



# Housing Overdose Prevention Site Manual

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## 2018

Housing Overdose Prevention Sites (HOPS) opened as part of the provincial response to the opioid overdose (OD) emergency in December 2016 as directed by the British Columbia Minister of Health. HOPS are rooms in housing facilities where residents of those buildings can go to use substances. VCH provides clinical protocols, training and supplies. The primary goal is to provide a space for people to inject previously obtained illicit drugs, with sterile equipment, in a setting where trained HOPS staff/Peers can check-in, observe via a camera and intervene in overdoses as needed. The HOPS will last for the duration of the public health emergency.

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## 1. INTRODUCTION

### HOUSING OVERDOSE PREVENTION SITE OBJECTIVES

#### Vision

As part of a temporary emergency response offered by BC Housing, various non-profit housing providers and Vancouver Coastal Health (VCH), Housing Overdose Prevention Sites (HOPS) provide a space for residents who inject drugs to inject, with sterile equipment, in the building where they reside. Persons who inject drugs (PWID) are encouraged to inform staff or trained Peers (fellow residents or non-residents who are persons with lived experience with drug use) if they are using the room for injection. This service was initiated due to increasing mortality from illicit drug overdoses in the province of British Columbia (BC), Canada. To date spaces for smoking illicit substances are not provided.

The HOPS are a *welcoming, safe, and supportive* environment.

#### HOPS Objectives

- To foster community, relationships and a sense of belonging amongst people in their homes
- To provide space for PWID where an overdose can be responded to with immediacy, either because of in-person Peer supervision, staff cameras or because of other residents in the room
- To reduce the harm associated with illicit drug use (e.g., discarded needles, public drug use, incarceration) that affects communities
- To reduce health, social, legal, and incarceration costs associated with drug use
- To create opportunities for Peer leadership

#### HOPS Core Services

- Space for PWID
- Distribution of needles, condoms and other harm reduction supplies

## 2. SERVICE DELIVERY GUIDELINES AND PROTOCOLS

Agency operational protocols will vary. The VCH HOPS manual is a guide to assist agencies in a framework for providing services in a HOPS should they choose to offer this service for their residents/guests.

### ASSESSING READINESS FOR THE SERVICE

#### Resident Survey

(See Appendix A for example)

Do the residents in your building need a HOPS? Would they use a HOPS? Residents should be involved and consulted before implementing any new service. In addition, if any new service does not have the resident uptake that was initially anticipated, consider using the survey or any other agency tool to understand why the service may not be at capacity.

#### Site Assessment

(See Appendix B for example)

Has your agency assessed buildings for operational implications and staff buy-in? Execute a site assessment prior to starting a HOPS in any of your agency's buildings.

## STAFFING AND HOURS OF SERVICE

Staffing a HOPS is up to the discretion of the individual agency. Some agencies prefer to have the HOPS open when they have higher staff to resident ratios. This might mean that the HOPS is closed during certain hours. Other agencies leave their HOPS open 24 hours daily.

### Models for HOPS and Overdose Prevention

HOPS models will vary across BC depending on the environment and context. An institutionalized, 'one size fits all' approach is not appropriate for participant-centered, trauma-informed and culturally responsive services, and a tailored approach may be required which enables a wide variety of people who are vulnerable to overdoses and other harms of injection drug use to access services. Providers have found that by allowing people who use drugs to contribute to rules and building culture development, they have better staff-client relationships than in more formal health care settings.

**Below are some ideas for models currently operating in BC:**

#### Staff Monitoring

**Description:** Staff check the HOPS on a scheduled basis via in-person visits or by use of a wall-mounted camera. The camera can be placed in the HOPS or in the hallway directly outside of the HOPS, with the video transmitted to an office monitor.

##### Benefits

- Consistent monitoring ensures HOPS safety and prevents overdoses

##### Considerations

- Use of cameras might be problematic for some residents, check to make sure this is not a deterrent from use of the HOPS
- Are the hall-mounted cameras sufficient for knowing whether the HOPS is occupied?
- Not all residents want to be checked on by staff – consider using a Peer model if this is an issue
- Scheduled visits need to be based on knowledge of HOPS use (e.g., residents collect their supplies at the front desk and sign into the visit log). Otherwise, timing may be insufficient for ensuring a rapid response to an overdose.
- Staff are responsible for restocking supplies, room cleanliness, critical incident forms, documenting naloxone usage and administration and/or entries in the visit log and sharps disposal.

#### Peer Program Monitoring

**Description:** Agency hires Peers/residents to work in the building to either monitor the HOPS or attend to residents in private rooms for injection or post-injection observation.

##### Benefits

- Some residents would prefer to have a fellow resident/Peer to monitor their drug use safety, as residents have been evicted from many residences for drug use .

##### Considerations

- A Peer program is unique to each agency
- Peers are usually offered stipends to monitor/clean HOPS on a scheduled basis and to attend suggested education sessions
- Additional tasks for Peers could include: restocking supplies; room cleanliness; critical incident forms; documenting naloxone usage & administration; sharps disposal; and entries in the visit log.

#### Self-initiated Monitoring

**Description:** Signs inform residents and/guests to bring another person into the room who can intervene/call for help in the event of an overdose. This should be done particularly if residents are choosing not to inform staff of their use of the HOPS.

##### Benefits

- Residents/guests have a room to use their drugs that is not someone's private room and are autonomous in finding the help they need for observation assistance.

##### Considerations

- Not all residents/guests will have trusting relationship with others in the building for monitoring assistance. Having a backup plan with agency support is best for this option.
- Staff are responsible for restocking supplies, room cleanliness, critical incident form, documenting naloxone usage and administration and/or entries in the visit log and sharps disposal.

## Confidentiality

(Agency specific, see Appendix C for example)

Service providers, including volunteers and Peers, should receive basic training in confidentiality and sign a confidentiality agreement.

## Support for Peers Providing Overdose Prevention and Response Services

(agency specific, see Appendix D for example).

Provision of HOPS requires particular attention to the mental health and wellness of staff. Attendance to repeated overdoses, sometimes several during the same shift, can be traumatic. Peers may face additional stresses given they are often working within their own community, often witnessing high overdose and mortality rates among their friends and family. (BC Overdose Prevention Services Guide, 2017).

For support for staff/Peers (e.g., training, education, and crisis response), please contact the PHSA Mobile Response Team.

### TRAINING

In order to run a HOPS the recommended education for staff/ Peer workers is:

- 1) **OD prevention, recognition & response training** - Resources include the BCCDC [online training](#) & [Training Manual](#); St. Paul's [Web app training](#) & in-person training support from your local health authority.
- 2) **First Aid Training/Cardio Pulmonary Resuscitation (CPR)**, with a focus of responding to ODs - This is essential for unregulated care providers working where OD risk is high. Depending on response times, higher levels of intervention may be required including chest compressions.
- 3) **Harm Reduction Training** - Knowledge of harm reduction practices is fundamental for staff who work with people who use substances. Harm reduction training addresses: safer use of drugs & alcohol; appropriate use of harm reduction equipment; access to health care; personal & cultural safety practices; & mechanisms for dealing with critical incidents. Contact your local health authority for training opportunities. Access the online [Harm Reduction Training](#) from Learning Hub.
- 4) **Regular OD response drills** – These exercises will be agency specific and will be dependent on how much exposure the team has with ODs. These are also recommended activities for casual and new staff who may need to practice in order to incorporate their OD response skills

### PHYSICAL SPACE

The physical space used for a HOPS will vary from building to building, even within a single agency. Some buildings will be able to free up a room previously designated for a resident, while others might use an area within a common space. Selection of the physical space will be highly dependent on whether residents will use this space for injection. Resident consultation in determining this space is encouraged from the beginning of this process.

**\*For buildings receiving funding from BC housing, contact your BC Housing Rep for permission to use room for this purpose.**

The following are recommended space attributes:

- The space should be warm and well-lit so that clients can easily inject
- Mirrors may be strategically placed to facilitate monitoring and/or self-injection; or the agency should provide portable mirrors for clients on request
- Sharps disposal box should be easily accessible for each client and secured physically to the site
- Table and chairs should have non-permeable, non-flammable surfaces, which can be easily cleaned with hospital grade cleaning supplies
- There should be adequate space for staff or volunteers to perform naloxone administration and artificial respiration if necessary (i.e., space for someone to lie down)
- The area should have a clear and open pathway to the entrance/exit should medical transport by emergency health services be required
- If the room has open hours that are unmonitored, then a camera on the room or hallway to observe participants is recommended. The agency should also consider how to secure furniture in the room to avoid theft

## SUPPLIES

The following supplies should be available onsite:

- Sharps disposal boxes
- Puncture resistant and liquid resistant gloves
- Tongs or a small dustpan or brush
- Syringes
- Alcohol swabs
- Filters
- Sterile water
- Disposable cookers
- Matches
- Tea light candles
- Tourniquets
- Gauze
- Band aid
- Cavicide wipes

## ENTERING HOPS/ RECEPTION

### Eligibility Criteria

(Agency specific)

**In order to be eligible to access the HOPS, the person should:**

- Be a resident of the building or a guest of a resident
  - Some agencies will prefer the resident to accompany their guest while using the HOPS
  - Guest policy is specific to each agency – However, some agencies that have not provided guest access have noticed that guests then use alone in stairwells, washrooms or outside of facility, increasing the possibility of an unwitnessed overdose
  - If an agency allows HOPS access for guests, ensure policy is communicated clearly (e.g., signs for the location of the HOPS) on each floor near stairwell and/or elevator
  - Some agencies will serve youth – it is up to that agency to determine their policy for youth access to the HOPS

To ensure the safety of all in the HOPS, staff retains the authority to refuse entry and to ask ineligible residents to leave (agency-specific). Upon request, residents will have access to information to initiate the building appeal process.

### Needle Distribution

Staff will encourage all residents to inject at the HOPS, but in the event that residents are ineligible to do so, or wish to leave and go elsewhere, injection equipment will be provided. If residents choose to inject in their room, then the facility should have a policy to address overdose prevention in resident rooms (**see Appendix E for check sheet to guide policy development**).

### HOPS Safer Injection

- Each resident entering the HOPS will have access to all necessary injection equipment, such as: a syringe; an alcohol swab; filters; sterile water; a disposable cooker; matches; tea light candles; a tourniquet; gauze and a band aid, either within the room or at the front desk
- Residents will be encouraged to have a time limit in HOPS (**agency specific**)
- Participants should self-inject where possible
- Service providers/Peer workers are not permitted to perform venipuncture or administer the drug to the participant
- In the event a resident is noticed nodding off, tweaking or behaving in a way that is potentially self or 'other' threatening, staff will monitor until there is no longer a risk of OD or other harms

## Disposal of Injection Equipment

- After injecting, residents will dispose of their used injection supplies in the sharps container, which is readily accessible at each injecting station
- Residents will be encouraged to not bend or break off needles before disposal – broken needle tips are hard to see and have caused many accidental needle stick injuries especially while cleaning
- Before leaving the HOPS, residents should be encouraged to clean debris off their own table
- If staff need to pick up a needle they must do so with tongs, or dustpan and brush provided
- The disposal containers will be a puncture resistant plastic not filled to more than three-quarter capacity. The sharps disposal container will be sealed.
- Because many rooms do not have 24-hour observation, sharps containers must be attached securely in the room in order to prevent theft of needle box or the contents:
  - Sharps containers should be attached to a wall stud or similar sturdy structure that cannot be removed from the wall
  - Plastic sharps containers that are not tamper resistant are also discouraged as used sharps can easily be removed from many sharps containers
- Filled sharps containers will be removed and placed in a bin provided by the hazard waste pick-up company
- All full sharps containers will be in a locked non-service area
- The hazard waste pick-up company commonly used is Steri-Cycle at 604-552-1011 (**agency specific**)
- Needle disposal/pick-up will be arranged by the building

## Cleaning

### (See Appendix F for example of daily cleaning checklist and sign)

To guard against infection and contamination, the HOPS should be kept as clean and tidy as possible at all times. When staff/Peers clean tables, take out garbage, biohazard or tidy up the HOPS space - the focus is to AVOID NEEDLE STICK INJURIES by:

- Paying close attention – do not get distracted when cleaning debris off the booth or floor
- Wearing thick black puncture resistant gloves
- Never using hands to take garbage off a table, counter or chair surface. Always sweep with a small dustpan and brush before wiping surfaces with a gloved hand as broken needle tips can be hard to spot and can pierce a glove.
- Using tongs or small dustpan and brush to pick up needles
  - If no tongs are not available, use a gloved hand to carefully pick up needles and dispose of gloves. HAND WASHING should occur after needle contact
  - Always hold needle tip away from you
- Using a dustpan and large broom to remove debris from floor

Additionally, prior to having the table ready for use, make sure to:

- Wearing thick black rubber gloves, wiping down tables/mirrors with industrial disinfectant wipes such as CaviWipes.
- Looking for and clean blood splatters under tables and on walls with CaviWipes
- Table is now ready for use

**\*Most sites instruct residents/guests to clean up after themselves before staff/Peers, provided there are tools to do so.**

## Disposal of HOPS Garbage

Where possible, agencies should avoid having a garbage bin in the HOPS to prevent sharps being disposed here. If a building chooses to have a garbage bin in the HOPS:

- Physical handling of garbage in the HOPS should be kept to a minimum
- Use waterproof garbage bags
- Be alert! If possible look for sharps protruding from the garbage bag, and listen for broken glass when moving the bag
- Don't compress garbage or reach into garbage containers with your hands or feet
- Don't use bare hands when handling garbage. Wear puncture resistant and liquid resistant gloves or use other tools designed for picking up garbage

- Don't let garbage get too full. Leave enough free space at the top of the bag, so that when you grab it, you grab the top of the bag only
- You may have to change bags more often to prevent them from getting too full. This will also make them lighter and thus easier to hold away from your body
- Don't place one hand under the bag to support it

## DATA COLLECTION

### Participant Agreement

(See Appendix G for example)

The User Agreement – This is an agency specific tool. If these items are not already addressed by being a resident of the building, the agency can use this agreement for anyone that uses the HOPS. This tool may prove to be additionally useful for guests of residents that use the building.

### VCH Housing Overdose Prevention Site Data Collection Form

(Appendix H)

This log sheet will be kept at the front desk and used to track residents and their guests who use the HOPS. A designated staff person will then enter this information weekly in the VCH app. The app functions both on desktop and mobile devices. Hard copies will be collected by staff and given to the designated VCH staff on a predetermined schedule. Hard copies will be used to verify that the data entry has been done accurately as needed. Comprehensive, quality data is essential for the HOPS evaluation research project. HOPS staff are responsible for collecting data on this form and then entering it in web app link below.

The app link is: <https://vchhealthsurvey.phsa.ca/HOPS.aspx> (Appendix I)

## CODE OF CONDUCT

(Agency specific, see Appendix J for example)

**A collaborative Code of Conduct should be developed cooperatively with staff and residents**

A Copy of the HOPS Code of Conduct should be posted in all work areas and made available when required. If residents are denied access related to inability to adhere to the Code of Conduct, they will have to contact the building manager.

## OPIOID AND STIMULANT OVERDOSE INFORMATION

(See Appendix K)

The purpose of this protocol is to assist **all HOPS staff** with identifying and managing residents with opioid and stimulant overdose. For the SAVE ME steps, refer to **Appendix L**.

## RESCUE BREATHING

(See Appendix M)

In a witnessed overdose, it is likely that the client's heart is still beating. Towards the Heart (BCCDC) recommends prioritizing giving breaths because the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 5 seconds while preparing to administer naloxone. If the overdose is unwitnessed, this could be a case for using CPR. See Appendix to help you determine if this is your course of action should someone on your staff team have CPR training.

## NALOXONE HYDROCHLORIDE (NARCAN)

Naloxone is a safe and highly effective antidote to opioid overdose. It is an opioid antagonist. Naloxone has a much higher affinity (attraction) for the same receptors in the brain to which heroin and other opiates bind. For this reason, naloxone displaces and prevents any opioids from working at the receptor. It has no effect on non-opioid drugs and no potential for addiction. Naloxone is an important part of managing an opioid overdose.

If there are two first-responders, one can administer naloxone while the other manages airway, breathing, and circulation. Once the naloxone is administered, both responders can perform airway, breathing, and circulation interventions. Naloxone has a short half-life: 15 to 30 minutes. This is much shorter than most opioids, so it is important to monitor a person after an overdose for 30 minutes or more. This is best done at the hospital.

If the resident declines to go with the ambulance following an overdose, check on the resident every 30 minutes for a two hour time period following the overdose. As well, staff are to always remind residents/guests who have been injected with naloxone that they should wait several hours before using a substance that might contain opioids; in order to decrease the chance of a second overdose once the naloxone wears off. Because people who experience a non-fatal overdose have an increased chance of a future fatal overdose, always ask if residents are interested in connecting to opioid replacement therapy after an overdose incident. The VCH Overdose Outreach Team can support in providing support and connections to addictions care in the VCH region. To make a referral, call 604-360-2874.

### JUGULAR SELF INJECTION (JUGGING)

Jugular veins pose high risk of medical complications. If a resident/guest plans on using the HOPS to inject in their jugular vein, support the resident with providing a mirror so that they are not using alone in their room or bathroom.

### UNKNOWN SUBSTANCE LEFT BEHIND

(Agency specific, see Appendix N for example)

Any controlled or unknown substances left on site at the HOPS will immediately be brought to the attention of the building manager, who will then follow the agency policy.

### REFUSAL OF SERVICE TO HOPS

(Agency specific, see Appendix O for example)

Reasons for Refusal to HOPS

The HOPS policy is to remain as accessible as possible to all PWID all the time. However, there are a few circumstances in which they may refuse someone entry to the HOPS.

## 3. OCCUPATIONAL HEALTH & SAFETY (OH&S)

### NEEDLE STICK INJURIES/EXPOSURE TO BLOOD AND BODY FLUIDS

(Agency specific, see your agency policy)

### MANAGEMENT OF ESCALATING AGGRESSIVE BEHAVIOURS

#### Assessment for Potential Aggression:

1. Assess the resident's potential for aggression on admission using the risk indicators outlined below.
2. Assess own personal self-awareness as to thoughts, attitudes, feelings and actions towards people who are aggressive or have the potential to be.
3. Assess environment for overall activity, e.g. a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

#### Risk Factors:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, adverse mental health condition
- Cognitive impairment
- Psychosis
- Delirium/dementia

- Lack of inhibition
- Labile mood
- Suicide intent, plan, thoughts or history
- Psychological factors, poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief
- Loss of central love interest, family member
- Loss of housing
- Loss of income
- Loss of health
- Feelings of powerlessness, anger, fear and failure
- Socio-economic indicators
  - Low-income households
  - High residential mobility
  - Marital status (single)
- Demographic indicators
  - Age (20-4- years)
  - Gender (male)

## MANAGEMENT OF OBSERVABLE BEHAVIOURS

### **Anxiety:**

Anxiety is an observable increase of change in behaviour. Mild anxiety can be good; it motivates us, heightens our awareness and can stimulate problem solving. Moderate to severe anxiety can cripple our ability to perceive, think and conceptualize - in other words, our ability to cope with the situation that faces us. Stimulant use can increase anxiety.

### **Anxiety Behaviours:**

- Eye contact- loss of soft focus eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.
- Verbal contact- talkative, quiet, laughing, crying, joking, talking faster.
- Physical- rocking, restless, pacing, sitting very still, a need for more personal space, holding their breath.
- Hands- wringing hands, drumming fingers, opening and closing hands.
- Others- asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions), very poor short-term memory, procrastination.

### **Staff Response to Anxiety:**

- A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours in 95% of the population.

### **Staff Intervention to Anxiety:**

- Be respectful of the resident's belongings and personal space (do not touch the resident without their permission).
- Actively listen to the resident, to have an understanding from their point of view and what is driving the behaviour.
- Answer questions to give the resident back a sense of control and reassurance.
- If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain to them it is a question to which there is no answer (do not ignore the question or need).
- Focus on what you can do for the resident and how it will benefit them, not what you cannot do (e.g. "How can I help?").
- Assist the resident to verbalize feelings in their own words, avoid using leading questions.
- Re-direct resident's energy into safe activities.

## **Verbal Aggression:**

As verbal aggression escalates from the lowest to highest,

1. Challenging behaviours;
2. Refusing behaviours;
3. Loud behaviours; and
4. Threatening behaviours,

The person acting out will lose rational control and the ability to process information and think clearly. Eye contact will become focused and intensify as the level of verbal aggression escalates. Personal space will shrink and the acting out person will move closer to you, crowding your personal space.

### **1. Challenging Behaviour (First Level of Verbal Aggression)**

- Relentless questions, with no satisfaction with the answers to these questions or they really do not care what the answer is
- Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction
- Rhetorical questions which are a form of distraction
- Demanding/instant gratification
- No respect for rules or regulations - challenge and test staff.

If this line of questioning continues, it could become very personal and the individual might challenge you on your credibility, skill or knowledge. If they are not satisfied with the answers that you give, this behaviour usually turns out to be a refusal in disguise, which is the next level of verbal aggression.

#### **Staff Response to Challenging Behaviour:**

- Staff have to acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression. This acknowledgement is key for staff to match their response to the level of verbal aggression.

#### **Staff Intervention to Challenging Behaviours:**

- Remain calm.
- Do not argue; focus on a common goal.
- Redirect them back to the issue at hand.
- Ask them a question to distract them (e.g. "Can I ask you something?").
- Give a positive directive that will assist them in getting their needs met.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.
- Use time and space.

### **2. Refusing Behaviour (Second Level of Verbal Aggression)**

- Disagreeable
- Refusing
- Silence
- Walking away
- Verbally (this can be done in a calm or aggressive manner)
- Distracting behaviours (refusal in disguise)
- Repeated complaints
- Repeated requests
- Repeated demands
- Blaming others
- Exaggerated response of annoyance

#### **Staff Response to Refusing Behaviours:**

Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.

**Staff Intervention:**

- Remain calm.
- Verify that they are refusing.
- Verify the reason for the refusal.
- Give a positive directive.
- Give the individual reasonable choices or consequences- positive first, and a specified time to decide.

### **3. Loud Behaviour (Third Level of Verbal Aggression)**

- Button pushing
- Yelling, shouting

**Staff Response to Loud Behaviours:**

At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The resident may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.

**Staff Intervention to Loud Behaviours:**

- FIRST PRIORITY IS SAFETY FOR STAFF AND RESIDENT.
- Remain calm.
- Isolate the acting out person if safe to do so, and either move them or clear the area of on-lookers (people play to a crowd).
- Give a directive to the resident that puts your safety first (e.g. "Please leave the building").
- Time and space.
- Assess the need for additional staff to be present, or call police.

### **4. Threatening Behaviour (Fourth Level of Verbal Aggression)**

Verbal threats are intolerable behaviour and will be managed as intolerable behaviour.

**Staff Intervention to Loud Behaviours:**

The following behaviours have been identified as intolerable to the HOPS. All staff must follow this list to present a consistent approach to residents. The key to the successful use of behaviour modification techniques is a consistent approach by all staff. When a staff member asks a resident to leave and restricts access to the service or agency, all staff must respect that staff member's decision to enforce limits on the resident's behaviours.

#### **1. Verbal Aggression**

**Verbal threats that are:**

- A direct threat of physical harm to a staff member, resident or family member.
- A direct threat to damage the physical environment or the service or building.
- A threat of a weapon (imaginary or real).

**Verbal comments that are:**

- Intended to dehumanize a staff member, resident or family member.
- Intended to demoralize a staff member, resident or family member.
- Intended to insult a staff member, resident or family member.
- Intended to sexually exploit a staff member, resident or family member.
- Intended to frighten and verbally control a staff member, resident or family member.
- Intended to start a fight in the facility.

## 2. Physical Aggression

- Sexual touching.
- Physical touching with the intent to harm a person or damage the facility.
- Throwing objects with the intent to harm a person or damage the facility.
- Punching or slapping a staff member or another resident.
- Kicking with the intent to harm a person or damage the facility.
- Spitting that is directed at a staff member or another resident.
- Fighting in the facility.
- Defacing the facility.
- Damaging equipment in the facility.
- Setting fire to the facility.
- Walking around with an uncapped needle.

## 3. Challenge of Facility Rules

- Refusing to stop drinking alcohol in the facility.
- Stealing.
- Refusing to stop any behaviour that facility staff have requested the resident to stop.

### **Staff Response to Intolerable Behaviours:**

- Staff safety always comes first. If you have any concerns regarding another staff member's behaviour in dealing with the resident, this is not a safe or appropriate time to question or challenge another staff member. These concerns should be brought up in the informal briefing.
- Be aware of your own limitations and the volatility of the situation.
- Assess the need for more staff to be present when asking the resident to leave the facility, or whether it is necessary to contact the police. If more staff is required or the situation is volatile, remove yourself from the situation until appropriate support can be put in place.
- Know what you can and cannot do ahead of time, so that you are always prepared for the unexpected:
  - Who is available to assist you?
  - What are your options and choices at this time?
  - When are you going to request the resident to return to the HOPS for follow-up?
  - Where are your exits?
  - What is your past history with the resident, and do you have a rapport with them?

### **Staff Intervention to Intolerable Behaviours:**

In a calm, clear, matter-of-fact manner:

- State why you are asking the resident to leave the facility.
- Direct the resident to leave the facility.
- State when the resident may return to the facility (e.g. after meeting with manager, after 24 hours, etc.).

### **Intervention for Staff Member Being Assaulted:**

A staff member that is being physically assaulted is to:

- Call for help.
- Trigger an emergency call if available.
- Protect the vulnerable areas of the body (e.g. face, neck)
- Move to an area occupied by other staff
- Ensure that help is on the way.

**Staff Intervention to Physical Aggression:**

- Quickly assess the situation
  - Call 911
  - Assess if weapons are present
  - Clear exits for staff
  - Remove bystanders from the area
- One staff responder is to give direction to the staff member being assaulted to assist them in protecting themselves and removing themselves from the attacker. They need to clearly identify themselves to the staff member being assaulted as the one voice to concentrate on, so more than one person talking to them does not confuse the person being assaulted.
- Call 911 (or ensure 911 has been called).
- A second staff responder will be the responder who directs the resident to stop the attack and leave the facility. The responder can attempt to distract the attacker (e.g. flicking the lights on and off or throwing ice water on the attacker), this can give the victim a window of opportunity to escape.
- Clear bystanders from the area.
- Remove any potential weapons from the area.

### 3. WORKS CITED

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Vancouver Coastal Health (2016) *Overdose Prevention Site Manual*. Retrieved from:  
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## 4. APPENDICES



**RESIDENT SURVEY: HOUSING OVERDOSE PREVENTION SITES  
FOR AGENCIES CONSIDERING THIS OPTION**

**This is an anonymous survey – please do not write your name on this survey**

**1. Do you currently use drugs in the building?**

- Yes
- No

**If yes, where do you use them?**

- personal room
- other resident's room
- washroom
- common area
- other \_\_\_\_\_

*Any comments?:*

---

**2. If your building were to have an overdose prevention site within the building, would you be comfortable with it? An overdose prevention site would give residents the option to be observed while consuming drugs.**

- Yes
- No

*Any comments?:*

---



**3. If you use illicit substances by injection (needle), snorting or oral would you use the overdose prevention site?**

- Yes
- No
- I do not use illicit substances in these ways.

*Any comments?:*

---

**4. If you use illicit substances by smoking would you use an overdose prevention site?**

- Yes
- No

*Any comments?:*

---

**5. Would you be interested in volunteering as Peer support for an overdose prevention site?**

- Yes
- No

*Any comments?:*

---

## APPENDIX B: SITE ASSESSMENT



### HOUSING OVERDOSE PREVENTION SITE (HOPS) – SITE ASSESSMENT

#### SITE IDENTIFICATION

Hours of operation of the HOPS

[Click here to enter text.](#)

HOPS floor-plan - Description

[Click here to enter text.](#)

#### ACCESS TO OTHER HEALTH SERVICES

Description of other drug treatment services (e.g. counselling, withdrawal management, methadone program, etc.) available to residents

[Click here to enter text.](#)

#### HEALTH, SAFETY & SECURITY OF CLIENTS, STAFF AND LOCAL COMMUNITY

With respect to room usage, who will have access to the HOPS? Residents and guests? Only residents? Will guests need to be accompanied by a resident? Will guests be signing a waiver prior to first use (see manual)?

[Click here to enter text.](#)

How will residents/guests be directed to the HOPS? Where will they check in pre-injection?

[Click here to enter text.](#)

What is the time limit for an individual in the HOPS?

All staff have been trained in overdose prevention and response, CPR, first aid, and data collection in the last year. All sites to keep records of their staff trainings

[Click here to enter text.](#)

Additional site operational procedures (number of people in the room, alcohol usage in the HOPS, threats of violence, damage to property)

[Click here to enter text.](#)

What is the proposed staffing/peer model if someone is using the HOPS?

[Click here to enter text.](#)

Roles and responsibility of each staff member have been clearly outlined

[Click here to enter text.](#)

All staff and peer workers have signed confidentiality agreement

[Click here to enter text.](#)

Waste and used supplies can be disposed of safely on-site

[Click here to enter text.](#)

Version 2, January 8, 2018

#### INFORMATION MANAGEMENT

- Description of HOPS usage record keeping procedures

[Click here to enter text.](#)

#### SUPPLIES

- Harm reduction supplies are onsite and there is a reliable system for obtaining supplies in a timely manner

[Click here to enter text.](#)

- The site is a participant of the BCCDC THN Program and the FORB Program

[Click here to enter text.](#)

- The site has a process for ordering other HOPS supplies (tables, chairs, Cavicide, gloves, sharps containers)

**APPENDIX C: SERVICE PROVIDER CONFIDENTIALITY AGREEMENT TEMPLATE**

(BC Overdose Prevention Services Guide, 2017)

**(Your Agency Logo Here)**

CONFIDENTIALITY UNDERTAKING FOR OVERDOSE PREVENTION SERVICES SERVICE PROVIDERS In consideration of my contract placement at \_(indicate regional health authority [RHA]/agency)\_; I acknowledge and agree to the following: 1. I will adhere to the Information Privacy and Confidentiality Policy and related policies and subsequent amendments, concerning the collection, use and disclosure of information obtained in the course of my service with (indicate RHA/agency); 2. I understand that all personal information concerning staff and the people who receive services (including medical records) is confidential and may not be communicated to anyone in any manner, except as authorized by (indicate RHA/agency) or applicable policies; 3. I understand and acknowledge that all information regarding the affairs of (indicate RHA/agency), including corporate, financial and administrative records is confidential and may not be communicated or released to anyone in any manner except as authorized by (indicate RHA/agency) or applicable policies; 4. I will not copy, alter, interfere with, destroy or remove any confidential information or records except as authorized by (indicate RHA/agency) and in accordance with established policies; and 5. I understand that compliance with confidentiality is a condition of my placement with (indicate RHA/agency) and that failure to comply may result in immediate termination of my placement, in addition to legal action by (indicate RHA/agency) and others. Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Dated (mm/dd/yr) \_\_\_\_\_

## APPENDIX D: SUPPORT FOR PEERS PROVIDING OVERDOSE PREVENTION AND RESPONSE SERVICES

(BC Overdose Prevention Services Guide, 2017)

The experience of witnessing and/or responding to an overdose is often stressful and overwhelming. The impact on health care providers responding in emergency situations is well recognized and acknowledged in the health care system; with resources such as critical incident debriefing and counseling available through employers. As part of the overdose response, it is important to have resources available for all of those providing overdose prevention and response services. Experiences such as these, if unresolved, may interfere with performing one's daily life and work commitments, and trigger further trauma, grief and loss. Unlike most health care professionals, Peers (a person who has both lived experience with drug use (either past or present), and uses that lived experience to inform their professional work) may be in a position where they lack the institutional support systems for immediate and ongoing emotional/mental health and well-being, thus often left to cope with the psychological impact of overdoses on their own. A critical step in mitigating some of these impacts lies in the support and provision of regular and standardized services for Peers. These initiatives can be implemented at three levels: Peer-to-Peer, organization/agency for Peer, and community initiatives. They should all provide relevant, appropriate, and timely Peer supports. Peer-to-Peer Peers themselves are best positioned to empathize and intimately understand the lived experiences of other Peers. Peer-to-Peer support cultivates a setting whereby Peers can both look to other individuals who may have lived similar experiences for support, whilst other Peers can share their knowledge and expertise. One potential Peer-to-Peer initiative whereby this may occur includes the formation of a Peer support team specifically oriented to people with lived experience, who are working as Peer workers at Overdose Prevention Sites.

This team could:

- work with Peers to develop active Peer support practices within teams through training and education;
- offer support and debriefing to all Peer workers at Overdose Prevention Sites;
- nurture self-care and self-assessment among Peer workers; and,
- triage to other services if needed and available.

## APPENDIX E: OVERDOSE PREVENTION CHECKSHEET



### OVERDOSE PREVENTION & RESPONSE: POLICY AND PROTOCOL RECOMMENDATIONS FOR SERVICE PROVIDERS

#### PURPOSE

To provide guidance for service providers to develop overdose (OD) prevention & response policies & protocols.

#### OD PREVENTION, RECOGNITION & RESPONSE: FIRST AID & HARM REDUCTION TRAINING

Do your staff have:

- OD prevention, recognition & response training? Training resources include the BCCDC [online training](#) & [Training Manual](#); St. Paul's [Web app training](#) &; Learning Hub's [Train-the-Trainer](#). Contact your local health authority for in-person training support.
- First Aid Training that includes responding to ODs? This is essential for unregulated care providers working where OD risk is high. Depending on response times, higher levels of intervention may be required including chest compressions.
- Harm Reduction Training? Knowledge of harm reduction practices is fundamental for staff who work with people who use substances. Harm reduction addresses: safer use of drugs & alcohol; appropriate use of harm reduction equipment; access to health care; personal & cultural safety practices; & mechanisms for dealing with critical incidents. Contact your local health authority for training opportunities. Access the online [Harm Reduction Training](#) from Learning Hub.

#### CLIENT INVOLVEMENT

Does your agency:

- Encourage clients to get OD prevention, recognition, & response training including acquiring their own naloxone kit?
- Have accessible venues to solicit meaningful client feedback? A variety of options can be used in combination such as: monthly client peer meetings; annual anonymous surveys; & a suggestion/complaint box.
- Have paid client positions/peer trainers? Peer trainers are an asset to both client & staff trainings.

#### DRUGS POLICY

Does your agency:

- Have current [policies related to substance use](#) that might increase isolation & OD risk associated with using alone such as 'no guest policies', 'no use onsite', or police attending 911 calls? Have punitive sanctions in relation to drugs that would change or compromise an individual's ability to access services & supports? This will likely inhibit communication about drug use, ODs, & staff's ability to intervene effectively.
- Have a transparent drugs policy for clients & staff? Share it with clients/staff in conversations, posters & training.

#### OVERDOSE PREVENTION

Does your agency:

- Recommend that all staff who have contact with clients receive the training referenced above?
- Have a protocol addressing both onsite & offsite ODs? Have a protocol for volunteers & practicum students?
- Track staff training? Training for staff should occur annually, or more regularly if needed.
- Have an agency staff trainer (or an external resource)? This will help with refresher, new staff, & client trainings.
- Have OD response drills at regular intervals at each facility in your agency?
- Identify quiet corners where clients & their guests might use substances & be at risk for OD? (e.g., washrooms & stairwells.) Develop a system for checking these spaces & posting signs to direct people to ask for assistance.
- Have public access washrooms? If so, does this space have its own protocol to prevent ODs that includes:
 

<input type="checkbox"/> Regular safety checks?	<input type="checkbox"/> Secured, tamper resistant sharps containers?
<input type="checkbox"/> Locks that can be opened from the outside?	<input type="checkbox"/> Posted washroom OD prevention policy?
<input type="checkbox"/> Doors that open outward?	<input type="checkbox"/> A timer system when washroom door locks?

\*All underlined text is connected to a hyperlink  
<http://towardtheheart.com/resource/overdose-prevention-response-protocol-recommendations/open>

Have regular facility safety site assessments to address OD? This will ensure a review of all OD prevention & response measures. If ODs happen regularly or there has been an OD death, consider implementing evidence-based OD response practices, including observation tables/rooms for residents to consume substances more safely.

Does your agency have signage that includes:

- List of staff who are trained in OD response (particularly if not all staff are trained)?
- List of clients who are trained in OD response (voluntary)?
- SAVE ME signs? Cue people on OD response steps (including those with low literacy).
- Door signs for clients who have naloxone & are trained in opioid OD interventions (voluntary)?
- A naloxone sign at the front desk? To inform clients & guests that staff are trained to respond with naloxone.

Does your agency have client-focused OD prevention such as:

- How to determine which clients are at risk of OD? OD risk should be assessed at intake & on an ongoing basis. Clients can be at higher OD risk at different times. A resource for this is: [Housing Opioid OD Risk Assessment Tool](#).
- Developed care plans in collaboration with clients during known times of OD risk. Can include but not limited to:
  - How to facilitate supporting clients to use alone more safely in their rooms:
    - Encourage clients to inform staff or trusted peer when using substances (with OD potential) in their room to facilitate a follow-up room check (may be via: in-person, phone call, intercom, baby monitor).
    - Timing for room checks should be based on route of administration, time of use, & ease of use.
  - Support client to be trained in OD prevention, recognition & response.
  - Discuss with client when to call 911.
- Addressing stigma? Is stigma around substance use preventing clients from accessing services?
  - Vertical stigma – staff to peer.       Lateral stigma – peer to peer.       Self-stigma – self-judgment.
- OD prevention as a standing item on all client advisory groups & staff meetings? This will ensure continued evaluation, input & feedback from both groups.

## OVERDOSE RESPONSE

Does your agency:

- Allow trained staff to administer naloxone to clients in the event of an OD? Is there a protocol describing this intervention? Is staff trained yearly? Does your agency have naloxone onsite? if not, contact [BCCDC](#).
- Have a shift change checklist that:
 

<ul style="list-style-type: none"> <li><input type="checkbox"/> Details OD responses that occurred on that shift.</li> <li><input type="checkbox"/> Requires a communication log review.</li> <li><input type="checkbox"/> Establishes roles &amp; responsibilities of each person on shift in case of an OD (including volunteers/students).</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identifies clients with new or increased OD risk.</li> <li><input type="checkbox"/> Includes inventory checks of naloxone kit &amp; emergency supplies.</li> <li><input type="checkbox"/> Explains how staff can notify the health authority when there is a marked increase in ODs.</li> </ul>
--	---
- Have a means of emergency communication (e.g., cell phones, walkie-talkies, panic buttons)?
- Provide clients with access to phone, 24/7?
- Have system to ensure staff is always reachable ( e.g., posted phone # &/or staff location when away from desk)?

## POST OVERDOSE INCIDENT FOLLOW-UP

Does your agency:

- Debrief with staff & clients following an OD (Is leadership is aware of provincial Mobile Resource Team resource)?
- Have post-OD intervention duties (e.g., restocking supplies, reporting: critical incident form, naloxone usage log, naloxone administration, OD response information form, supervisor notification, staff care plan)?
- Make alert posters to notify clients? After how many ODs? Is a template used? When are posters removed?
- Alert extended community after OD incidents? After how many ODs? Who is information shared with (managers, health authority, other non-profit organizations)?
- Have a [guide to promote staff resiliency & prevent distress](#) after an OD reversal?
- Know about this resource: [A Public Health Guide to Developing a Community Overdose Response Plan?](#)

\*All underlined text is connected to a hyperlink

<http://towardtheheart.com/resource/overdose-prevention-response-protocol-recommendations/open>

Version 9, 2017



# BOOTH CLEANING SAFETY

**Encourage Participants to clean debris off their own booths**



**Always wear thick black rubber gloves, don't let yourself get distracted**

**Use the broom and dustpan to take garbage off a booth, not your hands.**



**Wipe the table (surface, edges and underside) and the chair with Cavicide. Always check the wall and floor for blood splatter**



*But, if you get stuck with a needle...*

**\*\* Wash puncture site thoroughly, allowing it to free-bleed**

**\*\* Alert the RPIC on duty**

**\*\* If possible, ascertain whose needle it was**

**\*\* Go to VGH or SPH using a OPS taxi voucher**

**\*\* Complete WGB forms and an "Unusual Incident Report"**



(Insert Agency Logo here)

## Participant Agreement, Release and Consent Form: Housing Overdose Prevention Site (HOPS)

Prior to using the HOPS, I agree to the following:

- I have injected drugs in the past, am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health.
- I will follow the direction of HOPS staff and any Code of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize HOPS staff to provide emergency medical services if necessary.
- I am aware of the harmful effects of drug use and accept full responsibility for all risks to myself, including my death, and on behalf of myself and my heirs, hereby release the Housing Overdose Prevention Site Agency, Vancouver Coastal Health Authority, and their employees, partners and agents from any and all liability for any loss, injury or damage I may suffer as a result of my use of this facility.

I understand the above and am able to give consent.

Name: \_\_\_\_\_ (must include first & last initials)

Date of Birth: \_\_\_\_\_ (D/M/Y)

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_ (D/M/Y)

Handle or Identifier:  
(Name, nickname, or #,  
Ideally same as at Insite/other SCS/OPS)



# APPENDIX I: PICTURE OF APP DATA ENTRY SCREEN



## OPS Daily Data Collection Portal

\*Visit Date (DD/MM/YYYY):

\*Site:

- Flint (1516 Powell St.)
- Hotel Canada (518 Richards St.)
- Gastown (110 Water St.)
- Hazelwood (344 E Hastings St.)
- London (208 E Georgia St.)
- Dominion (210 Abbott St.)
- Sereena's (143 Donlevy St.)
- Empress (235 E Hastings St.)
- Arco (81 W Pender St.)
- Colonial (122 Water St.)
- Tamara House (396 Powell St.)
- Walton (261 E Hastings St.)
- Yukon (2088 Yukon St.)

Staff Name:

Shift:

- Morning
- Afternoon
- Evening

\*Visits:

	#
Visits:	<input type="text"/>
Overdoses:	<input type="text"/>
Persons Administered Naloxone:	<input type="text"/>
Persons Transferred to an ED:	<input type="text"/>

Notes:

## APPENDIX J: CODE OF CONDUCT IN HOPS

### Rights and Responsibilities of Overdose Prevention Site Residents

#### **Rights**

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by HOPS staff/Peers.
- To be in a clean environment.
- To receive appropriate support and attention.
- To access services even while under the influence of drugs or alcohol.
- To have a voice in the operations and functioning of the HOPS, in conflict resolution processes and in regards to complaints or concerns.

#### **Responsibilities**

- To respect others while in HOPS.
- To help create and maintain a safe place.
- To not cause physical harm to other residents or staff/Peers.
- To use the HOPS for self-administration when possible.
- To not deal, exchange, share or pass drugs to anyone else in HOPS.
- To not use alcohol or smoke while in HOPS.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money in the HOPS.
- To not bring outside conflicts into the HOPS.
- To not engage in solicitation of any kind in the HOPS.
- To respect the property and privacy of others in the HOPS.
- To follow the reasonable directions of HOPS staff/Peers.
- To bring concerns or complaints to the attention of the building manager.

## APPENDIX K: OPIOID AND STIMULANT OVERDOSE

The purpose of this protocol is to assist **all HOPS staff** with identifying and managing residents with opioid overdose.

### Opioid Overdose

#### Background

The opiate class includes:

- Substances directly derived from the opium poppy (such as opium, morphine, and codeine)
- The semi-synthetic opioids (such as heroin)
- The purely synthetic opioids (such as methadone and fentanyl)

The opiate affects the mu, kappa and delta types of central nervous system receptors. The mu receptors' pharmacological effects include sedation, respiratory depression and analgesia as well as intoxication and withdrawal. The time to peak serum concentration and the half-life depends on the specific opiate in question and will affect the length of time to intoxication.

#### Commonly used opioids:

Codeine  
Heroin  
Morphine  
Demerol  
Amiloridine (Leritine)  
Methadone  
Hydromorphone (Dilaudid)  
Fentanyl  
Opium  
Pentayocine (Talwin)  
Percocet (Percodan)

#### Opiate intoxication symptoms include:

Depressed level of consciousness (LOC)  
Constricted pupils  
Decreased respiration  
Gurgling, snoring  
Body is limp  
No response to noise or knuckles being rubbed firmly on the sternum  
Skin looks pale or blue, and feels cold  
Slow or no pulse  
Person cannot stay awake  
Pinpoint pupils  
Cannot talk or walk

#### Opiate withdrawal symptoms include:

Anxiety, irritability  
Dilated pupils  
Sweating  
Nausea/vomiting

#### Opioid intoxication is a continuum of four stages based on LOC including:

1. Drowsiness
2. Nodding (intermittently falling asleep)
3. Nodding with respiratory rate less than ten breaths per minute
4. Unresponsive

**In this situation, HOPS staff will:**

- Remain calm
- Attempt to wake up resident
- Shake and talk to resident
- Get resident to open eyes
- Get resident to talk
- If responsive, assist to walk around
- If above steps are unsuccessful, initiate the **Opioid Overdose Protocol**

**Opioid Overdose Protocol** (BCCDC, 2016)

**Identify**

- Before approaching MAKE SURE AREA IS SAFE- clear away any needles and put on gloves
- UNRESPONSIVE (doesn't respond to verbal stimulation (shout their name) or pain (tell them what you are going to do: nudge/touch them, then do sternal rub/pinch ear lobe/finger webbing)
- SLOW BREATHING (less than 1 breath every 5 seconds), may be snoring/gurgling
- Skin (may be pale or blue, especially lips and nail beds; may be cool or sweaty)
- Eyes (pinpoint (i.e. very small) pupils)

**Take Charge**

- DELEGATE tasks (examples below, some can be done by 1 person, some may not be needed)
- (1) Phone 911 (2) Rescue breathing (3) Meet emergency responders and direct them to the OD (4) Get overdose response supplies (5) Give naloxone (6) Crowd control (7) Read these instructions

**Call 911**

- PHONE 911
- Say it is a medical emergency (not responsive not breathing) make sure ambulance is dispatched
- Give the address to the dispatchers
- Send someone to meet emergency responders at main entrance or street and direct them to the agency of the overdose

**Rescue Breathing**

- Clear mouth/airway & tilt head back
- You can use a breathing mask as a barrier
- PINCH NOSE and give 2 breaths
- Continue to give 1 BREATH EVERY 5 SECONDS (even after giving naloxone, until the person regains consciousness or paramedics arrive)

**Give Naloxone**

- If the person has not regained consciousness with rescue breathing:
- Swirl the ampoule, then snap the top off the ampoule (away from your body)
- Draw up all of the naloxone in the ampoule (1 mL) into the Vanishpoint syringe
- Inject entire dose at 90° STRAIGHT INTO A MUSCLE (THIGH, upper arm, butt) can inject through clothes

**Evaluate**

- WAIT 3-5 MINUTES to see if the person regains consciousness
- Don't forget to CONTINUE RESCUE BREATHING 1 breath every 5 seconds until the person is breathing on their own
- You should give 40-50 breaths before deciding to give an additional dose of naloxone

**More Naloxone**

- If there is no response after 3-5 minutes, GIVE A 2<sup>ND</sup> DOSE OF NALOXONE (as described above)
- WAIT 3-5 MINUTES - about 40 breaths (CONTINUE TO GIVE RESCUE BREATHS)
- Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive

**Document and Debrief**

Tell paramedics about all emergency care provided (including # naloxone injections given)  
 Fill out your organization's Critical Incident form and any other required paperwork  
 Talk to your co-workers and/or agency coordinator and/or agency manager and/or access support through your employer (BCCDC, 2016)

**Stages of Opioid intoxication:**

Stage	Services Provider Response
<b>One: Drowsy</b>	<ul style="list-style-type: none"> <li>• Monitor Closely</li> </ul>
<b>Two: Nodding</b> (intermittently falling asleep)	<ul style="list-style-type: none"> <li>• Remain calm, monitor – paying attention to respiratory rate/minute</li> <li>• May verbally check in with the participant – being mindful not to disrupt their experience</li> </ul>
<b>Three: Nodding</b> with respiratory rate less than ten breaths per minute	<ul style="list-style-type: none"> <li>• Remain calm, attempt to wake participant</li> <li>• Gently shake and talk to participant</li> <li>• Get participant to open eyes</li> <li>• Get participant to talk</li> <li>• If responsive, assist to walk around</li> <li>• If available, may require oxygen</li> </ul>
<b>Four: Unresponsive</b>	<b>Initiate Opioid Overdose Protocol</b>

(BC Overdose Prevention Services Guide, 2017)

**Stimulant Overdose (PHS, 2016)**

Stimulants can cause increased heart rate, blood pressure, and body temperature. A stimulant overdose can cause cardiac or respiratory arrest as well as seizure. Patients may report chest pain, shortness of breath, disorientation, or panic. These symptoms require medical attention, and the person should be supported to attend hospital via ambulance.

Commonly used stimulants include:

- Cocaine
- Crack cocaine
- Amphetamines
- Ritalin
- Adderall

**Responding to a Stimulant Overdose**

Stimulant overdose has a variety of presentations and can be precipitated by lack of sleep. Signs that a person may have taken too much of a stimulant drug includes agitation, shaking or chest pain and a high level of anxiety. The person should be monitored, kept safe and encouraged to attend hospital.

A stimulant overdose can lead to seizure, heart attack, or stroke as a result of elevated body temperature, heart rate, blood pressure, as well as dehydration.

**If the person is having a seizure:**

- Don't restrict their movement
- Don't put anything in their mouth
- Protect their head (place a pillow underneath their head)
- Place the person in the recovery position.
- Call 911

**Additional steps you can take in the event of a stimulant overdose:**

Apply cool cloth to back of person's neck or to forehead

Limit stimulation by moving the person to a quiet location with low light

Encourage person to take slow, deep breathes

If person becomes unconscious or has chest pain call 911. Perform assessment and intervention to maintain airway, breathing, and circulation (PHS, 2016)

# HOW TO RESPOND TO AN OPIOID OVERDOSE

## Know the signs



Not moving and can't be woken



Slow or not breathing



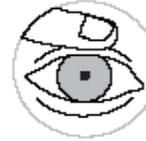
Blue lips and nails



Choking, gurgling sounds or snoring



Cold or clammy skin



Tiny pupils

**Call 911**



Stay and help. Canada's Good Samaritan law can protect you\*  
More at: [canada.ca/opioids](http://canada.ca/opioids)

## Know the SAVE ME steps to save a life



**STIMULATE**  
Unresponsive? Call 911



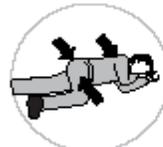
**AIRWAY**  
Check and open



**VENTILATE**  
1 breath every 5 seconds



**EVALUATE**  
Breathing?



**MEDICATION**  
1 ml of Naloxone

Keep giving breaths. Brain damage can occur within minutes.



**EVALUATE & SUPPORT**  
Another dose?

\* If you are at the scene of an overdose and you or someone else calls 911 to get medical assistance, you are not to be charged with simple possession (possession for your own personal use) of an illegal substance. You are also not to be charged for breach of probation or parole relating to simple drug possession.

**APPENDIX M: RESCUE BREATHING**

**Should you give breaths or compressions?**

In a witnessed overdose, it is likely that the client’s heart is still beating. Towards the Heart (BCCDC) recommends prioritizing giving breaths because the person is lacking oxygen due to depressed activity of the central nervous system. Breathes should be given every 5 seconds while preparing to administer naloxone.

If you come across someone who is unresponsive and suspect overdose:

- Check the scene for safety, clear uncapped rigs or other hazards
- Confirm level of consciousness with a firm trapezoid pinch or by rubbing your knuckles on their sternum
- Check for breathing and carotid pulse (10 seconds max) while looking for signs of cyanosis or insufficient blood oxygen, like bluishness around the lips and eyes
- In addition to breaths, if the person has been oxygen deprived for a long or unknown amount of time and you are CPR trained, give chest compressions in addition to breaths while preparing to administer naloxone

**Simple Face Shield or Bag-Valve Mask (BVM)?**

- A face shield with a one-way valve is easy to use and recommended by the BCCDC for those trained in the SAVE ME steps to respond to an overdose
- Management of ventilations with a BVM is a high-skilled intervention that should only be use by trained professionals.

Problems that can arise from improperly using a BVM are:

- Inadequate ventilations due to improper seal
- Over-ventilating
- Difficulty maintaining airway while using the BVM
- Complications arising from forcing air down the esophagus (vomiting)

**Would you give rescue breaths, chest compressions, or both, in the following scenarios?**

a. Clients observed their friend overdosing and come find you immediately	Rescue Breaths
b. You are doing a room check and come across a resident who is unconscious and not breathing	Both
c. You watch a client slump over and stop breathing	Rescue Breathing
d. On your scheduled bathroom check you find a client unconscious but gurgling and taking shallow breaths	Rescue Breathing

\*Although liability related to administering naloxone is a common concern, there are no known legal action cases. Bystanders are protected under the BC Good Samaritan Act.

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**Note:** This is a **controlled** document for VCH internal use. Any documents appearing in paper form should always be checked against the electronic version prior to use. The electronic version is always the current version.

**References:**

Pozner, C. M. (2016, April) Basic life support (BLS) in adults. Retrieved December 12<sup>th</sup> from [https://www.uptodate.com/contents/basic-life-support-bls-in-adults?source=search\\_result&search=basic%20life%20support%20in%20adult%20bls&selectedTitle=1~40](https://www.uptodate.com/contents/basic-life-support-bls-in-adults?source=search_result&search=basic%20life%20support%20in%20adult%20bls&selectedTitle=1~40)

Wittels, A. K. (2016, January) Basic airway management in adults. Retrieved December 12<sup>th</sup> from [https://www.uptodate.com/contents/basic-airway-management-in-adults?source=search\\_result&search=basic%20airway%20management%20in%20adults&selectedTitle=3~150](https://www.uptodate.com/contents/basic-airway-management-in-adults?source=search_result&search=basic%20airway%20management%20in%20adults&selectedTitle=3~150)

BCCDC (2016, November) Retrieved December 12<sup>th</sup> from [http://towardtheheart.com/assets/uploads/THN%20Training%20Manual%20Final\\_2016.11.30.pdf](http://towardtheheart.com/assets/uploads/THN%20Training%20Manual%20Final_2016.11.30.pdf)

## Unknown Substances Left Behind Policy (VCH, 2016)

(Includes fillable form and log, Insite, 2016)

Any controlled or unknown substances left on agency will immediately be brought to the attention of the manager. The substance may be a variety of forms:

**Solid:** powder/crystals/resin etc. and contained in an envelope, flap or other wrapping. Use a gloved hand to transfer contained substance into an envelope which is then sealed, dated and initialed by the manager. The envelope will be placed in a locked safe in the SIS staff-only area. Fill out form and log sheet for 'Unknown Substance Left Behind' and place in locked safe by the manager. The Vancouver Police Department (VPD) will be contacted on the same day to collect the substance and a VPD officer must sign the form when removing substance from the premises.

**Liquid:** in a used/unused syringe. Use a gloved hand to handle tongs, which will be used to transfer syringe to a sharps container. Fill out form for 'Unusual Substance Left Behind' with a witness, logging incident on log sheet and accessing locked safe not necessary for a liquid form.

**Agency Specific:** Describe any physical security measures that restrict access to and protect the controlled substances and precursors, that are currently or will be in place (for example: safe, locked cabinet, locked room, security monitoring, access keypads, swipe cards, door contact protection, video surveillance, etc.).

Store all documentation in "Unknown Substances Left Behind" Binder.

### Theft

In the event of theft from the locked safe, VPD will be notified. There is no other controlled substances and precursors for controlled substances stored on agency.

# UNKNOWN SUBSTANCE LEFT BEHIND

Any member of staff or client who finds an amount of 'unknown substance' in the facility that is not upon a client's person, must complete this form and report the incident to the manager.

Date of report: \_\_\_\_\_

**Reported by:** \_\_\_\_\_ **Position:** \_\_\_\_\_

## WHERE SUBSTANCE FOUND

- Washroom
- Reception/waiting area
- Injection room
- Chillout Lounge
- Other

## LOG IN

If substance found was in:

1) Solid form, place in envelope and numbered according to next # on log sheet:

# \_\_\_\_\_ and sign form with witness.

Sealed, numbered and put in safe by: \_\_\_\_\_ (print name)

2) Liquid form in syringe, dispose in sharps container and sign form with witness (log form not necessary).

Witnessed by: \_\_\_\_\_ (print name)

Witness signature: \_\_\_\_\_

## LOG OUT

Date VPD called for pick up: \_\_\_\_\_

Date VPD removed from SIS: \_\_\_\_\_

VPD name: \_\_\_\_\_

VPD signature: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Witness signature: \_\_\_\_\_

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## APPENDIX O: REASONS FOR REFUSAL

### Reasons for Refusal to OPS (Insite, 2016)

People may be politely denied admittance if:

- They refuse to sign a waiver or to give reception their OPS handle
- They have a medical condition which needs emergency attention
- They have no intention of injecting drugs on the premises
- They have a child with them
- They are under 16 years of age (note: see youth policy for details on access for 16-19 yr olds)
- They are currently on the temporarily prohibited list
- The site is full (note: see policy on staff: participant ratios)

### Prohibited from Using the Site:

There are 3 levels of prohibited access to the site:

1. Prohibited from using the site for the rest of the shift/day:

- Participant's behavior that is extremely difficult to control or refusing to follow staff direction

2. Prohibited from using the site for 24 hours, and access again only after speaking with RPIC:

- Threats or violence directed against staff or participants, or dealing on site

3. Prohibited from using the site for a period over 24 hours, and access again only after conferring with staff and arranging a meeting with 2 RPICs or an RPIC and Manager:

- Repeated or serious threats or violence
- 2-RPIC prohibitions are requested by staff (via email to explain the incident in more detail than the alert flag note) and set by RPICs

### **Participants can be prohibited from using the site for the day by any staff, due to:**

- Uttering threats of violence or carrying out violence against anyone on the premises.
- Attempting to deal, purchase or share drugs on the premises.
- Periods of prohibition of more than one day will be set by the RPIC if they determine that the circumstances are severe enough to warrant it.

### **Readmission after Being Prohibited from Using the Site**

Readmission After Being Prohibited from Using the Site:

- Barred participants must meet with the RPIC/ARPIC. They will be readmitted after RPIC/ARPIC is assured that the behaviour will not continue.

### **The Steps for Staff/Participation Safety**

1. The first step is to avoid triggering conflict (e.g. communicate openly and respectfully with participants, do not get angry or demanding).
2. The second step is de-escalating conflict when it arises. This includes backing up co-workers by appropriately intervening in conflict in ways that do not make the participants more defensive and by giving the parties to a conflict an easy way out.
3. The final step, when a situation cannot be de-escalated, is to call the police. In any situation involving violence, when staff or participants feel unsafe, the police should be called.

### **Documentation of Prohibition from Using the Site**

- Staff must communicate with RPIC/ARPIC as soon as a prohibition occurs.
- The RPIC/ARPIC is responsible for making the decision to place a person on 2 RPIC prohibition after a review of the documented events.
- The prohibition list will be kept current at the Reception desk. Reason for refusal will be clearly documented.

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