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INTERNATIONAL CONSENSUS STATEMENT ON THE ROLE OF NURSES IN SUPERVISED CONSUMPTION SITES

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ABSTRACT

Background and Objective

There are currently more than 150 supervised consumption sites (SCS) worldwide. These sites offer a much-needed point of contact between the health care system and people who use drugs and, as such, have been proven to effectively reduce harms and improve health. SCS are typically staffed by mental health and harm reduction workers, social workers, workers with living or lived experience, and registered nurses. It has been established that the care provided by nurses within SCS fall within their legislated scope of practice but the actual role of nurses in SCS remains poorly defined and understood.

Material and Methods

To address this significant practice, policy and research gap, a consensus statement was developed based on information generated by 17 content experts from 10 countries namely, Canada, Spain, Australia, France, Denmark, Norway, Ireland, Switzerland, Germany, and Scotland. The statement was developed from "the ground up" by gathering information on three content areas: nursing practice in SCS, training, and needs. This information was summarized, and then submitted to two rounds of voting using a modified Delphi method to build consensus.

Results

The final content of the consensus statement is comprised of five sections: (1) Philosophy of care, (2) Framework, (3) Nursing role, (4) Training requirements, and (5) Needs of nurses.

Conclusion

This consensus statement is the first step toward a better understanding of the role of nurses in SCS. There is immense responsibility on nurses in this setting, as the majority of people who access SCS face many barriers in accessing other health and social services, even when their need for those services may be critical. For these reasons, it is essential to better prepare nurses for these realities. We hope that this first international consensus statement can serve as a foundation to guide practice, policy, research, and operational decisions in SCS.

Supervised consumption sites (SCS) have been implemented in Europe, North America, and Australia, reaching a total of more than 150 sites worldwide. In addition to reducing harms and preventing overdoses and overdose deaths, SCS act as a point of service for people who use drugs to access much-needed health care services. Registered nurses who work in SCS provide care, support, education, and resources to reduce health risks and improve health. It has been established that these interventions fall within the legislated scope of practice of registered nurses but the actual role of nurses in SCS remains poorly defined and understood, especially by decision-makers, employers, health care providers, and the broader community.

To address this significant practice, policy and research gap, SCS nurses from Canada, Spain, Australia, France, Denmark, Norway, Ireland, Switzerland, Germany, and Scotland joined together to generate the first International Consensus Statement on the Role of Nurses in Supervised Consumption Sites. The purpose of this working group, which was created and supported by the Harm Reduction Nurses Association (HRNA)[*], was to build a consensus statement "from the ground up" with a specific focus on the actual role of nurses in SCS, the training required to

[*] HRNA is a Canadian national organization with a mission to advance harm reduction nursing through practice, education, research, and advocacy. It serves as a national voice for harm reduction and related nursing issues, promotes education and continuous learning opportunities for nurses, provides opportunities to share nursing knowledge, expertise and practices, encourages evidence-based harm reduction nursing practices, and strives to create a dynamic network to support and mentor nurses across Canada – and beyond.

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work in SCS, and the support required. This article will present the results of this consensus statement process and discuss their implications.

METHODS

Due to the lack of literature and research on the role of nurses in SCS, this consensus statement was developed based on information generated by content experts (i.e., nurses with experience of working in SCS). Two co-chairs (Marilou Gagnon and Tim Gauthier) oversaw the entire process, which began in September 2018 and ended in May 2019. The working group was composed of 17 content experts from 10 countries: Canada (6), Spain (1), Australia (2), France (1), Denmark (1), Norway (2), Ireland (1), Switzerland (1), Germany (1), and Scotland (1).

We began the process by circulating an open-ended questionnaire to gather information on three content areas. In the first content area (nursing practice in SCS), we asked nurses to document in a detailed way all the health issues and interventions that fell under their role in SCS. In the second content area (training), we asked nurses to identify the ideal training requirements for new nurses in SCS (i.e., duration, content, format, and trainers). Finally, for the third content area (needs), we asked nurses to identify what they needed to support their practice, including informational needs, clinical needs, practical needs, and organizational needs. Each content expert was responsible for completing the questionnaire – alone or in consultation with colleagues.

The answers to the questionnaire were compiled into a 150-page document by the working group co-chairs (M.G. and T.G.) and then summarized into a 10-page document. This summarized document was submitted to the working group for general feedback and revised based on that feedback. Next, we used a modified Delphi technique to develop the content of the statement. The Delphi technique is "a widely used and accepted method for achieving convergence of opinion concerning real-world knowledge solicited from experts within certain topic areas."[1] Content was broken into sections and uploaded onto Survey Monkey to prepare for the voting process. Each working group member was sent the survey link and asked to register a vote for each section using the following Likert scale: Strongly disagree (1 point), Disagree (3 points), Neutral: (5 points), Agree (7 points), and Strongly agree (9 points).

During the first round of voting, working-group members were asked to provide detailed feedback if they recorded a neutral, disagree, or strongly disagree vote. Following the first round of voting, all of the sections achieved consensus but three required some editing and minor additions. To ensure that full consensus was obtained for all sections, we submitted the three revised sections to a final vote. All three sections achieved consensus on the second round of voting. This article summarizes the main results of this consensus-building process and discusses their implication.

RESULTS

The final content of the consensus statement is comprised of 5 sections:

1. Philosophy of care
2. Framework
3. Nursing role
4. Training requirements
5. Needs of nurses

PHILOSOPHY OF CARE

Nurses who work in SCS should draw on a broad philosophy of care located at the intersection of harm reduction, health equity, cultural safety, relational care, social justice, and anti-oppression. Harm reduction recognizes the importance of reducing the harms (health, social and economic) associated with the use of drugs while also acknowledging that such harms are a direct result of prohibition and criminalization. As such, harm reduction emphasizes the need to address the broader structural determinants that negatively impact the health and the lives of people who use drugs. Health equity provides an important lens to understand that certain groups such as those living in poverty, those experiencing mental illness and/or homelessness, racialized communities, women, and Indigenous people are disproportionally impacted. These groups will present greater inequities in health status and access to health care.[2] In their capacity,

SCS nurses should strive to reduce such inequities by increasing access to primary health care and using their full scope of practice to offer a wide range of services onsite (i.e., wound care, testing, treatment initiation, and monitoring, and so forth). To further address inequities, nurses should practice cultural safety.[3] They need to examine their power, privilege, values, and assumptions – and how this may impact their care. They should also understand history: the history of drug policy and the history of people who use SCS (i.e., personal history, previous experiences with the health care system, histories of trauma, violence, racism, etc.). Finally, they should ensure that SCS are safe spaces – physically, psychologically, emotionally, and spiritually – for people who use drugs. When providing care in such spaces, nurses should focus on the relational aspects of care and use approaches that foster respect, trust, meaningful engagement, and strengths. From an advocacy standpoint, nurses who work in SCS should adopt a social justice lens and call for system-wide interventions to address conditions that create and exacerbate the harms associated with drug use including poverty, unemployment, housing, racism, colonialism, criminalization, and capitalism. They should also engage in anti-oppression work, with a primary focus on prohibition as a system that punishes, marginalizes, excludes, shames, silences, and disempower people who use drugs.

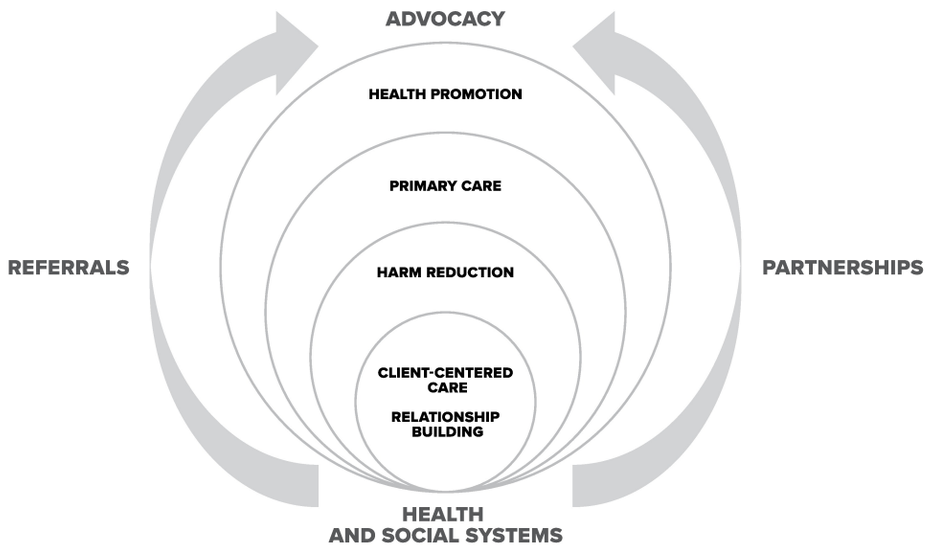
Framework

In SCS, nurses work in collaboration with other team members including (but not limited to) mental health and harm reduction workers, social workers, and workers with living or lived experience to meet clients where they are at. In their day-to-day work, they should draw on core principles of health promotion, harm reduction, and primary care to provide client-centered care. Relationship building is at the heart of nursing care in SCS. As such, fostering trust, dignity, safety, and empowerment is paramount to any nursing intervention in SCS.

Nursing Role

The care provided in SCS falls within the legislated scope of practice of registered nurses. Scope of practice "refers to the activities nurses are authorized, educated and competent to perform."[4] Scope of practice takes into account various factors including legislation, professional regulation, professional guidelines, standards and position statements, employer policies, individual competence, and client needs.[4] When making decisions about hiring and staffing, three factors of equal importance should be considered: (1) Client factors, (2) Nurse factors, and (3) Environment factors.[4]

FIG. 1 Framework (adapted from Lightfoot et al., 2009).



In SCS, the client situation is likely to be complex and unpredictable, and the environment dynamic and rapidly changing. Nurses hired to work in these environments should be able to demonstrate the greatest level of professional autonomy (i.e., assessment, decision-making, planning, implementation, evaluation, and coordination), critical thinking, flexibility, creativity, and leadership.

Practicing to their full scope of practice, nurses who work in supervised consumption services should be able to anticipate and recognize changes (including subtle changes) in clients' condition, be responsible and accountable in providing further assessment, identify relevant risk factors, understand the significance of their findings, provide a nursing diagnosis, and initiate interventions. They should also be able to undertake a comprehensive assessment of issues and priorities verbalized by the clients. In order to practice competently and safely in SCS, nurses should be able to conduct the following assessments: health history assessment, general and focused assessments (with demonstrated competencies regarding injection and substance-related emergencies as well as emergency situations requiring rapid and focused assessment); vital signs assessment; mental health status assessment; harm reduction assessment, and needs assessment (education, counseling, coaching, support, referrals, etc.). In addition to this, nurses should be prepared to recognize signs and symptoms associated with various health conditions including but not limited to the ones listed in Table 1.

Working with the client to identify priorities and needs – and in collaboration with other team members – nurses should be able to develop a plan of action to address the health conditions listed above (see Table 1). Potential interventions include but are not limited to:

- Monitoring
- Airway management
- Cardiopulmonary resuscitation
- Oxygen administration
- Medication administration
- First aid for trauma and injuries
- Management of acute conditions
- Triage
- Crisis intervention
- Education
- Counseling
- Advanced wound care
- Health promotion
  - Immunization
  - Smoking cessation
  - Nutrition
  - Hydration
  - Safer sex education and material
  - Contraception
- Primary prevention
- Harm reduction
- Screening and testing
  - Blood-borne and sexually transmitted infections
  - Pregnancy
  - Cervical cancer
- Consultation
- Active listening and support
- Treatment
  - Blood-borne and sexually transmitted infections
  - Infections requiring antibiotics
- Referral
  - Substance use counseling and treatment
  - Community clinics and services
  - Blood-borne and sexually transmitted infections
  - Hospital emergency
  - Housing, welfare, and social support
  - Family planning (including abortion)

In addition to direct patient care, nurses who work in SCS should build partnerships with groups of people with lived/living experience and community-based organizations. These partnerships are essential to maintaining and improving the quality of the care provided in supervised consumption services and ensuring that the care remains centred on the needs of people who use drugs. In addition to and in the context of these partnerships, nurses should engage in advocacy activities to promote the wider implementation of harm reduction policies and practices, to address structural conditions that create harms for people who use drugs, and to defend the rights and dignity of people who use drugs and their families.

Training

To be able to engage in safe, ethical, compassionate, and competent care in SCS, nurses should receive

TABLE 1 Health Conditions

Heart	Brain	Blood	Temperature
• Arrhythmias • Congestive heart failure • Acute coronary syndrome • Valvular disease • Cardiac arrest • Endocarditis • Hypertension • Hypotension	• Transient ischemic attack • Cerebral vascular attack • Brain embolism • Syncope • Seizures • Meningitis • Encephalitis • Headache • Cognitive impairments • Tics • Spinal cord abscess	• Anticoagulation • Hypercoagulation • Dehydration • Electrolyte imbalances • Sepsis	• Hypothermia • Hyperthermia • Heat exhaustion and heat stroke
Blood vessels	**Lungs**	**Gastrointestinal**	**Kidneys, bladder, genitals**
• Deep vein thrombosis • Aneurysm • Infected aneurysm • Vascular injury • Vascular rupture • Vascular collapse • Vasoconstriction • Peripheral edema • Hematoma • Phlebitis • Chronic venous insufficiency • Chronic arterial insufficiency • Impaired circulation • Claudication • Vascular access management (including peripheral and central lines) • Limited vascular access • Compartment syndrome	• Pulmonary emboli • Asthma • Chronic obstructive pulmonary disease • Pneumonia • Tuberculosis • Cough • Thoracic pain • Upper respiratory tract infections • Hypoventilation • Hyperventilation • Respiratory arrest • Pulmonary hypertension • Pulmonary edema • Shortness of breath • Dyspnea • Hemoptysis • Bronchospasms • Pulmonary granulomatosis • Pulmonary fibrosis • “Crack lung” (acute pulmonary syndrome post-inhalation)	• Constipation • Diarrhea • Gastric reflux • Esophageal varices • Liver cirrhosis • Hepatic encephalopathy • Liver cancer • Portal hypertension • Malnutrition • Vitamin deficiency • Vomiting • Pancreatitis • Bowel obstruction	• Incontinence • Urinary tract infection • Urinary retention • Rhabdomyolysis • Pyelonephritis • Dialysis • Chronic kidney failure • Acute renal failure • Prostate hyperplasia • Pregnancy (including termination of pregnancy) • Menstrual irregularities • Yeast infection • HPV • Genital warts • Bacterial vaginosis • Trichomoniasis • Mucopurulent cervicitis • Gonorrheal & Chlamydia • Nongonococcal urethritis • Pelvic inflammatory disease • Decreased libido • Erectile dysfunction
Skin and soft tissue	**Extremities**	**Ear, eyes, nose, and throat**	**Trauma and injuries**
• Frostbite • An abscess (including intramuscular) • Psoriasis • Bruising	• Tremors • Decreased sensation • Cramps • Reduced mobility	• Tooth decay • Tooth infection • Ophthalmic problems • Dysphonia (loss of voice)	• Assault • Sexual assault • Traumatic brain injury • Penetrative trauma (knife, bullet or other)

TABLE 1 Health Conditions (Continued)

Skin and soft tissue	Extremities	Ear, eyes, nose, and throat	Trauma and injuries
• Necrosis • Bites: insect, animal, human • Ulcers: venous, arterial, pressure • Cellulitis • Scabies • Tinea • Intertrigo • Dermatitis • Eczema • MRSA • Delusional parasitosis/ Morgellons • Lice • Wounds • Lacerations • Herpes zoster	• Arthritis (including septic arthritis) • Muscle wasting • Swelling • Osteomyelitis • Osteoporosis • Bursitis • Hand or foot drop • Issues related to limb amputation • Podiatric problems **Nerves** • Compressed nerve • Neuropathic pain • Radial neuropathy • Nerve injury related to injection practices	• Cerumen impaction • Foreign body: ears / eyes • Ear infection • Conjuctivitis (allergic, infectious, chemical, traumatic) • Eye injuries • Sinusitis • Septal defect/injury • Opthalmic infection • Pharyngitis: strep / gonococcal / viral • Lymphadenopathy • Thrush • Vision loss / disturbance	• Blunt trauma • Fractures • Sprains • Burns • PTSD • Intimate partner violence
Mood and behaviours	**Blood-borne and sexually transmitted infections**	**Allergic or hypersensitivity reactions**	**Substance use**
• Impaired judgement • Impaired impulse control • Aggression • Agitation • Bipolar disorder • Borderline personality disorder • Hallucinations • Delusions • Paranoia • Anxiety • Depression • Suicidal ideation • Homicidal ideation • Psychosis • ADHD • Dissociation • Crisis • Self-harming • Grief and loss • Isolation • Lack of support • Loneliness • Lethargy • Anorexia • Sleep deprivation • Insomnia	• Gonorrhea • Chlamydia • HIV • Viral hepatitis • Herpes zoster • Syphilis **Other infections** • Influenza • Cold	• Allergic reactions • Anaphylactic shock • Urticaria • Rash	• Opioid-related overdose: typical and atypical overdose • Stimulant overdose • Alcohol toxicity (including ethylic coma) • Substance interactions • Withdrawal • Issues related to opioid agonist and assisted therapy

training that ranges between 2 and 4 weeks. Ideally, candidates should be screened through a rigorous process and in some cases, required to complete one shadow shift before hiring. Training should be tailored to the experience and needs of each newly hired nurse and delivered using a mixed and gradual approach including orientation time, shadowing of experienced nurses, buddy shifts with experienced nurses, lectures, readings, internet-based learning, mock scenarios, debriefs, and mentoring. In order for training to be adequate and reflect the complexity of the care provided in SCS, a range of experts need to be involved: managers and educators, experienced SCS nurses, experienced SCS staff, other health care providers (i.e., physicians, paramedics, social workers), people with living and lived experienced, and specialists in hepatology, HIV, wound care, mental health, and so forth.

Training should cover content specific to the philosophy of care, health conditions encountered in SCS, nursing assessments and interventions as well as content specific to illicit drugs. To be able to practice according to the philosophy of care previously described, nurses should receive training on drug policy, theories on substance use, harm reduction, trauma-informed approach, patient-centered care, strength-based approach, relational care, cultural safety, power and privilege, advocacy, professional role (autonomy, judgement, decision-making). They should also receive training to be able to recognize the signs and symptoms of the conditions listed in Table 1 and intervene appropriately. By the end of the training, nurses should understand their role and responsibilities, policies and procedures, their scope of practice (including how to work in the "grey zone"). Special attention should be focused on developing skills related to assessment, therapeutic communication, conflict resolution, and de-escalation, crisis intervention, problem-solving and prioritizing, teaching and coaching, team building and debriefing, reflective practice, and wound care (i.e., the skills generally required to go beyond general nursing skills and need to be specific to SCS). Content-specific to illicit drugs is not typically included in nursing education and is often lacking in newly hired nurses. Comprehensive training must include terminology, types of drugs (including appearance, color, texture), preparation of drugs, route of administration, effects of street drugs, potential interactions and toxicities, safer consumption techniques, vascular access and health, safer injection education and coaching, types of safer consumption supplies. withdrawal recognition and management, stimulant and opioid overdoses, overdose management, injection-related injuries and risks, and finally opioid agonist therapies and substance use treatment models.

Supporting Nurses in SCS

In the process of developing the consensus statement, working group members identified key areas that needed more support are detailed below.

Recruitment and Retention: Employers should develop a recruitment and retention plan to attract highly qualified nurses, to retain nurses with more seniority and expertise over time, to prevent employee turnover, and to promote continuity of care. Exit interviews should be conducted with nurses who decide to leave to identify pressing issues and needs. A comprehensive, standardized, orientation should be offered to all new hires.

Practice Supports: Employers should implement clear policies and procedures to support decision-making in practice. They should also support nurses in addressing "grey zones" that come up in practice. Clinical tools that are relevant to nursing practice in SCS should be readily available. Standardized documentation should be implemented and equipment should be made available to support nursing practice including but not limited to: drug checking, vein scanner, practice arm, CPR dolls, medical equipment, wound care equipment.

Professional Development: Employers should provide regular continuing education opportunities within the workplace. In addition to this, they should support continuing education by offering professional development funding for conferences, workshops, certifications, etc. Nurses should undergo regular evaluation and be provided with feedback on performance by their immediate supervisors. To create a supportive and stimulating environment, clinical support and mentorship should be available to all nurses.

Gaps in Care: To address gaps in care, employers should implement solutions such as: having an on-call

prescriber (physician or nurse practitioner) available to nurses, hiring an onsite nurse practitioner, creating urgent referral pathways, building private consultation rooms, and providing access to translators. Creating nursing positions with an expanded scope of practice for registered nurses onsite (e.g., prescribing, suturing, diagnosing, etc.) is another solution that should be explored and implemented.

Organizational Supports: Employers should hold regular team meetings and provide team-building opportunities. Employee recognition and assistance programs (including access to free counselling and support) should be available to all nurses. Employers should support nurse-led practice, policy and research initiatives – and they should have access to computers and office space to engage in this work. A system for data monitoring and reporting should be implemented with the input of nurses and the care team.

Working Conditions: Employers should address workplace safety (i.e., safety protocol and panic buttons) and quality (i.e., ventilation, light, noise) requirements. They should provide decent and healthy working conditions (i.e., break times, schedules, rotation of roles) and maintain adequate staffing (i.e., number of staff and skill mix) at all times. Salaries should take into consideration expertise, complexity, workload, and demanding schedules. Flexible schedules and leaves should be available to promote work-life-family balance and to support nurses during pregnancy.

Discussion

This consensus statement reflects the current state of knowledge on the role of nurses in SCS. In the absence of literature and research specific to this role, we opted to work "from the ground up" by drawing on the expertise of SCS nurses from 10 different countries. This approach presents some limitations because it is not grounded in empirical research and only captures the experience of a small group of content experts. However, the diversity and extensive experience of our content experts (ranging from less than 5 years to more than 15 years), the rigorous process is undertaken to collect and compile the data, and the use of a consensus-building method all contribute to strengthening the results presented in this article.

Our results indicate that the role of nurses in SCS is complex and unique. It requires a breadth of knowledge that ranges from acute care nursing to primary care. It also requires the greatest level of professional autonomy and critical thinking. This tends to be poorly understood by decision-makers and employers who often base their hiring decisions based on budget rather than the scope of practice of the nurses they employed. This document was first and foremost intended to inform decision-makers and employers about the role of nurses in SCS. By clarifying the role, we hope that training and support of nurses can improve. We also hope that attention can be directed toward the role of SCS nurses in increasing access to care and improving the health of people who are often excluded from traditional health and social services. As the number of overdoses has been rising drastically over the past few years, particularly in Canada, we have seen a narrowing of the focus on overdose prevention and management. There is no denying that the overdose crisis requires our immediate attention. However, we should not lose sight of that fact that SCS was created to improve access to a broader range of health care and social services. To achieve this goal, we need to address the care gaps identified by our working group by allowing nurses to play a greater role in prescribing, referring, diagnosing, initiating treatment, and engaging in more advanced skills (i.e., suturing) which are commonly done by outpost nurses.[5]

This consensus statement points to the importance of engaging in nurse-led research on the role of nurses in SCS. Despite the fact that SCS has been operating since the 1980s, the role of nurses has been largely overlooked with the exception of the work of Lightfoot et al.[6] and Wood et al.,[7] and it is worth noting that almost all of the studies conducted on SCS have been primarily conducted by researchers who do not work in SCS. Following the recent scale-up of SCS and the new hiring of nurses, there is a need to understand the role of nurses, their practice, and the issues they face. One main issue highlighted by our working group is the need to better document the turnover of nurses in SCS and the factors affecting the retention of nurses in the field. Anecdotally, we know the turnover is high and that invaluable expertise is lost every time an expert

SCS nurse leaves the field. In a recent systematic review conducted on the determinants and consequences of nursing staff turnover, Halter and colleagues[8] found that at the individual factors such as stress, burnout, and job dissatisfaction and organizational factors such as managerial style and lack of supervisory support played a significant role in turnover. This is particularly relevant for nurses in SCS who are likely to experience high levels of stress, burnout, trauma and grief, role ambiguity, lack of organizational support, high workload with complex and unpredictable clients, dynamic and rapidly changing work environments, shift work without adequate compensation (i.e., premiums), an insufficient level of engagement at the level of leadership and decision-making.

CONCLUSION

This consensus statement is the first step toward a better understanding of the role of nurses in SCS. This work is pressing and timely, as more and more nurses are entering into nursing practice in SCS. There is immense responsibility on nurses in this setting, as the majority of people who access SCS face many barriers in accessing other health and social services, even when their need for those services may be critical. For these reasons, it is essential to better prepare nurses for these realities. We hope that this first international consensus statement can serve as a foundation to guide practice, policy, research, and operational decisions in SCS. Of course, the content of the statement will need to be updated to reflect the ever-developing state of knowledge and research in the field. While consensus was reached within the working group, research on the role of nurses in SCS is quasi-inexistent and we should, therefore, seek to develop empirical understandings of the role of nurses, their needs, and the issues they face. This is imperative to retain nurses in the field and improve the quality of the care in SCS.

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