Nurses at Vancouver’s Dr. Peter Centre are leading the way to better health care and services for a population that our traditional health system has largely failed. They are passionate and tireless advocates for their clients whom they respectfully refer to as program “participants.” They wrestle with ethical dilemmas and traditional ways of thinking while practising harm reduction in a way that truly meets participants’ needs. These nurses look to RNABC’s Standards for Nursing Practice in British Columbia for guidance and support along the way.

BY HELEN GRIFFITHS, RN
PHOTOS BY DON MACKINNON

For most participants at the Dr. Peter Centre day program, home is the streets of Vancouver’s Downtown Eastside. According to Statistics Canada, it is this country’s poorest neighborhood. The centre provides health services to an impoverished group, marginalized by their daily challenges. Participants are dealing with addictions, mental health issues, homelessness, past physical and sexual abuse, criminal histories, and employment in the sex trade. A common thread for all Dr. Peter Centre participants is that they are HIV-positive and at risk for declining health.

They are also people for whom the traditional system of health care delivery does not work very well. Alan Wood is Dr. Peter Centre’s Director of Nursing. He describes health services in terms of “degrees of threshold.”

“Threshold has to do with the extent of barriers that must be crossed in order to access a health care service,” Wood explains. “If you have to make an appointment, sit in a waiting room, go to a lab and then find a pharmacy, that’s high threshold. It doesn’t work for a lot of people. They’re left out because they don’t fit the mold. Low threshold is to remove...
Dr. Peter Centre
nurses Alan Wood,
Patti Zettel and
Wil Stewart.
the hoops and say, ‘We’re here whenever you decide to walk in the door.’”

Low threshold is what the staff at the Dr. Peter Centre strive to achieve. Wood says, “Above all else, we want to address the issues related to problems accessing care that are historic to marginalized groups.” Nurses at the day program reach people who might otherwise fall through gaps in service delivery. That speaks to meeting Standard 5: Provision of a Service to the Public, Indicator 5: Participates in, encourages, and supports initiatives for quality improvement.

There are no appointments needed for the 150 day program participants. By dropping in to the centre, they can receive help with their medications, including antiretrovirals, free vitamins and over-the-counter medications, laxatives (much needed by participants using opiates), a simple wound dressing, counseling services, resource information, a compassionate ear, or a hot meal.

Nursing care is provided within the context of an interdisciplinary team that includes counselors, recreation therapists, complementary practitioners, and a food services crew that offers two meals a day. This again reflects Standard 5: Provision of Service to the Public — Provides nursing services and collaborates with other members of the health care team in providing health care services.

The nurses collaborate with various health care providers in the community. For example, many participants don’t have a doctor. “Getting a doctor can be very challenging. There are very few doctors serving the Downtown Eastside and patient loads are high,” says Patti Zettel a registered nurse at the Dr. Peter Centre. “And some of our participants have burned their bridges with doctors.”

Even if they do have physicians, says Wood, there may be times when they don’t want to see a physician for fear the physician will note the obvious signs of injection drug use.

For these people, even emergency departments can be extremely intimidating. “In emerg, our participants are often labeled as drug-seeking,” says Wil Stewart, a registered nurse at the Dr. Peter Centre. “Their complaints are seen as less valid and they get low priority. It’s tough because many of them have authority issues to begin with, and they’re anxious and in pain.”

So Zettel and Stewart assist program participants to work around these obstacles. They realize they have a unique advantage in this role. It’s an extension of Standard 5: Provision of Service to the Public, Indicator 6: Explains health care services to clients and others. “As nurses, we are given an automatic amount of trust and really have an opportunity to breakdown barriers.” Zettel says. “Being in the middle, liaising with doctors, pharmacists and hospital staff, is a big part of our job.”

An example of this is when the nurses attend in the emergency unit with a participant needing medical treatment, such as IV antibiotics for an abscessed wound. Zettel has years of experience working in critical care and is able to talk to the emergency nurses in their language. “Sometimes the participant can’t wait and leaves emerg to prepare their next fix,” says Zettel. “For them, the abscess becomes secondary at that moment. But sometimes, by identifying the issues with hospital staff, we can pave the way and it makes the difference between getting treatment or not.”

This liaison role is a component of advocacy. In the RNABC policy statement Advocacy and the Registered Nurse, advocacy occurring at the level of the individual client is defined as “… supporting others to act for themselves or speaking on behalf of those who cannot speak for themselves.” Advocacy is considered “an integral part of nursing” that “forms the foundation of the trust inherent in the nurse-client relationship.” Advocacy is also a component of Standard 4: Code of Ethics, Indicator 5: Acts as an advocate to protect and promote a client’s right to autonomy, respect, privacy, dignity and access to information …”

Many of the nursing activities at the Dr. Peter Centre fall under the label of ‘harm reduction.’ “For us, that means meeting the clients where they are at,” says Zettel. In addition to establishing a low threshold environment, that means providing sterile drug injection supplies through the needle exchange program, teaching about safe sex, offering condoms, talking with sex trade workers about safer ways of dealing with “johns,” counseling on addiction, supporting methadone maintenance regimes, and helping those who are ready to gain access to detox programs or rehabilitation.

Another service offered at the Dr. Peter Centre is medication storage. Stewart says, “A lot of folks in the Downtown Eastside are preyed upon for their medication, so it’s unsafe for them to keep their own meds.”

When the Dr. Peter Centre opened in 1997, there was a rule prohibiting drug use (other than medication) on site. The philosophy was to “separate the drugs from the drug user and the addict from the addiction,” says Zettel. However, three years ago there was an incident that made nurses question this convention. A participant with a 20-year drug habit overdosed and went into respiratory arrest behind a locked door in the centre’s basement. Fortunately, Wood was able to break down the door and the man was resuscitated. Wood recalls, “It was shocking. This guy just about died right here under our noses, with the clinical team right here.”

For Wood, it was a call to action. He asked, “What are the implications for nursing practice? Should harm reduction go further?”

The nurses at the Dr. Peter Centre knew that the majority of their time in the day program was being spent with participants who were injection drug users. Zettel says, “The number of abscesses, cases of cellulitis, and hospital admissions was much higher with this group. Their chaotic lifestyles resulted in the basic determinants of health being unmet.”

Wood realized something else. Despite the fact that nurses were spending a considerable amount of time with participants who were injection drug users, there was a limit to the rapport the nurses were able to establish with them. “What was making me crazy,” recalls Wood, “was that we were not able to have a candid, open conversation . . . about their drug use. We would try, but we couldn’t cross the bridge with them. We couldn’t get them to trust us enough to say, ‘This is what my life is really like.’”

Stewart adds, “They would tend to minimize the extent of their use. That comes
from stigma, feelings of shame, and being conditioned by the health care system to lie about drug use.”

Says Zettel, “It became important for us to break down the false relationships and start engaging with participants regarding the reality of their drug use.”

Nurses were addressing Standard 4: Code of Ethics, Indicator 7: Assumes responsibility for ensuring that relationships with clients are therapeutic and professional. Over time, and with increased awareness, nurses started to question if they could meet the standard without a major change in their nursing practice.

Zettel remembers, “At a certain point, it became difficult to practice here — unconscionable even. As nurses, we felt negligent. We were sending a double message. People would come to see us and we would give them clean rigs and supplies. We knew that they would then go out to ‘shake’ in the bushes.”

Shaking, she explains, “is removing the plunger from the syringe to add cocaine or heroin in powder form, replacing the plunger and inserting the needle into the arm to aspirate blood, withdrawing the needle to shake the mixture, then injecting it again, usually without a tourniquet. Sometimes, puddle water is used instead of blood. The bottom line is that there is no cooking, no filtering, the needle and solution are contaminated, and the skin is repeatedly broken. That’s what they were doing. And by sending them outside, we were not providing them any other options at that time.”

Zettel continues to explain that safer practice would be to dilute the drug in sterile water, possibly cook it (depending on the drug), filter it, clean the skin and use a tourniquet. However, it is difficult to do all that quickly while hiding from sight in a doorway, feeling agitated or desperate.

Injecting alone is another risk factor. Nurses at the Dr. Peter Centre were very aware of the risks of overdose. They had been following statistics from the Coroner’s Office. Since 1992, there have been more than 2,000 overdose deaths in British Columbia. For five years in a row, overdose has been the leading cause of death among people aged 30-49. In one Vancouver study, overdose was the leading cause of death in injection drug users regardless of HIV status. A number of Dr. Peter Centre participants had also suffered overdose and overdose-related deaths.

It became clear to the nurses that if they were going to reduce risks for their participants, if they were going to teach them safer ways of coping with their addiction, and if they wanted a chance to suppress opportunistic infections, they needed to embrace harm reduction strategies more aggressively. The nurses felt that their current practice was no longer ethical in light of what they saw and knew.

“We realized we needed to help them get the drugs into their body safer and cleaner,” says Zettel. That would require increased trust from the participant and a major shift in the nature of the nurse-participant relationship. To truly meet people where they were at, the provision of service could no longer be conditional on keeping drug use practices hidden from view at the centre. It was a big departure from the conventional philosophy of separating the drugs from the user. However, the nurses felt it would be the only way to achieve a relationship with the clients that was truly therapeutic.

After achieving consensus among the nurses at the centre, they embarked on a process of information gathering. As Zettel says, “There was no textbook on this, no template, no policy and procedure manual.” They consulted with their interdisciplinary team and talked to street nurses and staff from Wish Drop-in Centre (a resource for female sex trade workers) and became actively involved in the Harm Reduction Action Society, a Vancouver-based group advocating for safe injection facilities.

Wood went to Europe to visit safe injection sites and Zettel studied the local picture in the Downtown Eastside with assistance from the Vancouver Area Network of Drug Users.

They then consulted with an RNABC nursing practice consultant to confirm that it is within the scope of nursing practice to supervise injections for the purposes of education, prevention and health promotion.

(Note: RNABC does not have a policy con-
“RNABC’s clarification paved the way for our nursing practice in relation to harm reduction,” says Stewart.

The Dr. Peter Centre board of directors has a governance policy stating that all professional staff are required to provide evidence-based care and practice according to the standards and ethics of their professional regulatory bodies.

It became evident to the board that nurses should be providing the service of supervising injections. In this way, they would meet the needs of the Dr. Peter Centre participants and not be neglecting their duty to provide care.

“It was an incredibly positive experience for us,” reports Zettel. “Through the RNABC Standards for Nursing Practice, we could better see the issues around providing service to the public, and the ethical implications of not providing appropriate care.”

The research has led to a major change in nursing practice at the Dr. Peter Centre. Prohibition is over. Participants are now invited to use the day program treatment room for their injections. Twenty of them do so on a regular basis. “The response has been phenomenal,” says Zettel. “They are amazed they have this opportunity, and they’re taking it. Even in the middle of a coke run, they will still come in and fix with us despite the chaos in their lives.”

Nurses have sat with participants during their fix and, on a few occasions, have been asked to call detox. “They’ll say, I’m sick of this. It’s a horrible way to spend a life,” adds Zettel.

One of the benefits this change in thinking has brought about has been in terms of relationship building and barrier breaking. Participants now say things such as, “I’ve never been like this with a nurse before.”

The result is that the door has been opened to other interventions such as skin care and education on safer ways to inject.

Wood remembers a participant with a 30-year history of drug use who didn’t know how to use a bevel to protect his veins, and another who expressed appreciation about learning vein care from an expert. Everything this participant knew about injections was learned from a friend who learned from another friend.

Nurses at the Dr. Peter Centre now have an opportunity to teach about and provide sterile water, alcohol swabs and clean filters. They can demonstrate the use of tourniquets, encourage cooking heroin to eliminate particulate, show which areas of the arm are safer to use for injecting, explain the “one rig/one fix” rule, and underline the importance of testing the drug before fully injecting it (called “tasting”).

The nurses acknowledge that there is no such thing as safe injection of street drugs. “Inherently it’s very dangerous,” says Zettel. “Even if they do the injection perfectly, you don’t know what’s in it. But they’re going to put that needle in their arm regardless. And it’s safer to do it in front of us with a telephone, Narcan and resuscitation equipment nearby.”

Standard 4: Code of Ethics, Indicator 2 reads: ‘Complies with the codes of ethics endorsed by the RNABC. The Canadian Nurses Association Code of Ethics for Registered Nurses is a document that provides guidance for decision-making on ethical matters. Along with RNABC’s Standards for Nursing Practice in British Columbia, it is a resource that Dr. Peter Centre nurses referred to. The Code of Ethics identifies values that are central to ethical practice: safe, competent, and ethical care, health and well-being, choice, dignity, confidentiality, justice, accountability, and quality practice environments.

While elements of each of these values are reflected in the care that participants receive at the Dr. Peter Centre, the one that is starred and circled in the nurses’ personal copies is Choice: Nurses respect and promote the autonomy of clients and help them to express their health needs and values, and to obtain appropriate information and services. Wood says, “Everyone has the right to choose to live at risk, and the right to access health care that supports their right to choose and is not conditional on making the choices someone else thinks are appropriate. This is what we are offering.”

Zettel adds, “Supervised injection is just another harm reduction activity in the range of clinical services offered by nurses here.” However, by challenging the conventional thinking, the nurses have gained much more than another activity. “What we are doing now,” she says, “gives us so much more opportunity to be there when they (participants) are ready to make changes.”

Wood agrees, “It’s all about building trusting relationships that allow us to provide health care and services for some of the people who need it the most but are able to access it the least.”