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UNIVERSITY OF CALGARY

Exploring the role of the nurse in opioid use disorder treatment: A focused ethnographic study

by

Amie Kerber

A THESIS

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Abstract

Opioid use disorder (OUD) affects people across the continuum of life, in all geographic locations, irrespective of gender, age, nationality, and socioeconomic status. From January to March 2021, 1792 opioid toxicity deaths occurred in Canada. As front-line healthcare professionals, nurses make substantial contributions toward the prevention, treatment, and management of OUD. However, little research has been conducted regarding the role and impact of the nurses working in these unique practice settings. Using focused ethnography, this qualitative study aimed to explore the understanding of the role and impact of the nurse working in OUD treatment. Individual in-depth interviews were conducted with ten registered nurses who worked across the spectrum of OUD treatment. Analysis of the qualitative data revealed six themes to better understand the role and impact of the nurse: (a) the art of addiction nursing, (b) direct patient care, (c) indirect patient care, (d) the shared experience of stigma, (e) perceived barriers, and (f) looking to the (uncertain) future. The present study offered several implications for nursing practice, education, and research. Study results identify similarities and differences of the role of the nurse working across a variety of treatment programs; future research opportunities exist to explore the role of the nurse in specific OUD treatment programs, and the role of the nurse in OUD treatment transnationally. Nurses working in this practice area are hardworking, compassionate, and deeply committed to providing high-quality healthcare to patients with OUD across various practice areas. Despite this, nurse participants emphasized perceived challenges and barriers that negatively impacted their ability to meet patient's needs.

Keywords: opioid use disorder, nursing role, harm reduction, focused ethnography

Preface

This thesis is original, unpublished, independent work by the author, A. Kerber. The data collection and analysis reported in Chapters three, four, and five were covered by the Ethics Certificate ID number REB21-0792, issued by the University of Calgary Conjoint Health Research Ethics Board for the project "Exploring the role of the nurse in opioid use disorder treatment: A focused ethnographic study" on June 30, 2021.

Acknowledgements

It has always been my dream to work in the area of addictions and harm reduction. Beyond frontline care, I never imagined that I would be able to complete research in this practice area that I hold so close to my heart. Learning from, and holding space with clients who use substances has taught me about compassion, about love, about the intrinsic value and worth of all people, regardless of their history. First and foremost, I want to acknowledge the clients I have worked with over the years, those who are still here, and those who have died by opioid poisoning. You are loved, you are missed, you are worthy.

This thesis would not have been possible without the ten nurse participants who shared their passion, struggles, joy, and hardships with me. Thank you for trusting me to share your messages. You inspire me through the meaningful work that you do each day.

I want to acknowledge and thank Sheila McKay for her support and mentorship during my undergraduate degree, and in my first years as a Registered Nurse. I value your guidance and friendship. You helped me to dream about my career, and instilled a foundational love of the profession of nursing within my heart.

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Thank you to my research committee, which included Dr. Aniela dela Cruz, and Dr. Candace Lind for their expertise and insights throughout the research process. I have learned so much from you both, and I am very grateful for that.

To my husband, Matthias; thank you for your never-ending support. When I told him of my hopes to complete this degree and thesis he wholeheartedly supported me, without truly knowing what it meant or how long it would take. Thank you to my daughter Ivy, for sitting at the kitchen table with me as I did my school work, and doing her own school work and art alongside me. I am so lucky to love you both.

Finally, I want to thank my friends, Ashleigh, Katrina, Carlina, and Stephanie. I am so blessed to have you in my life. I fall short of finding the appropriate words to describe how valuable your friendship is to me. You are amazing nurses and amazing human beings.

Dedication

This thesis is dedicated to my sweet daughter Quinn Nicole Kerber, who passed away unexpectedly in September 2020 at the age of five. At times I was not sure how I would continue on with this work in the aftermath of her death. I was afraid I would never again find joy or purpose in professional projects. Loving her gives me the strength to push through the difficult, and I know she would be so proud of me for completing this work.

You are my sunshine,

my only sunshine,

you make me happy,

when skies are grey,

you'll never know, dear,

how much I love you,

please don't take my sunshine away.

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List of Abbreviations

AHS	Alberta Health Services
AISH	Assured Income for the Severely Handicapped
BCCSU	BC Centre on Substance Use
CASN	Canadian Association of Schools of Nursing
CHREB	Conjoint Health Research Ethics Board
CIWA	Clinical Institute Withdrawal Assessment
CARNA	College and Association of Registered Nurse of Alberta
CRNA	College of Registered Nurses of Alberta
CNA	Canadian Nurses Association
COWS	Clinical Opioid Withdrawal Scale
CRISM	Canadian Research Initiative in Substance Misuse
ECG	Electrocardiogram
EDI	Equity, diversity and inclusivity
IntNSA	International Nurses Society on Addictions
iOAT	Injectable Opioid Agonist Treatment
OAT	Opioid Agonist Treatment
OUD	Opioid Use Disorder
PPE	Personal Protective Equipment
SCS	Supervised Consumption Service
SDOH	Social Determinants of Health
STBBI	Sexually Transmitted and Blood Borne Infection
SUD	Substance Use Disorder

Chapter 1: Introduction

1.1 Background

Opioid use disorder (OUD) is a chronic relapsing illness associated with elevated morbidity and mortality rates (Government of Canada, 2022). It involves the problematic use of illicitly manufactured opioids, such as heroin or street fentanyl, or pharmaceutical opioids acquired illicitly or used for non-medical reasons (Canadian Research Initiative in Substance Misuse (CRISM), 2018). In 2018, 12.7% of Canadians 15 years and older (roughly 3.7 million) reported the use of opioids in the last year (Statistics Canada, 2019). Furthermore, approximately 351,000 people reported problematic opioid use (Statistics Canada, 2019). Long-term effects of opioid use include increased tolerance leading to OUD, liver damage, infertility in women, worsening pain, and increased risk of overdose-related death (Government of Canada, 2022). Dependence on opioids intensifies pre-existing mental health concerns, causes difficulties adjusting to stress, and entrenches people within social marginalization (Bell et al., 2018). Physical dependence on opioids occurs during OUD in as little as four to eight weeks, leading to severe withdrawal effects if the person experiencing dependence stops taking opioids or lowers their consumption drastically (Government of Canada, 2022). Physical withdrawal symptoms include chills, diarrhea, insomnia, anxiety, diaphoresis, agitation, nausea, and increased pain (Government of Canada, 2022). “Recognized as one of the most challenging forms of addiction facing Canadian healthcare systems, OUD is a major driver of the critical rise in overdose deaths across several Canadian provinces” (CRISM, 2018, p. 14). *The Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (American Psychiatric Association, 2018) described OUD as:

A problematic pattern of opioid use leading to problems or distress, with at least two of the following occurring within a 12-month period:

1. Taking larger amounts or taking drugs over a longer period than intended.
2. Persistent desire or unsuccessful efforts to cut down or control opioid use.
3. Spending a great deal of time obtaining or using the opioid or recovering from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Problems fulfilling obligations at work, school or home.
6. Continued opioid use despite having recurring social or interpersonal problems.
7. Giving up or reducing activities because of opioid use.
8. Using opioids in physically hazardous situations.
9. Continued opioid use despite ongoing physical or psychological problems likely to have been caused or worsened by opioids.
10. Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount)
11. Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms. (American Psychiatric Association, 2018, para 7-8)

The present opioid epidemic is a result of massive growth in the use of prescription opioids in Canada in the last 30 years (Belzak & Halverson, 2018). It is estimated the volume of opioids sold to pharmacies and hospitals has increased 3000% since 1980, placing Canada as the second-highest consumer of prescription opioids in the world, after the United States (Belzak & Halverson, 2018). According to the Canadian Institute for Health Information (2018), OUD, opioid-related deaths, and opioid-related harms, such as opioid poisoning, adverse drug

reactions, often require medical attention at various levels of the healthcare system. Furthermore, over the past five years, hospitalizations related to opioid poisoning have increased 27% (Canadian Institute for Health Information, 2018). It is estimated in Canada the cost of substance use in society has reached a staggering high of $46 billion dollars per year (Canadian Centre on Substance Abuse and Addiction, 2020). Between January 2016 and June 2021, more than 24,600 Canadians lost their lives to an opioid-related overdose (Government of Canada, 2021). Risk factors that increase the possibility of an opioid-related death include the combined use of opioids with other substances such as benzodiazepines and alcohol, being Indigenous, and homelessness (Belzak & Halverson, 2018). Considering the severity of OUD and its growing burden on the Canadian healthcare system, it is critical nurses provide evidence-based care across the spectrum of available treatment options.

1.1.1 Treatment

Treatment for OUD exists along a continuum, ranging from harm reduction to abstinence (Dell, 2008). An important element of an evidence-based response to OUD treatment is the provision of health services that enhance engagement and treatment of people with OUD; recognizing the need for diversity of available treatment options that can be matched to individual patient needs and circumstances (BC Centre on Substance Use (BCCSU), 2017). Short-term treatment objectives include initiation and stabilization of opioid agonist treatment (OAT) and routine offering of psychosocial treatment and support (BCCSU, 2017). "The objectives of long-term management are reduced risk of death, improvement in physical and mental health, and restoration of impaired social role, including a reduction in any criminal offending" (Bell et al., 2018, p. 1340).

1.1.1.1 Harm Reduction.

Harm reduction is an evidence-based approach for decreasing the unfavorable consequences of substance use without requiring abstinence (Canadian Nurses Association (CNA), 2018a). Ball (2007) described harm reduction as "a principle, concept, ideology, policy, strategy, set of interventions, target and movement" (p. 684-685) that aims to reduce the adverse health, social, and economic consequences of substance use. Understanding the concept of harm reduction will assist nurses in delivering patient-centered healthcare to people with addictions (Kerber et al., 2020). Harm reduction emphasizes that a non-judgmental approach is required to treat people with respect and compassion irrespective of their substance use (CNA, 2018a). It has been documented that various communities have been practicing harm reduction principles since the use of psychoactive substances began (Ball, 2007). Early implementation of harm reduction strategies included maintaining a registry, providing opium to dependent citizens in Europe and Asia in the 18th and 19th centuries, and disseminating safer substance use education in "underground magazines" in the 1960s (Ball, 2007). Ball (2007) described that in the last three decades, harm reduction principles had been focused on decreasing the transmission of bloodborne illnesses through public policy and advocacy. With the opioid epidemic emerging and increased mortality in recent decades, the principles of harm reduction emphasize the importance of promoting policies and programs with the goal of decreasing opioid-related deaths (CNA, 2018a; Kerber et al., 2020; Morin et al., 2017).

Kerber et al. (2020) describe five essential attributes that are inclusive of all applications of harm reduction, including safety, education, supplies, partnership, and policies. Safety is dependent on client needs and may mean a combination of physical, psychological, or emotional safety (Kerber et al., 2020). When clients feel safe, it increases access of healthcare services and

the likelihood of continued engagement in harm reduction programs (Deren et al., 2017; Hilton et al., 2001). Appropriate education ensures clients are mindful of how to reduce the harm they are exposed to. Nurses can educate clients on how to lower the risks of overdose and death, such as by avoiding the use of opioids and benzodiazepines concurrently (Canadian Centre on Substance Abuse and Addiction, 2018) and not using substances alone (Kulikowski & Linder, 2018), or if clients wish to decrease their substance use, how to connect with agencies that provide detox services. One of the most well-known attributes of harm reduction is the availability and accessibility to safe supplies such as syringes, cookers, sterile water, condoms, pipes, take-home naloxone kits, and sharps containers (Ford, 2010; Kerr et al., 2006; Kulikowski & Linder, 2018). Mutual partnerships result in improved access to healthcare services, such as medication assistance treatment models that provide OAT (BCCSU, 2017; CRISM, 2018). By maintaining strong partnerships between community organizations, clients have greater access to other healthcare services leading to improved overall wellness (Kerber et al., 2020). Finally, the CNA (2018a) emphasizes harm reduction "policies and programs must be based on best evidence, cost-effectiveness and local needs – all while involving the participation of those who use substances in decisions that affect them" (p. 2). Appropriate and effective policies at all levels of government and programs could help to increase public awareness and effectively address the problem of OUD (Kerber et al., 2020).

Evidence has shown that improving the quality of life of people who use substances through the implementation of harm reduction strategies decreases the rate of opioid overdoses and improves the relationship between clients and healthcare providers (Estreet et al., 2017; Pauly et al., 2013). Furthermore, other positive outcomes of harm reduction have been well documented, including the decreased transmission of bloodborne illnesses (Kerr et al., 2010),

decreased injection-related injury (Kulikowski & Linder, 2018; Pauly et al., 2013), improved access to healthcare (Kulikowski & Linder, 2018), increased referrals for primary healthcare needs, reduced stigma (Goodyear et al., 2018), and decreased risk of opioid overdose death (Estreet et al., 2017).

1.1.1.2 Abstinence.

Abstinence is "the practice of not doing or having something that is wanted or enjoyable" (Merriam-Webster, 2022). The term *abstinence,* when used in the context of OUD, can have a variety of meanings, from complete abstinence from all opioids to abstinence from illicit opioids while still using a prescribed OAT medication. This lack of clarity leads to confusion about what can appropriately be considered abstinent. The overarching commonality from the literature asserts that abstinence means the cessation of using illicit opioids in a problematic way (Gallagher et al., 2019; Harvey et al., 2020; Klein & Seppala, 2019; Schuman-Olivier et al., 2014). The confusion arises within the philosophical underpinnings of the approaches to achieving abstinence.

The most common and mainstream approach to substance abuse treatment is the residential treatment model. Residential treatment provides short or long-term substance abuse treatment in the context of 24-hour supervised drug and alcohol-free centres (InformAlberta, n.d.). Structured programming is offered to clients who are removed from the triggers of daily life (InformAlberta, n.d.). This intensive treatment is considered a higher level of care than can typically be accessed from a community or "outpatient" perspective (Klein & Seppala, 2019). The residential treatment model is often ideologically based on the principles and philosophy of Alcoholics Anonymous (Klein & Seppala, 2019). This approach stresses the importance of using the 12-step process to achieve recovery and sobriety from OUD (Klein & Seppala, 2019;

Schuman-Olivier et al., 2014). Facilitation through the 12-step process is achieved through techniques such as motivational interviewing, cognitive behavioural therapy, and contingency management (Klein & Seppala, 2019). Individual therapy sessions also occur with addiction counsellors, and mental health concerns are addressed by the appropriate care provider (Klein & Seppala, 2019). In these facilities, substance use disorder is seen as a progressive disease of the brain, with the goal of treatment to help people achieve long-term complete abstinence from opioids (Klein & Seppala, 2019). It has been identified that 12-step group engagement increases positive social support among people who have substance use disorder, which has the potential to aid in post-treatment abstinence (Harvey et al., 2020). However, it is also well documented that relapse after abstinence-based residential treatment is very common among people with OUD (Schuman-Olivier et al., 2014). "OUD medications are used in clinical settings that do not typically utilize a 12-step approach, and 12-step based treatment settings focusing on OUD do not typically utilize medications" (Klein & Seppala, 2019, p. 52). The use of medications to treat OUD deviates from the typical 12-step treatment model as these medications mimic the action of opioids, leading some to believe that people who take these medications are not "sober" or abstinent (Harvey et al., 2020).

1.1.1.3 Medication.

The use of medications such as methadone and suboxone to treat OUD has been extensively researched (BCCSU, 2017; Canadian Centre on Substance Abuse and Addiction, 2018; Canadian Psychological Association, 2019; CRISM, 2018). The primary methods of substitution treatment include oral OAT, such as methadone and suboxone, and injectable OAT (iOAT), which includes the administration of injectable hydromorphone or diacetylmorphine in a clinic setting (BCCSU, 2017; CRISM, 2018). Opioid agonist treatments are superior to

withdrawal management alone in terms of morbidity, mortality, treatment retention, and sustained discontinuance of problematic opioid use (BCCSU, 2017). Suboxone (Buprenorphine/Naloxone) is promoted as the first-line treatment for medication-assisted treatment as it "has a safety profile that is six times greater than methadone in terms of overdose risk" (BCCSU, 2017, p. 11). Methadone is encouraged as a first-line treatment if the use of suboxone is contraindicated (BCCSU, 2017; CRISM, 2018). Regardless of the medication administered, treatment should incorporate provider-led counselling, long-term substance use monitoring, and appropriate referrals to psychosocial supports as required (BCCSU, 2017).

Within the philosophies of abstinence and harm reduction, the spectrum of care ranges from supervised consumption services, detox, opioid replacement therapy, and withdrawal management alone. Adjunct treatments include residential treatment, outpatient treatment, 12-step programs, and other therapy-based approaches. Prescribers are strongly recommended to avoid withdrawal management alone without plans to transition to oral OAT (BCCSU, 2017). Withdrawal management alone has been associated with nearly universal relapse rates, elevated risk of unsafe drug use, and increased risk of overdose compared to no treatment provision (BCCSU, 2017; CRISM, 2018). Supported recovery should be defined by the people engaging in treatment; the dichotomy of being either a harm reduction or abstinence-based program should be avoided in favor of viewing treatment options along a spectrum (Gallagher et al., 2019). Evidence-informed and client-centered treatment has been shown to improve the lives of people living with OUD (Canadian Center on Substance Abuse and Addiction, 2018).

1.1.2 Nursing Role

People living with OUD in Canada should have access to comprehensive treatment options that meet their needs (Canadian Center on Substance Abuse and Addiction, 2018).

Opioid use disorder affects people across the continuum of life, in all geographic locations, irrespective of gender, age, nationality, and socioeconomic status; this puts nurses in a unique position to make substantial contributions toward the prevention, treatment, and management of OUD (Mumba & Snow, 2017). Nurses care for people across the lifespan and could encounter patients where substance use has a direct or indirect impact on their health in a variety of practice settings (CNA, 2018a). The CNA (2018a) asserts that nurses have an ethical and professional responsibility to provide care that promotes safety and non-judgement, further reinforcing their important role with patients with OUD. Nurses work across the OUD and substance use treatment spectrum in a variety of roles and programs. These practice areas include supervised consumption services and harm reduction outreach, detox facilities, inpatient and outpatient treatment programs, addiction counselling services in the community, addiction consultation services in the hospital, and medication-assisted treatment programs. In OUD settings, nurses construct and engage in the primary therapeutic relationship with clients (Plaza et al., 2007). Nurses comprehensively understand the interconnectedness and influence of social determinants of health (SDOH) (CNA, 2022) on a client's life. Nurses are important healthcare providers in OUD treatment as they have a broad knowledge base of disease complexity, encompassing how the relationship of neurobiological, psychosocial, and spiritual factors leads to maladaptive practices in clients (Abram, 2018). However, their roles are not well understood, which might lead to confusion, devaluation, and stigmatizing attitudes from other healthcare professionals and the public.

1.2 Problem Statement

A review of the literature identified the role of the nurse working in OUD treatment is often unclear and underutilized. Little research has been undertaken to examine the role and

value of the registered nurse in OUD treatment (Abram, 2018; McCall et al., 2019). "This problem undermines the sharing of knowledge that can lead to improving nursing interventions and strategies for patients who are opioid dependent" (Plaza et al., 2007, p. 14). The approach to treating OUD in Canada is evolving, and the significant impact of nurses in OUD management is increasingly recognized; therefore, the nurse's role should be reflective of evidence-based care to improve patient outcomes. Gray (2016) believes that when providing care to clients with OUD, nurses should be able to manage dynamic situations, lead innovation, and practice compassion when assisting clients throughout their treatment. However, problems still exist in understanding the unique role of the nurse in providing care to clients accessing OUD treatment.

1.3 Research Purpose

This qualitative research study aimed to explore the understanding and experiences of the role of the nurse working in OUD treatment. Research findings demonstrated the role of nurses and how nurses working across the treatment spectrum can benefit people with OUD, contributing to improved patient outcomes, continued access of services, and appropriate project planning. In the following chapter, I present the literature review results and knowledge gaps which guided the research question formation.

Chapter 2: Literature Review

2.1 Literature Search Strategy for the Role of the Nurse in OUD Treatment

Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, MEDLINE, and PsycINFO were the databases used to collect articles due to their extensive and varying literature base. The objective of this literature review was to explore existing knowledge of the role of the nurse across OUD treatment settings. The search focused on two concepts: (i) opioid use disorder and (ii) nurse role. Keywords were generated for each concept by key terms, subject indexing, and seed articles reviewed for similar terms. Subject headings included substance abuse treatment centers, opioid substitution treatment, opioid related disorders, heroin dependence, opiate substitution treatment, methadone, buprenorphine, heroin, hydromorphone, and nurse's role. Keywords were selected when there was no existing subject heading and often included synonyms such as medication-assisted treatment or injectable opioid treatment. Truncation was used to include minor grammatical changes to ensure the search was comprehensive. Keywords were consistent across databases, and subject headings were translated from MEDLINE to CINAHL to ensure accuracy. The search was conducted in February 2020 and was saved for each database for future follow-up. A follow-up literature search using the same method was conducted in March 2022 to generate recently published literature. See Appendix A for a complete search strategy.

Inclusion criteria included peer-reviewed articles, full-text availability, English language, abstract, and reference availability. Articles were narrowed down to the time frame of 2007-2022 as this was when OUD treatment methodologies began to be more comprehensively researched. One article from 1999 was retained as a seminal source due to its primary focus on the role of the registered nurse working in OUD treatment. The initial search yielded 1052

studies to be screened. Duplicates, commentaries, editorials, case studies, and letters to the editor were removed. As this literature review focused on the registered nurse's role, articles examining the role of advanced practice nurses, nurse practitioners, or nurse prescribing were also excluded. Ninety-four full-text articles were reviewed. Full-text articles were excluded if they did not focus on the role of the registered nurse in OUD treatment. Through these criteria, twenty-one full-text articles were included in this review to better understand the current literature exploring the nursing role in caring for clients with OUD (Figure 1: Integrative literature review flow chart).

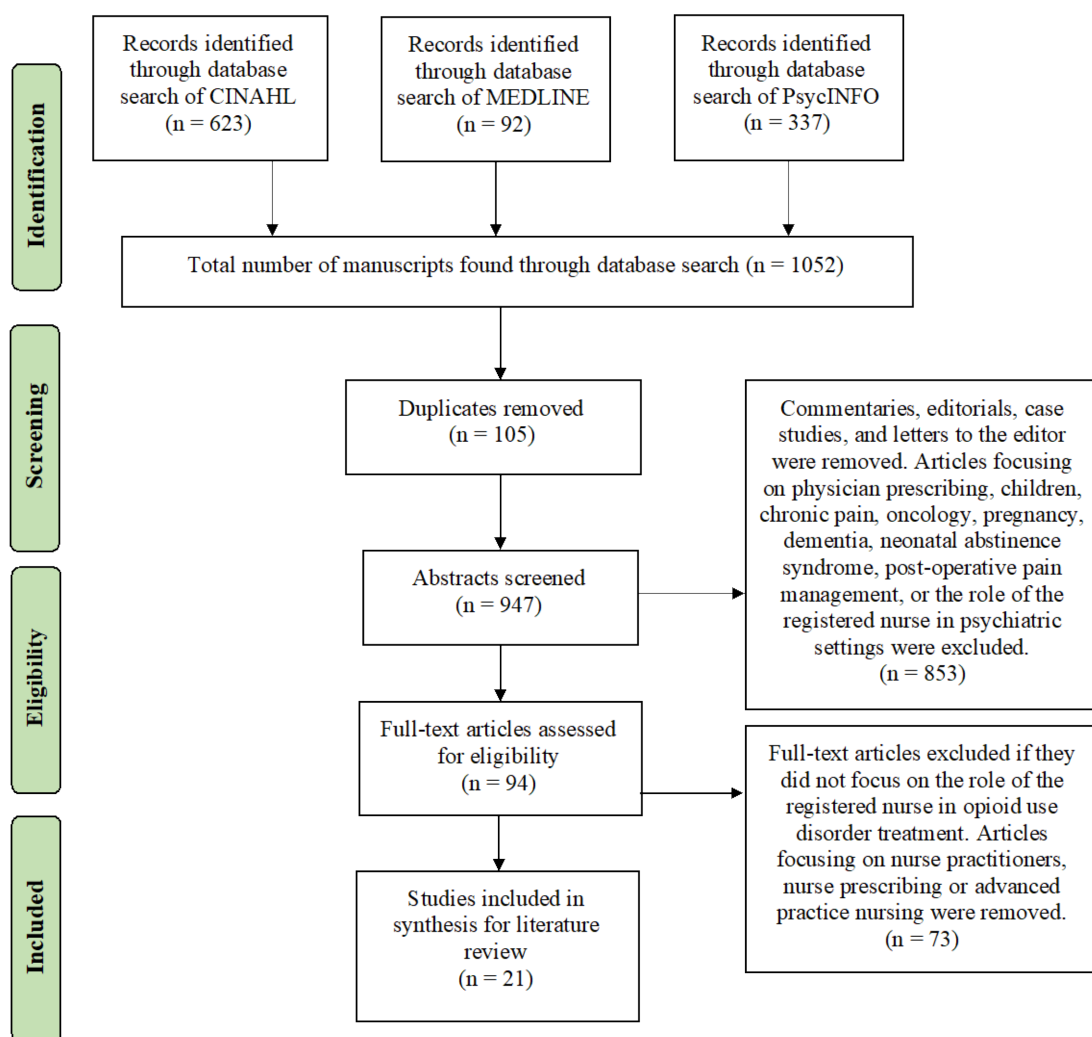

Figure 1: Literature review flow chart

2.2 Literature Synthesis and Thematic Analysis

Twenty-one full-text articles were collected for this literature review that identified the role of the nurse in substance use disorder and OUD treatment. Three articles were specific to iOAT clinics, four discussed methadone, two described buprenorphine treatment in a clinic setting, one examined the role of the nurse in supervised consumption services, and eleven were general to substance use disorder treatment, gathering participants and information from varying practice areas. The articles originated from four primary locations – six from Canada, nine from the United States, five from the European Union, and one from Australia. Twelve articles reported primary research studies, which include seven qualitative, one quantitative, one mixed method study, and three studies with unclear methodologies. All primary studies were appraised using the Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong et al., 2018). Eight studies met the full methodological quality criteria identified in the MMAT. The remaining four studies lacked coherence between the data source, collection, analysis, and interpretation. Furthermore, these studies had unclear qualitative methodologies, which made it difficult to interpret how the collected data answered the research questions. For detail of the studies' appraisal, see Appendix B for the Literature Appraisal Matrix and Thematic Analysis.

There was little research targeting "the role of the nurse in OUD treatment," and articles that touched on this highlighted historically minimal research in this area. Recommendations for future research to clarify the nurse's role were made in ten of the studies. Articles specific to the role of the nurse in OUD treatment were published from the years 2018-2022, indicating this topic of research is gaining popularity. The thematic data analysis of 21 articles included in this review highlighted the nurse's role as falling into three general themes of care: physical care, psychosocial care, and healthcare navigator.

2.2.1 Physical Care

Fourteen articles acknowledged the role of the nurse was intertwined with providing physical care to clients engaging in OUD treatment. While not all articles highlighted the same tasks, the primary physical care tasks the nurses provide included: assessment (Bernhardt, 2021; Clark & Lucey, 2021; Comiskey et al., 2019; Go et al., 2011; Happell & Taylor, 1999; Konrad, 2004; Ling et al., 2017; Sowicz et al., 2022); medication management and administration (Abram, 2018; Azimi-Bolourian & Fornili, 2010; Bernhardt, 2021; Comiskey et al., 2019; Demaret et al., 2012; Deren et al., 2017; Go et al., 2011; Happell & Taylor, 1999; Konrad, 2004; Ling et al., 2017; Plaza et al., 2007; Sowicz et al., 2022); and general physical care (Abram, 2018; Clark & Lucey, 2021; Comiskey et al., 2019; Ling et al., 2017; Konrad, 2004; Sowicz et al., 2022; Plaza et al., 2007; Strobbe et al., 2011; Wilson et al., 2007). General physical care encompassed: wound care (Sowicz et al., 2022), blood draws, infection prevention and management (Abram, 2018); monitoring patient condition (Clark & Lucey, 2021; Go et al., 2011; Sowicz et al., 2022); assistance with self-injection technique (Clark & Lucey, 2021; Plaza et al., 2007); and urine drug screens (Strobbe et al., 2011).

Treatment of OUD can span from hospital settings to outpatient clinic support (Clancy et al., 2019). "Nurses have a significant role in [addiction] services, particularly in the delivery of medical care" (Ling et al., 2017, p. 110). Nurses working in different practice areas might perform different tasks related to physical care. A prominent subtheme of physical care was *"the nurse's role extending beyond just physical care."* Abram (2018) highlighted participants in their study were confident the "jurisdiction" of the nurse's role was managing the physical aspects of care, even if their role could more broadly encompass emotional and behavioural management. Clancy et al. (2019) described a paradigm shift in the nurse's role in the

Netherlands that changed from a minor role associated with methadone maintenance to a broader case-manager style role in a nurse-driven team. This shift facilitated nurses to assert their role and competencies more clearly, improving workplace satisfaction (Clancy et al., 2019). While physical care comprised a large part of the literature reviewed, many studies stressed psychosocial care was important to facilitate relationship development and care between staff and clients (Abram, 2018; Bernhardt, 2021; Clark & Lucey, 2021; Go et al., 2011; Ling et al., 2017).

2.2.2 Psychosocial Care

All but three articles emphasized various ways nurses provide psychosocial care to clients in OUD and substance use disorder treatment. While some articles highlighted specific characteristics nurses should have, such as hardiness, patience, tolerance, a non-judgemental attitude (Clancy et al., 2006), empathy, and assertiveness (Plaza et al., 2007), others focused on the implementation of psychosocial skills. Building therapeutic relationships and patient-centered care was the central foundation from which other psychosocial treatments could be established (Abram, 2018; Clark & Lucey, 2021; McCall et al., 2019; Wilson et al., 2007). "Communication is the fundamental basis for nursing activities, especially in the nurse-patient relationship, because it enables the continuity of attention and, at the same time, the establishment of personal relations that influence recovery and the quality of healthcare by prioritizing the patient's welfare" (Plaza et al., 2007, p. 18). Communication as a therapeutic intervention was also included in psychosocial care (Bernhardt, 2021; Happell & Taylor, 1999; Seabra, 2018; Wilson et al., 2007). Additionally, patient education was seen as an important aspect of the nurse's role. Patient education could focus on topics of relapse prevention and recovery (Happell & Taylor, 1999; Strobbe et al., 2011; Wilson et al., 2007), trauma support

(Comiskey et al., 2019; Ling et al., 2017), or self-care education (Deren et al., 2017; Go et al., 2011; Mumba & Snow, 2017; Seabra, 2018).

Naegle (2015) emphasised how nurses should provide psychosocial care to clients. They stressed nurses might be prevented from providing health promotion, counselling, education, and harm reduction strategies due to the narrow interpretation of the nursing role in OUD being mostly related to physical care. However, Konrad (2004) suggested knowledge and skills related to crisis management allows nurses to see clients holistically. This can assist them in making connections with other health issues external to, or related to, the addiction being addressed (Konrad, 2004). Nurses should be seen as instrumental in developing treatment plans and providing counselling services to clients (Azimi-Bolourian & Fornili, 2010). With psychosocial care being one of the most prevalently reported characteristics of the nurse's role in OUD treatment, it is important to continue advocating for a broader understanding of how nurses provide this care. Psychosocial care and building therapeutic relationships are the foundation for nurses to be able to assist clients in navigating the healthcare system.

2.2.3 Healthcare Navigator

The nurse's role as a healthcare navigator, described in sixteen articles, was seen as taking place both within and outside of the clinic structure. Within the confines of the clinic or unit, nurses were seen as being "the enforcers" who manage the environment and function of the unit or clinic, the client's behaviours, and interactions with others (Happell & Taylor, 1999), sticking to the rules (Abram, 2018), maintaining clinic flow (Demaret et al., 2012), case management and program administration (Deren et al., 2017). Beyond their role in the clinic setting, nurses were expected to be advocates for their clients, facilitating access and referrals to other required healthcare services such as counselling, hepatitis C treatment, or primary care

services related to general healthcare (Bernhardt, 2021; Clark & Lucey, 2021; Comiskey et al., 2019; Go et al., 2011; Ling et al., 2017; Mumba & Snow, 2017; Strobbe et al., 2011). Four studies alluded to the nurse's role as being "secondary" to the physician, which means that the nurse's role was to carry out the physician's orders; the physicians were the drivers of the care provided in OUD treatment (Abram, 2018; Clancy et al., 2019; Naegle, 2015; Strobbe et al., 2011). Naegle (2015) stated that "ignorance of contemporary nursing practice and retention of stereotypes … restrict the freedom of nurses to fully practice; they are often viewed as dependent on physician's orders or employed to only administer medications" (p. 1155). Despite this, Abram (2018) found that nurses took comfort in this secondary role and believed it helped them to perform their role more clearly as there was less overlap with other healthcare providers working within the clinic. Liaising and consulting with other units and programs to facilitate client care was seen as an evolutionary aspect of the nurse's role, occurring when clinical skills maturity is reached (Clancy et al., 2006; Happell & Taylor, 1999).

People who access services related to OUD treatment often have co-occurring mental health concerns, meaning nurses providing care in this setting should have the skills to manage a multitude of concerns (Ling et al., 2017). Azimi-Bolourian and Fornili (2010) believed nurses should improve access for clients, provide education, and connect clients with appropriate community resources such as housing and social support services. Nurses act as healthcare navigators as they "pay attention to medical and psychosocial comorbidities and address them comprehensively, because pharmacotherapy rarely achieves long-term success without [engaging with] concurrent psychosocial/behaviour therapies and social therapies" (Azimi-Bolourian & Fornili, 2010, p. 185). Acting as a healthcare navigator, as with psychosocial care, provides the nurse with opportunities to work in a leadership capacity as the coordinator of care within the

team. This area of the nurse's role is often underutilized, which detracts from the care provided to clients (Clancy et al., 2019; Mumba & Snow, 2017; Naegle, 2015).

2.2.4 Harm Reduction and Patient-Centered Care

Two other themes – *harm reduction* and *patient-centered care* – intertwined with the three primary themes (physical care, psychosocial care, and healthcare navigator) identified above. Largely positioned within the context of *street nursing*, *harm reduction* was established by nurses who cared for clients who were facing multiple barriers (Danda, 2021). Danda (2021) described street nursing as "outreach nursing care delivered in non-traditional locations (e.g., back alleys or homeless shelters) to homeless and otherwise marginalized people" (p. 122). Historically, harm reduction contrasted with traditional abstinence-based approaches to care, with nurses seeking to minimize personal and social harms (Danda, 2021). Harm reduction includes providing physical care to clients, such as when assisting with injection techniques or providing safe supplies (Bernhardt, 2021; Demaret et al., 2011; Deren et al., 2017; McCall et al., 2019; Plaza et al., 2007). Providing psychosocial care with an approach that is compassionate and non-judgemental allows clients to create therapeutic relationships with healthcare staff, which can lead to further healthcare system engagement through the role of the healthcare navigator (McCall et al., 2019). Reducing harm is a central component of the care being provided to clients regardless of what OUD treatment practice area nurses work in.

As OUD is a chronic condition, nurses understand that relapse is often a part of addiction (Clancy et al., 2006; Konrad, 2004; McCall et al., 2019). The concept of *patient-centered care* ensures clients are active in the treatment goal-setting process. The care provided allows socially-marginalized people to be engaged in their treatment rather than simply accommodated or told to follow goals that might not meet their needs (Kolind & Hesse, 2017). "The findings

exemplify the importance of the quality and the nature of relationships established between clients and healthcare professionals" (Wilson et al., 2007, p. 993). Patient-centered care encompasses physical care, psychosocial care, and healthcare navigation, as it allows the client to direct their care and interventions, rather than the healthcare staff being the directors of treatment (Comiskey et al., 2019; Ling et al., 2017). This could look like patients identifying the type of OAT they would like to receive, offering appropriate social support, and making referrals the patient agrees would be beneficial.

2.3 Gaps in the Literature

Several deficiencies in the literature were noted. As many of the studies used exploratory methodologies, it was difficult to compare findings between the studies, and much of the role of the nurse had to be inferred and pieced together. Additionally, I was unable to locate any ethnographic research exploring the nurse's role in OUD settings. Some studies reviewed were greater than ten years old (Clancy et al., 2006; Happell & Taylor, 1999; Konrad, 2004; Wilson et al., 2007); as OUD treatment has expanded in scope and approach with the growing opioid epidemic, it can be assumed these articles are outdated. Clancy et al. (2019) stressed there is no consensus on the definition of the addiction nurse's role, leading to a lack of standard qualifications, insufficient workforce data, and limited research on the role and impact of nurses working in OUD treatment. This makes it difficult to understand the effectiveness of the role of the nurse as it has not been clearly defined, differs substantially based on geographical location, and has not been explicitly researched. Future research should address the persistent negative stigma often experienced by nurses working in OUD and substance use disorder treatment (Naegle, 2015). Abram (2018) asserts that nurses work in a variety of treatment settings; future research should be undertaken to explore different views, operational approaches, and structure

of the nursing role in substance use disorder treatment. A comprehensive understanding of what nurses have been doing is essential for future expansion and refinement of the role of the nurse working in OUD treatment (Sowicz et al., 2022).

2.4 Implications for Research

There is a general sense that nurses working in other healthcare settings do not understand the unique role of nurses working in OUD and substance use disorder treatment (Abram, 2018; Clancy et al., 2006; Happell & Taylor, 1999; Happell et al., 2013; McCall et al., 2019); leading to experiences of stigma for nurses working in this practice setting (Abram, 2018; Happell & Taylor, 1999; Happell et al., 2013; McCall et al., 2019; Mumba & Snow; 2017). Nurses who embark on a career path within psychiatric and substance use disorder treatment often derive satisfaction from the therapeutic relationships they can create with clients (Halter, 2002). "Somewhere along the way [these nurses] learned they are adept at listening, understanding the plight of others, providing guidance, and seeing others holistically" (Halter, 2002, p. 27). Despite their passion, it has been documented that nurses who work in this field experience stigmatization from other healthcare professionals, including nurses working in other disciplines (Abram, 2018; Halter, 2002; Halter, 2008; Happell & Taylor, 1999; McCall et al., 2019; Ross & Goldner, 2009). Stigma and anti-stigma initiatives remain an unperceived and unprioritized knowledge gap in many healthcare organizations due to conflicting priorities, lack of awareness, and organizational constraints (Knaak et al., 2016).

Stigma is a complex social occurrence that can be communicated as a negative belief, attitude, or assumption about the characteristics of others (Goodyear et al., 2017). *Associative stigma* describes the stigmatization of people who are closely associated with a person with a mental illness or addiction (Halter, 2008). Healthcare professionals, including nurses, might

assume nurses choose to work in OUD treatment due to a psychological flaw or unresolved trauma (Halter, 2002). This can lead to negative perceptions from healthcare staff that do not fully understand the complexity of care required to treat people who use opioids (Halter, 2002). The stigmatization experienced by nurses who work in OUD treatment is reflective of the societal perception that addiction is a moral failing and personal flaw (Halter, 2002). In a study by Halter (2008), psychiatric and addictions nursing was ranked as the least preferred area to work by 122 nurses. "Psychiatric nurses were rated lowest in four of nine characteristics that were measured; they were more often described as unskilled, illogical, idle, and disrespected" (Halter, 2008, p. 24). These negative characteristics are similar to the leading stereotypes attributed to people who have an addiction or mental illness (Halter, 2008).

Nurses feel a lack of credibility when working in OUD treatment, and this could be due, in part, to a poor understanding of what is included in the role of the nurse when working in this unique field (Happell & Taylor, 1999). This was echoed by Abram (2018) and McCall et al. (2019), who indicated nurses had to create an "insider identity" to avoid negative perceptions when communicating their area of practice to other colleagues, family, and friends. Nurses working in specialty areas have historically been thought of as being subservient to physicians (Halter, 2002), "[nurses were] often viewed as dependent on physician's orders or employed only to administer medications" (Naegle, 2015, p. 1155). This perception was also reinforced by several articles referring to a belief by healthcare professionals that working in OUD treatment was not considered to be "real" nursing due to the lessened focus on physical tasks (Happell & Taylor, 1999; Happell et al., 2013; Natan et al., 2015; Ross & Goldner, 2009).

Many articles identified that working in OUD treatment was emotionally draining due to the instability of the patients (Abram, 2018; McCall et al., 2019). "Nurses who were unable to

develop a ‘tolerance’ arising from an understanding that relapse is part of the natural history of addictive behavior, quickly became disillusioned and tired of working in the specialty [of OUD treatment]” (Clancy et al., 2006, p. 166). Patient relapse or recovery was a factor in determining nurse’s role satisfaction (Abram, 2018). Despite many articles highlighting the psychosocial aspects of the nursing role in OUD treatment, it seems these vital contributions go “unspoken” in role and job descriptions, implying that they are less important when compared to the physical task’s nurses are accustomed to providing.

2.4.1 Research Questions

Seabra (2018) found nursing care contributes up to 29% of health outcomes improvement for clients with OUD; however, it was not clearly defined how this was accomplished or which areas of the nurse’s role comprised the most value. My primary research question was: “How do nurses understand their role and its impact in providing care to clients in opioid use disorder treatment?” Additional research objectives explored to assist with answering the research question were:

1. The nurse’s understanding of their role in providing care to clients in OUD treatment.
2. The impact of the role of the nurse on client care.
3. Perceived supportive influences in providing care.
4. Perceived barriers in providing care.
5. Utilization of the nurse’s role to improve healthcare for clients with OUD.

These objectives provide a comprehensive look at how nurses can be utilized across a variety of OUD treatment settings. In the following chapter, I describe the theoretical theory that guided this research, demonstrate the research method of inquiry in relation to the research

question and purpose of the study, and discuss how the method of inquiry guided the research process.

Chapter 3: Methodology

3.1 Theoretical Theory: Social Constructionism

Ethnography strives to *learn about people* rather than *study people* (Jones & Smith, 2017). When ethnographic research focuses on certain problems within a specific context it is called a *focused ethnography* (Roper & Shapira, 2000). There is some ambiguity and critique regarding the epistemology and ontology of ethnography, and it is recommended that researchers be explicit about their chosen theoretical underpinnings when conducting an ethnographic study (Jones & Smith, 2017; Rashid et al., 2015; Venzon Cruz & Higginbottom, 2013). Within this focused ethnographic study, I used social constructionism as a theoretical guide for the interpretation of collected research data. This data includes multiple viewpoints; social constructionism aided with exploring and integrating perspectives from a variety of nurses working in differing treatment programs. Social constructionists assert that all ways of understanding are culturally and historically informed and depend on the economic and social context where the knowledge is constructed (Burr, 2003; Gergen, 2015). Burr (2003) stated that "particular forms of knowledge that abound in any culture are therefore artefacts of it, and we should not assume our ways of understanding are necessarily any better, in terms of being any nearer the truth, than other ways" (p. 3). Multiple truths can co-exist, and the goal of the ethnographic researcher should be to capture and interpret these cultural truths, producing an ethnography.

The nurses participating in this research study had a range of years of experience, alternate approaches to care, and fostered relationships with their clients differently based on length of engagement with the service offered. Nurses working across the spectrum of OUD treatment are a part of a subculture that strives to be inclusive of clients who have otherwise

avoided medical treatment (Abram, 2018) and, in doing so, set themselves apart from a healthcare system that is focused on *cure* instead of *care.* Nurses working in OUD treatment often value hardiness, patience, tolerance, an attitude that is non-judgmental (Clancy et al., 2006), empathy, and assertiveness (Plaza et al., 2007), and they strive to provide patient-centered care (McCall et al., 2019). Their culture is often more focused on the relationship being fostered with the client, a contrast to the task-focused medical model prevalent within the healthcare system.

Historically, the constructionist paradigm started as a "countermovement" to positivism, proclaiming that reality is not a fixed unit but rather a construction by the people within the research (Polit & Beck, 2017). *Positivism*, often thought of as the traditional scientific method, is reductionist; it reduces the subject or experience being researched into predetermined concepts rather than allowing the subjectivity of the data to emerge (Holloway & Galvin, 2017). Constructionist traditions, similar to ethnography, emphasize the complexity and uniqueness of humans and strives to understand the "human experience as it is lived" (Polit & Beck, 2017, p. 12). "Constructionism invites a certain humility about one's assumptions and ways of life, fosters curiosity about others' perspectives and values, and opens the way to replacing the contentious battles over who is right with the mutual probing for possibilities" (Gergen, 2015, p. 27).

Social constructionism emphasizes that knowledge of the world is constructed between people during daily interactions over time, focusing on language as a tool to create reality (Burr, 2003; Gergen, 2015). Burr (2003) stated:

> By placing center-stage the everyday interactions between people and seeing these as actively producing the forms of knowledge we take for granted and their associated social

> phenomena, it follows that language too has to be more than simply a way of expressing ourselves. When people talk to each other the world gets constructed. (p. 6)

This is congruent with focused ethnography, as researchers set out to observe and learn about participants' experiences to gain a greater understanding of how everyday interactions between people create a shared meaning and culture (Robinson, 2013; Roper & Shapira, 2000). Language is a key component of conducting a focused ethnography; it is a shared expression of the societal and cultural norms participants are engaged in (Roper & Shapira, 2000). "What we take to be the truth about the world importantly depends on the social relationships of which we are a part" (Gergen, 2015, p. 3). Nurses working in OUD treatment build unique and trusting relationships with their clients. These relationships are constructed from a shared language during interactions between the nurse and the client. Gergen (2015) asserted that people use words and language to explain their truths about their reality, and researchers using social construction understand that there is no single reality that is valued above another. Furthermore, nurse participants have utilized a shared language to describe their role, culture, and how they understand their reality of working in OUD treatment to answer the research question. Utilizing a social constructionist orientation invites the researcher to utilize reflexivity as a tool to view the value of all perspectives and to be "both appropriately curious and critical" (Gergen, 2015, p. 29). This replaces the notion of having one truth, to understanding that multiple truths can exist (Gergen, 2015).

3.1.1 Reflexivity

Reflexivity is the purposeful awareness of the researcher's internal values, thoughts, and beliefs while seeking to understand how these might shape responses or influence the understanding of the situation being researched (Roper & Shapira, 2000). "Reflexivity allows

nurses to become aware of their role as ethnographers and to identify biases and their potential influence on the data and the interpretation of the data" (Roper & Shapira, 2000, p. 26). For nurses researching healthcare services, it is crucial to recognize the effect any preconceived beliefs may have on the research process to ensure that data is collected and analyzed in a rigorous fashion (Roper & Shapira, 2000). *Rigor* can be defined as the quality of being careful, exact, precise, thorough, and accurate (Cypress, 2017). Reflexivity aims to be transparent about potential influences and is particularly important for researchers who understand or have personal involvement with the explored culture (Venzon Cruz & Higginbottom, 2013). This transparency will assist in establishing the validity of the results (Cyprus, 2017), ensuring they are not solely an expression of the researcher's ideology (Venzon Cruz & Higginbottom, 2013).

Reflexivity was crucial to ensure transparency of my social and professional positions, and the impact of my own values, biases, and assumptions at all stages of data collection, analysis, and interpretation. I began my reflexive process prior to conducting in-depth interviews with participants. Through the identification of personal, cultural, and professional belief systems I was able to reflect and ensure awareness of how these might impact the research process. I utilized field notes during data collection, described later in more detail, to highlight emerging feelings or thoughts that could influence my understanding of what the nurse participants were telling me about their role. Memoing, also described later in more detail, occurred during data analysis to ensure a reflexive approach to interpreting multiple sources of data concurrently. Member checking and follow-up questions with participants occurred to ensure accuracy of data interpretation during the writing of this ethnographic report. My reflexive approach at all stages of the research process has ensured rigor and validity of this study.

3.2 Method of Inquiry: Focused Ethnography

Focused ethnography was used as the method of inquiry for this research project. Within this unique subculture of nursing, key informants were interviewed and observed to gain a deeper understanding of the nurse's role in a variety of OUD treatment settings. Ethnography provides a systematic process of acknowledging and interpreting patterns of behavior within a culture (Robinson, 2013). Traditional ethnographies incorporate long-term field visits, social contexts, an open time frame guided by the emerging data, and the researcher gaining insider knowledge from participants with whom they have developed a close relationship (Venzon Cruz & Higginbottom, 2013). Focused ethnographies might omit field visits altogether, focusing instead on communicative activities such as in-depth interviews (Venzon Cruz & Higginbottom, 2013). They have a specified timeframe, with the researcher gaining specific background knowledge from key participants with insider understanding and experience (Venzon Cruz & Higginbottom, 2013).

Although the origins of ethnography are anthropological (Holloway & Galvin, 2017; Roper & Shapira, 2000; Venzon Cruz & Higginbottom, 2013), focused ethnographies have evolved to be used in academia and healthcare services (Muecke, 1994). Due to their smaller scale, focused ethnographies tend to have the conceptual orientation of a single researcher and a limited number of participants who hold specific knowledge related to the research question (Muecke, 1994). The overarching purpose of completing a focused ethnography is to understand the meaning of experiences and integration of health beliefs within the culture being studied (Roper & Shapira, 2000). Focused ethnography was an appropriate methodology as this study had the orientation of myself as the researcher, focused on the specific healthcare area of OUD

treatment, with the intent to gain understanding by interviewing nurse participants who hold specific knowledge of the nurse's role in OUD treatment.

The outcome of ethnographic research "is a rich and holistic description of culture" (Polit & Beck, 2017, p. 469). Culture is a social construction of the "way of life" and communication system of a group of people (Holloway & Galvin, 2017). Data is presented as an initial culture landscape, including a first-level description, followed by a thick description, or an interpretation, of the collected data (Roper & Shapira, 2000). According to Roper and Shapira (2000), these interpretations then take on the final form of description in the written ethnographic report. "This consists of signs such as gestures, mime and language as well as cultural artefacts – all messages that the members of a culture recognize, and whose meaning they understand" (Hollow & Galvin, 2017, p. 160). Values, ideas, and knowledge are shared among members, which directs how members behave within the culture (Roper & Shapira, 2000). It is up to the researcher to describe patterns of behavior and beliefs to uncover the processes embedded within the culture being studied (Holloway & Galvin, 2017). Focused ethnographies are often performed within the researcher's working environment, and there is a heightened need for reflexivity during the process of interpretation to uphold rigor and validate the conclusions that are drawn (Higginbottom et al., 2013).

Abram (2018) described how substance use treatment programs have a unique culture where boundaries with clients are emphasized by the healthcare staff as unchangeable, and each discipline is responsible for a different aspect of client care. McCall et al. (2019) also identified there is a culture specific to OUD treatment. "Being immersed in work at the clinic meant that staff were immersed in the culture of their patients, which is different from their own. Being immersed in this way led to a change in thinking, including increased compassion, accepting

differences, and recognizing societal ills" (McCall et al., 2019, p. 50). It is important to clarify that these values and beliefs are often based on the subculture, gender, age, or ethnic group, which may differ based on the geographical location where the research is conducted (Holloway & Galvin, 2017). With this understanding, researchers should acknowledge the potential lack of transferability of their results and instead focus on the production of knowledge as the first step to improving the care being provided to clients (Holloway & Galvin, 2017). This study explored the specific subculture of nurses working in OUD treatment and revealed values, ideas, and shared beliefs across a variety of OUD practice areas. The initial cultural landscape and rich, thick description of culture will be described in further detail in Chapters Four and Five.

3.2.1 Emic and Etic Knowledge

Two types of knowledge are relied upon during ethnographic research – emic knowledge and etic knowledge (Holloway & Galvin, 2017). *Emic knowledge* comes from the insider's view of the world (Roper & Shapira, 2000) and uncovers the reasons why people act as they do within their culture (Holloway & Galvin, 2017). This type of knowledge is specific to the culture being researched and includes patterns, rules, and definitions of reality from the informants (Holloway & Galvin, 2017). Prior involvement with the culture, or studying a culture that already involves the researcher, can be challenging as the researcher may "lose awareness of their role as researchers and [might] rely on assumptions which do not necessarily have a basis in reality" (Holloway & Galvin, 2017, p. 168). Emic knowledge regarding the role of the nurse and how nurses provide care was obtained from nurse participants working in OUD treatment. Nurses from a variety of programs were interviewed to incorporate their varying perspectives within this research to ensure the emic knowledge that is shared is inclusive of the various ways nursing care is provided to clients with OUD.

Etic knowledge is produced by the researcher and includes their intellectual and theoretical view, encouraging the researcher to maintain reflective of their perceptions of the cultural setting while trying to make sense of it (Holloway & Galvin, 2017). This knowledge occurs during and after data collection as the researcher attempts to identify patterns of behavior and understand the data (Roper & Shapira, 2000). Etic knowledge is a principle outcome (product) of ethnographic research (Roper & Shapira, 2000). The etic knowledge produced from conducting this research provided a broad understanding of the role of the nurse across the spectrum of OUD treatment. The interpretation and creation of etic knowledge from this research can provide insight into the gaps of care that may exist within the OUD treatment spectrum. From the nurses' perspective, it might also increase awareness about how services and programs could better utilize the nursing role to improve patient outcomes. Emic and etic standpoints provide collaboration between myself as the researcher and nurses as participants to create a *thick description* of the patterns and ideas within the subculture of OUD treatment studied (Holloway & Galvin, 2017).

3.3 Research Process

3.3.1 Sampling and Recruitment of Participants

Sampling includes finding a portion of participants for research to represent a larger population so interpretations about the population can be comprehended and presented as findings (Polit & Beck, 2017). The steps for sampling include identifying inclusion and exclusion criteria, creating a sampling plan, specifying sample size, identifying how to gain entry, and recruiting the sample for the research (Polit & Beck, 2017).

3.3.1.1 Participant Inclusion Criteria.

Inclusion criteria were: voluntary, consenting English-speaking registered nurses or registered psychiatric nurses working at one of the identified sites with a minimum of two years of experience working in addiction treatment. Licenced practical nurses rarely work in specialized addiction services and were excluded as their scope of practice and educational requirements differ from registered nurses and registered psychiatric nurses. Nurse manager inclusion was considered on a case-by-case basis. It was decided that if a manager was included as a participant, they also had to have front-line addiction treatment experience and must not be in a leadership position over any other participants interviewed. Nurse manager inclusion was considered beneficial as it might provide an organizational perspective to further understand the role of the nurse. Additionally, nurse practitioners were excluded from this study as their scope of practice is beyond the scope of a registered nurse.

3.3.1.2 Sampling Plan.

Maximum variation sampling was used for this research. This type of purposive sampling is popular as it purposely selects a specific group of people with variation to be included, such as through diverse backgrounds, perspectives, differing genders, or socioeconomic status (Polit & Beck, 2017). An advantage of maximum variation sampling is that any emerging common patterns will capture essential shared experiences despite the diverse sample included (Polit & Beck, 2017).

Network sampling, or snowball sampling, occurs when participants of a study refer others to participate (Polit & Beck, 2017). While not initially planned, snowballing also occurred within this study, as participants shared the study with their colleagues or colleagues who worked at other included OUD programs.

3.3.1.3 Research Site Selection and Sample Size.

A review of OUD treatment programs within the urban area where the study occurred was undertaken to identify potential sites. Six sites were initially identified for participant recruitment to ensure data collected includes nurses working across the spectrum of OUD treatment. Prior to data collection commenced, two identified sites merged together into one community program. The sites selected all had nurses working within their OUD programs in a central role and included both acute care programs and ambulatory programs. The following sites were identified as being ideal for recruiting participants: an OAT clinic with a multidisciplinary team that included both (1) an oral medication program as well an (2) injectable medication program, (3) a supervised consumption service, (4) a hospital-based addiction nurse consult program, (5) a hospital-based addiction consult program with a large multidisciplinary team, and (6) a medically assisted detox program which offers abstinence and harm reduction models of care. All of the sites selected housed programs that are publicly funded through the provincial health authority. Despite the programs offering addiction services through an overarching health authority, it is important to note that not all of these programs fell within the same portfolio or had access to the same funding structures. This influenced how their services were run, their staffing models, program directives, and outcome measures. Selecting these sites was purposeful to ensure a wide range of participants could be included in the study. Residential treatment programs are often abstinence-based. These programs were not intentionally excluded; however, it is important to note that no provincially funded residential treatment programs were located in the urban area where this study occurred.

To ensure maximum variability and inclusiveness, I decided to recruit two participants from each identified program, leading to a maximum sample size of 12. This sample size

ensured data saturation (when no new significant information was identified) would occur. Adequacy of the sample size was guided by the expertness of the participants, and their ability to articulate their experiences. Recruitment of participants was stopped after ten interviews when data saturation was reached, and no new major information was identified.

3.3.1.4 Gaining Entry and Recruitment.

To recruit participants, I contacted the managers of each identified program, explaining the study and the prospective participants' eligibility criteria for the study. I included a Research Poster and Presentation (Appendix C) to be shared with the nursing staff. These documents contained researcher contact information for participants to reach out independently. Managers forwarded this email to their nursing staff. Nurses reached out to me by email to express their interest in participating. During initial contact, I confirmed participant eligibility and scheduled a time for a Zoom interview or in-person interview, depending on participant preference.

3.3.2 Data Collection

Focused ethnography sets out to answer predetermined questions, and data collected have the expectation of being pragmatic for healthcare professionals (Muecke, 1994). Similar to classic ethnographies, focused ethnographies commit to data collection through rigorous participant observation, asking questions of key informants, and using other available resources to gain an in-depth understanding of the area of interest (Roper & Shapira, 2000). Three methods of data collection are common in ethnographies: interviews, field observation, and document review (Roper & Shapira, 2000). When these three sources of data are collected, it creates the opportunity to use *triangulation* to enhance the validity of the results (Roper & Shapira, 2000). Roper and Shapira (2000) state that triangulation generally occurs during the collection and analysis stage of research. The data from each source is used to evaluate the

strength of the data gained from the other sources (Roper & Shapira, 2000). This results in a consistent and trustworthy account of the culture being researched (Robinson, 2013). The data collection and data analysis processes are a continuous and iterative process.

3.3.2.1 Formal Interviews.

The primary method of data collection occurred through formal individual in-depth interviews with all ten participants. Language, and therefore, narrative data, are a key to understanding the construction of the nurse's role. Interviews were offered via a secure telecommunication method (i.e., institutional-licensed UCalgary Zoom) as a primary option to mitigate the risk of COVID-19. In-person interviews were also offered based on participant preference. An audio recording was the only method of interview recording used for interview transcription. All participant interviews lasted 50-75 minutes. Three participants chose to be interviewed in person; physical distancing and use of personal protective equipment (PPE) were maintained during all in-person interviews. Seven participants were interviewed via Zoom.

Interviews began with introductions and an explanation of the purpose of the interview and research. Before participants signed the consent form (Appendix D), I ensured the participant was fully informed about the purpose, aims, and goals of this study by reviewing these components with them. Questions from participants were invited before signing the consent form. Participants were informed the interview would be audio recorded, and confidentiality of participants would be maintained through the use of a pseudonym in written materials. For interviews held in person, a signed copy of the consent form was retained, and a signed copy was provided to the participant. For interviews held via telecommunication, a signed copy of the consent form was emailed to the participant. If the participant was unable to print and sign the consent form or sign it electronically, the consent form was read to the

participant before the interview began, and an audio recording of verbal consent was obtained. Signed consent forms were uploaded to the Secure Computing Data Storage (SCDS) to maintain a detailed and organized audit trail.

A semi-structured questionnaire (Appendix E) with open-ended questions was used as a guide to collect demographic data as well as to ensure rich descriptive data was collected to inform the research question for this study. In addition, probing questions such as “Can you tell me more about that?” or “Can you give me an example?” were used to expand on details of the nurse’s role and experience of working in OUD treatment. When major concepts had been covered, and participants felt they had shared their experiences in detail, the interview was concluded by asking the participants if they would like to add any further comments.

3.3.2.2 Participant Observation.

Opportunities for field observation, the second data collection technique used in ethnography, through site tours for a general sense of the practice area were explored; however, it is important to note this was not able to occur at every site due to the nature of the service provided (such as hospital addiction services that work on a consulting basis across the entire facility) and the present COVID-19 public health restrictions. Participant observation occurred at one site, an urban OAT program that includes both an oral OAT program and an injectable OAT program. Approval for participant observation was obtained by the manager of the program, and a mutually agreed upon date was arranged. The observation period occurred between the hours of 0700 and 1700. Observational data were used to supplement the interviews, which were the primary method of data collection. All COVID-19 restrictions were upheld during participant observation, and physical distance was maintained at all times, with appropriate PPE in place for the entire observation period. Participant observation included

observing the nurses perform their job functions, attend team meetings, and engage with clients. Social constructionism informs participant observation as it seeks to observe how the role of the nurse is constructed between people during their daily interactions over the course of time. "As we confront the world, our descriptions and explanations emerge from our existence in relationships. It is out of relationships that we foster our vocabularies, assumptions and theories about the nature of the [concept being researched]" (Gergen, 2015, p. 13). Written descriptive and reflective field notes were recorded. No patient identifiers were obtained or recorded. Informal interviews with nurses and psychosocial staff occurred throughout the day. Verbal consent was obtained prior to all interactions.

Ethnographers will occasionally complete a windshield survey or an assessment of a location to map important features of the community being researched (Polit & Beck, 2017). A windshield survey of one urban supervised consumption service occurred on the day of scheduled participant observation. Descriptive notes were written regarding the location of the service relative to the other programs within the facility, and a general physical description of the building. In an ideal scenario with more availability of resources and without the impact of the COVID-19 pandemic, more opportunities for participant observation would have been beneficial in providing further enrichment and validation of the in-depth interviews that occurred as the primary method of data collection.

3.3.2.3 Document Review.

Triangulation of the data through review of pertinent documents such as national policy frameworks, clinic medical guides, and other policy documents occurred concurrent to data collection to reinforce the emic knowledge gained from participant interviews. A document appraisal matrix (Appendix F) was created to review all applicable documents obtained

collectively. I reached out to all program managers and inquired about pertinent policy documents, procedure guides, nurse's role information, and job descriptions that could be shared to triangulate the data. While not every manager responded to this request, I was able to collect and review documents from four of the programs. It is important to note that most national guideline documents reviewed were prescriber-focused, and the nurse's role was often inferred within the documents but not explicitly stated. Documents received directly from the programs seemed to be geared towards the program entirety or were generalized to apply to all staff as opposed to being nurse specific. This is congruent with the available data that reinforces the nurse's role is ambiguous and difficult to define (Clancy et al., 2019). Despite these challenges, the reviewed documents were often aligned with the information gathered from the participant interviews to further understand the nurse's role in OUD treatment.

3.3.2.4 Reflexivity.

To further incorporate reflexivity, I kept a log of field notes and observations I included with each participant interview transcript and the participant observation session. By acknowledging these thoughts during the interviews or observation, I was able to incorporate their presence into the analysis and interpretation of the data. This is an important consideration for reflexivity as I have previously worked within the culture of providing care to clients with OUD. *Descriptive field notes* provided depictions and physical descriptions of the interview setting if conducted in-person, as well as the participant interactions and behaviours. *Reflective field notes* contained reflective commentary focused on the role or standpoints of the researcher relative to the setting and participants. Roper and Shapira (2000) affirm that reflexivity within focused ethnography is important to maintain; field notes can assist with this through exploration of any uncomfortable moments, reflection on potential ethical dilemmas or challenges faced with

the interviews, as well as detail revelations and reflections of past experiences working in OUD treatment relating to the data obtained.

3.3.3 Data Analysis

Analyzing ethnographic data is an iterative process, beginning in the field when data is collected through field observation notes and continuing after data collection by going back and forth between data sets (Venzon Cruz & Higginbottom, 2013). "A significant aim of ethnographic analysis is to discover an ever expanding and ever more abstract network of interrelated concepts to explain the events and activities" (Roper & Shapira, 2000, p. 100) observed during ethnographic data collection. Social constructionism maintains that numerous social constructions of reality exist, and the researcher "understands that all research [and data] is value invested" (Gergen, 2015, p. 72). This means that data analysis is a construction that is informed by the valuable insights provided during data collection. Data is collected about what people do and say, as well as the personal reflections of the researcher during this process (Roper & Shapira, 2000). "To generalize findings about the cultural world of study, [researchers] find linkages between the emic meanings and worldview of study participants and [the researchers] etic interpretations of those meanings" (Roper & Shapira, 2000, p. 100). In this study, social constructionism aided in exploring, integrating, and respecting perspectives from all participants, field observations, and reviewed documents.

3.3.3.1 Procedure.

Data collection and data analysis happened concurrently. To uphold rigor of data analysis, the detailed step-by-step process was recorded. After each interview was completed, I transcribed the interview verbatim and checked for accuracy by replaying the audio recordings. Analysis began with the identification and primary classification of first-level codes (Roper &

Shapira, 2000). These codes are descriptive labels assigned to sentences, paragraphs, or chunks of words, that condense the data into themes (Roper & Shapira, 2000). Each transcript was read and initially coded before the following interview was completed. All transcripts, and initially coded transcripts, were reviewed by the principal investigator (my program supervisor) with feedback provided.

The next step involves sorting or grouping labels into emerging patterns and a smaller number of thematic codes (Roper & Shapira, 2000). Codes were organized into broad categories: Physical Care, Psychosocial Care, Healthcare Navigator, Challenges, Motivators to Providing Care, and Outliers. After all the interviews were completed, transcripts were read and re-read to identify further codes and broad emerging themes. Emerging themes were written down, with appropriate codes matched up as interview transcripts were reviewed.

Themes and codes were written in a list format, and groupings between the codes were identified to organize subthemes. Transcripts were re-read and compared to broad themes and subthemes. Themes, subthemes, and codes were re-examined and reorganized to reduce overlap. The principal investigator reviewed all themes, subthemes, and codes. After this, the themes, subthemes, and codes were re-examined and compared with the initial research question to ensure the accuracy of data analysis with the intent of the project. Roper and Shapira (2000) describe this method as leading to a "global picture of why things happen as they do, and explains recurring relationships between" (p. 98) study participants.

Memoing, a process that involves personal reflections of the data to create connections, occurred throughout data analysis (Roper & Shapira, 2000). As patterns emerge, comparisons, contrasts, and outliers are used to test and strengthen the analysis (Roper & Shapira, 2000). I utilized memoing of notes, thoughts, comments, and questions to ensure reflexivity of my social

and professional positions, the impact of my own values, biases, and assumptions during data analysis. My memoing process occurred with each reading of the transcript, field notes from participant observation session, and throughout document review. Notes, thoughts, comments, and questions were written within the margins of the transcripts, field notes, and documents to deepen the reflections and comparisons that occurred during data analysis and coding. Social constructionism emphasized the complexity and uniqueness of humans (Burr, 2003), and memoing aide's reflexivity as it strives to understand and make sense the human experiences shared during interviews or observed during participant observation.

Document review occurred after all participant interviews were conducted. It consisted of the purposeful organizing of documents based on program type (e.g., some documents were specific to programs such as ambulatory OAT programs or supervised consumptions services, and other documents were frameworks that were generalized to OUD treatment). Understanding the context in which the document was created assisted with identification of the nurse's role. Information was summarized and then compared with interview transcripts and participant observation field notes by memoing.

3.3.3.2 Validity and Reliability.

Roper and Shapira (2000) state that *validity*, "the accuracy of the methods used to collect and analyze information collected during research" (p. 82), is a strength of the ethnographic methodology. Validity is increased through triangulation of the data collected, specifically when the three activities of data collection: interviews, participant observation, and document review, are undertaken (Roper & Shapira, 2000). The data collected from each method was congruently compared to each other during analysis.

Reliability refers to the consistent, repeatable, and stable method of data collection; ethnographic researchers have the opportunity to observe events, collect a large amount of data through interviews, and review documentation over a period of time to improve confidence in the cultural interpretation that is presented in an ethnography. "Scrupulous attention to recording concrete and objective descriptions of events and verbatim accounts of conversations and interviews in field notes allows others to substantiate [the researcher's] interpretations" (Roper & Shapira, 2000, p. 83). Using an interview guide can strengthen reliability; this ensures interview questions are asked to multiple participants. Careful attention was given to participant observation field notes, interview field notes, and transcription to ensure reliable data collection.

3.3.4 Ethical Considerations

Conjoint Health Research Ethics Board (CHREB) Approval and Alberta Health Services (AHS) Administrative Approval were obtained for this study. Informed consent after full disclosure of the study, including known risks and benefits, was obtained from all participants who participated in formal interviews. During participant observation, verbal consent was obtained prior to informal interviews; however, formal consent was not required (Roper & Shapira, 2000).

To ensure confidentiality, all audio-recording and electronic transcripts will be kept on the SCDS for a minimum of five years after the research is concluded, per the University of Calgary policy. Physical documents are stored in a locked cabinet and will be shredded by the researcher and disposed of on campus after the minimum specified five-year period where documents are to be retained. The researcher will destroy digital data after the five-year period by overwriting and clearing the SCDS.

Focused ethnographies are often performed within the researcher's working environment (Roper & Shapira, 2000). An important ethical consideration in undertaking this study was my previous knowledge and work experience within the OUD treatment field across a variety of programs. While I no longer provide direct patient care in these settings, I have established relationships with nurses in some of these programs. This also means that I have personal emic knowledge I have had to be aware of in conducting interviews to prevent bias. Ensuring a strong reflective and reflexive process was prioritized during all participant interviews and observation to prevent bias. Through self-reflection, I identified personal, cultural, and professional belief systems prior to conducting this research to ensure awareness and avoid bias influencing the research process. I noted any emotional reactions I had to topics of conversation during interviews, and I ensured the questions being asked were exploratory of the participant being interviewed. If participants assumed I knew something from my history of working in this practice area, I ensured they understood my role as a researcher by asking them for more details about the topic being discussed. I confirmed they were aware to respond to all of my questions as if I were an "outsider" and knew nothing about the nurse's role in working in OUD treatment. Through these methods I was able to highlight awareness of my own social construction of the nurse's role. This ensured that I was cognizant of how my awareness could impact interpretation of results leading to a greater awareness of the value of differing truths. "The constructionist is aware that [their] own values may not be shared. Thus, research should be accompanied by critical reflection and an openness to dialogue" (Gergen, 2015, p. 64).

A benefit to this knowledge and established presence within this practice area is the trust built between myself and the nurse participants early within the interviews. The role of the ethnographic researcher is complex, striving for a balance of being fully immersed as an *insider*

while remaining an *outsider* to objectively describe and analyze the data (Roper & Shapira, 2000). I was clear with each participant about my goals in completing this research, how the data would be handled during and after collection, confidentiality, and how the data collected would be used to inform nursing practice. This led to rich data collection, transparent and often candid discussions about nursing practice within OUD treatment, and established familiarity that allowed participants to feel safe sharing their experiences.

There was very little risk to participate in this research. However, the confidentiality of participants is also ensured with the use of pseudonyms in all written text. No identifying information was recorded during field observations or included in the final research report. Direct participant quotations do not contain identifying information. Benefits of participating in this research impact the broader nursing profession. These include: informing evidence-based practice regarding the value of the nurse's role in OUD treatment and improving the utilization and clarity of the nursing role within addictions treatment. In the following chapter, I present the results of this research, including the major themes and subthemes that emerged from the qualitative data analysis.

Chapter 4: Results

Addressing the primary research question identified in section 2.4.1, "How do nurses understand their role and its impact in providing care to clients in opioid use disorder treatment?" this chapter presents study results. Triangulation of data will be demonstrated by participant observation field notes and program document data. Using a focused ethnographic approach and social constructionist lens, an analysis of the qualitative research data was conducted to present an initial cultural landscape (Roper & Shapira, 2000) and determine the understanding of the role of the nurse working in OUD treatment. Direct quotations are presented as cultural insights to deepen understanding of the nurse's role. Quotations ensure the reported findings are credible and accurately represent the participants' views and experiences.

4.1 Characteristics of Participants

Demographic data were collected to describe the characteristics of the participants and provide the context in which the study results can be understood (See Table 1). As per the inclusion criteria, participants were to have a minimum of two years of experience working in OUD treatment. However, two participants who volunteered had less than two years of experience working in addiction treatment. In consultation with the principal investigator, these nurses were included in participant interviews as they had other characteristics that improved maximum variation within the sample. Participants had varying years of experience as a nurse, ranging from 2.5 to 16 years. The average years of general nursing experience were 9.35 years. Nurse participants had varied practice backgrounds, ranging from urban and rural acute care, emergency, intensive care, surgical care, community mental health, inpatient psychiatry, and sexual health. Participants also had variable experience working for a large publicly funded health authority, and in non-profit community agencies. All participants had at least one year of

experience working in OUD treatment, with an average of five years working in this practice area. The demographic characteristics of the study participants are not necessarily representative of the demographics of all nurses working in OUD treatment. However, their varied areas of past nursing practice, years of experience, genders, and ethnicities made it possible to gain diverse insights into this unique area of practice.

Table 1: Participant Demographics

Characteristic	**Category**	**N (%)**	**Value**
Sex	Female	7 (70%)	
	Male	3 (30%)	
Ethnicity	White	7 (70%)	
	Multiple Visible Minority[1]	2 (20%)	
	Lebanese	1 (10%)	
Age	Range		26-42 years
	Mean		32.3 years
	Median		31 years
	Mode		27 years
Nursing Program Attended	University of Calgary	2 (20%)	
	University of Alberta	2 (20%)	

[1] Both participants self-identified as biracial.

	Red Deer College	1 (10%)	
	Mount Royal University	3 (30%)	
	University of Saskatchewan	2 (20%)	
Years of Experience in OUD Treatment	Range		1-9 years
	Mean		5.1 years
	Median		5 years
	Mode		5 years 8 years

4.2 Themes and Subthemes

The role of the nurse working across the spectrum of OUD treatment is complex and includes a broad scope of practice depending on the setting the nurse is working in. Analysis of the data revealed six themes to better understand and describe the nurse's role. The themes included: (a) the art of addiction nursing, (b) direct patient care, (c) indirect patient care, (d) the shared experience of stigma, (e) perceived barriers, and (f) looking to the (uncertain) future. A diagram of the themes and subthemes (Figure 2) is presented below to outline how the themes interact with one another to provide a rich understanding of the role of the nurse in OUD treatment.

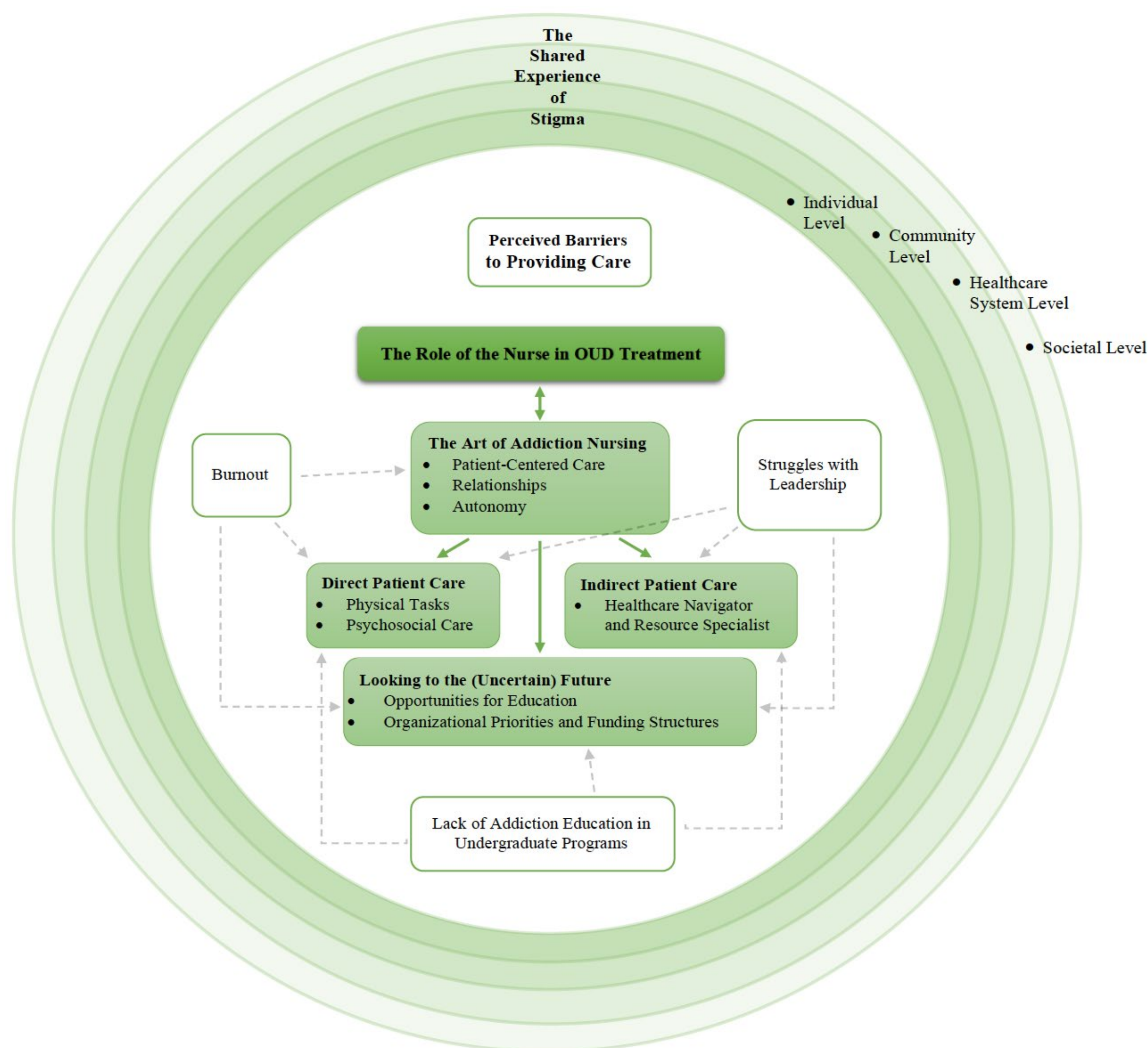

Figure 2: Themes and Subthemes

Based on the information provided by nurse participants, the role of the nurse in OUD treatment includes the art of addiction nursing as central to how the remainder of the role is understood. The art of addiction nursing comprises three subthemes, *patient-centered care*, *relationships*, and *autonomy*. The art of addiction nursing sets a precedent for how nurses approach the tasks they have to complete within their role. Nurses provide direct patient care to clients, which includes *physical tasks* and *psychosocial care*. They also provide indirect patient

care, which is care that benefits the patient, but might not be directly involved with nurse-patient interactions. Indirect patient care is summarized by the subtheme *healthcare navigator and resource specialist*. Nurses also conceptualize how nursing care in OUD treatment might be understood by looking to the (uncertain) future. This theme is presented underneath the direct and indirect care provided to patients or clients. Looking to the (uncertain) future includes two subthemes: *opportunities for education* and *organizational priorities and funding structures*.

Two overarching themes impact the understanding of the nurse's role and their ability to provide patient care: the shared experience of stigma and perceived barriers to providing care. These themes are not role components but provide important insights into some of the challenges nurses face while working in this practice area. The shared experience of stigma, presented as outer rings, provides details on how stigma is experienced at four levels: *individual, community, healthcare system, and societal*. Stigma influences all other themes, including perceived barriers. Perceived barriers to providing care include *burnout*, *struggles with leadership*, and *lack of addiction education in undergraduate nursing programs*. This theme is presented by floating subthemes with corresponding arrows to the impacted role components. Together, these themes and subthemes provide a rich and comprehensive understanding of the role of the nurse in OUD treatment and how nurses influence patient care in this practice area.

4.2.1 The Art of Addiction Nursing

The art of addiction nursing is rooted in relational care; nurse participants understood this to be an ongoing process of engaging and building relationships to support client well-being. Participants were cognizant of the importance of how they approached the provision of care to clients with OUD. Nurse participants described how clients might struggle to engage with the healthcare system. Therefore, nurses emphasized how their understanding of this challenge

changed their priorities to be focused on what their clients wanted, as opposed to what they – nurse participants – wanted for their clients. All participants identified the importance of three sub-themes that co-occur to comprise the art of addiction nursing: *patient-centered care*, *relationships*, and *autonomy*. The art of addiction nursing summarizes the motivating factors nurses describe in their care for patients with OUD. Participant J described the art of addiction nursing by stating:

> There's just a passion, a compassion, a desire to help, to do better, and to support individuals with wherever they are on their journey. I think it's a very particular style of nurse that likes to work with this population. And I think ultimately, you know, when I think about all of the nurses I've worked with, there's just this piece about them that you couldn't necessarily pinpoint and say that's it, but there is something that ties them all together.

4.2.1.1 Patient-centered Care.

All participants discussed the sub-theme of patient-centered care as a motivating factor in providing care to patients. *Patient-centered care*, which ensures clients are active participants in their treatment process (Kolind & Hesse, 2017), is aimed at reducing barriers to care and improving and streamlining patient experience through advocacy, trauma-informed care, and cultural competence. Participant A described patient-centered care as asking, "What are we going to do to support [the client]? Literally, we just do whatever they want, whatever they need." This was used in the context of ensuring clients feel welcomed into the program, even if they have stopped attending for a period of time, and then re-engage with the staff at a later date. Participant E described how trauma-informed care and patient-centered care go hand-in-hand by stating:

> People who are using substances and have developed an addiction or dependence… most of that stems from trauma. So, we need to change our mindset as to how we look at drug dependence… and just meet them where they're at in that moment.

Thus, Participant A questioned, "So why aren't we just acknowledging that [people who use substances require individualized care] and embracing it and saying, so… how do we best serve?" Patient-centered care ensures that the right level of treatment intensity matches the patient's needs. Participants stressed that patient-centered care is not applying a "one-size-fits-all" approach to everyone but mindfully assessing patients' needs and goals and supporting them to accomplish them. Participant F said, "You're not promoting your own agenda, you're leaving it at the door, you're not here to judge, [you're here to ask] do you need help? Great, what kind of help? It's not a one size fits all [approach]." Nurses described their role in addiction consultations as being able to assess patients and collaborate with other team members to ensure patients' needs are being met while hospitalized. Nurse participants stated this could include referrals to treatment programs, OAT initiation, or pain management support while in the hospital. A job description for addiction consult nurse's stated, "The nurse offers care to clients that [is] rooted in a patient-centered philosophy, advocating for client's needs; and supporting an integrated harm reduction-oriented experience within the acute care space" (AHS, 2022, para. 1). In the community, participants described being able to engage with clients over an extended period, thus being able to critically assess and ensure that the level of treatment intensity is consistent with what the client is wanting.

De-escalation skills and crisis management are methods rooted in patient-centered care frequently used when engaging with clients with OUD. Participant D described how crisis management was rooted in patient-centered care by stating, "When they come in this state of

feeling like a failure, it's about making sure they hear they are not a failure, that you are supporting them through whatever they [are going through] at that moment." Participant A affirmed this by describing how de-escalating distress is an important aspect of patient-centered care, "On a daily basis, they will come in with some form of distress. And so, there is a lot of crisis management, which really just involves sitting down and listening to them because a lot of the things we can't change." Participants expressed how they provide a stable relationship for clients, and it is important for them to be able to model and promote a balance of rules and healthy boundaries. Participant D stated:

> When you're new, you're taught like follow the rules, follow the rules, follow the rules, but then, if you are one of the more senior staff, it's very much like okay, we are here for the clients, and so finding the balance of like cohesion between everybody, yes we have to follow the rules [within reason], but also be client-centered.

An example of balancing patient-centered care with maintaining clinic protocol was witnessed during participant observation at an urban OAT program. During a team meeting, the charge nurse of the program discussed how de-escalation techniques were not used the previous day with a client who had an outburst in the clinic. Another healthcare team member requested the client have more punitive consequences going forward, such as a ban from accessing the program. The charge nurse reiterated how de-escalation techniques, such as a calm approach, active listening, providing reassurance, and following up the next day when the client was more settled (Observation, January 17, 2022), would have been more effective in supporting the patient and avoiding the use of punitive consequences. She was clear in describing the goal of the program is to maintain patient engagement through patient-centered care, which can prevent overdose death. Clinic protocols reviewed during document analysis have a clearly outlined

exclusionary process that is reviewed during the multidisciplinary team conference before an exclusion is initiated. This process intends to be reflective of the situation rather than reactionary to keep clients engaged while helping them create healthier coping techniques without unnecessary punishment. The ability to de-escalate clients in crisis while also promoting stability through rules and boundaries leads to the development of therapeutic relationships, which is an essential component of providing patient-centered care.

4.2.1.2 Relationships.

Participants described connection, compassion, and empathy as foundational for building reciprocal and meaningful nurse-client relationships. These relationships are one of the primary motivating factors in providing care. “Nurses are the ones who know the patients best and who are spending the most time with them,” Participant B stated. Relationships between nurses and clients with OUD are also built by balancing “leaving the profession at the door” (Participant D) during all interactions. Participant D described this as:

> One of the biggest things you’re taught is like the professional façade of I’m the nurse, and you’re the client, and I remember my nurse voice is so professional [sounding] and just a little bit higher pitch than it is typically. And when I got to [this program] I realized, oh this doesn’t work; being yourself, and being true to who you are is going to be [received better by the] clients, and that includes swearing once in a while… and sharing a bit of yourself as well.

Participant D went on to elaborate:

> There is already so much mistrust in general with our clients and the healthcare profession. And having nurses in there to build those relationships with clients is huge in reducing barriers for clients to access other healthcare services… Just allowing clients to

> get to know you, and vice versa, so that you can provide the proper support and guidance and education that they want and [so they] feel safe in coming back to you.

This was echoed by Participant A, who said, “We sit, we talk to them, we treat them like human beings … we have formed relationships with them where we care about their well-being and they care about our well-being.”

While all participants stressed the importance of relationships, not all program mandates provided nurses with the timeline to create long-term therapeutic relationships. For example, addiction consult nurses in the hospital stated they often only work with patients for a short amount of time. Additionally, depending on workload, staff working in detox services reported they might not have enough time within their shift to have one-to-one conversations with clients. Despite these barriers, all participants stressed how compassion and empathy led to meaningful connections with patients and this increased role satisfaction. Participant G described how they create trusting relationships with clients:

> You have to be understanding and empathetic … and keen on building rapport because it is a huge component of it. And so, you know, watching your face and your posture and positions because that means a lot to people who’ve been institutionalized. And you know, being careful about what you say. You have to go about it in a trauma-informed way with giving choices and with what you say, so you don’t become another notch in this person’s wall of shitty authority figures and shitty healthcare experiences.

4.2.1.3 Autonomy.

Participant interviews revealed nurses working in OUD treatment often experience autonomy differently than nurses working in more structured medically-focused practice areas.

To them, autonomy involved using critical thinking skills to complete in-depth assessments and histories of their clients to ensure they meet their needs. Participant G said:

> You're kind of the first one to get a good look at them, and to try and understand them. A lot of my job is skillful interviewing, and trying to really grasp what a person's needs are, and sometimes you have to kind of ask them in certain ways or ask the right questions to kind of help them get to their own answers, you know, building good rapport with them so they feel at ease and can answer truthfully and without fear of being looked at in the wrong way.

Across the spectrum of OUD treatment, care teams were described as varying in size and composition; however, nurses were consistent members across all teams, demonstrating their central importance and competence in providing care to clients with OUD.

Over the last five years, nurses have seen a shift to fentanyl as the primary opioid being abused by clients. This has led to changes in OUD treatment, described by participants as more relaxed prescribing of OAT and more programs being available to access, including community programs that have nurses travel to client's homes to provide their OAT medication. Participant C described some of the ongoing practice changes:

> It keeps evolving rapidly because now we can do micro-inductions of suboxone, or we have patches that can slowly transition them to suboxone. When I started this job, we couldn't even start someone on methadone or suboxone because there was nobody in the community to continue them.

Participant B, who works in a different program, echoed this:

> People don't have all the chains of the guidelines following them, that has been helpful for methadone because it was so highly controlled and so highly punitive, so people

> weren't able to stabilize because it was so hard. Suboxone has come a long way and we can be so much more relaxed with it. Opiate withdrawal is horrifying and not safe for so many people, and the idea of having the micro-induction has been such a game changer too.

Participant F described the importance of nurses staying up-to-date on changing treatment practices:

> It's up to us as nurses to stay relevant on topics of what's happening in healthcare and the needs of the community. Educate yourself, find resources. And if you can't… ask, because they are all around and that is part of your professional responsibility.

In general, participants described how physicians were mostly involved in prescribing medications. However, the majority of all other care received by patients was provided by nurses, with little to no direction from physicians. Care provision was self-directed and aimed at meeting the needs of patients. Participants who worked with nurse practitioners described a closer and more synchronous relationship with them. This was a contrast to physicians who were described as being "overwrought and spread too thin" (Participant A) as they work at multiple locations and programs.

4.2.2 Direct Patient Care

A central component of the nurse's role in OUD treatment is to provide direct patient care to all patients or clients. Participants emphasized that harm reduction is a guiding principle in practice regardless of the OUD practice setting. Many participants stated, "We meet them where they are at," to describe how they understand how harm reduction guides care provision. Harm reduction described by Participant A is "a wrap-around service of just meeting people, literally, in the current state they are in, sometimes that is a good and healthier state, sometimes it

is entirely dysfunctional." The participants discussed all of the tasks completed during direct patient care as having the foundational intent of reducing harm. Nurses described how they understood patients were at risk of overdose death because of their opioid use and the comorbid effects of substance use. Direct patient care included assessments and interventions aimed at improving patient well-being and decreasing additional harm resulting from opioid or substance use. Direct patient care can be divided into *physical tasks* and *psychosocial care*.

4.2.2.1 Physical Tasks.

Physical tasks differ based on the OUD practice setting of the nurse; however, they can include a wide variety of nursing interventions to improve patient well-being. Assessments identified by participants can include vital signs, suicide risk, admission history, addiction history, pre-injection, and post-injection assessments, as well as completing common withdrawal tools such as the Clinical Opioid Withdrawal Scale (COWS) assessment or Clinical Institute Withdrawal Assessment (CIWA). A large part of the role of the nurse described by participants is medication administration and management. According to participants in the community setting, this can include direct oral and injection medication administration, observing substance use in supervised consumption services, and assisting with OAT management by liaising with community pharmacies. This was confirmed to be a primary physical task completed by nurses working in an urban oral and injectable OAT clinic during my participant observation session; nurses were preparing and administering medications throughout the day, as well as ensuring medication continuity within the community by engagement with prescribers and pharmacists on behalf of patients (Observation, January 17, 2022). In the hospital setting, addiction nurse consultants described how they complete thorough medication assessments and encourage patients to request their OAT or pain medication from unit staff. Supervised consumption

service nurses explained how they regularly engage in overdose response. While this task could be completed in other areas, it is a central component of the nurse's role in this specific practice area. Additionally, supply distribution such as needle exchange and naloxone distribution, was described by participants as a healthcare service happening across all areas where nurses engage with OUD clients. Other tasks identified by nurses working in OUD treatment include phlebotomy, electrocardiograms (ECGs), sexually transmitted and blood-borne infection (STBBI) testing, and wound care.

Addiction consult nurses reported they complete fewer physical nursing tasks with patients, as completing this work was not within their job description. Participant G stated, "I don't think [basic nursing care] are necessary for my role… My role is kind of a weird, obscure nurse role that doesn't involve [the direct physical care]." A job posting for nurses working in this program confirmed this:

> As a registered nurse (RN), you will provide a wide variety of nursing services to patients, families, communities and populations, while taking necessary steps to ensure their safety and well-being. In your role, you will utilize nursing processes, through critical thinking, problem solving and decision making, as well as teach, counsel and advocate on behalf of patients and their families. (AHS, 2022, para. 2)

Nurses working in supervised consumption services stated they felt very limited in the amount of physical care they could provide due to working in a small, restricted space, which prevented the storage of basic wound care supplies and having a private room to complete assessments. This was confirmed during my windshield survey of the supervised consumption service at one urban site. Clients enter through a side door of the building, and the location is separated into a long waiting room with a door to an open space and booths along the side. There is a larger room that

clients move into after they have used their substance, where they are encouraged to wait and be observed for up to 30 minutes. There are no private areas where staff can provide additional patient care; the only visible storage is a small room attached to the main room and some large shelving units with doors (Observation, January 17, 2022). Participant J highlighted nurses working in different areas of OUD treatment would likely complete different physical tasks and stated, “It does come back to resources. So, money, financial support, location. If the [program] isn’t actually set up to do that, if we don’t have all the pieces and parameters in place, if we just don’t have access to that, I can’t do [the task].”

4.2.2.2 Psychosocial Care.

All participants emphasized the nurse’s role involves direct psychosocial care to patients, including education and social support. Participants describe patient education as being largely focused on ways to reduce harm when using substances, such as vein care, overdose prevention education, naloxone education, and how to access appropriate support services. For clients receiving OAT or iOAT, patient education focused on medication management, medication compliance, and other pertinent medication information such as side effects and treatment course. Patient education was shaped significantly by the type of health service and program area. For example, nurses working in detox services stated they would emphasize post-acute withdrawal symptoms. In contrast, nurses working in supervised consumption services spoke of how they would educate on how to safely consume an opioid and a stimulant simultaneously.

Three participants identified counselling as a specific psychosocial intervention that might be a part of the nurses’ role. Participants described counselling as being inclusive of providing structured mental health support to clients. Nurse participants clarified that while it

can be a task completed with patients, it is not something that is routinely a part of the nurse's role. Participant A stated:

> Nurses are not trained to be counselors, full stop. That is not our wheelhouse of expertise. What we are good at though, is being an advocate, that linking point, but to be a good advocate, you need to have some awareness of counselling, and there needs to be an understanding and a link between counselling and nursing.

Nurses with a background working in psychiatric care were more likely to list counselling as a part of their role.

It is important to differentiate between counselling and social support. All nurses identified the importance of providing social support to clients. Social support was often connected to building patient relationships and creating a safe space for clients to feel like they could share themselves authentically. Participants stated it was not a structured intervention like counselling but more-so focused on getting to know them; as described by Participant G, "I find after talking with them, sitting down and being casual, you get to know them, and they tend to open up and be receptive [to the support you are offering]." Participant I described how social support included celebrating small incremental changes:

> I like to say we celebrate those little victories. Which I think sometimes gets missed. You know, if someone was injecting for ten years, and I see them again, and now they're smoking weed… that is something we should celebrate. Look at these great things you've done. [We need to] make sure people feel educated and included, to make decisions for themselves. And for them to know we are there to kind of support them in those decisions and help them navigate them if they want.

Celebrating change and offering social support allowed the nurses to create a safe and reciprocal alliance with patients. Participant D described how social support fostered a safe community:

> It's really like providing that space for clients to know that they are heard and that even though you might not be able to do exactly what they want to do, that you hear them, that you are listening, and that, in a sense, you wish you could do what they need.

Social support was observed during patient observation through the easy dialogue and emphasis on checking in with each client. Nurses were observed actively listening and asking questions about what was going on in the lives of their patients. They held eye contact and had open body posture, and were inviting of client engagement (Observation, January 17, 2022). However, it is interesting to note that social support was not listed as a key aspect of the nurse's role within the reviewed documents, such as clinic policy and procedure resources and nurse job listings for OUD treatment programs.

4.2.3 Indirect Patient Care

Similar to direct patient care, harm reduction is the driver for all indirect patient care provided by nurses working in OUD treatment. During participant observation, I wrote down a field note that demonstrate how indirect patient care is rooted in harm reduction:

> I witnessed nurses being "expert jugglers" to ensure seamless patient care focused on improving outcomes. They document, assess, prepare medications, connect patients with others, coordinate the day, and attend meetings; all of this is happening simultaneously. During the morning meeting, a client came in, and it was an important day because they would be getting Assured Income for the Severely Handicapped (AISH). The charge nurse had planned the steps they needed to take; the client needed to bring an ID and go with an outreach worker to open a bank account, then the client needed to return to the

> clinic so the nurse could phone AISH and set up a commencement appointment. As the client was leaving the clinic, they left their glove on the booth table. It was a cold winter day. While the nurse had returned to listening to the meeting they were in before discussing the plan with the client, they saw this glove, got up, and ran it out to the client. There is this constant scanning and awareness of all things happening that nurses seem to be doing subconsciously. (Observation, January 17, 2022)

This field note depicts how nurses understand what needs to happen outside of direct nursing care to ensure the client can get financial assistance, which will greatly reduce the harm they might otherwise experience if they remained without an income. Indirect patient care encompasses work done on behalf of a patient to connect them to other services or healthcare professionals, such as assisting a patient in connecting with other resources, completing referrals, and patient advocacy. It is guided by the overarching knowledge of the complexity of addiction treatment. Participant F stated:

> I think it's so much simpler than that. I think it's just respecting people and their choice and providing them with all the information they need to make an informed decision for themselves. So, you're not promoting your own agenda; you're leaving it at the door; you're not here to judge; you're here to ask, 'do you need help?' [and,] 'what kind of help?'

4.2.3.1 Healthcare Navigator and Resource Specialist.

To become a healthcare navigator and resource specialist, nurses described the need to be acutely aware of the breadth of disparities experienced by clients who have OUD. Participants described how much of the disparity is rooted in traumas, including intergenerational trauma experienced by Indigenous persons, traumas related to homelessness, or a history of physical,

emotional, or sexual assault. Participant D described this by stating, "It's a holistic approach… we're looking at the whole person, not just their OUD." Participant D went on to describe some of the challenges faced by clients:

> When I look at what my job entails, it starts with a relationship, and the medication administration comes second. They come in to get their meds, but at the end of the day, they're also coming in because they might not have slept, they might need a safe place or a warm meal, they haven't had a great day, and want someone to talk to.

Nurses described how during assessments, planning, and interventions, the knowledge of the SDOH (CNA, 2022) informs them of the full complexity of patient care that could be required.

Anticipatory care is a concept identified by participants that can be applied across diverse OUD practice areas. It was described by participants in varying ways depending on their practice setting. For example, in supervised consumption services, nurse participants described anticipatory care as having knowledge of the level of strength of street opiates at a specific time, being aware of increased overdose risk, and being on alert to respond. Participant D described how staff used anticipatory care in this practice setting:

> The staff are on high alert, [they] notice when somebody is using [fentanyl], we can watch them, give them the Hawkeye, and then monitor them, like okay, now they are sedated, they're slumped over, let's get an [oxygen] sat[uration] monitor on them, our fast response and quick intervention with oxygen and airway support helps prevent us from giving Naloxone and throwing them into withdrawal.

Participant C explained anticipatory care in the hospital setting as having a detailed understanding of a patient's opioid debt based on their community opioid use, leading the nurse

to advocate for higher opioid replacement volumes or further education to unit staff about managing withdrawal. Participant C stated:

> The main role of my job would be assessing their use in the community, assessing what their opiate debt is, and by opiate debt, I mean what is their tolerance, and how much more opiates do we need to give them, just to make them level, because we owe them that before even giving them any other opiates for pain control.

All nurse participants acknowledged awareness of the breadth of treatment available for people seeking addiction care, ranging from inpatient residential treatment to supervised consumption services. However, not all nurses felt informed about the available social support for clients. Participant H said, “Sometimes I feel like we don’t know enough, as nurses, about social services and that street leg piece, you know it’s not exactly an accessible setting to learn about. It’s not necessarily a hindrance [to providing care], but it’s a little bit frustrating.” Advocacy and referrals to other services were identified as the two primary ways nurses work as healthcare navigators to bridge gaps for clients with OUD.

All nurse participants described advocacy as an important part of the role of the nurse. Participant D said, “I think that being able to advocate for clients as healthcare professionals is huge.” Participants stated that advocacy could take on many forms, including advocating for change within a specific program to make the program more client-centered, advocacy with other team members, advocacy to other programs or services, and advocacy within the hospital setting to unit staff and primary care providers. “It’s a lot of barriers… You just never know where the next barrier is. So, you just always keep advocating,” Participant C stated why advocacy is needed. Participant A also described how nurses could utilize advocacy, “I think nurses do well at being the connection piece, so it’s not that I am trying to step on your toes; it’s that I’m

advocating for my client… It's on us as nursing staff to advocate and be the voice of our clients." Participant G described advocacy as a means of harm reduction:

> I think a harm reduction thing I do is where I try to explain what [a patient] is going through, I try to explain their story to [the unit nurses] and give them some details of the interview where I can, so they can understand the patient and treat them better. It's my job to make sure that [patients] aren't being treated like shit, basically.

By having an awareness of client needs and the knowledge of services available to support patient goals, nurses can refer clients to other disciplines, agencies, or programs. Participant G stated:

> When you meet a patient, we can assess whether they are wanting to make a change and make it clear to them no pressure, either way, we can support them, and offer resources, give them teaching on suboxone or methadone, and what it's going to look like for them, what it's going to feel like… And again, it's a lot of referring people to the right places and being able to be a resource specialist… knowing when it's time for a pharmacist to step in when it's time for a social worker to be the one to take charge, and you know, help them get where they need.

Participant J described the overarching role that the nurse plays in referrals:

> And so, I think in terms of nursing care, it really is providing all of the pieces that we need to support an individual in being able to continue with their medication, and then all of the other aspects of housing and financial, you know, all the pieces that ultimately are still tied back to their [opioid] use, the nurse would then support that work.

There was also frustration expressed about the process of referring clients to other services. Participant D said, "It's so many referrals, and here's a resource for that, and here's the

information for this, but there is a lack of [available] services in general in the city for clients." While advocacy for these connections was present, participants identified their ability to access other services was sometimes limited, leading to participants perceiving missed opportunities for intervention and support for their clients.

An interesting overlap between identifying patient needs and advocacy was observed during patient observation. While it was not as prevalently voiced by all participants during in-depth interviews, I observed community OAT nurses working closely with their interprofessional team members. Nurses were often in discussion with physicians, nurse practitioners, peer support workers, pharmacy staff, social workers, and addiction counsellors throughout the day. They engaged in team conferences regarding patient care and liaised with other team members to ensure patient care needs were met. These discussions were always focused on the client's current state and future goals. Interprofessional collaboration was observed to be a prevalent aspect of these nurse's role.

4.2.4 The Shared Experience of Stigma

Stigma was described as a shared experience between OUD nurses and their clients. Participants perceived they were stigmatized by other healthcare staff because of their work with clients who have OUD. Participants also described how stigma contributed to feelings of burnout and frustration. Nurses believed stigma was felt by clients who needed care from healthcare staff who were not knowledgeable in OUD treatment. Participants explained how this might prevent clients from receiving sufficient pain management while in the hospital or lead to early discharge before patients have received adequate medical care. Stigma was raised by half of the participants and was portrayed differently depending on their OUD practice area. There

are four levels of stigma identified from the data: *individual, community, healthcare system*, and *societal*.

4.2.4.1 Individual Level.

Stigma at an individual level occurred frequently and in many ways. Stigma occurred from staff to staff; nurses working in OUD treatment experienced stigmatizing attitudes from other healthcare staff. Participant A stated, "I think there is a shared experience of stigmatization, healthcare workers in mental health and addiction, especially within our program, harm reduction, and OAT is definitely stigmatized. There's intersectionality there." They also said, "There is a stigmatization of opioid users and people who work with opioid users, and that is, interestingly, internalized [by patients and nurses]." Participants believed this stigmatization resulted in feeling they needed to legitimize their role to other healthcare staff, as described by Participant F:

> We need to keep ourselves alive because if there is no need for us, the program gets dissolved. I've only ever seen that happen in public health and community. Acute care… no one has to worry; they are too busy doing other things. They're not going to shut down a medicine unit. That would never happen.

Another form of stigma frequently discussed was stigma from healthcare staff to clients, with addiction seen as a moral failing. Participant E said, "How we look at addiction as a whole, a lot of the time people think, well you chose that. So, if you chose that, why should I put my tax dollars towards [helping you with] something you chose." Within hospital settings, unit staff or healthcare providers not familiar with OUD often stigmatize patients; as Participant C stated:

> It's really just coming down to education because when you start to explain it to [unit staff] that the behaviour around addiction is actually how you classify someone as having

> an addiction. So, the symptoms of the disease are how you diagnose it, and a lot of those symptoms are behavioural. And why should you discriminate against someone for exhibiting symptoms of their disease?

Some staff also discussed the hierarchy of addiction, with injection drug use seen as the "lowest" form of substance use. Participant C said:

> Do I notice a noticeable difference in the care from [unit] staff if they choose to inject [street opioids] as opposed to taking what we give them? 100%. Yes. You'll come across nurses who won't even give any opioids because [the patient] has a history of addiction, even if they're in pain because it's against their morals.

Participant B agreed, "Our folks have been so poorly treated by the system. They've been so poorly treated by our colleagues, including nurses in emergency rooms and hospital units… they've been highly stigmatized, and their pain is not treated." They went on to say, "I think the [clients who inject opioids] are the most stigmatized through all of this; their programs are highly publicized, highly stigmatized, and publicly threatened to be shut down." This was also witnessed during participant observation, where some staff believed a client should have their medication withheld for having a behavioural outburst in the clinic. A charge nurse, understanding the significant impact of medication, stated, "We cannot weaponize our medications. Medications cannot be tied to behaviours" (Observation, January 17, 2022). Withholding OAT medication based on behaviours could lead clients to use the poisoned supply of street opioids, increasing their risk of overdose death.

4.2.4.2 Community Level.

At the community level, stigma towards OUD clients comes from community members, leading to a push to keep OUD services "tucked away" or behind closed doors. Participant F described their experience working in another city:

> It was never a big issue as it is here because, in my humble opinion, [the services] were already placed in an undesirable area, so no one gave a shit, it didn't change their day-to-day routine, it didn't change their businesses… It was already in the sketchy parts of town, already next to shelters.

Many community programs have faced high levels of backlash and community resistance to having programs remain functioning in their current locations. Participant F stated:

> I remember this one woman said, 'I can't walk around barefoot in the park anymore because there are needles there now,' and I just thought, 'Why are you doing that in a downtown park to begin with?' We've all seen needles, I'm not going to lie, but there are teams in place, so you don't have to pick them up. But if you felt so inclined, like, are you able to pick up a pen without writing on yourself? Probably… The problem doesn't go away because you close down a site; it just changes.

Participant E summarized how it is important for nurses to continue advocating for reduced stigma at the community level:

> I think it's just something that you keep advocating for; you keep talking about it on different platforms, you keep educating folks on what people need, you keep looking at your community because your community is only as strong as your most vulnerable. So, if we're not caring for our most vulnerable, our community is failing.

4.2.4.3 Healthcare System Level.

Some participants talked about how stigma impacted their role at a healthcare system level. They felt policies are punitive to patients who experience addiction within the healthcare system. Sometimes policies or procedures might change within the OUD programs, which can increase stigma towards certain patients, further reinforcing the hierarchy of addiction presented earlier. Participant E described how program changes increased stigma towards clients:

> When we merged, a divider was put up, so folks who were injecting had to go behind the divider so others couldn't see them. So, the entire space they developed and felt safe in all of a sudden changed. It really said to them that people shouldn't see this, then why should we trust [the staff] and create a relationship with them?

Participant A also discussed how healthcare policies could be seen as promoting stigma towards patients and nursing staff:

> People are being told consistently, through operationalized stigmatization that has been incorporated into policies, that they do not have value… I think it's relevant and obvious to say that we don't even keep track of the numbers [of clients], we don't test the potency of drugs coming into the province, so that should tell you how the [healthcare institutions] view the importance of what I do for a living.

Participant C explained how hospitals are not supportive places for people who use opioids by stating, "They have released a harm reduction in acute care policy, which is still very vague and can be interpreted any way you want." The policy outlines, "Health care providers shall not restrict access to any health care service (including mental health services) that would normally be provided to a patient because of a presence of psychoactive substance use" (AHS, 2020, p. 6). However, Participant C felt that some healthcare staff still withhold medications and might not

adequately treat the client's pain. They went on to describe how they work around this stigma in order to ensure clients receive adequate pain management, "Instead of ordering opioids as PRN, [the addiction consult physician will] order it as scheduled so that [unit staff] have to give it, and it isn't at nurse discretion. So that's how we've been able to work around a lot of [the stigma]."

4.2.4.4 Societal Level.

At the societal level, there is a values-based competition between harm reduction services and abstinence-based treatment that could be perceived as being fueled by the government that funds the health authority. As described earlier, harm reduction seeks to provide patient-centered care to improve patient well-being regardless of the desire to abstain from substances (CNA, 2018a). Abstinence from substance use is the cessation of problematic usage, and might not be the patient's goal, as described by Participant B, "It's hard to let go of the idea that not everyone wants sobriety, not everyone wants recovery as we see it." Since 2019, Alberta's government has announced significant investments in abstinence-only treatment programs, committing to making spaces in these programs universally accessible and publicly-funded (Morris et al., 2020). In addition, participants who worked in supervised consumption services described how the government announced they would be closing down their facility at an unknown date in the future.[2] Supervised consumption nurses eluded to their funding not being operational; every March, they wait to hear if the site will continue to remain open for another year. This leads to uncertainty with program direction and funding that is not guaranteed to continue. Participant J said:

> I think we've seen that evolution over time, with the government shifting, that shifted values from harm reduction to abstinence-based. It's been a bit of a roller coaster for the

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[2] At the time of interviews.

> last ten years…. I think across the province there have been a few shifts. A shift in politics which absolutely has values attached to it, but also a shift in practice.

Participant A stated:

> Alberta really assigns itself to addiction as a choice. It's a flaw in the person, not the system…. Because of the mismanagement and the stigma, and the political agendas attached to the war on drugs, the system and the population's perception of addiction is values-based and condemning, and difficult to change.

Stigma at the societal level, driven by divisive governmental decisions, negatively impacts patients and nurses working in OUD treatment.

4.2.5 Perceived Barriers to Providing Care

Participants were very passionate and engaged with the care they were providing. However, they identified perceived barriers to providing care that brought about frustrations and difficulties within their role in OUD treatment. Perceived barriers were best summarized with two sub-themes, *burnout* and *struggles with leadership*. There was an expression of these two perceived barriers by all nurse participants to varying degrees. Another perceived barrier identified by some participants was the *lack of addiction education in undergraduate nursing education*.

4.2.5.1 Burnout.

The largest contributor to nursing burnout, according to participants, was feeling unable to provide the level of care that is needed by clients or not being able to fully meet their needs. Some challenges in meeting patients' needs were related to space and resources; a difference in program funding could lead to a lack of physical space and resources to complete common nursing tasks like wound care or to provide care over a longer period. Participant D said:

> I was exhausted fighting the rules and having to have a reason for a client to stay longer than their hour because they needed the support; whether it be physical or mental, they needed the support. I think the biggest thing for me that led to my burnout was not being able to provide that wrap-around support for clients.

There was also an expressed struggle with assisting clients in accessing other levels of OUD treatment. Participant D said:

> I worked primarily night shifts and was not able to directly bring someone to a service or send them in a cab to get there because it's the middle of the night and nothing is open… and for our clients finding the right moment when they are ready is the time that you need to act, and if those services aren't readily available, that opportunity is lost, and you have to wait for the next opportunity to present itself.

As OUD is a chronic and relapsing condition, nurses working in this practice area for an extended time sometimes felt disheartened by a lack of medication and treatment compliance resulting in long-lasting change for their clients. This could lead to burnout, as participants cared for people who faced the same challenges of substance use, trauma, homelessness, and overall patient struggle, without seeing significant behaviour change among patients. Participant J stated:

> I think it's hard sometimes like you're just not doing enough. And it feels sometimes, like, even if you've done everything you possibly can, that person doesn't come in for their appointments or follow through, or uses, or passes away from an overdose, or all of these other things.

Participant H explained how clients could be verbally aggressive, leading to feelings of burnout:

> I think it kind of wears on staff, dealing with the same clients all the time, doing the same things… vicarious trauma… and then there is not necessarily violence, but there is verbal violence, and sort of just aggression from clients, and staff become a target. I think that's a very draining part.

Additionally, grief that accompanied adverse events like the death of a patient or prolonged exposure to overdose responses was challenging for nurses to process and contributed to burnout. Participant B described their grief:

> What do they call it? The enduring grief, the prolonged grief of knowing every day… I'm expecting someone to be dead or overdosed… having to tell a client someone they knew and loved was dead was the worst day I've had in a long time… it's the prolonged grief and like the demoralizing feeling of doing a little but just not doing enough and knowing it.

Participant D echoed this, "The hardest part is not being able to provide the support to clients that you wish you could."

4.2.5.2 Struggles with Leadership.

Participants described struggles with leadership as a general barrier across all practice settings. The nurses interviewed for this research work in programs across funding portfolios within the provincial health authority. This can result in nurses experiencing different leadership approaches, funding allocation, and team structure. While some programs presented as being generously funded, nurses in other programs expressed frustration at the lack of consistent funding, which they saw as the consequence of ineffective leadership. Participant C expressed, "We have no funding for this program. Zero, like bare bones… So why, during an opioid epidemic, [they] have not received more funding for addiction support is beyond me. I will

never understand that." Participant H, who works in a different OUD practice setting, explained how lack of communication from leadership impacted patient security in accessing services:

> Right now, my role has changed in that it's just reassuring clients that we are still here for them as long as we can be. But it's morally distressing to have to say, well, I don't know how long we are going to be around. I don't know when we are going to shut down, and also, for my own job, I don't know when I'm gonna have to get a new job.

Participants also conveyed how they felt healthcare leaders did not communicate program direction due to inconsistent guidelines and policies. Participant A described their struggles with leadership:

> [Nurses] are used to leaning on each other… We've had no management or leadership [with how the program should function]… We're just kind of disengaged and disenfranchised with the situation… There isn't a lot of respect, I would say, between our institution, management, our leadership, and staff. There is a major disconnect there.

This was stated in the context of two programs merging that had different operational approaches to OUD treatment. As the government did not operationalize funding for the iOAT program, these programs were merged to transition iOAT clients to OAT. Not having a clear direction on how nurses should implement harm reduction practices could lead to role uncertainty; nurses might perceive their scope of practice as variable or unclear. This was also prevalent in the policy and procedure documents reviewed to triangulate data. Many documents were not role-specific or did not provide specific direction about which team member would be responsible for different parts of client care. This could lead to role overlap with other professions or blurred role boundaries. Participant E said, "You know, I would love to see nurses actually working to what their full scope of practice is, or actually finding out what full scope is [in OUD

treatment].” They went on to say, “We need to know what full scope entails before we can advocate for it… It’s hard to advocate for something when you don’t have all the facts as well.”

Staffing shortages or inadequate staffing levels were described as prevalent across OUD programs. Some nurses expressed working beyond their scope of practice to meet client needs by completing tasks typically undertaken by allied health team members, such as arranging transportation to treatment centers; other nurses felt as though they couldn’t meet their client’s needs at all; nurses believed staffing challenges contributed to both of these scenarios. Participant I explained:

> Staffing has been tough, as I am sure for many placed with COVID. We had some [nursing positions] that were open for a while, so that put a bit of strain [on the staff]… I think people are pretty tired; people are burnt out.

Participant E echoed this, “[The nurse role includes putting out] fires with the staffing. We are routinely short-staffed here… staffing is a constant issue or shifts are constantly needing to be filled.” Staffing challenges also impacted the relationships between the nurses and the clients, as Participant D expressed:

> We’ve gone through a huge turnover since they announced they were going to shut [the program] down. And so that brought a lot of staff changes, and with staff changes comes mistrust and no relationships built between the clients and staff, which causes tension. It causes stress on the clients not knowing if this relationship they built with this staff member, with this nurse, is now going to be done in three months or six months because there is no funding or because they got a new job to go somewhere else.

Struggles with leadership result in nurses not feeling secure in their roles. Participants believed this increased staff turnover levels, leading to diminished nurse-client relationships.

4.2.5.3 Lack of Addiction Education in Undergraduate Nursing Education.

One-third of the nurse participants identified a general lack of addiction education within their undergraduate nursing programs as a barrier to providing comprehensive care to patients with OUD. Participant I said:

> I find sometimes people [who do not work in OUD treatment] want to know more, or they want to be informed, and they just don't feel that they have the option to do that, or they're not quite sure where to reach out. People will say, I didn't learn this in my undergrad or I never learned this in nursing school. The addictions treatment section is so small in your nursing school; I felt like it was, you know, one slide of the mental health PowerPoint that you get.

Participant F affirmed this, "[We should be] having [addictions treatment content] taught in [nursing] school. We can start there. I think it is, from what I understand, harm reduction [should be] at least a topic of discussion now." A lack of education can also impact the care clients receive. Participant E said:

> When nurses start, they don't get the appropriate training they should have, so they are kind of set up for failure from the get-go. I feel like the education has been very much left to the individual nurse to take on themselves, or it's kind of just left out. And I think the more we know, the better we are as nurses, and without proper training, you're setting yourself up for failure, but you're also setting the clients up for failure as well.

Participants believed a lack of standardized addiction treatment education in nursing programs could lead to a communication breakdown of hospitalized patient needs, particularly by uninformed nursing staff who have received no education on OUD or how it is treated. Furthermore, they described how negative experiences from uninformed healthcare staff could

prevent patients from accessing healthcare services in the future, increasing barriers to creating a therapeutic nurse-patient relationship.

4.2.6 Looking to the (Uncertain) Future

Working in a practice area that is constantly changing and evolving meant the nurses identified important considerations for the future role of the nurse in OUD treatment. Two sub-themes emerged from the data: *opportunities for future education* and further clarification of *organizational priorities and funding structures*. Participant J said:

> I think there has been this ebb and flow of [uncertainty], but I think underneath all of that, there's research and there's practice and all of these other practices and policies that influence where we are at [and where we are going].

4.2.6.1 Opportunities for Education.

Across all interviews, there was discussion by participants regarding how further education will reduce stigma and improve patient care. Participants explained further education should include opportunities for other healthcare staff to better understand the characteristics of OUD, trauma-informed care, harm reduction, and emerging OUD treatment practices. Participants stressed the outcome of more education is reduced stigma for clients and nurses working in this practice area. Participant F stated, "The education piece [currently] falls to the nurses to educate the staff on the units and in the emergency room… it [shouldn't only be their] job to bring [people's biases] to light and to help bridge the gap, the provision of care." Participant B also described how there should be more educational opportunities for nurses within OUD treatment, "There's just not enough opportunity for nurses to learn about all of the ways that we could intervene… how we can help with all of the complications that come from drug use." Nurse participants described how using current and emerging research to guide care

and program direction could help to bring more normalcy in having discussions and learning from each other. Participant I said:

> If we could just normalize OUD treatment in the same way you normalize diabetes treatment, or I think that goes for mental health in general. Nurses would be able to provide better care because we would just be more informed, and it would be so much easier to be informed.

Hopes for role expansion were mentioned by many of the participants interviewed. Nurses felt role expansion would reduce barriers in accessing care and increase continuity of care between patients and a trusted healthcare provider. Participants explained expanding the role could include physical and psychosocial tasks already considered to be within the scope of practice for nurses, such as expanding STBBI testing. They also described how it could include things not yet in the nurse's current scope of practice, such as nurse prescribing of certain medications and ordering laboratory tests or diagnostic imaging. Participant G stated:

> If I could just be the one to prescribe Naltrexone or Acamprosate… I could easily prescribe those medications because I understand them really well. And they are safer medications. They aren't as controlled as methadone or suboxone… I think with training we would be capable of it, and it's kind of a waste of time to not.

Participant D echoed this:

> How many clients come in and they are so nauseous, and they feel so sick, and even just to give them a Gravol to help them through it, or someone comes in with wicked heartburn, and you can't even do anything for them sucks a lot. So, it seems like so dumb, the smallest thing of giving them an over-the-counter med that we can't do.

4.2.6.2 Organizational Priorities and Funding Structures.

Overall, participants expressed that *wrap-around care*, care that provides all of the medical and psychosocial care required by a patient in one location, saves money and lives. Nurses believed that more wrap-around services are needed across the spectrum of OUD treatment. This was also witnessed during participant observation; an urban OAT clinic has a large multidisciplinary team to ensure patients' medical, physical, emotional, and social needs are met (Observation, January 17, 2022). Participant E said, "I personally think the wrap-around services come first, the OAT is kind of always second, because the safer [the clients] feel in an environment, the more likely they are going to continue coming to get their medications." Participants emphasized reducing barriers to accessing treatment would benefit patients and decrease the burnout experienced by nurses. Additionally, participants believed services offered should be patient-directed; care should not be values-based. Nurses stated abstinence does not need to be the patient's goal to receive care for their OUD. Participant B said:

> These folks have survived every single day up until now, and they know how to survive and to live without us… I think just kind of getting out of that old mindset of sobriety-based recovery as the only option, AA as the only option, and that there does not need to be punishment [are ways we can move OUD treatment forward].

The concept of a *safe supply*, or a pharmaceutically safe opioid replacement in lieu of a poisoned street supply, was discussed by most participants. Safe supply presented as an abstract concept for some nurses, but due to the lethal strength of street opioids that are being used, it was understood safe supply could save lives and reduce harm to patients who use opioids. Participant H stated:

> I think the gold standard might be safe supply vending machines like they're done in Vancouver, plus methadone, plus a dedicated care team. And all of this could be done in harm reduction housing where people's needs are met and with ease of access to services.

Participant B stressed, "Of course safe supply, first and foremost, safe supply. Whatever it is people are actually using, please give it to them in a safe form." Participant A echoed this:

> As long as we are getting clean supply into them because I'd much rather get our stuff into them than street stuff. Even if they are still using street stuff, I would prefer them getting at least a bit of our stuff in there.

Participants suggested safe supply could include methadone, suboxone, or other oral OAT medication, as well as iOAT medication used in place of street opioids. Additionally, a safe supply could include opioid replacement while a patient is in the hospital, so they are not entering into withdrawal and are receiving adequate pain management. Participant C described safe supply in a hospital setting:

> My ultimate end goal would be that every client could take the hospital source hydromorphone that we have and self-inject if they wanted to do that… That is how I would like to see harm reduction in the hospital. A safe supply, big time.

Participant G offered a contrasting opinion:

> It would be nice to have if it was done properly. There's been some good arguments for why not to have it because there might be some people who it stimulates them to use because they otherwise wouldn't have access to it, but I don't know… The amount of shitty fentanyl out there, it's so much riskier for overdosing or detoxing unsafely. So, in the purest harm reduction sense, safe supply is a key factor that is just not in place [here],

> and it would be pretty sweet if we could actually be able to use that because it has shown success elsewhere.

Nurse participants who worked in supervised consumption services, and ambulatory OAT clinics, described how their programs might be closed in the future due to government funding priorities. Participant A said, “As soon as it hit that we were being shut down, everything, the trust, the safety net we provided to our clients, was removed, and it’s very disjointed now; we don’t serve clients like we are supposed to.” This uncertainty around the continuation of supervised consumption services and other OUD programs was expressed by many participants. Participant F stated, “Are [supervised consumption sites] needed? Yes. The problem doesn’t just go away because you don’t see it anymore.” Participant D said, “Am I hopeful for the future? I have no idea. I have no idea what the future holds for supervised consumption services in all of Canada, really.” Participant B summarized the uncertainty:

> I think it was incredibly demoralizing to have programs flagrantly assailed by the top levels of the provincial government and that it was demoralizing to watch our clients be demoralized by it… this is not a province that has been open to research-based and evidence-based practice.

4.3 Summary

The role of the nurse working in OUD treatment is extensive. Participant J stated, “There is definitely a special group of nurses that want to do this work day in and day out.” As evident from the interviews with study participants, the nurse’s role can have differences based on practice area, but many common themes of the role overlap. Nurses strive to decrease the harm experienced by the vulnerable people they provide care to. Participant B stated:

> I think our nurses are highly qualified. They come from such vast experiences. So many of them are leaders in the field who had led programs, built programs, built harm reduction programs, and had their funding shut down in other ways by the government before they got here. So, they are a resilient crowd, and they have so many ideas. I think that when we're given the flexibility to adjust and to build something and not have so many constraints or guidelines, nurses are the most innovative in how a program can actually thrive and self-actualize.

In this study, nurses working in OUD treatment had the opportunity to describe the important role they undertake when working within this subculture of nursing practice. Findings demonstrated the breadth and depth of nursing care in OUD treatment. The following chapter discusses the results and significant implications for nursing practice, healthcare, research, and education.

Chapter 5: Discussion

This qualitative study yielded findings that shed light on the role and impact of the nurse working in OUD treatment settings. A focused ethnographic analysis with a social constructionist theoretical lens provided insight into how nurses understand their role, engage within their subculture of nursing, and provide care to patients who have OUD. This chapter recaps relevant information from the preceding chapters to demonstrate how I have answered the research question, "How do nurses understand their role and its impact in providing care to clients in opioid use disorder treatment?" Additionally, this chapter will present a thick description, or cultural interpretation (Roper & Shapira, 2000), of the initial cultural landscape presented in Chapter 4. Implications for nursing practice and healthcare, nursing education, and research are presented to describe the nursing role in OUD treatment and how to improve the outcomes of patients seeking care for this chronic and relapsing illness. This chapter will conclude with study limitations.

5.1 The Art of Addiction Nursing

The art of addiction nursing encompasses participant-identified motivating factors and supportive influences for nurses working in OUD treatment. *Patient-centered care*, *relationships*, and *autonomy* provide the basis for how nurses can best support clients with OUD. The intrinsic heart, or *culture* (Roper & Shapira, 2000), of the role of the nurse working in OUD treatment is evident within this theme, as all nurses subtly identified how these subthemes were central to the care they provided. Although other studies outline the concepts of patient-centered care (McCall et al., 2019), relationships (Clark & Lucey, 2021; Wilson et al., 2007), and autonomy (Clancy et al., 2019; Comiskey et al., 2019) individually as components of the nurse's

role, the present study highlighted how these are foundational and interrelated principles from which the rest of the role is moulded.

5.1.1 Patient-centered Care

Participants understood patient-centered care as a cultural phenomenon widely embraced by nurses working across the OUD treatment spectrum. McCall et al. (2019) found similar results in their study, describing how patient-centered care was an important aspect of the nurse's role. Aside from McCall et al. (2019), other literature alluded to the nature of patient-centered care being a part of the role of the nurse without explicitly identifying it (Comiskey et al., 2019; Kolind & Hesse, 2017; Ling et al., 2017). In contrast, the findings of present study highlighted how nursing staff concretely understood their role in providing options to their patients, ultimately allowing patients to identify the care they would like to receive. The language used by participants in describing patient-centered care demonstrated the intrinsic importance of this concept within the nurse's role. This was expressed by addiction consult nurses working in hospitals as well as nurses working in community-based OUD programs. Alberta Health Services (2019) confirms that patient-centered care is an important value in alignment with harm reduction care. This is congruent with the direction from the CNA (2018a), which emphasizes the importance of including patients as key decision makers in their care. Patient-centered care was a motivating factor for participants of this study. Although they identified they were not always able to meet the patient's needs, it provided them satisfaction to be present for their patients in ways that were meaningful to both the patient and the nurse. Drawing on social constructionism, we recognize that the reality of the nurses is different from the reality of their patients. This understanding is in alignment with patient-centered care, as it strives for collaborative decision making between healthcare providers and patients. "Decisions should

carry the voices of the [patients]. When decisions are implemented, they will represent logics and values in which the [patients] are already invested" (Gergen, 2015, p. 202).

Abram (2018) and Wilson et al. (2007) described how the nurse's role includes enforcing clinic rules while demonstrating practical crisis management skills to de-escalate patients in crisis. This was similarly identified by nurse participants in this study who worked in community-based programs and had established long-standing relationships with clients. Two policy documents reviewed during my analysis identified the importance of non-violent crisis intervention as a de-escalation technique. Both documents were not nurse-specific, yet participants confirmed that non-violent crisis training is a requirement to work in community-based OAT programs.

5.1.2 Relationships

The College and Association of Registered Nurses of Alberta (CARNA)[3] (2013) define the therapeutic relationship as "a planned, goal-directed, interpersonal process occurring between the nurse and client that is established for the advancement of client values, interests, and ultimately, for promotion of client health and well-being" (p. 12). Despite the different lengths of engagement that might occur based on the nature of the OUD program, participants understood their role to include fostering therapeutic relationships with clients. "As constructionists' reason, the worth or value of [the nurse's] efforts emerges from relationships" (Gergen, 2015, p. 197). The social construction of relationships between nurses and patients, through a shared language, was a key motivating factor in their role. Similar to the literature regarding patient-centered care, the nurse's role in creating therapeutic relationships was directly identified in only a small number of studies (Clark & Lucey, 2021; Demaret et al., 2012; Wilson

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[3] As of 2022, CARNA is now the College of Registered Nurses of Alberta (CRNA).

et al., 2007). This was consistent with the documents provided by the OUD treatment programs; a blended job description for nurses working in a community OAT clinic did not refer to the relational aspect of the nurse's role in providing care to clients. Additionally, a job description for an addiction consult team presented the nurse's role as having the opportunity to counsel and educate but did not refer to building a therapeutic relationship. This could be due to the historical understanding of the nurse's role being centered around completing physician's orders (Abram, 2018; Clancy et al., 2019; Naegle, 2015; Strobbe et al., 2011). It is interesting to note that the participants did not identify their nursing role as being secondary to a physician's role. Instead, they felt their role was primary and central to the care being provided, and that was due, in part, to the relationships and rapport they built with clients. While it could be argued that relationship-building is inherent in the nurse's role, nurse participants emphasized the importance of this aspect of their role in OUD treatment programs. Further clarity of the nurse's role within program job descriptions and documents could decrease role ambiguity and improve nurse job satisfaction.

5.1.3 Autonomy

Nurse participants within this study understood their role to be fluid and changing depending on their location of practice. To them, there was no single truth to describe the nurse's role, but multiple truths dependent on the program where the nurse was working. Clancy et al. (2019) also described how the nurse's role in OUD treatment has evolved from a minor role associated with dispensing medication to a focus on primarily nurse-driven interventions, including case management and overall clinic supervision. The results of this research suggest that nurses understand their central impact in improving patient outcomes as they are prominent healthcare team members across many different OUD treatment programs. This understanding

fostered these nurses' sense of agency and autonomy. Abram (2018) and Seabra et al. (2018) discussed how autonomy could be associated with job satisfaction. The present study results also identified autonomy as a motivating factor in providing care. Clancy et al. (2006) explained how nurses sought out the practice area of OUD treatment as the concept of autonomous practice was alluring and provided job satisfaction. Conversely, findings from my review of documents from AHS (2020), BCCSU (2017), and the Canadian Psychological Association (2019) did not identify autonomy as central to the nurse's role. However, many of these documents were not role-specific but generalized to the broader teams that comprise OUD treatment programs. Acknowledgment of the autonomy associated with the nurse's role in OUD treatment can foster further role clarity and satisfaction for nurses in this practice area.

5.2 Direct Patient Care

Congruent with the literature (Abram, 2018; Azimi-Bolourian & Fornili, 2010; Bernhardt, 2021; Clark & Lucey, 2021; Comiskey et al., 2019; Demaret et al., 2012; Deren et al., 2017; Go et al., 2011; Happell & Taylor, 1999; Konrad, 2004; Ling et al., 2017; Plaza et al., 2007; Sowicz et al., 2022; Wilson et al., 2007), nurse participants expressed that a significant portion of their role involved providing direct patient care to clients with OUD. This included both physical care tasks and the application of nursing skills, as well as psychosocial care to varying degrees. Study results highlighted harm reduction as an underlying guiding principle of care. Go et al. (2011) described how OAT is rooted in harm reduction as it is intended to decrease overdose-related deaths; however, similar studies reviewing the role of the nurse (Abram, 2018; Konrad, 2004; Plaza et al., 2007; Wilson, 2007) did not make the same connection to harm reduction as the underlying foundation of care being provided by nurses. Harm reduction as a cultural norm and role expectation was promoted by participants in this

study as a foundation for them to provide patient care. Taylor et al. (2021b) described harm reduction as a set of tasks on a checklist that can be completed, such as preventing overdose, developing an opioid overdose response protocol, providing harm reduction supplies, and educating clients on safer substance consumption techniques. While completing direct patient care tasks will likely reduce patient harm, nurse participants in the present study saw harm reduction as a culturally established standard that was imperative to and embedded in the care provided in all nurse-client interactions.

5.2.1 Physical Tasks

It was not surprising that nurse participants identified physical tasks as a large part of how they understood their role, which is well supported by the literature. The nurse's role in conducting comprehensive histories and physical assessments is discussed broadly in the literature on the nurse's role in OUD treatment (Bernhardt, 2021; Clark & Lucey, 2021; Comiskey et al., 2019; Go et al., 2011; Happell & Taylor, 1999; Konrad, 2004; Ling et al., 2017; Sowicz et al., 2022). Nurses in this study highlighted a variety of assessments they completed, including admission history, addiction history, withdrawal screening, vital signs, suicide risk, and injection assessments, providing more specificity to the range of assessments that can be completed by nurses working in OUD treatment. Nurses understood that completing these assessments significantly improved patient outcomes, as these assessments would drive further interventions and patient care as necessary.

Medication management and administration have been documented as a primary nursing task completed in OUD treatment (Abram, 2018; Azimi-Bolourian & Fornili, 2010; Bernhardt, 2021; Comiskey et al., 2019; Demaret et al., 2012; Deren et al., 2017; Go et al., 2011; Happell & Taylor, 1999; Konrad, 2004; Ling et al., 2017; Plaza et al., 2007; Sowicz et al., 2022).

Participants of this study understood this; however, study results shed light on the differing approaches to medication management based on the program participants worked in. For example, consult addiction nurses in the hospital were more focused on monitoring ordered opioid medication to ensure the dose was sufficient to keep patients out of withdrawal. These nurses felt tasked with ensuring that emergency department or unit nurses were administering ordered opioid medications to patients. In contrast, nurses working in community settings saw themselves as responsible for administering medications and liaising with pharmacies to ensure the continuance of OAT. Ultimately, as OAT is seen as a first-line treatment for OUD (BCCSU, 2017), nurses believed their role in medication management and administration could improve patient outcomes, medication compliance, and treatment retention.

Wound care (Sowicz et al., 2022), blood draws, infection prevention and management (Abram, 2018), monitoring patient condition (Clark & Lucey, 2021; Go et al., 2011; Sowicz et al., 2022), assistance with self-injection technique (Clark & Lucey, 2021; Plaza et al., 2007), and urine drug screens (Strobbe et al., 2011) were presented as other direct patient care tasks completed by nurses working in OUD treatment. Participants in this study described similar activities; however, they also described additional activities including STBBI testing, ECGs, overdose response, and distribution of consumption supplies and naloxone kits as physical health-related tasks. In contrast to the literature, urine drug screens, a procedure in which a nurse collects a urine sample from a client to check what substances they have consumed and are excreting, was not mentioned as a physical task within the nurse’s role. Nurse participants believed urine drug screening was punitive towards patients, favoring transparent communication regarding ongoing substance use.

Additionally, addiction consult nurses confirmed that providing general physical care was not typically within their role. The constructionist dialogue promotes critical awareness to different truths and realities (Burr, 2003; Gergen, 2015). While the role of the nurse in certain programs was identified to heavily include physical nursing tasks, the reality of the nurse role is different for consult addiction nurses. Despite this difference, nurses from both programs provided direct patient care within their role. It was understood by nurse participants that the direct patient care they provided, whether it be through assessments, medication management, or general physical care tasks, impacted the patients positively and reduced harm they might have otherwise experienced.

5.2.2 Psychosocial Care

Providing patient education was the most common form of psychosocial care identified by participants. Similarly, it has been documented throughout the literature that patient education is a key aspect of the role of the nurse in OUD treatment (Bernhardt, 2021; Clark & Lucey, 2021; Deren et al., 2017; Konrad, 2004; Mumba & Snow, 2017; Naegle, 2015; Plaza et al., 2007; Strobbe et al., 2011). "Nurses provide education to support the informed decision-making of capable persons. They respect the decisions a person makes, including choice of lifestyles or treatment that are not conducive to good health, and continue to provide care in a non-judgmental manner" (CNA, 2018b, p. 11). Nurse participants perceived that patient education positively impacted patient care and allowed clients to feel more engaged and empowered with how they access healthcare services.

The present study further clarifies other types of psychosocial care provided to patients in OUD treatment. A range of literature supports the idea that nurses are in a unique position to provide counselling support for clients who have OUD (Azimi-Bolourian, 2010; Bernhardt,

2021; Go et al., 2011; Konrad, 2004; Ling et al., 2017; Plaza et al., 2007; Naegle, 2015); however, this was contrasted by the participants of this study who felt that counselling was not within the scope of practice for nurses. Participants highlighted that active listening, crisis intervention skills, and creating a safe environment for clients to feel that they could authentically share and express themselves as ways to provide psychosocial support instead of direct psychological counselling. Nurse participants believed psychological counselling required additional training, which they did not have; thus, this intervention was not routinely included in the care provided by nurses. Wilson et al. (2007) described how *psychosocial support* is best conceptualized by dynamic interactions that are respectful, empathetic, and mutually influential. This was reaffirmed by participants in this study who felt that relationships with clients were understood to be mutually engaged with a conscious effort to remove power differentials.

5.3 Indirect Patient Care

The literature exploring the nurse's role in OUD is primarily focused on the direct patient care tasks performed by nurses. The participants of this study highlighted the importance of looking beyond what nurses commonly do in their role to include indirect care tasks and responsibilities in a less direct fashion such as placing referrals to other services, advocacy, and anticipatory care. Harm reduction as an overarching principle guiding indirect patient care is a new concept identified by this study's results. As discussed earlier, harm reduction tends to be understood more generally as consisting of the tasks that will reduce harm, such as needle exchange, expanded access to STBBI testing, and patient education, as opposed to the cultural interpretation of harm reduction as a foundational approach to the provision of care. The College and Association of Registered Nurses of Alberta (2013) described that one of the practice standards registered nurses must uphold is coordinating "care activities to promote continuity of

health services" (p. 8). Congruently, nurse participants understood that a large part of their role is to be resource specialists assisting patients in navigating the healthcare system. This study further illuminated the positive impact of this, as nurse participants generally felt satisfaction when clients successfully accessed other healthcare services obtained through advocacy and referrals.

5.3.1 Healthcare Navigator and Resource Specialist

According to Kalaitzidis and Jewell (2015), nurses generally maintain advocacy as a central aspect of the nurse's role; nevertheless, there are conflicting definitions of advocacy as it pertains to nursing. It is interesting to note that the concept of advocacy as an aspect of the role of the nurse is not broadly identified in the OUD-specific literature; however, being an advocate for clients was identified by all nurse participants in this study. This could be due to the general expansion of the role of the nurse from being perceived as secondary to physicians and bound by physician orders (Naegle, 2015) to being more autonomous and centralized in aspects of patient-centered care and case management. Advocacy could include *patient advocacy*, which includes supporting or providing recommendations to patients; *policy advocacy*, which focuses on health policy and how this impacts patients; or *information provision*, whereby nurses provide patients with information to make decisions (Kalaitzidis & Jewell, 2015). Within the present study, nurses most often identified their role as including patient advocacy and sometimes including policy advocacy. Nurse participants strongly identified their role as being advocates for their patients as they understood that clients with OUD often faced additional challenges when engaging with the healthcare system. The CNA (2018b) reinforces advocacy as an aspect of the role of all nurses in the *Code of Ethics for Registered Nurses*. "Nurses advocate for persons

receiving care if they believe the health of those persons is being compromised by factors beyond their control, including the decision-making of others" (CNA, 2018b, p. 11).

It is generally understood, and consistent with the literature, that placing referrals to other services is within the role of the nurse (Konrad, 2004; Ling et al., 2017; Strobbe et al., 2011). Assessing and referring clients to other necessary services was confirmed by triangulating data obtained from program protocols; however, most protocols did not outline which specific multidisciplinary team members would be doing the tasks. Nurses should work as case managers with OUD clients as they provide linkages and refer clients to other services (Go et al., 2011). Unfortunately, nurses working as case managers can also experience role ambiguity within teams of many disciplines, which could decrease role satisfaction (Abram, 2018). The results of this study echo both sentiments; nurses working in hospital addiction services felt strongly about ensuring appropriate referrals and seamless care transitions, whereas nurses working in community-based OAT clinics were much more aware of role overlap and the difficulty this presented in ensuring clients received the care they needed.

The results of this research highlighted the emerging concept of *anticipatory care* as an aspect of the role of the nurse in OUD treatment. I was unable to find supporting literature related to anticipatory care in OUD settings. *Anticipatory care planning*, often described in continuing care or long-term care, is defined as an integrated care approach to anticipate, avert, or delay future decline through the early identification of at-risk individuals (Brazil et al., 2022). Nurses from all included OUD treatment areas identified ways they utilized anticipatory care within their patient care. Further exploration of this concept and its intersection with the nursing role in this setting would be valuable.

Interestingly, while advocacy and referrals were widely acknowledged as components of the nurse's role in OUD treatment, interprofessional collaboration was not identified by all participants as a prevalent aspect of their role. This could be related to differing practice areas and team structure. During participant observation, community OAT nurses were heavily collaborative with their interprofessional colleagues. Additionally, this program's blended nurse job description and program manual identified the importance of interprofessional collaboration. This apparent contradiction between what participants expressed and what was observed could be due to the "unspoken" aspects of the nurse's role that are inherently assumed and not widely voiced. "Knowing what nurses have been doing [within their role] is essential for envisioning how these practices may be expanded and refined" (Sowicz et al., 2022, p. 10). Social constructionism recognizes that collaborative work shifts discussions of patient care from monologue, where one team member, such as physicians, is directing others, to dialogue, where all healthcare team members are able to contribute to the care being provided. As such, interprofessional collaboration is an important part of the nurse's role, which should be encouraged and practiced to improve patient care.

5.4 The Shared Experience of Stigma

This study brings further awareness about where stigma is occurring directly or indirectly in relation to patients receiving care for their OUD. The experience of stigma influences all aspects of the role of the nurse in OUD. As described earlier, stigma is a complex social experience resulting in negative beliefs, attitudes, or assumptions about the characteristics of others (Goodyear et al., 2017). This research identifies that stigma is the expression of the social construction that assumes OUD is problematic and undesirable. Four subthemes, or levels of stigma, arose from the data provided by participants. Nurses described how stigma contributed

to adversity experienced by both clients and nurses. "Adversity is a common element in the addictions field, where workers constantly battle public perceptions about people who have addiction issues" (McCall et al., 2019, p. 49).

5.4.1 Individual Level

It is easiest to identify stigma when it occurs overtly and directly. Hence, it is unsurprising that individual level stigma, towards nurses working in OUD and OUD clients, was revealed as a common subtheme in this research. McCall et al. (2019) asserted that stigma surrounding addiction is a common occurrence for the patient and staff who work with OUD patients. Similarly, the results of this study highlighted the occurrence of *associative stigma*, stigmatization of nurses working in OUD treatment who are in close association with people who have a mental illness or addiction (Halter, 2008). A review of the literature revealed that nurses in this care setting felt a lack of respect for their role credibility, which caused frustration (Halter, 2008; Happell & Taylor, 1999). This was similarly identified by some of the study participants, who felt they experienced stigma for working with people who have OUD due to a general lack of knowledge about OUD by other healthcare professionals. There was also a shared misconception that nurses who work in OUD treatment have an easier role; therefore, working in this practice area was not considered "real" nursing (Happell & Taylor, 1999). Halter (2002) identified how healthcare professionals, including nurses, might assume nurses who choose to work in OUD treatment have psychological flaws or unresolved trauma. Ultimately, the stigmatization experienced by nurses who work in OUD treatment is reflective of the societal construction that addiction is a moral failing and personal flaw (Halter, 2002). Abram (2018) shared how nurses overcome negative views of being "othered" pertaining to the nurse's role in OUD treatment by creating a sense of community through mutual experience. Although nurse

participants expressed stigma was not a deterrent to their perceived role satisfaction, stigma remains challenging for nurses working in this practice area.

The nurses interviewed in this research also discussed how stigmatization towards clients created barriers to seeking medical attention. Similarly, Dion (2019) reported unpredictability in how patients anticipated they would be treated by healthcare staff, which influenced their decision to seek healthcare services. Nurses articulated that their role was to be present for clients and to mitigate the stigma clients experienced whenever possible. This occurred first and foremost by creating a safe, inclusive, and non-judgemental culture for patients; this spanned across practice areas where nurses worked in OUD treatment. Dion (2019) reinforced this, "perceived positive experiences led to engaging in self-care, incorporating harm reduction practices, and seeking healthcare earlier" (p. 105), which ultimately would lead to improved patient outcomes. The findings of this research emphasized the importance of educating others to reduce the stigma experienced by patients receiving care for their OUD. Hoover et al. (2022) stated, "[OUD] education to reduce negative and stigmatizing interactions should be integrated into clinical practice of all providers who interface with patients to reduce stigma" (p. 6).

5.4.2 Community Level

Study participants understood that stigma from the community impacted their ability to provide care to patients. "Public stigma contributes to underinvestment in high-quality addiction treatment infrastructure, and suboptimal care for people with substance use disorders" (McGinty & Barry. 2020, p.1291). McGinty and Barry (2020) discussed how public stigma could also lead to a collective "not-in-my-backyard" (p. 1291) resistance to community services, which is similar to how the present study highlighted community backlash to an urban supervised consumption program. Tsai et al. (2019) described how public stigma is driven by socially

constructed stereotypes about people with OUD, such as perceiving them as dangerous or having poor morals; this could lead to persistent negative attitudes and reluctance to support initiatives that would benefit people with OUD. This aligns with the study by Taylor et al. (2021a), which found that people who deny OUD is a medical condition are more likely to hold stigmatizing beliefs about OUD and its treatment. Social constructionism claims that communities accept and sustain shared truths, values, and realities (Burr, 2003). Nurses in the present study identified the challenge this construction presented in caring for patients with OUD. Clancy et al. (2019) affirmed nurses must continue advocating for OUD awareness to dispel stigma within the wider community. The results from this research highlighted that participants understood and acknowledged that community-based stigma is challenging for nurses and their patients with OUD. Ultimately, public stigma led to community resistance to evidence-based interventions such as naloxone distribution and supervised consumption services which could increase the risk of overdose deaths within communities (Beachler et al., 2021).

5.4.3 Healthcare System Level

The impact of healthcare system level stigma can be demonstrated in how care and services for clients with OUD are financed and delivered (Tsai et al., 2019). Nurse participants expressed how healthcare system stigma impacted how they were able to provide care to patients with OUD across community-based programs and within the hospital. Within the provincial health authority, program funding, leadership, policy direction, and team structure vary, which ultimately leads to various approaches to care. Unfortunately, I found little literature about how healthcare system stigma impacts the nurse's role in OUD treatment. However, stigmatizing policies generally lead to patients being apprehensive or unable to access required services (McGinty & Barry, 2020). From a social construction perspective, when a community's

accepted knowledge becomes policy, ideas of privilege and power within the community become codified (Gergen, 2015). This means that the construction of OUD as problematic and undesirable has influences policies within the healthcare system to further support this narrative. “These types of policies and related decision-making not only reinforce the ways in which people with OUD are treated separately from others, but also implicitly classify people with OUD as being unworthy of investment and undeserving of treatment, thereby potentially having direct effects on health outcomes” (Tsai et al., 2019, p. 5). The present study highlighted the importance of creating a safe and inclusive environment for patients, regardless of what level of treatment they access, with supportive policies in place to enhance patient outcomes.

5.4.4 Societal Level

As described by participants, healthcare system level stigma emerges from the perceived values-based competition between harm reduction services and abstinence-based treatment fueled by the government that funds the health authority. Social constructionism recognizes that knowledge production is politically-driven; therefore, when knowledge is created it has social, cultural, and political consequences. This study highlighted a lack of research and understanding of how government systems and ideology influence OUD treatment within a provincially funded health authority. Participants were aware of and directly referenced the stigma they perceived as filtering down from the government and impacting their ability to provide care to patients with OUD. Much of this was understood by participants as resulting in a lack of consistent operational funding, which led to job instability and perceived high staff turnover rates. There is little research discussing the complexity of government and its approach to OUD. Tsai et al. (2019) stated, “The language used to frame the [OUD] crisis can influence norms about OUD and about people with OUD among policymakers and their constituents, directly affecting the

policy levers that are brought to bear on the opioid overdose crisis response" (p. 5). In general, stigmatizing language used by people with power will continue to perpetuate negative beliefs and punitive judgements of people with OUD, which could lead to a "lack of public support for public health-oriented policies to address the opioid overdose crisis" (Tsai et al., 2019, p. 5). Nurse participants expressed that their role could be valued or devalued by the government and healthcare leaders. This could further impact patient outcomes depending on if the government saw a program as being rooted in harm reduction philosophy or abstinence philosophy. If governments valued only one aspect of treatment, funding could be decreased in other areas of treatment, leading to inequities and decreased opportunities to access other levels of addiction treatment.

5.5 Perceived Barriers to Providing Care

It is important for OUD nurses to understand their role while also articulating perceived barriers to care provision, so that healthcare leaders can be informed about and work to address issues to improve patient outcomes. According to the CNA (2018b), nurses must recognize and work "to address organizational, social, economic and political factors that influence health and well-being within the context of nurses' roles in the delivery of care" (p. 18). Burnout and struggles with leadership directly influence the nurse's ability to provide care. Participants highlighted that perceived barriers could lead to higher staff turnover rates, disengagement from the program or care team, increased workloads due to staffing challenges, and an overall sense of disconnection between what a patient might need and how nurses can meet that need. Ultimately, perceived barriers are constructed through interaction with the healthcare system, and nurse participants understood that burnout, struggles with leadership, and a lack of appropriate addiction education negatively impacted their ability to provide patient care.

5.5.1 Burnout

Literature supports that burnout is a common occurrence among nurses who work in OUD treatment (Abram, 2018; Clancy et al., 2006). *Burnout* includes feelings of fatigue, pessimism, and a decline in role satisfaction, which could lead to nurses experiencing deterioration in physical and mental health and an inability to remain in their practice area or program (Reese et al., 2020). Some participants described how sadness and grief increased their feelings of burnout in this practice area. Clancy et al. (2006) noted that sadness and grief are a shared experience within the OUD nursing culture as this practice area "is associated with working with a client group that experiences high morbidity and mortality rates" (p. 168). This could foster unhappiness within the nurse's career, leading to program and staffing instability if they leave the practice area (Clancy et al., 2006). Nurses who are unable to develop a tolerance to some of the challenging aspects of providing care to patients with OUD, such as relapse, could become disillusioned and worn out (Abram, 2018; Clancy et al., 2006). Horner et al. (2019) stated that burnout is commonly associated with nurses expressing frustration for working with a more "demanding" patient population, which could lead to feelings of being let down by patients when they become disruptive, inappropriate, unstable, or threatening. The results of this study corroborate this, attributing adverse events such as overdose death, difficulty referring clients to other programs, and difficulty with the continuance of OAT treatment due to medication shortages or lack of compliance as factors that contributed to feelings of burnout within their role. Additionally, lack of physical space within clinic areas decreased workplace satisfaction as this influenced the ability of participants to provide patient-centered care and complete nursing-related tasks. It was beyond the scope of the current study to explore what supports participants could access to manage burnout. However, nurse participants stressed that burnout was

increasing, leading to the assertion that more support and resources are needed to address this challenge.

5.5.2 Struggles with Leadership

The identification of leadership struggles as a perceived barrier to providing care is an addition to the current knowledge base surrounding the role of the nurse in OUD treatment. I was unable to find supporting literature related to struggles with leadership in OUD settings. However, literature exists to describe nursing struggles with leadership in general practice areas (College of Nurses of Ontario, 2018). The College of Nurses of Ontario (2018) identified that workplace conflict could occur from a lack of communication to staff about organizational policies, from a lack of role clarity, and when staff perceives job insecurity. These factors align with this study's results; nurse participants described difficulty with communication, role ambiguity, and an overall lack of program security, leading to additional stressors within their role. "For constructionists, organizations are held together by shared meaning. Together they create the meaning of work, who is responsible for what tasks, the importance of what they are doing, and so on" (Gergen, 2015, p. 194). Nurses who work in OUD treatment settings construct an understanding of their role based on cultural and historical information, which is often communicated to them during orientation periods by leadership teams. Role clarity for the nurse and increased clinical and professional support could result in improved role satisfaction (Dion, 2019).

5.5.3 Lack of Addiction Education in Undergraduate Nursing Programs

The Canadian Association of Schools of Nursing (CASN) (2015) has developed an undergraduate level entry-to-practice competency framework for mental health and addiction. This framework was developed to "determine from a national, consensus-based perspective,

what the core entry-level competencies should be in a given, longstanding specialty area of nursing education. These are intended to be consistent with a generalist education and reflect required regulatory body entry-to-practice competencies but provide greater specificity and detail" (CASN, 2015, p. 7). In contrast, nurse participants from the present study highlighted a lack of addiction-related education within undergraduate nursing programs. This gap could be due to the overriding emphasis on undergraduate education being "generalist" in nature, and the assumption that specific education related to addiction would not be feasible for nursing students within the confines of a general nursing program. Gagnon et al. (2020) studied the current state of substance use education in Canadian undergraduate nursing programs, revealing that nursing students often feel underprepared to work with people who use substances. Although students identified certain educational components related to the philosophy of harm reduction, they described a gap in learning how to "translate harm reduction into practice" (Gagnon et al., 2020, p. 512), especially in OUD treatment programs. Hoover et al. (2022) asserted that education about evidence-based treatment for OUD should be provided to nurses earlier in their careers to improve interactions with patients with OUD, as well as with nurses who work in practice areas outside of OUD treatment. Study participants felt the lack of knowledge and education regarding addiction and OUD were barriers to their initial ability to provide care. Dion (2019) identified that "nurses should be trained in addiction, trauma-informed care, and motivational interviewing, to further enhance the interpersonal relationship with the substance-dependent person" (p. 106) as an important implication for future practice. Abram (2018) stressed that nurses should be recruited within the OUD practice area to help advance the OUD nurse specialty; this would assist with role identity, increased their visibility, and enhance awareness of the role within the healthcare system. The results of this research suggest that the lack of

specific addiction education available to nurses within their undergraduate programs is a perceived barrier to providing care, which could have a negative impact on patient outcomes.

5.6 Looking to the (Uncertain) Future

This study highlighted the underlying cultural belief held by OUD nurses that nursing practices are evolving, OUD treatment continues to become more accessible and mainstream, and outcomes for patients can continue to be improved. Nurse participants felt hope mixed with uncertainty as they described their current roles and their understanding of how the role of the nurse can be better optimized. Two subthemes emerged from the data specific to how nurses envision the future: opportunities for further education and organizational priorities and funding structures. Nurses are able to assist people with OUD "in making incremental changes to reduce the harm from their drug use" (Dion, 2019, p. 106). Social constructionism recognizes that reality can change as understanding changes (Burr, 2003; Gergen, 2015). This is in alignment with the present study's results which saw nurses envisioning a different future for their role. Nurses, healthcare leadership, and policymakers need to continue looking toward the future of healthcare services for people with OUD to improve patient outcomes.

5.6.1 Opportunity for Education

McCall et al. (2019) stated that educational preparation is important in changing attitudes and increasing skills for healthcare staff who work with OUD patients. Literature identifies that more addiction-specific education is needed throughout the healthcare system (Abram, 2018; Clancy et al., 2019; Hoover et al., 2022; McCall et al., 2019). Ould Brahim et al. (2020) asserted that "fostering nurses' knowledge and understanding of collaborative, strengths-based philosophies and developing the relational skills that enable nurses to apply these philosophies

throughout the course of their interactions with patients" (p. 257) who have OUD is an important priority to improve patient outcomes across all areas of healthcare.

The results of this study highlight how nurse participants understood their role had expanded and could continue to expand with treatment advancements. One area where nurses felt their role could further develop was the addition of nurse-prescribing of medications and ordering diagnostic tests. Currently, nurses must apply to the provincial nursing regulatory body (now known as CRNA) for authority to prescribe Schedule 1 medications and order diagnostic tests (CRNA, 2019). Additionally, nurses must complete an approved nursing program for prescribing and ordering diagnostic tests, have worked a minimum of 3000 hours as a registered nurse, with 750 of those hours being in the practice area where they will order and prescribe, and provide a supportive reference from their employer regarding the intent of the registered nurse to prescribe (CRNA, 2019). At this time, nurses must follow an:

> Established clinical support tool in a specific clinical practice area before they are authorized to prescribe schedule 1 drugs and order diagnostic tests in that practice area. The clinical support tool must guide both prescribing decisions and the ordering of diagnostic tests. The clinical support tool may be in the form of a protocol, algorithm, or clinical practice guideline. (CRNA, 2019, p. 6)

This study highlighted the desire of nurse participants to be able to prescribe medications in order to improve access to care and primary healthcare treatment for patients with OUD. Although there are still limitations, restrictions, and additional required education for registered nurses to be able to prescribe and order diagnostic tests, it is important to acknowledge that this has been a recently welcomed change to practice.

5.6.2 Organizational Priorities and Funding Structures

This study highlighted the larger issue of healthcare funding prioritization within the province where the research occurred. Nurse participants felt devalued in their role by government systems and the provincial health authority across all OUD practice areas. Nurse participants perceived unstable funding structures negatively impact the provision of care to patients with OUD, leading to higher levels of burnout, staffing challenges, and general staff turnover rates within their treatment programs. Leadership at the top of an organization is important in changing the organizational culture of OUD treatment (Horner et al., 2019). High-level leadership should be committed to ensuring funding will adequately support OUD treatment and that policies and procedures are created to support clients' needs. Gallagher et al. (2019) stressed OUD recovery should remain an important healthcare issue; programs should offer a wide range of interventions and services focused on the recovery needs identified by the patients being served. "Just as we cannot force people to change, or force them to not use opioids, we also cannot conceptualize recovery for them" (Gallagher et al., 2019, p. 411). The results of the present study echo this sentiment, and highlight that governments prioritizing one aspect of treatment, such as abstinence-based programs, could be harmful to the overall spectrum of care that patients with OUD require.

Access to a safe opioid supply has been identified as a key harm reduction intervention to prevent opioid overdose deaths resulting from exposure to the toxic street opioid supply (Health Canada, 2022). The results of this study highlighted that OUD nurses believed access to a safe supply was an important form of healthcare for patients with OUD. This approach to care is intended to be less structured than typical OAT and is geared towards people who are most at risk of opioid overdose death (Health Canada, 2022). From a national perspective, Health

Canada has begun researching the effectiveness of offering a safe supply through pilot projects and issuing exemptions from the Controlled Drugs and Substances Act (Health Canada, 2022). Unfortunately, this approach has not been undertaken within the province where this research study occurred. In September 2021, the Government of Alberta established a committee to complete a rapid review of safe opioid supply (BCCSU, 2022).

> The BC Centre on Substance Use (BCCSU) previously raised significant concerns regarding the structure of the committee's work, including the failure to engage individuals involved in the evaluation of existing safer supply interventions, a lack of involvement of individuals with lived and living experience of substance use, addiction medicine specialists, families impacted by substance use, researchers and public health experts. A further concern relates to the committee's overreliance on submissions from individuals with a history of being critical of safer supply. (BCCSU, 2022, para 5)

The completed provincial review asserted that safe supply was a harmful intervention and not effective (BCCSU 2022). However, the BCCSU (2022) deemed the rapid review to be of critically low quality due to a flawed search strategy, inclusion of studies unrelated to safe opioid supply, and exclusion of relevant studies. Evidence-based research supports that "overdose deaths continue to be attributed primarily to the illicit and toxic drug supply and not the introduction of safer supply programs" (BCCSU, 2022, para 10). As with stigma, social constructionists recognize that at this time, safe supply as a construction of reality is bound with power relations for what is permissible and accepted and what is not (Gergen, 2015). Just as participants were frustrated with decisions to shut down supervised consumption services, they also felt frustrated when they perceived governments did not adequately fund evidence-based healthcare interventions for vulnerable populations. The impact of inconsistent program funding

could lead to unpredictable planning and leadership approaches, which could increase nurses' experience of burnout and negatively impact patient care.

Nurse participants expressed that patient advocacy work is within their role; however, they felt disillusioned in not being able to advocate on a broader policy scale to improve OUD treatment. Participants felt that nursing leaders did not advocate for increased OUD treatment awareness and policy expansion, and they often had little knowledge of what the nurse's role entailed. "From a nursing leadership perspective, nurse leaders must be present at the table in [OUD] legislation and policy development" (Kidd et al., 2020, p. 21). Participants believed that more policy advocacy should occur. The study findings also revealed that healthcare leadership has broad impacts on the nurse's role, on patients' experience of stigma and ultimately, on how care is being provided to patients with OUD.

5.7 Implications

Understanding the role of the nurse in OUD treatment is central to how nurses and the healthcare system will respond to the opioid epidemic going forward. The opportunities nurses have to influence care provision in OUD treatment extend from the bedside to the level of government policy (Kidd et al., 2020). The results of this study have revealed several important implications for nursing practice and healthcare, nursing education, and nursing research.

5.7.1 Implications for Nursing Practice and Healthcare

Advocacy for harm reduction and OUD treatment programs across a continuum of care is crucial. This study highlighted how nurses perceive government funding priorities to be volatile and dependent on the values of the governing political party. Nurse participants identified that based on how the government allocates healthcare funding, programs might not remain operational if they do not align with government ideology. Evidence supports a continuum of

care approach to OUD treatment (BCCSU, 2017; Clancy et al., 2019; Kidd et al., 2020), and this study further reinforces that all aspects of OUD treatment require adequate funding and accessibility for patients. Nurses identified advocacy as an important part of their role; however, advocacy was primarily geared towards advocacy for patient needs. This could be due to feelings of job insecurity and nurses feeling unsupported by their leadership to engage in policy advocacy. Nursing leaders should support policy advocacy in this practice area by supporting and encouraging front-line staff to become involved in specialty practice groups and associations. Nurses are important change agents that can address equity, diversity, and inclusivity (EDI) through patient and policy advocacy work. From the perspective of the current study, it would be beneficial for nursing leadership, nursing specialty practice groups, and nursing associations to engage in further policy advocacy to sustain and improve OUD treatment programs and services. Furthermore, advocacy and positive change could be facilitated by nurses and nursing leaders should advocating to their local government representatives, including Members of Legislature, Members of Parliament, as well as the Minister of Addiction and Mental Health. Additionally, active involvement by nurses in activities related to National Overdose Awareness Day would increase the visibility of OUD treatment, overdose prevention, and the influential work nurses do with OUD patients.

This study identified opportunities for harm reduction nursing practices to continue expanding within the inpatient setting. “Harm reduction nursing started within the realm of community nursing but is now moving into the hospital setting” (Danda, 2021, p. 124). The nurse participants who worked in a hospital addiction consult role identified difficulties with implementing harm reduction interventions. This could be due to the medical model of care prevalent within the inpatient setting, which stresses that physicians guide care and patients

follow treatment plans without deviation. Harm reduction strategies within the hospital should include early referral to addiction teams, provision of adequate pain management based on opioid tolerance levels, support for patients to continue iOAT treatments within the hospital, provision of supervised consumption spaces within hospital settings to support continuity of medical care, patient access to sterile consumption supplies, and education for nursing and healthcare staff to support harm reduction initiatives.

Clearly defined nurse and healthcare staff roles within OUD treatment areas should be communicated by healthcare leaders. "A comprehensive understanding of nurses' practices with persons with OUD is foundational for advancing this area of practice and research" (Sowicz et al., 2022, p. 10). Knowing what nurses do in OUD treatment is important to envision how their role can be advanced to improve patient outcomes (Sowicz et al., 2022). The results of this study highlight some of the overarching aspects of the nurse's role within OUD, as well as some of the areas where the role differs depending on the practice area. Healthcare leaders should understand the tasks nurses do in their roles, directly and indirectly. Clearly communicated role descriptions could reduce role blurring and overlap and improve interpersonal relationships within OUD treatment teams. Healthcare leaders should support role clarity by including specific role descriptions within job postings, outline staff roles during orientation, and incorporate role definitions into department protocols. Additionally, some participants expressed that their direct leadership provided minimal program oversight, and had very little understanding of the breadth of work the nurse did within their role, which led to feelings of devaluation. Naegle (2015) stated that a lack of appropriate leadership contributes to the inconsistent understanding of the nurse's role and "further isolates nurses from both support and expectations to adhere to national standards for general and addictions nursing" (p. 1155). It is

crucial for nurses to be acknowledged for the complex and difficult work they do, and for healthcare leaders to commit to understanding the roles of their frontline team members.

The opportunity exists for creating specific nursing policy, procedure, and framework documents by health authorities and specialty practice groups. Many of the policy and procedure documents reviewed for this study were not specific to the nurse's role or did not clearly delineate the nurse's role in OUD treatment. Healthcare leadership, provincial and national nursing associations, specialty practice groups such as the International Nurses Society on Addictions (IntNSA), and provincial research groups such as the BCCSU have the knowledge, information, and expertise to suggest ways in which the role of the OUD nurse can be standardized through OUD treatment framework documents. Research has highlighted a lack of understanding of the nurse's role in OUD treatment (Abram, 2018; Clancy et al., 2019; Mumba & Snow, 2017; Sowicz et al., 2022). The results of this study provide insight into the nurse's understanding of what their role in OUD treatment entails and how they impact patient care.

More supports are needed for nurses experiencing burnout in the challenging practice area of OUD treatment. Abram (2018) highlighted that nurses shared different coping strategies amongst themselves to cope with workplace stress. Nurses can sometimes feel entrenched within their culture and powerless to change their working environment, compounding the burnout they can experience while working with a perceived complex population (McCall et al., 2019). The results of this study highlight varying factors that influence burnout which stems from feeling unable to meet patient needs or from encountering traumatic events. This study illuminates some areas where leaders could provide additional support to nursing staff. These include difficulty assisting patients to access other levels of patient care, lack of space and patient care resources, and when nurses experience emotionally challenging situations such as

repeated exposure to overdoses or patient death. It is essential that managers and leaders ensure adequate staffing levels and appropriate workloads for nursing staff. Managers and leadership teams must also communicate about and encourage the utilization of available resources for emotional and psychological support, such as Employee Assistance Programs and health benefits. Indeed, following complex or traumatizing incidents such as patient death, grief support and debriefing services should be provided to all nurses involved. The findings of this study reveal that providing tangible resources to support nurses in coping with traumatic events and complex patient problems is imperative. Addressing some of these barriers could lessen burnout, decrease staff turnover rates, and improve nurse job satisfaction and patient outcomes.

5.7.2 Implications for Nursing Education

Nursing education regarding opioid addiction, risk factors, epidemiology, assessments, treatment modality, and how to best provide care to patients with OUD should be taught more comprehensively within undergraduate nursing programs. The results of this study highlight a perceived lack of addiction education being taught in undergraduate nursing programs. Nurse participants emphasized that it would be beneficial for undergraduate programs to provide more education on OUD treatment, harm reduction practices, and trauma-informed care models. Abram (2018) similarly reported that nurses had minimal education on OUD within general nursing training. "Although it has been demonstrated that educational programs can positively affect the attitudes of nurses towards [patients with OUD], education concerning drug and alcohol issues tend to constitute only a minor portion of undergraduate curricula" (Happell & Taylor, 1999, p. 21). Gagnon et al. (2020) assert education can eliminate stigma and decrease barriers to treatment, which will ensure OUD patients have access to "safe, competent and ethical nursing care" (p. 512). While CASN (2015) indicates that there are specific criteria and

competencies that need to be included in undergraduate programs about mental health and addiction care, the results of this study affirm that nurses have little recollection of any specific curriculum related to OUD treatment from their undergraduate education. Nursing education programs have a responsibility to ensure nurses are adequately prepared to encounter OUD within a generalist practice area as the number of people with OUD continues to increase.

More awareness and understanding of the nurse's role within OUD treatment can guide and structure nurse orientation within OUD treatment programs. Participants in this study discussed how their orientations lacked accurate information on the nurse's role within their program. This could be due to a limited understanding of the role by leadership. Specific addiction education is important to prepare nurses to care for populations with OUD; targeted workplace orientation, first-hand experience, and ongoing education and support are critical (McCall et al., 2019). When nurses clearly understand their role at the start of their employment, perhaps they will be less likely to become disillusioned with their practice area. The present study highlighted an eagerness to provide high-quality patient care to clients, but revealed that nurses struggle to understand where they fit in the treatment team as compared to other team members, such as addiction councillors or social workers. This could be related to the prevalence of psychosocial or social support services that marginalized clients might require when accessing treatment for their OUD. Although nurses generally could assist with these tasks, and the study participants highlighted they often did, it would be beneficial for orientation materials to clearly indicate specific program role expectations to reduce role blurring and overlap. "Vague descriptions of nurses' practices with people with OUD fail to articulate potentially novel and unique aspects of nursing work that differ from the practices of other health and social service professionals" (Sowicz et al., 2022, p. 10).

More post-graduate nursing education and awareness of OUD treatment and the role of the nurse could decrease the stigma experienced by patients with OUD, and improve patient retention and treatment outcomes. The results of this study highlight that, in general, inpatient healthcare service providers might lack an understanding of OUD and evidence-based treatment approaches to OUD. "Healthcare systems should consider educating their medical staff to eliminate the use of stigmatizing language when documenting patient encounters and writing medical notes in charts" (Hoover et al., 2022, p. 6). Education should be offered broadly and could include eLearning's through approved education platforms, in-service or lunch and learn presentations from community agencies, and more in-person education courses across the province. Nurse leaders and managers must be supportive of their staff attending courses that will supplement the care they provide, and could further support the creation of evidence-sharing practice structures like journal clubs or other mechanisms to share knowledge resources directly with their staff.

Additionally, the healthcare system should strive toward the use of person-first language, use medical terminology to appropriately diagnose patients, and offer a broad range of OUD treatment education opportunities for staff (Hoover et al., 2022). Horner et al. (2019) assert that re-humanizing care for people with OUD will help to mitigate the burnout nurses feel and decrease the amount of stigma experienced by patients. This study emphasizes that OUD nurses believe there is an opportunity for further education within the healthcare system about OUD treatment, resulting in reduced stigma ranging across all four levels identified from the data.

5.7.3 Implications for Nursing Research

The results of this study provided further insight into how OUD nurses understand their role and impact on providing care to clients. Participants included hospital-based addiction

consult nurses, community OAT nurses, medical-detox nurses, and nurses working in a community supervised consumption program. Further research should examine the role of the nurse in each of these programs, role satisfaction, stigma, and scope of practice. Additionally, further research should examine the role of the nurse transnationally, as role and scope of practice can differ based on regulatory bodies, minimum educational requirements, and practice settings.

Within this research, nurse participants were employed by the provincial health authority. Research opportunities exist to compare the role of the nurse within provincially funded addictions treatment, non-profit addictions treatment, and privatized addictions treatment programs. Comparative research between these settings could provide further insight into the difference in scope of practice, team composition, availability of resources, patient retention and treatment compliance, as well as longer-term patient outcomes.

Future research designs should critically examine and incorporate principles of equity, diversity and inclusion (EDI). Critical social theory could address the ways in which societies or communities are oppressive and unjust (Manias & Street, 2000) toward people who use opioids to gain further insight into these important issues. Additionally, participatory action research involves researchers and participants working together to understand and change problematic situations (Schubotz et al., 2019). This type of research would be beneficial in ensuring appropriate research questions and processes are formulated to address EDI. Involving and including diverse populations in research, such as indigenous populations, immigrant populations, youth, incarcerated people, and homeless populations, is imperative. Research should also explore OUD and EDI as it pertains to the social determinants of health (SDOH) (CNA, 2022).

Finally, more research should be conducted about stigma intervention in OUD treatment settings. The results of this study highlight the impact of stigma on the role of the OUD nurse as well as how nurses perceive stigma towards patients with OUD. Tsai et al. (2019) stated:

> Stigma influences everyday attitudes, agenda setting, and policy-making. Stigma compromises the financing of care for OUD, shapes the distribution of access to care, and impinges upon care delivery. Stigma even undermines the health of people with OUD in ways that have nothing to do with the treatment of OUD. (p. 7)

Research on the impact of stigma intervention can help provide further insight and strategies for staff, organizations, and policymakers to decrease stigmatizing language, beliefs, and values, reform stigmatizing policy, and improve patient interactions with the healthcare system.

5.8 Limitations

Due to the number of programs included to recruit participants, a sample size of approximately two participants per program was implemented. While this was purposeful in gaining a wide variety of perspectives on the nursing role, it also could have limited some of the specific nuances within each program from being presented during participant interviews. As the result of limited resources and COVID-19 restrictions, I was only able to complete one day of participant observation. Further participant observation at more programs could yield further insights into the nurse's role in OUD treatment. Additionally, the transferability of the results could be limited, as the sample of participants for this research was specific to registered nurses working within one urban city in Alberta, Canada. The goal of focused ethnography is to provide a knowledge base from which to further understand the experience of the population being researched (Roper & Shapira, 2000). Readers of this study need to carefully evaluate the

findings to determine if they are transferable to nurses working in OUD treatment in other locations.

The programs included in this study were all funded by the provincial health authority. I did not include any programs or sites from the non-profit sector of services offered to treat OUD. This decision was due to limitations with gaining entry to these sites, and staffing patterns in these programs. With smaller budgets, non-profit organizations might be more likely to employ licenced practical nurses, peer support workers, and social workers within their programs. As this study focused on the role of the registered nurse, it was important to identify programs that had registered nurses to gain an understanding of their role and scope of practice. Scope of practice differs between nursing groups; licenced practical nurses have a different scope of practice than registered nurses. As such, all nurses should be aware of how these results could be interpreted based on their own ability, fitness to practice, and understanding of patient care based on the context of their training and education.

Additionally, residential addiction treatment programs were not included because there were no provincially funded residential addiction programs in the urban study area. Although the provincial health authority does fund some residential treatment programs in other areas of the province, many residential treatment programs are privatized. Further research on the role of the nurse in residential treatment programs would be beneficial.

The majority of participants self-identified as relating closely to harm reduction principles. Only one of the participants believed abstinence-based treatment could be beneficial for certain OUD patients. This could be due to a general shift in practice identifying OAT and harm reduction as first-line approaches to OUD treatment. Although this research did not purposefully exclude participants who identified with abstinence-based philosophies, it is

important to note that none of the participants interviewed identified this as their primary approach to approaching OUD treatment. It is possible that research completed in residential treatment facilities could produce more knowledge on nurses who identify more closely with abstinence-based philosophies.

This study examined nurses' perceptions and understanding of their role in OUD treatment. The interpretation of collected data across practice areas, themes, and subthemes was conducted through my own lens of understanding. Though I sought to remain impartial through attention to reflexivity through personal and professional reflections, field notes, memoing, and member checking, the possibility of misinterpretation exists due to my own experiences and emic knowledge of the role of the nurse in OUD treatment. Interpretation is one of the key characteristics of focused ethnography, and it is impossible to interpret results without a subjective perspective (Venzon Cruz & Higginbottom, 2013). "The task of the [social constructionist] researcher becomes to acknowledge and even to work within their own intrinsic involvement in the research process and the part that this plays in the produced results" (Burr, 2003, p. 107). However, the findings of this study provide considerable insight into how nurses function within their role in OUD treatment and how they could contribute even more to the provision of care to clients. These findings also create opportunities for discussion and further research among healthcare professionals, front-line healthcare leadership, provincial governments, funders of programs and services, and advocates for people with OUD.

Chapter 6: Conclusion

Opioid use disorder is a multifaceted and complex public health issue (Tsai et al., 2019) involving the problematic use of opioids (CRISM, 2018). Opioid use disorder causes increased levels of opioid tolerance, which leads to physical dependence (Government of Canada, 2022). The costs of OUD and the rate of hospitalization related to opioid-related harms are rising (Canadian Institute for Health Information, 2018). Opioid toxicity leads to approximately 20 deaths in Canada per day (Government of Canada, 2022). In response to the opioid epidemic, the Government of Canada has decreased prescriber restrictions for OAT treatment to decrease barriers patients may face in seeking opioid replacement healthcare services (Canadian Centre on Substance Use and Addiction, 2018). "While the federal government is able to make policy changes to regulations and has provided $150 million to the provinces and territories to enhance evidence-based treatment [for OUD], the individual [provinces] are responsible for service delivery" (Canadian Centre on Substance Use and Addiction, 2018, p. 11). Evidence supports the need for people to have access to comprehensive treatment options and the importance of working with knowledgeable healthcare providers when setting goals for their OUD treatment (BCCSU, 2017; Canadian Centre on Substance Use and Addiction, 2018). Treatment for OUD can include a variety of interventions such as screening, harm reduction care, withdrawal management, pharmacologic interventions such as OAT, abstinence-based treatment, and psychosocial interventions (Canadian Centre on Substance Use and Addiction, 2018).

Nurses often spend the most time with patients who have OUD when they seek healthcare treatment (Horner et al., 2019; Ling et al., 2017; Sowicz et al., 2022). "Nurses are in a position to play a critical role in the opioid epidemic battle" (Kidd et al., 2020, p. 21). Nurses work with patients who have OUD across a variety of practice settings, including hospitals,

community clinics, and OUD treatment programs. Nurses working with OUD patients often face challenges that differ from those in mental health nursing or other nursing specialities (Ling et al., 2017). It has been documented that the role of the nurse in OUD treatment is unclear and not well understood (Abram, 2018; McCall et al., 2019). It is important to have a comprehensive understanding of the role of the nurse in OUD treatment to continue to advance this practice area (Sowicz et al., 2022). As the nurse's role continues to evolve, OUD nurses should be able to articulate their unique knowledge base and understanding of their role when providing care to clients (Clancy et al., 2019; Sowicz et al., 2022). This qualitative research study provided insight into how nurses understand their role and its impact in providing care to clients in OUD treatment. Six themes emerged from the data to summarize how nurses understood their role in providing care to patients with OUD, the factors influencing their role, and the impact of their role on patient care. These six themes include: (a) the art of addiction nursing, (b) direct patient care, (c) indirect patient care, (d) the shared experience of stigma, (e) perceived barriers, and (f) looking to the (uncertain) future.

Based on the present study, I have offered several implications for nursing practice and healthcare, nursing education, and health research. Nurses must continue to advocate for expanded access to OUD treatment within the healthcare system. The results of this study highlight perceived challenges related to a disconnection between policymakers, high-level healthcare leadership, and evidence-based OUD treatment options. Participants recognised healthcare funding priorities, driven by divisive government ideology, could negatively impact OUD patient care. Lack of consistent funding leads to increased nurse turnover, challenges with staffing, and programs with uncertain timelines, leading to an increased risk that patients disengage from services because they feel devalued and stigmatised. Clearer communication

from leadership regarding the nurse's role in OUD treatment could inform program-specific policy and procedure documents, leading to well-defined role designations in the provision of care. Additionally, nurse participants overwhelmingly identified difficulties with feelings of burnout. More supports are needed to address the underlying issues that could lead to the experience of nurse burnout. Implications for nursing education included clearer and more comprehensive addictions treatment education at the undergraduate level and increased OUD treatment educational opportunities within the healthcare system. Nurse participants believed increased education would have a direct impact on stigma reduction. Finally, this study highlighted several implications related to future research. Further research should be conducted to better understand the impact of targeted OUD treatment education on stigma reduction within the healthcare system. The present study identified similarities and differences in the role of the nurse working across a variety of treatment programs; future research opportunities exist to explore the nurse's role in specific OUD treatment programs, and the role of the nurse in OUD treatment transnationally.

In conclusion, the role of the registered nurse is understood to have significant impact in OUD treatment. With an upward trend in opioid-related harms and deaths across Canada, healthcare leaders need to support nurses in providing care to clients with OUD. Nurses working in this practice area are deeply committed to fostering transformative relationships with patients who have historically been marginalized and treated poorly by the healthcare system. These nurses are steadfast in acknowledging the intrinsic worth of these vulnerable people. They believe supportive care practices can be strengthened and will improve their patients' quality of life. However, nurses emphasized perceived challenges and barriers which negatively impact their ability to meet patients' needs. The current focus on the opioid epidemic stresses the

extensive opportunities for nurses working in OUD treatment to significantly impact patient outcomes. Participant B concludes, “I think we’ve progressed, but we’re not quite there yet.”

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Taylor, J. L., Johnson, S., Cruz, R., Gray, J. R., Schiff, D., & Bagley, S. M. (2021b). Integrating harm reduction into outpatient opioid use disorder treatment settings. *Journal of General Internal Medicine, 36*(12), 3810–3819. https://doi.org/10.1007/s11606-021-06904-4

Tsai, A. C., Kiang, M. V., Barnett, M. L., Beletsky, L., Keyes, K. M., McGinty, E. E., … Venkataramani, A. S. (2019). Stigma as a fundamental hindrance to the United States opioid overdose crisis response. *PLoS Medicine, 16*(11), e1002969–e1002969. https://doi.org/10.1371/journal.pmed.1002969

Venzon Cruz, E., & Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36–43. https://doi.org/10.7748/nr2013.03.20.4.36.e305

Wilson, K., MacIntosh, J., & Getty, G. (2007). “Tapping a tie”: Successful partnerships in managing addictions with methadone. *Issues in Mental Health Nursing, 28*(9), 977–996. https://doi.org/10.1080/01612840701522176

Appendix A – Search Strategy

MEDLINE:

#	SEARCH TERM	RESULTS
1	(opi* adj3 treatment).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	10503
2	(opi* adj3 clinic).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	148
3	(methadone adj3 clinic).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	286
4	(heroin adj3 treatment).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	1140
5	hydromorphone.mp. or exp Hydromorphone/	2098
6	diacetylmorphine.mp. or exp Heroin/	5648
7	exp Buprenorphine/ or buprenorphine.mp.	7488
8	methadone.mp. or exp Methadone/	16670
9	injectable opi* treatment.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	16
10	injectable opi* agonist treatment.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	10
11	exp Opiate Substitution Treatment/ or opi* substitution treatment.mp.	3016
12	exp Opioid-Related Disorders/ or medication assisted treatment.mp. or exp Opiate Substitution Treatment/	26708
13	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	48805
14	exp Nurse's Role/ or nurs* role.mp.	43813
15	addiction nurs*.mp.	20
16	(addiction adj3 nurs*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	101
17	14 or 15 or 16	43903

18	**13 and 17**	**84**

PsycINFO:

#	SEARCH TERM	RESULTS
1	(opi* adj3 treatment).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	4286
2	(opi* adj3 clinic).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	69
3	(methadone adj3 clinic).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	257
4	(heroin adj3 treatment).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	946
5	hydromorphone.mp. or exp Hydromorphone/	323
6	diacetylmorphine.mp. or exp Heroin/	2788
7	exp Buprenorphine/ or buprenorphine.mp.	2945
8	methadone.mp. or exp Methadone/	8026
9	injectable opi* treatment.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	16
10	injectable opi* agonist treatment.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	5
11	exp Opiate Substitution Treatment/ or opi* substitution treatment.mp.	1372
12	exp Opioid-Related Disorders/ or medication assisted treatment.mp. or exp Opiate Substitution Treatment/	3930
13	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	14523
14	exp Nurse's Role/ or nurs* role.mp.	45756
15	addiction nurs*.mp.	24
16	(addiction adj3 nurs*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	80
17	Nurs*	108134

18	14 or 15 or 16 or 17	108134
19	**13 and 18**	**234**

CINAHL:

#	SEARCH TERM	RESULTS
1	opi* treatment or "Opioid Substitution Treatment"	
2	opi* clinic	
3	methadone clinic	
4	heroin treatment or "heroin"	
5	Hydromorphone or "hydromorphone"	
6	Diacetylmorphine or "diacetylmorphine"	
7	Buprenorphine or "buprenorphine"	
8	Methadone or "methadone"	
9	injectable opi* treatment	
10	injectable opi* agonist treatment	
11	opi* substitution treatment	
12	medication assisted treatment	
13	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	29711
14	nurs* role or "Nurse's Role"	
15	addiction nurs*	
16	14 or 15	111357
17	**13 and 16**	**531**

SUBJECT HEADINGS:

- Substance Abuse Treatment Centers
- Opioid Substitution Treatment
- Opioid Related Disorders
- Heroin Dependence
- Opiate Substitution Treatment
- Methadone
- Buprenorphine
- Heroin
- Hydromorphone
- Nurses Role

Appendix B – Literature Appraisal Matrix and Thematic Analysis

Citation	Aim	Sample Size and Population	Design, Methodology, Measurement	Intervention	Results	Strengths	Weaknesses	Comments
Abram, M. D. (2018). The role of the registered nurse working in substance use disorder treatment: A hermeneutic study. *Issues in Mental Health Nursing, 39*(6), 490–498. doi:10.1080/01612840.2017.1413462	Describe the meaning of the professional role of the registered nurse working in the substance use disorder (SUD) setting.	N = 9 Purposive Sampling Registered Nurses working in SUD treatment	Qualitative Heideggerian Phenomenology w/ a modified Colaizzi method for analysis and interpretation	Audiotaped interviews Broad questions & probe questions	- *3 major themes* (sub themes): *Defining the role for Self* (overcoming the outsiders' view; the medical tasker; managing the structure: the enforcer, the custodial caretaker, the cheerleader; comfort in the handmaiden role) *Learning the Role* (coping to avoid burnout; experience: the mother of all learning; the savvy nurse) *Navigating with Ease in an Unchangeable Culture* (rigid role boundaries provided comfort; patient relapse/recovery determined job satisfaction; reflecting on an evolving contemporary role)	- Participants worked in variety of settings - Discussed reflexivity - Literature supported study results - Clear identification of the role of the RN in SUD treatment	- Small sample size - Limitations not addressed	- Thorough review of a variety of different areas nurses working in substance use disorder treatment work, leading to a broad conceptualization of the role of the nurse
Azimi-Bolourian, S., & Fornili, K. (2010). Buprenorphine: A guide for nurses (technical assistance publication). *Journal of Addictions Nursing, 21*(4), 183-186. doi: 10.3109/10884601003628146	This guide highlights the addiction management skills of nurses and promotes a mutually respectful team environment to improve care for clients who have OUD.	Resource Guide			- Helps nurses to apply evidence-based practice during pt. assessment, induction, stabilization, maintenance, and medical withdrawal if appropriate. - Role of the nurse: Conducting, screening, assessment, tx monitoring, counselling and supportive services, educating about buprenorphine therapy, improving access, assisting patients in accessing care elsewhere as needed.	- Clear identification of the nurse's role in BUP therapy	- Not a research study, so limited in terms of informing evidence-based practice - Unclear rationale for selection of materials used in manuscript	
Bernhardt, J. M. (2021). Nurse-sensitive indicators in the care of individuals with opioid use disorder. *Journal of Addictions Nursing*, Publish Ahead of Print. doi: 10.1097/JAN.0000000000000431	To determine if nurses working in an ambulatory opioid treatment clinic provide nurse-sensitive care, which consists of activities that make a difference in patient outcomes	N = 100 All records screened (total of 256, 25 excluded for not having a nurse intake visit recorded)	Content Analysis of 368 nursing notes from 100 patients enrolled at one urban ambulatory opioid clinic	Three data collectors conducted a retrospective chart review of nursing notes to identify statements related to identify Nurse-sensitive indicators	- 368 nursing notes that included statements indicative of nurse activities categorized as either care coordination (*n*=321), or transition management (*n*=288) - *Care Coordination*: discussed harm reduction techniques, medication management, assessment of withdrawal, communication, promoting adherence to care plan, goal setting, general health education - *Transition Management*: connection to social support/community resources,	- Identification of the role of the nurse working in an outpatient opioid clinic	- Only reviewed nurse-sensitive indicators at one location with a relatively small sample size	

					referral facilitation, medication reconciliation, direct prehospital and posthospital needs			
Clancy, C., Kelly, P., & Loth, C. (2019). State of the art in European addictions nursing: Perspectives from the United Kingdom, Ireland, and the Netherlands. *Journal of Addictions Nursing,* 30(3), 139-148. doi: 10.1097/JAN.0000000000000293	Reviews addiction nursing in the UK, Ireland, and the Netherlands.	Research Review			- Highlights the variety of ways addiction nurses are utilized and how the role can differ substantially. - Role can vary from medication administration to case manager or nurse-led programming. - Harm reduction highlighted across all 3 countries. - There is no definition on what the role covers and there is a lack of clear career pathways. - Addictions nurses work across a range of practice areas. - Future key areas of work include: fighting stigma, raising awareness, focusing on recovery, preparing education for other nurses, and designing a scope and standards for addiction nursing.	- Provides suggestions for how nurses can assert their autonomy and expand their role	- Not a research study, so limited in terms of informing evidence-based practice - Varying data collection from each country which suggests the data might be based more on opinion.	
Clancy, C., Oyefeso, A., & Ghodse, H. (2006). Role development and career stages in addiction nursing: An exploratory study. *Journal of Advanced Nursing, 57*(2), 161–171. doi:10.1111/j.1365-2648.2006.04088.x	To explore factors influencing recruitment and retention in addiction nursing, and the stages and features of role acquisition and personal qualities important to that role.	N = 26 Purposive Sampling Addiction nurses	Qualitative Focus Groups (4) Analysis based on Burnard's (1991) Six Content Stages	Semi-structured topic guide asked to each focus group	- Positive factors influencing recruitment and retention: prior knowledge of working environment, opportunities for autonomous practice, client profile, associated treatment philosophy and care approach - Consensus that nurses need to be non-judgmental, and have the personal characteristics of hardiness, patience and tolerance. - 5 Role development stages: (i) encounter, (ii) engagement, (iii) stabilization, (iv) competency, and (v) mastery	- Explores some of the factors that lead nurses to selecting to work in SUD treatment - Identifies characteristics required for nurse success	- Exploratory study - Findings may not apply to other parts of the UK or elsewhere - Data analysis did not take account of the influence of clinical work setting (ex. community vs residential)	- Research is a bit outdated (conducted in 2004)
Clark, A. D., & Lucey, J. R. (2021). A thematic synthesis of the roles of nurses at safer consumption sites. *Journal of Addictions Nursing, 32*(4), 235–248.	Describe and synthesis the roles of nurses at SCSs to better understand their importance in a rapidly proliferating public health intervention	N = 48 articles	Thematic Synthesis 4 Electronic Databases Used	Qualitative, peer-reviewed gray literature and primary source narrative articles, 1992-2016	- 11 Roles encompassing a breadth of nursing interventions within three analytical themes - *The primary aim of SCS Nursing Care is to reduce Morbidity and Mortality*: Observing injection and responding to overdose, creating a safer environment and respite, providing safer injection	- Clear description of the role of the nurse - Current research - Clear search strategy and review of articles	- Focused specifically on the role of the nurse in SCS, findings may not apply to nurses working in other areas related to OUD treatment	

doi:10.1097/JAN.0000000000000435					education, providing primary nursing care - *SCS Nurses Create a Therapeutic Community*: Being present, building relationships and affirming worth, offering mental health nursing care, increasing access to services - *SCS Nurses Engage in Research, Professional Activities, Ethical Deliberation, and Activism to Better Understand and Promote SCSs*: Conducting research and participating in professional activities, translating ethics into action, engaging in activism,			
Comiskey, C., Galligan, K., Flanagan, J., Deegan, J., Farnann, J., & Hall, A. (2019). Clients' views on the importance of a nurse-led approach and nurse prescribing in the development of the healthy addiction treatment recovery model. *Journal of Addictions Nursing, 30*(3), 169–176. doi:10.1097/JAN.0000000000000290	Establish from clients their nursing needs and to use these findings alongside an objective measurement of clients' health, to inform the development of a nurse-led treatment model	N = 131 Convenience Sample Clients from 6 methadone (MTD) clinics	Qualitative Cross-sectional survey Data analysis with 6-phase guide by Braun & Clark (2006); enabling qualitative data to be grouped into themes	Interviews with open-ended questions	- *6 key themes* (sub themes)*:* Physical care and assessment; essential sources of mental health, psychological, and trauma support; expanding the autonomy of the nurse's role (prescribing and dispensing. communicating client needs, additional checks by nurses); managing MTD treatment (managing dose reductions, length of time in treatment, client autonomy and voice); facilitate access to other services; additional resources	- Large sample size - Visual diagram depicting role	- Convenience sample - Other limitations not addressed	- Helpful diagram that shows what the nurse can help with, what is currently working well, and what is missing from nursing services
Demaret, I., Lemaitre, A., & Ansseau, M. (2012). Staff concerns in heroin-assisted treatment centres. *Journal of Psychiatric & Mental Health Nursing, 19*(6), 563–567. doi:10.1111/j.1365-2850.2011.01810.x	Visited 7 heroin assisted treatment (HAT) centres in order to observe heroin administration and gain info useful to create a protocol	N = 7 (1 nurse interviewed at each site) Purposive sample	Qualitative Unclear methodology, seems exploratory without specific details	No standardized list of questions 4 interviews were recorded	- Concerns were identified based on 3 separate times of client interaction: Before administration (closing time, concern for the risk of overdose (OD)); During administration (diversion of diacetylmorphine (DAM), injection rituals, incorrect needle sizes), and After administration (long wait time was concern for clients but appreciated by staff to enhance therapeutic relationship) - Nurse role consisted of monitoring, dispensing of medication, and clinic flow	- iOAT focused	- Inconsistent collection of data (only 4 interviews were recorded, only 2 sites allowed observation of HAT admin, 2 visits were in a group context) - Limitations not addressed - Unclear rationale for	- Nurses were invested in HAT treatment - Nurses identified that wait times following injection were beneficial to enhance relationships with clients

							variation in data collection	
Deren, S., Naegle, M., Hagan, H., & Ompad, D. C. (2017). Continuing links between substance use and HIV highlight the importance of nursing roles. *JANAC: Journal of the Association of Nurses in AIDS Care, 28*(4), 622–632. doi:10.1016/j.jana.2017.03.005	Review of the evidence-based interventions that decrease HIV risk in people who use drugs (PWUD)	Research Review			- Addressed substance use by people living with HIV (PLWH) - 4 key interventions for PWUD: (i) needle/syringe programs, (ii) medication assisted treatment (MAT), (iii) engagement in the HIVE care continuum (including ART), (iv) pre/post-exposure prophylaxis (PrEP/PEP) - Role of the nurse is patient care, education, program administration, research, case management	- Thorough overview and connections between the care nurses can provide in HIV care and with PWUD	- Not a research study, so limited in terms of informing evidence-based practice - Unclear rationale for selection of materials used in manuscript	
Go, F., Dykeman, M., Santos, J., & Muxlow, J. (2011). Supporting clients on methadone maintenance treatment: A systematic review of nurse's role. *Journal of Psychiatric & Mental Health Nursing, 18*(1), 17–27. doi:10.1111/j.1365-2850.2010.01628.x	Discusses findings from a systematic review of literature pertaining to MTD maintenance in relation to the role of the nurse working in a general practice setting	N = 32 articles	Systematic Review 5 Electronic Databases used	Included studies were peer reviewed, no earlier than 2000, represented a primary study, systematic review or meta-analysis, not for pain, and were English	- *3 broad themes*: identifying the client's personal characteristics, having knowledge about methadone, supporting clients in MTD programs - Tasks found to be most important: administer MTD, observe patient condition, provide counselling, offering ongoing support as needed - Screening and assessment are important	- Used multiple tools to assess the quality of literature included in the review - Table included that reviews literature	- Search strategy was broad - Small # of articles included - Studies included were heterogenous in design - Most studies did not directly look at nurse's role - Difficult to compare findings across studies	- Only 1 article was directly related to the nurse's role in MTD programs, which shows the gap in the literature
Happell, B., & Taylor, C. (1999). "We may be different, but we are still nurses": An exploratory study of drug and alcohol nurses in Australia. *Issues in Mental Health Nursing, 20*(1), 19–32. doi:10.1080/mhn.20.1.19.32	Reports on a qualitative research project exploring the specific skills nurses have when working with patients who abuse alcohol and drugs	N = 6 Convenience Sample Nurses working on a Drug/ETOH unit in Australia	Qualitative exploratory design Trustworthiness of data based on the principles by Lincoln & Guba (1995), member checking	Semi-structured interviews	- Role is less task-oriented - Primary skills: physical skills, assessment and management skills, group therapy skills, and communication skills - Greater involvement of patient in decision making - Liaison role - Sense that nurses working in general settings did not understand their unique role	- Clear articulation of the skills and role of the nurse on an in-patient drug and ETOH unit	- Outdated literature (from 1999) - Small sample size - Limitations not addressed	
Konrad, S. (2004). Nursing in addictions services. *Alberta RN /*	Review of the role of the nurse working in	Research Review			- Detox; supervise withdrawal, medication management, physical	- Pertinent information to this research proposal	- Article is from 2004	- Canadian Literature

Alberta Association of Registered Nurses, 60(11), 8-9. Retrieved from: http://ezproxy.lib.ucalgary.ca/login?url=https://search-proquest-com.ezproxy.lib.ucalgary.ca/docview/67215360?accountid=9838	addictions services within Alberta.				assessments, responsible for direct client care, team environment - Residential Tx; Support clients undergoing psychotherapeutic interventions, assess and screen applications, patient education or counselling, referral to other services - Opioid Dependency Programs; provide treatment, assist physicians, administering medications, assessments, referrals as needed.	as the research will be conducted in Alberta	- Not a research study, so limited in terms of informing evidence-based practice - Unclear rationale for selection of materials used in manuscript	
Ling, S., Watson, A., & Gehrs, M. (2017). Developing an addictions nursing competency framework within a Canadian context. *Journal of Addictions Nursing, 28*(3), 110-116. doi:10.1097/JAN.0000000000000173	Describes the method used by the Advanced Practice Nurses at a large, Canadian urban teaching hospital to discuss actual or potential opportunities for an Addiction Nursing Competency Framework with a Canadian Context	N = 14 Convenience sample Nurses with an average of 14 years of experience.	Qualitative Exploratory Design	Adaptation of the CCSA's competencies framework by (a) selecting elements that were modified to include content from nursing and addiction medicine literature and (b) key stakeholder validation by focus group discussion	- Competencies include: understanding concurrent disorders and substance use, case management, community development, counselling. family and social support, group facilitation, medication management, outreach, prevention and health promotion, screening and assessment, trauma-informed care, treatment planning and referrals and physical crisis intervention.	- Comprehensive review of the nurse's role in Canada in addiction care	- Small sample size - Results could be taken further to be validated and distributed more widely	- Canadian literature
McCall, J., Phillips, J. C., Estafan, A., & Caine, V. (2019). Exploring the experiences of staff working at an opiate assisted treatment clinic: An interpretive descriptive study. *Applied Nursing Research, 45*, 45–51. doi:10.1016/j.apnr.2018.12.003	Uncover how clinic staff provide care to those who attend an iOAT clinic, and their opinions about the program itself	N = 22 Convenience sample 18 nurses, 2 social workers, and 2 peer support workers	Qualitative Interpretive descriptive methodology underpinned with critical social theory Thematic analysis	In-depth semi-structured individual interviews that were audiotaped Open-ended questions 2 follow up focus groups were held to obtain feedback on preliminary findings	- *6 themes*: From chaos to stability; It's not all roses; A little preparation would be good; Putting the patient at the center; The stigma hasn't gone away; and the clinic is life transforming	- iOAT focused - Focus groups to review preliminary findings can ensure accuracy of the thematic analysis	- Not directly related to nursing role - Limitations not addressed	- Recent publication
Mumba, M., & Snow, D. (2017). Nursing roles in addiction care. *Journal of Addictions*	A review of the historical and chronological role	Research Review			- The authors believe that they key areas where nursing as a profession could be influential are in advocacy and patient education, screening, brief	- North American focused articles - Review of the organizations and	- Not a research study, so limited in terms of informing	- Reviewed grey literature from IntNSA and they are

Nursing, 28(3), 166–168. doi:10.1097/JAN.0000000000000181	of the nurse in addictions				intervention and referral to treatment, increasing competency and shaping of health policy through research and evidence-based practice - Nursing has historically been the "invisible" member of the treatment team	associations that are in place trying to advance Addictions Nursing (IntNSA)	evidence-based practice - Unclear rationale for selection of materials used in manuscript	currently updating their Nursing Role guidelines, so was unable to use this literature to support my lit review
Naegle, M. A. (2015). Nursing care in alcohol and drug user treatment facilities. *Substance Use & Misuse, 50*(8/9), 1153–1158. doi:10.3109/10826084.2015.1007681	Highlights the increasing demand for the delivery of integrated care to psychiatric and substance use populations	Research Review			- Factors related to funding, management, and de-centralization (various treatment approaches and ideologies) and the nursing profession itself contribute to the long-standing failure to maximize nursing competencies in addiction treatment - Narrow interpretation of the nursing role prevents health promotion, counselling, education, and harm reduction strategies from being implemented by nurses	- Examines barriers to full scope utilization of nurses in North America	- Not a research study, so limited in terms of informing evidence-based practice - Unclear rationale for selection of materials used in manuscript - Similar articles used as above article	
Plaza A., Oviedo-Joekes E., & March J. C. (2007). Nursing in an intravenous heroin prescription treatment. *Journal of Addictions Nursing, 18*(1), 13–20. doi:10.1080/10884600601174425	To describe the nursing actions provided in the care of patients in an iOAT program	N = 62 Patients were identified as the population, despite the article looking at nurse role	Unclear	Unclear – a description of the nurse's role within the clinic is provided	- Nursing performance comprised of administration and supervision of the treatment and other actions aimed at reducing harm, encouraging healthy habits, monitoring the patient and counselling - Described flow of patient through the clinic and the nurse's actions with each stage - Highlighted injection technique education - Health workshops and education sessions; not highly attended and were regarded as a failure	- iOAT related - Articulates the specific role of the nurse	- Unclear study design, methodology, measurement or participant profile - Unclear data collection strategies - Unclear ethics approval - Identified that conclusions were drawn from the data due to data collection techniques	
Seabra, P. R. C., Amendoeira, J. J. P., & Sá, L. O. (2018). Testing nursing sensitive outcomes in	To identify factors that contribute to a better outcome in drug users and to understand the	N = 180 clients N = 10 nurses Randomly selected	Quantitative Correctional, Cross Sectional Study	A variety of surveys and socio-demographic variables were collected	- Treatment time, lower co-morbidities, less poly-drug use, family support and being employed contribute to a better quality of life, better mental health, less substance addiction consequences, and	- Process of random selection clearly articulated	- Sample of nurses is small - Timespan since collection of data and interpretation	- Only quantitative study identified

out-patient drug addicts, with "nursing role effectiveness model." *Issues in Mental Health Nursing, 39*(3), 200–207. doi:10.1080/01612840.2017.1378783	effectiveness of nursing interventions by applying "Nursing Role Effectiveness Model" (NREM)	participants from 3 community services	Combined correlational, factorial analysis with linear regression techniques to demonstrate the adequacy of the theoretical model		more satisfaction with nursing care ($p < 0.05$) - Nursing care contributes to 29% of health outcomes improvement	- Process of ethics and consent described	of data (due to PhD research that required time delay before publication of findings)	
Sowicz, T. J., Huneycutt, B., & Lee, J. M. (2022). Nurses' practices with persons experiencing opioid use disorder: A narrative literature review. *Journal of Addictions Nursing, 33*(1), 3–12. doi:10.1097/JAN.0000000000000444	To understand nurses' actions, practices, and work with persons with OUD.	N = 21 articles	Narrative Literature Review 4 Electronic Databases	Included studies between 1989-2018 that included human subjects and were in English, articles that were related to the purpose of the review, full text availability and had nurses as participants	- Used Implementation, Assessment, Diagnosis, Planning, Evaluation and Outcomes Identification to organize the themes - Implementation: preparing and administering medications, communication, group therapy, managing an overdose, treating pain, wound care, coordination of care, health teaching and promotion, consultation - Assessment: health and physical, vitals, family support, pain, intoxication - Diagnosis: overdoses and intoxication, problematic drug use, behaviours resulting from pain - Planning: discharge planning begins early - Evaluation: progress, surveillance, follow-up, monitoring of medication - Outcomes identification: identifies outcomes and plans healthcare individually	- Clearly described search strategy - Organization of themes into a recognizable framework	- Inclusion and exclusion criteria were a bit vague	- Some of the research included is outdated to current practices with treating OUD
Strobbe, S., Mathias, L., Gibbons, P. W., Humenay, E., & Brower, K. J. (2011). Buprenorphine clinic for opioid maintenance therapy: Program description, process measures, and patient satisfaction. *Journal of Addictions Nursing, 22*(1/2), 8–	Describe a quality improvement project for a monthly buprenorphine (BUP) clinic for opioid maintenance therapy	N = 12 BUP clients contacted by the nurse to participate Purposive Sample	Mixed Methods Patient satisfaction surveys, urine drug screens (UDS), and clinic attendance were examined	A single monthly visit to a multidisciplinary team (psychiatrist, addictions nurse, and social worker) in the evenings to have a prescription renewal, urine drug tests, and participate in a	- Patients attended 90% of scheduled clinic sessions, with more than half attending all available sessions when enrolled - 37/40 UDS' were negative for ETOH, and 39/40 were negative for other drugs - Addictions nurse (i) participated in design and implementation of the model, (ii) identified and contacted prospective patients, (iii) arranged referrals, (iv) assisted the MD with prescription management, (v) collected	- Identified the role of the nurse within this specific service delivery model - Clear description of data analysis	- Small number of patients - Selection and Self-Selection bias - Short evaluation period - Highly specialized treatment setting - Homogenous sample (educated	- Only mixed methods - Used a variety of tools to examine effectiveness

12. doi:10.3109/10884602.2010.545090				group therapy session	UDS', (vi) provided education and support, (vii) assembled demographic data, and (viii) distributed and collected surveys		and employed Caucasian males) - Might not be generalizable results	
Wilson, K., MacIntosh, J., & Getty, G. (2007). "Tapping a tie": Successful partnerships in managing addictions with methadone. *Issues in Mental Health Nursing, 28*(9), 977–996. doi:10.1080/01612840701522176	To describe the development of the Fredericton Community Health Clinic (FCHC) and the findings in which nurse researchers interviewed stakeholders about their perceptions of, and experiences with, the role of nurses as it evolved within the FCHC.	N = 12 (6 nurses and 6 clients) Purposive Sample Stakeholders included nurses, students, volunteers, clients and workers in other agencies dealing with the FCHC	Qualitative Descriptive Design Analysis involved qualitative interpretation, themes coded line-by-line. All researchers negotiated 7 categories then coded remaining interviews and merged themes.	Semi-structured interviews	- *2 themes* (sub-themes): *Finding a Way Out* (Feeling trapped; Learning about MTD; Finding a safe place)*, Enhancing Client Capacity* (Supporting client attempts; Caring; Differences in care) - Nursing role was mostly captured under the Enhancing Client Capacity theme, and included education, support, establishing limits, communication physical care, personal care, emotional support, and maintaining therapeutic relationships - Developed a community that was viewed as being trustworthy	- Clear description of client perception of the role of the nurse (other studies examine nurse perception of their role) - Canadian Example	- Limitations not addressed - Single site model, not necessarily generalizable - Small sample size	

Article	Physical Care	Psychosocial Care	Healthcare Navigator
Abram, M. D. (2018). The role of the registered nurse working in substance use disorder treatment: A hermeneutic study. *Issues in Mental Health Nursing, 39*(6), 490–498. doi:10.1080/01612840.2017.1413462	X	X	X
Azimi-Bolourian, S., & Fornili, K. (2010). Buprenorphine: A guide for nurses (technical assistance publication). *Journal of Addictions Nursing, 21*(4), 183-186. doi:10.3109/10884601003628146		X	X
Bernhardt, J. M. (2021). Nurse-sensitive indicators in the care of individuals with opioid use disorder. *Journal of Addictions Nursing*, Publish Ahead of Print. doi:10.1097/JAN.0000000000000431	X	X	X
Clancy, C., Kelly, P., & Loth, C. (2019). State of the art in European addictions nursing: Perspectives from the United Kingdom, Ireland, and the Netherlands. *Journal of Addictions Nursing, 30*(3), 139-148. doi:10.1097/JAN.0000000000000293	X		X
Clancy, C., Oyefeso, A., & Ghodse, H. (2006). Role development and career stages in addiction nursing: An exploratory study. *Journal of Advanced Nursing, 57*(2), 161–171. doi:10.1111/j.1365-2648.2006.04088.x		X	X
Clark, A. D., & Lucey, J. R. (2021). A thematic synthesis of the roles of nurses at safer consumption sites. *Journal of Addictions Nursing, 32*(4), 235–248. doi:10.1097/JAN.0000000000000435	X	X	X
Comiskey, C., Galligan, K., Flanagan, J., Deegan, J., Farnann, J., & Hall, A. (2019). Clients' views on the importance of a nurse-led approach and nurse prescribing in the development of the healthy addiction treatment recovery model. *Journal of Addictions Nursing, 30*(3), 169–176. doi:10.1097/JAN.0000000000000290	X	X	X
Demaret, I., Lemaitre, A., & Ansseau, M. (2012). Staff concerns in heroin-assisted treatment centres. *Journal of Psychiatric & Mental Health Nursing, 19*(6), 563–567. doi:10.1111/j.1365-2850.2011.01810.x	X		X
Deren, S., Naegle, M., Hagan, H., & Ompad, D. C. (2017). Continuing links between substance use and HIV highlight the importance of nursing roles. *JANAC: Journal of the Association of Nurses in AIDS Care, 28*(4), 622–632. doi:10.1016/j.jana.2017.03.005	X	X	X
Go, F., Dykeman, M., Santos, J., & Muxlow, J. (2011). Supporting clients on methadone maintenance treatment: A systematic review of nurse's role. *Journal of Psychiatric & Mental Health Nursing, 18*(1), 17–27. doi:10.1111/j.1365-2850.2010.01628.x	X	X	X
Happell, B., & Taylor, C. (1999). "We may be different, but we are still nurses": An exploratory study of drug and alcohol nurses in Australia. *Issues in Mental Health Nursing, 20*(1), 19–32. doi:10.1080/mhn.20.1.19.32	X	X	X
Konrad, S. (2004). Nursing in addictions services. *Alberta RN / Alberta Association of Registered Nurses*, 60(11), 8-9. Retrieved from: http://ezproxy.lib.ucalgary.ca/login?url=https://search-proquest-com.ezproxy.lib.ucalgary.ca/docview/67215360?accountid=9838	X	X	X
Ling, S., Watson, A., & Gehrs, M. (2017). Developing an addictions nursing competency framework within a Canadian context. *Journal of Addictions Nursing, 28*(3), 110-116. doi:10.1097/JAN.0000000000000173	X	X	X
McCall, J., Phillips, J. C., Estafan, A., & Caine, V. (2019). Exploring the experiences of staff working at an opiate assisted treatment clinic: An interpretive descriptive study. *Applied Nursing Research, 45*, 45–51. doi:10.1016/j.apnr.2018.12.003		X	
Mumba, M., & Snow, D. (2017). Nursing roles in addiction care. *Journal of Addictions Nursing, 28*(3), 166–168. doi:10.1097/JAN.0000000000000181		X	X
Naegle, M. A. (2015). Nursing care in alcohol and drug user treatment facilities. *Substance Use & Misuse, 50*(8/9), 1153–1158. doi:10.3109/10826084.2015.1007681		X	
Plaza A., Oviedo-Joekes E., & March J. C. (2007). Nursing in an intravenous heroin prescription treatment. *Journal of Addictions Nursing, 18*(1), 13–20. doi:10.1080/10884600601174425	X	X	

Seabra, P. R. C., Amendoeira, J. J. P., & Sá, L. O. (2018). Testing nursing sensitive outcomes in out-patient drug addicts, with "nursing role effectiveness model." *Issues in Mental Health Nursing, 39*(3), 200–207. doi:10.1080/01612840.2017.1378783		X	
Sowicz, T. J., Huneycutt, B., & Lee, J. M. (2022). Nurses' practices with persons experiencing opioid use disorder: A narrative literature review. *Journal of Addictions Nursing, 33*(1), 3–12. doi:10.1097/JAN.0000000000000444	X		
Strobbe, S., Mathias, L., Gibbons, P. W., Humenay, E., & Brower, K. J. (2011). Buprenorphine clinic for opioid maintenance therapy: Program description, process measures, and patient satisfaction. *Journal of Addictions Nursing, 22*(1/2), 8–12. doi:10.3109/10884602.2010.545090	X	X	X
Wilson, K., MacIntosh, J., & Getty, G. (2007). "Tapping a tie": Successful partnerships in managing addictions with methadone. *Issues in Mental Health Nursing, 28*(9), 977–996. doi:10.1080/01612840701522176	X	X	
Canadian Research Initiative in Substance Misuse (CRISM). (2019). Injectable opioid agonist treatment (iOAT) for opioid use disorder. Vancouver, BC, Canada: Author. Retrieved from https://crism.ca/wp-content/uploads/2019/09/CRISM_National_IOAT_Operational_ Guideline-17Sept2019-English-FINAL.pdf	X	X	X

Appendix C – Research Poster & Presentation

Faculty of Nursing - University of Calgary

REGISTERED NURSE PARTICIPANTS NEEDED FOR

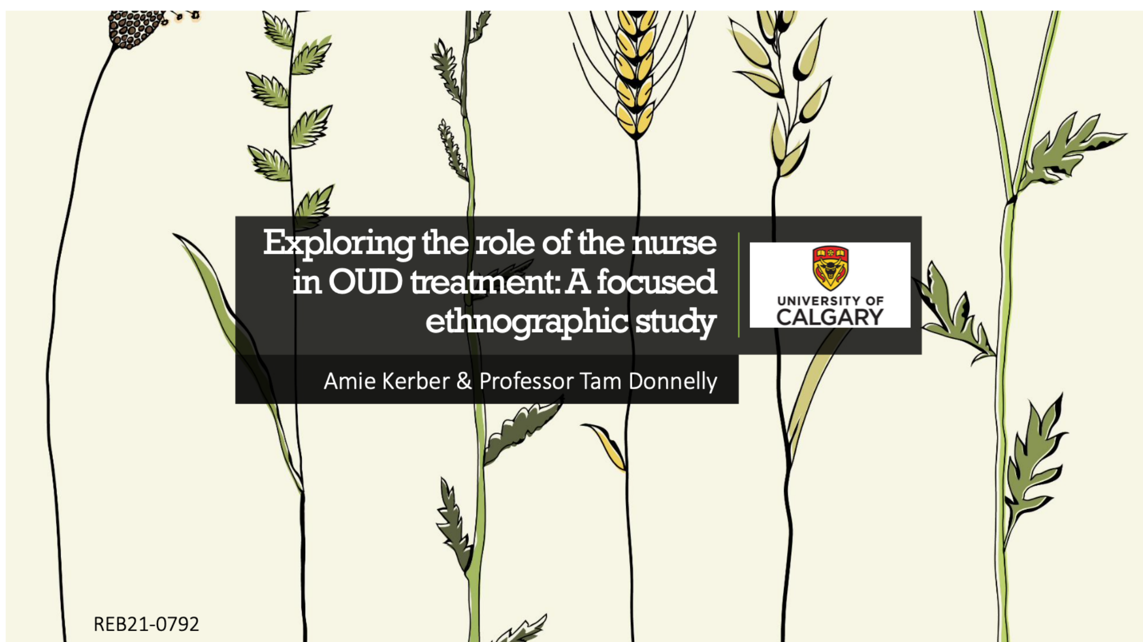
RESEARCH IN OPIOID USE DISORDER TREATMENT

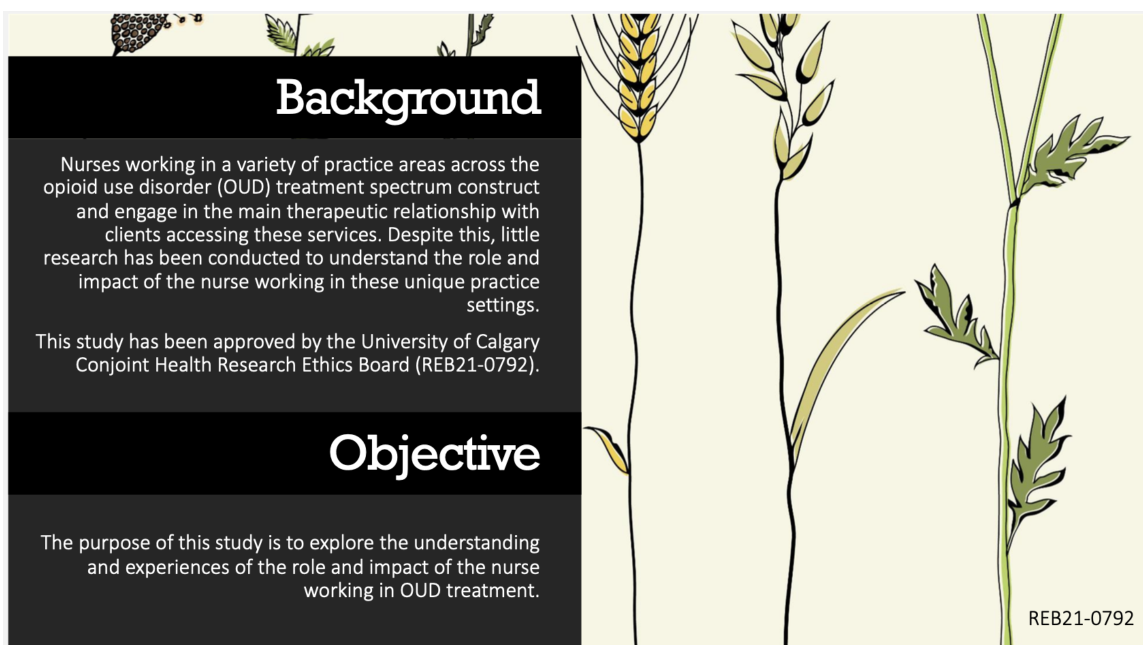
We are looking for registered nurse volunteers to take part in a study exploring the role of the nurse in opioid use disorder (OUD) and substance use disorder (SUD) treatment programs. As a participant in this study, you would be asked to complete one interview, lasting between 45 minutes to 1 hour.

In appreciation for your time, you will receive a $10 gift card.

For more information about this study,
or to volunteer for this study, please contact:
Amie Kerber
Faculty of Nursing

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board (REB21-0792)


Exploring the role of the nurse in OUD treatment: A focused ethnographic study
UNIVERSITY OF CALGARY
Amie Kerber & Professor Tam Donnelly
REB21-0792


Background
Nurses working in a variety of practice areas across the opioid use disorder (OUD) treatment spectrum construct and engage in the main therapeutic relationship with clients accessing these services. Despite this, little research has been conducted to understand the role and impact of the nurse working in these unique practice settings.
This study has been approved by the University of Calgary Conjoint Health Research Ethics Board (REB21-0792).
Objective
The purpose of this study is to explore the understanding and experiences of the role and impact of the nurse working in OUD treatment.
REB21-0792

Research Process

Identify Participants

Interested individuals can reach out to the primary interviewer to schedule an interview.

Interviews

In-depth individual interviews to gather data

Data Analysis

Ethnographic analysis will be used to discover an abstract network of interrelated concepts to explain the role of the nurse

REB21-0792

Role of the Nurse OUD

Method of Data Collection

Individual In-Depth Interviews

Interviews will be offered via secure telecommunication methods (i.e. Zoom) to mitigate the risk of COVID-19.

Nurse Participants

- Registered Nurse or Registered Psychiatric Nurse
- Minimum 2 Years of experience working in addictions treatment

Participation

One interview will be conducted with participants, that will last approximately 45-60 minutes. Interviews will be audio recorded for transcription purposes.

A $10 gift card will be provided to all participants.

REB21-0792

Benefits

Benefits of this research will impact the broader nursing profession.

- Informing evidence based practice regarding the value of the nurse role in SUD treatment
- Improving the utilization and clarity of the nursing role within addictions treatment
- Contribute to the development and implementation of the nurses role

REB21-0792

Role of the Nurse OUD

Summary

There is minimal research exploring how the role of the registered nurse can be optimized to maximize patient outcomes across the OUD treatment spectrum.

- Registered Nurse participants will be interviewed one time to explore their role in the program where they work
- If a participant identifies that a site tour will add value in understanding the role of their work in that setting, manager approval for a tour will be obtained. A site tour is not required to participate in an interview.
- A 45-60 minute investment of time is required for this study
- Confidentiality of all participant information will be maintained
- There is little risk to participate
- This research project has the potential to provide qualitative data on how the role of the nurse can benefit people with OUD, providing clarity and direction for future program planning.

REB21-0792

Role of the Nurse OUD

Appendix D – Consent Form

UNIVERSITY OF CALGARY

CONSENT TO PARTICIPATE IN RESEARCH (REB21-0792)

TITLE: Exploring the role of the nurse in opioid use disorder treatment: A focused ethnographic study

SPONSOR: University of Calgary, Faculty of Nursing – Graduate Program

INVESTIGATORS: Dr. Tam Truong-Donnelly, BScN, MScN, PhD, Amie Kerber, RN, BScN, MN Student

CO INVESTIGATORS: Dr. Aniela dela Cruz, PhD, MSc, RN, Dr. Candace Lind, PhD, RN

INTRODUCTION

Tam Truong-Donnelly, Principal Investigator, and associates from the Faculty of Nursing, Graduate Program, at the University of Calgary are conducting a research study. This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your involvement will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form for your records. You were identified as a possible participant in this study because you are a registered nurse working in opioid use

disorder (OUD) or substance use disorder (SUD) treatment. Your involvement in this research study is voluntary.

WHY IS THIS STUDY BEING DONE?

The purpose of this research study is to explore the understanding and experiences of the role of the nurse working in OUD treatment. This research study has the potential to provide data on how nurses working across the OUD treatment spectrum can benefit people with opioid use disorder.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

12 people will take part in this study through the University of Calgary.

WHAT WILL HAPPEN IF I TAKE PART IN THIS STUDY?

You will be interviewed, either in-person, or via a secure remote telecommunication method such as telephone or through a University Licenced Zoom account, to gain a better understanding of the role of the nurse in OUD treatment. You will be asked questions such as:

- Tell me about a typical day working in your program?
- What is your understanding of the role of the nurse in your program?
- From your understanding, are the nurses working to their full scope of practice in this program?

Your interview will be audiotaped and transcribed to improve the quality and understanding of the information shared. No video recording will occur if the interview is held via Zoom. Your involvement is completely voluntary, and you

may refuse to take part altogether, may refuse to take part in parts of the study, may decline to answer any and all questions, and may withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled.

HOW LONG WILL I BE IN THIS STUDY?

Participation will take a total of about 45 minutes to 1 hour.

SITE TOURS

If beneficial, a site tour for a general sense of the practice area will be arranged through the site manager. These tours would occur at a separate time from the participant interview. The student researcher will gain approval and schedule these tours with the manager. Personal protective equipment (PPE) will be worn during all interactions that occur in person. Physical distancing will be maintained at all times as per COVID-19 protocols. Site tours are optional and will not occur at every facility. You do not need to agree to a site tour to participate in an interview.

ARE THERE ANY POTENTIAL RISKS OR DISCOMFORTS THAT I CAN EXPECT FROM THIS STUDY?

In-person meetings increase the exposure to other people, possibly increasing the risk of contracting COVID-19. Secure telecommunication will be offered as the first choice for interviews to be completed to mitigate this risk. If you opt to have an in-person interview appropriate use of PPE, COVID-19 screening,

sanitization of surfaces, and use of strict physically distancing will be employed to mitigate this risk.

ARE THERE ANY POTENTIAL BENEFITS IF I PARTICIPATE?

There will be no direct benefit to you from participating in this study. However, this study may help the researchers and healthcare providers learn more about the role of the nursing working in a variety of OUD treatment settings.

WHAT OTHER CHOICES DO I HAVE IF I CHOOSE NOT TO PARTICIPATE?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you. Your decision will not affect your employment.

CAN I STOP BEING IN THE STUDY?

Yes. You can decide to stop at any time. Tell the researchers if you are thinking about stopping or decide to stop.

WITHDRAWAL OF STUDY DATA

You can withdraw from the study until data analysis begins in February, 2022. If you chose to withdraw from the study all data you have contributed to the study will be destroyed unless this is not feasible or there are compelling reasons not to do so.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will receive a $10 gift card for participating in this study. This will be provided to you via email. You will not be reimbursed for any out-of-pocket expenses, such as parking or transit fees.

WILL INFORMATION ABOUT ME AND MY PARTICIPATION BE KEPT CONFIDENTIAL?

The researchers will do their best to make sure that your private information is kept confidential. Information about you will be handled as confidentially as possible, but there is always the potential for an unintended breach of privacy. The research team will handle data according the Data Management Plan as outlined below:

No names or genders will be linked with the information you provide. Your occupation and program type may be accompanied with the information you share if it provides context to the data that is shared. All electronic data will be stored on a secure data server through the University of Calgary. All physical documents will be stored in a locked cabinet at the University of Calgary. Only authorized people will have access to the data collected. The study investigators will make every effort to maintain the confidentiality of your research records, to the extent permitted by law (e.g., disclosed child abuse or neglect must be reported) and legal requests (e.g., court applications seeking disclosure of research data are possible).

HOW LONG WILL INFORMATION FROM THE STUDY BE KEPT?

The researchers intend to keep the research data and records for 5 years. After this, all electronic data will be deleted from the server. All physical paper documents will be shredded. Any future use of this research data is required to undergo review by a Research Ethics Board.

RESEARCHER CONFLICTS OF INTERESTS

The researchers declare no conflicts of interest.

CONTACT FOR FUTURE RESEARCH

University of Calgary researchers may contact me in the future to ask me to take part in other research studies.

❑ YES

❑ NO

Contact email address: ___________________________________

WHOM MAY I CONTACT IF I HAVE QUESTIONS ABOUT THIS STUDY?

The Research Team:

You may contact Amie Kerber at ______________ or Tam Donnelly at ____________ with any questions or concerns about the research or your involvement in this study.

Conjoint Health Research Ethics Board (CHREB):

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

HOW CAN I FIND OUT ABOUT THE STUDY RESULTS?

Study results will be available by request via a link to publication.

Do you wish to have the results made available to you?

❑ YES

❑ NO

Contact email address for results: ___________________________________

WHAT ARE MY RIGHTS IF I TAKE PART IN THIS STUDY?

Taking part in this study is your choice. You can choose whether or not you want to participate. Whatever decision you make, there will be no penalty to you.

- You have a right to have all of your questions answered before deciding whether to take part.
- Your decision will not affect your employment
- If you decide to take part, you may leave the study at any time

HOW DO I INDICATE MY AGREEMENT TO PARTICIPATE?

Your signature on this form indicates that you have understood to your satisfaction the information regarding your involvement in the research project and agree to take part in the study. In no way does this waive your legal rights

nor release the investigators or involved institutions from their legal and professional duties.

SIGNATURE OF STUDY PARTICIPANT

____

Name of Participant

________________________________	_____________________
Signature of Participant	Date

SIGNATURE OF PERSON OBTAINING CONSENT

________________________________	_____________________
Name of Person Obtaining Consent	Contact Number
________________________________	_____________________
Signature of Person Obtaining Consent	Date

SIGNATURE OF THE WITNESS

____

Name of Witness

________________________________	_____________________
Signature of Witness	Date

Appendix E – Interview Guide

Introduction

Thank you for taking the time to speak with me today. As you know, I am very interested in hearing about your experience with providing care to clients in OUD treatment programs/services. My goal is to find ways to help to improve nursing care among patients accessing treatment for their addiction by understanding the role of nurses and its impact on care for patients. I will be asking for your experience about nursing care in OUD treatment/service settings, your perspective regarding your roles as a nurse, what prevents or motivates you to provide health care to patients who access OUD treatment, and what you think are best ways to support and promote the nurse's role in these settings. I want to assure you that your identity will be kept confidential; a pseudonym will be used in written material. If there is a question which you do not want to answer, all you have to say is "I do not want to answer that question." You also have the right not to participate in the project at any time. During our conversation, if you feel upset, we can stop the interview. We can also arrange for a health care professional to talk with you if you think that would be helpful.

Do you have any questions before we begin?

Are you okay if we begin?

First, I would like to start with some personal and demographic questions:

Demographics

1. Where did you do your nursing training?
2. How many years of nursing experience do you have?

3. What area do you currently work in? How many years have you worked in this service/program?
4. What areas have you worked in the past?
5. How many years of experience do you have working in OUD Treatment?
6. How would you describe your cultural background/ethnicity?
7. Would you mind telling me your age?

Interview Questions

- Tell me about a typical day working in your program?
- What is your understanding of your role as a nurse in OUD treatment?
- How is opioid substitution therapy incorporated into your program?
- What is the impact of the nurses' role in the services offered at your program?
- How is the harm reduction incorporated into your program?
- What are some strengths nurses bring to your program?
- What are some of the areas of improvement or growth for the nurses within your program?
- From your understanding, are the nurses working to their full scope of practice within your program?
- What do you think would be the gold standard of nursing care for patients in OUD treatment?
- What recommendations would you give to increase utilization of nurses in OUD treatment?
- What else would you like to tell me? Is there anything important that I did not ask?

Appendix F – Document Appraisal Matrix

Citation	Program	Purpose	Intended Audience	Nursing Role	Strengths	Weaknesses	Comments
Supervised Consumption Services – Procedure, PS-94-01, 2017	Supervised Consumption Services	- define eligibility for SCS - direct staff how to move patients through SCS - provide staff with guidance on expectations - provide staff information on working with specific populations (pregnant, using substances for the first time, ect…)	Staff working at the SCS (non-specific)	- Consumption Room section of document: direct patients to booth, ensure only 1 patient in booth, provide direction, education, support in injection drug use, provision of clean supplies	- details on limitations and how staff specifically cannot intervene (ex. when assisting with injection through coaching only)	- does not specify which staff in each section, it is broken up by room (reception, consumption, post-consumption)	- in alignment with information gathered in interviews
Suspected Overdose – Procedure, PS-94-04, 2019	Supervised Consumption Services	- to provide staff direction with assessment and intervention of patients who display signs and symptoms of overdose while accessing Supervised Consumption Services (SCS).	Staff working at the SCS (non-specific)	- Unclear as document does not specify staff who would implement this procedure, however we can assume that nursing is a part of this based on the information provided in the interviews - Medication administration - Post Administration Assessment	- specific signs to assess for that would trigger immediate intervention - directions on how to administer Naloxone - Stimulant Overdose assessment and intervention - Documentation requirements - Transfer of Care requirements	- does not specific which staff specifically	- in alignment with information gathered in interviews

Harm Reduction & Addictions Presentation, Popovich, M.,	Supervised Consumption Services	- Substance use & addiction - Harm reduction in practice - Overdose crisis - Community based Naloxone	Staff working at the SCS (non-specific) ? Orientation Presentation	- General overview of the SCS and the services provided without specifically identifying what the role of the nurse is.	- Reviews Harm reduction principles as well as medication assisted treatment options - Includes information about needle exchange and community-based naloxone - Values based assessment	- not all references appear as scholarly (some YouTube videos included) - briefly touches on STBBI testing and safe sex education	- in alignment with information provided in interview however does not indicate which staff complete and is overall a more basic presentation
Trauma and Violence Informed Care Presentation, Popovich, M.	Supervised Consumption Services	- Overview of trauma-informed care - Correlation of Trauma and Stigma	Staff working at the SCS (non-specific) ? Orientation Presentation	- Some elements would be applicable to the Nursing Roles (eg. Suicide Risk Assessment, Providing Trauma-informed Care) but this presentation is non-specific as to the roles within the service.	- Information on how to assess for a trauma response - Addresses the stigma that is associated with substance use - Reviews suicide risk assessment	- Suicide risk assessment information is not referenced back to provincial AMH AHS policy - Lacking scholarly references	- much of the information collected on the role of the nurse was related to how nurses are managers of patient crises, this is relevant and pertinent to that theme
ODP Blended Team Job Posting	ODP/iOAT	- Registered Nurse Job Posting	RN’s	- Assessment, supervision medical intervention (BLS, overdose response, stimulant intoxication response), medication prep and dispensing oral OAT and other meds, supervising injection through iOAT, Phlebotomy, Vaccinations, ECGs - Case management (follow up, treatment, referral, discharge planning and collaborating with allied health - Support in maintaining triplicate prescriptions with ODP and urinalysis drug testing - Naloxone training and dispensing - Wrap-around care	- Comprehensive list of various medical tasks and associated role of the nurse working within the program	- No information on the relationship aspect of care, which was strongly highlighted in all of the interviews	

Exclusion from Injectable Opioid Agonist Therapy Program, 2019, HCS-227-01	iOAT	Provide direction on situations that would warrant excluding a patient from accessing iOAT	Staff working at iOAT	- Consult with care manager re: exclusions or temporary exclusions - Liaise with Protective Services - Use non-violet crisis intervention strategies	- Clarifies that patients who are excluded from injection can be maintained during their exclusion period on oral medications	- Is it within the role of the nurse to assess exclusion criteria with clients or is it more for awareness of what would exclude a patient	- doesn't really describe the role of the nurse
Suspected Overdose Management Protocol, 2019, HCS-227-03	iOAT	To provide health care professions direction on assessment and intervention with patients who display signs and symptoms of opioid overdose while accessing iOAT	Staff working at iOAT	- Prescriber is required to initiate the protocol (outside of the nurse's role) - Assessment of overdose and contacting of prescriber - Naloxone administration - Post administration monitoring and/or transfer of care to EMS - Documentation	- Comprehensive document of how to manage an opioid overdose	- Vague on which healthcare providers are specifically responsible for management	- in alignment with information provided in interviews
Frequency of Medical Appointments, 2017	ODP	- To identify the frequency of which ODP clients are to be seen by the physician to ensure they are receiving optimal care	Staff working with ODP	- To assess the Stabilization Client List to ensure all clients have been seen weekly by physician	- Clear description of each role within the clinic related to appointment frequency (physician, administrative assistant, nurse)	- revision from 2017, outdated and pre-COVID	- Not specifically in alignment with information provided in interviews
Calgary ODP Medical Emergency Process	ODP	- Reviews process for medical emergencies	ODP Staff	- Emergencies include: Overdose, Chest Pain, Seizure, Suicidal Ideation Anaphylaxis	- Reviews signs and symptoms of some medical emergencies and when to call EMS	- Not a formalized document - Draft document? Not all are completed	- Not sure where the role of the nurse fits in with this document as the document is not completed.
Guidelines for the Use of Buprenorphine/Naloxone (Suboxone) in the Treatment of Opioid Dependence, 2017	ODP	- To provide information on the use of Suboxone in the treatment of opioid dependence	ODP Staff and Physicians	- Assessment of Opioid Withdrawal - Initiation Assessment and Stabilization Assessment during first week of Suboxone Treatment - Clients must be seen by RN once every six months once stabilized	- Reviews initiation, ongoing maintenance and discontinuation of suboxone as well as other clinic practices during the process of treatment	- Outdated – this document is 4+ years old and practices have changed since its creation	

Calgary Zone iOAT Medical Protocols, 2019	iOAT	- Full overview of the iOAT program medical protocols	iOAT Staff and Physicians	- Pre-injection assessment using the Behavioural Activity Rating Scale (BARS) - Post injection assessment using BARS - Administering Hydromorphone IM - Oral medication dispensing - PRN ECG's - Referrals to the Southern Alberta Clinic for HIV treatment	- Describes some of the primary tasks that are in association with the medical based care provided at the clinic	- Has not been updated since iOAT merged with ODP in 2020	- Validated and in alignment with information provided in interviews
Injectable Opioid Agonist Treatment Program (iOAT) Manual, 2021	iOAT	- Overview of the iOAT service beyond medical protocol	iOAT Staff	- 2 Nurses must be on at all times - **Full time (1.0) nurse is designated as Charge Nurse** - Maintain overall operational responsibility - Ensure iOAT staff complies with protocols and policies - Ensure appropriate levels of staffing - Authorize OT in absence of manager - Ensure communications tools up-to-date in transfer of care - Liaise with Pharmacy, housekeeping, protective services, CPS, EMS and Supply management as needed - Ensure debriefs occur as needed - Support new staff - Respond to client concerns or complaints - Designate staff duties (pre-assessments, post-assessments) - Connect with MD/NP for medication re-ordering - Review safety supplies **- Staff not working in Charge Role** - Assessments - Medication Administration and Charting (Oral and IM) - Be attentive to clients who are expressing further information/support - Ensure safety - Use de-escalation techniques for aggressive behaviour	- Updated since the merger of ODP/iOAT - Detailed document with processes on how to escalate issues and responsibilities of team members - Clear description of charge nurse	- Lacking some guidance around other staff responsibilities (Allied Health vs. Nursing)	- Validated and in alignment with information provided in interviews.

				- Work collaboratively with other team members - Follow guidelines from IP&C - Narcotic Count - Tidy medication room - Check client lockers - Stock injection supplies			
Guidance Document on the Management of Substance Use in Acute Care	ARCH	- Provide a comprehensive explanation for how to change the approach of care of patients who use substances in hospital to be more patient-centered and harm reduction based	Staff working in Acute Care settings who work with patient who have substance use disorders	- Welcoming admission processes, being adaptive, asking permission, providing clear explanations, person-centered language - Involvement and Connection with Other professionals (Allied Health, Addiction Counselling, Peer Support) - Discharge Planning - Supporting patients' level of usage and understanding their base level of usage - Using a non-judgemental approach in communication	- Alberta Based Document - Very comprehensive and evidence based - Reviews OUD, EtOH Use Disorder, Stimulant Use Disorder - Reviews special populations (pregnant, youth) - Spiritual and Cultural considerations of care (Including Indigenous Considerations)	- Very detailed - Not specific to roles, would benefit by splitting documents with one being physician focused as prescribing information not necessarily appropriate to nurses	
Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder, 2018	Not specific	- To develop a document that defines the continuum of outreach, interventions and treatment supports for opioid use disorder, including rapid access to addictions medicine and mild to moderate social supports (i.e., brief intervention and counselling), [and] make recommendations on best practices and drive policy development to improve quality care across the country.	Staff working with patients who have OUD	- Customize a treatment plan to meet a client's individual needs/goals - Culturally competent care - Trauma and Gender informed Care - Reduce stigma - Education on how to respond to overdose - Motivational interviewing	- Overview of medical intervention, assessment, psychological intervention, the continuum of care across treatment and special considerations	- Not role specific - Somewhat outdated – not updated since 2018 and there have been changes within AB since then	- Not task specific, and more so looking at the global picture of how to provide care to patients who have OUD

CRISM National Guideline for the Clinical Management of Opioid Use Disorder	Not specific	- Practice guideline based on evidence to provide Canadian healthcare professions with education and a tool with practice recommendations for treatment of people who are experiencing OUD. - Intended to further discussion with program and policy planning at the government level.	Physicians and allied healthcare providers, nurse practitioners, pharmacists, medical educators, or clinical care case managers with or without specialized experience in addiction treatment	- Initiate OAT with Suboxone to reduce toxicity - If individuals are responding poorly to Suboxone, transition them to Methadone - If neither of these are working, consider use of SROM (Slow release Oral Morphine) - Withdrawal management alone should be avoided - Psychosocial interventions should be offered, but should not be a requirement to receive OAT - Harm reduction strategies should be routinely offered	- Detailed overview of different OAT treatment modalities -		- Clearly states that this document is not iOAT Specific, but focuses on Oral OAT
A Guideline for the Clinical Management of Opioid Use Disorder, BCCSU, 2017	Not specific	- Comprehensive guidelines for medication and psychosocial management of clients with OUD - Structured literature review	BC Physicians, Nurses, Allied Health, and other care providers for individuals with OUD	- Recommends against withdrawal management alone as this has been associated with elevated risk of HIV and Hep C, and overdose death, and nearly universal relapse rates - Suboxone as a 1st line treatment - Stepped and integrated care approach, where treatment is adjusted to match the individual patient needs, which could allow patients to move between treatment needs (intensifying when needed, and transitioned to more flexible when needed) - Psychosocial treatment interventions and supports should routinely be offered alongside pharmacologic treatment - Take home naloxone training and harm reduction services should be routinely offered	- Comprehensive overview of the different OAT treatments, including methadone, suboxone, iOAT, slow release oral morphine, ext.. - Reviews residential treatment, withdrawal management alone, and harm reduction practices	- While the intended audience of this document is quite broad, it is highly focused on the pharmacology of OAT	

iOAT for Opioid Use Disorder, National Clinical Guideline, CRISM, 2019	Not specific	- Provide a framework and clinical guideline for iOAT - Rationale and supporting evidence for iOAT treatment	iOAT prescribers, pharmacists, and nurses, however, there is clinical utility for other members of iOAT care teams	- iOAT should be considered for care for individuals with severe, treatment refractory OUD and injection drug use - Hydromorphone and Diacetylmorphine are acceptable treatment options - iOAT should be offered as an open-ended treatment - Pre-injection assessment, witnessing of medication self-administration and disposal of supplies, post injection assessment, assistance with IM medications - Patient-centered care - Harm reduction approach - Wellness-focused goal setting	- Thorough descriptions of iOAT treatment when other substances are also being consumed - Specific recommendations for dealing with youth, pregnancy, and indigenous populations	- Very small subsection of trauma-informed care information - These documents tend to be more providers specific – this one has a titration protocol within it that providers can use when initiating treatment	- Generally reaffirmed a lot of the information provided within the interviews, without being explicit about the role of the nurse in comparison to other professions working with iOAT patients.