Creating Safer Care Experiences:

Keeping people who use opioids alive and well in and after the ED

January 20, 2022
Territorial Acknowledgement and Elder’s Blessing
Outline and Learning Objectives

**Elder’s Blessing and Intention Setting**

**4-5 ED Scenarios and Shared Learning**
- Review common ED scenarios related to safer drug use and harm reduction
- Practically apply harm reduction approaches to ED interactions
- Integrate a realistic trauma resiliency informed approach to improve ED experience for staff and patients
- Keep people alive, reduce harm, connect with common humanity, make our work more enjoyable

**Putting into Practice and Closing Remarks**
Everyone introduce yourself in the chat: name, role, community, what you want to get out of today

Elder Coleen Pierre, Katzie First Nation
Dr. Martha Koehn – *Emergency Physician, New Westminster/Port Moody*
Dr. Jerusha Millar – *Emergency Physician, New Westminster/Port Moody*
Tracey Stoneson – *ED Manager, Patient Care Coordinator (PCC), Emergency Nurse, Chilliwack*
Janelle Tarnow – *Clinical Nurse Educator, Emergency Nurse, Fraser Health*
Reija Roberts – *Peer Advocate, Person with Living Experience*
Aimee Chalifoux - *Outreach Coordinator-Society of Equity, Inclusion and Advocacy- Indigenous Literacy Coordinator, Person with Living Experience, Nanaimo*
Ken Crockett – *Person with Living Experience, Nanaimo*
Dr. Melissa Allan – *Emergency Physician, Burnaby/Rural Locums*
Erin Gibson – *Harm Reduction Manager, Fraser Health*
Dr. Misha Bawa - *Addiction Medicine Physician, Fraser Health*
Dr. Allison Marmel – *Addiction Medicine Physician, Fraser Health*
Paula Tait – *Indigenous Wellness Educator, FNHA*
Dr. Andy Kestler – *Emergency Physician, Vancouver*
Dr. Isabelle Miles – *Emergency/Addiction Medicine Physician, Vancouver/Burnaby*
Nicole Meyer – *BCCSU Coordinator*
Intention Setting

• This webinar is interactive! All teach, all learn.
  – Post in chat, use the “raise hand” function, speak up
  – We want to hear your experience and pearls
• In dialogue keep your cameras on, if able
• Scenarios are based on real clinical examples, but have been adapted for simplicity
• We will stay after the webinar to continue a casual conversation for those who are interested
• 4th of a 6 part series – all available online
• **For more detail, see learning materials available on our platform: [https://www.bccsu.ca/edcare/](https://www.bccsu.ca/edcare/)
• ED Modules on Opioid Agonist Treatment (OAT), Bup-Nal, Pain and Withdrawal, Harm Reduction, Trauma Informed Care
We want to thank and express appreciation for all of you working hard under difficult conditions to protect our communities.

We acknowledge and honour the lives lost and harmed from toxic drug poisoning and impact on our families, friends and communities.
• Justine – 23 yo woman. Right arm cellulitis. Has been on oral antibiotics and worsening. You think she needs IV antibiotics. EMR shows 1 ED visit for “overdose” in last 6 months. Pacing in ED, looks uncomfortable, mildly agitated.
Some Take Aways – Justine

- Address presenting medical concerns and ask about substance use – universal, give context, tone
- Fears of patient
- Clarify mode of substance use
- Shared decision making about outpatient IV
- If OUD offer OAT

- Offer safer equipment and connect to community
- Stock supplies
  - www.towardtheheart.com
- Treat pain and withdrawal
- Be aware of possible past and ongoing trauma and how that affects interaction
- What do you need right now?
- Overdose Safety Plan

• Dave – 25 yo man. Mother found him unresponsive - OD. In your ED once last week with OD. Left 60 day residential treatment 2 weeks ago. Hx of OUD. Not on OAT. Carpenter. Lives with parents.
Some Take Aways – Post OD

- Focus on safety
- Mortality 1 year 5-10+%  
- Not everyone who overdoses has OUD
- If OUD offer OAT – options if people don’t want??
- For all: THN, drug testing, safety plan, safe use tips, safer equipment, outreach/peers

- Higher risk after period of abstinence
- Effect of contaminants – benzodiazepines
- What options do they have not to use alone?
- OPS, SCS, buddy up
- Virtual options:
  - Lifeguard app
  - Besafe/Brave app
  - NORS National Overdose Response Service 1-888-688-6677 (NORS)
• Terrance – 36 yo man. Fever, sepsis. Needs admission pending investigations. History of opioid use disorder. Staff come to you suspecting that he is using drugs in the ED washroom. He had earlier commented he wanted to leave “against medical advice”.
Some Take Aways – Terrance

- Have a curious conversation – use a trauma informed and harm reduction approach
- Safety (staff + patients), Choice, Collaboration
- Let the patient guide you – ask them what they need
- Offer pharmaceutical alternatives while in ED or admitted – IR opioids

- Treat pain, withdrawal, anxiety
- Offer OAT
- 24/7 Addiction Medicine Phone Line 778-945-7619
- Options for observed use
- Peer support
- Think of where he is placed in the ED
• Dr. Jones – colleague you work with and respect. When handing over after very busy shift they comment “there is an addict in the hallway, another overdose, CTAS 4 so I haven’t seen yet. Was clean for a few months but abusing drugs again, dirty urine. I don’t think anything we do makes a difference.”
Some Take Aways – Dr. Jones

✓ Model non-stigmatizing language and behavior
✓ Question bias affecting CTAS and placement
✓ We do make a difference - give examples
✓ People we work with have family / friends with harm from substance use

✓ Recognize how burnout, compassion fatigue and our own trauma may affect our interactions with patients + colleagues
✓ Ways to increase resiliency and compassion satisfaction
✓ Stories of people we see when they aren’t in crisis – find commonality, be aware of “othering”
### Using Non-Stigmatizing Language

**Four Guidelines for Using Non-Stigmatizing Language**

<table>
<thead>
<tr>
<th>Use person-first language</th>
<th>Use language that reflects the medical nature of substance use disorders</th>
<th>Use language that promotes recovery</th>
<th>Avoid slang and idioms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person who uses opioids</td>
<td>Instead of… Opioid user or addict</td>
<td>Person experiencing barriers to accessing services</td>
<td>Instead of… Unmotivated or non-compliant</td>
</tr>
<tr>
<td>Person experiencing problems with substance use</td>
<td>Instead of… Abuser or junkie</td>
<td>Person experiencing barriers to accessing services</td>
<td>Instead of… Unmotivated or non-compliant</td>
</tr>
<tr>
<td>Positive test results or negative test results</td>
<td>Instead of… Dirty test results or clean test results</td>
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Adapted with gratitude from the BCCDC
• Open Scenario – what ED situation do you want to discuss?

• What will you put to use during your next few shifts?
Approach to Harm Reduction in the ED

“What do you need right now? What might make you more comfortable?”

“What might be helpful to you? I’m worried about you. Is it ok if we talk about ways that may help keep you safe when you leave hospital?”

Foster a non-judgmental environment
Use person-first language. Share that it is an ED best practice to screen all patients for substance use.

Screen for substance use
How many times in the past year have you used a street drug or a prescription medication for non-medical reasons?

≥1

Harm reduction strategies

Take Home Naloxone kit
Safer injection and inhalation supplies

Safer drug use tips
Supervised consumption sites
Lifeguard or BeSafe App

Walking alongside the person means allowing them to guide you on their needs

“This is something I ask everyone to provide the best care possible.” Give context.

Next Webinar – Managing Pain and Withdrawal in Patients with OUD in the ED

Feb. 15, 2022

https://www.bccsu.ca/edcare/

LOUD in the ED presents

MANAGING PAIN AND WITHDRAWAL IN PATIENTS WITH OUD IN THE ED

Join us for a case-based discussion!

This will be session 5 of 5 in a webinar series exploring ways to enhance care experiences for the treatment of people with opioid use disorder in the ED.

In our fifth webinar, we will discuss the management of opioid withdrawal, review an approach to pain management in patients with OUD and discuss common scenarios that pose challenges to these types of cases.

February 15, 2022
5:30 PM to 6:30 PM
Register at bit.ly/EDcare5

Keep an eye out for the rest of the series!

Mar 2022: Overview of medication for OUD

For more information on this series including recordings of previous webinars, visit www.bccsu.ca/edcare
Help is just a phone call away

Telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists providing addiction and substance use care.

Available 24/7, 365 days a year. More info at www.bccsu.ca/24-7.

CALL 778-945-7619
Trauma is an experience that overwhelms an individual’s ability to cope. Many of your patients have some history of trauma. Disclosure of trauma is NOT REQUIRED for providing trauma-informed care. Rather, services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one’s treatment.

Possible Signs of a Trauma Response

**IMPORTANT TO REMEMBER!!!**

In some cases, trauma may have been experienced within the healthcare system. It is important to recognize that:

- A hospital may not feel like a safe place for certain patients because any institutional setting may trigger the memory of other traumatizing institutional settings.
- Patients may not want to engage with you because you remind them of other health care workers who may not have treated them well.

Credit: Fraser Health Addiction Medicine
HOW TO PRACTICE
TRAUMA-INFORMED CARE

Physical + Emotional Safety

Attend to the patient’s immediate needs
Consider food, transportation, child care, medical concerns, housing, and clothing.
What does the patient feel is important?
You might not be able to address all the needs, but you can validate what a patient feels is important.

Be as transparent, consistent and predictable as possible
Follow through on promises in a timely manner, explain why before doing something.

Limit trauma-related information to a need-to-know basis
Do not ask for details out of curiosity, only if needed for current care.

Obtain informed consent and explain limits to confidentiality
Explain how the information would be shared, and with whom.

Collaboratively develop grounding strategies
Use open questions to develop a plan together. “What have you found helpful to calm down and get focused when you’re feeling anxious?”

Choice + Control

Work through details together
How to contact the patient, the time of appointments/meetings, how and whether messages can be left.

Explore and problem-solve barriers to participation and attendance
Brainstorm ideas together to remove or reduce barriers such as childcare, transportation, language, etc.

Elicit the patient’s priorities and expectations for treatment
Find out what is the most pressing for them and what their hopes are for treatment.

Use statements that make collaboration and choice explicit
“I’d like to understand your perspective”, “Let’s work through this together”.

Work in a feedback-informed way
Purposefully elicit feedback from patients and family e.g. “What was it like for you to get here today?”.
## Terms You May Hear

<table>
<thead>
<tr>
<th>Slang</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Dopesick</td>
<td>Opioid withdrawal</td>
</tr>
<tr>
<td>Dope, down, smack</td>
<td>Heroin, fentanyl</td>
</tr>
<tr>
<td>Side, jib, ice, speed</td>
<td>Crystal meth</td>
</tr>
<tr>
<td>Up, rock, blow</td>
<td>Crack cocaine</td>
</tr>
<tr>
<td>Juice</td>
<td>Methadone</td>
</tr>
<tr>
<td>Shooting, fixing, smashing</td>
<td>IV injection</td>
</tr>
<tr>
<td>Muscling / juggling / skin popping</td>
<td>IM / injection into jugular vein / subQ</td>
</tr>
<tr>
<td>Point</td>
<td>0.1 g or 100 mg</td>
</tr>
<tr>
<td>Eight-ball / half-ball</td>
<td>3.75 g / 1.5 g</td>
</tr>
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Credit: Burnaby Hospital Addiction Medicine
Provincial Opioid Addiction Treatment Support Program

Register Here