Observed Consumption Best Practice Guidelines

Updated: August 2025

Provincial Health Services Authority

BC Centre for Disease Control
Provincial Health Services Authority

Acknowledgements

The BC Centre for Disease Control (BCCDC) works to improve the health and wellbeing of all people and communities living on the territories of many distinct First Nations in what is colonially known as British Columbia. The BCCDC head office is located on the unceded and ancestral territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səl̓ílwətaʔ (Tsleil-Waututh) Nations. As a provincial agency, the BCCDC operates on the unceded, traditional, and ancestral territories of First Nations Peoples and serves a diverse population, including First Nations, Métis, and Inuit Peoples. We acknowledge the existence of systemic racism in the healthcare system and recognize our shared responsibility to eradicate Indigenous-specific racism, and promote culturally safe and equitable care.

We thank all individuals involved in engagement and consultation to ensure best practice is reflected in these recommendations. We are grateful to the people who have provided observed consumption, many of whom are people with lived and living experience of substance use, who did so to support communities, often without the formal support of institutions or protective legislation.

Prepared by

British Columbia Centre for Disease Control
Sammy Iammarino
Blake Stitilis
Carly Welham
Julienne Jagdeo
Brittany Graham
Tessa Cheng
Molly Mastel
Cherlyn Cortes
Shaila Jiwa
Stephanie Meier
Emma Johnson

BC College of Social Workers

Carrier Sekani Family Services
Tracey Day

Dr. Peter Centre
Bryce Koch

Professionals for Ethical Engagement of Peers
Kail-olt Sedgemore
Jessica Lamb
Paul Choisil

BC Ministry of Health
Courtney Sabey
Bradley Robinson

BC Centre for Substance Use
Rebecca Anthony
Christina Chant

BC College of Nurses and Midwives

Community Action Initiative
Andrea Derban

Fraser Health
Kristi Colp
Jennifer Conway-Brown
Lee Erickson

Interior Health
Amanda Lavigne
Heather Lee
Adrian Preece
Jen Driscoll
Amanda Kudelis
Shannon Thomas
Cassie Van Camp
Whitney Chanter
Andrew Kerr

Provincial Health Services Authority
Alycia Fridkin
Nina Preto
Michelle Green
Nicole Carter
Sarah Moreheart
Lori Gallins
Alice Virani
Brittany Watson
Roger Autio

Vancouver Coastal Health
Nancy Chow
Tim Gauthier
Kyle Yrjola
Dar Michaleski
Sarah Levine
Marjory Ditmars
Wendy Bufton

First Nations Health Authority
Jolene Pagurut
Keishia Cleaver
Emma Garrod
Amanda Cochrane
Tara Claxton

Island Health
Tracey Thompson
Sarah Hughes

Métis Nation BC
Mike Mercier

Nurses and Nurse Practitioners of BC
Alayna Payne

Northern Health
Ashley Gueret
Hawkfeather Peterson
Nick Rempel
Reanne Sanford
Kerensa Medhurst

Providence Health Care
Karen Scott
Serena Eagland

The Vancouver Area Network of Drug Users
Jon Brathwaite
Hugh Lampkin

University of Victoria & Canadian Institute for Substance Use Research
Marilou Gagnon

How to cite this document

British Columbia Centre for Disease Control. Observed Consumption Best Practice Guidelines. 2025.

Table of Contents

Key Terms

Anaphylaxis means a severe and life-threatening allergic reaction.

Aseptic technique refers to practices to prevent the spread of infection.

Consumption means the act of taking a substance by various means, including injection, ingestion, rectal administration (booty bumping), snorting, inhalation (smoking), amongst others.

Cultural humility means a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

Cultural safety means an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care (or any) system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care or services.

Drug poisoning refers to physiological harms that can occur from consumption of substances. Drug poisoning does not indicate the type of substance. Sometimes referred to as 'overdose'.

Destigmatizing means removing shame and negative associations associated with an identity or practice.

Embolism refers to an object (e.g. blood clot, air, etc.) that travels through the bloodstream and becomes lodged in a blood vessel causing a blockage.

Episodic overdose prevention service (eOPS) refers to the act of observing consumption of substances by a service provider to support safer substance use practices and to prevent and respond to drug poisoning, wherever services are required. eOPS usually takes place outside of established overdose prevention sites, such as outreach settings, private residences, care homes, etc.

Indigenous-specific racism refers to stereotypes, bias, and discrimination against First Nations, Inuit, and Métis Peoples. Indigenous-specific racism is a direct impact of White supremacy and settler-colonialism.

Opioid poisoning refers to a drug poisoning caused by opioids (e.g. fentanyl, heroin, hydromorphone).

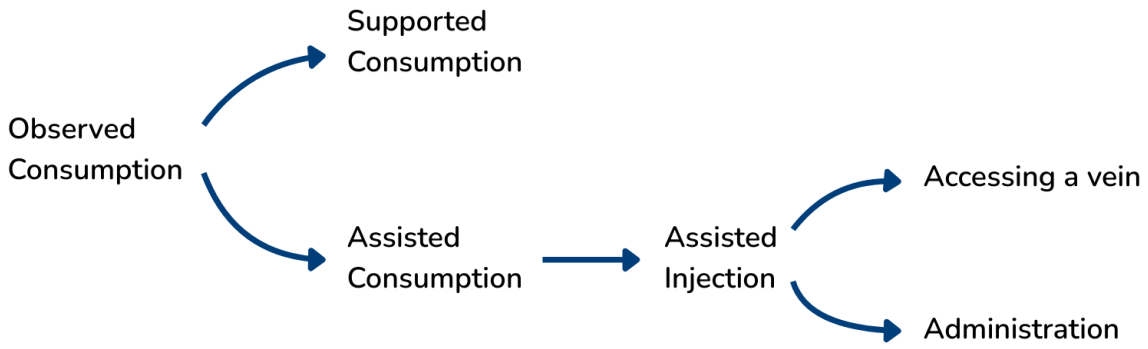
Overdose prevention site (OPS) refers to a setting staffed with people trained and equipped to respond to drug poisoning (overdose). OPS includes fixed, temporary, and mobile sites.

Peripheral intravenous (IV) catheter refers to a type of vascular access device (VAD) that is inserted into a vein located in an extremity. They are inserted into superficial veins located just under the skin. Also called a peripheral IV.

Peripherally inserted central catheter (PICC) refers to an indwelling device that is inserted into a large central vein and advanced until the catheter resides in the vena cava or right atrium of the heart. A peripherally inserted central catheter (PICC) is a common type of central venous catheter that is used for mid and long term central venous access.

Observed consumption is a general term that includes supported and assisted consumption. Observed consumption may be carried out at overdose prevention sites (OPS), supervised consumption sites (SCS), and through episodic overdose prevention services (eOPS). Sometimes referred to as "booth help" at OPS/SCS.

- **Supported consumption** refers to assistance provided to support safer consumption of substances including handling safer substance use supplies, cleaning the injection site, preparing foil hooters, applying the tourniquet, and providing coaching and education on safer substance use practices.
- **Assisted consumption** refers to hands-on assistance to directly administer the substance. Due to the nature of assisted substance use, assisted consumption generally refers to injection substance use, called assisted injection. Assisted injection includes: (i) assistance with accessing a vein and (ii) assistance with administration.



Regulated substance refers to a substance that is controlled by regulations to monitor for quality and consistency (e.g. prescription medication, cannabis, alcohol).

Saline lock refers to an indwelling peripheral intravenous catheter that maintains patency and access to a peripheral vein.

Service provider refers to someone who is employed to provide health or social services. A service provider can be regulated or non-regulated.

- **Regulated service provider** refers to a profession or occupation that is governed by a regulatory body (e.g. nurse, registered social worker, physician, etc.).
- **Non-regulated service provider** refers to a role that is not governed by a regulatory body (e.g. outreach worker, mental health worker, peer worker, etc.)

Settler-colonialism refers to a system of power that seeks to eliminate Indigenous Peoples and establish settlers' rights to Indigenous land. Settler-colonialism is rooted in White supremacy.

Supervised consumption site (SCS) refers to a setting staffed with people trained and equipped to respond to drug poisoning. SCS operates through a federal exemption to Section 56 of the Controlled Drugs and Substances Act.

Thrombosis refers to a blood clot that is lodged in a blood vessel and blocks blood flow.

Trauma- and violence- informed care refers to services and care delivered in a way that acknowledges the effects of interpersonal and systems-level trauma and violence on a person's behaviour and health. Trauma and violence informed care aims to promote safety and trust through connection and collaboration and using strengths-based approaches.

Unregulated substance refers to a substance that is not monitored for quality or consistency (e.g., crystal methamphetamine). Often referred to as "illicit substances" or "street drugs".

Vascular access device (VAD) refers to a type of device that are inserted into the body through a blood vessel to deliver medicine, fluids, or nutrients to the body. For example, peripheral intravenous (IV) catheter, central venous catheter (CVC), and peripherally inserted central catheters (PICC) are types of vascular access devices.

White supremacy refers to values and behaviours rooted in a false and socially constructed racial hierarchy in which White people and White ways of knowing and being are deemed superior.

Upholding Indigenous Rights

In Canada, Indigenous Peoples, including First Nations, Inuit, and Métis, experience disproportionate substance use related harms due to the ongoing effects of settler-colonialism and systemic Indigenous-specific racism.[82,83] These harms are made worse by inequitable access to culturally safe and accessible health services, including harm reduction services.[84]

Health and social service organizations and service providers have an obligation to implement recommendations outlined in the Truth and Reconciliation Commission's Calls to Action, In Plain Sight Report, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), the B.C. Declaration on the Rights of Indigenous Peoples Act (Declaration Act) and the Declaration Act Action Plan and the MMIWG2SLGBTQQIA+ Calls for Justice.

Additionally, nurses have a responsibility to practice according to the BC College of Nurses and Midwives (BCCNM) Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard. Registered Social Workers have a responsibility to commit to ongoing professional development and learning related to cultural safety, cultural humility, anti-discriminatory practice, Indigenous specific cultural learning, and anti-Indigenous racism and discrimination, as mandated in the BC College of Social Workers (BCCSW) Code of Ethics and Standards of Practice.

These foundational reports identify responsibilities and actions to end Indigenous-specific racism and discrimination and recognize self-determination and the inherent rights of First Nations, Inuit, and Métis Peoples.

Aims

This guideline provides evidence-informed best practice recommendations for observed consumption. Section 1 provides best practice guidelines for supported consumption and Section 2 provides considerations for nurse-assisted injection.

The recommendations in this document were developed by synthesizing research evidence with the expertise of people with lived and living experience of substance use, clinical and content experts, and professional regulatory experts with consultation from professional practice and legal services.

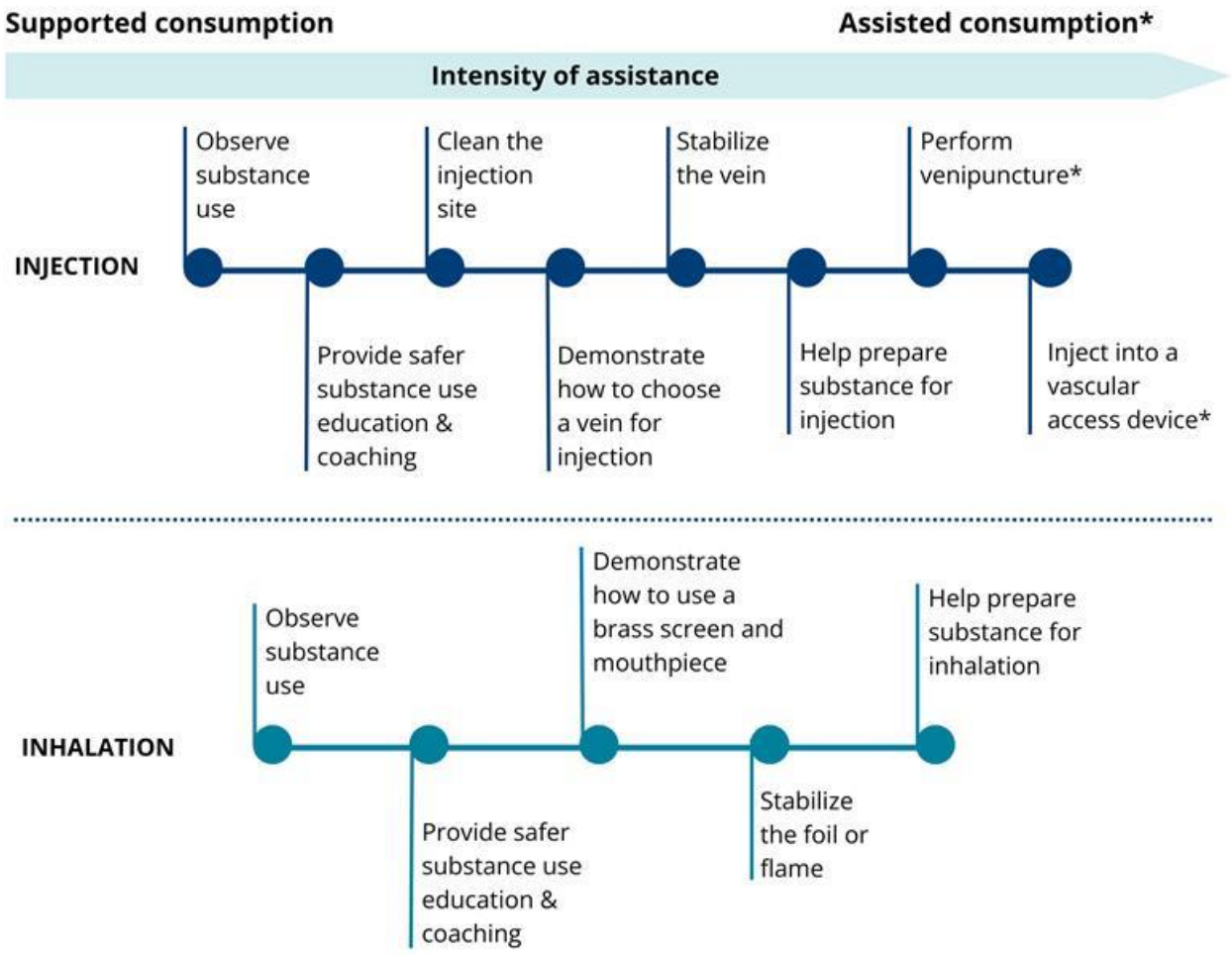
The guidance in this document aligns with current regulatory and legal frameworks. Providers should ensure their practice aligns with their individual scope of practice, training and competence, professional standards and regulations, and organizational policies.

Background

Health and social service providers are essential to deliver harm reduction and drug poisoning prevention and response services for people who are at risk for harms from substance use, especially due to the ongoing public health emergency from the toxic unregulated drug supply.

Observed consumption is a general term that includes supported consumption and assisted consumption.[1] Observed consumption is the act of helping someone to use substances more safely to prevent and respond to substance use related harms. Observed consumption occurs across a continuum, from supported consumption with minimal service provider involvement to assisted consumption where there is intensive hands-on administration (Figure 1).

Figure 1. Continuum of observed consumption



Observed consumption - also called “spotting” by community members or “booth help” by injection sites - has been a community led practice by people who use substances for decades. Peer-led community driven services are essential. The aim of this guideline is not to replace peer led services, but to increase access to drug poisoning prevention and response services across health and social service settings.

Supported consumption is a routine harm reduction service that can be delivered in various health and social service settings, including overdose prevention sites (OPS), supervised consumption sites (SCS),[a] and wherever services are needed through episodic overdose prevention services (eOPS). It typically involves offering education, coaching, and demonstrating practices to prevent and reduce harms. The service provider delivering supported consumption is trained and equipped to prevent and respond to common substance use related harms, including drug poisoning (overdose). Supported consumption can be provided for many different methods of substance use, including injection, inhalation (smoking), oral, and intranasal (snorting) consumption.

Assisted consumption refers to the direct administration of a substance by a service provider through different modes of substance use (e.g., injection, rectal). This guidance focuses on assisted injection, where a trained service provider assists with hands-on injection of substances.[1,2]

It is important to note that not all activities across the continuum of observed consumption are legally or professionally supported.[1,2] For example, nurses can provide supported consumption for all substances (including regulated and unregulated). Whereas nurse-assisted injection is limited to prescribed medication administration. It is not within the scope of practice for nurses to prepare unregulated substances for supported consumption or for nurses to provide assisted injection of unregulated substances. Similarly, social workers are required to provide services that are within their regulated scope of practice, which does not include some activities of supported consumption such as preparation or handling of regulated or unregulated substances and providing hands on assistance administering substances.

There is a need for observed consumption best practice guidelines to enable service providers to deliver high quality care, support the health of people who use substances, and reduce liability risks.[1]

[a] Overdose prevention sites (OPS) and supervised consumption sites (SCS) operate differently with different rules. Both provide similar services, including drug poisoning prevention and response. However, OPS operate under a provincial ministerial order, whereas SCS operate under federal legislation. This means that there may be different rules, staffing, and reporting requirements. OPS are often lower-barrier and peer-led, compared to SCS.

Supported Consumption

Research has demonstrated the benefits of nurse-delivered and peer-led models of supported consumption across settings. These models have been shown to increase access to healthcare, promote safer substance use practices, and prevent harms from drug poisoning.[2-6] However, many people who need support - including people with disabilities - do not have adequate access to supported consumption.[1,7,15]

Service providers - including nurses, social workers, community health workers, and peer workers - may provide supported consumption by offering a range of services that could include distribution of safer substance use supplies, education and coaching on safer substance use practices, providing hands-on assistance, and other supports to assist people to consume substances more safely and reduce harms.

Assisted Injection

Research has demonstrated that somewhere between 24% to 49% of people who use substances require assistance with injection due to a lack of venous access, illness, disability, or a lack of knowledge and skills.[7-13] Research has also demonstrated that some people who use substances, including youth, women, and people with disabilities, are at increased risk for harms and are more likely to need assistance with injection.[10] However, access to assisted injection is highly restricted and inaccessible to most people who require assistance. This is particularly concerning because people who need assistance injecting and who already experience marginalization, can be turned away from services and have no choice but to inject in riskier ways outside of supported settings.

Currently, assisted injection is highly restricted to two specific situations:

1. Peer assisted injection at supervised consumption sites (SCS) with an exemption for Peer Assistance.
2. Nurse-assisted injection of medication with a client-specific order at a community health facility or hospital. Put simply, this is medication administration of a controlled substance.

In 2020, Health Canada approved peer assistance with injection as an authorized service at select supervised consumption sites (SCS).[b] This means that SCS can apply to include peer-to-peer assistance as an authorized service. It is important to note that this exemption only applies to specific SCS who

[b]Peer assistance in a supervised consumption site refers to one person providing assistance to another in the course of preparing and consuming substances. Friends or other clients may help assist, but employees of a supervised consumption site may not provide this service.

have received this exemption and peers who are not working at the SCS. This exemption does not authorize service providers (including peers currently working at the site, nurses, mental health workers etc.) to provide assisted injection. Currently, this service is largely inaccessible to people who require assistance injecting.[1,15]

Under current legislation, service providers are not permitted to provide assisted injection of unregulated substances. Service providers risk criminal and civil liability and regulated service providers also face professional liability from their regulatory body.[2,14]

See Section 2: Assisted Injection for more information.

Observed Consumption for Equity Deserving Groups

Equity deserving groups refers to groups of people that have historically faced barriers to participating fully in society due to systemic discrimination.[85] Access to low barrier harm reduction services are particularly important for people who experience barriers to accessing appropriate care, including young people and people who require assistance with preparation or administration of substances.[87-91]

Service providers and organizations should aim to reduce barriers and facilitate access to observed consumption for equity deserving groups. This section identifies considerations for equity deserving groups to access observed consumption.

People Who Require Assistance with Preparation or Injection of Substances

People who require assistance with injection may also need assistance with preparation of substances.

Service providers may provide most aspects of supported consumption for people who require assistance. However, service providers are not legally permitted to handle or inject unregulated substances.[1,2] Under current legislation, assisted injection is highly restricted to two specific scenarios: peer-assisted injection at an SCS with a Peer Assistance exemption and nurse-assisted injection of medication with a client specific order at a health facility. See Section 2: Nurse-Assisted Injection for more information on these situations.

Young People

Children (also called "minors", refers to anyone under 19 years old), and youth (up to and including 24 years old), can access supported consumption without a formal capacity assessment. Service providers should ensure that the young person agrees with any interventions and is provided with opportunities to ask questions and receive information to make decisions.

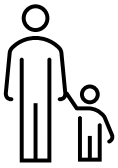
Assisted injection of regulated substances is considered medication administration, which requires a formal capacity assessment by a regulated healthcare provider.[22] According to the BC Infants Act, minors may consent to healthcare services on their own as long as the healthcare service provider:[23]

- Has explained to the minor and is satisfied that the minor understands the details of the treatment, including any reasonably foreseeable risks and benefits, and
- Has made reasonable efforts to determine and has concluded that the healthcare service is in the minor's best interests.

Service providers who deliver healthcare services to young people should follow their regulatory body guidance, organizational policies, best practice guidance, and other relevant legislation to deliver safe, ethical, and accessible health services to young people. If a service provider has reason to believe that a person under 19 years of age is in immediate risk of being physically or emotionally harmed, sexually abused or exploited, and/or neglected, or otherwise needs protection, there is a legal duty to report their concerns to a director under the Child, Family and Community Service Act. Directors are employed by the Ministry of Children and Family Development (MCFD) and by Indigenous Child and Family Service Agencies (ICFSA).

A report should not be made solely because a minor is using substances or accessing harm reduction services. If a report is necessary, service providers are encouraged to consult with team members and be transparent with the minor. All service providers should understand regulations around access to harm reduction services, supports available to young people, and legal duty to report. See the BCCDC Guidelines to Providing Harm Reduction Services to Youth in British Columbia.

People Who Are Pregnant or Parenting



Service providers should support people who are pregnant or parenting to access observed consumption services. Substance use by a pregnant person or parent, without indication or concerns of immediate risks for harm to a minor who has been born, should not be reported to the director at the Ministry of Children and MCFD or the ICFSA or to the Indigenous authority.

Service providers have a duty to report to the director or to the Indigenous authority if they have reason to believe that a minor is in immediate risk and needs protection, including if there is a concern that the parent and family are unable to provide safe care to the minor due to significant impairment in judgement, behaviour, or level of consciousness and they have not made adequate arrangements for the minor's care. Service providers should not make a report to a director or Indigenous authority if the parent or family have made adequate arrangements for the minor's care during a period or periods when the parent is unable to provide safe care due to significant impairments.

Service providers should understand regulations around access to harm reduction services, supports available, and legal duty to report. See Related Resources for more information.

Healthcare Provider Scope

Healthcare providers who deliver observed consumption should aim to provide services in ways that are low barrier, trauma- and violence- informed, culturally safe, and destigmatizing.[20,21]

Nurses

Nurses[c] have a professional and legal obligation to provide safe, competent, and ethical care to their clients in alignment with the BC College of Nurses and Midwives (BCCNM) scope of practice and standards of practice. The BCCNM does not advise nurses to act outside the current legal framework.

Supported consumption is a professional nursing service that should be provided in alignment with professional and ethical standards of practice.

Nurse-assisted injection is highly restricted. Nurses can administer prescribed regulated substances (medication) if they have a client-specific order and can meet the BCCNM standards, limits, and conditions, including the Medication Practice Standard. As with all clinical skills, a nurse's ability to provide assisted injection will depend on their scope, competence, and training in accordance with their organizational policies and professional standards of practice.

Nurse practitioners who meet all of the requirements can prescribe for opioid use disorder and/or pharmaceutical alternatives for safer supply in accordance with BCCNM standards, limits, and conditions. Nurse practitioners are subject to meeting the prescribing standards and the limits and conditions for controlled drug prescribing (#10) and opioid agonist treatment for opioid use disorder and pharmaceutical alternatives for safer supply (#10.3). This means that some nurse practitioners who meet the educational and regulatory requirements may both prescribe and administer the medication.

[c] Throughout this document, the term 'nurse' refers to licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

Social Workers

Registered Social Workers have a professional obligation to practice competently and with a duty of care as described within the BC College of Social Workers (BCCSW) Code of Ethics and Standards of Practice.

Certain basic harm reduction activities within the continuum of supported consumption aligns with the professional and ethical standards of social work practice. Such basic harm reduction activities may include providing harm reduction supplies, training and giving out take home naloxone kits, providing information about drug checking services and education, providing emergency response (including naloxone) during drug poisoning if the social worker is competent to do so, and other services that can be provided by someone with basic training and equipment for drug poisoning response.

Registered Social Workers should provide supported consumption services in alignment with the BCCSW Code of Ethics and Standards of Practice. For example, it is not within the scope of practice of registered social workers to handle unregulated or regulated substances or provide assisted injection of unregulated or regulated substances. Registered Social Workers may be subject to professional liabilities from their governing regulatory body if they were to engage in activities that fall outside of their scope of practice and do not align with professional standards of practice and code of ethics principles.

Section 1

Supported Consumption Best Practice Guidelines

Scope

This document outlines best practices to deliver supported consumption. The guidance in this document is intended to support regulated (e.g. nurse, social worker) and non-regulated health and social service providers (e.g. outreach worker, community health worker, peer worker) who provide supported consumption services in BC.

The recommendations describe skills and practices for novice service providers. Where appropriate, this document identifies advanced practices and skills for service providers with a higher level of skill and training using professional judgement.

It is important to understand the potential legal liability risks of supported consumption and what you can do according to your professional scope and standards of practice, individual training and competence, organizational policies, and legal frameworks.

Legal Issues

Most aspects of supported consumption are not legally contentious. [1,2] However, service providers assume legal and professional liability risks for handling unregulated substances to assist with preparation.

Federal law regulates controlled substances through the Controlled Drugs and Substances Acts (CDSA). According to the CDSA, a service provider may be criminally liable for possession charges for handling unregulated substances and trafficking charges if the service provider injects another person with unregulated substances or provides the person with unregulated substances for self-injection.[2]

Most activities associated with supported consumption align with current legislation. For example, observing substance use, providing coaching and education on safer substance use, stabilizing a vein, inserting filters in a pipe, and demonstrating skin care are all activities that align with current legislation. Whereas handling unregulated substances during supported consumption does not align with current legislation.

Requirements

Service providers should meet minimum education and training requirements and carry the minimum equipment and supplies to provide supported consumption.

Education and Training

Minimum education and training

1. Basic drug poisoning prevention and response training, including naloxone administration.
2. Understanding of a harm reduction approach to substance use, including basic principles of harm reduction and safer substance use practices.
3. Knowledge of services and referral processes for health and social services, such as housing, primary care, cultural supports, and substance use services, including treatment and recovery.
4. Knowledge of employer-specific policies, including health and safety, infection prevention and control, violence prevention, needlestick injuries, etc.
5. Understanding of ethical considerations, legal and professional regulations, and standards of practice.
6. Up to date vaccines. See BCCDC recommended vaccines for healthcare workers.

Additional recommended education and training

1. Basic life support training (CPR training).
2. Advanced drug poisoning prevention and response training.
3. Advanced training in safer substances use practices.
4. Education on current trends in the unregulated drug supply.
5. Advanced training to improve health equity, such as trauma- and violence-informed care, anti-racism, Indigenous cultural safety and humility, and anti-stigma.

Advanced training and education

1. How to recognize and respond to common complications from substance use, including:
    - Injection substance use:
        - Bacterial infections (e.g. abscess, cellulitis, endocarditis).
        - Skin inflammation (e.g. hives, redness, swelling, vein inflammation, phlebitis).
    - Inhalation:
        - Cuts, burns, and sores to the lips, mouth, and hands.
        - Inhalation of materials (e.g. Brillo) and burns to the throat.
2. How to recognize and respond to common emergency events associated with substance use, including:
    - Thrombosis or embolism caused by injection (e.g. thrombophlebitis, pulmonary embolism).
    - Injection into an artery.

- Respiratory distress (difficulty breathing, shortness of breath).
- Anaphylaxis.
- Chest pain.

3. How to recognize and respond to harms associated with self-injection into a vascular access device (VAD) such as peripheral intravenous lines (IV) and PICC lines, including:
    - Common complications: infection, phlebitis, thrombus.
    - Adverse events: accidental removal, occlusion.

Equipment and Supplies

Minimum equipment and supplies

1. Safer substance use supplies, depending on mode of consumption
    - Inhalation: pipe (bubble/bowl, stem), foil sheets and straw, brass screens, vinyl tubing (mouthpiece), push stick, and sharps container.
    - Injection: tourniquets, alcohol swabs, needle tips and syringe barrels, cookers, sterile filters, 1 cc syringes, vitamin c (acidifier), sharps container.
2. Basic drug poisoning response equipment (e.g. Take Home Naloxone kit):
    - Naloxone ampoules and syringes (or intranasal naloxone), CPR face shield, alcohol swabs, and gloves.
3. Hand hygiene supplies (e.g. hand sanitizer).
4. Personal protective equipment depending on the setting and exposure risk.
5. Supplies to clean surface (e.g. disinfecting wipes).
6. Cell phone to call for help.

Additional recommended equipment and supplies

1. Take Home Naloxone kit training and kits for distribution.
2. Drug checking resources for unregulated substances (FTIR if available, testing strips)
3. Safer sex supplies: lube, lubricated and non-lubricated condoms, internal condoms.
4. Safer injection supports: heat packs, hand warmers, vein finder, stress balls, pill crushers, reading glasses, neck pillow.
5. Basic wound care supplies: gauze, bandages, saline/sterile water, tape.
6. Snacks and water.
7. Clothing donations.

Advanced supplies[25-29]

1. Advanced drug poisoning response supplies:
    - Pulse oximeter, oral and nasopharyngeal airways, bag-valve-mask, simple face mask, oxygen tank, suction and Yankauer catheters, automatic external defibrillator (AED),

blood pressure cuff and stethoscope, glucometer, pen light, emergency medications (e.g. epinephrine, glucose tabs, antihistamine, etc.), and other crash cart supplies.

Supported Consumption Practice Recommendations

Before Supported Consumption

Service providers should recognize that people who use substances are the experts in their own lives. Many people who require supported consumption have knowledge about their needs, what supports they require, and what alternatives work for them. Service providers should follow the persons' lead and respect their preferences.

1. Determine if you can deliver supported consumption services

I. Can you safely, competently, and ethically provide supported consumption?

- Conduct a self-assessment of your ability to provide low barrier, trauma- and violence-informed, culturally safe, and non-stigmatizing services.
- If you are a regulated service provider, ensure you know the scope of practice for the care you can provide.
- Determine if you meet the minimum education and training requirement.
- Determine if you have the minimum equipment and supplies on hand.

II. Do you have access to a safe and appropriate space?

- Settings will vary from purpose built supervised consumption sites to makeshift areas to provide episodic overdose prevention services (eOPS). Use your judgement to select a safe and appropriate space.
- At minimum, the space should allow access to respond to a drug poisoning and aim to provide privacy.
- The space should be well-lit so the person using substances can use safely (e.g. setting up equipment, finding veins, etc.).
- Ideally the space will have smooth surfaces (not plush) for easy cleanup afterwards. If there are no smooth surfaces, consider using a tray or other solid surface.
- If the space is outside, ensure you can see the person to recognize and respond to a drug poisoning and are aware of legislation on public substance use. See Related Resources for more information on decriminalization in BC.
- For inhalation, only use outdoors or in a dedicated OPS. Ensure the person is using away from building entrances and air intakes and the space is well ventilated.

If you are unable to provide supported consumption:

- Provide access to an immediately available alternative such as transfer to another trusted service provider, nearby OPS, or virtual services such as the Lifeguard app and NORS phone line (1-888-688-6677).
- Service providers may decline to provide support if there are imminent safety concerns that place the service provider or person at an unacceptable level of risk or danger (e.g. having an open flame close to an oxygen tank).
- Nurses should follow practice standards, including the BCCNM Duty to Provide Care.
- Identify barriers to providing observed consumption and develop a plan to address these gaps.
- If there are unreasonable risks to personal safety, service providers should immediately do what make things safer for the person and communicate the safety risks to appropriate organizational leadership.
- If the person accessing services experiences agitation (e.g. due to withdrawal), use a low barrier relational approach to de-escalation prior to declining services. This may include listening, validating feelings, calmly providing options, offering breaks, and opportunities for rest, food, and other supports.

2. Apply infection prevention and control practices[37,38]

- Understand organizational safe work procedures and occupational health and safety policies.
- Follow routine infection prevention and control practices and implement additional measures when your local or provincial public health authorities identify an elevated level of risk of communicable disease transmission.
- Conduct a point-of-care risk assessment, perform hand hygiene, clean and disinfect surfaces, and choose appropriate PPE.
- Use best practices for wearing gloves. This means changing gloves between each person, washing hands before putting on and after taking off gloves, and changing gloves if they are soiled.
- Perform hand hygiene:
    - Before and after direct contact with the person,
    - After contact with body fluids,
    - After touching the person's surroundings,
    - Before putting on gloves, and
    - After removing gloves and other PPE.

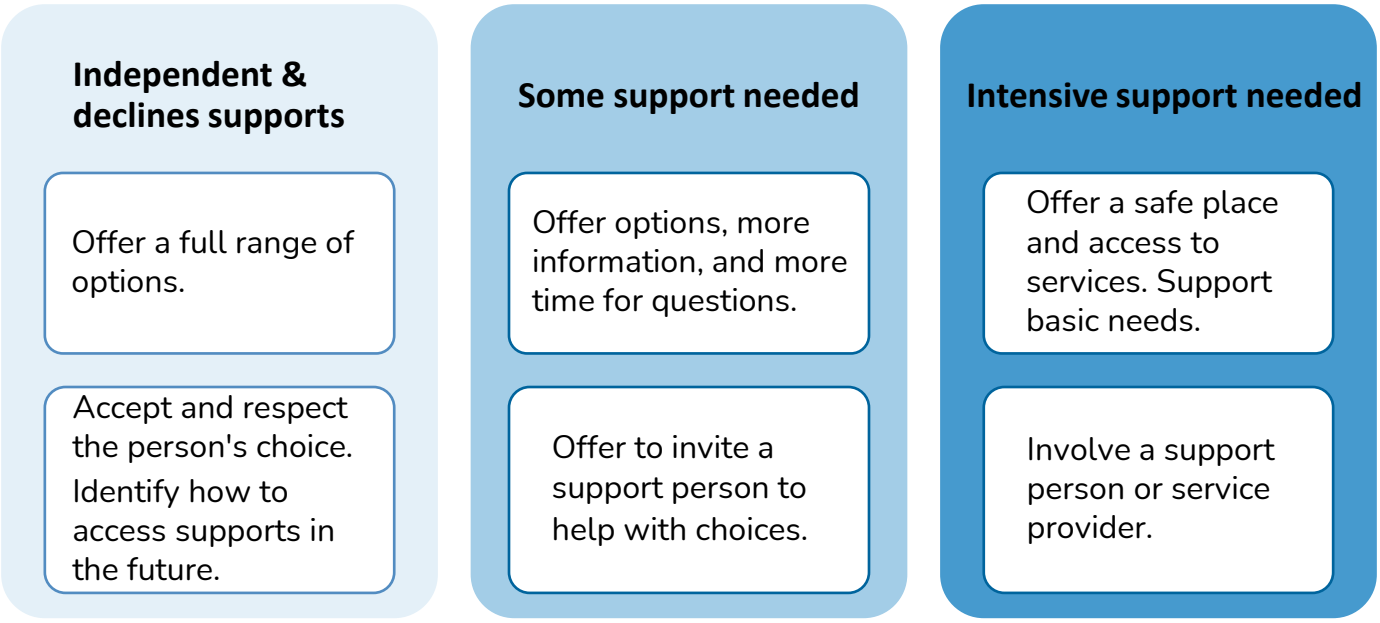
3. Engage with the person[2,21,30-33]

- Introduce yourself and ask the person how they would like to be addressed.
- Support the person's independence and choices throughout the process.
- Avoid assumptions about substance use, amount of assistance needed, and reason for requesting supported consumption.
- Ask the person what kind of support they need— "*what do you need help with today*?"
- Support and respect routines and rituals associated with substance use.
- Prioritize comfort and trust:
    - Ask permission before touching the person— "*Is it ok if I put my hand on your arm to feel your veins?*"
    - Tell the person what you are going to do during each step of the process— "*now I will move my hand away*"
    - Respond to verbal and non-verbal communication.
- Check in regularly about the person's comfort— "*would you like me to stay with you or should I come back in a few minutes?*"

4. Provide support to access services

- Identify the level of support required to access services. This might include meeting basic needs (e.g. food, sleep, water, clothing) or support for ongoing needs (e.g. symptoms of withdrawal, physical disability etc.)
- Adjust the intensity and duration of supportive strategies to meet the person's needs and preferences (Figure 2).
- Do not turn people away if they demonstrate a need for intensive supports.
- Include two staff members or a support person in discussions. When possible, share responsibilities for providing services to people who require intensive supports.

Figure 2. Strategies for different intensities of support.



5. Discuss the process and service provider role

- Discuss the process of supported consumption, including risks and alternatives.
- Discuss service provider responsibilities, including the need to administer naloxone and transport to hospital (depending on organizational policies) in case of drug poisoning or medical emergency.
- Discuss service provider limitations –"*I cannot hold the needle or inject into the skin*"
- Provide opportunities for the person to ask questions and identify their preferences.

6. Obtain informed consent[38]

- Ensure ongoing verbal agreement by explaining any actions, asking permission before you do anything, and inviting questions.
- Ensure the person agrees to receive support voluntarily and without persuasion.
- Allow time to answer questions about the process, service provider role, limitations and alternatives.
- Ensure the person is aware they can withdraw their consent at any time, and you will stop.

7. Ask preference for intensity of support

- Ask the person how much support they would like during and after substance us— "*would you like me to stay with you or would you rather I come back in a few minutes?*":
  - *High support*: stay with the person throughout observed consumption and provide continuous assistance through coaching, supporting safer use practices, and nearby monitoring after substance use.
  - *Occasional support*: provide personal space during substance use. Provide support when requested and check in every few minutes after substance use.
  - *Low support*: maintain sightline of the person. Observe from a distance to monitor for drug poisoning.
- Recognize that support needs may change throughout the process. Follow the person's lead and check in— "*call me over if I can help*"

8. Support safer substance use

- Provide access to safer substance use supplies, depending on the mode of consumption. See equipment and supplies for more information.
- Offer supports:

Communication and sensory supports

- Translator, augmentative/alternative communication device, pen and paper.
- Support person, music, headphones, decreased noise or light.

Physical supports

- Injection props: pillow, vein finder, pill crusher, reading glasses, brighter lighting, hot towel, glove filled with hot water or hot towel for veins, stress ball, hand warmer.
- Food: high calorie meal replacement drink (e.g. Ensure), protein bar, water,
- Comfort items: travel pillow to support neck, access to a space heater, clothing.

During Supported Consumption

1. Reduce risk for injuries[34, 97]

Reduce needlestick injury risk:

- Dispose of previously used or opened sharps before supported consumption.
- Place sharps on a flat surface with the needle facing away from the body.
- Leave sharps on a flat surface facing away from the body, until the person is ready to inject.
- Maintain appropriate body positioning and space with the person who is injecting (about 1.5 arms lengths away).
- Position your body in a way that allows you to move away in case of unexpected movements.
- Position your body on the person's side opposite the hand holding the syringe.
- Advise the person injecting to give notice before moving the syringe while in close proximity.
- Dispose of sharps in a sharp's container immediately after use.
- After three unsuccessful pokes, switch with another provider.
- Advise the person to avoid breaking off needle-tips.

Reduce musculoskeletal injury (MSI) risk:

- Share tasks amongst team members and take regular breaks to allow your muscles to rest and recover.
- Change your body position regularly to avoid strain.
- Avoid holding your body in a single position long enough to feel aches or pain.
- Avoid awkward postures (bending or twisting your body outside of your range of motion).

2. Promote safer substance use handling and preparation[2,27,39]

- Encourage the person to perform hand hygiene prior to preparing and consuming substances, whatever mode of consumption they are using.
- Avoid judgement and correcting behaviour if the person prepares or consumes substances in a way that does not align with best practices.
- Follow the person's guidance, obtain informed consent throughout the process, and identify supports and props to help the person handle and prepare their own substances as much as they can.
- If the person is unable to prepare their own substances (e.g. due to a physical disability), organizations and service providers should determine how to support safer substance use practices within the current legal framework.

3. Offer information to reduce harms from drug poisoning

- Consider current health status, tolerance, and type of substance and how it will be consumed:
    - Use less if sick, using in a different way (e.g. smoking instead of snorting), using a new batch, or have not used in the last few days.
- Get drugs checked,
- Stay up to date with Toxic Drug Alerts in your area,
- Start low and go slow: test a small amount first and use slowly,
- Use one substance at a time. If using more, try to use less than usual and use slowly,
- Try to avoid cross-contamination (unintentional mixing) of stimulants and opioids on equipment by using new injection equipment and your own inhalation supplies, every time.
- Carry naloxone and know how to use it,
- Avoid using alone every time you use. Use at an OPS, use with a buddy and take turns using, or use a virtual service such as Lifeguard app or NORS phone line 1-888-688-6677

4. Offer safer substance use education and coaching[27, 39, 58]

- Support the person to determine their need for education or coaching.
- Adapt coaching based on the person's current knowledge, abilities, and needs. Be responsive to the person's preferences and try to avoid unsolicited advice.
- Practice non-judgement and provide low barrier services if the person chooses to use higher risk substance use practices (e.g. injection into jugular, injection of tablets, use of Brillo instead of screen, etc.).
- Provide alternative ways of learning about safer substance use practices, including videos and written resources.
- Offer basic or advanced safer substance use education and coaching, depending on mode of consumption and your skill and experience:
  - Basic Safer Inhalation Education
  - Basic Safer Injection Education
  - Advanced Safer Injection Education

Advanced Practice for Regulated Healthcare Providers[30, 64]

If a person chooses to self-inject into a vascular access device (VAD)[d] or inject tablets or capsules:

- Discuss risks associated with self-injection into a vascular access device:
  - Drug poisoning from substances staying in line, then being dislodged by flushing or activity and entering bloodstream,
  - Embolism from injection of air, blood clot, or other materials (e.g. dirt),
  - Infection from introduction of bacteria in line, not cleaning properly, or from substances,
  - Occlusion (blockage) from blood or substances and not flushing properly.
  - VAD line can be moved or dislodged.
- If it is within your professional scope of practice and competence, provide harm reduction-based education to support the person to reduce harms.
  - Advanced Practice: Self- injection into a peripheral IV
  - Advanced Practice: Self- injection into a peripherally inserted central catheter (PICC)
  - Advanced Safer Injection Education: Tablet and Capsule Injection

[d] A vascular access device (VAD) is a medical device that provides access to a person's bloodstream, usually to deliver medication. An intravenous (IV) line and PICC line common types of VADs seen in community settings.

Basic Safer Inhalation Education[39,44-51]

Prevent transmission of infection and accidental drug poisoning:

- Wash your hands before using. Use alcohol wipes if you can't wash them.
- Use your own inhalation supplies: pipe, mouthpiece (vinyl tubing), foil, and straw.
- Don’t share your pipe, mouthpiece, foil, or straw especially if you have burns, sores, or cuts in your mouth or if you have an infection, such as hepatitis C.
- Used inhalation supplies can have blood on them- even if you cannot see it- that can spread infection when shared.
- If you cannot access your own pipe, try to use your own mouthpiece, every time.
- Get a new pipe when:
    - yours is cracked, scratched, chipped, or has burnt residue that can't be cleaned, OR
    - when someone else has used yours, OR
    - it has been used with an unknown substance.
- Inhale the vapour slowly and exhale immediately. Avoid holding the vapour in the lungs as this can cause burns.
- Avoid using a lockable torch and blow out sources of flame after use.
- Dispose of pipes in a sharps container.

Using a glass pipe (e.g. straight stem, bubble/bowl, hammer):

- Use brass screens with glass pipes. Avoid Brillo which can break off and cause burns. If you use Brillo, pack it between brass screens.
- Use a push stick to pack brass screens into the pipe to avoid damaging the pipe.
- Use your own mouthpiece that is at least 1.5 inches long to reduce the chance of burns and cuts to the lips and mouth.
- Let pipe cool down on its own. Do not speed up the cooling process.
- If you share a pipe:
    - **Ask** people what they've inhaled in their pipe,
    - **Tell** people what you've inhaled in your pipe,
    - Use whatever personal supplies you have (mouthpieces, foil, or hooter),
    - Use 1 pipe for opioids (down) and another pipe for stimulants (up, side, crystal meth, crack)
    - Be aware that people use different ways to tell their pipes apart (colours, stickers, etc.). There is no common system - always ask and tell.
- Keep your pipe in a safe spot where it can’t break when you are not using it.
- Try not to store your pipe in your Naloxone kit. If you do store it there, label the kit to avoid confusion.

Basic Safer Inhalation Education

Using foil and hooter (tube to inhale vapour):

- Use foil made for substance use available through harm reduction distribution programs because it is thicker, more stable, and does not have coatings. Other types of foil can be coated in oil, which is harmful when burned and inhaled.
- Avoid direct flame on the foil as this can burn holes in the foil.
- Avoid sharing foil. Each sheet should only be used once.
- The safest options for a hooter from the BCCDC supply program are rolled foil and vinyl tubing. Paper straws are not recommended because they can catch fire and cause burns. People can also use other materials, such as pens or metal straws. Avoid using a glass stem to ensure that people who need access to inhalation supplies can get them.

Advanced Safer Injection Education[25,27,35,36,39-43,48,54,55,58-6]

Offer information on safer substance use supplies:

- Encourage use of the right needle size (gauge). Start with a smaller needle size first.
- Encourage the safer use of acidifiers (e.g. vitamin C) for dissolving some substances before injection (e.g. crack cocaine, tar heroin, fentanyl that has solidified or "gelled").
- If the person chooses not to cook substances, encourage them to filter their substances with a sterile filter.

Demonstrate how to choose a vein for safer injection:

- Inspect and feel for veins.
- Find a straight vein that is easy to feel with your fingertips.
- Use veins furthest away from the centre of the body.
- Use a vein on the non-dominant arm.
- Feel the vein to determine condition.
- Choose veins that feel full (bouncy) and unobstructed.

Offer education and coaching on safer vein care:

- Demonstrate how to tie a quick-release tourniquet.
- Discuss removal of the tourniquet before injection to prevent vein damage and bleeding from injection site.
- Demonstrate how to self-anchor veins and the syringe to avoid vein movement.
- Encourage the person to "flag" before injecting: aspirate blood into the syringe to ensure placement in a vein.
- Once blood appears in the syringe ("red flash"), remove the tourniquet and inject slowly.
- Advise the person to avoid injection into an artery. An artery is deeper in the body, has a heartbeat, and will hurt a lot if injected into. Injection into an artery requires immediate assessment by a trained healthcare provider.

Advanced Safer Injection Education: Tablet and Capsule Injection[93, 94]

Offer information on safer tablet and capsule injection:

- Discuss ways to reduce harm if injecting tablets or capsules:
    - Tablets and capsules are made for oral use and are not made for injection.
    - Tablets and capsules contain coatings and powder (called fillers) or waxes that can damage veins and the body when injected.
    - To reduce risks, aim to reduce the number of large particles, fillers, and microorganisms (e.g. bacteria, fungi) injected by using sterile safer substance use supplies and thorough filtering.
- Use sterile filters to reduce the amount of fillers injected.
- If injecting a tablet, use a clean pill crusher to crush the tablet to a fine powder before injection to decrease the risk for injecting large particles.
- If injecting contents in a capsule, open the capsule and pour out the beads or powder into a sterile cooker. Crush the beads into a fine powder.
- People may choose to use heat or the cold method. There are risks and benefits to each. See CATIE Injecting Opioid tablets and Capsules for more information.
- Offer information on safer use of filters:
    - Sterile filters (e.g. Sterifilt FAST) can remove some of the fillers.
    - Filter slowly over 20-60 seconds.
    - Cigarette filters, cotton balls, and other makeshift filters are not sterile or made for injection. Makeshift filters can contain bacteria that cause infection and materials that cause harm.

Advanced Practice: Self- injection into a peripheral IV [30, 77,78]

Discuss risks and options:

- Discuss risks of self-injection including embolism, infection, blockage, drug poisoning, or line failure.
- Identify alternative options including injection into a muscle or vein using a needle and different modes of consumption (e.g. rectal use, inhalation).
- Discuss safer substance use practices and considerations when injecting into an IV.
- Provide opportunities for the person to ask questions and clarify risks.

Safer preparation:

- Offer supplies: Gloves, alcohol swabs, and 3 ml, 5 ml, or 10 ml prefilled 0.9% normal saline flushes.
- Encourage hand hygiene and put on gloves.
- Support to clean and disinfect surfaces in the area.
- Provide information on the use of safer substance use supplies to prepare substances for injection:
    - Cook substances with more sterile water than is usually used for injection into the vein.
    - Filter substances using a sterile filter.
    - Avoid using a tourniquet when injecting in an IV.

Check the IV site and care for the site:

- Check the IV site, dressing and skin for:
    - Swelling, pain, discharge, and heat at site or extending away from site.
    - Dressing condition (e.g. secure, dry, intact, unsecured or soiled).
    - Surrounding skin condition (e.g. skin blistering).
    - Signs of infection such as pain or redness to veins or site.
    - Vein hardness.
    - Patency (openness) of line, presence of blood, blockage.
    - Line condition (e.g. dislodged, blockage, leak)
    - Any other concerns regarding the overall health, skin, veins, or site.
- Depending on the issue and severity, care for the site by changing the IV dressing, removing the IV, or escalating care. Offer to connect with the person's healthcare team for continuity of care.

Advanced Practice: Self-injection into a peripheral IV

Support safer self-injection by encouraging the person to:

- Scrub top of needleless connector with an alcohol swab for 15 seconds. Allow to dry completely (minimum 30 seconds).
- Connect the needleless barrel syringe (3 or 5 ml) with a luer lock connection to the IV.
- Flush before substance use with 3 ml 0.9% normal saline. Flush until the line is clear.
- Maintain positive pressure. Some IVs will have positive pressure connectors. If the IV does not have a positive pressure cap, clamp the tubing as the syringe is removed.
- Inject slowly, do not force against resistance.
- Flush after substance use with 3 cc normal saline slowly, then clamp extension tubing.

Aftercare and teaching:

- Discuss considerations for flushing. Explain that substances can still be in the IV line and not reach the bloodstream until enough fluid is pushed through the IV.
- Discuss signs and symptoms of common complications and when to seek medical care.
- Provide safer substance use education and supplies for self-injection into a peripheral IV (e.g., prefilled saline flushes, alcohol swabs, extra dressings, hand hygiene).
- Provide safer substance use education for self-care of IV line, including:
    - IV's require regular flushing with normal saline (0.9%) to keep open and unblocked.
    - Peripheral IVs should be removed every 3-4 days and as needed (or depending on organizational policy where IV was inserted).
    - Try to avoid using the IV every time. Rotate veins or use different modes of substance use.

Advanced Practice: Self-injection into a peripherally inserted central catheter (PICC)[63-65,77, 78, 79,80]

Discuss risks and options:

- Discuss risks of self-injection including embolism, infection, blockage, drug poisoning, or line failure.
- Identify alternative options including injection into a muscle or vein using a needle and different modes of consumption (e.g. rectal use, inhalation).
- Discuss safer substance use practices and considerations when injecting into an IV.
- Provide opportunities for the person to ask questions and clarify risks.

Safer preparation:

- Offer sterile supplies, such as:
    - Antiseptic swabs (e.g. chlorhexidine/alcohol),
    - 10 ml prefilled 0.9% normal saline flushes,
    - Luer lock 10 cc needleless syringe,
    - Dressing supplies to keep the site clean and dry.
- Encourage hand hygiene and put on gloves.
- Support the person to clean and disinfect surfaces in the area.
- Encourage cooking substances with more sterile water than is usually used for injection.
- Encourage use of a sterile filter to filter substances.
- Avoid using a tourniquet when injecting into a PICC line.

Check the PICC line and care for the site:

- Check the PICC line, site, and skin around the site to identify:
    - Type of PICC line including number of lumens and valves,
    - Date of insertion,
    - Patency (openness) of line,
    - Last dressing change and change of needleless connectors,
    - Dressing condition (e.g. dry and intact, unsecured or soiled)
    - Signs of infection at the site (redness, pain, swelling, discharge) or fever/chills,
    - Signs of phlebitis (redness, pain, swelling, heat, hardness at the site)
    - Line appears to be pulled out or dislodged
    - Line occlusion or leak
    - Any other concerns regarding the overall health, skin, veins, or site.
- Use aseptic technique to change the dressing if the dressing is soiled, overdue for a dressing change, falling off, or missing.
- Use aseptic technique to change the connectors if they are overdue or change is indicated.

Advanced Practice: Self-injection into a PICC

Support safer self-administration by encouraging the person to:

- Vigorously swab the needleless connector using a single use antiseptic solution (e.g. alcohol swab or chlorhexidine) for 30 seconds. Allow the connector to dry for 1 minute.
- Flush with 1-2 mls of saline prior to confirming patency. Use a needless syringe that is 10 mls or larger.
- Check patency by aspirating (pulling back on the syringe) until blood is visible in the line or connector. Always use a needleless syringe that is 10mls or larger.
- Flush the PICC line before and after substance use:
    - Connect the needleless barrel syringe with a luer lock connection.
    - Flush before self-injection of substances with 20 ml saline (two 10 ml pre-filled saline flushes) using turbulent (pulsating push pause) action before administering medication.
    - Administer the substance slowly.
    - Flush after medication administration with 20 ml saline (two 10 ml pre-filled saline flushes) using turbulent (pulsating push pause) action and finishing with positive pressure.
    - Maintain positive pressure on the PICC by removing the syringe from the connector as you push in the last 0.5 ml to 1 ml of saline.
    - Try to flush the PICC every twelve hours.
    - Do not force flushing or aspiration if there is resistance. Seek medical assistance if there is resistance.

Provide aftercare and teaching:

- Provide safer substance use education and supplies for self-injection into a PICC, including prefilled saline flushes, chlorhexidine/alcohol swabs, extra dressings, hand hygiene supplies.
- Ensure proper flushing as the substance can still be in the line and will not reach the bloodstream until enough fluid is pushed through.
- PICC lines require regular flushing with normal saline (0.9%) to keep open and unblocked.
- Discuss signs and symptoms of common complications and when to seek medical care.
- Advise to avoid using the PICC line every time. Encourage rotating veins or use different modes of substance use.

If the PICC has more than 1 lumen, try to use 1 lumen for self-injection and leave the other lumen for use by the healthcare team.

If the person is unable to self-inject after individualized supports, education, and coaching:

- Ensure you offer all other options available to the person (e.g. physical supports, communication tools, support person, etc.)
- If available, discuss access to assisted injection of safer alternative to the unregulated drug supply (e.g. injectable opioid agonist therapy [iOAT]).
- Provide information on other routes of administration including intramuscular injection, inhalation (smoking), snorting, or rectal use.
- If the SCS is authorized for peer-assistance and a peer is available, the peer can provide assisted injection.
- If the person is unable to self-inject and alternatives to self-injection are not available, service providers may encounter ethical tensions around access to assisted injection. Refer to documents in the Legal and Practice Reports for further discussion.

Peer Assisted Injection

Under current legislation, assisted injection of controlled drugs is restricted to peer assisted injection at supervised consumption sites (SCS) with an exemption for peer assisted injection.

Service providers can offer safer substance use education and coaching to peers providing assisted injection.

After Supported Consumption

1. Support safety

- Remove sources of flame, provide sharps disposal, encourage body repositioning to keep airway open, support the person to put away their supplies or dispose of supplies in sharps disposal, etc.

2. Monitor for drug poisoning

- Monitor for signs of drug poisoning.
- Provide the person's preferred intensity of support as discussed:
    - *High*: stay with the person during monitoring.
    - *Occasional*: provide personal space, give support when requested, and check in every few minutes while maintaining sightline.
    - *Low*: observe the person from a distance to monitor for signs of drug poisoning.
- If the person declines monitoring:
    - Respect personal choice and autonomy. Individuals may decline services without jeopardizing future access to drug poisoning prevention services.
    - Support the person to identify a safety plan: recommend the person stays with someone or at a location with people trained and equipped to respond to drug poisonings; access a virtual overdose prevention service (e.g. Lifeguard); or call an overdose prevention phone line (e.g. NORS).
    - If appropriate, discuss how to recognize opioid poisoning and stimulant toxicity (overamping) and when to seek care.
    - If the person becomes unresponsive, consent is not necessary to provide emergency drug poisoning response.
- Use trauma- and violence- informed practices when monitoring:
    - Monitor the person's breathing and level of consciousness while providing personal space.
    - If you are concerned about the person's breathing or level of consciousness, first use your voice to get their attention— "*are you doing ok*?"
    - Ask before you touch the person. If they are unresponsive, tell the person what you are going to do before you touch them— "*I am going to touch your shoulder*"
- If able, provide access to a space to relax (e.g. a chill space), food, water, and other supports as requested and available.

3. Respond to drug poisoning, if necessary[67]

- If the person shows signs of opioid poisoning, follow the SAVE ME steps to respond.
- If the person shows signs of stimulant toxicity (overamping) or another medical emergency, call 911 and provide supportive care.

4. Provide aftercare and referrals[25,39]

- Ask the person if they have support needs, such as substance use services, treatment and recovery services, housing, primary care, cultural supports, income supports, etc.
- Provide timely referrals and connections to health and social services and cultural supports.
- If able, facilitate direct connections to services at the time they are requested: contact an outreach team, introduce the person to a service, phone the service together, support transportation or walk with the person to the service, etc.
- Agree on a plan to check in and follow up on support needs. For example, the person may wish to follow up in a few days or with their primary care provider or connect with an Elder. With permission, share identified support needs with the team to provide ongoing care.
- Consider aftercare for service providers, including the need to debrief or access supports.

5. Discuss safety planning

- Offer information on harm reduction and drug poisoning prevention resources, including drug checking, access to opioid agonist therapy (OAT), overdose prevention services, safer substance use practices etc.
- Provide access to to-go harm reduction supplies and a take home naloxone kit and training.
- Always use at an OPS, with a buddy and alternate who is using, or use a virtual service like the Lifeguard app or NORS phone line 1-888-688-6677.

Document According to Organization and Professional Requirements

Documentation

Documentation includes written and electronic information about a person's care or services delivered by a service provider. Documentation requirements are different depending on the setting, organizational policy, and professional standards and regulations. Documentation requirements also differ across sites and between regulated and non-regulated service providers.

It is important for all service providers to know their organizational documentation requirements (if any) for providing observed consumption and emergency drug poisoning response. Regulated service providers (e.g. nurses, social workers, physicians) should also understand their professional documentation responsibilities.

Service providers should be aware that written records of substance use and drug poisoning can deter people who use substances from accessing services due to fears of surveillance and negative impacts on future care. 69 A person should not be required to share identifying information to receive harm reduction services, including observed consumption.

Organizations may consider implementing documentation systems to support communication, client safety, and privacy through an anonymous charting system separate from the primary electronic record (e.g. electronic client chart). The anonymous charting system may use pseudonyms instead of personal identifiers and can be accessed by service providers delivering harm reduction or substance use services.

Documentation for Health Authority Settings in BC

Settings that are associated with a provincial or regional health authority should follow their health authority policy for guidance on reporting procedures. Sites that use the BC Patient Safety and Learning System (PSLS) should follow up with their organization to determine whether drug poisonings should be documented as a patient safety event in PSLS. The PSLS report is not linked to a patient and should not include identifying information.

Regulated Healthcare Service Providers

Regulated healthcare service providers should document observed consumption according to their organizational requirements and their professional regulatory body's standards and guidelines for practice.

Documentation of observed consumption should safeguard confidentiality, facilitate access to low barrier drug poisoning prevention and response services, and communicate relevant interventions and adverse safety issues.

Nurses

Nurses are required to document medication administration and adverse safety events. Nurses providing supported consumption should document medication administration and adverse events (e.g. drug poisoning response). If a drug poisoning occurs after providing supported consumption, drug poisoning response interventions and naloxone administration should be documented in the person's medical record. Nurses should follow the relevant BCCNM Documentation Standard.

Section 2

Assisted Injection Considerations

Assisted Injection Considerations

Peer-assisted injection by friends, family, and peers (commonly referred to as "doctoring") has been a long-standing practice to support people who inject substances. Assisted injection by a nurse is not intended to replace peer-assisted injection. Instead, this document aims to clarify practice to improve access to a range of safer substance use services and care. It is important to understand the potential civil, criminal, and professional liability risks of assisted injection, depending on your role, where you work, and the types of substances.

Assisted injection refers to hands-on assistance with the act of injection. There are two phases of assisted injection:[1]

1. Performing venipuncture on a peripheral vein or installation of a peripheral intravenous (IV)

2. Assistance administering the substance

Under current legislation, service providers are not legally permitted to provide assisted injection of unregulated substances.[92] It is outside the scope of practice for social workers to dispense, administer or assist with the administration of regulated or unregulated substances.

Assisted injection of controlled substances is restricted to specific situations for peer assisted injection[e] and nurse assisted injection:

[e] Peer assisted injection is an optional service at SCSs in Canada. To provide this service, the SCS must apply to the Health Canada Office of Controlled Substances for peer-assistance authorization. This exemption means that a peer may provide assisted injection within the SCS. This exemption does not extend to peers employed at the SCS.

Peer-assisted injection	Peer assisted injection at supervised consumption sites (SCS) with an exemption for peer assistance.	Health and social service providers can support peers providing assisted injection through supported consumption (e.g. safer substance use coaching, education, supplies, etc.).
Nurse-assisted injection	Nurses can administer prescribed regulated substances (medication) with a client-specific order at a community health facility (e.g. clinic, SCS) or hospital.	Access to administration of medication by a nurse as an alternative to the toxic unregulated drug supply is currently limited to injectable opioid agonist therapy (iOAT).

Some nurse practitioners who meet educational and regulatory requirements may prescribe and administer iOAT. Nurses providing iOAT should follow the National Clinical Guideline iOAT for Opioid Use Disorder[95] and BCCSU Guidance for Injectable Opioid Agonist Treatment.[96]

Legal Issues

Nurses and other service providers are best protected from liability and professional consequences by working within the prohibitions on assisted injection until the Controlled Drugs and Substances Act (CDSA) is changed or the courts intervene.[92]

Currently, assisted injection of unregulated substances by nurses and other service providers is not permitted. Service providers assume legal and professional liability risks for providing assisted injection of unregulated substances.

Please see the HIV Legal Network's Service provider-Assisted Injection in Ontario's Supervised Consumption Services: Frequently Asked Questions Report[2] for an in-depth discussion of the legal issues.

Peer-assisted injection is exempt from possession and trafficking charges in supervised consumption sites (SCS) with a Peer Assistance exemption from Health Canada. These sites have received an exemption for Peer Assistance that provides specific authorization for assisted injection only by peers at these sites. This exemption does not extend to regulated healthcare service providers or peers employed at the site and not all SCS are authorized for peer assistance injection. See the Health Canada Supervised Consumption Sites: Status of Applications for a list of sites with peer assistance as an authorized service.

Decriminalization

Health Canada has granted an exemption from the CDSA to the Province of B.C. regarding simple drug possession. This is effective from January 31, 2023 to January 31, 2026. Under this exemption, adults (18 years and older) in B.C. will not be arrested or charged for possessing small amounts of opioids, crack/cocaine, methamphetamine, and MDMA. Adults found in possession of any combination of these drugs that adds up to a combined total of 2.5 grams or less are not subject to criminal charges and drugs are not seized.[86]

On May 7, 2024, the Federal Government announced that they approved the Province of B.C.'s request to exempt public spaces from B.C.'s decriminalization policy, effective immediately. This provides law enforcement back with the authority to seize illegal drugs possessed in public, in any amount, and make an arrest. Possession of substances under the 2.5 gram threshold for personal use by adults in private residences, designated addictions health care facilities, places where individuals are lawfully sheltering, and overdose prevention and drug checking sites remains decriminalized.[86]

Decriminalization applies for personal use and does not apply to service providers delivering assisted injection services, as the substances are not for the service providers' personal use.

Criminal Liability

Federal law regulates controlled substances through the CDSA. According to the CDSA, a service provider may be criminally liable for possession charges for handling unregulated substances and trafficking if the service provider administers an unregulated substance or provides the person with unregulated substances for self-injection.[2] The service provider may also be liable for handling regulated substances in a way that does not align with the CDSA and the exemptions provided to BC. Further, service providers could be criminally liable for charges (such as assault) if a person experiences harms or death because of assisted injection.[2]

In the current legal landscape, offering assisted injection by an employed service provider (e.g. nurse) at a SCS could jeopardize site operation. The operation of an SCS is subject to the terms approved by Health Canada, which means that Health Canada can revoke its approval of an SCS for non-compliance with the terms of the agreement. Health Canada must expressly permit service provider-assisted injection by adding it as an authorized service in the Section 56 exemption.

Civil Liability

Service providers delivering assisted injection of unregulated substances could be liable for civil charges - including battery and negligence - for harms experienced because of assisted injection.[2] In this case, a client could potentially sue a service provider if they experienced harms from assisted injection.

Professional Liability

See Healthcare Provider Scope for more information on professional liability.

Practice Issues

There are several practice issues related to nurse-assisted injection. First, people who are unable to self-inject and require assistance with injection face inequitable barriers to accessing overdose prevention services (OPS).[1] Removing barriers to accessing OPS should be prioritized in the context of an ongoing drug poisoning emergency.[1] Another practice issue is limited access to IV administration of iOAT. A recent report has identified a need to address the issue of nurse-assisted iOAT injection and restricted route of administration. Limiting to nurse-assisted intramuscular (IM) injection of iOAT may pose barriers to access for people unable to self-inject.[1]

iOAT and Route of Administration

The National iOAT Guideline from CRISM identifies that nurses may be able to provide intravenous (IV) injection when requested by the patient and determined appropriate.[95] The guideline recommends institutional policies should outline the orders required, protocols for IV injection, and staff education.[95]

> "If the prescription indicates that the medications should or can be administered intravenously, assisting with venous access would be appropriate. This is important to highlight because we know, anecdotally, that safe supply medications prescribed IM/IV are often administered IM. This can pose problems, because the volume of medication to be injected is often high, resulting in the need for multiple IM injections. There is also a potential risk of reduced therapeutic effects and outcomes. If IV administration is indicated on the prescription (i.e., the medication prescribed is intended for IV injection) and preferred by the client, injection assistance should be provided in accordance with standards, limits, and conditions set out by BCCNM."
>
> *Gagnon et al. (2022) Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services.*

Scope

Under current legislation, assisted injection of controlled substances is restricted to specific situations for peer assisted injection[f] and nurse-assisted injection:

1. *Peer-assisted injection:* Peer-assisted injection at supervised consumption sites (SCS) with an exemption for peer assistance.
    - See Section 1: Supported Consumption Best Practice Guidance for recommendations on how to support peers providing assisted injection.
2. *Nurse-assisted injection:* Nurses can administer prescribed regulated substances (medication) with a client specific order at a community health facility (e.g. clinic, supervised consumption site) or hospital.

Nurse-assisted injection is currently limited to injectable opioid agonist therapy (iOAT). Nurses providing iOAT should follow the National Clinical Guideline iOAT for Opioid Use Disorder[95] and BCCSU Guidance for Injectable Opioid Agonist Treatment.[96]

The considerations outlined in this section aim to supplement existing guidance and to identify best practices for staff education and nurse-assisted injection by venipuncture or peripheral IV, where appropriate.[96]

[f] Peer assisted injection is an optional service at SCSs in Canada. To provide this service, the SCS must apply to the Health Canada Office of Controlled Substances for peer-assistance authorization. This exemption means that a peer may provide assisted injection within the SCS. This exemption does not extend to peers employed at the SCS.

Education and Training

Recommended Education and Training[1]

1. Harm reduction principles and practices.
2. Venipuncture and IV training that includes:
    - Structure and function of peripheral veins,
    - Venous access through venipuncture,
    - Insertion of a peripheral IV,
    - Medication administration through venipuncture and peripheral IV,
    - Assessment, care, maintenance, and removal of peripheral IV lines,
3. Prevention and response to common complications and emergency events associated with medication injection, including:
    - Opioid poisoning prevention and response, including naloxone administration,
    - Infection: cellulitis,
    - Inflammation: allergic reaction, hives, redness, swelling, bruising, hematoma, phlebitis.
    - Thrombus and embolism: pulmonary embolism, thrombophlebitis,
    - Anaphylaxis.
4. Basic CPR training.
5. Knowledge of services and referral processes for local health and social services, such as housing, primary care, food, cultural supports, substance use services, treatment and recovery, etc.
6. Knowledge of employer-specific policies, including occupational health and safety (e.g. safely performing injections, bloodborne pathogens, personal protective equipment, violence prevention etc.) legal regulations, and professional regulations and standards of practice, and understanding of ethical considerations.

Additional Education and Training[1,27]

1. Advanced training to improve health equity, such as trauma- and violence- informed practices, anti-racism, Indigenous cultural safety and humility, and anti-stigma.
2. Advanced drug poisoning prevention and response training.
3. Advanced training in safer substance use practices and current trends in the unregulated drug supply.

Practice Recommendations

Currently, nurse-assisted injection is limited to iOAT. Accordingly, nurses should follow existing practice guidance for iOAT as well as their organization's policies and procedures on medication administration for all prescribed medication, as well as the BCCNM Medication Practice Standard and BCCNM Acting with Client Specific Orders.

Related Resources

Decriminalization

BC Government Decriminalizing People who use Drugs in BC

Drug Poisoning Response

Toward the Heart Naloxone 101 Training Course

Toward the Heart SAVE ME Steps to Respond to Opioid Poisoning

Toward the Heart Overdose Survival Guide

Toward the Heart: How to use Naloxone Video

Equity-Oriented Care

EQUIP Equity Action Toolkit

Indigenous Cultural Safety & Humility

FNHA Cultural Safety and Humility

Legal & Practice Reports

Nurse Assisted Injection: A Path to Equity in Supervised Consumption Services

Canadian Nurses Protective Society- Request for Nurse-Assisted Injection in BC Article

HIV Legal Network Service Provider – Assisted Injection in Ontario's Supervised Consumption Services: Frequently Asked Questions

Mental Health and Substance Use Services

KUU-US Crisis Line

BC Government Help Starts Here

211 Community Resources

Nurses

BCCNM Practice & Standards

Occupational Health and Safety

BCCDC Accidental Fentanyl Exposure Skin

BCCDC Accidental Fentanyl Exposure Smoke

PICNET Infection Prevention and Control Resources

PICNET Point of Care Risk Assessment Tool

PICNET Hand Hygiene Poster

WorkSafe BC Ergonomics

Safer Substance Use Practices

BCCDC Safer Inhalation Tips

CATIE Harm Reduction Fundamentals: a toolkit for service providers

CATIE Sharp Shooters: Harm Reduction Info for Safer Injection Drug Use

CATIE Safer Injecting Information: Crystal Meth

CATIE Safer Injection Information: Powder and Crack Cocaine

CATIE Safer Smoking Information Crack Cocaine

CATIE Safer Smoking Information: Smoking with Foil

OHRN Connecting- a Guide to Using Harm Reduction Supplies as Engagement Tools

Social Workers

BCCSW Code of Ethics and Standards of Practice

Social Workers Act and the Social Workers Regulation.

Youth

Child, Family and Community Service Act

Interior Health Youth Harm Reduction Toolkit

Interior Health Youth Harm Reduction 101

References

1. Gagnon M, Gauthier T, Cleveland E, et al. Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services.: Canadian Institute for Substance Use Research;2022.
2. HIV Legal Network. Service provider-Assisted Injection in Ontario's Supervised Consumption Services: Frequently Asked Questions. 2022.
3. Wood RA, Wood E, Lai C, Tyndall MW, Montaner JS, Kerr T. Nurse-delivered safer injection education among a cohort of injection drug users: Evidence from the evaluation of Vancouver's supervised injection facility. International Journal of Drug Policy. 2008;19(3):183-188.
4. Fast D, Small W, Wood E, Kerr T. The perspectives of injection drug users regarding safer injecting education delivered through a supervised injecting facility. Harm reduction journal. 2008;5(1):1-8.
5. Wood E, Tyndall MW, Stoltz J-A, et al. Safer injecting education for HIV prevention within a medically supervised safer injecting facility. International Journal of Drug Policy. 2005;16(4):281-284.
6. Small W, Wood E, Tobin D, Rikley J, Lapushinsky D, Kerr T. The injection support team: a peer-driven program to address unsafe injecting in a Canadian setting. Substance use & misuse. 2012;47(5):491-501.
7. Gagnon M. It's time to allow assisted injection in supervised injection sites. CMAJ. 2017;189(34):E1083-E1084.
8. Cheng T, Kerr T, Small W, et al. High prevalence of assisted injection among street-involved youth in a Canadian setting. AIDS and Behavior. 2016;20:377-384.
9. O'Connell JM, Kerr T, Li K, et al. Requiring help injecting independently predicts incident HIV infection among injection drug users. JAIDS Journal of acquired immune deficiency syndromes. 2005;40(1):83-88.
10. Wood E, Spittal PM, Kerr T, et al. Requiring help injecting as a risk factor for HIV infection in the Vancouver epidemic: implications for HIV prevention. Canadian journal of public health. 2003;94:355-359.
11. Kral AH, Bluthenthal RN, Erringer EA, Lorvick J, Edlin BR. Risk factors among IDUs who give injections to or receive injections from other drug users. Addiction. 1999;94(5):675-683.
12. Kennedy MC, Hayashi K, Holliday E, Wood E, Kerr T. Assisted injection within supervised injection services: uptake and client characteristics among people who require help injecting in a Canadian setting. International Journal of Drug Policy. 2020;86:102967.
13. McNeil R, Small W, Lampkin H, Shannon K, Kerr T. "People knew they could come here to get help": an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting. AIDS and Behavior. 2014;18:473-485.

14. Dogherty E, Patterson C, Gagnon M, et al. Implementation of a nurse-led overdose prevention site in a hospital setting: lessons learned from St. Paul's Hospital, Vancouver, Canada. Harm Reduction Journal. 2022;19(1):1-6.
15. Pijl E, Oosterbroek T, Motz T, Mason E, Hamilton K. Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm reduction journal. 2021;18(1):1-11.
16. Biancarelli DL, Biello KB, Childs E, et al. Strategies used by people who inject drugs to avoid stigma in healthcare settings. Drug and alcohol dependence. 2019;198:80-86.
17. Paquette CE, Syvertsen JL, Pollini RA. Stigma at every turn: Health services experiences among people who inject drugs. International Journal of Drug Policy. 2018;57:104-110.
18. Sleeper JA, Bochain SS. Stigmatization by nurses as perceived by substance abuse patients: A phenomenological study. Journal of Nursing Education and Practice. 2013;3(7):92.
19. Muncan B, Walters SM, Ezell J, Ompad DC. "They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. Harm Reduction Journal. 2020;17(1):53.
20. Varcoe C, Browne AJ, Bungay V, et al. Through An Equity Lens: Illuminating The Relationships Among Social Inequities, Stigma And Discrimination, And Patient Experiences of Emergency Health Care. International Journal of Health Services. 2022;52(2):246-260.
21. Wathen CN, Varcoe C. Trauma- & violence-informed care (TVIC): a tool for health & social service organizations & service providers. . 2021.
22. BC Centre for Disease Control. Provincial Episodic Overdose Prevention Services (eOPS) Protocol. In:2023a.
23. R.S.B.C., 223 c. Infants Act. In. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_011996.
24. Government of BC. B.C. Handbook for Action on Child Abuse and Neglect for Service providers. In:2017.
25. Strike C, Miskovic M, Perri M, et al. Best Practice Recommendations for Canadian Programs that Provide Harm Reduction Supplies to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms. In. Toronto, ON2021.
26. BC Centre for Disease Control. Naloxone Administration Decision Support Tool. In:2023b.
27. CATIE. Sharp Shooters: Harm Reduction Info for Safer Injection Drug Use. In:2021.
28. McAuley A, Aucott L, Matheson C. Exploring the life-saving potential of naloxone: a systematic review and descriptive meta-analysis of take home naloxone (THN) programmes for opioid users. International Journal of Drug Policy. 2015;26(12):1183-1188.
29. Maghsoudi N, Tanguay J, Scarfone K, et al. Drug checking services for people who use drugs: a systematic review. Addiction. 2022;117(3):532-544.

30. Lightfoot B, Panessa C, Hayden S, Thumath M, Goldstone I, Pauly B. Gaining Insite: harm reduction in nursing practice. Canadian Nurse. 2009;105(4).
31. Rickard G, Hart B. Survival, safety and belonging: An ethnographic study of experiences and perceptions of people who inject drugs accessing a supervised injecting Centre. Australian Journal of Social Issues. 2022;57(4):829-846.
32. Anderson NC, Kesten JM, Ayres R, et al. Acceptability of, and barriers and facilitators to, a pilot physical health service for people who inject drugs: A qualitative study with service users and service providers. International Journal of Drug Policy. 2022;99:103437.
33. McNeil R, Kerr T, Pauly B, Wood E, Small W. Advancing patient-centered care for structurally vulnerable drug-using populations: a qualitative study of the perspectives of people who use drugs regarding the potential integration of harm reduction interventions into hospitals. Addiction. 2016;111(4):685-694.
34. Insite. Insite Self-Injection Protocol. 2021.
35. Flynn, J. Procedures in Phlebotomy. 2023.
36. World Health Organization. WHO guidelines on drawing blood: best practices in phlebotomy. World Health Organization; 2010.
37. Provincial Infection Control Network. Point-of-Care Risk Assessment (PCRA). In. https://picnet.ca/wp-content/uploads/Point-Of-Care-Risk-Assessment-Tool-2023-July-25-FINAL.pdf2023.
38. Gorski LA, Hadaway L, Hagle ME, et al. Infusion therapy standards of practice. Journal of Infusion Nursing. 2021;44(1S):S1-S224.
39. Miskovic M, Zurba N, Beaumont D, Conway J. Connecting: A guide to using harm reduction supplies as engagement tools. In: Ontario Harm Reduction Distribution Program, ed. Kingston, Ontario2020.
40. Scott J, Kennedy EJ, Winfield AJ, Bond C. Investigation into the effectiveness of filters for use by intravenous drug users. International Journal of Drug Policy. 1998;9(3):181-186.
41. Scott J. Laboratory study of the effectiveness of filters used by heroin injectors. Journal of Substance Use. 2005;10(5):293-301.
42. Harris M, Scott J, Hope V, Wright T, McGowan C, Ciccarone D. Navigating environmental constraints to injection preparation: the use of saliva and other alternatives to sterile water among unstably housed PWID in London. Harm reduction journal. 2020;17(1):1-11.
43. Keijzer L, Imbert E. The filter of choice: filtration method preference among injecting drug users. Harm Reduction Journal. 2011;8(1):1-7.
44. Strike C, Watson TM. Education and equipment for people who smoke crack cocaine in Canada: progress and limits. Harm reduction journal. 2017;14:1-7.

45. Hunter C, Strike C, Barnaby L, et al. Reducing widespread pipe sharing and risky sex among crystal methamphetamine smokers in Toronto: do safer smoking kits have a potential role to play? Harm Reduction Journal. 2012;9(1):1-9.
46. CATIE. Safer Crack Smoking. In:2020.
47. CATIE. Safer Crystal Meth Smoking. In:2020.
48. Harm Reduction Fundamentals: A toolkit for service providers. 2022. https://www.catie.ca/harmreduction.
49. CATIE. Smoking drugs using foil: steps to safer smoking. In:2023.
50. Fischer B, Powis J, Cruz MF, Rudzinski K, Rehm J. Hepatitis C virus transmission among oral crack users: viral detection on crack paraphernalia. European journal of gastroenterology & hepatology. 2008;20(1):29-32.
51. Harris M. An urgent impetus for action: safe inhalation interventions to reduce COVID-19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom. International Journal of Drug Policy. 2020;83:102829.
52. Jain S, Chraiti M, Pittet D, Mclaws M. Blood collection guidelines for inpatients and outpatients, home-based care and long-term care facilities. Journal of Hospital Infection. 2020;104(4):600-602.
53. CATIE. Mapping the body: choosing a vein for safer injection. In:2022.
54. Ball LJ, Venner C, Tirona RG, et al. Heating injection drug preparation equipment used for opioid injection may reduce HIV transmission associated with sharing equipment. Journal of Acquired Immune Deficiency Syndromes (1999). 2019;81(4):e127.
55. Harris M, Scott J, Wright T, Brathwaite R, Ciccarone D, Hope V. Injecting-related health harms and overuse of acidifiers among people who inject heroin and crack cocaine in London: a mixed-methods study. Harm reduction journal. 2019;16:1-15.
56. Perry AG, Potter PA, Ostendorf WR, Laplante N. Clinical nursing skills and techniques-E-Book. Elsevier Health Sciences; 2021.
57. Yasuda K, Shishido I, Murayama M, Kaga S, Yano R. Venous dilation effect of hot towel (moist and dry heat) versus hot pack for peripheral intravenous catheterization: a quasi-experimental study. Journal of Physiological Anthropology. 2023;42(1):23.
58. National Harm Reduction Coalition. Getting off right: a safety manual for injection drug users. In:2020.
59. Rhodes T, Briggs D, Kimber J, Jones S, Holloway G. Crack–heroin speedball injection and its implications for vein care: qualitative study. Addiction. 2007;102(11):1782-1790.
60. Doran J, Harris M, Hope VD, et al. Factors associated with skin and soft tissue infections among people who inject drugs in the United Kingdom: a comparative examination of data from two surveys. Drug and alcohol dependence. 2020;213:108080.

61. Roux P, Carrieri MP, Keijzer L, Dasgupta N. Reducing harm from injecting pharmaceutical tablet or capsule material by injecting drug users. Drug and Alcohol Review. 2011;30(3):287-290.
62. Ng H, Patel RP, Bruno R, Latham R, Wanandy T, McLean S. Filtration of crushed tablet suspensions has potential to reduce infection incidence in people who inject drugs. Drug and Alcohol Review. 2015;34(1):67-73.
63. Chase J, Nicholson M, Dogherty E, et al. Self-injecting non-prescribed substances into vascular access devices: a case study of one health system's ongoing journey from clinical concern to practice and policy response. Harm Reduction Journal. 2022;19(1):130.
64. Providence Health Care. Guideline: PICC/PIV and Substance Use: Patients Who May be Using Their IV Line to Inject Substances. In:2021.
65. Vancouver Coastal Health PCSS. Procedure for supervised self injection education through a PICC or PIV. In:2019.
66. BC Drug and Poison Information Centre. Opioid Overdose Best Practices Guideline. In:2017.
67. BC Centre for Disease Control. SAVE ME Steps to Respond to Opioid Poisoning. In:2023.
68. BC Centre for Disease Control. Responding to Prolonged Sedation. 2023. https://towardtheheart.com/assets/uploads/1692222620domF8SIa8UtM2B39m5j2TM78btD8LGn0RFfxMLc.pdf.
69. Van Boekel LC, Brouwers EP, Van Weeghel J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and alcohol dependence. 2013;131(1-2):23-35.
70. Government of British Columbia. Decriminalizing people who use drugs in BC. 2023; https://www2.gov.bc.ca/gov/content/overdose/decriminalization#:~:text=Under%20this%20exemption%2C%20adults%20(18,Crack%20and%20powder%20cocaine.
71. Palis H, Haywood B, McDougall J, et al. Factors associated with obtaining prescribed safer supply among people accessing harm reduction services: findings from a cross-sectional survey. Harm Reduction Journal. 2024;21(1):1-13.
72. Kolikof J, Peterson K, Baker AM. Central venous catheter. 2020.
73. BC College of Nurses and Midwives. Medication Practice Standard for All BCCNM Nurses. In. https://www.bccnm.ca/NP/PracticeStandards/General%20Resources/NP_PS_Medication.pdf2023.
74. Smeulers M, Verweij L, Maaskant JM, et al. Quality indicators for safe medication preparation and administration: a systematic review. PloS one. 2015;10(4):e0122695.
75. Astle BJ, Duggleby W, Potter PA, Perry AG, Stockert PA, Hall A. Potter and Perry's Canadian Fundamentals of Nursing-E-Book: Potter and Perry's Canadian Fundamentals of Nursing-E-Book. Elsevier Health Sciences; 2023.

76. Heydari A, Manzari Z-S, Khalili H. The effect of local warming before vascular access on vascular access indicators in adult patients receiving chemotherapy: A systematic review. Nursing and Midwifery Studies. 2021;10(4):213-221.
77. Providence Health Care. Injectable Opioid Agonist Treatment (iOAT) for Opioid Use Disorder and IV fentanyl for Withdrawal Management. In:2022.
78. Vancouver Coastal Health, Providence Health Care. IV Therapy, Peripheral: Insertion, Care and Maintenance In:2021.
79. Vancouver Coastal Health, Providence Health Care. Peripherally Inserted Central Catheter (PICC) Basic Care and Maintenance (Adult). In:2019.
80. BC Women's Hospital. Peripherally Inserted Central Catheters Basic Care and Maintenance. In:2023.
81. Pijl E, Oosterbroek T, Motz T, Mason E, Hamilton K. Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm reduction journal. 2021;18(1):1-11.
82. Lavalley J, Kastor S, Tourangeau M, Society WAHR, Goodman A, Kerr T. You just have to have other models, our DNA is different: the experiences of indigenous people who use illicit drugs and/or alcohol accessing substance use treatment. Harm Reduction Journal. 2020;17:1-10.
83. Allan B, Smylie J. First peoples, second class treatment. 2015.
84. Goodman A, Fleming K, Markwick N, et al. “They treated me like crap and I know it was because I was Native”: The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. Social Science & Medicine. 2017;178:87-94.
85. Equity and inclusion glossary of terms - UBC Equity & Inclusion Office. UBC Equity & Inclusion Office. Published July 5, 2023. https://equity.ubc.ca/resources/equity-inclusion-glossary-of-terms
86. Government of British Columbia. Decriminalizing Personal Possession of Illicit Substances - Province of British Columbia. www2.gov.bc.ca. Published March 7, 2023. https://www2.gov.bc.ca/gov/content/overdose/decriminalization
87. Stowe M, Feher O, Vas B, Kayastha S, Greer A. The challenges, opportunities and strategies of engaging young people who use drugs in harm reduction: insights from young people with lived and living experience. Harm Reduction Journal. 2022;19(1):83.
88. Bozinoff N, Small W, Long C, DeBeck K, Fast D. Still “at risk”: An examination of how street-involved young people understand, experience, and engage with “harm reduction” in Vancouver’s inner city. International Journal of Drug Policy. 2017;45:33-39.
89. Wolfson L, Schmidt RA, Stinson J, Poole N. Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. Health & Social Care in the Community. 2021;29(3):589-601.

90. Grewal J, Kennedy CJ, Mamman R, Biagioni JB, Garcia-Barrera MA, Schmidt J. Understanding the barriers and facilitators of healthcare services for brain injury and concurrent mental health and substance use issues: a qualitative study. BMC Health Services Research. 2024;24(1):1-11.
91. Boyd J, Maher L, Austin T, Lavalley J, Kerr T, McNeil R. Mothers Who Use Drugs: Closing the Gaps in Harm Reduction Response Amidst the Dual Epidemics of Overdose and Violence in a Canadian Urban Setting. American Journal of Public Health. 2022;112(S2).
92. Canadian Nurses Protective Society. Nurse-assisted Injection in British Columbia: Legal Risks and Considerations. 2024.
93. Provincial Health Services Authority (PHSA). Guidance for Injecting Tablet Medication. YouTube. Published November 19, 2020. Accessed March 17, 2025. https://www.youtube.com/watch?v=Qh6eTS9q4bA
94. Injecting opioid tablets and capsules: Steps to safer preparing and injecting. CATIE - Canada's source for HIV and hepatitis C information. Published March 31, 2023. https://www.catie.ca/injecting-opioid-tablets-and-capsules-steps-to-safer-preparing-and-injecting
95. Canadian Research Initiative in Substance Misuse (CRISM). National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline. Published September 23, 2019. Available at: https://crism.ca/projects/ioat-guideline/
96. British Columbia Centre on Substance Use (BCCSU). Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder. 2021. https://www.bccsu.ca/wp-content/uploads/2021/07/BC_iOAT_Guideline.pdf
97. WorkSafe BC. Preventing Musculoskeletal Injury (MSI). 2025. https://www.worksafebc.com/en/resources/health-safety/books-guides/preventing-musculoskeletal-injury-msi-a-guide-for-employers-and-joint-committees?lang=en