HARM REDUCTION AND WOUND CARE BEST PRACTICE:

Promoting Skin and Wound Care for People Who Use Drugs in Consumption and Treatment Service Settings:

A Nurse's Journey

By Erin Telegdi, RN BA BScN

Introduction

I am a registered nurse, and I am passionate about working with people who use drugs. I am grateful to work for a community of people who care deeply about the well-being of themselves and their communities and work tirelessly for positive change. I work at the Moss Park Consumption and Treatment Service (CTS), a service that provides a safe space for people to inject pre-obtained drugs and receive support services such as harm-reduction education, overdose response, and nursing and social service supports.

Harm Reduction

The philosophy of the Moss Park CTS is to reduce harm. According to the Harm Reduction Coalition, harm reduction is a "set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."[1] The Canadian Nursing Association and Canadian Association of Nurses in AIDS Care add that harm reduction is an "essential evidence-based approach for reducing the adverse health, social, and economic consequences of substances use without requiring abstinence."[2]

A harm-reduction approach means that service providers meet people where they're at, without judging their drug use or requiring them to change. It is a philosophy centred on working to meet people's personally defined goals and needs, and understanding that systemic barriers, such as poverty, racism, criminalization and colonialism, cause much greater harm in people's lives than drugs themselves. It also acknowledges that people use drugs for a wide variety of reasons, and that for many, using drugs is a way to manage pain—ranging from physical to emotional to spiritual.

As a health-care professional, practising harm reduction also means acknowledging and resisting the ways in which the health-care system perpetuates stigmas against people who use

Patient Profile 1

M knocks on the door. It's a Monday. We don't usually provide care on Mondays, but M knows that there's always a nurse there doing admin work. She asks me if I can change a dressing. It is saturated, and she's obviously in discomfort. I invite her in and change the dressing. She had developed an abscess at a site where she injects fentanyl and had gone to a hospital emergency department the previous day to have it managed. She presented to me with a calcium alginate (saturated) covered with a transparent film dressing (Figure 1). The dressing was a perfect storm for occlusion and maceration. I asked her if they had prescribed antibiotics. She said yes, but she hadn't filled the script yet. She also told me that they'd given her IV antibiotics; the doctor had said, "I think we'd better give her a dose of antibiotics here—I suspect she's a flight risk."

M is in her thirties, and she is an injection drug user. Her drug of choice is street fentanyl. I have known her for almost a year. I know that she is a smart woman who previously worked in finance. She has an incredible sense of integrity and shows great kindness to the people in her community. She is a good person, and she cares about her health. She is an exemplary human, and I know this because I know her. But the Emerg doc doesn't know this. He doesn't know *her*. He just sees a drug user. And he treats her in the way that our society has allowed us to treat people who use drugs—that is, poorly and based on judgemental assumptions.

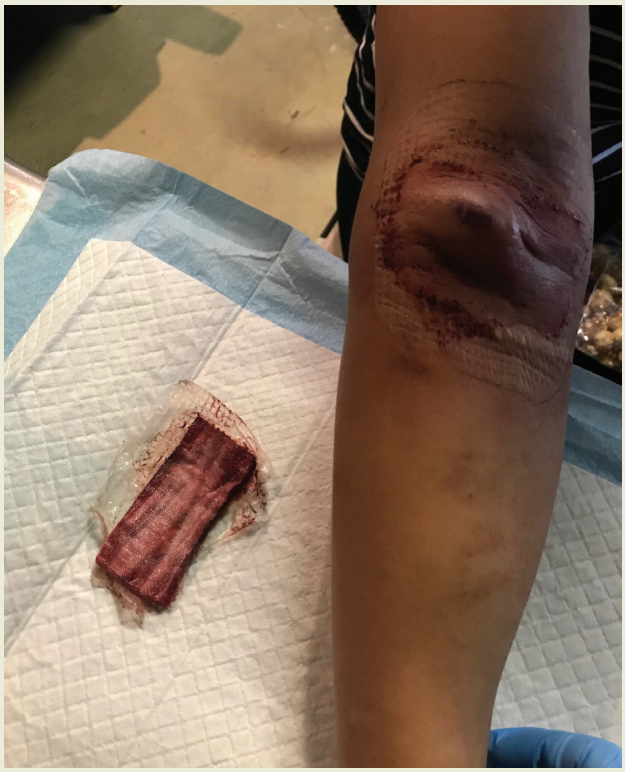


Figure 1: First dressing change less than 24 hours after an I&D performed in a hospital emergency department for an abscess.

drugs (PWUDs) and creates barriers to accessing safe, competent and compassionate care. Finally, "nothing about us without us," a foundational tenet of the harm-reduction movement, means prioritizing self-determination of PWUDs. As allies, it is our responsibility to support the issues and solutions that PWUDs identify as meaningful for themselves and their communities.

The Moss Park Overdose Prevention Site

In August 2017, as a nurse working at Casey House, a specialty hospital for people with HIV/AIDS, I heard the news that the Toronto Overdose Prevention Society (TOPS) and Toronto Harm Reduction Alliance (THRA) had opened an overdose prevent site (OPS) in Toronto's Moss Park. They did this in response to growing overdose deaths in the City of Toronto—a trend that was being seen across Ontario, Canada and North America. In 2018, 1,475 Ontarians lost their lives to an opiate overdose.[3] Through social media, I learned that there was a need for registered nurse (RN) volunteers to support the cause. The City of Toronto had stipulated that the unsanctioned OPS could operate as long as there was an RN present at all times. And so I volunteered. As a nurse, I'd never before dealt with an overdose, but I felt that if my credentials could support a just cause, it was something I needed to do. The team of seasoned harm-reduction workers and community of drug users were patient with me. They held my hand through my first overdose response. They nurtured me into this work. And I haven't looked back.

Moss Park is a small municipal park in downtown Toronto, and it is the heart of an area experiencing rapid gentrification. There has always been drug use and poverty in this neighbourhood; at the time when the unsanctioned Moss Park OPS opened, the four corners of the park were the top four intersections in the entire City of Toronto visited by EMS for overdose calls. As housing prices have soared in neighbouring communities, "not in my backyard" attitudes have flourished. The area has seen an increase in discrimination and economic violence against, and policing of, PWUDs. Unequivocally, drugs themselves are not the only danger of being a drug user. Increased criminalization and marginalization are real threats in the lives of PWUDs.

When the Moss Park OPS was an unsanctioned, volunteer-run operation, tents were set up each day at 4 p.m. and packed up again at 10 p.m. Each day, PWUDs accessed the service as a safe place to use drugs, free from the fear of accidental overdose, arrest or police harassment, and to access harm-reduction supplies, food and a space where all were welcome to come as they are and be treated with love and respect. It was a place where we stood in solidarity and validated the lives and experiences of PWUDs, and where together we fought for recognition of the value of their lives and their right to compassionate and appropriate services.

This was the first time I really understood what it means to be a good nurse. I was working for and with the people I served. The community made the rules and defined the work of the RNs. They told us what was helpful for us to do, and what was not. And we had to fall in line. The result amounted to nothing short of an epiphany for me. It gave me a deeper appreciation for my professional ethics, and for what it means to be part of a community and work together for a common cause.

As a result of the advocacy of TOPS, THRA, and the OPS volunteers in Moss Park, the province of Ontario expedited the opening of Supervised Consumption Services (SCS) and OPSs across the province. Under the previous provincial government, nine provincially funded SCS and OPS opened in Toronto, including the Moss Park OPS, which became a satellite of the South Riverdale Community Health Centre and which, with provincial funding, was able to move indoors. With the change to a Conservative government in 2018, two of the Toronto sites were defunded, but they continue to operate with private funding. The new premier had stated that all sites in the province would be shut down, but in the end, because of the enormity of the overdose crisis, the work of harm-reduction advocates, and the growing

Patient Profile 2

J is a man in his forties and a regular visitor to the Moss Park CTS as well as other CTSs. He is gracious and kind, giving reassuring feedback on my work, and asking how I'm doing and if I have anything special planned for my days off. He primarily injects fentanyl. He has difficulty accessing veins in his arms and primarily injects into his calves. He developed an abscess in his right calf, and his general practitioner (GP) performed an I&D. He was instructed by his GP to receive wound care at the Local Health Integration Network (LHIN) clinic. However, J has experienced multiple fentanyl overdoses in the past year, and it is important to him to access the CTS sites daily so that he can inject in a setting where he can receive assistance in the event of an overdose. Since he already accesses CTS services on a daily basis, it was more convenient for him to receive wound care in these settings. Initially the wound was healing well with povidone-iodine-soaked ribbon gauze, an absorbent second layer, and non-occlusive tape. After about a week, he was lost to our follow-up.

When he did return a couple of weeks later, he presented with an occlusive dressing on the wound and clear decompensation, with maceration, erythema, increased purulent exudate, foul smell, satellite skin breakdown and a fever. We accessed oral antibiotics for him through our nurse practitioner and resumed regular dressing changes. Again, however, he stopped coming regularly to Moss Park for some time.

When he did return, again he had an occlusive dressing with no topical antimicrobial, and I suspected *Pseudomonas* colonization (Figures 2 and 3). I focused on wound care education with J, explaining the factors to be considered for wound care and which dressings were appropriate and which weren't. I hoped that empowering him with this knowledge would help him advocate for himself when receiving wound care at other services. After many steps backward and forward over the past three months, J's wound is finally improving.

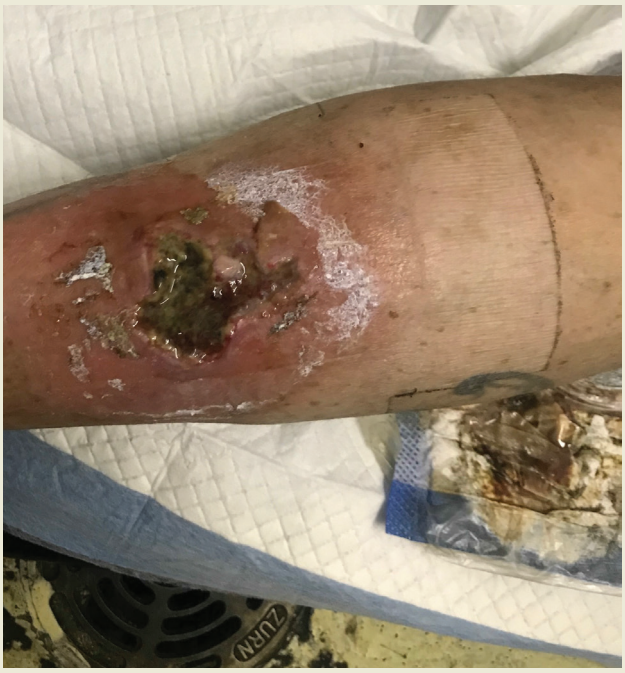


Figure 2: A wound that has become chronic post abscess I&D with multiples phases of improvement and decompensation.

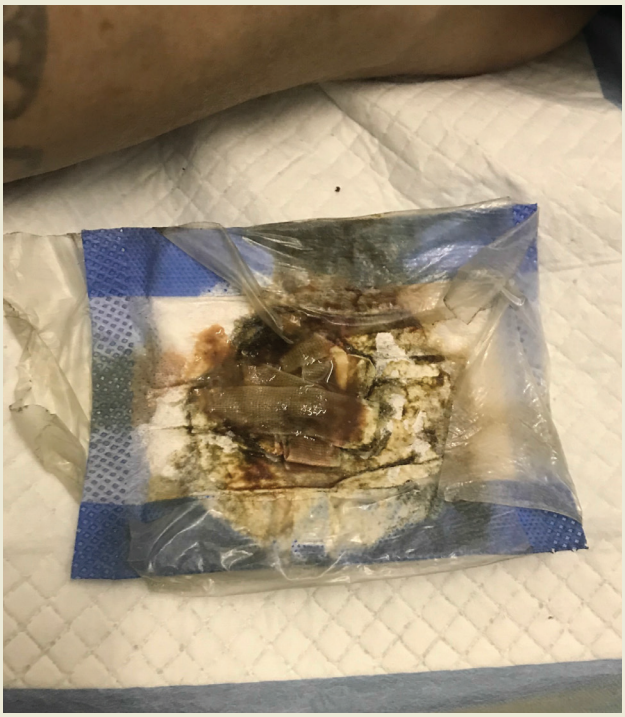


Figure 3: A dressing that had been done at another CTS site, removed for dressing change at the Moss Park CTS.

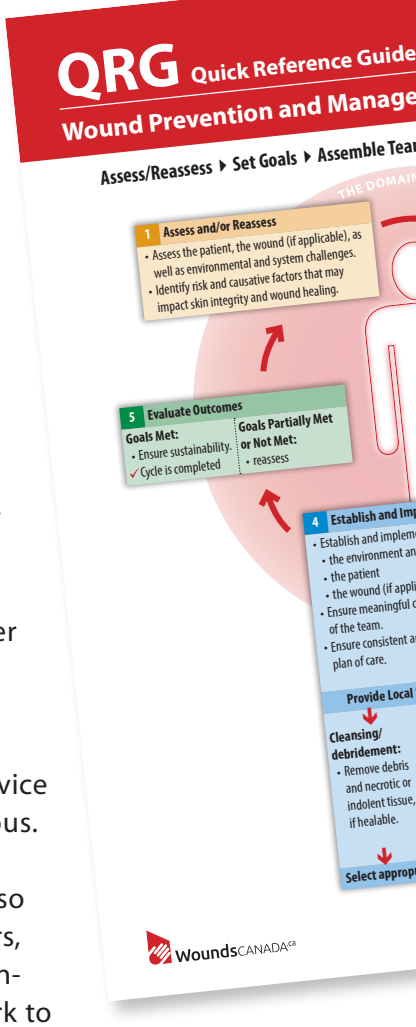
public support for harm reduction services, he backtracked and continued funding for most sites, though expansion of such programs was capped.

Moss Park Today

Today the Moss Park OPS—now called a Consumption and Treatment Service (CTS) under the new provincial government—operates Tuesdays through Sundays from 12 to 6 p.m. Many of the staff are people who were integral volunteers for the Moss Park OPS when it was an unsanctioned site in the park. We are a team of community health workers, overdose prevention workers and registered nurses. Most workers at the site have lived or living experience of drug use. As of March 31, 2019, we were averaging 88 visits to our injection service per day, and in our first year of operation reversed 617 overdoses. In addition to saving lives, we support access to needed social services and provide recreational activities and health services. We are able to facilitate referrals to occupational therapy, physical therapy, social work and chiropody; however, these services are not provided on-site.

The Moss Park CTS is unique because of its drop-in style. While our primary service is to supervise injections and reverse overdoses, we are also a place where people come to spend time with friends, engage in community and advocacy work, write letters to loved ones in jail, and create art—among many other things.

One notable observation about our site is that approximately 40% of our service users self-identify as Indigenous. (We collect minimal personal or demographic information, so we do not have exact numbers, but we have collected point-in-time data.) As a result, we work to



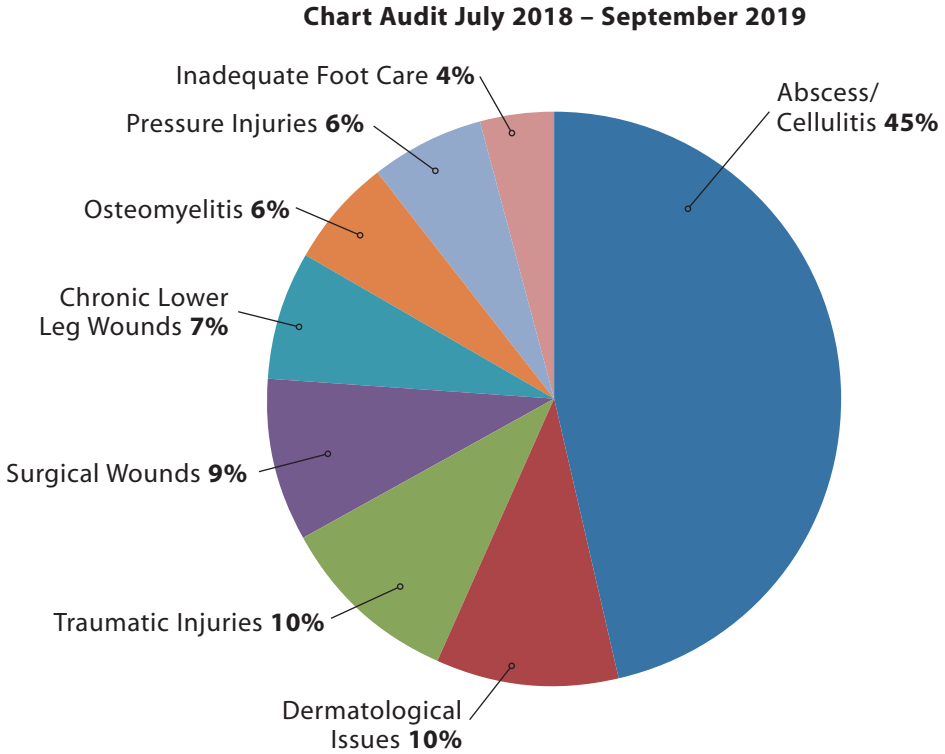
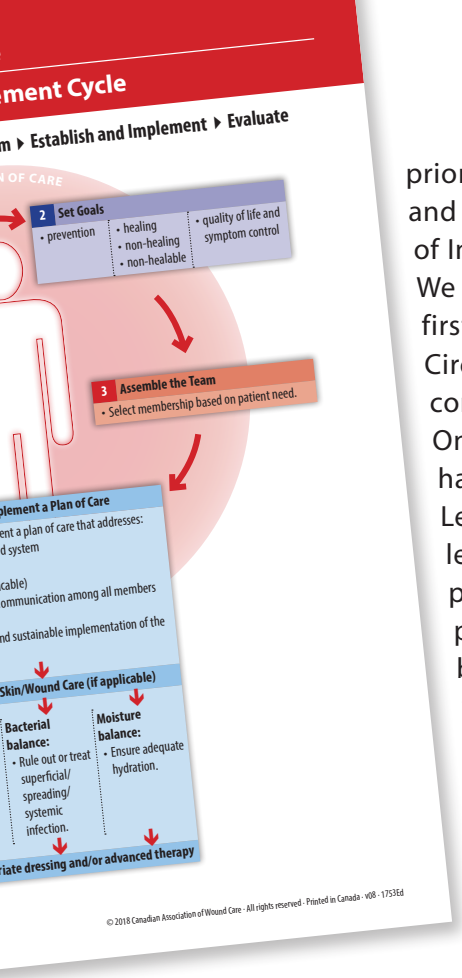


Figure 4: Types of Skin and Wound Issues at Moss Park CTS



prioritize Indigenous voices and respond to the needs of Indigenous service users. We are proud to have the first Indigenous Sharing Circle in a supervised consumption setting in Ontario, led by Indigenous harm-reduction activist Les Harper. We acknowledge that Indigenous people have been disproportionately affected by the overdose crisis, which is compounded by ongoing colonization; we also acknowledge that an important part of harm reduction is reducing the harms of colonialism.

Wound Care at Moss Park

The nurses at Moss Park provide a wide variety of primary and emergent health-care services. Some of those who access our service are well connected to other health-care services, but many are not, and these people generally access walk-in clinics, emergency departments or other CTS sites when they have acute health issues. The need for acute and long-standing wound care is significant.

A chart review of Moss Park nursing entries from July 2018 to September 2019 indicated that 50% of encounters involved skin and wound care issues. Not infrequently, I spend the majority of the day in a cramped, accessible washroom, caring for persons with wounds—dressing change after dressing change—and assessing the need for topical antimicrobials and systemic antibiotics.

Of the total nursing encounters involving skin and wound care, 45% were related to abscesses and cellulitis. In this group, 59% involved abscesses and cellulitis at a recent injection site and 41% at sites where the client does not inject. Abscesses and cellulitis are common complications of injection drug use, but also of living in poverty, not having access to basic hygiene, staying in cramped and unhygienic shelters, and the immunosuppression that comes with food insecurity, lack of sleep and lack of stable housing. The remaining encounters were related to dermatological issues, including pest- or parasite-related rashes, picking and self-harm, exposure to extreme weather, and drug-related rash and hives (10%), traumatic injuries, both accidental and secondary to violence (10%), surgical wounds (9%), non-healing lower leg wounds (7%), suspected or confirmed osteomyelitis (6%), pressure injuries (6%) and foot care (4%) (see Figure 4).

Working at Moss Park, I have seen, on multiple occasions, people avoiding hospital care because they have, over and over again, experienced violence and discrimination at the hands of the health-care system. Unfortunately folks must balance the potential harms of not getting an acute health-care issue treated with the potential harms they may experience at the hands of health-care providers. The stigma of being labelled a "drug user" by the health-care system is huge. It can mean harassment and violence from hospital security, mistrust and lack of compassion from health-care providers, and under-treatment of pain. The stakes are high. I have often seen folks leave hospital against medical advice because they can no longer tolerate how they are being treated. They end up back in the community with exposed surgical hardware, osteomyelitis and unmanaged infected wounds. Many of the wounds we see have become chronic because of inappropriate hospital discharge planning for unhoused people, lack of communication across health-care sectors and settings, and lack of access to stigma-free, consistent and informed wound care.

The Wound Prevention and Management Cycle

Establishing a trusting and safe relationship with service users is the first priority in supporting people with skin and wound issues at the Moss Park CTS. A benefit to accessing health services in a CTS is that people do not need to hide or

explain their substance use: first and foremost, it is a drug-user friendly environment. This eliminates one huge barrier PWUDs face when trying to access health care.

Once trust is established, our focus is to collaborate with service users to determine a plan of care. For this work, we use the guiding principles of the Wound Prevention and Management Cycle.[4]

Initially we work to identify the cause of the wound or skin issue and consider each individual patient's concerns for treating the cause. This includes engaging in conversations about safer injection techniques that can decrease the occurrence of injection-related infections, such as swabbing the skin before injecting and minimizing syringe re-use. We also consider where people inject. Some, over time, have increasing difficulty accessing veins, and are only able to inject in their hands, wrists or legs, all of which can increase the risk of injection-related complications. We support people in finding new veins to use so that other veins have an opportunity to heal.

There may also be a need to consider how a wound dressing or treatment protocol could impact the patient's ability to access veins for injecting.

Other patient concerns addressed include their access to shower facilities and ability to attend to personal care needs, and ways to be responsive to peoples' schedules so that dressing changes can be done consistently. Through assessment of the person's total health, environmental and system challenges, and identifying risk and causative factors, we are able to establish goals and work on a plan of care in collaboration with service users, as well as their support networks and other members of the CTS team.

Determining appropriate local wound care is the next challenge. We consider debridement, inflammation and infection, moisture balance and edge effect.

Many service users access nursing services for dressing changes at various locations such as other CTSs, emergency departments and other community health services. It has become evident to me that knowledge of appropriate local wound care varies greatly across settings. I have seen occlusive transparent film dressings on infected wounds, leading to maceration and skin breakdown; inappropriate use of oral antibiotics where a topical antimicrobial is indicated; and a discomfort among nurses to engage in debridement in order to address biofilms. This inconsistency in practice speaks to a lack of access to wound care best-practice knowledge. The gap in wound care knowledge and cross-site communication can lead to negative outcomes in wound healing.

Implications

Consumption and Treatment Services are becoming an integral part of health-care systems. They provide cost-effective, life-saving services, and connect people with the care they need for holistic health and well-being.

It is my hope that as we become more established, we can stay true to our harm-reduction roots and maintain the primacy of knowledge and experience of PWUDs. From a nursing perspective, I hope we will be able to increase our capacity to meet the wound- and skin-health needs of the people we serve. My experience has overwhelmingly shown that there is a great need for wound care services in CTS, and that we must meet the challenge of integrating wound care best practices. At Moss Park we have tried to promote improved skin and wound care through safer injection workshops for service providers and service users, personalized counselling around safer injection and how to minimize the risk of injection-related complications and wound care education within and across services.

In the coming year I plan to promote improving data collection on skin- and wound-related issues in CTS, work collaboratively across CTS, primary and tertiary care services to eliminate systemic barriers to accessing care and support the development of communities of practice in CTS that promote wound care best practice. In CTS, our service users are vibrant, smart, kind people who care deeply about their own health and the health of their communities. They deserve nothing but the very best care.

Patient Profile 3

E is a gregarious and creative woman in her fifties who was once a professional dancer. She has been homeless for several years. When I met her, she was mostly sleeping outdoors but sometimes accessed shelter services during extreme weather. She developed an epidural abscess that required surgical intervention. In the intensive care unit, she received pain medication commensurate with her opiate tolerance, which kept her comfortable. Once she was out of the intensive care unit, her pain medications were decreased to the point that she began experiencing excruciating withdrawal symptoms. She left hospital against medical advice with partial paraplegia and in a wheelchair. She had developed a sacral pressure injury (PI) while in hospital, which had progressed to stage 3. Back in the community she was unable to offload, as she's in a wheelchair—which had not been fitted for her—24 hours a day, was still sleeping rough, and had urinary incontinence related to the spinal abscess. Without a home, it was difficult for her to find spaces to change her briefs, and her skin was exposed constantly to moisture, exacerbating the original PI. She developed two additional PIs, one to her right ischial tuberosity and another to her right heel (Figure 5). Over that winter, our team spent a considerable amount of time supporting E with changing her briefs, finding new, dry clothes, keeping her PIs clean, and monitoring for signs of systemic infection, which we knew was a threat.

Through cross-agency collaboration, E was eventually able to access a transitional housing apartment. She is now able to offload, and has access to bathroom facilities for brief changes, with which she is independent. She still has two of the three PIs, but she is able to keep them clean and dry, and now has home-care coming to her apartment for regular wound care. Our next goal is to connect her with OT so she can be fitted for an appropriate chair. This task will be much easier now that she has stable housing and consistent case management support.

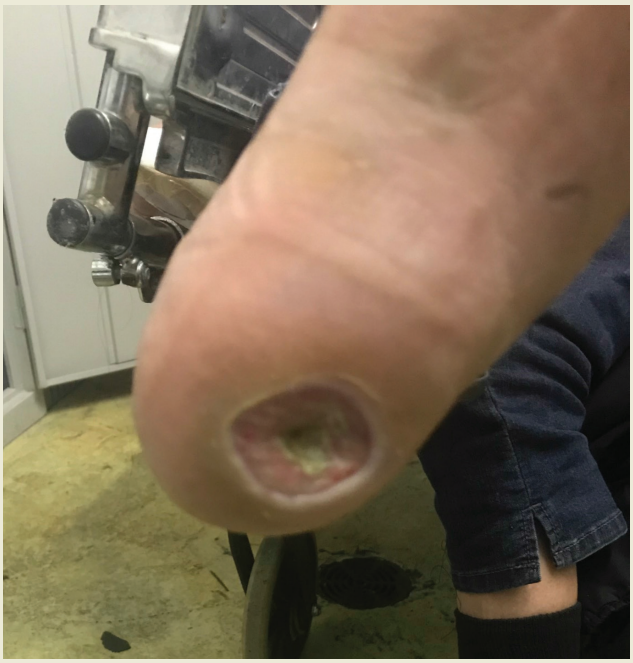


Figure 5: Pressure injury to the heel of a 54-year-old woman experiencing new paraplegia and homelessness, and in a wheelchair not professionally fitted.

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