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Emergency Department Registered Nurses' Perceptions of Substance Use Disorders and Supervised Consumption Sites

Aleksandra Ilievska[1], Gina Pittman[1], Jody Ralph[1]

[1]University of Windsor

Principal author: Aleksandra Ilievska, M.Sc.Inf., B.Sc.Inf., IA, University of Windsor, 3170 Viola Cres., Windsor, Ontario, N8N 0A3
ilievska@uwindsor.ca

Abstract

Background: Due to the increased drug-related harms that Canada is facing, a stronger emphasis has been placed on harm reduction strategies, such as supervised consumption sites (SCSs).

There is a lack of literature on emergency department (ED) registered nurses' (RNs') perceptions of SCSs and substance use disorders (SUDs), especially in small- to mid-sized Canadian cities.

Objective: This descriptive study aimed to determine ED RNs' perceptions of SUDs and SCSs.

Methods: A 27-question survey was sent to RNs currently working in EDs in Southwestern Ontario using an online Qualtrics® link. The research explored ED RNs' perceptions of SCSs and SUDs.

Results: Quantitative results indicated that ED RNs (*n* = 146) were empathetic toward drug use and SUDs, but felt neutral towars SCSs. They indicated positive impacts and potential concerns of SCS implementation. However, despite their apprehensions, most ED RNs reported that they would still refer their patients to such sites if one was available.

Discussion: The findings from this study provided recent data on ED RNs' perceptions of SUD and SCSs in small to mid-sized Canadian cities. It also identified services that SCSs and their EDs should offer from an ED RN perception.

Conclusion: This multi-site research offers an opportunity to compare perceptions from other disciplines, share new knowledge, and improve patient care and safety. Recommendations include a harm reduction referral partnership between the ED and community partners. It is essential to practice reflexively, decrease the influence of stereotypes and stigma-based decisions and care, and encourage legislation that supports ethical policies and procedures that increase the use and access to SCSs.

Keywords: harm reduction, emergency department, emergency nurses, supervised consumption sites, substance use disorder

Introduction

Background

Substance use has a tremendous impact on individuals, families, and communities. Canada has been greatly affected by substance use and is facing a national opioid overdose crisis (Government of Canada, 2022). This crisis has been exacerbated by the COVID-19 pandemic (Government of Canada, 2022). This contributed to a 62% increase in responses by emergency medical services for suspected opioid-related overdoses and a 27% increase in opioid overdose hospitalizations (Government of Canada, 2022). While the rates have constantly remained high in the western parts of Canada, such as British Columbia and Alberta, a considerable increase has recently been detected in Ontario (Government of Canada, 2022).

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With increasing drug-related harms, a stronger emphasis has been placed on harm reduction strategies (Kerr et al., 2017). The Registered Nurses' Association of Ontario (RNAO) views harm reduction strategies, such as supervised consumption sites (SCSs), as an essential tool that nurses can use to assist people who use drugs (PWUD), minimize the stigma that surrounds substance use and addiction and in turn, build healthier communities (RNAO, 2022). Supervised consumption sites are defined as legally sanctioned spaces where people can use their own drugs in a safe and clean environment in the presence of trained personnel (Government of Canada, 2021). They are a form of harm reduction and can offer a range of different services within them, such as drug checking, emergency medical care, access to counselling, rehabilitation, access to other health and social services, such as referrals to substance use or mental health treatments, and education on harms of drug use or safer consumption practices (Government of Canada, 2021). These sites are also places where people can safely dispose of needles and sharps, obtain new drug equipment, receive basic health services, get tested for infectious diseases, and gain access to medications such as naloxone, an opioid overdose reversal agent (Government of Canada, 2021). Moe et al. (2022) found that people with substance use disorders (SUDs) are among those who make persistent, frequent ED visits in Ontario. We need to understand the risk factors that contribute to repeated ED use, explore the healthcare needs of those who frequent the ED the most, and advocate for alternatives that better address the gaps in our healthcare system (Moe et al., 2022). An ED visit is an opportunity to improve patient outcomes by identifying those with SUDs and connecting them to treatment (Hawk & D'Onofrio, 2018). Since emergency nurses often are the first health care providers to see PWUD when coming to the ED, assessing ED registered nurses' (RNs') perceptions of SUDs and SCSs is crucial.

Purpose

This descriptive, multi-site study aimed to determine ED RNs' perceptions of SUDs and SCSs. Therefore, the research questions for this study were:

1. What are ED RNs' level of comfort and experience with people who have been diagnosed or have a suspected SUD?
2. What are ED RNs' level of comfort and experience with SCSs?
3. What are ED RNs' views toward SUDs and SCSs?
4. What do ED RNs identify as the impact of SCSs for people who use drugs, the ED, the healthcare system, and the community?
5. What services do ED RNs identify SCSs and their ED should offer?

Methods

Study Design

This quantitative study aimed to explore the perceptions of ED RNs toward SUDs and SCSs. Descriptive statistics were used and reported.

Data Collection Methods

A 27-question survey was used to gather data and answer the research questions. Of the 27 questions, four demographic questions were optional (age, gender, ethnicity, and primary worksite), one question ensured the inclusion criteria were met, one asked if respondents confirmed to have their responses submitted, and one invited participants to indicate if they would like to receive compensation and which e-gift card they would prefer. The remainder of the questions assessed ED RNs' work, education, and training experiences, their knowledge, experience, and comfort level with SCSs and SUDs, their views of SUDs and SCSs, the perceived impact on SCSs to PWUD, their ED, the healthcare system, and the community, and lastly, the services that should be offered in SCSs and in their ED (Jackson et al., 2022; Katz et al., 2017; Shreffler et al., 2021). This survey contained open-ended, closed-ended, multiple choice, multiple-answer, ranking, and matrix (Likert Scale from strongly disagree to strongly agree) questions. In addition to the optional questions, there were force completion questions, where participants were required to answer the question before proceeding to the next one. Finally, the last question asked participants to provide their contact information if they would like to be contacted for future studies regarding the same topic. If the participant chose "yes" to this question, they were taken to a separate survey where their personal information could not be linked to their survey responses.

The survey was adapted from Katz et al. (2017), Jackson et al. (2022), and Shreffler et al. (2021) with permission granted to use sections of the survey. Minor revisions to questions were made to improve the clarity, flow, and appropriateness of the questions. Reliability was maintained by using unambiguous language when writing questions to minimize misinterpretation and response errors. Overly similar questions were removed to prevent repetition and questions were added to answer the research questions better. Face validity was facilitated by three BScN-prepared nurses who did not participate in the data collection. The thesis committee also reviewed the structure and content of the survey before publishing. The target population was all ED RNs of the participating Southwestern Ontario hospitals.

Sample Characteristics

The setting for this study took place at four Southwestern Ontario hospitals, including five EDs. These EDs provide care for patients in various geographical regions ranging from urban to rural settings. The sample were employees in the EDs and they were recruited using purposeful sampling. To participate in this study, RNs had to currently work in the ED, were entitled to practice with no restrictions with the College of Nurses of Ontario (CNO) and were able to comprehend the English language. Nurses in the study did not need to have experience with SCSs. Registered practical nurses and other ED staff members were excluded. A link to the survey was sent to all 341 ED RNs at the participating hospitals. Of the 341 ED RNs, 146 (42.8%) respondents met the inclusion criteria and were included in the analyses. This is a descriptive study, so a sample size calculation was not conducted. We also did not receive the demographic data from the units as a competitor. However, the demographics are similar to the Canadian Nurses Association's public data (Canadian Nurses' Association [CNA], 2023).

Survey

Data were collected between February and April 2023. The survey was deployed via the University of Windsor Qualtrics® platform and could be accessed through an online link. Eligible

ED-employed RNs of Southwestern Hospitals were recruited through a series of e-mail announcements sent by their ED managers. An initial e-mail was sent using the hospital email system to notify the RNs that the survey was available. The study period lasted six weeks in length per site. The second email was sent two weeks before the study closed, and the final email was sent one week before the study closed. To prevent "multiple participation" of participants, the "prevent multiple submission feature" was applied in Qualtrics®, as well as the use of their institutional email was encouraged.

Study Preparation

An informational poster with a QR code that was linked to the survey was posted in the staff breakroom of the ED, away from patient care and remained posted until the end of the study period.

Ethical Considerations

Ethical clearance was obtained by a local university research ethics board (REB) and hospital REBs (REB #42546; REB #20-384). The survey was anonymous, and questions were designed to avoid collecting unnecessary or sensitive data. Demographic questions, such as age, gender, and ethnicity, were left optional. To protect the identity of the participants further, data was reported in aggregate format. The survey was made available to the participants only through their institutional email and via a QR code that was posted on a flyer in their designated breakroom. A consent form was provided to each participant along with information about resources available for addiction treatment, drug use, and abuse referral services before starting the survey and at completion.

Statistical Analysis

IBM Statistical Package for Social Sciences version 29 was used to analyze the data. Descriptive statistics (frequencies, percentages, means, standard deviations, and minimum/maximum values) were used to answer the research questions. A statistician was also consulted and validated the analysis. Data were explored for accuracy of entries, missing data, and normal distribution points. For ethnicity, there were 2% missing data (n = 3) and 6% for gender (n = 9). Missing data was not handled as it was not required for any statistical analysis. There were 11 incomplete survey responses, which were excluded from data analysis.

Results

Respondent Characteristics

The response rate to the survey was 50.1% (n = 171). Of those 171 responses, 25 were excluded due to incomplete survey responses (n = 11) and inclusion criteria not being met (n = 14). The remaining 146 (42.8%) of the total 341 respondents met the inclusion criteria and were included in the analyses. The Qualtrics® platform used was not set to track views, however, the first question of the survey was an eligibility screen and incentive was only provided to unique visitors.

Descriptive Findings

Participants' ages ranged from 20–61+ years of age. Most RNs were 40 years old or younger (n = 100, 68.5%), self-identified as female (n = 118, 80.8%), and as white (n = 132, 90.4%). Approximately half (n = 74, 50.9%) had over 10 years of experience as an RN, one-fifth (n = 31, 21.2%) had 6 to 10 years, one-quarter (n = 34, 23.3%) had 1 to 5 years, and only 5 of the participants (n = 7) had less than 1 year of nursing experience. Similarly, the highest proportion of nurses had over 10 years (n = 50, 34.6%) and between 1 to 5 years of specialized ED experience (n = 46, 31.5%). Most RNs were trained or worked only in Ontario (n = 115, 78.8%) and almost all RNs (n = 136, 96.3%) reported receiving some education or training on harm reduction. The RNs identified receiving most of their training or education while in school (n = 84, 36.9%) or during hospital orientation (n = 58, 25.7%).

Despite the reported high level of education and training received on harm reduction, ED RNs reported their level of knowledge regarding evidence and operations of an SCS as primarily low (n = 64, 43.8%), or moderate (n = 63, 43.2%).

Main Findings

ED RNs' Experience and Comfort Level Toward SUD

Approximately half of all participants (n = 72, 49.2%) felt comfortable interacting with this population. Almost all ED RNs have treated the following patients in the past six months: suspected or admitted to using intravenous recreational drugs (n = 141, 96.6%), suspected or admitted to smoking drugs such as crack-cocaine or methamphetamine drugs (n = 141, 96.6%), presented with an abscess or other bacterial infection suspected or known to be related to injection drug use (n = 138, 94.5%), presented with systemic infections (e.g., endocarditis) suspected or known to be related to injection drug use (n = 128, 87.7%), presented with another type of recreational drug overdose (n = 133, 91.1%), or presented with an opiate overdose (n = 136, 93.2%).

ED RNs' Experience and Comfort Level Toward SCSs

Most ED RNs reported they had no experience (n = 78, 53.4%) or a low level of experience (n = 47, 32.2%) regarding evidence and operations of a SCS. Roughly half of the participants reported a neutral level of comfort with referring patients to a SCS (n = 68, 46.6%), and approximately one-third reported feeling uncomfortable (n = 31, 21.2%), and very uncomfortable (n = 13, 8.9%) doing so.

ED RNs' Views Toward Drug Use and SUDs

A series of Likert-scale questions were used to assess ED RNs' views toward drug use and SUDs. In summary, 82.2% (n = 120) of ED RNs strongly agreed that recovering from a SUD is difficult, and the same number agreed or strongly agreed that individuals with SUD have usually experienced significant adverse life events. Approximately three-quarters (n = 114, 78.1%) of ED RNs strongly agreed that recovering from a SUD is a lifelong process. ED RNs agreed other nurses and physicians equally understand the difficulty of recovering from a SUD (n = 71, 48.6%), while patients understand slightly less (n = 59, 40.4%). An overwhelming number of RNs agreed or strongly agreed that more work needs to be done to minimize the stigma related to SUD (n = 122, 83.6%,), that there are not enough community services to treat people who use and/or inject and use drugs (n = 125, 85.6%), and that access to available treatment options for individuals in need is currently a

problem (*n* = 132, 90.41%). Approximately two-thirds (*n* = 95, 65.1%) of ED RNs strongly agreed that peer support can have a positive impact on the chances of recovery, and 64.4% (*n* = 94) agreed or strongly agreed that to recover, individuals suffering from SUD need to move to a new environment and consider drug use and addiction a public health issue (*n* = 94, 64.4%). Only 17.1% (*n* = 25) of ED RNs agreed that drug addiction is a choice, and 42.8% (*n* = 64) agreed that healthcare providers treat individuals with SUD differently than other patients. In terms of the ED, approximately two-thirds (*n* = 102, 69.9%) of ED RNs strongly agreed that the ED is not an optimal location for people who use and/or inject drugs to come for non-medical (e.g., social issues), and about half (*n* = 77, 52.7%) of ED RNs agreed or strongly agreed that people who use and/or inject drugs sometimes come to their ED for services that could be adequately provided by SCSs. Lastly, roughly three-quarters (*n* = 109, 74.7%) of ED RNs agreed or strongly agreed that people who use and/or inject drugs mostly come to their ED for problems that are preventable, 80.8% (*n* = 118) agreed or strongly agreed that people who use and/or inject drugs often come to the ED with advanced conditions that could have been controlled more easily with earlier medical treatment, and 78.8% (*n* = 115) agreed or strongly agreed that people who use and/or inject drugs place a heavy burden on their department by contributing to ED overcrowding.

A composite score was created to combine the above data into a single variable. The composite *Views Toward Drug Use and SUDs* score was normally distributed with a mean of 4.07 (SD = 0.35) and a range of 3.05–5.00. A mean of 4.07 indicates that there was mainly agreement, among the ED RNs, to the statements. Reliability of the combined items score was measured and found to have a Cronbach's alpha of 0.71.

ED RNs' Views Toward SCSs

A series of Likert-scale questions were used to assess ED RNs' views toward SCSs. In summary, ED RNs almost equally agreed (*n* = 47, 32.2%), and felt neutral (*n* = 49, 33.6%) that SCSs could create dangerous neighbourhoods. They also roughly equally agreed (*n* = 39, 26.7%) and felt neutral (*n* = 33, 22.6%) that SCSs promote drug use. Over half (*n* = 82, 56.2%) of ED RNs disagreed or strongly disagreed with being ethically opposed to SCSs, and approximately half (*n* = 75, 51.4%) felt neutral on whether the evidence supported SCSs in improving the health outcomes of patients with recreational drug addiction. Despite these feelings, 74.7% (*n* = 109) of the ED RNs still agreed or strongly agreed that they would refer their patients who use and/or inject drugs to a SCS for additional harm reduction and addiction services, and 62.3% (*n* = 91) agreed or strongly agreed that they would support an SCS in their community.

A composite score was created to combine the above data into a single variable. The composite *Views Toward SCSs* score was normally distributed with a mean of 3.19 (SD = 0.48) and a range of 2.17–5.00. A mean of 3.19 indicates that there were both agreement and neutral feelings among the ED RNs to the statements. The reliability of the combined items score was measured and found to have a Cronbach's alpha of 0.85.

Impact of SCSs on PWUD, the ED, the Healthcare System, and the Community

A series of Likert-scale questions was used to assess the impact of SCSs for PWUD, the ED, the healthcare system, and the community. In summary, ED RNs agreed or strongly agreed that SCSs could impact PWUD by being beneficial to the health of people who use and/or inject drugs (*n* = 110, 75.4%), reducing the pressure to share drugs with others (*n* = 63, 43.2%), enabling access to other supportive services (*n* = 117, 80.1%), helping people use more safely (*n* = 121, 82.9%), helping people get help with other health problems (*n* = 92, 63.0%), ensuring trained staff are ready to respond in case of overdose (*n* = 118, 80.8%), creating a safe place to use (*n* = 114, 78.1%), increasing links to care and support (*n* = 113, 77.4%), and reducing rates of human immunodeficiency virus (HIV) and hepatitis C among people who use and/or inject drugs (*n* = 116, 79.5%). ED RNs agreed or strongly agreed that SCSs could impact the ED by being beneficial to the operations of the ED (*n* = 98, 67.1%), reducing ED visits by preventing medical complications (e.g., abscess, systemic infections) through the distribution of new needles (*n* = 97, 66.4%), decreasing ED wait times (*n* = 69, 47.3%), reducing the number of visits to the ED by providing non-medical services (e.g., addiction services and resources, access to social workers; *n* = 116, 79.5%), and preventing some medical complications (*n* = 104, 71.2%). They agreed or strongly agreed that SCSs could impact the healthcare system by decreasing EMS use for individuals who are found with decreased responsiveness in the community due to drug overdose (*n* = 112, 76.7%). Finally, ED RNs agreed or strongly agreed that SCSs could impact the community by reducing exposure to recreational drug use (*n* = 101, 69.2%) and reducing drug-related paraphernalia discarded in public places (e.g., parks, streets; *n* = 118, 80.8%).

A composite score was created to combine the above data into a single variable. The composite *Impact of SCSs for PWUDs, the ED, the Healthcare System, and the Community* score was normally distributed with a mean of 3.87 (SD = 0.67) and a range of 1.33–5.00. A mean of 3.87 indicates that there was mainly agreement among the ED RNs to the statements. Reliability of the combined items score was measured and found to have a Cronbach's alpha of 0.94.

Services That ED RNs Identified SCSs Should Offer Within Them

The top five harm reduction services that ED RNs identified SCS should offer within them are shown in Table 1.

Services That ED RNs Identified Their EDs Should Offer

The top five services that ED RNs identified to be offered in their ED are shown in Table 2.

Discussion

Limitations

This study has some limitations. The survey was deployed electronically and may be subject to self-selection and self-reporting bias (Eysenbach & Wyatt, 2002). This survey relied on self-reporting of data, which is subject to biases such as social desirability, question interpretation, and respondents' ability to evaluate themselves accurately (Salters-Pedneault, 2020). This study used a single method of data collection (online surveys),

Table 1

*Services That ED RNs Identified SCSs Should Offer Within Them (n = 146)**

Variable	*n*	%	Top 5
Needle exchange program/distribution of new drug supplies (e.g., syringes, needles, sterile water, filters)	122	83.6	1
Addiction counsellors	121	82.9	2
Trained RNs for health care (e.g., wound/abscess care)	115	78.8	3
Naloxone/Narcan kits	113	77.4	4
Mental health professionals (e.g., social workers, psychologists)	111	76.0	5

**Note.* This is a select-all-that-apply question.

Table 2

*Services That ED RNs Identified Their EDs Should Offer (n = 146)**

Variable	*n*	%	Top 5
Referrals to withdrawal/addiction treatment centres	121	82.9	1
Mental health professionals (e.g., social workers, psychologists)	116	79.5	2
Naloxone/Narcan kits	104	71.2	3
Trained RNs for health care (e.g., wound/abscess care)	96	65.8	4
Addiction counsellors	86	61.0	5

**Note*. This is a select-all-that-apply question.

which may have limited the potential to fully understand ED RNs' perceptions. Purposeful sampling can result in sampling bias because the group is not randomly selected and may not reflect the population of interest. Lastly, this study was completed in Southwestern Ontario, and most participants identified as female, white, and trained within Ontario. Thus, findings may not represent all ED RNs in Ontario or Canada.

Interpretations

The findings from this study not only provided recent data on ED RNs' perceptions of SUDs and SCSs, but also added to the developing literature on perceptions of RNs in small to mid-sized Canadian cities, thus, filling gaps in the literature. To the researcher's knowledge, this study is the first to report the perceptions of ED RNs toward SUDs and SCSs together. It is also the first to identify services that SCSs and their EDs should offer from an ED RN perception.

ED RNs' Experience and Comfort Level with SUDs and SCSs

Even though almost all the RNs in the sample received harm reduction training or education and cared for patients with known or suspected SUDs on a daily basis, their knowledge and comfort levels toward SCSs remained modest.

RNs' Views Toward SUD

Results from the composite score that assessed ED RNs' views toward drug use and SUDs demonstrated that ED RNs were empathetic toward drug use and SUD and there was strong overall agreement with the statements provided (mean = 4.07).

The literature indicates that nurses have negative attitudes toward people who have SUDs (Arabaci, 2016; Chu & Galang, 2013; Howard & Chung, 2000; van Boekel et al., 2013). Howard and Chung (2000) found that older nurses hold more disciplinary and authoritarian stances toward PWUD, are more supportive of mandatory treatment, and are less accepting of personal and societal drug use, while younger nurses or nurses with higher degrees had more favourable views toward PWUD. Howard and Chung's (2000) finding that younger and more educated nurses have more favourable views yielded similar results to this study as this study's sample of RNs were primarily younger than 40 years, almost all received harm reduction training or education, and they were overall empathetic toward people with SUDs.

RNs' Views Toward SCS

Results from the composite score that assessed ED RNs' views toward SCSs demonstrated more reserved or neutral views (mean = 3.19). This sample of ED RNs' felt, overall, neutral about whether SCSs could create dangerous neighbourhoods or promote drug use, were ethically opposed to them, and that the current evidence does not support SCSs in improving the health outcomes of patients with recreational drug addiction. Similarly, the nurses in the study by Jackson et al. (2021) were also less supportive of harm reduction modalities, such as SCSs,

and key informants expressed potential opposition to SCSs due to linking SCSs with criminalized activity and thus bringing danger into the community. Likewise, stakeholders were concerned that SCS implementation would further degrade the safety and cleanliness of their community (Wegner et al., 2011). However, other literature demonstrated that SCSs can decrease crime, therefore creating safer neighbourhoods (Myer & Belisle, 2018), and improved health outcomes through decreased opioid-related overdoses and deaths (Behrends et al., 2019; Hayashi et al., 2021; Irvine et al., 2019; Kerr et al., 2007; Marshall et al., 2007; Milloy et al., 2008; Notta et al., 2019), and decreased bloodborne infections, such as HIV and hepatitis C infections (Bayoumi & Zaric, 2008; Enns et al., 2016; Government of Canada, 2021; Irwin et al., 2017).

Although ED RNs in this study conveyed some hesitation toward SCSs and reported no or low level of experience with SCSs, most RNs expressed that PWUD could access their needs through such sites, that they support the implementation of SCSs in their community, and would refer patients who use drugs to SCSs for additional harm reduction and addiction services. Their previous education and training in harm reduction may be the reason for this finding.

Katz et al. (2017) found that ED physicians were less reluctant than nurses toward SCSs and largely supported their implementation and use in Canada. Like this study, physicians who did not necessarily support the implementation of SCSs in their communities would still refer their patients from the ED to SCSs (Katz et al., 2017). This finding is relevant because harm reduction strategies such as SCSs have lacked global support in the past (Global State of Harm Reduction, 2018; Harm Reduction International, 2020). Additionally, as PWUD are among those who are most likely to leave hospitals "against medical advice" (McNeil et al., 2014), going to a SCS may provide them with more appropriate services that serve their needs better and, in turn, decrease the need for ED visits.

Impact of SCSs for PWUD, the ED, the Healthcare System, and the Community

Results of the third composite score that assessed the impact of SCSs for PWUD, and on the ED, the healthcare system, and the community, displayed an overall positive impact (mean = 3.87). Several studies in the literature reiterated the positive impact: SCSs provide access to health care providers and support staff that can prevent and respond to medical emergencies (Government of Canada, 2021), can offer a safe place to use drugs (Lange & Bach-Mortesen, 2019), decrease hospital and emergency medical services use (Government of Canada, 2021; Madah-Amiri et al., 2019), reduce risk of accidental overdose due to less rushed injections and injecting drugs alone (Government of Canada, 2021; Hayashi et al., 2021; Kerr et al., 2007; Notta et al., 2019; Pauly et al., 2020), decrease reusing and sharing of needles, and thus reduce HIV and hepatitis C infections (Bayoumi & Zaric, 2008; Enns et al., 2016; Government of Canada, 2021; Irwin et al., 2017), and increase access to social services and treatments (Bayoumi & Zaric, 2008; Government of Canada, 2021; Irwin et al., 2017; Wood et al., 2007).

Top Services Identified by ED RNs to be Offered in SCSs and ED

Emergency department RNs in this study and PWUD in the literature identified withdrawal management and access to new needles (Kenney et al., 2021), the presence of healthcare staff (Kerr et al., 2007), and naloxone accessibility (Lowenstein et al., 2022), as preferred services at a SCS. PWUD also valued safety from the police (Kenney et al., 2021) and drug-checking services (Kenney et al., 2021; Olding et al., 2020), but the ED RNs in this study did not prioritize these services as essential for SCSs or within their EDs.

Generalizability

Findings from this quantitative, multi-site study addressed the research gap in providing ED RNs' perceptions of SUDs and SCSs for small- to mid-sized cities in Ontario. It also contributes to the body of literature by offering recent data and providing the viewpoints of RNs, the most abundant healthcare team members. By recognizing their perceptions, providers can work toward ensuring these do not affect the quality of care they provide (Shreffler, 2021). Results from this multi-site study can serve as an opportunity to compare perceptions from other disciplines, share new knowledge, and improve patient care and safety. The findings can also improve RN practice, promote the inclusion of or continuation of education on SUDs, caring for PWUD, and harm reduction strategies such as SCSs, and help encourage policy creation to standardize care better. Additionally, the results from this study can assist city and government officials in deciding which services to include in the next SCS and hospital administrators in determining which harm reduction services are most valued by ED RNs and which to implement within the ED.

Implications for Emergency Clinical Practice

- Emergency nurses should practice reflexively and be aware of their attitudes, values, and perceptions when caring for patients with SUDs (RNAO, 2015; RNAO, 2018).
- Educational requirements regarding harm reduction in RN programs should be standardized at a national level.
- Standardized protocols are needed to facilitate the transition between hospital and community (Horner et al., 2019).
- Education should be included in hospital orientations, with frequent offerings of continuation education opportunities on SUDs and harm reduction strategies, such as SCSs. The newest literature should also be presented to ensure RNs are always practising up to date with research.
- The influence of stereotypes and stigma-based decisions and care should be decreased.

Author Notes

Aleksandra Ilievska, MSc.Inf., B.Sc.Inf., IA, University of Windsor

Gina Pittman, Ph.D., I, P M.Sc.Inf, University of Windsor

Jody Ralph, Ph.D., B.Sc.Inf., IA, University of Windsor

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Conflicts of Interest

None

Contribution and CRediT Statement

Aleksandra Ilievska: Conceptualization, Methodology, Formal Analysis, Investigation, Data Curation, Writing – Original Draft

Gina Pittman: Conceptualization, Methodology, Writing – Original Draft, Supervision

Jody Ralph: Conceptualization, Methodology, Writing – Original Draft

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