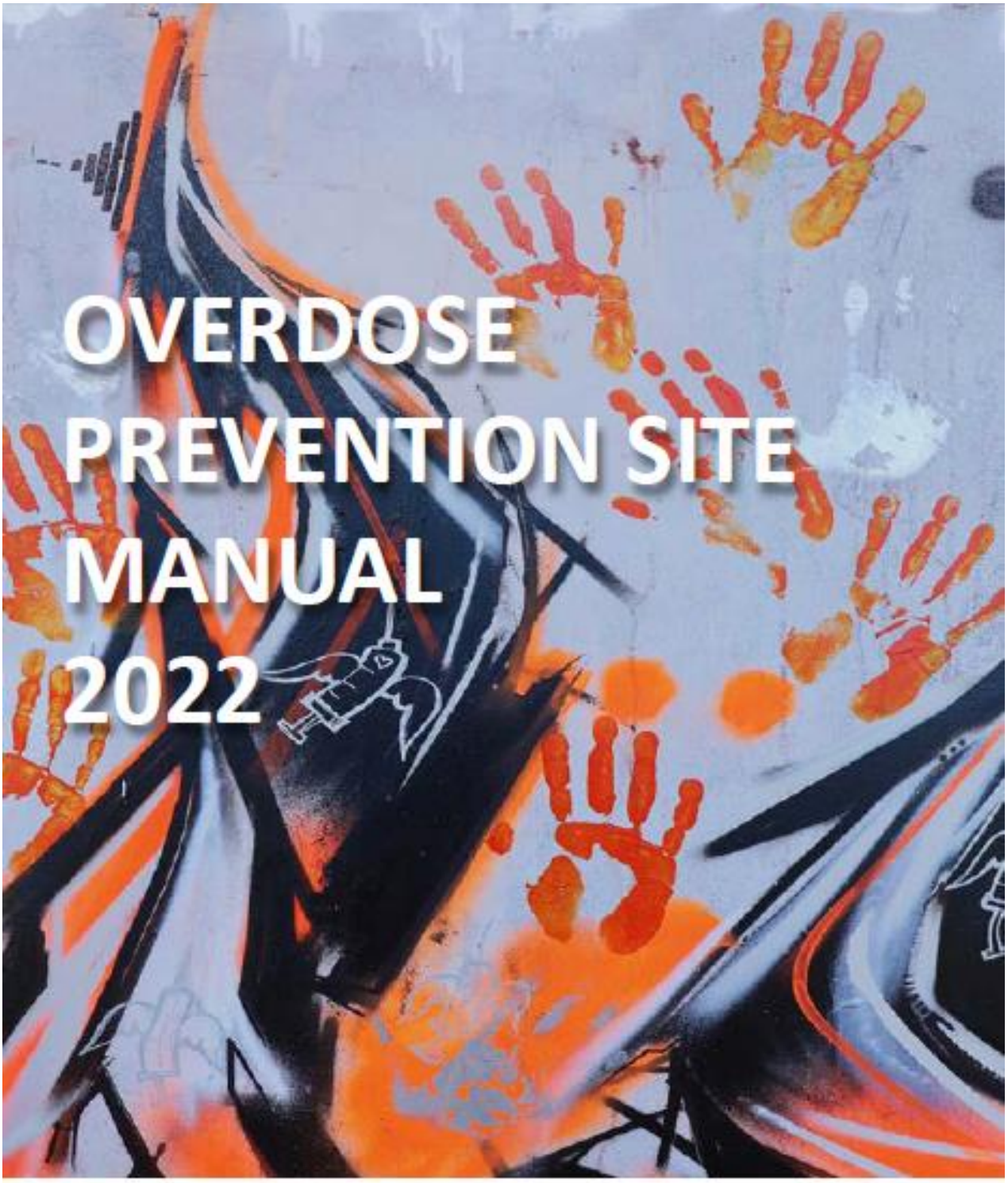

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an Ojibway mural artist & inspirational leader for street youth drop-in cultural programs.

Vancouver Coastal Health

Land Acknowledgement

We respectfully acknowledge that the work done in the Vancouver Coastal Health (VCH)Health Region lies on the traditional homelands of 14 First Nations communities of Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, Sechelt, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.

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Disclaimer

This manual is an updated version of the 2017 VCH Overdose Prevention Site (OPS) Manual.

The purpose of this manual is to give operational guidance to all OPS in the VCH region. It is not intended to replace existing policy and procedures for contracted VCH programs.

For any questions or feedback on this manual's content email: ToxicDrugResponse@vch.ca.

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To view online version:
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All updates to this current version will be listed here in subsequent versions.

Title page	**Graphic changed** to represent VCH Region
P 11	**Overdose Alerts** Updated to new number
P 13	**Orientation, training & resources** addition of online street degree Dec 2024
P 20	**Pregnant Participants** Updated with added resource Dec 2024
P 21-22	**Youth and Children, Participants Accompanied by Children, Duty to Report** Updated Dec 2024
P 29	**Methods of use** Updated resource links Dec 2024
P 31	**BC Tobacco and Vapour Products Control Act** - **Outdoor Consumption Site*** Aug 2023
P 33	**COVID 19, Infection Prevention and Control** Updated Dec 2024
P 37	**Management of Prolonged Sedation** Inserted Dec 2024
P 61	**Should you give Naloxone** Inserted, replaces outdated “benzo pointer” Dec 2024
P 60	**Oxygen Use Checklist** Updated, correct OPA measurement Dec 2024
P 69	**Youth Intake Form** Updated in alignment with update youth policy Dec 2024

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Table of Contents

LIST OF ACRONYMS & DEFINITIONS 8
BACKGROUND 9
OBJECTIVES 9
GOALS 9
GUIDING PRINCIPLES 10
CORE SERVICES 10
HARM REDUCTION 10
SUPPLIES 10
DRUG CHECKING 11
OVERDOSE ALERTS 11
STAFF GUIDELINES 12
INTRODUCTION 12
CONFIDENTIALITY 12
DATA COLLECTION 13
ORIENTATION, TRAINING & RESOURCES 13
STAFF RESPONSIBILITIES 15
AUTHORIZED ACTIVITIES 16
SPLITTING & SHARING 17
LEAVING THE OPS TO PROVIDE ASSISTANCE 17
UNKNOWN SUBSTANCE LEFT BEHIND 17
IN THE CASE OF A THEFT OF A SECURED SUBSTANCES LEFT BEHIND 17
RETURNING UNKNOWN SUBSTANCES TO PARTICIPANTS 18
OPERATIONAL GUIDELINES 19
PHYSICAL SPACE 19
INDOOR SMOKING SPACE 19
ANONYMITY 19
ELIGIBILITY CRITERIA 20
FIRST TIME PERSONS USING DRUGS 20
PREGNANT PARTICIPANTS 20
YOUTH AND CHILDREN 21
PARTICIPANTS ACCOMPANIED BY CHILDREN (LESS THAN 16-YEARS-OLD) 21
DUTY TO REPORT 22
INTOXICATED PARTICIPANTS 23

PARTICIPANTS WHO ARE REQUIRING ASSISTANCE TO INJECT 23
PARTICIPANTS WHO ARE UNABLE TO SELF INJECT 23
PARTICIPANTS OPERATING A VEHICLE AFTER LEAVING AN OPS 24
CODE OF CONDUCT 24
REFUSAL OF SERVICE 24
PROHIBITED FROM OPS 24
PARTICIPANT FLOW 25
SAFER USE GUIDELINES 26
WASHROOMS 26
OVERDOSE RESPONSE EQUIPMENT 26
SAFER INJECTION PRACTICES 27
SECONDARY HEALTH PROBLEMS RELATED TO INJECTION DRUG USE 27
ABCESSES/CELLULITIS 27
SEPSIS 28
ENDOCARDITIS 28
OSTEOMYLTIS 28
BURNS 28
PERIFERALLY INSERTED CENTRAL CATHETERS & PERIPHERAL IV CATHETERS 28
METHODS OF USE 29
DISPOSAL OF HARM REDUCTION SUPPLIES 30
OUTDOOR CONSUMPTION SITE 30
DESIGN FOR AN OUTDOOR CONSUMPTION SITE 31
SAFETY COMPONENTS 32
FIRE PREVENTION 32
SAFE DISPOSAL OF USED HARM REDUCTION SUPPLIES 32
LIGHTING 32
COVID-19, INFECTION PREVENTION & PERSONAL PROTECTIVE EQUIPMENT 33
OCCUPANCY LIMIT 34
EMERGENCY PROCEDURES 35
OPIOID OVERDOSE 35
STIMULANT OVERAMPING 37
UNUSUAL/COMPLICATED OVERDOSE PRESENTATION 38
MANAGEMENT OF PROLONGED SEDATION 39
AFTERCARE 42

NALOXONE HYDROCHLORIDE (NARCAN) 42
FIRE, EARTHQUAKE & OTHER EMERGENCIES 43
OCCUPATIONAL HEALTH & SAFETY 45
NEEDLESTICK INJURY / BLOOD AND BODILY FLUID EXPOSURE PROTOCOL 45
EYE SPLASH EXPOSURE (FOREIGN SUSTANCE IN EYE) 45
SAFE HANDLING & DISPOSAL OF USED SUPPLIES 45
SHARPS/BIOHAZARD CONTAINERS 46
GARBAGE DISPOSAL 46
PICKING UP USED INJECTION OR INHALATION SUPPLIES 46
PARTICIPANT EDUCATION 47
DEATH PROTOCOL 47
WEB LINKS 48
APPENDIX A: OVERDOSE RESPONSE CHECKLIST 52
APPENDIX B: STAGE OVERDOSE CARDS & TEAM ROLES (POCKET GUIDE) 53
APPENDIX C: ASSESSING OVERDOSE SEVERITY & RESPIRATION (POCKET GUIDE) 56
APPENDIX D: OXYGEN USE CHECKLIST WITH BVM (POCKET GUIDE) 57
APPENDIX E: OXIMETER & AED (POCKET GUIDE) 58
APPENDIX F: AIRWAY POSITIONING & ADJUNCT AIRWAYS (POCKET GUIDE) 59
APPENDIX G: WHEN TO GIVE RESCUE BREATHS, USE A BVM &/OR GIVE COMPRESSIONS 60
APPENDIX H: OXYGEN USE CHECKLIST 61
APPENDIX I: SEIZURES 62
APPENDIX J: SHOULD YOU GIVE NALOXONE? 63
APPENDIX K: OVERDOSE RESPONSE EQUIPMENT CHECKLIST 64
APPENDIX L: BOOTH (STATION) CLEANING & NEEDLE STICK INJURIES 65
APPENDIX M: CODE OF CONDUCT - OPS 66
APPENDIX N: PARTICIPANT (CLIENT) AGREEMENT 67
APPENDIX O: CARING FOR VULNERABLE POPULATIONS 68
APPENDIX P: SUPERVISED INJECTION INTO A JUGULAR VEIN 69
APPENDIX Q: YOUTH INTAKE FORM - OPS 70
APPENDIX R: OVERDOSE PREVENTION SITE DATA COLLECTION FORM 71
APPENDIX S: OVERDOSE PREVENTION SITE SUPPLIES 72
APPENDIX T: UNKNOWN SUBSTANCES LEFT BEHIND LOG & THEFT OF SUBSTANCES LOG . 73

*****NOTE*** ALL UNDERLINED TEXT IN DOCUMENT IS A HYPERLINK (WHEN USING ONLINE) OR IS SOURCED WITH WEBSITE LOCATION ON PAGES 48-51.**

LIST OF ACRONYMS & DEFINITIONS

Acronym	Definition
2SLGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit, Intersex, Asexual
Adjunct airway	Supplementary airway (oral or nasal)
AED	Automated External Defibrillator
BC	British Columbia
BCCDC	BC Centre for Disease Control
Benzos	Benzodiazepines
Biohazard waste	Sharps (used drug use supplies), objects contaminated with body fluids/blood
BVM	Bag Valve Mask
COVID-19	Coronavirus Disease 2019
Chill Space	Optional additional supervised space for participants to remain post use
CoP	Community of Practice
CPR	Cardiopulmonary Resuscitation
DOC	Drug(s) of Choice
Dyskinesia	Seizures
ER	Emergency Room
EHS/911	Emergency Health Services (Ambulance/Fire Department)
HCV	Hepatitis C Virus
FORB	Facility Overdose Response Box
Grinding	persistently asking someone for some of their drugs
HIV	Human Immunodeficiency Virus
HVAC	Heating, ventilation and air conditioning system
IV	Intravenous
IV	Intravenous (in the vein)
IM	Intramuscular (in the muscle)
OPS	Overdose Prevention Site
MCFD	Ministry of Children and Family Development
MRT	Provincial Overdose Mobile Response Team
PICC	Peripherally Inserted Central Catheter
PIV	Peripheral Intravenous Catheter
PWUD	People Who Use Drugs
PPE	Personal Protective Equipment
Rigs	Sharps/needles
Sharps	Needles/rigs/broken glass
SPO2	Blood oxygen level
SCS	Supervised Consumption Site
THN kits	Take Home Naloxone kits (available through BCCDC & any OPS)
VCH	Vancouver Coastal Health
VPD	Vancouver Police Department

BACKGROUND

In April 2016, British Columbia's (BC) Minister of Health declared a public health emergency under the Emergency Health Services Act. This action was in response to the increasing number of drug toxicity deaths in the province owing to a contaminated drug supply. Overdose Prevention Sites (OPS) opened in the Vancouver Coastal Health (VCH) Region as part of the provincial response on December 8, 2016. These sites opened to monitor persons at risk of drug toxicity & overdose and to provide rapid intervention & health services. OPS can be fixed or mobile sites. They are staffed by peers and other trained staff. The routes of administration allowed at each site depend on facility limitations. For example, smoking is not allowed at most sites due to ventilation issues and this manual provides a guide to creating a space for people who smoke drugs.

OBJECTIVES

- Provide a safe, welcoming and supportive space for People Who Use Drugs (PWUD)
- Supervise injection, inhalation and other ways to use drugs to prevent overdose or other health complications
- Reduce the harms associated with illicit drug use (e.g., crime, public use) that affect communities
- Increase the use of health and social services by PWUD
- Reduce health, social and legal costs associated with drug use
- Create opportunities for PWUD to access stabilization support, if and when desired

GOALS

OPS aim to reduce harms associated with drug use and promote health by:

- Reducing the number of overdoses and overdose fatalities
- Providing a supervised and hygienic area for drug use
- Increasing access to low barrier services
- Reducing the transmission of blood-borne diseases including Human Immunodeficiency Virus (HIV), Hepatitis A, Hepatitis B and Hepatitis C (HCV)
- Reducing potentially serious infections or health complications
- Providing referrals to other health and service providers
- Connecting participants with peer support services and peer connections
- Offering a safer and inclusive space to support de-stigmatization of drug use

GUIDING PRINCIPLES

- Follow a harm reduction model; encourage participants to reduce high-risk behaviour while respecting their choices
- Provide support and services to all participants
- Work with other organizations to provide a supportive network

CORE SERVICES

- Supervision of drug use, and intervention in overdoses including administering naloxone
- Harm reduction teaching and counseling
- Distribution of safer use, safer sex, and any other harm reduction supplies
- Safe disposal of harm reduction supplies (page 28)
- Health and social services referrals
- Data collection, use *Overdose Prevention Site Data Collection Form* (**APPENDIX R**, page 66)

HARM REDUCTION

SUPPLIES

Safer use supplies are available to all OPS participants, and must be easily accessible and available. Supplies come from the BC Centre for Disease Control (BCCDC) Toward the Heart Program, or VCH's Overdose Emergency Response. Check supplies and re-order on a weekly basis, as needed. Supplies can take 2-3 weeks for delivery, plan accordingly.

These are the places to acquire the variety of supplies needed:

BCCDC & Toward The Heart supplies (all underlined text in Web links pg 47)

- Take Home Naloxone (THN) kit supplies are for sites that are distributing kits to participants who are at risk of overdose or are in contact with people who are at risk for overdose.
    - THN New Site Registration Form
    - THN Supply Order Form
- Facility Overdose Response Boxes (FORB). This is for onsite overdose response supplies (including naloxone).
    - FORB New Site Registration Form
    - FORB Supply Order Form

Continued next page

BCCDC Harm Reduction Program

- This program provides registered sites with the harm reduction supplies listed here: Supply Requisition Form

VCH supplies

- *OPS Supply Order Form* (**APPENDIX S**, page 71) submit to overdoseresponse@vch.ca to order. This form is for OPS specific supplies.

DRUG CHECKING

Drug checking is offered at OPS (see map of Vancouver locations and schedules), and includes:

- **Fentanyl test strips**
  - Enable participants to test drug for fentanyl before use
  - Available for use at OPS, or as take-home strips. Staff must know how to use and to train participants on home use
  - To order supplies and for training needs email overdoseresponse@vch.ca
- **Benzodiazepine (benzo) test strips**
  - Enable participants to test drugs for Benzodiazepines (benzos) before use
  - Available for use at OPS only
  - To order supplies and for training needs email overdoseresponse@vch.ca
- **Spectrometer (only at some locations)**
  - A machine used to test a drug for its various components
  - Available at these OPS and Supervised Consumption Sites (SCS) on a rotating basis

Get Your Drugs Tested 880 East Hastings also offers test strip and spectrometer drug checking.

OVERDOSE ALERTS

OPS staff are to notify VCH if there are higher than unusual, severe, or unusual overdoses happening onsite.

If possible, safely collect a sample of substances causing unusual overdoses for spectrometer testing. For more information on accessing spectrometer testing, see the VCH drug checking website (above).

Staff can check for any active alerts for the VCH region here: https://towardtheheart.com/alerts

To sign up for alerts, text “JOIN” to 253787 (ALERTS)

STAFF GUIDELINES

INTRODUCTION

Beneficial staff traits include:

- General knowledge about trauma & violence informed care, harm reduction and cultural safety see *Caring For Vulnerable Populations* (**APPENDIX O**, page 67)
- A sensitive understanding of the participant population and local community
- A harm reduction mentality to support participants where they are at with respect and compassion
- An open mind and a willingness to reflect on one's own triggers and boundaries
- An ability to accept that participants will make changes in their own way and time
- A capacity for forgiveness, empathy and humility
- An ability to disengage should an intervention not be successful, or welcomed
- A willingness to work as a team and communicate effectively
- A willingness to be creative
- A good sense of humor
- A good personal support networks and habits of self-care

*The OPS is not a one-size-fits-all approach, but instead adapts to each participant based on their own priorities.

CONFIDENTIALITY

Participant information is confidential:

- This includes any participant information discussed on site
- Staff will not identify any participant in the OPS if someone comes inquiring about them
- This includes people who identify themselves as a friend, partner or family member

Participant's confidential information is only shared outside of the OPS:

- When there is an emergency involving BC Emergency Health Services (EHS) or the Vancouver Police Department (VPD)
- For data collection, surveillance, or other research purposes participant information is anonymized

DATA COLLECTION

Forms for participant documentation and data collection:

- *Participant Agreement, Release and Consent Form* - 1st visit only (**APPENDIX N**, page 66)
- *Overdose Prevention Site Data Collection Form* - daily (**APPENDIX R**, page 71)
- *Youth Intake Form* - 1st visit only (**APPENDIX Q**, page 70)

The process of data collection for the number of unique visits to the OPS:
Staff can use a paper recording system to record daily visits using their own documentation or the example provided by VCH (**APPENDIX R**, page 70):

- Staff submit this information into a Checkbox survey online called OPS Daily Collection
- Information is collected once a week by VCH
- If electronic data collection is not working, or not possible, submit paper records by fax/email to overdoseresponse@vch.ca

A weekly OPS report produced by VCH is shared with each site.

ORIENTATION, TRAINING & RESOURCES

Staff need to complete the following training prior to working at an OPS:

1. Toward The Heart (BCCDC's Harm Reduction Program) Overdose prevention, recognition and response (including naloxone administration). In person practice recommended in your community
2. Toward The Heart Naloxone Train-the-Trainer (a naloxone [THN] trainer can be anyone who has reviewed and understands the material)
3. VCH Harm Reduction 101 (available through Learning Hub)
4. Resisting Stigma on Substance Use and the Downtown Eastside (Learning Hub)
5. Opioid Overdose: Management of Suspected Opioid Overdoses in Community Settings (Adult & Youth) for Allied Health & Unregulated Care Providers

Additional courses are available through the VCH Street Degree in Overdose Prevention, either in person or via Zoom. To learn more, email overdoseresponse@vch.ca.

Some of the recommend Street Degree courses include:

- Advanced Overdose Response
- Safer Injection Practices
- Cardio Pulmonary Resuscitation CPR & Automated External Defibrillator (AED) practice
- Let's Talk About Drugs

Recommended **Online Street Degree Courses (on LearningHub) include:**

- Advanced Overdose Response
- Managing Medical Emergencies
- First Responder Collaboration

Continued next page

Remember to review training material on a regular basis to ensure staff know what to do in the event of an overdose. Because CPR and AEDs are rarely used, this material is especially important to review with staff every 6 months.

Mental health support

Witnessing or responding to an overdose can cause emotional, psychosocial, physical, or spiritual responses. Staff with lived experience can face additional impacts due to an overdose or death amongst their peers. Each OPS must have a staff debriefing and a psychosocial support process. Toward the Heart the BCCDC's harm reduction service offers A Guide to Promoting Staff Resiliency for staff. The Provincial Overdose Mobile Response Team (MRT) offers support to first responders and frontline workers in overdose response. The team is available daily (8:00 am – 4:30 pm) however, they do provide support outside of these hours. Contact MRT by email/phone at mrt@phsa.ca or 1-888-686-3022.

Consider joining the Overdose Community of Practice (CoP) call/online

The CoP phone meeting is primarily for any frontline workers in the VCH region. The goal for this meeting is for participants to share their experiences or concerns regarding overdoses, and to learn from each other. Meeting minutes shared online. The meeting is weekly at 8:00 am each Thursday.

The participants of this meeting also have an online community of practice. Meeting minutes, Street Degree training, best practices, and other resources are stored here. To sign up add yourself to this meeting and to receive updates and minutes https://www.overdosecommunity.ca/

Email overdoseresponse@vch.ca for additional questions or support.

STAFF RESPONSIBILITIES

Each staff member should:

- Provide services with awareness about trauma & violence informed care, harm reduction and cultural safety, see *Caring For Vulnerable Populations* (**APPENDIX O**, page 68)
- Cooperate and work respectfully with other staff
- Check supplies daily and order more as needed, see *Overdose Prevention Site Supplies* (**APPENDIX S**, page 72)
- Check emergency response equipment at beginning of shift including naloxone kits, AED and Oxygen, see *Overdose Response Equipment Checklist* (**APPENDIX K**, page 64)
- Review overdoses from last shift
- Communicate with participants
- Be attentive to participants who are presenting an interest in information or support, such as social, mental health or addiction services
- Attend to medical emergencies within knowledge and training (see Orientation Training & Support, page 13)
- Offer education on safer use and harm reduction supplies

Continued next page

- Control the flow and numbers of participants into and out of the OPS
- Ensure the safety of participants
- Monitor participants' activity and adherence to *Code of Conduct* (**APPENDIX M**, page 66)
- Use verbal de-escalation techniques and apply consequences for aggressive/violent behavior
- Build a sense of ownership and shared responsibility among participants
- Debrief work-related incidents at the end of each shift and report to leadership
- Help direct new staff and participants
- Maintain data collection as required (**APPENDIX R**, page 71)
- Maintain a structured healthy and clean worksite
- Clean stations after each use, see *Booth (Station) Cleaning & Needle Stick Injury* (**APPENDIX L**, page 65)
- Sweep and clean as needed throughout the day
- Refer all media inquiries or public presentation opportunities to an OPS leader
- Bring any concerns about possible breaches of the OPS guidelines and protocols to leadership

AUTHORIZED ACTIVITIES

If requested by participants, trained staff can provide the following:

- Verbal guidance on safer use
- Encourage hand washing and/or alcohol based sanitizing before and after drug use
- Tie off participant's arm
- Swab injection area with alcohol
- Feel (palpate) participant's arm for veins
- Identify potential injection areas, including physically guiding participant's arm to injection site
- Simulate safer use using a separate set of sterile supplies and the staff member's own body
- Provide information and guidance on safer jugular self-injection practices, upon request. See *Supervised Injection Into a Jugular Vein* (**APPENDIX P**, page 69)

Staff are encouraged to stand or sit on the side of the participant that is furthest from the hand holding the rig. This will help minimize the risk of needle stick injury.

Continued next page

SPLITTING & SHARING

Drugs brought into the OPS are eligible to be split and/or shared within the site:

- Splitting and sharing implies the acquisition, separation and/or transfer of a dose between participants
- Only drugs intended for personal use in that visit are allowed to be split or shared
- Clients will identify to staff when they intend to engage in a split/share of drugs
- If passing a syringe to another participant, request participants to cap the syringe prior to passing

LEAVING THE OPS TO PROVIDE ASSISTANCE

Staff choosing to leave the OPS to provide care should do so only if:

- The onsite staffing requirements are met - **2 STAFF MINIMUM**
- The safety of participants and other staff within the OPS is ensured
- The situation is immediately life-threatening and cannot wait until EHS arrive
- This does not disrupt the service of those already in the OPS
- The situation does not present a risk to the safety or health of staff
- EHS has been called
- A second person accompanies them or is able to observe them from inside the OPS

***It is the individual staff member's decision to leave the facility to provide service/support**. **No staff is expected to leave the facility to provide this service.**

Refer to Risk Assessment for Leaving a Fixed Site to Response to Intervene in a Suspected Opioid Overdose

UNKNOWN SUBSTANCE LEFT BEHIND

Any controlled or unknown substances left behind are to be brought to the onsite supervisor. Below is the Unknown Substance Protocol, which is based on legal guidelines, related to the transportation of illicit substances.

IN THE CASE OF A THEFT OF A SECURED SUBSTANCES LEFT BEHIND

- Leadership and VPD must be notified immediately
- The Office of Controlled Substance (Health Canada) should be notified within 24 hours by calling (613) 952-2177
- Record on the log sheet, see *Theft of Substances Log* (**APPENDIX T**, page 74)
- **Continued next page**

RETURNING UNKNOWN SUBSTANCES TO PARTICIPANTS

When a substance is left behind, and staff knows the owner, staff will secure the substance in a sealed envelope. With the supervisor's approval, place the substance in a secure location and delay logging in the log sheet until the end of shift. If the participant returns to claim the substance, return it. If the participant does not return, log the item and contact the VPD.

Solid substances - powder/crystals/resin etc. contained in a flap, baggie or other wrapping:

- Wear gloves to transfer the contents into an envelope then seal, date, and initial. Place in a designated secure location
- Complete the *Unknown Substances Left Behind Log Sheet* (**APPENDIX T**, page 73) in the designated binder
- The local police department needs to be contacted on the same day to collect the substance, an officer must fill in the log when removing the sealed envelope from the premises
- If police are not able to pick up the unknown substance prior to the completion of a shift, staff must deliver it to the nearest police department

Liquid substances (in a used/unused rig):

- Wear gloves to handle tongs, and then transfer the rig into a puncture resistant sharps container for disposal. Do not store on site. (Disposal of Supplies, pg. 30).
- Record the disposal on *Unknown Substances Left Behind Log Sheet* (**APPENDIX T**, page 73)

OPERATIONAL GUIDELINES

PHYSICAL SPACE

The space used for an OPS varies. Below are the list of requirements for OPS spaces:

- A warm well-lit room (individual stations might each need their own lighting)
- Enough physical space for staff to respond to an overdose. There should be enough room for at least 2 people to lie on the ground with enough room for staff to respond.
- Accessible mirrors placed for participants to use for self-injection. Mirrors help get people out of washrooms where they are at higher risk for overdose.
- Puncture resistant sharps containers are visible and secured to the wall at an accessible height in each station and throughout OPS
- Tables and chairs with non-permeable (no fabric/foam), non-flammable surfaces that can be easily cleaned (commonly used tables are small, 18 x 36-inch rectangular, stainless steel)
- Chairs with backs and armrests to prevent a participant who overdoses from falling off, and that also aid in tipping/sliding participant to the floor in the event of an overdose
- A bench to use as a place to lie down
- A clearly marked, obstacle-free pathway to the entrance/exit for medical transport by EHS or in the event of an evacuation
- A poster with your site's address. This is helpful for when staff call 911 and dispatch asks them the location of the emergency

INDOOR SMOKING SPACE

In accordance with the City bylaws for smoking indoors, an indoor smoking space must have ample air exchange in the space by installing a heating, ventilation, and air conditioning system (HVAC) system. As well, a consultation with WorkSafe BC to ensure a safe workspace for staff. This space is intended for the use of illicit substances, therefore not for smoking cigarettes or cannabis. A provincial guideline for indoor inhalation OPS is currently in development. (For Outdoor Consumption Site see pg. 30)

ANONYMITY

Participants are not required to verify their personal identity on entry. Participants will choose or be given a unique ID/handle. Do not record their personal contact information.

ELIGIBILITY CRITERIA

As a low-barrier service, the OPS aims to provide a safe and welcoming environment.

Participants must:

- Agree to, and sign, the *Participant (Client) Agreement Form* (**APPENDIX N**, page 67)
- Agree and adhere to the *Code of Conduct* (**APPENDIX M**, page 66)
- Have no demonstration or indication of aggressive behaviour
- Not be accompanied by any children under the age of 16 (see Youth, page 21)
- Have no previous prohibition from the OPS (see Refusal of Service (VCH) , page 24)

FIRST TIME PERSONS USING DRUGS

This population presents a critically important opportunity for harm reduction education. Usually, these participants are vulnerable young adults who are at a crossroads between increasingly high-risk behaviours and an opportunity to transition away from a street-entrenched lifestyle. It is unlikely that these participants will present themselves as a first-time PWUD to the OPS however, in this event staff will:

- Provide education on the potential complications associated with high-risk drug use
- Refer to other health and social services (if participant is interested)

Staff will not deny any participant access to the OPS under this circumstance.

PREGNANT PARTICIPANTS

OPS's are an important place to connect pregnant people to early prenatal care, which can make a huge difference in outcomes for clients and families. The stigma and discrimination experienced by pregnant PWUD are large barriers to accessing health and social services. Many have experienced trauma from victimization, including childhood physical, emotional, and sexual abuse. Providing a welcoming environment with trauma-informed care and harm reduction can help foster relationships that increase uptake of prenatal and other services Referrals to agencies are made only in collaboration with the participant.

Some referral options are:

- Sheway - A Pregnancy Outreach Program located in the Downtown Eastside of Vancouver. The program provides health and social service supports to pregnant women and women with infants, who are having issues with drugs and alcohol.
- Fir Square (BC Women's Hospital in Vancouver) – An inpatient unit that provides care to women using substances and infants exposed to these substances.
- Overdose Outreach Team (VCH) – Provide outreach support to pregnant people who use substances. Anyone can refer by calling the Overdose Outreach Team main line at (604) 360-2874.

Please note, there is no duty to report a pregnancy to the Ministry of Child and Family Services or an Indigenous Agency until a live infant is born. Reporting a pregnancy without client consent is a breach of confidentiality. Please see Duty to Report (p. 22) for more information.

YOUTH AND CHILDREN

The primary goal of OPS services is to ensure people's immediate safety and prevent deaths from toxic drugs.

Unregulated drug toxicity was the leading cause of unnatural deaths in BC among youth under 19 years from 2019-2023[1]. Most of these deaths occurred when young people were using alone, and in private residences.

Youth (16-19 years of age) [2]

Staff will treat youth (16-19 years) who use substances with respect, and offer substance use safety planning, along with additional supports if needed. Parental consent is not required to provide youth with harm reduction supports or safety planning.

When a youth presents at the OPS, staff will:

- Complete the *Youth Intake Form* (**APPENDIX Q**, page 70) (Inform the youth they only need to do a youth intake once and who to talk to if they get asked to do it again.)
- Review the site *Code of Conduct* (**APPENDIX M**, page 66)
- Refer youth (with their consent), to VCH Youth Central Addictions Team (CAIT) at 604-209-3705

See the section on "Duty to Report" below for information on reporting when staff have reason to believe that a youth is being abused or neglected.

Children (under 16 years of age)

It is rare that children under 16 years of age present to use an OPS. If a child under 16 presents at an OPS, they will need to meet in person with the **site manager or shift coordinator**.

The site manager or shift coordinator will:

- Provide immediate substance use safety planning,
- Create a safe space to discuss their drug use history,
- Refer them to VCH Youth Central Addictions Team (CAIT) at 604-209-3705
- Connect them with any additional/requested services.

See the section on "Duty to Report" below for information on reporting when staff have reason to believe that a child is being abused or neglected.

PARTICIPANTS ACCOMPANIED BY CHILDREN (LESS THAN 16-YEARS-OLD)

Participants accompanied by children (under 16 years of age) are restricted from accessing OPS. This is consistent with the Child, Family and Community Services Act, which identifies the need for parents to address the safety needs of their children by making appropriate alternative care arrangements. A participant's use of an illicit drug could impair their abilities to parent.

In this situation, staff will involve site manager or shift coordinator to develop a safety plan with the participant.

If there is a concern over the immediate health risk of the child, staff will advise leadership, and in consultation with site manager, leadership will make a report to the Ministry of Child and Family Development, or an Indigenous Agency as described in "duty to report" below. It is also important to

understand that if a parent or guardian is using substances, this does not automatically mean that their children are in need of protection. Substance use *on its own* is not a protection issue unless it is impacting the ability to care or protect the child as per Section 13. However, if the child or youth is in need of protection as noted in Section 13 of the Child, Family and Community Services Act then there is a duty to report. See the section on "duty to report" below for more information.

DUTY TO REPORT

All providers have a legal duty to report to a child welfare agency such as the Ministry of Children and Family Development (MCFD) or an Indigenous Child and Family Services Agency if they believe a child or youth is being abused or neglected[2].

A report to the MCFD *must* be made when you have reason to believe that a child or youth[3]:

- Has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or another person and the parent is unwilling to or unable to protect the child or youth;
- Has been or is likely to be physically harmed because of neglect by the child or youth's parent;
- Is emotionally harmed by the parent's conduct;
- Is or has been absent from home in circumstances that endanger the child or youth's safety or well-being;
- Has been abandoned and adequate provisions have not been made for the child or youth's care;
- Is living in a situation where there is domestic violence by or towards a person with whom the child or youth resides;
- Is likely to have seriously impaired development by a treatable condition and the child or youth's parent refuses to provide consent to treatment;
- Has a parent that is unable to unwilling to care for the child or youth and has not made adequate provisions for the child or youth's care; or
- Has a parent that is no longer alive and adequate provisions have not been made for the child or youth's care.

In cases of **immediate risk to a child or youth**, inform the child or youth that a phone call will be made to MCFD's Centralized Screening or an Indigenous Agency.

Please contact:

- Provincial Centralized Screening (24 hours) 1-800-663-9122
- Vancouver Aboriginal Child and Family Services Society (VACFSS)
    - Child protection concern (8:30am to 4:30pm) 778-331-4500
    - Child protection concern (after hours) 1-800-663-9122
- Helpline for Children in BC: 310-1234 (no area code is needed)
    - For children or youth who would like to talk to someone
- Kids Help Phone 1-800-668-6868
    - Counselling, referral and support service for children and youth under the age of 20 years old

For more information on duty to report, see: BC Handbook for Action on Child Abuse and Neglect, 2017

References

1. BC Coroner's Service, 2024
2. Child, Family and Community Service Act

3. BC Public Safety: Duty to Report Pamphlet

INTOXICATED PARTICIPANTS

Intoxicated participants present unique challenges due to the likelihood of a higher than usual risk of sharing harm reduction supplies, fatal overdose, assault, or other unsafe drug use if denied access to the OPS. Allowing intoxicated participants to use when they are clearly at greater risk for overdose still presents certain challenges. However, the outcome of an intoxicated participant overdosing outside of an OPS while intoxicated can be fatal.

Responding to intoxicated participants:

- Provide education about the increased risk of an overdose if combining alcohol and drugs
- Encourage them to walk around and/or stay and drink water before using
- Grant access to the OPS if they are determined to use

PARTICIPANTS WHO ARE REQUIRING ASSISTANCE TO INJECT

Some PWUD who are unable to inject themselves rely on others to perform this. This is a result of never learning how to self-inject or that there are factors affecting ability (e.g., vision/mobility loss, small veins). It is important to engage with these participants, as they are at a heightened risk of infection and violence.

Staff respond to non-self-injectors by:
Assessing and determining what prevents participant from self-injection (e.g., education or disability).

- Education - provide education to support the ability of the participant to self-inject
- Disability - determine whether any physical supports along with verbal guidance would help
- Explore other routes of administration

PARTICIPANTS WHO ARE UNABLE TO SELF INJECT

In cases where the on-site supervisor determines that self-injection is not possible, or cannot be performed safely, the on-site supervisor may allow assistance. An individual accompanying the participant can assist the participant with the injection if:

- Both individuals agree to arrangement
- The assistance is not in exchange for financial compensation, goods, or services
- The provision, administration, or transfer of the controlled substance is not in exchange for financial compensation, goods, or services
- The transfer of the controlled substance is only for the purposes of performing the injection on the participant who is unable to self-inject
- Both individuals are informed of the legalities of their decision

***Staff must offer safer injection education to the individual assisting with the injection.**

PARTICIPANTS OPERATING A VEHICLE AFTER LEAVING AN OPS

Driving while intoxicated constitutes a potentially significant risk to public safety. If a person arrives by car, staff need to address this with the client and work to create an immediate safety plan.

- Warn the person that they should not drive while intoxicated. What is their behavior?
  - Do they appear overly sedated or drowsy?
  - Can they complete normal functions?
  - Can they respond to questions?
  - Do they have a loss of coordination?
- Work with the participant to arrange for alternate transportation (bus, taxi, ride from a friend)
- If a participant who appears intoxicated after consuming a substance at the OPS and proceeds to operate a vehicle, staff have a duty to call local police or Regional Canadian Mounted Police (RCMP), depending on location of the OPS. Staff will need to immediately notify their supervisor or the manager on call

CODE OF CONDUCT

A Code of Conduct must be in all work areas (**APPENDIX M**, page 66). Participants denied access related to the Code of Conduct have the right to discuss and/or file a complaint with the OPS supervisor or leadership. Consider developing a Code of Conduct specific to your site with participants and staff.

REFUSAL OF SERVICE

Deny admittance to the OPS if a participant:

- Refuses to sign the waiver or to give reception their OPS handle
- Has a medical condition which requires immediate emergency attention
- Has no intention of using the services offered at the OPS
- Has a child less than 16-years-old with them
- Are under 16-years-old
- Are on the temporarily prohibited list

PROHIBITED FROM OPS

It is up to each OPS site to develop their policy for prohibiting participants' access to the OPS.

PARTICIPANT FLOW

Upon entering the OPS, participants must:

1. Wash or sanitize their hands
2. Provide their handle and sign in/or meet Eligibility Criteria (if first entry [page 20])
3. Inform staff what they are using in order to help guide staff in the event of an overdose (e.g., up (cocaine), down (e.g., opioids), side (crystal meth)
4. Use drugs in designated areas only
5. Wait for staff to direct them to an available station
6. Collect necessary supplies
7. Remain at their designated station while using
8. 30 minute time limit (if possible), to respect the needs of others waiting
9. Dispose of used supplies in the puncture resistant sharps container, and remove any other debris
10. Wash their hands upon exiting

Once a participant has entered the OPS, staff must:

1. Attempt to ensure that high-risk participants (e.g., youth, women and 2SLGBTQ+ people) feel safe
2. Ask participants what they are using
3. Encourage participants to wash or sanitize their hands upon entering
4. Encourage participants to remain (chill) on site for 10-15 minutes for observation after use (or longer post inter muscular [IM] or oral route of administration) so staff can provide overdose response assistance if needed
5. Attempt to discuss harm reduction strategies

Prior to participants leaving the OPS, staff must:

1. Ensure that participants are stable and coherent (e.g., able to walk, talk, etc.)
2. Ensure that participant's concerns are addressed and supported
3. Encourage participant to return for supervision as needed and for harm reduction supplies when using offsite
4. Encourage participants to wash their hands upon exiting
5. Ensure that high-risk participants, such as youth, women, and 2SLGBTQ+ people feel safe leaving (e.g., if late at night)

*** Encourage participants to remain at OPS - until they can safely leave.**

SAFER USE GUIDELINES

WASHROOMS

Even while at an OPS, participants might try to use the washroom to use their drugs.

Drug use is not allowed in the washrooms for safety reasons. This needs to be communicated to all participants using the washroom at the OPS.

Staff are responsible for monitoring washroom use if a participant is inside. Staff need to be prepared to respond to an overdose here. Prevention and response measures must be in place.

Refer to VCH's Overdose Prevention & Response in Washrooms recommendations.

Check washrooms throughout your shift and especially at the beginning/end of your shift and before the OPS closes each day.

OVERDOSE RESPONSE EQUIPMENT

The OPS is required to have the following equipment:

- Naloxone and equipment for administration
- An oxygen tank
- An oxygen saturation oximeter
- An AED

Overdose response equipment checks need to be done at the beginning of every shift, see *Overdose Response Equipment Checklist* **(APPENDIX K**, page 64**)**.

There must be enough oxygen tanks for use in a medical emergency (e.g., overdose), plus 1 or 2 for backup. Due to the risk of oxygen causing or intensifying a fire, all oxygen supplies (including personal use) must be more than 3 meters away from matches or lighters in use by participants. See the *Pocket Guide Oxygen Use Checklists* (**APPENDIX D** & **H**, pages 57 & 61).

Offer refresher training regularly (**APPENDICES A-G**, pages 52-60)).

*The *Pocket Guide* **(APPENDICES B,C,D,E,F**, pages 53-59**)** is useful to laminate and hang on oxygen tank with BVM, airways, Personal Protective Equipment (PPE).

SAFER INJECTION PRACTICES

Participants:

- Inject only 1 dose per visit
- Inject part of the dose first to test it, then finish a few minutes later
- Be encouraged to inject different drugs separately instead of mixed together
- Have access to sterile rigs and other harm reduction supplies provided at the OPS
- Must prepare their own drugs. No grinding (persistent asking) other participants for drugs
- Inform staff once they have finished so staff can monitor them

Staff supervising participants:

- Provide harm reduction supplies
- Assist participants to find veins, if requested
- Look for opportunities to educate participants about vein care and safer injection
- Do not insert rig into participant's vein nor inject the drug for them
- Staff are encouraged to stand or sit on the side of the participant that is furthest from the hand holding the rig. This will help minimize the risk of needle stick injury

The risk of infection and serious medical complications is even greater when injecting into a jugular vein (jugging). Staff should provide education to a participant observed to be jugging, see *Supervised Injection Into A Jugular Vein* (**APPENDIX P**, page 69). If the participant insists on jugging, make sure they have access to a mirror.

SECONDARY HEALTH PROBLEMS RELATED TO INJECTION DRUG USE

Participants expressing any of the following health concerns must be referred to a community clinic or Emergency Room (ER) for evaluation.

ABCESSES/CELLULITIS

An abscess is an enclosed collection of liquid (pus) anywhere in the body. It can form in the skin, muscles, or other soft tissues. Cellulitis is an infection of the skin or soft tissue. Bacteria is the cause of both abscesses and cellulitis. Bacteria can be introduced when skin is not cleaned well before injecting. The 4 primary signs and symptoms of soft tissue infection are heat, swelling, redness, and pain.

Participants with an abscess or cellulitis should seek medical attention, as they could need antibiotics. The serious bacterial infections are sepsis, endocarditis, or osteomyelitis. If not treated early these can lead to severe medical complications.

Refer to Toward the Heart, Harm Reduction Resources, Skin Infections.

Continued next page

SEPSIS

Sepsis is a blood infection. This can occur for many reasons related to IV drug use, and when the content of an abscess leaks into the body's blood circulation. It can result in severe organ damage or death. Signs and symptoms include chills, fever, aching, and general discomfort.

ENDOCARDITIS

Is a bacterial infection inside the heart's chambers or valves. One of the ways bacteria become a problem is when the skin is not cleaned prior to injection, allowing bacteria to enter the bloodstream and then the heart. Signs and symptoms include fever and/or chills; sweating and/or night sweats; weakness and/or fatigue; joint and/or muscle pain; shortness of breath; swelling of feet, legs, and/or abdomen; weight loss.

OSTEOMYLTIS

Is a painful infection of a bone and the surrounding tissue. IV drug use is a common cause of osteomyelitis, often from soft tissue infection near the bone. Signs and symptoms include pain (particularly low back); fever and/or chills; swelling, redness, and/or warmth over infected bone; and sweating.

BURNS

Burns in the OPS are most commonly caused by contact with fire from a match/lighter, hot cooker, or inhaling hot air/smoke.

- Minor burns (1st degree) are small and only affect the first layer of skin
- Major burns (2nd degree and more) are large area burns if they are deeper than the first layer of skin. Call EHS
- Inhalation burns are caused by breathing in hot air/smoke. This can burn airways and lung tissue, causing swelling of the airways and difficulty breathing. Call EHS in the event of a major inhalation burn

PERIFERALLY INSERTED CENTRAL CATHETERS & PERIPHERAL IV CATHETERS

If a participant wants to inject into a Peripherally Inserted Central Catheter (PICC) or a smaller Peripheral IV (PIV) catheter, the role of staff is to provide harm reduction education.

- PICCs are often inserted in a vein in the upper arm, but the catheter extends inside to a central vein. Participants injecting drugs are at a higher risk of soft tissue infections, and other more serious infections. These infections include endocarditis (infection in the heart) and osteomyelitis (infection in the bone). Immediate treatment with IV antibiotic therapy is the treatment for these infections, and often a PICC line is inserted to maintain IV access (see Secondary Problems Related to Injection Drug Use, page 27)
- A PIV catheter is usually inserted into a vein in the lower arm. It is for shorter-term medication administration, intravenous fluids or blood draws

If a participant at the OPS is injecting into their PICC, staff must make every effort to refer the participant to the nurses at Insite. Injecting into a PICC is not encouraged due to the high risk of medical complications and should be supervised by medical staff whenever possible.

If a participant at the OPS is injecting into their PIV, there is less risk of severe medical complications. However, the use of the PIV should be discouraged along with providing harm reduction education.

METHODS OF USE

Methods of use include:

- Injection
    - Intramuscular (IM/muscling)
    - Subcutaneous (skin popping)
    - Intravenous (IV)
- Oral
- Snorting (nasal/insufflation)
- Booty bumping/hooping/boofing (rectal administration)
- Smoking (inhalation)

Resources:

- VCH Safer Smoking guide and VCH Safer Injecting guide
- Safer snorting practices can help reduce the risk of contracting HCV and HIV. The Canadian AIDS Treatment Information Exchange (CATIE) website provides details
- CATIE also provides details on Safer Crystal Meth Smoking (CATIE) and Safer Crack Smoking (CATIE)
- How to Booty Bump Better (San Francisco Aids Foundation) is information on safer booty bumping

DISPOSAL OF HARM REDUCTION SUPPLIES

- Each participant will dispose of used supplies in the puncture resistant sharps container at their station, or in the main biohazard bin
- Encourage participants not to bend or break off needle tips before disposal
- Staff oversee the disposal process and encourage participants to remove and dispose of debris from their own station
- After participant leaves, OPS staff will clean the station in 3 steps to prevent needle stick injury, see *Booth (Station) Cleaning & Needle Stick Injuries* **(****APPENDIX L**, page 65**)**:
    1. Clean with your eyes – glance over all surfaces that need wiping
    2. Use hand brooms to sweep all surfaces
    3. Wipe surfaces with a puncture resistant gloved hand and approved disinfectant
- Sharps containers need to be firmly secured to walls or other secure surfaces
- When containers are 3/4 full, they must be sealed, removed and placed in a large bin provided by the hazardous waste pick-up company, and secured in a locked non-service area until scheduled pickup. This is set up by each individual OPS
    - Daniels Health-Biomedical Waste Management is typically used for disposal pickup: (604) 379-1768

***Under no circumstances should staff be dumping loose syringes from a smaller bin into a larger bin.**

OUTDOOR CONSUMPTION SITE

An outdoor consumption site provides a safe space for participants to use drugs in an open-air environment. Smoking is a common form of drug use. In Canada, there have been few consumption sites available for people who smoke drugs. The risk of injury and fatal overdose is high for people who smoke their drugs. Some smoking injuries that occur from hot smoke and used/broken pipes are burns, cuts, HIV, HCV, and heart & respiratory issues. The outdoor consumption site is primarily for people who prefer to smoke their drugs to have access to a supervised space. This is not a tobacco smoking area. Provide an alternative space for participants smoking tobacco.

Occupational Health:

- To prevent secondary smoke exposure, staff should limit entering the inhalation space to respond to overdoses and other emergencies.
- When entering the inhalation space, staff should assess the risk of inhalation exposure and when deemed necessary, to don the appropriately sized filtering PPE. Staff has the option of either:
    - Fit-tested N95 respirator
    - Fit-tested elastomeric (half facemask) respirator with ov/p100 filters. These respirators are re-usable and require routine cleaning/disinfecting.

DESIGN FOR AN OUTDOOR CONSUMPTION SITE

An outdoor consumption site could be a tent, gazebo, or a permanent structure that provides open air space to smoke.

Recommended components are:

- A large covered area to contain fumes, protect from weather, and provide privacy
- Maximum one enclosed side to permit air ventilation*
- Roof or covering of structure/tent to be minimum of 8.5 feet in height*
- Clear, flame-retardant walls to promote visibility of participants
- Stay 6 meters from any door, or window of a neighboring building
- Sandbags or rope ties to secure tent in cases of high wind
- Use stations spaced to promote distancing and allow participants to:
    - Sit (if desired)
    - Prepare drugs on a clean surface
    - Use drugs
- Hand washing/sanitizing area at entrance and exit
- Biohazard containers

*In accordance to Tobacco And Vapour Products Control Act

Additional (but not necessary) design components include:

- A post-use/chill area for participants to relax/cool down
- Cameras to promote the safety and security of participants and staff
- Fans to facilitate air flow
- Booth-style seating options for privacy that considers vulnerability of some participants (e.g., youth, women and 2SLGBTQ+ people)

Signage:

- Post signage that identifies space as a safer consumption area. Example from page 78, in the BC Overdose Prevention Services Guide (BCCDC):
    - 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 drugs within."
- *Code of Conduct* **(APPENDIX M**, page 66**)**

For further recommendations for outdoor inhalation OPS, refer to Appendix R of BCCDC OPS Guide.

SAFETY COMPONENTS

FIRE PREVENTION

- No open flame or gas/propane are to be used to heat tents unless certified for use within enclosed areas
- Any electric heating equipment must be a safe distance from any combustible materials (e.g., tent fabric)
- Oxygen tanks must beat least 3 feet from any open flame devices
- Provide non-combustible ashtrays
- Fire extinguishers must be maintained and accessible; staff must be trained in their use

SAFE DISPOSAL OF USED HARM REDUCTION SUPPLIES

- Sharps containers must be in all use stations and at an accessible height

LIGHTING

- Natural and/or bulb lighting is required at all times
- Each use station has an additional light source

COVID-19, INFECTION PREVENTION & PERSONAL PROTECTIVE EQUIPMENT

On July 26, 2024, B.C.'s Provincial Health Officer issued an order to end the public health emergency for COVID-19 and rescinded all related orders.

Resources on Infection Control for OPS:

BCCDC: Communicable Disease Prevention: Responding to Drug Poisoning at Overdose Prevention Services and Supervised Consumption Sites (June 2023)

The following *routine practices* should be followed at all times to prevent the spread of communicable disease:

- Support providers to stay home if they feel sick or have symptoms of illness (e.g. fever/chills, new cough). Promote hand hygiene and provide resources, including alcohol-based hand rub and hand-washing facilities.
- Support providers getting vaccinations against vaccine-preventable illnesses (e.g. COVID-19, seasonal influenza).
- Encourage respiratory etiquette (e.g. cover coughs and sneezes) and provide tissues and the ability to dispose of them.
- Maintain routine cleaning and disinfection practices.
- Follow relevant guidance on cleaning and disinfecting for community-based settings and health-care and clinic settings.
- Community-based OPS sites that are not considered clinical or healthcare settings (e.g. housing OPS, community-based peer-run OPS sites) are encouraged to follow a two-step cleaning process:
    - Clean surfaces with soapy water or a household cleaning product.
    - Disinfect surfaces with a store-bought disinfectant, accelerated hydrogen peroxide wipes, or follow BCCDC instructions to safely mix and dilute household bleach with room temperature water.
- Maintain adequate ventilation and air circulation throughout the building or space. Ensure ventilation systems are in working order and are regularly maintained. Air should flow through the space.
  Respect peoples' personal choice around mask use.
  Continued on next page

Point-of-care Risk Assessment (PCRA)

Before responding to a suspected drug poisoning, providers should conduct a Point-of-Care Risk Assessment (PCRA) to determine the next actions and select appropriate PPE. In addition to routine practices, additional precautions are recommended when:

- Person experiencing the drug poisoning has confirmed or suspected illness, signs or symptoms of illness, appears unwell, or additional precautions have been identified, AND
- A task or procedure in the drug poisoning response has an elevated risk for communicable disease transmission (e.g. use of bag-valve-mask ventilation), including potential for contact with blood or body fluids (e.g. sputum), AND/OR
- When the SCS/OPS environment has an increased likelihood of communicable disease transmission, such as poor air circulation or ventilation, insufficient space to carry out drug poisoning response, or lack of regular cleaning and disinfection.

When using a bag-valve-mask, wearing a fitted respirator (e.g. N95) is recommended when there is elevated risk of airborne or aerosol transmission (eg if the client is unwell/ coughing, has a confirmed respiratory infection, or if risk is unknown).

If using a bag-valve-mask, a HEPA filter attachment can provide additional protection to reduce aerosol transmission of communicable disease. Continue to wear appropriate PPE when using this added measure.

OCCUPANCY LIMIT

Occupancy numbers are determined by physical space and staff capacity. Adjust capacity in the event of staffing shortages. Your site might consider having a sign.

EMERGENCY PROCEDURES

SEE APPENDICES A-K

OPIOID OVERDOSE

An opioid overdose is when the body is overwhelmed by exposure to an opioid drug. In this case, a toxic amount of one drug or a combination of drugs causes the body to be unable to maintain or monitor functions necessary for life. The primary functions are breathing, heart rate, and regulating body temperature.

The BCCDC Toolkit: Responding to Opioid Overdose for BC service providers (2020) is a recommended resource which aims to help people who work in opioid overdose prevention and response. It provides the necessary resources to help train staff on how to respond effectively.

Common opioid drugs:

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

Signs/symptoms of opioid use:

- Tiny pupils
- Pale, cold or clammy skin
- Blue lips or nails
- Depressed level of consciousness: drowsiness, nodding, decreased respirations
- Unusual snoring, gurgling sounds or choking could mean that the person cannot protect their airway on their own
- Slow, shallow, irregular or no breathing – less than 1 breath every 5 seconds (less than 10 breaths/min)
- Unresponsive (to voice and pain) – can't be woken up
- Low levels of oxygen in the blood: SpO2 lower than 90%

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Staff response for suspected opioid overdose:

1. Call 911
2. Put on PPE and check for safety of all staff and participants
3. Use the **SAVE ME** steps:
    a) **S**timulate: use your voice first (shout their name if you know it) before touching and always tell someone before you touch them. If no response to voice try squeezing trapezius or nailbed to see if they respond to pain.
    b) **A**irway: head-tilt and lift chin. Check mouth for objects and clear if needed. Assess for the safe insertion of an oropharyngeal airway, if trained to do so.
    c) **V**entilate: if trained to do so use a bag valve mask (BVM) to give 2 rescue breaths (you should see the chest rise and fall. If not, reposition the BVM) then provide 1 breath every 5 seconds, see *Pocket Guide* (**APPENDIX D & G**, pages 57 & 60).
    d) **E**valuate: check for breathing/circulation or signs of consciousness, see *Pocket Guide* (**APPENDIX C**, page 56)
    e) **M**uscular injection of naloxone: if they are not consciousness prepare naloxone by swirling the vile to make sure all the medication is at the bottom. Then snap open the vial and draw up the naloxone. Using a Vanishing Point needle, inject the naloxone into a muscle (e.g., shoulder, thigh or buttocks).
    f) **E**valuate: continue rescue breathing for 3-5 minutes. If no response, give 2nd dose of naloxone. Wait 3-5 minutes, continue rescue breathing. If no response, give 3rd and/or additional doses of naloxone.
    g) Remove any furniture and equipment that may pose a hazard or block an exit/entrance route for EHS.
    h) Continue **SAVEME** steps until EHS arrives or person becomes responsive.
4. **Debrief:** Access debriefing services and additional support as needed from leadership

If the participant has no pulse or it was an unwitnessed event, start CPR right away. Bring an AED and be prepared to use it by following machine prompts.
Refer to the Opioid Overdose: Advanced Interventions in Supervised Consumption Settings (VCH)
SEE APPENDICES A-K, pages 52-64

STIMULANT OVERAMPING

Stimulant overamping can be challenging to identify. Overamping (versus overdosing) is the preferred term when referring to stimulants because it does not mean taking too much of a stimulant. Overamping can be caused by a variety of factors.

Factors to consider for overamping:

- Patterns of stimulant use: acute vs. prolonged binge (e.g., 'on a run'). The latter are more likely to present with stimulant-induced psychosis
- Type of stimulant taken – is this known?
- Dose of stimulant taken- is this known? Did they take too much?
- Mixing – have they been taking other drugs recently?
- Amount of sleep - are they sleep deprived?
- Eating/drinking – are they getting enough food and water?
- Underlying health conditions
  Setting - are they in a safe familiar space or not?

Common stimulant drugs:

- Methamphetamine
- Amphetamine
- Cocaine/Crack
- Bath salts (Cathinone)
- Ritalin (Methylphenidate)
- Ecstasy/MDMA/Molly
- 3-MMC (Metaphedrone)

Signs/symptoms of stimulant use:

- Dilated pupils
- Sweating
- Hyperactivity
- Hallucinations, paranoia
- Altered mood (elevated, euphoria, agitation)

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Signs/symptoms of stimulant overamping:

- Severe agitation
- Muscle rigidity, clenched jaw or teeth, grinding of teeth
- Severe headache
- Increased aggressiveness
- Chest pain or tightness
- Numbness, paralysis or disrupted eyesight on 1 side of the body
- Seizure
- Respiratory distress

Staff response for stimulant overamping:

Do	Don't
• Call 911 • Provide support and stay with the participant until EHS arrives • Use given preferred names • Speak in calm reassuring tone • Use open-ended questions • Encourage not using any more substances • Offer damp cloth to cool forehead, back of neck, armpits • Give only small amounts of water • Move participant away from activity and noise • Remove any furniture and equipment that may pose a hazard or block an exit/entrance route for EHS • Ensure safety of all staff and participants	• Have direct eye contact • Make any sudden movements • Use 'no' language (to avoid verbal altercations) • Make any loud noises • Restrain any participant

***There is no antidote to a stimulant overdose. Naloxone will not help unless there is a possibility of an opioid cross contamination of the stimulant (any illicit stimulant).**

****For more information see Overamping Stimulant Overdose by Coalition of Peers Dismantling the Drug War (CPDDW)**

SEE APPENDICES A-K, pages 47-59)

UNUSUAL/COMPLICATED OVERDOSE PRESENTATION

Unusual presentations are when it is unclear whether a participant is overdosing, has mixed substances (intentionally/unintentionally), is showing symptoms of a health condition, or a combination of the above. Stimulant and opioid overdoses that are only one drug are easier to figure out. If there is a high likelihood of an opioid overdose, even if any of the below symptoms are not present, it is necessary and safe to administer naloxone.

Unusual overdose presentation could include:

- Involuntary movements seizures/flailing/dyskinesia, see *Seizures* (**APPENDIX I**, page 62)
- Fentanyl Induced Muscle Rigidity
- Restlessness
- Staring/gazing
- Able to follow simple direction when walking or awake, yet may also have a physical appearance of lacking oxygen (e.g., blue lips, greyish skin colour, cool to the touch skin)
- Vomiting
- Confusion
- Psychosis - when a participant experiences reality differently to other people
- Paranoia - irrationally a participant might feel that others are 'out to get them'
- Benzodiazepine (benzos) overdoses: look similar to opioid ODs however the person is STILL BREATHING, see Management of Prolonged Sedation, below, and *Should You Give Naloxone?* (**APPENDIX J**, page 63)

Responding to a suspected unusual overdose:

- Monitor participant: check oxygen and pulse rate levels with oximeter, see *Pocket Guide* (**APPENDIX E**, page 58)
- If participant loses consciousness and is able to breath on their own, use a simple face mask and oxygen (6-10L/minute)
- If participant loses consciousness and is not able to breath on their own: call 911 and administer naloxone immediately while administering oxygen with a BVM (15L minute), see *Pocket Guide* (**APPENDIX D & G**, pages 57-60)
- Call 911 if participant is behaving in a way that could cause harm to themselves or others, monitor from a safe distance
- If participant is moving in a way that is not at risk of harming themselves or others, monitor at a safe distance
- Ensure safety of all staff and participants. Ask other participants to clear the area
- Remove any furniture and equipment that may pose a hazard or block an exit/entrance route for EHS
- For more information for responding to unusual overdose see Management of Dyskinesia in Suspected Opioid Overdose

MANAGEMENT OF PROLONGED SEDATION

Background and Objectives:

There have been numerous incidents of toxic drug poisoning caused from substances other than opioids, in particular depressants such as benzodiazepines and xylazine. These sedating substances are in the unregulated drug supply across BC. In these cases, overdose presentation is similar to that for an opioid poisoning, however, the response and management requires different interventions. The purpose of this document is to support staff in responding to

overdoses presenting with prolonged sedation caused by non-opioid depressants to prevent risk of harm to the client needing clinical intervention.

Procedure

1. Assess for signs of prolonged sedation symptoms:

- Unresponsive to stimuli (voice or pain) and cannot be woken up for an extended period of time (minimum 15 minutes and can be as long as several hours).
- The person's breathing may be normal (respiratory rate >10/min, oxygen saturation spO2 >90%).

If the person is sleeping and can be roused by voice or pain (trap squeeze or fingernail pinch), this is NOT considered prolonged sedation, and does not need the below intervention. To ensure the person is not experiencing an overdose, it is still important to check on them every 15-30 minutes.

2. Calling 911:

- **Upon initial assessment, the person is unconscious, or not waking up with pain stimulation: call 911, no exception.**
    - If person is drowsy or nodding, and status does not improve after administering two doses of naloxone call 911: o when respiratory rate is below 10/minute
    - spO2 is below 90%
    - heart rate is below 60 beats/minute
    - to rule out other concerns such as heart attack, stroke, head injury
    - If suspected/confirmed non-opioid drug poisoning call 911: o when breathing is normal, respiratory rate is greater than 10/minute
    - spO2 is greater than 90%
    - drowsy/sedated and unrousable to stimuli for greater than 15-30 minutes
- Stay with the person and continue to monitor breathing and responsiveness until EHS arrives

When the person remains unresponsive, they need to be transferred to hospital to be monitored by a clinical team. Communicate to the EHS team when transferring the hospital:

- the # of doses of naloxone that was administered with no response
- the time the person has not been responsive
- the type of substance and route of consumption (if information is available)

Overdoses may be due to a combination of substances that includes opioids. A severe opioid poisoning requires multiple doses of naloxone to restore breathing back to normal. It can be difficult to tell the difference between severe opioid poisoning and prolonged sedation from contamination with non-opioid depressants.

3. Intervention:

- Always use SAVE ME steps check for and respond to signs of opioid overdose first.

- Give Naloxone if client is breathing less than 10x per minute or oxygen saturation is less than 90%. See algorithm below.
- Where suspected non-opioid depressants are the cause of overdose, administer naloxone if breathing less than or equal to 10x per minute, continue to assess and support ventilations. Naloxone does not work on non-opioid drugs. When naloxone in given in this case, the person may not wake up after naloxone injection but may still be breathing.
- If the cause of overdose is unknown, administer naloxone until the person is breathing again. The person may appear somnolent and non-responsive but is clearly breathing. Stop administering naloxone if this is the case.
- Apply oxygen as per opioid overdose guideline.

4. Monitor after naloxone and/or oxygen:

Ensure the person is breathing

- Monitor as per naloxone administration guidelines.
- Place person in recovery position on their side. Do not reposition sitting in a chair due to risk of airway restriction and falls risk.
- Check vital signs every 15 minutes with focus on respiratory rate, heart rate, oxygen saturation/SpO2
- Closely assess person's airway and oxygen:
  - Improved central and peripheral circulation can by seen with improved warmth to skin and returned normal skin tone
  - Ensure airway patency- head tilt/chin lift or jaw thrust
  - If they vomit, clear their mouth and check breathing

- If respiratory status improves, and person still appears drowsy/sedated but is responsive and rousable:
  - Allow to sleep and monitor closely as listed above
  - Do not allow more than 2 clients to remain in this state for observation at the site while caring for others who are actively using as it is very challenging for staff to manage. Due to the half-life of naloxone, there is a risk for the person to decompensate again, therefore, need to limit the number of people being monitored.
  - If unable to continue monitoring (eg: due to staff capacity or because site is closing), call 911 to transfer to hospital

5. Tracking Prolonged Sedation as an Overdose

- All prolonged sedation is considered an overdose event.
- Enter each overdose will be tracked on the VCH Data Collection Form same way as all other overdoses.

AFTERCARE

Post overdose it is important to:

- Debrief with staff and participants
- Address any post-OD intervention duties relevant for your site (e.g., restocking supplies, reporting: critical incident form, naloxone usage log, naloxone administration, OD response information form, supervisor notification, staff care plan).
- Alert extended community after more/different than usual overdoses (Overdose Alerts)
- Connect participants with VCH Overdose Outreach Team (OOT) for temporary case management support and/or information on BC withdrawal management/risk mitigation prescribing.
- Access mental health support as needed like Provincial Mobile Response Team (MRT)

NALOXONE HYDROCHLORIDE (NARCAN)

Naloxone is a highly effective yet safe antidote (reversal) medication to reverse an opioid overdose. Breathing is more important than naloxone, as it keeps the brain alive. Naloxone has a much stronger attraction for the same receptors in the brain as other opioids. This results in naloxone removing opioids and preventing them from attaching to the same receptors. Naloxone does not affect non-opioid drugs. It has no potential for abuse.

Naloxone is an important tool that helps quickly reverse an opioid overdose in addition to rescue breaths or oxygen with a BVM. The lack of oxygen to the brain is what causes brain damage or death. Using naloxone in addition to providing oxygen with a BVM or rescue breaths, see *Pocket Guide* **(APPENDIX D & G**, pages 52 & 55)**)**, helps to prevent brain damage or death. Naloxone has a relatively short half-life; time taken for half of the drug to metabolize in the body. The half-life of naloxone is 30-60 minutes which means it will leave the opioid receptors in 30-60 minutes. After this time a participant is at risk for recurrent overdose if there are still significant opioids in their system. For this reason, it is important to monitor a person for at least 30 minutes after administering naloxone. If the participant declines monitoring, encourage them to stay with other people who can re-administer naloxone and call for help for at least 2 hours after the first overdose.

Continued next page

Administering naloxone assists to help:

- Increase breathing rate
- Increase alertness

More than 1 dose of naloxone maybe needed to reverse an overdose depending on the severity. The recommended wait time before administering another dose of naloxone is 2-5 minutes. During this time, it allows the body to absorb the naloxone.

Over-administering naloxone to any person may cause severe acute withdrawal symptoms. Giving more naloxone than necessary (for example, not waiting the recommended 2 to 5 minutes between doses) can cause a person to experience severe acute withdrawal symptoms, such as:

- Anxiety, irritability, aggression
- Sweating
- Nausea, vomiting, diarrhea
- Stomach cramps
- Fast pounding heart rate
- Tremors or shaking

At the beginning of shift staff should identify who will administer naloxone and who will focus on managing airway with oxygen and BVM, see *Pocket Guide* (**APPENDIX F & G**, pages 54-55). For team roles cards, see *Pocket Guide* (**APPENDIX B**, page 48**).**

More information at Toward the Heart

FIRE, EARTHQUAKE & OTHER EMERGENCIES

Staff should be prepared as much as possible in the event of emergencies by developing a site-specific emergency plan. This helps to ensure the safety of all participants and staff If you need help creating emergency plans, contact OverdoseResponse@vch.ca.

All fire exits must be identified with signs and must never be blocked.

Continued next page

If you see a fire follow RACE procedure:

- **R**escue: if safe to do so, remove participant from immediate danger
- **A**larm: call 911 or pull fire alarm and give the location and description of fire. Tell dispatcher that there are bio-hazardous materials (sharps and other used harm reduction supplies) on site
- **C**ontain: if possible, close doors to enclose the fire
- **E**xtinguish: if the fire is small, use an extinguisher by following **PASS**
  - **P**ull: pin
  - **A**im: extinguisher
  - **S**queeze: handle
  - **S**weep: hose or nozzle side to side

Evacuation to offsite meeting area

Designate an offsite meeting area where staff will meet in the event of an evacuation. Leadership is responsible for ensuring that all staff & participants are present and accounted for, at the designated offsite meeting area. Staff will then decide when/if it is safe for staff to re-enter the site.

Staff must ensure that all participants exit the site quickly and safely. Staff are not to leave the area until all participants are vacated and the area is secured (unless staff themselves are at risk).

NEEDLESTICK INJURY / BLOOD AND BODILY FLUID EXPOSURE PROTOCOL

See *Booth (Station) Cleaning & Needle Stick Injuries* (APPENDIX L, page 65):

1. Immediately clean the puncture wound with warm water and soap, or an antiseptic soap for 5-10 minutes
2. Report the needlestick injury to leadership or supervisor
3. Go directly to your local emergency department. Due to a needlestick injury you are requesting an assessment for workplace exposure to blood-borne pathogens, which needs to be done within 2 hours of the needlestick injury.
4. If the source participant of the exposure is known, site leadership/supervisor can ask that participant to attend the ER with you, if they consent to having a blood test for blood-borne pathogens.

EYE SPLASH EXPOSURE (FOREIGN SUSTANCE IN EYE)

Eye Splash (Foreign Substances In Eye) Protocol:

1. Immediately flush eye(s) following instructions on eye wash station
2. If an eyewash station is not available: flush eye(s) with tap water for 10-15 minutes, either by holding irritated eye open under slow running water, or holding the eye open in water that is cupped by/in the hand and blink rapidly, then repeat
3. Report the eye splash exposure to leadership or supervisor
4. Go to the nearest ER if the substance was a chemical or there is a foreign body in the eye. Explain the situation to triage, asking for assessment for workplace eye splash exposure. This should occur within 2 hours of the incident.

SAFE HANDLING & DISPOSAL OF USED SUPPLIES

It is important to ensure that staff who handle or are at risk of accidental contact with a used needle are aware of safe handling and disposal of supplies, to minimize the risk of exposure. The primary cause of HIV infection in occupational settings is from needlestick injury exposure to infected blood. HIV infection after a needlestick injury is rare; however, HCV is more easily transmitted through a needle.

Continued next page

SHARPS/BIOHAZARD CONTAINERS

- Mounted upright at each work station
- Remove when 75% (three-quarters) full
- Move minimally within the OPS
- One designated area for full containers waiting for pick-up

***Under no circumstance should sharps be emptied into larger bins. This practice puts staff at risk of needlestick injury and blood and bodily fluid exposure.**

GARBAGE DISPOSAL

- Use waterproof/thick plastic garbage bags to reduce the risk of any sharp items puncturing the bag
- Placing a few large central trash bins throughout the site reduces the risk of used/unused uncapped rigs being disposed into them, whereas, having a trash bin at each station has a higher risk of this happening
- Keep physical handling of garbage to a minimum (e.g., at the end of shift or when a bin is nearly full
- Keep garbage in large bin; when emptying garbage move bin to dump bag in garbage area
- Be Alert! If possible, look for sharps protruding from garbage bag, and listen for broken glass when moving the bag
- Do not compress garbage or reach into garbage containers with your hands or feet
- Do not use bare hands when handling garbage: wear puncture- and liquid-resistant gloves, or use other tools designed for picking up garbage (e.g., tongs)
- Do not let garbage get too full. Leave enough free space at the top of the bag, so that when grabbing it, only the top of the bag (and not contents) are grabbed
    - Alternately consider keeping garbage in the garbage bin and lift bin to dump into dumpster
- Garbage bags need to be changed frequently to prevent from getting to full and heavy
- Hold used garbage bags by the top of the bag, away from your body: do not hold garbage bag against your body
- Do not place hands under the bag to support it

PICKING UP USED INJECTION OR INHALATION SUPPLIES

- Use tongs to pick up rigs; if no tongs available, use a gloved hand to carefully pick up. Hold needle tip facing away from your body. Dispose of gloves and wash hands after.
- If no sharps container available, put used sharps (rigs/glass) in a puncture-resistant can or jar with a lid.

- Can help reduce staff exposure. Staff have a role in educating and advising participants about the kind of containers that are safe.
- Participants can check with their local pharmacy to see if used injection supplies can be returned for disposal.

DEATH PROTOCOL

Upon a death of an participant in the OPS, staff must:

1. Call 911 to request immediate assistance
2. Secure the immediate area around the individual and prohibit access to the area to other participants
3. Advise leadership immediately
4. Refer to your agency protocol

Offer debriefing opportunity for staff and participants and/or connect with the Provincial Mobile Response Team (BC) for psychosocial support after a death or complex overdose response.

WEB LINKS

In order of appearance in this document:

Pg #	Name & Hyperlink
9	Emergency Health Services Act
	https://www.bclaws.gov.bc.ca/civix/document/id/mo/hmo/m0488_2016
10	Take Home Naloxone (THN)
	https://towardtheheart.com/naloxone
10	THN New Site Registration form
	https://towardtheheart.com/assets/uploads/1531779615COk10E1lXnv89HBMei7H1mMkyexYZ1PBG0Of1wV.pdf
10	THN Supply Order form
	https://towardtheheart.com/assets/uploads/1593211076TNuKS9hqIpaFNKs6frqvWBey7I80E04HmnfoMiq.pdf
10	Facility Overdose Response Box (FORB)
	https://towardtheheart.com/forb
10	FORB New Site Registration form
	https://towardtheheart.com/assets/uploads/1528131864rTV0JruXXo7EO39b0I5FHheY7CXL6Olz1fImsfG.pdf
10	FORB Supply Order form
	https://towardtheheart.com/assets/uploads/1612991129ljexSahAma2bgrR9nfTZxeKZpcpmEalUPyYZFA4.pdf
11	BCCDC Harm reduction program supply requisition form
	http://www.bccdc.ca/resource-gallery/Documents/HR%20Req%20Form_07_Jul_2017.pdf
11	Drug checking
	http://www.vch.ca/public-health/harm-reduction/overdose-prevention-response/drug-checking
11	Drug Checking map
	https://5704661b-9f13-44ae-ac64-518d1916cea7.filesusr.com/ugd/d2e12e_3b645bc1537d40288ec8c9fba3960535.pdf
11	OPS and Supervised Consumption Site (SCS) Map
	http://www.vch.ca/Documents/VCH-overdose-alert.pdf
11	Spectrometer availability at OPS and Supervised Consumption Sites
	http://www.vch.ca/Documents/VCH-overdose-alert.pdf
11	Get Your Drugs Tested
	https://getyourdrugstested.com/
11	Provincial Toxic Drug Alerts
	https://towardtheheart.com/alerts
12	Naloxone Train the Trainer
	https://towardtheheart.com/naloxone
12	Learning Hub
	https://learninghub.phsa.ca/Learner/Home
13	OPS Daily Collection
	https://vchhealthsurvey.phsa.ca/OPSdata.survey
13	Overdose Prevention, Recognition and Response
	https://towardtheheart.com/naloxone-training
13	Opioid Overdose: Management of Suspected Opioid Overdoses in Community Settings (Adult & Youth) for Allied Health & Unregulated Care Providers
	http://shop.healthcarebc.ca/PHCVCHDSTs/BD-00-07-40094.pdf

13	Online Street Degree: Advanced Overdose Response
	https://learninghub.phsa.ca/Courses/27846/online-street-degree-advanced-overdose-response
13	Online Street Degree: Managing Medical Emergencies
	https://learninghub.phsa.ca/Courses/28485/online-street-degree-managing-medical-emergencies
13	Online Street Degree: First Responder Collaboration
	https://learninghub.phsa.ca/Courses/28486/online-street-degree-first-responder-collaboration
14	A Guide to Promoting Staff Resiliency
	https://towardtheheart.com/assets/uploads/1498603569uLoegEpvU14s7SqwcwLiarQYrM2ce2RW66ET9NW.pdf
14	Provincial Overdose Mobile Response Team
	http://www.phsa.ca/our-services/programs-services/health-emergency-management-bc/provincial-overdose-mobile-response-team
14	Overdose Community of Practice
	https://www.overdosecommunity.ca/
14	Orientation Training & Support
	Refer to all information and links on page 14 of this manual
17	Risk Assessment for Leaving a Fixed Site to Response to Intervene in a Suspected Opioid Overdose
	http://shop.healthcarebc.ca/vch/VCHDSTs/D-00-16-30117.pdf
17	Office of Controlled Substance (Health Canada)
	https://www.canada.ca/en/health-canada/corporate/contact-us/office-controlled-substances.html
17	Disposal of Harm Reduction Supplies
	Refer to information and links on page 28 of this manual
19	Youth
	Refer to information and links on page 20 of this manual
19	Refusal of service (VCH)
	Refer to information and links on page 22 of this manual
20	Sheway
	http://www.vch.ca/locations-services/result?res_id=900
20	Fir Square
	http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/pregnancy-drugs-alcohol
20	Overdose Outreach Team
	https://www.vch.ca/en/service/overdose-outreach-teams#short-description--7006
22	BC Handbook for Action on Child Abuse and Neglect, 2017
	https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/childabusepreventionhandbook_serviceprovider.pdf
22	BC Coroner's Service, 2024
	https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/youth_unregulated_drug_toxicity_deaths_in_bc_2019-2023.pdf
22	Child, Family and Community Service Act
	https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96046_01
23	Eligibility Criteria
	Refer to information and links on page 19 of this manual
26	VCH's Overdose Prevention & Response in Washrooms recommendations
	http://www.vch.ca/Documents/Washroom-Checklist-Service-Settings.pdf

27	Harm Reduction Resources, Skin Infections (Toward the Heart)
	https://towardtheheart.com/assets/uploads/1643053417hm9DDmdewRb9CLp0AlYyn80BlQWXaMmteuUDftI.pdf
26	Secondary Problems Related to Injection Drug Use
	Refer to information and links on page 26 of this manual
29	VCH Safer Smoking
	https://vch.eduhealth.ca/en/viewer?file=%2fmedia%2fVCH%2fDB%2fDB.500.S343.pdf#search=safer%20smoking&phrase=false
29	VCH Safer Injecting
	https://vch.eduhealth.ca/en/viewer?file=%2fmedia%2fVCH%2fDB%2fDB.500.S34.pdf#search=safer%20injecting&phrase=false
29	Canadian AIDS Treatment Information Exchange (CATIE)
	http://librarypdf.catie.ca/ATI-70000s/70220.pdf
29	Safer Crystal Meth Smoking (CATIE)
	https://www.catie.ca/client-publication/safer-crystal-meth-smoking
29	Safer Crack Smoking (CATIE)
	https://www.catie.ca/client-publication/safer-crack-smoking
29	How to Booty Bump Better (San Francisco Aids Foundation)
	https://www.sfaf.org/collections/beta/how-to-booty-bump-better/
31	Tobacco and Vapour Products Control Act
	https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96451_01
32	BCCDC BC Overdose Prevention Services Guide
	http://www.bccdc.ca/resource-gallery/GuidelinesBCOverdosePreventionServiceGuide_Jan2019.pdf
33	BCCDC: Communicable Disease Prevention: Responding to Drug Poisoning at Overdose Prevention Services and Supervised Consumption Sites
	http://www.bccdc.ca/Documents/CD_PreventionRespondingToDrugPoisoningsInOPS_FINAL%20June%208%202023.pdf
34	Point-of-Care Risk Assessment (PCRA)
	https://picnet.ca/wp-content/uploads/Point-Of-Care-Risk-Assessment-Tool-2023-July-25-FINAL.pdf
35	BCCDC Toolkit: Responding to Opioid Overdose for BC service providers (2020)
	https://towardtheheart.com/assets/uploads/1610668700M5CUWes9iDssX45XdoCISipddL2uVyX08CmViUF.pdf
36	Opioid Overdose: Advanced Interventions in Supervised Consumption Settings (VCH)
	http://shop.healthcarebc.ca/vch/VCHDSTs/D-00-13-30230.pdf
38	Overamping Stimulant Overdose
	https://1f79feed-35c3-4e11-be4f-b08e8bd6b24c.filesusr.com/ugd/1d8327_0acdcff9158046dca056289a7172a5c0.pdf
39	Fentanyl Induced Muscle Rigidity
	https://towardtheheart.com/assets/uploads/1539205695NfwcNy9kkIOIdZeFXV3xfr0yGPp66bvrrGfhidD.pdf
39	Management of Dyskinesia in Suspected Opioid Overdose
	http://shop.healthcarebc.ca/vch/VCHDSTs/D-00-12-30375.pdf
39	Overdose Alerts
	Refer to page 11
42	Overdose Emergency Response Team
	http://www.vch.ca/locations-services/result?res_id=1422
42	Provincial Mobile Response Team (MRT)
	https://www2.gov.bc.ca/gov/content/overdose/mobile-response-team
43	Toward the Heart
	https://towardtheheart.com/
47	Provincial Mobile Response Team (BC)
	https://www2.gov.bc.ca/gov/content/overdose/mobile-response-team

APPENDIX A: OVERDOSE RESPONSE CHECKLIST

Overdose Response Checklist:

☑ CHECKLIST	DETAILS TO CHECK
☐ **OPIOID OD RECOGNIZED** **TIME:____**	☐ **Alertness:** decreased or not responsive ☐ **Breathing:** decreased (less than 1 breath every 5 seconds) or absence of breathing. May also hear snoring or gurgling ☐ **Pale face and skin** with **blue to lips** and/or finger tips
☐ **STIMULATE**	☐ Call their name. If no response, sternal rub/trap squeeze and encourage breaths. Tell the person before you do any interventions on them ☐ If no response, call for onsite help
☐ **CALL 911**	☐ **Yes** (if NO response) ☐ **No** (if mild OD or able to stimulate person to breathe) *Put them in recovery position if you have to leave* ☐ Check pulse. **No pulse**=start CPR and get AED if available
☐ **OPEN AIRWAY**	☐ Open airway with head tilt, chin lift ☐ Clear airway of food, gum, rig caps, fluid, etc ☐ Insert oral airway if trained
☐ **GIVE BREATHS**	☐ **Simple Plastic Shield Mask:** pinch the nose and give **1** breath every **5** seconds until the person is breathing or ambulance arrives ☐ **Triangle Mask:** triangular end to cover the nose and flat end to chin, give **1** breath every **5** seconds ☐ **BVM:** use the thumb and forefingers of both hands to form a seal around the triangle mask, and squeeze about ½ of bag to give **1** breath every **5** seconds
☐ **OXYGEN**	☐ Give O_2 at 15 L/ min if using BVM **Time:_____** ☐ Give O_2 at 10 L/ min if using simple O_2 mask **Time:_____**
☐ **GIVE NALOXONE INTRAMUSCULAR** Swirl ampoule, snap top off, draw up, remove extra air	☐ 1 ampoule (0.4mg) Time:_____ Time 2nd dose:_____ Time 3rd dose:_____ ☐ 2 ampoules (0.8mg) Time:_____ Time 2nd dose:_____ Time 3rd dose:_____ *2 amp (0.8mg) if severe OD as per protocol
☐ **EVALUATE RESPONSE**	☐ **Continue giving breaths** until they respond: ↑Alertness ↑Breathing ↑Colour ↑Saturation (>90%)
☐ **AFTERCARE**	☐ Send to hospital or monitor at least 2 hours. Discourage use of opioids (Naloxone wears off in 20-90 minutes) and discuss harm reduction strategies) ☐ Lead responder gives report to Ambulance/Fire including: type of drug, time of OD, time breaths given, # of doses Naloxone ☐ Fentanyl check: **Positive ❑ Negative ❑** ☐ THN Kit and teaching: **Yes ❑ No ❑** ☐ Connect to Overdose Outreach Team(604-360-2874): **Yes ❑ No ❑**

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX B: STAGE OVERDOSE CARDS & TEAM ROLES (POCKET GUIDE)

Respond to a **MILD** overdose

Appearance	Drowsy
Respiratory Rate (RR)	At least 1 every 5 sec
Oxygen Saturation (SpO_2)	Over 90%
Level of Consciousness	Alert or Drowsy

- **Don't call 911**
- **Stimulate** by talking, encourage breaths, or use sternal rub/trap squeeze
- **Observe and monitor** respiration and consciousness until back to normal

If respiration or consciousness worsen, go to **Moderate** OD

Respond to a **MODERATE** overdose

Appearance	Nodding
Respiratory Rate (RR)	Less than 1 every 5 sec
Oxygen Saturation (SpO_2)	81 to 90%
Level of Consciousness	Eyes closing, confused, may not respond to voice or touch

- **CALL 911** If no response to stimulation
- **Stimulate** by talking and encourage breaths. Use sternal rub/trap squeeze to wake
- **Apply O_2** 6-10 liters per min by simple face mask or support breaths using pocket mask. If SpO_2 less than 90% and no simple mask available, hold bag-valve mask over face at 15 liters per min
- **Administer Naloxone** 0.4mg intramuscular. Repeat dose of 0.4mg every 3-5 min until respirations over 10/min, SpO2 over 90%, and alertness increases
- **Monitor** respiratory status
- **Observe** for two hours or send to hospital for observation

If SpO_2 decreases to less than 80%, respiration decreases to less than 10, or client appears blue, go to Severe OD

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

Respond to a SEVERE overdose

Appearance	Unresponsive or BLUE
Respiratory Rate(RR)	No respirations OR Gasping/Gurgling
Oxygen Saturation (SpO_2)	Less than 80% *Note: Very pale skin and blue/grey lips means the SpO_2 is about 66%*
Level of Consciousness	Eyes closed, confused or not talking, NO response to pain

- **Call 911**
- **Airway/Oxygen (O_2):** Open airway using head tilt/chin lift or jaw thrust. If trained (with manager approval) insert oral airway to prevent tongue from blocking airway. Give oxygen at 15 liters/min attached to bag-valve. Watch for chest rise to ensure a good mask seal. Readjust head position if needed

  Note: *with chest rigidity, chest may not rise

- **Administer Naloxone 0.4mg (1 vial) intramuscular**
  - **If SpO_2 and RR increase within 2 min, continue with SAVE ME steps and repeat giving 0.4mg Naloxone every 3-5 min apart as needed until RR over 10/min and SpO_2 over 90%**
  - **If SpO_2 and RR do NOT increase within 2 min, administer 0.4mg – 0.8mg (2 vials)Naloxone at 2 minute intervals until SpO_2 and RR improve**

If client loses pulse, begin CPR, continue to assist ventilation

Respond to a SEVERE overdose

- **If vomiting:** Turn head to side, clear out airway, and use suction if available
- **If delirious:** Provide assurance and re-orientation to time and place. Give space

If status does not improve, be sure 911 is called

If any or more of the following, this is a complex overdose:

- ✓ Muscle rigidity:
- ✓ *Jaw clenching*
- ✓ *Wooden chest or chest wall stiffness*
- ✓ Flailing limbs or hands flexed inward at wrists and elbows
- ✓ Seizures
- ✓ Walking overdoses
- ✓ Staring gaze
- ✓ Slow or no heart rate
- ✓ Vomiting
- ✓ Extreme confusion/psychosis

Feb-18

Vancouver Coastal Health

Team Roles

Before every shift, decide who does what:

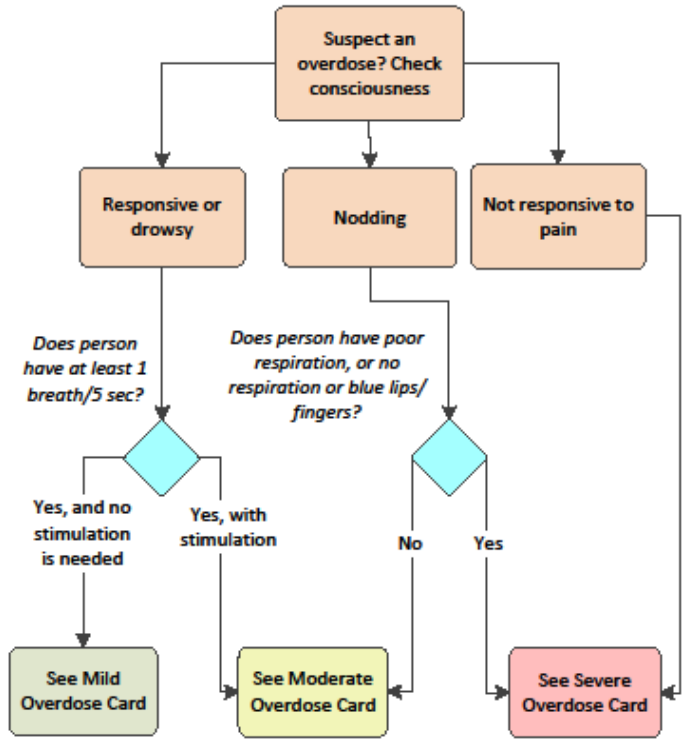
Role	Responsibilities
#1/Lead	• Call **911** • Administer naloxone **2-5** min apart • Oversee the response and monitor the time • Tell resident or someone to let ambulance/fire in • Report to ambulance/fire
#2/ Airway	• **Open and clear the airway** • Place the oximeter • Check respirations and chest rise • Hold the face mask or Bag-Valve-Mask (good seal)
Breathing	• **Administer breaths every 5 sec** OR • Squeeze the half the BVM bag **every 5 sec** (+ check for chest rise) **until** ambulance arrives or the person wakes up

Sep-21 Sep-21

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX C: ASSESSING OVERDOSE SEVERITY & RESPIRATION (POCKET GUIDE)

Assessing Overdose Severity



Note: If any one or more of the following, this is a **Complex Overdose** (See Complex Overdose Card):

- Muscle rigidity (e.g., *jaw clenching, "Wooden chest" or chest wall stiffness)*
- "Flailing" limbs or hands flexed inward at wrists and elbows
- Seizures
- "Walking" overdoses
- Staring gaze
- Slow or no heart rate
- Vomiting
- Extreme confusion/psychosis

Assessing Respiration

Use your eyes, skin, and ears

- Eyes – chest is rising?
- Skin – Do you feel respiration on your cheek?
- Ears – Do you hear respiration from the mouth or nose?

Count the respirations

- Over 1 every 5 sec → OK
- Less than 1 every 5 sec → give breaths

Has the colour of the person changed?

- Blue / grey / blue lips / blue fingertips
- Give breaths and O2 if available

Using an oximeter

- Always assess the person before reading the number
- Over 90% → OK
- Less than 90% → Need O2!!

Always call 911 when respiration is compromised

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX D: OXYGEN USE CHECKLIST WITH BVM (POCKET GUIDE)

Oxygen use checklist

- Complete the *oxygen safety checklist* **every shift**
- Check pressure gauge on the tank **before** starting each shift and **after** every use:

At 1000 PSI or less, switch for a new O2 tank

- To prep, make sure hose on bag-valve-mask (BVM) is **connected** to the tank
- Remove plastic cover from face mask
- Place bag-valve-mask back in bag and hang from tank, so it is ready to use

Do not smoke near oxygen tanks or when O2 is in use!

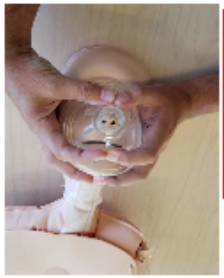
Keep open flames away from tanks at all times

Keep oxygen in its stand or trolley to reduce the risk of it falling over

Sep-21

Bag-valve-mask (BVM) (2 person response)

- **Be sure the airway is clear**; scoop out any objects or fluids if necessary
- Start with the **head-tilt chin-lift** to open the airway
- 1st person: Form a **seal** with the mask, pointy end to the nose and straight end over the mouth. Make a "C" grip with your thumb and forefinger and an "E" grip under the chin with your other fingers



Lift the jaw/chin up into the mask rather than pushing the mask down onto the face

- Turn oxygen tank on to **15 liters** of O_2 [15-25L range]
- 2nd person: Squeeze about **a third** of the bag every **five seconds** (counting out loud "1 one thousand, 2 one thousand", etc.)
- Watch for **chest rise**, improved color, and monitor O_2 saturation if possible (should be **over 90%**)

Sep-21

NOTE: DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT

APPENDIX E: OXIMETER & AED (POCKET GUIDE)

Oximeter guide

Goal: measure oxygen level in the blood and pulse rate

How to use:

- Clip the oximeter on the finger (nail polish can decrease the reading)
- Wait 2 seconds, the oximeter will power on automatically
- After a few seconds read the percentage

Possible reasons for bad reading:

- Person is moving/agitated
- Hands are cold
- Oximeter is not placed far enough on the finger
- Batteries are dead
- Fingers are wet or dirty
- Polish on nails or long nails

Try another finger if you do not get a reading number

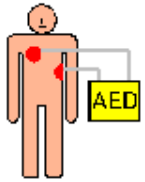
Always look at the person 1st (respiration, colour, airways…) to interpret the numbers

Normal range:
Saturation of O2: between 90% and 100%
Pulse: 60 to 100 beats per minute for adults

Oct-21

AED (Automated External Defibrillator)

- Call 911 if irregular or no heart rate
- Turn on the AED (know the location of the closest AED)
- Check the person:
  - Pull the person clear from any water or fluids
  - Remove all clothing, jewellery and medical patches that may come in contact with the pads
  - Make sure the chest is dry and free of hair
- Follow the diagrams on the pads to place them on the person:



If you see a small scar and lump on the chest, apply the pads about 2.5 cm (1 inch) away from the lump

- Follow the AED's instructions. When the AED prompts you to give a shock, stand clear
- **Make sure that no one is touching the person during the shock phase**
- If shock not delivered or unsuccessful, **continue CPR** until paramedics arrive

Oct-21

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APPENDIX F: AIRWAY POSITIONING & ADJUNCT AIRWAYS (POCKET GUIDE)

Adjunct Airways

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Oropharyngeal Airways (OPA)

- Indicated to maintain an oral airway when someone becomes unconscious
- Inserted into the mouth towards the throat
- For UNCONSCIOUS persons only otherwise the gag-reflex could lead to vomiting and aspiration
- Prevents tongue from making contact with the back of the throat and prevents teeth and mouth from closing during ventilation
- Before inserting check that:
  - Person is unconscious
  - Person has no oral trauma
  - Correct size is being used
  - Using head-tilt, chin-lift

Inserting an Oropharyngeal Airway

- Measure OPA: corner of mouth to earlobe
- Use tongue depressor or crossed-finger technique to open the mouth
- Tilt head back and hold lower jaw
- Gently slide OPA "tip up"
- When you feel the hard palate, rotate it so tip is down.
- *Watch for gag reflex
- Maintain head-tilt, chin-lift

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX G: WHEN TO GIVE RESCUE BREATHS, USE A BVM &/OR GIVE COMPRESSIONS

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When to give rescue breaths, use a Bag-Valve mask, and/or give compressions?

In a witnessed overdose, it is likely that the client's heart is still beating. Towards the Heart (BCCDC) recommends prioritizing giving breaths because the person is lacking oxygen due to depressed activity of the breathing center as part of the central nervous system. Breaths should be given every five seconds while preparing to administer naloxone.

Breaths are crucial to an overdose response to keep the brain alive!

If you come across someone who is unresponsive and suspect an overdose:

- Check the scene for safety, clear uncapped rigs or other hazards
- Confirm level of consciousness with a firm trapezoid pinch or by rubbing your knuckles on the sternum
- Check for breathing and carotid pulse (on the neck) for ten seconds max while looking for signs of cyanosis or insufficient blood oxygen, such as blueness around the lips or grey/whitish skin around the mouth for people with darker skin
- Open airway and give rescue breaths every five seconds while preparing to give naloxone
- In addition to breaths, if the person has been oxygen deprived for a long or unknown amount of time and you are CPR trained, give chest compressions in addition to breaths while preparing to administer naloxone

Simple Face Shield or Bag-Valve Mask (BVM)?

- A face shield with a one-way valve is easy to use and recommended by the BCCDC for those trained in the SAVE ME steps to respond to an overdose
- Managing ventilations with a BVM is a highly-skilled intervention that should only be use by trained professionals. Problems from improperly using a BVM are:
  1. Inadequate ventilations due to improper seal
  2. Over-ventilating leading to "popped" lungs (pneumothorax) or vomiting
  3. Difficulty maintaining airway while using the BVM

Would you give rescue breaths, chest compressions, or both, in the following scenarios?

a. Clients observed their friend overdosing and come find you immediately	
b. You are doing a room check and come across a resident who is unconscious and not breathing	
c. You watch a client slump over and stop breathing	
d. On your scheduled bathroom check you find a client unconscious but gurgling and taking shallow breaths	

*Although liability related to administering naloxone is a common concern, there are no known legal action cases. Bystanders who respond to a suspected opiate overdose are protected under the BC Good Samaritan Act.

References:

Pozner, C. M. (2016, April) Basic life support (BLS) in adults. Retrieved December 12th from https://www.uptodate.com/contents/basic-life-support-bls-in-adults?source=search_result&search=basic%20life%20support%20in%20adult%20bls&selectedTitle=1~40

Wittels, A. K. (2016, January) Basic airway management in adults. Retrieved December 12th from https://www.uptodate.com/contents/basic-airway-management-in-adults?source=search_result&search=basic%20airway%20management%20in%20adults&selectedTitle=3~150

BCCDC (2016, November) Retrieved December 12th from http://towardtheheart.com/assets/uploads/THN%20Training%20Manual%20Final_2016.11.30.pdf

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX H: OXYGEN USE CHECKLIST

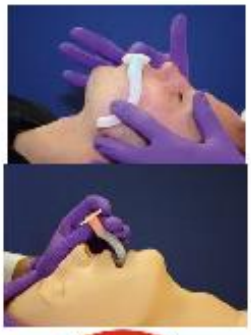
Oxygen Use Checklist:

- Check pressure gauge on the tank before starting each shift and after each use!
- At **1000 PSI** or less switch out for new O2 tank
- To prep, make sure hose on bag-valve-mask (BVM)/Ambu Bag is connected to the tank and ready
- Remove plastic cover from face mask
- Once ready, place BVM/Ambu Bag back in bag and hang from tank, so it is ready to go

Using a BVM/Ambu Bag (Ideally a 2-person response):

- Be sure the airway is clear; scoop out any objects or fluids if necessary
- Start with the head-tilt chin-lift to open the airway
- Lift the jaw/chin up into the mask rather than pushing the mask down onto the face
- Form a seal with the mask pointy end to the nose and straight end over the mouth. Make a "C" grip with your thumb and forefinger and an "E" grip under the chin with your other fingers
- Turn oxygen tank on to 15 liters of O2
- Squeeze about a third of the bag every five seconds (counting out loud "one, one thousand"...)
- Watch for chest rise, improved color, and monitor O2 saturation if possible

Using an Oral Airway (only with manager approval and training):



- Measure from corner of the mouth to the ear lobe
- Insert oral airway upside down or along the cheek and turn into place towards the throat.
- If participant gags when oral airway inserted OR you don't have the right size, use BVM/Ambu Bag without an airway

Safety:

- Do not smoke near oxygen tanks or when O2 is in use!
- Keep open flames away from tanks at all times
- Keep the oxygen in its stand or trolley to reduce the risk of it falling over

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APPENDIX I: SEIZURES

Seizures

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Seizures may be the result of substance use, epilepsy, withdrawal from alcohol, electrolyte imbalance, brain injury, infection, or electric shock.

There are 3 major types of seizure:

- Generalized tonic-clonic (grand mal)
  - Sustained contraction of muscles followed by extension of limbs
  - 2-5 minutes in duration
  - Complete loss of consciousness
- Partial or focal
  - Involuntary arm or leg movements
  - Distorted sensations or periods of automatic movements with decreased or absent awareness
- Absence
  - Blank stare lasting for a few to many seconds

Response to any seizure type:

1) Call 911
2) If participant is standing or sitting, gently assist to the floor into recovery position, with a pillow under their head
3) Clear the immediate area
4) Loosen clothing around participant's neck and waist; remove glasses
5) Assess vital signs and follow associated protocols (e.g., blood sugar, oxygen)
   - During seizure activity, breathing might stop and start (apnea) for up to 45 seconds due to increased muscle tone
6) If seizure stops before 911 arrives, reassure participant and talk to them in a calm tone - they may not know what happened or where they are
7) Decrease potential sensory overload: minimal people, minimal stimulation
8) Encourage participant to remain for assessment

VCH: Seizures October 2021 V1

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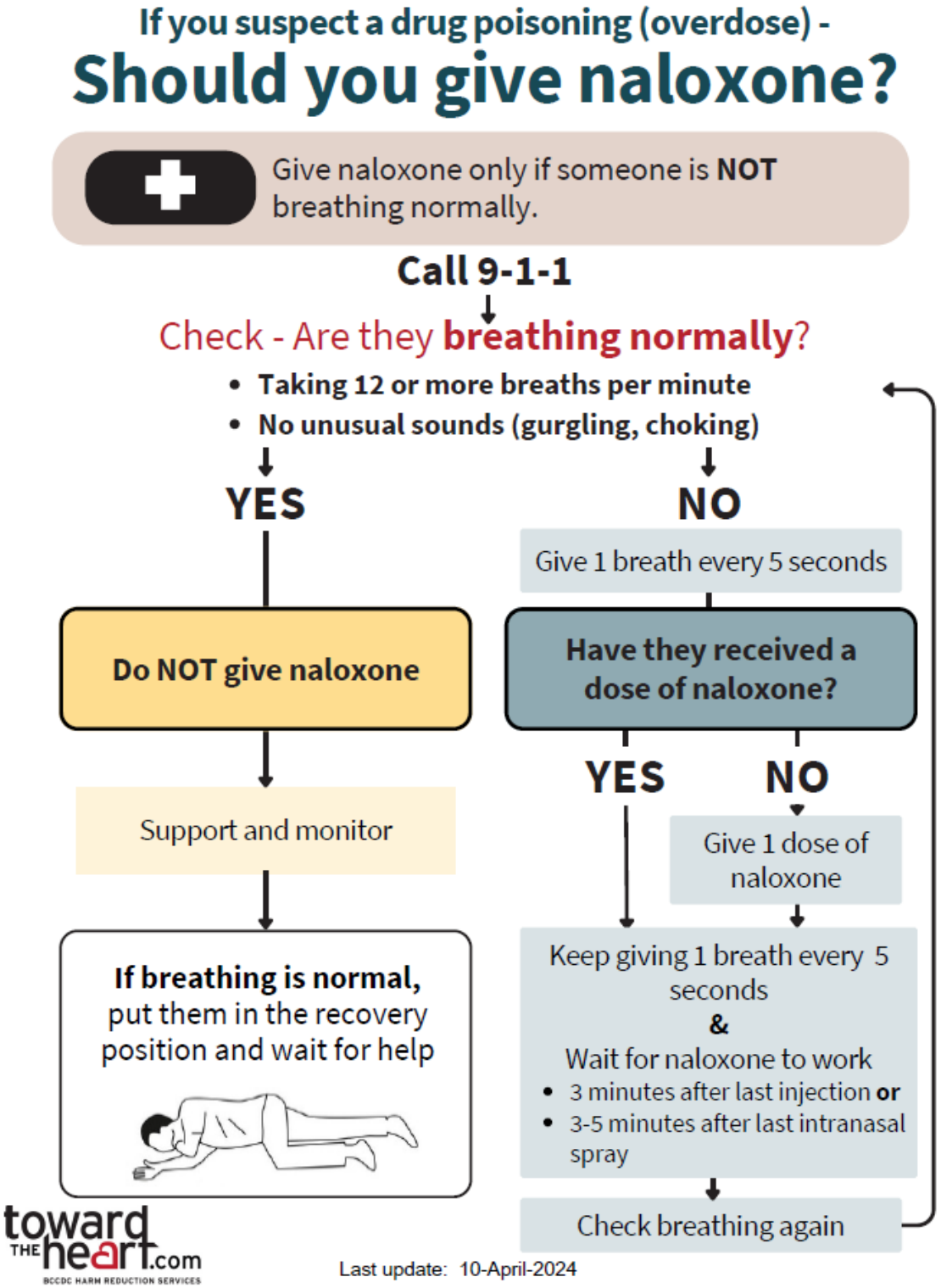
APPENDIX J: SHOULD YOU GIVE NALOXONE?



NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

Source: Towards the Heart: **Responding to Opioid Poisoning with Prolonged Sedation**. April 24. 2024

APPENDIX K: OVERDOSE RESPONSE EQUIPMENT CHECKLIST

Overdose Response Equipment Checklist

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Date															
Naloxone															
# of naloxone vials															
Expiry dates checked	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Need to order?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oxygen Tank															
O_2 tank functional	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
O_2 level >1000 PSI	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BVM , O_2 mask, & oral airway attached & checked	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OD pocket guide attached	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No smoking signs visible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tank upright in stand	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oximeter works	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# of O_2 tanks in stock															
Need to order tanks?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
AED															
Pads seal intact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pads exp. date > 1 mo	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto-test done (turn the AED on when lid is closed)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Extra set of pads in case	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emergency kit (scissors, razor, mask...)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Initials															

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX L: BOOTH (STATION) CLEANING & NEEDLE STICK INJURIES

Booth Cleaning

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Steps to Avoid Needle Stick Injuries

1) Wear thick, **black rubber gloves (puncture resistant)** for booth cleaning
2) **Encourage clients to clean** debris off their own booths
3) Don't let yourself get **distracted** when cleaning
4) Clean with your **eyes** first – glance over all surfaces that need wiping (look for broken needle tips)
5) Use **hand brooms** to sweep all surfaces - Never use your bare/gloved hands to take garbage off a booth
6) Wipe surfaces with a puncture resistant gloved hand and approved disinfectant

If you get stuck with a needle:

1) Immediately clean the puncture wound with warm water and soap, or an antiseptic soap for 5-10 minutes
2) Alert the RPIC/ARPIC on duty
3) Immediately go to Emergency Room (within 2 hours)
4) If the source participant of the exposure is known, site leadership/supervisor can ask that participant to attend the ER with you, if they consent to having a blood test

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX M: CODE OF CONDUCT - OPS

Code of Conduct - OPS

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New participants will be provided with the OPS Code of Conduct ("Rights and Responsibilities"). A copy of the OPS Code of Conduct will be kept on hand in all work areas and made available when required. If participants are denied access related to inability to adhere to the OPS Code of Conduct or do not meet eligibility criteria, they will have the right to seek redress with the RPIC (or their designate) and, failing that, to file a complaint or request an appeal.

Rights and Responsibilities of Participants of the OPS

Rights

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by Insite 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 not deal drugs to anyone else on-site.
- To not use alcohol while on-site.
- To only smoke drugs on site if your site has a smoking area with ventilation.
- 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 Manager or RPIC.

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APPENDIX N: PARTICIPANT (CLIENT) AGREEMENT

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STAFF USE (for statistical information only)

GENDER: _____

ETHNICITY: _____

Client Agreement, Release, and Consent Form

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

- I have used drugs in the past and I am in this facility for the purpose of using drugs, and I intend to use them regardless of any risks to my health or the health of my unborn baby, if I am pregnant.
- I will follow the direction of staff and the OPS Code of Conduct.
- I will remain in possession of my own drugs for use at all times.
- I authorize 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 Vancouver Coastal Health, and any of 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 and last initials)

DATE OF BIRTH: _____

VCH STAFF: _____

DATE: _____

OPS Identifier is: | |

This identifier you can use every time you come in, it could be your name, nickname, or a number – whatever is easiest for you to remember.

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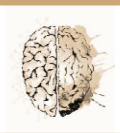
APPENDIX O: CARING FOR VULNERABLE POPULATIONS

Caring For Vulnerable Populations During a COVID-19 Public Health Emergency

Population Care Guidelines

Trauma and Violence Informed Practice (TVIP)



TVIP recognizes that services are provided in ways that value an individual's need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. Indeed, it is the application of three core concepts of person and family centered care; dignity and respect, information sharing and participation.

1. **Trauma Awareness:** Trauma is a common experience that people experience, and it can be central to personal development. People make a wide range of adaptations to cope and survive trauma, which result in a range of physical and mental health concerns.
2. **Safety and Trustworthiness:** Emphasis on physical, emotional and cultural safety is crucial. Environments where indivisual safety, choice and control is essential.
3. **Opportunity for Choice, Collaboration, and Connection:** Individual care must focus on self-determination, dignity and personal control. As safe connections and interactions are created, it may serve as a reparative experience for individuals coping with trauma.
4. **Strength Based and Skill Building:** Care providers partner with clients to identify strengths, and develop self-efficacy, agency, resiliency and coping skills.

Harm Reduction

Harm Reduction is both a set of service delivery practices, and a fundamental philosophical approach to providing equitable health promotion, illness & injury prevention, treatment and care across all areas of health care. There are 6 Guiding principles:

1. **Peer Involvement:** A peer is someone who may experience health harms related to drug use or sexual activity. Peers have a lot of knowledge and experience and must be involved in creating and delivering services for others.
2. **Priority of Immediate Goals:** Meet the client "where they are at" & their most pressing needs.
3. **Focus on Harms:** The goal is to decrease potential harms related to an activity, not to stop people from doing certain activities.
4. **Maximize Intervention Options:** By providing prompt access to a broad range of services, harm reduction helps keep people alive and safe.
5. **Human Rights:** respects the basic human dignity of people regardless of their activities, & emphasizes a person's right to choice & responsibility for their actions.
6. **Pragmatism:** Substance use & sexual activity happen in all communities, can have benefits for individuals, but can also have harms. We need to do everything we can to reduce any harms.

Culturally Safe Care

Cultural Safety reduces barriers to care, increases the quality and safety of services, positively impacts patterns of service utilization, improves clinical outcomes and leads to fewer disparities in health status between Indigenous and non-Indigenous people. There are 3 areas in which healthcare can be transformed:

1. **Inclusion of Indigenous Knowledge and Expertise in Health Care:** Indigenous communities are central in the identification, development, delivery and evaluation of health services for Indigenous people.
2. **Welcoming and Acknowledgment of Traditional Territory:** Indigenous people's connection to traditional and unceded territories is recognized as an integral component to Indigenous health, well-being and care.
3. **Right to Traditional Medicines:** Indigenous cultural practices are included in culturally competent health care delivery for Indigenous people. Indigenous people have an inherent and recognized right to access cultural practices as part of their health care plan.

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APPENDIX P: SUPERVISED INJECTION INTO A JUGULAR VEIN

Supervised Injection into Jugular Vein

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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 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 or near jugular vein could potentially cause compression or narrowing of airway
- An infection in the jugular could easily travel to the brain or heart.
- An air embolus can easily enter the blood stream during jugular injection and travel into the heart and coronary arteries (causing a heart attack), the brain (causing a stroke), or to the lungs (causing a pulmonary embolism). Air is more likely to enter through injection into the Jugular vein because of the lack of valves and the negative pressure in the jugular associated with inspiration.

It is part of the role of the nurse to provide injection education, within the context of harm reduction, with regards to injecting into the jugular vein.

It is the role of all staff to build a trusting and therapeutic relationship. Staff are to be constantly scanning the room for opportunities for education while performing daily tasks, as well as for overdoses.

If staff notice a participant injecting into the jugular, staff are to approach and offer education, such as safer veins to inject. Staff should determine:

1) Participant's rationale for using the jugular, and participant's knowledge of risks of injecting into the jugular
2) Whether the participant has any visible or palpable venous access other than the jugular
3) Whether or not the participant is able to inject their drugs intramuscularly

Based on the above, staff should do the following, in priority sequence:

1) Educate the participant to self-inject into a different vein.
2) Educate the participant to self-inject intramuscularly.
3) Educate the participant about the risks involved with injecting into the jugular IF and only IF the participant is determined to do so.

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX Q: YOUTH INTAKE FORM - OPS

Youth Intake Form OPS

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Date: _____ Name & last initial: _____
Handle: _____ Date of birth: _____

***Youth under 16 must meet in person with the site manager or shift coordinator**

Drug(s) of Choice (DOC) and route (injection/ inhalation/ other):

_____

Teams/ services or clinics that youth is connected to (including MCFD or Indigenous Agency)

_____

_____

_____

_____

_____

- ☐ Offer referral to Youth CAIT at 604-209-3705
- ☐ Discuss harm reduction education or safer use info (e.g., risks of substance use, overdose prevention & response, safer use education, harm reduction supplies). Notes for safety/ care plan:

_____

_____

_____

- ☐ Review site code of conduct that must be followed in order to access the OPS.
- ☐ Inform youth of staff duty to report child abuse or neglect
- ☐ ****Inform them they only need to do this intake once and who to talk to if they get asked to do it again.**

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX R: OVERDOSE PREVENTION SITE DATA COLLECTION FORM

VCH Overdose Prevention Site Data Collection Form Site: _____ Date: _____ Page #: _____

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

	Handle	Gender (M/F/T)	Booth #	Time In			Time Out	Substance Involved (Fill the letter to represent the substance involved) H – Heroin F – Fentanyl D – Dilaudid M – Morphine O – Down (Unknown Opioid) C – Coke CM – Crystal Meth S – Side (Unknown Stimulant)	Fentanyl Check Result (+/-)	Did the person overdose? (Yes/No)		If the client overdosed, answer these questions: Was naloxone given?		Taken by ambulance to hospital?	
				Time of day	am	pm				Yes	No	Yes	No	Yes	No
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

Depressant – includes benzo (Xanax, etizolam or clonazepam), GHB and other
Psychedelic – includes 2C-B, 2C-E, DMT, Ketamine, MDMA, mushroom extract, MXE, cannabinoids and other.

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX S: OVERDOSE PREVENTION SITE SUPPLIES

Overdose Prevention Site Supplies

Through ePro - PeopleSoft:				
Item Description	ePro Item ID	Price	Manufacturer	Manufacturer Item ID
WIPE CAVIWIPE SURFACE DISINFECTANT CLEANER XL	*80169	10.06 per can of 65 sheets	Metrex	11-1150
WIPE CAVIWIPE SURFACE DISINFECTANT CLEANER REG	*69408	9.32 per can of 160 sheets	Metrex	11-1100
BAG RESUSCITATOR ADULT AMBU SINGLE USE	*8720	12.23 each	Ambu Inc	520611000
BANDAGE ADHESIVE ROUND (SPOT) PLASTIC 7/8IN	*32406	1.14 per box of 100	Medline Industries Inc	NON25501
BANDAGE ADHESIVE STRIP PLASTIC 1X3IN	*32920	1.38 per box of 100	Medline Industries Inc	NON25600
BANDAGE ADH ISL PATCH FABRIC BANDAID CLR 2x3"	*72625	13.81 per box of 50	BOWERS MEDICAL SUPPLY CO	ACME1622033
GLOVE EXAM NITRILE SENSICARE ICE NS POWDER FREE SMALL	*89476	10.76 per box of 250	Medline Industries Inc	486801
GLOVE EXAM NITRILE SENSICARE ICE NS POWDER FREE MEDIUM	*89477	10.76 per box of 250	Medline Industries Inc	486802
GLOVE EXAMINATION NITRILE SENSICARE ICE NS POWDER FREE LARGE	*89474	10.76 per box of 250	Medline Industries Inc	486803
GLOVE EXAMINATION NITRILE SENSICARE ICE NS POWDER FREE EXTRA LARGE	*89475	10.76 per box of 230	Medline Industries Inc	486804
MASK OXYGEN ELONGATED MEDIUM CONCENTRATION ADULT W/TUBING 7F	*21977	.85 each	Cardinal Health Medical Products	1201
BAG ZIPLOCK 2"X2" 2MIL	*83129	.72 per 100 bags	N/A	N/A
OXIMETER FINGERTIP PULSE	*85944	116.25 each	West Care Medical	194PC60B1
CUP PAPER SOUFFLE 1oz PK = SLEEVE250EA	*53280	1.99 / pack of 250		
GAS OXYGEN MEDICAL USP VANTAGE GRABnGO E SIZE 0-25LPM INTEGRAL REGULATOR	*78784	10.21 each	PRAXAIR CANADA INC	OX M-AEGNGVNTG
WALL ENCLOSED LOCK 8516 1 BDY W/RECT WINDOW	*113488	25 each	COVIDIEN CANADA	85161H
PILL CRUSHER ECU	*54466	69 each		
Special Orders:				
Item Description	Category	Price	Vendor ID	Vendor Item ID
BLACK GLOVES. SIZE SMALL	M_TOOL	50.88 per box (of 12)	RUSSEL FOOD EQUIPMENT LTD	459B Small
BLACK GLOVES. SIZE MEDIUM	M_TOOL	50.88 per box (of 12)	RUSSEL FOOD EQUIPMENT LTD	459B Medium
BLACK GLOVES. SIZE LARGE	M_TOOL	50.88 per box (of 12)	RUSSEL FOOD EQUIPMENT LTD	459B Large
BLACK GLOVES. SIZE EXTRA LARGE	M_TOOL	50.88 per box (of 12)	RUSSEL FOOD EQUIPMENT LTD	459B Extra Large
Guedel Oral Airway – Green (80mm)	42271901	4.34 per box (of 6)	Cardinal Health Canada Inc	122780A
Guedel Oral Airway – Yellow (90mm)	42271901	4.62 per box (of 6)	Cardinal Health Canada Inc	122790A
Guedel Oral Airway – Red (100mm)	42271901	4.61 per box (of 6)	Cardinal Health Canada Inc	1227100A
TEALIGHTS	12131706	2.79 per pack	Dolly Worldwide	074992MW
MATCHES	12131706	99.99 per case	Dolly Worldwide	900936CM
ATLAS GRAHAM- COUNTER BRUSH BLACK FIBRE	42142600	10.49 each	ACKLANDS - GRAINGER INC.	ATG85
RESCUE BREATHER CPR POCKET MASK	42142600	7.41 each	STEVENS COMPANY LIMITED	462-01-PV1503W-CS-X
RESCUE BREATHER CPR POCKET MASK (printed)	42142600	8.13 each	STEVENS COMPANY LIMITED	462-01-PV1500W-CS-X
BREATHER REPLACEMENT VALVE 1-WAY & FILTER BLUE RESCUE	42142600	23.18 per case of 10	STEVENS COMPANY LIMITED	462-01-PV1505W-CS
GRABnGO Oxygen Cart -2 wheels	12141904	35 each	PRAXAIR CANADA INC	WES PX-1020
GRaBnGO Oxygen Rack -holds 6 cylinders	12141904	80 each	PRAXAIR CANADA INC	WES PX-1025
Rapid Response Drugs of Abuse (Fentanyl (FYL) Test Strip) FYL 20NG/ML	41116138	$99/box of 100	BTNX	FYL-1548-100

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

APPENDIX T: UNKNOWN SUBSTANCES LEFT BEHIND LOG & THEFT OF SUBSTANCES LOG

Unknown Substances Left Behind Log

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ENVELOPE #	DATE FOUND	LOCATION FOUND	RPIC/ARPIC NAME	RPIC/ARPIC SIGNATURE	DATE VPD NOTIFIED	DATE VPD PICKED UP	VPD NAME	VPD SIGNATURE

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*

Theft of Substances Log

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Promoting wellness. Knowing care.

TIME AND DATE SUBSTANCE WAS STOLEN OR DISCOVERED MISSING	ENVELOPE #	TIME AND DATE VDP WAS NOTIFIED	TIME AND DATE THE OFFICE OF CONTROLLED SUBSTANCES WAS NOTIFIED	Staff who discovered the theft/loss and notified VPD and OCS

NOTE: *DOUBLE CLICK ON THE ABOVE EMBEDDED DOCUMENT TO OPEN THE FULL WORD DOCUMENT*