

SECTION 5

Health and Safety

It is critical to create a workplace that is healthy and safe for all participants, staff, and volunteers. “Health” and “safety” are two short words that cover a lot of territory, from personal physical well-being to healthy interpersonal dynamics; from safe food-handling to sanitary cleaning practices; from fire emergency plans to safe garbage disposal; from nutritious cooking to building security.

This Section covers the good practices involved with:¹

- **5A HEALTH AND SAFETY OVERVIEW**
 - Attachments
 - Appendix 5A.1 – Health and Safety Checklist
 - Appendix 5A.2 – List of Relevant Legislation and Websites

- **5B DROP-IN HEALTH AND SAFETY**
 - Infection Control
 - Managing Staff Health
 - Hand-Washing
 - Routine Practices
 - Cleaning up a Mess
 - Safe Handling of Sharps
 - Outbreak Contingency Plan
 - Immunization
 - TB Testing
 - Emergencies
 - Maintaining Safe Facilities
 - Attachments
 - Appendix 5B.1 – List of Reportable Communicable Diseases in Ontario
 - Appendix 5B.2 – Sample Incident Report Form
 - Appendix 5B.3 – First Aid Kit Contents
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- **5C STAFF HEALTH AND SAFETY**
 - Safety Training
 - Safe Money Handling
 - Workplace Safety and Insurance Board (WSIB)
 - Joint Health and Safety Committee (JHSC)
 - Refusal to Work

¹ The headings and subheadings in Section 5 are based on and adapted from the Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

- **5D PARTICIPANT SUBSTANCE USE**
 - Defining Harm Reduction and Abstinence Approaches
 - Harm Reduction Strategies
 - Harm Reduction as Outreach and Entry Point
 - Attachment
 - Appendix 5D.1 – Sample Suspected Drug Overdose Policy

- **5E PARTICIPANT SEXUAL HEALTH**
 - Indirect Interventions
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 - Combining Direct and Indirect Strategies

- **5F CRISIS PREVENTION**
 - Managing the Space
 - Physical Environment
 - Spatial Capacity
 - Staff Training and Preparation
 - Inter-Agency Coordination
 - Informal Counseling and Conflict Resolution Workshops

- **5G CRISIS INTERVENTION AND CONFLICT RESOLUTION**
 - Step-By-Step Intervention Process
 - Communication
 - De-Escalation Techniques
 - Documentation
 - Attachment
 - Appendix 5G.1 – Sample Incident Report Form

- **5H CLEANING AND SANITATION**
 - Sanitizing Solution
 - Surfaces and Appliances
 - Dishes and Utensils
 - Kitchen Linen
 - Bathrooms
 - Attachment
 - Appendix 5H.1 – Bleach and Water Solutions

- **5I SAFE STORAGE**
 - Dishes and Utensils
 - Cleaning Materials
 - Garbage
 - Pest Control

- **5J FOOD AND NUTRITION**

- Obtaining Food
- Fruits and Vegetables
- Special Diet Needs
- Allergies
- Food Storage
- Food Preparation
- Temperature Control
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- Attachment
 - Appendix 5J.1 – Temperatures for Cooking and Reheating Hazardous Food

SUBSECTION 5A

Health and Safety Overview

It is vital to create a workplace that is healthy and safe for all participants, staff, and volunteers. This involves creating health and safety policies and guidelines that comply with current legislation. It is a good practice to update these policies as legislation is amended and review these policies on a regular basis with feedback from stakeholders within the drop-in.

When developing or reviewing your health and safety guidelines, ask yourself:²

- Do you have policies and procedures that promote the health, safety, and well-being of those involved with the drop-in?
- Are the health and safety policies and guidelines current with municipal, provincial, and federal legislation?
- Do all new employees receive a copy of a health and safety manual or set of guidelines? If not, are there other mechanisms in place to ensure that new employees are familiar with the drop-in's health and safety policies? Are they sufficient? Do all new employees have a person they can speak with if they have any questions or concerns about the policies, and their responsibilities for ensuring compliance with the policies and procedures?
- Are the health and safety guidelines kept in an accessible location for easy reference?

Appendix 5A.1 provides a checklist to facilitate the review and development of policies and guidelines in your drop-in. This checklist outlines some of the main health and safety topics in workplace legislation and relevant to drop-ins.

Health and safety legislation regulates the standards of workplace safety with the aim to prevent workplace accidents and injuries, and outlines the consequences of breaching those standards. It details responsibilities of employers, supervisors, and employees. Generally, this legislation requires that employers do everything they can reasonably do to protect the health and safety of their employees; for example, providing appropriate training for handling potentially dangerous equipment or material, informing employees

² Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

of potential dangers in the workplace, and setting up safe work practices. Employees have the right to refuse work that is unsafe.

Drop-ins need to consult health and safety legislation and regulations on a variety of issues, including (but not limited to):³

- Employee refusal to work because of unsafe conditions,
- Violence in the workplace,
- Dangerous equipment or material,
- Lifting heavy objects,
- Emergency procedures,
- Food preparation and storage,
- Infection control, and
- First Aid skills requirements.

You may contact your provincial office dealing with Occupational Health and Safety if you have any questions or concerns about your workplace. See **Appendix 5A.2** for a list of relevant legislation and helpful websites.

ATTACHMENTS:

- **Appendix 5A.1 – Health and Safety Checklist**
- **Appendix 5A.2 – List of Relevant Legislation and Websites**

³ *Ibid.*

Appendix 5A.1 Health and Safety Checklist

Source: Adapted from the Health and Safety Checklist in the Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

Note: The following checklist is a point-form list of the good practices discussed more fully throughout Section 5. For clarification or more information, please refer to the relevant Subsections indicated in the list.

CHECKLIST

Health and Safety Overview (5A)		
CRITERIA	In Place	To Be Developed
<p>Policies and Procedures</p> <ul style="list-style-type: none"> • Policies and procedures are in place that promote the health, safety, and well-being of those involved with the drop-in • Policies and procedures are in line with current legislation and are periodically reviewed • All staff are familiar with the drop-in's health and safety policies and procedures • Policies and procedures are stored in an accessible location for easy reference including incident/accident report forms. • The drop-in has a Joint Health and Safety Committee or Representative as required by law 		
Personal Safety (5B, 5C, 5D, & 5E)		
CRITERIA	In Place	To Be Developed
<p>Staff and Volunteers</p> <ul style="list-style-type: none"> • Safety training (e.g. First Aid and CPR, Food Handling Certification, WHMIS Handling and Storage of Chemicals, Conflict Resolution) 		
<p>Participants</p> <ul style="list-style-type: none"> • Substance use interventions (e.g. safe space, monitoring, overdose protocol, crack kits, non-judgmental conversations, referrals) • Sexual health interventions (e.g. condoms and lube, brochures, workshops, testing, education, non-judgmental conversations, referrals) 		

<p>Drop-In <i>Infection Control</i></p> <ul style="list-style-type: none"> • Infection control practices consistent with local public health requirements • Proper hand-washing practices by staff • Hand-washing posters are on display • Baseline and periodic TB testing for all staff • Staff immunizations are current • Staff are trained in how to clean up messes involving body fluids and have the tools to do so (e.g. bleach, disposable gloves) • Container(s) for safe sharps disposal • Outbreak contingency plan 		
<p><i>Emergencies</i></p> <ul style="list-style-type: none"> • First Aid kits are accessible and well stocked • A fire safety plan has been developed and approved by the Fire Marshall and is posted in a visible place • Search and evacuation protocol • Emergency numbers are posted by every phone • Current emergency contact information for every staff and volunteer is on file 		
<p><i>Maintaining Safe Facilities</i></p> <ul style="list-style-type: none"> • Joint Health and Safety Committee or Representative conducts regular inspections of workplace, following guidelines set out by the City • All equipment and furniture is maintained and broken items repaired promptly • The maximum capacity of the drop-in space is known and is not exceeded • There is no smoking within the building and “No Smoking” signs are posted • Fire extinguishers are available and checked regularly • Chemicals and cleaning supplies are labeled clearly and stored out of reach of children 		
Crisis Prevention and Conflict Resolution (5F & 5G)		
CRITERIA	In Place	To Be Developed
<p><i>Crisis Prevention</i></p> <ul style="list-style-type: none"> • Rules for behaviour within the drop-in exist and are clearly posted 		

<ul style="list-style-type: none"> • Drop-in has an anti-discrimination and anti-harassment policy • Staff know how to manage and monitor the space effectively (e.g. look for warning signs, do not exceed maximum capacity, respond to harmful comments and behaviours in timely and appropriate ways) • Staff have been trained in crisis prevention, de-escalation techniques, and conflict resolution • Staff are aware of their own triggers 		
<p><i>Crisis Intervention</i></p> <ul style="list-style-type: none"> • Staff have ways to communicate with each other while in different rooms of the drop-in • Staff have procedures in place for handling a crisis situation • Staff debrief after a crisis • All crisis situations are documented in standardized incident reports 		
Cleaning and Sanitation (5H)		
CRITERIA	In Place	To Be Developed
<p><i>General</i></p> <ul style="list-style-type: none"> • Staff are aware of and use proper cleaning, sanitizing, and disinfecting procedures • Staff have been trained in routine practices for cleaning up body fluids • Bleach and water solution is made fresh for disinfecting purposes 		
<p><i>Dishes</i></p> <ul style="list-style-type: none"> • The drop-in has a dishwasher • If the drop-in washes dishes manually, dishes are soaked in a sanitizing solution for at least 45 seconds 		
<p><i>Surfaces</i></p> <ul style="list-style-type: none"> • Counters, tables, and cutting boards are sanitized before and after each use • High-traffic surfaces (e.g. door knobs, light switches) are sanitized at the end of each drop-in day 		
<p><i>Appliances</i></p> <ul style="list-style-type: none"> • Appliances that come into direct contact with food (e.g. dishwasher strainer, sinks, blenders) are sanitized after each use 		

<ul style="list-style-type: none"> • Microwaves are cleaned immediately when there is a spill and thoroughly at least once a week • Other appliances are cleaned immediately when there is a spill and thoroughly at least once a month (e.g. ovens, fridges) • Freezers are cleaned immediately when there is a spill and thoroughly at least twice per year • Freezer food is not stored for over 1 month 		
<p><i>Other</i></p> <ul style="list-style-type: none"> • Kitchen linen is changed at least once a day and as required throughout the day • Toilets and flushing handles are cleaned and sanitized at least once a day • Bathroom sinks and countertops are cleaned and sanitized at least once per day • Bathroom floors are swept or vacuumed daily and mopped with cleaner when obviously dirty 		
Safe Storage (5I)		
CRITERIA	In Place	To Be Developed
<p><i>Dishes and utensils</i></p> <ul style="list-style-type: none"> • Knives, spoons, and forks are stored in clean containers with the handles all pointing in one direction • Glasses and cups are stored upside-down on a clean, dry surface • All dishes are stored on clean shelves or in clean cabinets 		
<p><i>Cleaning materials</i></p> <ul style="list-style-type: none"> • Soap, detergents, sanitizer, and any other cleaning products are clearly labeled and kept in a locked cupboard • Staff are familiar with the requirements of the Workplace Hazardous Material Information System (WHMIS) • Dry floor mops are shaken outside after every use and laundered when noticeably dirty • Sponge mops are hung with the head up to dry and the head is washed in a sanitizing solution and wrung out once a week • Rag mops are hung head up to dry and laundered once a week 		
<i>Storing and disposing of garbage</i>		

<ul style="list-style-type: none"> • Separate garbage containers are available in the washrooms, kitchen, eating, and program areas • Garbage containers are waterproof, lined with plastic bags, kept tightly covered, and distanced from food • Garbage is disposed of daily • Garbage containers are sanitized once a week and whenever containers are visibly soiled • Staff follow proper recycling methods • Staff never touch garbage; they lift it out of the container by the bag, or, if the bag breaks or overflows, by using tongs or some other tool 		
<p><i>Pest control</i></p> <ul style="list-style-type: none"> • The areas behind stationary equipment and shelves are kept clean • Doors and windows have screens, and all holes and crevices are caulked or stuffed with steel wool • Received goods are checked for infestations • Staff report any sightings of pests or infestations • Any dead pests are disposed of immediately 		
Food and Nutrition (5J)		
CRITERIA	In Place	To Be Developed
<p><i>Planning Menus</i></p> <ul style="list-style-type: none"> • Meals are planned, nutritious and balanced • Participants' special dietary needs are taken into consideration (e.g. health concerns, allergies, religious restrictions) • Donations of food are accepted from reliable sources 		
<p><i>Handling Food</i></p> <ul style="list-style-type: none"> • Staff and regular volunteers have taken the Food Handler Certification Program • Food is prepared, served, and stored in a safe and hygienic manner • Hand soap and paper towels are available • There is a separate hand-washing sink in the kitchen • There are mechanisms in place to avoid cross-contamination 		
<p><i>Food Storage</i></p> <ul style="list-style-type: none"> • Food items are stored at least fifteen centimeters (6 inches) above the floor 		

<ul style="list-style-type: none"> • Items are checked regularly for expiry dates and thrown away as needed • Food is not stored in the same areas as possible sources of contamination • Refrigerated food is kept below 4°C and frozen food is kept below -18°C • Meat and non-meat items are stored separately • Ready-to-eat foods are stored in a separate fridge or on a shelf above raw foods • All food and drinks are kept covered inside the fridge 		
<p><i>Temperature Control</i></p> <ul style="list-style-type: none"> • Hazardous food is not permitted to remain in the danger zone (4°C to 60°C) for more than two hours • Food is cooked thoroughly and until its internal temperature has reached the appropriate level according to a probe thermometer • There are reliable thermometers in the fridges and freezers • Leftover food is reheated to at least 74°C • Participants who take home leftover food are aware of the temperatures it must be stored at and the timeframe within which it must be eaten 		

Appendix 5A.2 List of Relevant Legislation and Websites

LIST OF RELEVANT LEGISLATION AND WEBSITES

1. Occupational Health and Safety Act

www.e-laws.gov.on.ca/DBLaws/Statutes/English/90o01_e.htm

The Canadian Centre for Occupational Health and Safety has an excellent, comprehensive web site (www.ccohs.ca). The “OSH Answers” section (www.ccohs.ca/oshanswers/) addresses common questions, including information about legislation, and is a good source of information about occupational health and safety.

2. Workplace Safety and Insurance Act

www.e-laws.gov.on.ca/DBLaws/Statutes/English/97w16_e.htm

3. Workplace Safety and Insurance Board (WSIB)

www.wsib.on.ca

A copy of the Employer’s Report of Injury / Disease (Form 7) is available at:

[www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileReportofInjuryForm7/\\$File/Form7.pdf](http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileReportofInjuryForm7/$File/Form7.pdf)

A copy of the Worker’s Report of Injury / Disease (Form 6) is available at:

[http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileForm6forWorker/\\$File/0006A.pdf](http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileForm6forWorker/$File/0006A.pdf)

4. Workplace Hazardous Materials Information System (WHMIS) Regulation

www.e-laws.gov.on.ca/DBLaws/Regs/English/900860_e.htm

WHMIS is a Canada-wide system that was put in place through a range of complementary federal, provincial and territorial legislation. In Ontario, it was incorporated into the Ontario Health and Safety Act as Regulation 860. The OSH Answers page (www.ccohs.ca/oshanswers) responds to frequently asked questions about the legislation, and the Ontario Ministry of Labour provides a comprehensive guide to each of its component sections (www.labour.gov.on.ca/english/hs/whmis).

5. Toronto Public Health

www.toronto.ca/health/index.htm

The home page of Toronto Public Health, given above, is an excellent source for up-to-date information on health issues affecting Toronto. For example, it tells you when there is an extreme heat alert or a cold weather advisory in effect for the day you are checking it on. For more general information, the A-Z index is an excellent resource (www.toronto.ca/health/az_index.htm).

6. Health Canada

www.hc-sc.gc.ca

The Health Canada website provides connections to a variety of federal laws, regulations, programs, and general information sources. For example, it gives information on Diseases and Conditions (www.hc-sc.gc.ca/dc-ma/index_e.html), Environmental and Workplace Health (www.hc-sc.gc.ca/ewh-semt/index_e.html), First Nations and Inuit Health (www.hc-sc.gc.ca/fnih-spni/index_e.html), Food and Nutrition (www.hc-sc.gc.ca/fn-an/index_e.html), and the Health Care System (www.hc-sc.gc.ca/hcs-sss/index_e.html), among others.

7. Toronto Fire Services

www.toronto.ca/fire/prevention/workplace.htm

The Toronto Fire Services website has links to a variety of useful resources, including by-laws and safety standards (www.toronto.ca/fire/bylaws.htm) and a downloadable pamphlet on “Fire Safety in the Workplace” (www.toronto.ca/fire/prevention/pdf/fire_work_place.pdf).

SUBSECTION 5B

Drop-In Health and Safety

Ensuring the safety and well-being of drop-in participants, staff and volunteers is one of the primary concerns in running a drop-in. In general, unsafe situations should be:

- Prevented where possible,
- Anticipated and prepared for,
- Addressed calmly and quickly,
- Reported and documented immediately, and
- Followed up with appropriately.

Infection Control

Many drop-in participants lead lives that put them at risk for a variety of infectious diseases, and many already have compromised immune systems. Drop-ins need to be aware of specific diseases and their means of transmission, and take careful precautions to avoid this.

Infection control is the use of proper procedures to reduce the likelihood of infection or the spread of infectious disease. These procedures include:⁴

- Hand-washing,
- Using routine practices when handling body substances,
- Using gloves and other methods of barrier control,
- Safe handling of sharps (sharp objects),
- Proper handling of waste, and
- Cleaning physical facilities.

This Subsection draws on Toronto Public Health's recently developed manual called ***Breaking the Chain: Infection Prevention and Control for Homeless and Housing Service Providers***. This manual will be distributed to all service providers working with socially marginalized people, and TPH will be conducting training sessions in Fall 2006. It is also available online at the City of Toronto's website, and contains posters that service providers are encouraged to download, print, and post (www.toronto.ca/health/cdc/infectioncontrolmanual.htm).

⁴ Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005 and Toronto Public Health (TPH), *Breaking the Chain: Infection Prevention and Control for Homeless and Housing Service Providers*, March 2006. Available at: www.toronto.ca/health/cdc/infectioncontrolmanual.htm.

Managing Staff Health

Staff and volunteers have an important role to play in managing their own health. It is recommended that everyone eat well, exercise moderately, get sufficient rest, and practice proper hygiene in order to stay healthy and avoid getting sick. When staff are sick and there is the possibility of transmitting their illness to others, they should not come into work. Even a relatively minor illness, like a cold or a flu bug, can have serious consequences for participants living with HIV/AIDS, with chronic pulmonary infections, or with otherwise compromised immune systems. Compensating employees while they are off sick is good practice. Staff and volunteers should be encouraged to get flu shots and check with their physician to ensure that they receive immunizations when appropriate.

Hand-Washing

Hand-washing is the single most important thing drop-in staff (and especially food workers) can do to control the spread of pathogenic bacteria. Hand-washing posters should be posted in the drop-in; posters are available for downloading and printing from the Toronto Public Health web site.⁵

The following hand-washing procedure should be followed by all staff and volunteers:⁶

1. Use liquid soap and warm running water.
2. Wet your hands and add soap.
3. Rub your hands vigorously for fifteen seconds.
4. Wash all surfaces, including the backs of hands and between fingers.
5. Rinse your hands well under running water.
6. Dry your hands thoroughly with a single-use towel.
7. Turn off the taps with a single-use towel and dispose of it in waste container.

Hand-washing is always done:⁷

- Before and after all meals, snacks, and food-handling of any kind;
- After using the bathroom;
- After sneezing, coughing, blowing your nose, touching or scratching the body;
- After touching pets or other animals;
- Before and after assisting with or performing First Aid;
- Before and after handling clean dishes or utensils;
- After handling garbage; and
- After outdoor activities.

⁵ TPH, "Handwashing:" www.toronto.ca/health/sars/pdf/sars_handwashing.pdf.

⁶ This list has been adapted from TPH, *Breaking the Chain*, page 103, and MAFRP, *Family Support Health and Safety Toolkit*, 2005.

⁷ *Ibid.*

Routine Practices

“Routine practices,” “universal precautions,” and “blood-borne precautions,” are all terms that are used to describe the process of treating all blood as if it were infected with blood-borne germs, such as HIV or Hepatitis B. This means that basic procedures are to be followed either to avoid or prevent contact with blood, to use a barrier (such as gloves) when blood contact is unavoidable, and to kill germs correctly.⁸

All body fluids from any individual should be handled in a routine manner to prevent the spread of infection, and staff and volunteers should recognize that infectious disease does not have to be evident to be present. Good routine practices are based on an understanding of the chain of infection. The chain shows that disease-causing organisms must first be transmitted in the environment from an infected person, contaminate a new person, and enter that person’s body.⁹

The single most important method of reducing the spread of infectious diseases is frequent and thorough hand washing with soap and water and hand disinfection with an alcohol-based hand sanitizer. Hand sanitizer is an effective disinfectant, but it does not replace hand-washing. If there is any dirt or debris on your hands, use soap and water.¹⁰

The drop-in should also develop a systematic approach for dealing with people who are already exhibiting signs of illness. For example:¹¹

- Any participant, staff, or volunteer cannot come to the drop-in if they have a contagious illness;
- Anyone who is suffering from vomiting and/or diarrhea will not be permitted into the program until it has stopped for at least 24 hours;
- Anyone with an extensive rash will be asked to see a doctor before returning to the program;
- Everyone should be asked to advise staff if they have been diagnosed with a communicable disease that could be transmitted through incidental contact with others;
- Signs of illness should be recorded in the daily log; and
- Any signs of a serious infectious illness should be reported to the Communicable Disease Surveillance Unit (CDSU). See **Appendix 5B.1** for a list of reportable communicable diseases in Ontario.

Cleaning up a Mess

⁸ TPH, *Breaking the Chain*, page 24, and MAFRP, *Effective Practices Project*, 2005.

⁹ MAFRP, *Effective Practices Project*, 2005.

¹⁰ *Ibid.*, page 25.

¹¹ Adapted from MAFRP, *Effective Practices Project*, 2005.

Messy accidents that involve urine, feces, vomit or blood are events that happen in drop-ins. Because body fluids can be infectious, it is important to clean and sanitize surfaces after a spill. However, when following these precautions and procedures, it is important to avoid creating an atmosphere of fear and suspicion.¹²

Toronto Public Health's *Breaking the Chain* manual recommends cleaning up messes involving body fluids in the following way:¹³

1. Make sure that the area where the body fluid spill has occurred is blocked off and program participants are away from the affected area.
2. Wash hands for at least 15 seconds using soap and water.
3. Put on disposable rubber gloves specific for cleaning. Latex gloves should not be worn as they are not designed for withstanding cleaning solutions.
4. Wipe up the spill using disposable paper towels, then place paper towels in a garbage bag.
5. Clean area using soap and water or a detergent solution. Rinse and dry the area with disposable paper towels.
6. Sanitize all contaminated areas using a fresh bleach solution of nine parts water to one part bleach. Be careful not to spill the bleach on your skin or clothing.
7. Let the area air dry for 20 minutes.
8. Any mops or non-disposable materials should be soaked in the bleach solution and air dried.
9. Remove gloves and place in the garbage bag. Double bag and secure the garbage bag before throwing out.
10. Wash hands for at least 15 seconds using soap and water.

Kit. A clearly labeled "Cleaning up Messes" kit should be kept in the centre in a safe place containing:¹⁴

- One plastic pail,
- One mop,
- One or more package(s) of disposable gloves,
- One large container of bleach,
- Two packages of paper towels, and
- One package of heavy plastic bags.

Wearing gloves.¹⁵ Gloves do not replace hand washing; they provide additional protection over and above hand washing. Gloves should be worn whenever you expect

¹² MAFRP, *Effective Practices Project*, 2005.

¹³ TPH, *Breaking the Chain*, page 30.

¹⁴ MAFRP, *Effective Practices Project*, 2005.

¹⁵ *Ibid.*

your hands to have direct contact with blood, body fluids or substances, mucous membranes, non-intact skin, or the surface of articles that are soiled with the same.

Recommended guidelines for using gloves:

- Gloves must be worn when there is contact with most body parts or bodily substances;
- Gloves must be worn to clean soiled supplies or surfaces;
- Use either non-latex or vinyl gloves;
- One pair of gloves should be used for one person only;
- Thoroughly wash your hands before putting gloves on, removing them, or changing pairs; and
- Do not wash or otherwise attempt to reuse gloves.

You should not delay emergency action (such as stopping bleeding) because you do not have gloves. The risk to you is not nearly great enough to justify further endangering the person who needs your help. It is important, however, to check to see if your hands already have breaks in the skin.

Safe Handling of Sharps

Blood-borne infections are often transmitted by sharp object injuries. “Sharps” refer to items such as **syringes, razors, and broken glass**.

Needles are especially dangerous, since it is relatively easy to accidentally puncture your skin when attempting to dispose of them. There is potential for injection of hazardous drugs, but injection of infectious fluids, especially blood, is by far the greatest concern. Even small amounts of infectious fluid can spread certain diseases, such as HIV, Hepatitis B, and Hepatitis C.

If you find a needle, do not attempt to re-cap it – this is one of the major causes of needlestick injury. It is essential to dispose of needles properly. If needles are tossed into the garbage, they can poke through the bag and injure people. If a needle punctures your skin, make sure that it does not plunge and release its contents. You need to report this injury right away and seek immediate medical attention. You should also complete an incident report as soon as you can (see **Appendix 5B.2** for a sample form).

It is a good practice to provide **needle disposal containers** made of puncture-resistant material at the drop-in, so that participants know they have safe methods for throwing out their syringes. Some drug stores or pharmacies will provide sharps containers and will empty them for you when they are full. You may also contact hospitals, health units, and municipal waste facilities for assistance in disposing of sharps.¹⁶

¹⁶ TPH, *Breaking the Chain*, pages 27 and 107.

Outbreak Contingency Plan¹⁷

A centre is having an outbreak if the number of ill participants and/or ill staff exceeds what you would normally expect for a certain time period, age group, program time, geographic area.

The following steps are to be followed if an outbreak is identified:

1. Clarify housing status with the ill individual.
2. Send any ill individual home or make arrangements for accommodations.
3. Exclude participants, staff and volunteers until symptom-free for a prescribed period of time before returning to the program.
4. Record names, all symptoms, and the date and time of the onset of illness for each individual.
5. Contact the Toronto Public Health Regional Office to report the outbreak or contact Communicable Diseases Surveillance Unit (See **Appendix 5B.1**).
6. Step up sanitizing procedures. Increase frequency of cleaning and disinfecting. Some program participants have allergies so it is a good practice to sanitize after programs have ended and participants have left (if possible).
7. Reinforce the importance of good and frequent hand-washing for all participants, staff, and volunteers.
8. Suspend any water play activities.
9. Post a notice in the centre to advise participants of the situation.

Immunization

Drop-in workers should be encouraged to maintain up-to-date and age-appropriate immunization as recommended by the current Canadian Immunization Guide.¹⁸ Because of the risk of exposure to blood and sharps injury, it is recommended that drop-in staff be immunized for Hepatitis B.

¹⁷ MAFRP, *Effective Practices Project*, 2005.

¹⁸ See the Public Health Agency of Canada (PHAC) website for the latest edition: www.phac-aspc.gc.ca/publicat/cig-gci/index.html.

Drop-in centre staff and volunteers are encouraged to check with their physician to ensure that they receive immunization when appropriate, and to check whether specific types of immunization (e.g. the flu shot) are appropriate for them given their medical history.

Toronto Public Health recommends flu shots for everyone except:¹⁹

- Anyone who is allergic to eggs, thimerosal, neomycin or gelatin.
- Anyone who has had a reaction to the shot in the past.
- Anyone who has a fever (you must be recovered prior to getting the shot).
- Anyone who has a history of Guillain-Barré syndrome.

TB Testing

Tuberculosis (TB) is more common in homeless and underhoused populations. It can remain latent within the body for months or years, and then flare up when the body's immune system is weak. TB is only contagious during the active phase when symptoms are present.

To protect both their own health and the health of participants, staff must take a **“baseline” two-step TB skin test (TST)** when they first begin work at the drop-in (ideally, before they begin work, but otherwise within 7 days of beginning employment). Regular volunteers should be encouraged to take the test as well.

If staff have had a positive TST within the last 12 months, they should not take the test again. They should visit their family physician for medical assessment including a chest X-ray and counseling on the signs and symptoms of active TB disease.

Staff whose baseline TST shows a negative result should continue to take the TST once a year to monitor for any changes in their status. It is also a good practice for the drop-in to hold annual educational sessions on how to identify TB symptoms, risk factors for contracting and spreading the disease, reporting requirements to Toronto Public Health's Communicable Disease Surveillance Unit, and referral requirements to appropriate medical personnel.

Emergencies

First Aid. It is important to recognize that emergencies that require First Aid will occur. The following guidelines ensure that your organization is prepared to respond to emergencies quickly and effectively:

- Always have at least one staff member on site during program hours who has a current Standard First Aid Certificate and Basic CPR Certificate.
- Always keep a minimum of two, well-maintained First Aid kits at the drop-in. One of these kits can be brought on external trips when necessary. See **Appendix 5B.3** for a list of the contents of First Aid kits.

¹⁹ MAFRP, *Effective Practices Project*, 2005.

Emergency searches and evacuations. Emergency search and evacuation policies should be followed in any situation where remaining in the building may put people at risk.

Examples of when to use emergency evacuation procedures include:

- Fire,
- Gas leak or chemical spill,
- Natural disaster,
- Finding a suspicious object, and
- Any other threatening situation which could affect people's safety.

All staff and volunteers should be familiar with the drop-in's evacuation policies and procedures and review them with program participants during orientation. See **Appendix 5B.4** for sample emergency search and evacuation procedures.

Fire safety.²⁰ Every drop-in centre site needs to have a Fire Safety Plan posted in a very visible place that is approved by the Fire Marshall. **Appendix 5B.5** provides a sample outline of the steps and procedures that need to be considered as part of a Fire Safety Plan. Part of this plan involves regular education and drills with staff, volunteers, and participants to prepare for the event of a fire. After a fire has occurred, an incident report should be filled out (see **Appendix 5B.2** for a sample incident report form).

You should consult with Toronto Fire Services to develop a plan tailored to your programs and sites. For the Fire Prevention Office in your area visit www.toronto.ca/fire/contact_tfs.htm#prevention or call Access Toronto at 416-338-0338.

Emergency numbers. Drop-in centres need to ensure that emergency numbers (e.g. 911, Works Department, Toronto Public Health, etc.) and the location of the closest major intersections to the organization are posted by all phones. Drop-ins can access emergency contact information from the City of Toronto annually for posting in each site. Dialing 211 or visiting www.211toronto.ca are also ways to access information about community, social, health and government services, including medical and emotional crisis supports.

Calling 911 is appropriate in the following situations:

- Someone has become violent or aggressive with staff or others;
- Someone is seriously ill (e.g. seizure, bleeding, or injury);
- Someone is actively suicidal (they have threatened to kill themselves or have already taken steps to harm themselves);
- You believe that you or others are in immediate danger; or
- Another staff requests that you call 911.

²⁰ Adapted from MAFRP, *Effective Practices Project*, 2005.

For tips on how to handle 911 calls, please see **Appendix 5B.6**. In non emergency situations, call the Toronto Police Service non-emergency line at 416-808-2222. You may also reach this line by dialing *TPS on a cell phone.

Emergency contact information. Emergency contact names and numbers should be on file for all staff and volunteers. This information should be kept confidential, yet stored in an easily accessible location in case of an emergency. This information must be kept up-to-date; inform your supervisor if it changes.

Maintaining Safe Facilities²¹

It is the responsibility of the Joint Health and Safety Committee or the Health and Safety Representative (discussed in detail in Subsection 5C: Staff Health and Safety) at your organization to conduct regular inspections of the workplace to ensure its safety; however, everyone in a drop-in has an important role to play in ensuring that the space is safe. This includes the following considerations:

- **Basic safety protocols.** Working safely and using common sense can prevent many accidents and injuries. For example, all equipment and furniture should be well maintained and all broken items removed promptly; and all cleaning materials and supplies should be clearly labeled and stored safely.
- **Maximum capacity.** Drop-in centres need to know what their maximum capacity is and not exceed it in any room or program. The Toronto Fire Services will come and inspect your premises and advise you as to how many people can be in any one area at a time. In consulting with Toronto Fire Services about a Fire Safety Plan (as discussed above), they will address room capacity with you.
- **Non-Smoking.** The *Smoke-Free Ontario Act* came into effect on May 31, 2006, prohibiting smoking in enclosed workplaces and public places. Designated smoking rooms are no longer permitted, “No Smoking” signs must be posted in highly visible places, and ashtrays must be removed.²²
- **Reporting Unsafe Conditions.** Drop-in centres need to be committed to promptly addressing any and all unsafe conditions. Taking a risk management approach to health and safety requires staff to think ahead and work to prevent accidents before they happen. All staff and volunteers should report any conditions or situations that appear unsafe to your immediate supervisor and to the Health and Safety Committee or Representative.

ATTACHMENTS:

- **Appendix 5B.1 – List of Reportable Communicable Diseases in Ontario**
- **Appendix 5B.2 – Sample Incident Report Form**

²¹ Adapted from MAFRP, *Effective Practices Project*, 2005.

²² For information on acquiring signs, contact Toronto Health Connection at 416-338-7600.

- **Appendix 5B.3 – First Aid Kit Contents**
- **Appendix 5B.4 – Sample Emergency Search and Evacuation Procedures**
- **Appendix 5B.5 – Sample Fire Safety Policy**
- **Appendix 5B.6 – Calling 911: Tips for Front Desk Staff**

Appendix 5B.1 List of Reportable Communicable Diseases in Ontario

Source: Toronto Public Health, "Communicable Disease Reporting," September 2004.

Available for download at:

www.toronto.ca/health/cdc/communicable_disease_surveillance/monitoring/pdf/reportable_diseases_list_2004.pdf

COMMUNICABLE DISEASE REPORTING

Communicable Disease Surveillance Unit (CDSU)

277 Victoria St., 10th Floor, Toronto, ON M5B 1W2

Phone: 416-392-7411 * After hours: 416-690-2142 * Fax: 416-392-0047

Timely reporting of communicable disease is essential for their control. The following specified Reportable Communicable Diseases (Ontario Regs 559/91 and amendments under the *Health Protection and Promotion Act*) are reportable to the local Medical Officer of Health:

Acquired Immunodeficiency Syndrome (AIDS)	*Hepatitis, viral, including:	*Severe Acute Respiratory Syndrome (SARS)
Amoebiasis	1. *Hepatitis A	*Shigellosis
*Anthrax	2. Hepatitis B	*Smallpox
*Botulism	3. Hepatitis C	*Streptococcal infections, Grp A invasive
*Brucellosis	4. Hepatitis D (Delta hepatitis)	Streptococcal infections, Grp B neonatal
Campylobacter enteritis	Herpes, neonatal	Streptococcus pneumoniae, invasive
Chancroid	Influenza	Syphilis
Chickenpox (Varicella)	*Legionellosis	Tetanus
Chlamydia trachomatis infections	Leprosy	Transmissible Spongiform Encephalopathy, including:
*Cholera	*Listeriosis	1. Creutzfeldt-Jakob Disease, all types
*Cryptosporidiosis	Lyme Disease	2. Gastmann-Straüssler-Scheinker Syndrome
*Cyclosporiasis	Malaria	3. Fatal Familial Insomnia
Cytomegalovirus infection, congenital	*Measles	4. Kuru
*Diphtheria	*Meningitis, acute, including:	Trichinosis
*Encephalitis, including:	1. *Bacterial	Tuberculosis
1. *Primary, viral	2. Viral	*Tularemia
2. Post-infectious	3. Other	*Typhoid Fever
3. Vaccine-related	*Meningococcal disease, invasive	
4. Subacute sclerosing panencephalitis	Mumps	
5. Unspecified	Ophthalmia neonatorum	

*Food poisoning, all causes	*Paratyphoid Fever	*Verotoxin-producing E. coli infection indicator conditions including Hemolytic Uremic Syndrome
*Gastroenteritis, institutional outbreaks	Pertussis (Whooping Cough)	*West Nile Virus illness, including:
*Giardiasis, except asymptomatic cases	*Plague	1. West Nile fever
Gonorrhoea	*Poliomyelitis, acute	2. West Nile neurological manifestations
*Haemophilus influenzae b disease, invasive	Psittacosis/Ornithosis	*Yellow Fever
*Hantavirus Pulmonary Syndrome	*Q Fever	Yersiniosis
*Hemorrhagic fevers, including:	*Rabies	
1. *Ebola virus disease	*Respiratory infection outbreaks in institutions	
2. *Lassa Fever	*Rubella	
3. *Marburg virus disease	Rubella, congenital syndrome	
4. *Other viral causes	Salmonellosis	

*Note: Diseases marked with * (and influenza in institutions) should be reported immediately to the Medical Officer of Health by telephone. Other diseases are to be reported by the next working day by fax or mail.*

Appendix 5B.2 Sample Incident Report Form

Source: Adapted from documents collected from TDIN drop-ins during the Good Practices Toolkit consultations, May-July 2006.

Note: This incident report form is intended to be general enough to be used in a wide variety of situations (e.g. fires, medical emergencies, participant service restrictions, etc.), so not all lines will need to be filled out for all situations.

INCIDENT REPORT

Date of incident: _____ **Time:** _____ **Duration:** _____

Location and Program: _____

Participant(s) involved: _____

Staff involved: _____

Name of Ambulance Attendant / Police Officer and badge # (if applicable):

TYPE OF INCIDENT

Behavioural **Medical** **Injury** **Property damage**
Emergency **Specify:** _____ **Other** **Specify:** _____

DESCRIPTION OF INCIDENT (*attach another page if more space needed*)

ACTION TAKEN (*attach another page if more space needed*)

Service restrictions or time away? **If yes, please state:**

Who? _____

Type/length of service restriction? _____

Follow-up / next steps: _____

Staff completing report: _____

Witness: _____

Supervisor / Manager: _____

Appendix 5B.3 First Aid Kit Contents

Source: Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

FIRST AID KIT CONTENTS

- Scissors (1)
- Blunt-nosed tweezers (1)
- 5 cm x 5 cm (2 in. x 2 in.) sterile gauze dressings (10)
- 10 cm x 10 cm (4 in. x 4 in.) sterile non-adherent dressings (5)
- Regular-size plastic bandages (10)
- Sling or triangular bandage (1)
- 8 cm (3 in.) gauze roll (1)
- Roll of non-allergenic adhesive tape (1)
- 8 cm (3 in.) elastic tensor bandage (1)
- Safety pins (5)
- Small bottle of skin antiseptic (Note: Soap and water should be used at all times, and antiseptic only with the permission of the individual, or their parent/caregiver)
- Pocket-sized First Aid reference book (1)
- Pairs of disposable non-latex gloves (2)

Appendix 5B.4 Sample Search and Evacuation Procedures

Source: Adapted from the Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

EMERGENCY SEARCH AND EVACUATION PROCEDURES

Basic Emergency Evacuation Procedure:

- Pick up sign-in sheets (if any) and leave the area immediately.
- *Follow any procedures specific to the situation (see below for more details).*
- Ensure that all disabled persons have the assistance they need to evacuate the building.
- Designated staff must check washrooms, offices, meeting rooms, etc.
- Go to the nearest exit and leave the building. DO NOT use elevators.
- Close all doors behind you. Take keys with you.
- Call 911 as soon as possible. Give the correct name and address of the building, the type of emergency, and your name.
- Meet at a designated nearby location and verify that all program participants, staff and volunteers are accounted for. (When conducting drills or discussing evacuation procedures with participants, volunteers, and staff, emphasize the importance of meeting at this designated spot and not leaving the area until others have been able to account for your whereabouts. Explain that if others do not know you are safe, someone may risk their lives to try to find you.)
- Advise emergency officials of any missing person, their age, physical description, and possible whereabouts in the building.
- Notify the Executive Director and/or supervisor.
- No employee other than the Executive Director or his/her designate may speak to the public or the media about the emergency or evacuation.
- Do not re-enter the building until you are given permission to do so by emergency officials on the scene.
- Complete any reporting required as per your organizational policies.

In addition to the basic procedure outlined above, the following measures should also be used in specific evacuation situations:

In the event of a fire:

- Before opening any door, feel the knob for heat. If it is not hot, brace yourself against the door slightly and open it. If you feel air pressure or a hot draft, close the door quickly.

- If you encounter smoke, consider taking an alternate stairwell/exit. Crawl low under the smoke.
- Activate fire alarm and call 9-1-1 regardless of the size of the fire. Never assume that this has already been done. Give the correct name and address of the building, the location of the fire, and your name.
- If parents are meeting in a separate room from their children, the staff who are with the children are responsible for evacuating them

If you cannot leave your room or have returned to it because of fire or heavy smoke:

- Close your door.
- Be sure the door is unlocked so that firefighters can reach you.
- If you require assistance and can call 9-1-1, do so and let the Fire Department know where you are in the building.
- If smoke comes into the room, seal the base of the door with a wet towel or blanket and crouch down low to the floor.
- Move to the most protected area you can, and partially open a window if possible. (Keep the window closed if smoke comes in).
- Wait to be rescued.
- Listen for any instructions by emergency personnel.

If an unidentified and suspicious object is found in the building, a quiet and systematic evacuation of the building is required. In such an event, staff must:

- Direct people to quickly and quietly leave the building, maintaining control and minimizing panic.

In conducting searches of their designated area, staff should:

- Look for something that doesn't belong or seems out of the ordinary.
- Conduct your search quickly but thoroughly (maximum of 15 – 20 minutes).
- If you find a suspicious object, DO NOT TOUCH IT.
- Note the description of the object, its location, and any other important pieces of information, and report it immediately to the authorities.

Appendix 5B.5 Sample Fire Safety Policy and Procedures

Source: Adapted from the Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

FIRE SAFETY POLICY AND PROCEDURES

Policy. Fire safety is an important consideration of [Drop-In Name]. To ensure the safety of all individuals in our programs, we have established the following procedures.

Procedures.

- Fire drills will be conducted by a designated staff person in coordination with the Toronto Fire Department. Drills will be done on a regular basis to ensure that all participants, staff, and volunteers are familiar with building evacuation procedures.
- After each drill a designated person will complete a Fire Drill Report.
- Fire extinguishers will be placed throughout the facility and will be tested annually and logged by a designated person.
- Fire extinguishers do not replace the need to call Toronto Fire Services. Always call 9-1-1 when a fire occurs, even a small fire. Fire extinguishers are not designed to fight large or spreading fires.
- All staff and volunteers must be familiar with the location and operation of fire extinguishers.
- All new staff, volunteers, and program participants must be oriented to fire exits and building evacuation procedures.
- At least one staff member per shift, and, where possible, all staff members, is required to have a recognized First Aid and cardiopulmonary resuscitation (CPR) certification and should be trained in basic First Aid and emergency procedures. This will be updated every two years.
- If an individual is injured, staff will ensure that the person receives appropriate First Aid and medical attention. An accident report will be completed and filed in the program's records.
- The program must complete any reporting required as per organizational policy.

Appendix 5B.6 Calling 911: Tips for Front Desk Staff

Source: Adapted from documents collected from TDIN drop-ins during the Good Practices Toolkit consultations, May-July 2006.

CALLING 911: TIPS FOR FRONT DESK STAFF

There will be times when you are on shift when the drop-in will require emergency services to intervene in a volatile situation.

When you call 911:

- The operator will ask you which emergency service you require: police, ambulance, or fire.
- They will ask the address. Say the address clearly and give them the nearest major intersection.
- Give them your name and explain that you are staff.

Answering 911 Operator Questions

911 will ask a series of questions about the location of the incident, how many people are involved, and for a description of the individual(s) in question. Answer as calmly as possible and give as much detail as you know. If the incident is happening in another part of the building, explain to the operator that you are communicating with other staff on-site and must have information relayed. Use the radio to ask each question as it is asked to you and get a response from staff.

When 911 asks what the problem is, stick to the facts but ensure that they understand the urgency of the situation. If someone is violent or has a violent history, tell them. If someone has issued a threat of any kind of violence, tell them.

Managing communications

Communicate urgency. If they do not believe the situation is serious, they will give the call a low priority. The 911 operator may make judgmental statements about the situation: simply reiterate that it is very serious, that you would not have called otherwise, and urge them to send help.

911 may ask questions that we cannot answer (i.e. do you know the person's name). If it is not reasonable to obtain this information safely, then explain that you can't provide it but reiterate that help is still needed.

If the situation escalates, call 911 back immediately and tell them. If emergency crews do not respond, call back and ask for a re-call. Continue to do this until the situation is completely resolved to staff satisfaction.

Do not cancel police calls, even if an individual leaves the building. The person may stay in the area and it is important to make a report.

Back-up

Make sure that you are safely able to make a 911 call. Front Desk staff must be able to stay on the line uninterrupted with 911 during an incident. If you are being threatened directly, call maintenance or other staff for back up and maintain a safe distance.

For All 911 Calls

Document all dealings with 911 in an incident report and a report to the Manager. Give details about how the operator treated you, whether or not emergency crews responded, and what the outcome of the incident was.

Any contact with 911 is considered an incident and requires an incident report to be filled out and filed with the appropriate managers.

SUBSECTION 5C

Staff Health and Safety

Safety Training

Safety training is defined as workshops or programs that a drop-in provides to improve the general safety of participants, volunteers and employees. It is a good practice for drop-ins to make every reasonable effort to provide personal safety training for its staff and, where resources permit, its volunteers, as well. Safety training includes, but is not limited to:

- First Aid
- Crisis Prevention and Conflict Resolution Training
- Workplace Hazardous Material Information System (WHMIS) Training
- Food-Handling Certification

These specific training topics are discussed in more detail elsewhere in Section 5. General good practice tips for training staff and volunteers are in Section 4.

Safe Money Handling

Money may be located in some program sites, and safe cash handling practices should be in place to ensure the security of staff managing cash on site.

Good practices for safe handling of money include:

- Storing cash in a safe or lock-box;
- Keeping petty cash floats in a locked and hidden location;
- Ensuring that money management occurs out of public view and, when possible, involves two people;
- Never leaving cash unattended;
- Not moving cash around unless it is being used for purchases or for a deposit to the bank; and
- Obeying the robber's orders when harm is being threatened.

Workplace Safety and Insurance Board (WSIB)

In Ontario, the Worker's Compensation Board is called the Workplace Safety and Insurance Board (WSIB). The WSIB oversees Ontario's workplace safety education and training system, provides disability benefits, monitors the quality of health care, and assists in employees' safe return to work.

The WSIB provides a range of benefits to injured or ill workers for health care, loss of earnings, and loss of retirement income, as well as survivor benefits for families of workers who die as a result of workplace injuries and illnesses. The WSIB also protects employers from being sued by their employees.

Drop-in centre coverage. Drop-ins are not automatically covered under the *Workplace Safety and Insurance Act*. This means that staff in these organizations may not be covered in the case of work-place injuries. Since workplace injuries and illnesses can happen to anyone and the consequences for people, families, and organizations can be devastating, drop-ins may choose to voluntarily apply to the WSIB for coverage.

The premium you pay for WSIB coverage is based on several factors including the nature of your business, the size of your payroll, and your injury-and-illness experience.

Benefits to employers include.²³

- Protection from lawsuits,
- No-fault insurance,
- Workplace insurance benefits for workers,
- Prevention and training programs, and
- Help in returning injured workers to the job.

Further, if your drop-in centre is covered through WSIB, it can access resources as a member of the Health Care Health and Safety Association of Ontario (HCHSA). HCHSA is a non-profit organization that is a “designated entity” under the *Workplace Safety and Insurance Act* and provides the following services to its members:²⁴

- Conducting needs assessments,
- Developing strategies and implementation plans,
- Procuring training and delivery of resources,
- Evaluating trends on a sector basis for employers, and
- Providing education and informational resources and technologies.

Basic requirements. For drop-ins that have WSIB coverage, it is critical that all reporting requirements and timelines are met in order to ensure that coverage is provided as required.

If someone is injured on the job, the employer must ensure that:²⁵

1. First Aid is given immediately and an incident report is completed;
2. The person is taken to a doctor or hospital if necessary, and any fees associated with transporting them are paid by the employer;
3. The causes of the incident are investigated, and all steps taken are recorded;
4. The employee is paid a full day’s wages for the day of the injury (any WSIB benefits begin the next working day after the incident occurs).

²³ List from WSIB, “Benefits – An Employer’s Perspective:”

www.wsib.on.ca/wsib/wsibsite.nsf/public/EmployersBenefitsbyemployers. Last updated May 18, 2006.

²⁴ For more information about the HCHSA, visit their website at www.hchsa.on.ca.

²⁵ WSIB, “What Should I Do Immediately when a Worker Is Ill or Injured?”

www.wsib.on.ca/wsib/wsibsite.nsf/public/EmployersIImmediately. Last updated May 18, 2006.

In the case of a workplace fatality or critical incident, the employer must, in addition to the steps outlined above:²⁶

- Contact the police and ambulance services immediately;
- Immediately contact by telephone, telegram or fax, the local office of the Ministry of Labour and the employee's union (if applicable). Within 48 hours, you must also notify, in writing, the Ministry of Labour, giving the circumstances of the incident; and
- Contact your customer service representative or account manager, or call the Occupational Disease and Survivor Benefits Program at 416-344-1010 or 1-800-465-9646. The WSIB can provide a Crisis Intervention Counsellor to help you and your employees deal with the incident.

Reporting. To report the work-related injury or disease to the WSIB, the employer needs to fill out an Employer's Report of Injury/Disease (Form 7). This form, along with a reference guide to help you complete the report, is available for download from the WSIB website.²⁷ If possible, have the worker sign your Form 7. This signature permits the worker's doctor to send you a report that helps identify what tasks your worker can take on during recovery.

The Worker's Report of Injury/Disease (Form 6) and a reference guide for filling it out are also available for download from the WSIB website. Workers are not required to fill out this form, but may do so if they wish to make a claim. Please note that there is a time-limit to making a claim and it is best to do so as soon as possible.

Joint Health and Safety Committee (JHSC)²⁸

The *Occupational Health and Safety Act* requires that all workplaces that regularly employ 20 or more workers establish a Joint Health and Safety Committee (JHSC). This Committee must meet at least four times per year. In smaller workplaces where six or more workers are regularly employed, and where no JHS Committee has been established, a Health and Safety Representative is required. The individual must be chosen by the workers or by the union if there is one. The Health and Safety Representative has many of the same powers and responsibilities as a JHSC except for the power to stop work.

In workplaces with more than 50 employees, the Act further specifies that such Committees must be made up of at least four people and at least half of those people must be workers not in managerial functions.

²⁶ *Ibid.*

²⁷ For more information, or to download Form 6, Form 7, or reference guides for completing these forms, visit www.wsib.on.ca.

²⁸ Adapted from Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

According to the Act, Health and Safety Committees or Representatives are responsible for:

- Identifying situations that present a danger to workers;
- Investigating critical injuries and work refusals;
- Designating a worker member of the Committee to be responsible for inspecting the workplace monthly (or yearly) according to a pre-determined schedule; and
- Making recommendations to management and/or the Board for programs and procedures to improve the health and safety of workers.

The City of Toronto's online Human Resources Policies provide two useful documents for JHSCs:²⁹

1. **JHSC Recommendations Guidelines** – this document gives advice to JHSCs on how to make effective recommendations and to organizations on how to respond to these recommendations.
2. **JHSC Workplace Inspection Checklist Template** – this document provides a checklist for specific structural and environmental problems to look for when assessing the safety of the building.

Refusal to Work³⁰

According to the *Occupational Health and Safety Act*, staff have the right to refuse to do work that they believe may endanger themselves or others.

Any employee who feels that work may endanger themselves or others are to follow the following steps:

1. The employee should promptly report the work refusal to his or her supervisor.
2. The supervisor should promptly investigate the grounds for the refusal with the employee present. If possible, a Health and Safety Representative (where applicable) should also be present.
3. If the problem can be resolved and an agreement reached, then the work can resume.

²⁹ These documents (along with other Human Resources policies, guidelines, and templates) are available for download from City of Toronto's website at: <http://wx.toronto.ca/intra/hr/policies.nsf>.

³⁰ MAFRP, *Effective Practices Project*, 2005.

4. If a resolution cannot be reached and the employee still believes the work is unsafe, then the employee should notify the Ministry of Labour about their refusal to work.
5. The Ministry of Labour inspector should respond within two hours, during which time the employee shall remain in a safe place or continue with reasonable alternate work.
6. No other employee will be assigned the refused work pending the decision of the Ministry of Labour inspector.
7. The Ministry of Labour will render a judgment.

SUBSECTION 5D

Participant Substance Use

It is a good practice for drop-ins to take an approach to substance use by participants which balances:

- The recognition that addictions to alcohol or drugs are harmful, and providing options or referrals for counseling and treatment to overcome these addictions, with
- The recognition that people need to overcome their addictions at their own pace, and interventions that are too aggressive can have the unwanted effect of closing down the lines of communication between participants and staff, or cutting participants off from much-needed services.

This balanced approach can be incorporated into either a harm reduction or an abstinence model.

Defining Harm Reduction and Abstinence Approaches

The ways that drop-ins deal with substance use fall into two broad categories: harm reduction or abstinence. Both are operating approaches that dictate how staff handle participants' substance use in their practical, day-to-day work. However, harm reduction is a rationale for a particular set of practices, while abstinence refers to one practice with many different rationales.

The **abstinence** model requires participants to abstain from using drugs or alcohol as a condition of service. If someone comes to the drop-in who is demonstrably high or drunk, they will not be permitted access. This practice is adopted for a number of reasons:

- The drop-in may be faith-based and oppose drug or alcohol use on moral grounds;
- The drop-in may not have the staff or resources to handle the disruptions that intoxicated people may cause;
- The drop-in's main population may be individuals who are recovering from addictions and need to have access to a place where there will be no temptations for them to fall back into old patterns.

This approach is fairly rare among drop-ins, but it fills an important niche for individuals who are trying to "dry out" or to quit drugs.

It is a good practice for staff running on an abstinence model to provide help to people even as they deny them access to the drop-in. This means that, rather than simply turning someone away at the door, chat with them awhile to determine what kinds of services

they came to your drop-in looking for. Let them know about other drop-ins or agencies nearby that could help them. If it is within your drop-in's means to do so, it is a good practice to accompany them to make sure that they get there safely, or, if your drop-in has a vehicle, to provide them with transportation to the referral site.

This approach has been instituted in abstinence-based homeless shelters in Toronto. They are required to refer individuals to other shelters if they cannot accommodate them; contact the other shelter to ensure that there is space; help the individual to get there; and follow-up with the other shelter to make sure that the individual arrived safely.³¹

The **harm reduction**³² approach works to reduce the negative consequences of substance use by meeting individuals “where they are at.” If a person is not ready to consider quitting, harm reduction workers accept that and work with the individual on strategies for staying safe while using drugs.

It is important to note that abstinence and harm reduction approaches are **not necessarily exclusive**; a drop-in may generally operate according to a harm reduction model, while some of its programs or activities may have an abstinence requirement.

Harm Reduction Strategies

These strategies vary according to the resources that an agency is able to offer and the legislation and regulations in place governing local initiatives of this kind. Some strategies currently adopted by Toronto drop-ins are:

- **Crack kits.** Toronto has recently begun making crack cocaine kits available for distribution by drop-ins and other social agencies. The kit contains a variety of elements, including, among other things, mouthpieces and glass stems – to reduce the likelihood of people burning their lips on more heat-conducting materials and the risk of Hepatitis C transmission through sharing pipes; a condom – because crack users often trade sex for drugs or money; and information on disease prevention practices.³³
- **Clean needle exchange.** A few drop-ins contract with Toronto Public Health to provide needle exchange services. TPH runs a program called “The Works” that provides free clean needles to intravenous drug users, and safely disposes of used

³¹ City of Toronto, “4.5 Substance Use,” *Toronto Shelter Standards*, 2005, page 13. Available at: www.toronto.ca/housing/pdf/shelter_standards.pdf.

³² “Harm reduction” is often defined exclusively in terms of illicit drugs, but this distinction is not necessarily helpful to on-the-ground strategies for dealing with people who are under the influence. This section on substance use discusses “harm reduction” as an approach to dealing with participants who have taken any mood-altering substance; while this Toolkit, more generally, defines harm reduction more broadly and discusses harm reduction strategies that relate to behaviours other than substance use (see Subsection 1B, Framing Our Work, and Subsection 5E, Participant Sexual Health, for further discussion.

³³ City of Toronto, “Fact Sheet: Distribution of Safer Crack Use Kits,” June 2006. Available at: www.toronto.ca/health/drugstrategy/pdf/tds_crack_kits.pdf. See also City of Toronto, *The Toronto Drug Strategy: A Comprehensive Approach to Alcohol and Other Drugs*, Toronto: Drug Strategy Advisory Committee, 2005, pages 31-32. Available at: www.toronto.ca/health/drugstrategy/pdf/tds_report.pdf.

needles. The program also provides condoms; education about safe injection and safer sex practices; testing for HIV, hepatitis, and syphilis; free vaccinations for Hepatitis B, the flu, tetanus, and pneumococcal infections; a methadone maintenance program; basic medical care; support for HIV-positive drug users; and referrals to detox, drug treatment, and other services.³⁴ The Works is a good example of the harm reduction approach because it illustrates the combination resource provision (e.g. condoms, clean needles, etc.) with outreach and intervention (education, referrals, testing, and so forth).

- **Safe use sites.** Many drop-ins have indicated their interest in operating safe use sites, or supervised consumption sites, that offer a safe, non-judgmental space for people to imbibe, inject, or inhale their pre-purchased substances. Aside from some managed alcohol consumption programs (for example, the Annex at Seaton House and the Lounge at Women’s Residence), Toronto has not yet authorized safe use sites (though the City is considering this possibility).³⁵ Research has shown that these programs can:³⁶
 - Reduce the risk of overdose and the potentially fatal consequences of overdosing,
 - Reduce criminal activity by those using the site,
 - Reduce the transmission of blood-borne viruses,
 - Lead to a significant increase in users seeking detoxification help,
 - Reduce the number of needles and other drug-related equipment being discarded in public spaces, and
 - Alleviate community concerns regarding intoxicated individuals on public streets or in parks.

- **Safe post-use sites.** Most Toronto drop-ins allow intoxicated or inebriated participants to access the drop-in and its services, unless or until their behaviour becomes disruptive to others. This practice provides a safe space where people can be under the influence and not be vulnerable to attack, sexual exploitation, or theft. Also, if the person begins to have a negative reaction to substances in their system, their condition will be monitored and they will be taken care of in whatever way they need (for example, they may become dehydrated and need water, or they may have a reaction that requires medical attention). It is a good practice to have procedures and resources in place to ensure staff know how to handle overdoses. This requires specialized staff training and/or medical supervision. (**Appendix 5D.1** gives a sample.)

³⁴ Toronto Public Health (TPH), *Breaking the Chain: Infection Prevention and Control for Homeless and Housing Service Providers*, March 2006, pages 37 and 112. Available at: www.toronto.ca/legdocs/2006/agendas/committees/hl/hl060410/it009.pdf.

³⁵ City of Toronto, *The Toronto Drug Strategy: A Comprehensive Approach to Alcohol and Other Drugs*, Toronto: Drug Strategy Advisory Committee, 2005, pages 33 and 58. Available at: www.toronto.ca/health/drugstrategy/pdf/tds_report.pdf.

³⁶ This list has been adapted from the City of Toronto, *The Toronto Drug Strategy*, 2005, and from Rod Mickleburgh, “Safe drug sites lauded,” *Globe and Mail* (British Columbia), July 20, 2006, page S1.

Harm Reduction as Outreach and Entry Point

All harm reduction practices are intended to act as point of entry for people who might not otherwise be able to access much-needed services. By not restricting service because of substance use, the harm reduction approach opens the lines of communication so that participants can talk to staff without feeling judged or punished, or that they must keep their addiction a secret. It allows staff to ask participants how they are doing and how they are keeping safe.

Distributing crack kits provides a way to reach out to marginalized people who otherwise might not come in to a drop-in or make contact with any social service agency. Harm reduction street outreach workers emphasize that crack kits give them a way to connect with people by providing them with items they need and establish trust relationships that can help them access other services.³⁷

ATTACHMENT:

- **Appendix 5D.1 – Sample Suspected Drug Overdose Policy**

³⁷ City of Toronto, *The Toronto Drug Strategy*, page 32.

Appendix 5D.1 Sample Suspected Drug Overdose Policy

Source: Adapted from documents collected from TDIN drop-ins during the Good Practices Toolkit consultations, May-July 2006.

SUSPECTED DRUG OVERDOSE POLICY

Policy. Drop-in staff will coordinate emergency response when they suspect that a participant has taken a drug overdose.

Procedures. If staff suspect that a participant has taken a drug overdose, they should take the following actions:

- Immediately notify another staff member of this suspicion (ideally the supervisor or coordinator of the program area involved)
- Clarify the kind of substance ingested
- Clarify the amount of the substance ingested. If it is a liquid, find out the amount in fluid ounces. If it is a medication, find out the number of pills taken and the dosage amount of each pill
- Clarify or estimate the time lapse since ingestion of the substance
- Call for an ambulance and provide basic response information:
 - Gender and age of the person
 - Description of substance and amount taken (if known)
 - Current physical status (e.g. conscious or unconscious)
 - Location of drop-in
- Document the time of the emergency response request
- Arrange for staff to meet the emergency response unit at the front door
- Make the person as comfortable as possible. Assign a staff to remain with the person and provide support. Your single responsibility at this point in time is to try to and link the person to emergency ambulance services for further assessment and transportation

If staff are unsure of the validity of the reported overdose they should still respond in accordance with this protocol. They should not let their investigation slow down potential emergency response to the incident.

In the event that emergency response services are unable to assist the person in difficulty, staff should continue to monitor the suspected overdose and take further action as necessary.

SUBSECTION 5E

Participant Sexual Health

Sexual health is often a difficult subject to bring up in drop-ins. Some participants come from cultures where there are strong taboos against having sex outside of marriage or discussing sex in any setting. They may not benefit from attempts to initiate open discussions about sexual health in group settings, especially if those groups include other members of their culture. Some participants may not feel comfortable discussing sexual matters in front of people of the opposite gender. Other participants may not feel comfortable coming out to a community that may have shown violently homophobic tendencies in the past. There may be a strong feeling in both participants and staff that sexuality is a private issue, to be dealt with privately.

However, drop-ins work with many people who are at risk sexually; they may be professional sex workers or they may occasionally exchange sexual favours for drugs; they may be vulnerable to sexual predation, whether because they are very young, new to the street, frequently intoxicated, or have mental health problems; they may not know the risks of unprotected sex, or be aware of the range of sexually transmitted infections (STIs) that exist; and so forth. Drop-ins should recognize sexual health, like food or housing, as one of the primary needs of their community, and should do their best to respond to it.

This involves taking both **direct and indirect approaches** in an effort to create a positive environment where people feel like they can talk about these issues if they want to, but can still access important resources (like condoms or informative pamphlets) on their own if they don't want to talk to a staff member. Some excellent resources are available on the Toronto Public Health website, which gives information on sexual health matters, workshops, and training sessions, and provides telephone numbers, links to other resources, and brochures for downloading.³⁸

Indirect Interventions

Addressing sexual health in the drop-in is often best accomplished through indirect approaches to reduce individuals' discomfort in accessing information or resources. Indirect intervention strategies include:

- **Discreet condom distribution.** Making baskets of condoms and lube available in a variety of locations around the drop-in, including in semi-private areas like bathrooms. This way, a person may access condoms and lube without it being obvious. It is important for staff to monitor the contents of the basket – sometimes it will become empty, or it will contain only packets of lube, and participants will not inform staff.

³⁸ See TPH's Sexual Health homepage at: www.toronto.ca/health/sexualhealth/index.htm or TPH's Sexual Health homepage for community workers, educators, and health care providers at: www.toronto.ca/health/sexualhealth/sh_educator_actual_main.htm.

Toronto Public Health provides a yearly allotment of condoms to service providers who request it (the telephone number to call is: 416-338-0901). Drop-in staff often ask for twice as much as they estimate they will need for the year, because TPH is typically only able to provide half of the amount requested by each group. Other drop-ins have partnerships with local health centres, and receive condoms from them.

- **Brochures.** Including sexual health pamphlets in a rack of brochures that cover a range of topics relevant to the drop-in population – for example, housing, extreme weather, West Nile Virus, tuberculosis, police, English classes, etc. – allows people to access any sex-related information they might need without doing so overtly.
- **Combination packs.** The crack kits distributed by Toronto Public Health contain condoms along with the glass stems and other equipment that are more directly connected to crack use. If there is any other type of packaged resources that drop-in staff are making available to participants, it may be a good practice to add condoms and lubrication packets.
- **Risk management.** The strategies here depend in part on the population of your drop-in. One drop-in, which works primarily with adults in their thirties who have been street-involved for a long time, does not permit younger people to come in. Staff explain that this drop-in is not a place for youth and that there are people with predatory behaviours there. They direct the person to other drop-ins and agencies that are more youth-focused (for example, YouthLink or Evergreen.)

Direct Interventions

While indirect interventions can be very effective, direct interventions are often necessary to ensure that people are aware of the risks associated with particular behaviours and are receiving the services and resources they need to manage those risks. Direct intervention strategies include:

- **Interventions on the drop-in floor.** People do not (for the most part!) have sex on drop-in centre premises. However, sexuality may be a factor in the way that participants interact in the drop-in – people flirt, fall in love, break up, get back together; some prey on vulnerable individuals; some sex workers seek out new clients; some participants physically or verbally harass people who are lesbian, gay, bisexual, transgendered, transsexual, queer (LGBTQ) or involved in the sex trade.

When these interactions involve conflict or predatory behaviours, staff should intervene and **talk about the situation with those who are involved**. For example, if there is a man who you know has a history of violent relationships and coercive sexual behaviour, and you see him making advances toward a vulnerable woman (she may be new to the drop-in, or intoxicated, or mentally challenged, for example), you should intervene. Discuss the situation with both parties. Reiterate

to the man that predatory behaviours are not acceptable and recommend that he not pursue this relationship further. Chat with the woman about your concerns.

In the case of intolerance toward sex trade workers, staff should try to **negotiate respect**. This may involve reiterating that all participants have the same right to enjoy the drop-in space, and holding participants **accountable to the drop-in's anti-harassment and discrimination policies**. This conversation may involve discussion of systemic oppression and the criminalization of poverty, as a way of connecting sex trade workers' lives and histories with those of other participants.

In order for staff to intervene effectively in instances of intolerance toward transgendered or transsexual people, **staff may need training** so that they can accurately and sensitively discuss these issues with participants. This is particularly important in drop-ins that are either women-only or men-only, because in these situations participants may feel strongly justified in their exclusion of the a trans person, on the grounds of the drop-in's rules themselves. Staff must be educated on trans issues if they are to be able to effectively explain why "that man" is allowed in a "woman's space," or vice versa. In addition to welcoming LGBTTQ people into the drop-in and negotiating respect with other participants, it is also a good practice to advise them about LGBTTQ-specific programs and drop-ins in the city (for example, the 519 Community Centre and its Meal Trans program).

Finally, it is important to recognize that intolerance – whether sexual, racial, religious, or any other form of discrimination – can't be separated from **power dynamics**. Engaging participants in debates or discussions about the content of their remarks addresses only part of the problem. Discriminatory comments are also a way of asserting one's power or dominance over other people in the drop-in. People who make these comments may be "backed up" by other participants as a political survival tactic – side with the strongest – rather than as an expression of agreement with their statements.

- **Workshops and focus groups.** It is a good practice to run workshops, focus groups, or any other type of educational sessions that raise awareness of sexual health issues. If you would like a Sexual Health Educator to come in and talk to a group, you can access one through a referral process by calling the Toronto Health Connection number (416-338-7600).

It is a good idea to **consider cultural issues and differences** when planning workshops. For example, one drop-in with a large community of First Nations people has an elder come in who discusses relationships, HIV, and other sexual health issues from a specific cultural perspective. A staff member from another drop-in reported that in discussing AIDS with Afro-Canadian youth living in Scarborough, the message did not begin to penetrate until he showed a video of, specifically, young, Afro-Canadians in Toronto who were living with AIDS.

On the other hand, drop-ins report strong resistance from members of specific communities – for example, Chinese Torontonians and newcomers from Eastern Europe – to discussing sexual health issues or attending workshops where there is a possibility that they might see someone they know. Drop-in staff who work with Chinese participants emphasize the importance of **building trust over a long period of time**; once this rapport has been established, participants will feel more comfortable in discussing sexual issues.

Attendance at workshops is often very low, particularly among men. One way to overcome this is to provide **incentives** – for example, food, gift certificates for a popular local restaurant or business, and/or TTC tokens. Another way to increase attendance is to combine the sexual health information with other useful health information, and to cut the word “sex” from the title. For example, one drop-in worker organized a successful “Health and Wellness” workshop.

- **Shots and vaccinations.** There are vaccines available for Hepatitis A and Hepatitis B (there is no vaccine for Hepatitis C). Contact Toronto Public Health’s Immunization Information Line at 416-392-1250 for information on immunizing drop-in participants to these diseases.
- **Testing.** Street-involved people are at higher risk for contracting and spreading sexually-transmitted infections and diseases. Some drop-ins hold health clinic sessions two or three times a year where participants can get tested for HIV and Hepatitis C, two of the most dangerous STIs. The difficulty lies in convincing participants to come back a few weeks later to pick up their results. It is a good practice to offer incentives – for example, food, gift certificates for a popular local restaurant or business, and/or TTC tokens.

Combining Direct and Indirect Strategies

It is also a good practice to combine direct with indirect approaches. For example, when intervening in situations on the drop-in floor, discuss the specific interpersonal issues directly with the involved participants, but also bring up the larger social issues later in an action group meeting or organize a workshop or training session. When holding a sexual health workshop, make brochures and pamphlets available. Consider holding a question period with anonymous submissions – for example, questions written down and placed in a box to be withdrawn and responded to by the presenter later on.

SUBSECTION 5F

Crisis Prevention

Note: This Subsection should be read in conjunction with Subsections 2S: Participant Rights and Responsibilities, 2T: Complaint Process, 2U: Service Restrictions, Barring Policies, and Appeals, and 5G: Crisis Intervention and Conflict Resolution.

There is an old saying that “an ounce of prevention is worth a pound of cure,” and this may be nowhere more true than when dealing with crises in drop-ins. One TDIN drop-in notes that “the best crisis intervention responses are not the work you see acted out occasionally on the public stage of the drop-in floor or the street. Crisis intervention at this stage is often indicative of gaps in earlier prevention strategies that observe, anticipate, and respond to the stress signals and needs of the person in crisis.”

Managing the Space

It is important to create and foster an atmosphere of respect, tolerance, and security within the drop-in. As the UK-based organization Homeless Link notes, “Setting the culture of what is acceptable and unacceptable behaviour, and challenging unacceptable behaviour at an early stage is vital.”³⁹

Rules. “Setting the culture” of acceptable and unacceptable behaviour means, among other things, making sure that there are clear rules for conduct within the drop-in that everyone is aware of. These rules also need to be applied consistently or they will not be respected.⁴⁰

Mood. Moods are catching – if your family, friends, or coworkers are in a good mood, this can lighten your own spirits. If a dark cloud is hanging over one person, it often drifts over to others. In this way, the drop-in space itself can develop a collective mood or personality of its own that is generated and influenced by everyone in it. One of the goals in running a drop-in is to keep this mood on an even keel.

Staff contribute to this mood through their own attitudes and behaviours, but they should also take on the task of monitoring, assisting, and communicating with the mood of participants. For example, if it is clear that a participant is having a rough day and is feeling tense, it is a good practice to get them talking about it with you away from the group dynamic, to give them a chance to let off some steam in a safe way. This should be done informally, by asking them to come with you for a walk or a coffee, not formally, by asking them to step into an office. It should be a friendly and relaxed gesture, not a gesture that makes the participant feel singled out and called to account.

³⁹ Homeless Link, “5: Implications for Safety,” *Day centres handbook: A good practice guide*, London (UK), 2004, page 5.4.

⁴⁰ *Ibid.*, page 5.9.

Monitoring. As discussed above, it is important to monitor the mood of the drop-in as an indicator of the potential for a crisis to erupt. This can be done through:

- **Observing the general behaviour of participants.** What is participants' body language telling you? Are they sitting in relaxed postures, or are they restlessly pacing? Are there people who seem upset and are isolating themselves from others? Is their behaviour a response to the way other people are acting? Is this behaviour different from the normal conventions of participants using the drop-in?
- **Listening to the conversational patterns of the drop-in.** Is the general emotional content of the conversations calm, or can you hear agitation in rising volume levels and breaks in the normal rhythms of speech? If the latter, what is this agitation in response to? Interpersonal disagreement? An environmental disturbance? Inner conflict?
- **Communicating with participants.** It is a good practice for staff to develop good relationships with participants and engage them in warm, friendly chats whenever time permits. Whether or not the person is behaving calmly or erratically in the moment, these conversations will help to give a window on what is going on in people's lives and what the interpersonal dynamics in the drop-in are, so that you can see early on what kinds of tensions are building.
- **Communicating with participants who are potentially at risk.** Some participants may demonstrate over time that they are more emotionally volatile or less able to control their impulses. These participants should be welcomed at the door by a drop-in staff member as soon as they come in, both as a way to gauge their mood and as a way to set a positive tone for their time in the drop-in. These steps are also important with new participants whose personalities, histories, and needs are unknown, and with participants, regardless of past behaviour, who arrive at the drop-in intoxicated.

However, it is very important to keep these interventions friendly and low-key. When individuals who have exhibited violent or harassing behaviour in the past are subjected to vigorous monitoring when they enter the drop-in, this can trigger them to react aggressively. The key is to remember that crisis prevention and intervention are about engagement, not control.

- **Identify triggers and flashpoints.** In observing and monitoring the drop-in's mood and community dynamics, you may come to recognize "flashpoints," or particular situations where tensions run high and may erupt into crises. For example, any time people are required to wait in a long line for a particular resource or service, tempers may flare.⁴¹ In communicating with participants about their lives, you may come to understand their "triggers," or particular

⁴¹ *Ibid.*, page 5.4-5.5.

situations that will set them off. For example, a particular offensive slang term might trigger them, or a particular behaviour (e.g. somebody cutting into a line).

- **Communicating regularly with other staff.** Staff should regularly check in with each other to share their assessments of the drop-in's mood and to let each other know if they perceive a problem brewing.

Fostering Respect for the Physical Environment

Part of fostering a safe, calm, positive atmosphere in the drop-in has to do with improving the physical environment. **Make the drop-in space attractive and pleasant**, not “institutional” in appearance. If you have funding to make structural changes, try to reduce or eliminate any “blind spots” in the building. Keep the drop-in as open-concept as possible. When furniture or equipment breaks, repair it promptly: if the management and staff take care of the surroundings, this will encourage participants to do so as well.⁴²

Another technique is to **encourage participants to take ownership of the space**. If they feel that the drop-in is their place, they will be more likely to treat it with respect and to criticize inappropriate behaviours or try to defuse crisis situations themselves. There are two main ways for staff to work toward fostering participants' sense of ownership:

- Involving participants in **decision-making** processes and hiring them to do odd jobs around the drop-in (see Section 3 for further discussion); and
- Involving participants in the **decoration** of the drop-in, whether this is through displaying participant artwork, or hiring participants to decorate the space before a special event, or hanging photographs of participants, or putting up posters on the walls with motivational sayings, poems, or words of wisdom from participants.

Spatial Capacity

The number of people your drop-in can accommodate at any given time depends on:

- The maximum capacity of the **physical space** itself, and
- What the **staff** working that day can handle (for example, newly hired staff with no established relationships with the participants may not be able to handle the same number as a staff member who has been working in the drop-in for years).

You should have a rough number in mind of how many people the drop-in space can accommodate at any given moment, and take steps to ensure that this number is not exceeded. Not only is overcrowding a **legal and safety issue** (since it contravenes the Building Code and the Fire Code), but it is also a highly stressful situation that can lead to crisis situations. Overcrowding also limits the ability of staff to respond to conflicts, and the situation can quickly get out of control.

Strategies. Strategies for ensuring that your drop-in's capacity is not exceeded vary according to how much of a concern this is for you. For example, if one of your programs is very over-subscribed and you consistently have dozens of people arriving that you

⁴² *Ibid.*, “9: Warnings and exclusions,” page 9.4.

cannot accommodate, you may want to institute a **ticket system**, where the first hundred (or whatever your limit is) participants to show up receive a ticket and may come into the drop-in when it opens its doors, and the others are not permitted to come in until the first group leaves.

If your drop-in rarely experiences a demand that it cannot meet, this formal type of system may be unnecessary. However, it is a good practice for all drop-ins to have some kind of **door-person, front desk worker, or greeter**. This person's job is twofold: to encourage access – to welcome people into the drop-in and help direct them to whatever services or staff they may be looking for – and to limit access – to prevent participants from coming in if the drop-in is overcrowded or to get people to leave if they are violating the rules for behaviour within the drop-in.

Staff Training and Preparation

As good as your drop-in team is at heading off conflicts before they have a chance to fully develop, crisis situations will still occasionally occur. These situations can be extremely volatile, since the safety of many people – the agitated participants, other drop-in users, staff, and volunteers – may be at risk. In high stress situations, the smallest gesture or most seemingly inconsequential word can provoke someone's anger further. It is important to be prepared for these situations so that you can keep your cool and handle the situation effectively.

Training. It is a good practice for staff to receive training in crisis prevention and de-escalation techniques. The Toronto Hostel Training Centre offers courses in crisis prevention, which include:

- Non-Violent Crisis Intervention,
- Understanding and Managing Aggressive Behaviour, and
- Defusing Hostility – Crisis Intervention with the Hostile and Aggressive Individual.

These are now offered through the Drop-In Service Skills Training Certificate (DISSTC), a program developed by the THTC in conjunction with the Toronto Drop-In Network. Further information and registration forms are available at the THTC website.⁴³

Personal and staff dynamics. Handling a crisis situation involves effectively managing internal, personal dynamics as well as external, interpersonal dynamics. **Self-knowledge is an important tool for constructively handling conflicts.** Staff need to be encouraged to trust their intuition and gain insights into their own anxieties and feelings about crisis situations and their own styles or preferences regarding conflict management as well as those of others.

Just as participants have “triggers” that should be monitored, so too staff have “**triggers**” that should be monitored. “Triggers” or “buttons” are sensitive points that, when activated, can cause the individual to become emotional and escalate the situation rather

⁴³ Toronto Drop-In Network (TDIN) and Toronto Hostels Training Centre (THTC), “Drop-In Service Skills Training Certificate (DISSTC),” n.d. Available at: www.thtcentre.com; last updated July 26, 2006.

than defuse it. Staff need to identify and discuss their triggers with coworkers so that they can strategize on how to handle these concerns as a team. For example, some staff mentioned that any hint of domestic abuse will set them off, and they have trained the volunteers and other staff members that they work with to intervene in those situations. Other staff members may be triggered when participants use racial slurs to address them. **Recognizing your own triggers and developing contingency plans with other staff members can help to defuse these situations and result in constructive resolutions for all individuals involved.**

Management strategies. Staff team leaders – whether supervisors, managers, or coordinators – should work actively to foster a safe space for staff to talk about their personal triggers, anxieties, and concerns in dealing with crisis situation. This may not be easy to do, because it requires talking about vulnerability in situations where staff are most worried about being or appearing to be vulnerable.

Management should also ensure that a discussion of **service restrictions** occurs in the team. In the heat of the moment during a crisis, it may seem like the best course of action for all concerned to bar an individual. However, drop-ins exist to serve the most marginalized populations, and “hard-to-serve” people should be their priority. Subsection 2U provides a further discussion of these points and outlines alternative service restriction and time away strategies.

In a moment of crisis, staff can feel vulnerable and as though the agitator is in control of the situation. However, even in these moments staff need to be conscious of the fact that they have the power to cut the participant off from much-needed services and resources, and that they should avoid doing this if at all possible.

Management should also take care of staff – providing opportunities for frontline workers to de-stress and **encouraging self-care or ways to debrief and wind down**. The best learning comes from a debriefing meeting after a crisis situation. Staff can take the time to reflect on the experience and their reactions, and build these insights into plans for handling the next crisis. It is important for staff to have **open lines of communication** so that staff know that they can speak to each other honestly about their concerns or suggestions. **Team-building** is also important – coworkers need to know that they can rely on each other in crisis situations. (See Subsection 4C for a more detailed discussion of staff communication and team-building strategies.)

Inter-Agency Coordination

It is a good practice for drop-ins that are located near each other to coordinate on issues of safety and security. Often agencies coordinate their hours of operation and programming so that the participants who frequent both (or all) of them have increased access to service and expanded choices; it is a good practice for these drop-ins to communicate with each other both formally and informally about concerns regarding their shared population. Formally, they may hold monthly meetings to coordinate their approach with particular individuals or to discuss security mechanisms. Informally, they

may simply call each other on an as-needed basis, for example, when a frustrated and angry participant storms out of one drop-in and is likely heading to the next.

Informal Counseling and Conflict Resolution Workshops

Participants often lead very stressful lives and many may not have the emotional tools to resolve conflicts constructively. It is a good practice for staff to work with participants both informally, as part of the daily round of the drop-in, and formally, over the course of directed training sessions or workshops, on positive conflict resolution techniques. This approach puts some of the power and responsibility into participants' hands, and gives them the tools they need to defuse situations both within and outside of the drop-in.

SUBSECTION 5G

Crisis Intervention and Conflict Resolution

Note: This Subsection should be read in conjunction with Subsections 2S: Participant Rights and Responsibilities, 2T: Complaint Process, 2U: Service Restrictions, Barring Policies, and Appeals, and 5F: Crisis Prevention.

As much as it is important for staff to train, prepare, and think through their responses to crisis situations ahead of time, it is also important for them to recognize that every conflict is unique, every person in crisis is an individual, and every conflict resolution approach needs to be tailored to the context of the situation and the particular people involved.

Team-building also needs to continue, not just in training, meetings, or social events, but also on-the-spot during crisis situations. It is a good practice for staff to work on building the capacity and confidence of all staff, recognizing each team member's skills and drawing on them to help resolve a situation. Sometimes there are one or two people who happen to be very skilled at crisis intervention, but you should avoid the temptation to let them handle every conflict.

Step-By-Step Intervention Process

The TDIN and THTC training program offers the following steps and strategies for intervening effectively in a crisis situation:⁴⁴

1. Make other staff on duty aware of the situation. Do not challenge the participant.
2. The first staff member on the scene becomes the **“lead” staff**, and the others act as **back-up**. If this is you and you feel that you are unable to handle the situation, ask reinforcement staff to act as the lead while you act as back-up.
3. **Back-up staff should not rush into the situation**, even if they assume they have a good relationship with the participant. It can be very intimidating for a participant to suddenly be surrounded by staff, and this may serve to escalate the situation rather than defuse it.
4. “Back-up” staff should provide exactly that – back-up. It is important for staff to **present a united front**. It is more useful for all staff to be working together on one solution, than for each person to try to

⁴⁴ Adapted from Evelyn Mitchell, “Non-Threatening Crisis Interventions,” *Drop-In 101: Workshop Facilitator’s Manual*, Toronto (ON): TDIN and THTC, 2005.

implement their own solution. If you have a concern with the way the lead staff is handling the situation, this should be addressed later, in private, or during the debriefing.

5. **Ensure that other participants are out of the way.** This will both ensure their safety and may help prevent escalation of the situation. If other participants remain present, their “audience participation” may trigger the participant who is “ready to blow.”
6. If another participant is the target, get them to a **safe place**, and if possible, have someone else stay with them.
7. Place yourself in such a way that you can leave the room without obstruction (look for the **nearest exit**).
8. Keep a **safe distance** from the participant (but not so far that you have to shout). Give participant space to move and do not reach out to touch the person if they are agitated or angry. Do not turn your back on participant.
9. Advise participant, in a calm, steady voice, of **consequences** if this behaviour continues. Give participant time to back down.
10. Use **de-escalation techniques** (described further below) as you engage the participant.
11. Encourage the person to leave so that they can **cool down**. Do not follow participant through the door as many violent incidents happen in a doorway. Your guard may be down and then there is a shift in power. Let them leave of their own accord.
12. If the participant refuses to go, warn them that you will have to call the **police** if they will not leave. Often, talking about calling the police is enough to convince the participant that it is in their best interests to leave. However, if they continue to refuse to leave, you should follow through with the call.
13. Do a **debriefing with the targeted participant(s)**.
14. Do a **debriefing with the staff** involved.
15. Fill out an **incident report** (see **Appendix 5G.1**).

Communication

Making other staff at the drop-in aware of the escalating crisis is, in some ways, the most important step. There need to be mechanisms in place to facilitate your ability to make other staff on duty aware of the situation.

Often, a drop-in is small enough that staff elsewhere in the building can hear loud and agitated voices. Nevertheless, it is a good practice to have other communication mechanisms in place; for example, **walkie-talkies**, **intercoms** in each room, or “**floating staff**.” The latter is a system where there is a worker in each room of the drop-in, and one additional worker who moves from room to room. This means that if coworkers have messages for each other, they can communicate them through the floating worker.⁴⁵

De-Escalation Techniques

Often the best way to defuse an explosive situation is simply to talk to the person and give them some space to let off steam. Anger and belligerent behaviour require a lot of energy to maintain, and talking can be a kind of pressure-release valve that keeps these outbursts short. As people begin to talk, you can validate their feelings and help them find constructive solutions to their problems.

In addition to the steps described for the intervention process above, there are some further tips to help you as you engage the participant in conversation.⁴⁶

- **Active listening.** Show support in a way that is respectful and real, and not condescending. Explain to the agitated person that you want to understand what is going on, and that you want to hear both (or all) sides of the story. Give them supportive feedback, even as you are trying to make suggestions for modifying the behaviour. For example, “I understand why you became angry, but we need to find another way to resolve this situation.”
- **Separate space.** If at all possible, take the agitated person to a separate space that provides confidentiality and allows the participant to save face when they back down. It is best to take the person to a neutral area, like outside the drop-in, or down a hall, or to go get a coffee, or out for a smoke. Taking them into an office can feel punitive, humiliating, and infantilizing.
- **Avoid “why” questions.** Avoid asking participants “why” questions, because this can exacerbate aggression and frustration.
- **Tone of voice.** While it is a good practice to speak in a calm voice and not get agitated in response, be wary of being too calm or too soothing. Appearing too calm can seem like an inappropriate emotional response to an intense situation,

⁴⁵ Homeless Link, “5: Implications for Safety,” *Day centres handbook: A good practice guide*, London (UK), 2004, page 5.7.

⁴⁶ These tips are adapted from a list given in Homeless Link’s *Day centres handbook*, page 5.6, and somewhat modified according to information gathered during the Good Practices Project consultations with TDIN drop-in staff.

while being soothing can be perceived as condescending and can trigger participants further. Further, these soft tones of voice are often part of a therapeutic approach that individuals who have been recipients of mental health services have experienced before, and this as well may trigger them further.

- **Panic spots.** Recognize and take advantage of “panic spots” – these are moments where the person loses steam and is unsure how to continue or end the conflict. Staff may be able to use this hesitation to make their own suggestion of the direction this interaction should take, and participants may be more willing to agree at these times.
- **Writing it down.** Depending on the explosiveness or intensity of the outburst, it may be helpful to offer the person a piece of paper and a pen and ask them to write down their concerns. This may help them calm down and focus, and it can help you demonstrate that you are committed to working with them on the particular issues they are having.
- **Talking someone down.** As you are talking someone down, use their name, and your name. This shows that you see them as a person and encourages them to see you the same way. Keep your points short and simple. You may find it effective to repeat the same point.
- **Slow things down.** You may feel that you need to act quickly, but it is critical to take a few moments to reflect, order your thoughts, and bring coworkers in. Often situations can ignite by sudden movements, noise, gestures, or obvious displays of nerves. Tell the other person what you’re going to do before you do it, particularly if it means moving about, and certainly if you have to move out of sight.

Documentation

After an incident occurs in the drop-in, a report must be filled out as a record of what happened, who was involved, what staff interventions took place, and any required follow-up that needs to be done.

The incident report form should be a **standardized template**, rather than a blank piece of paper. This will ensure that important details do not get lost and forgotten, and will help to standardize the information that gets recorded and how it is used. Further, staff will be less vulnerable to individual criticism or accusations of bias if the matter ever goes to court or becomes part of an inquiry.⁴⁷

It is important that this record be **filled out as soon after the event as possible**, so that the memory of all the details is still fresh. It should be signed, not only by the staff who completed the form, but also by a staff who witnessed the situation occur as well.

⁴⁷ Homeless Link, “4: Dealing with serious incidents,” *Day centres handbook: A good practice guide*, London (UK), 2004, pages 4.4-4.5.

If the manager is present, the manager should also sign the report. If the manager is not present, they should be given the report the next time they are at the drop-in and they should sign it at that point. See **Appendix 5G.1** for a sample incident report form.

ATTACHMENT:

- **Appendix 5G.1 – Sample Incident Report Form**

Appendix 5G.1 Sample Incident Report Form

Source: Adapted from documents collected from TDIN drop-ins during the Good Practices Toolkit consultations, May-July 2006.

INCIDENT REPORT

Date of incident: _____ Time: _____ Duration: _____

Location and Program: _____

Participant(s) involved: _____

Staff involved: _____

Name of Ambulance Attendant / Police Officer and badge # (if applicable):

TYPE OF INCIDENT

Behavioural Medical Injury Property damage
Emergency Specify: _____ Other Specify: _____

DESCRIPTION OF INCIDENT *(attach another page if more space needed)*

ACTION TAKEN *(attach another page if more space needed)*

Service restrictions or time away? If yes, please state:

Who? _____

Type/length of service restriction? _____

For how long? _____

Follow-up / next steps: _____

Staff completing report: _____

Witness: _____

Supervisor / Manager: _____

SUBSECTION 5H

Cleaning and Sanitation

Many sanitation practices and guidelines are determined by the requirements of drop-in funders, Toronto Public Health, and local municipal regulations. A drop-in is responsible to comply with these specific procedures to ensure good health. This Section covers some of the basic expectations for cleaning and sanitation protocols in Toronto drop-ins.

Sanitizing Solution

A mix of bleach and water is an effective sanitizing solution. **Appendix 5H.1** gives instructions on the proper ratios of bleach and water.

To use the bleach and water solution as a disinfectant, follow these procedures:

1. Ensure that the area to be disinfected is first washed with soap and water.
2. Rinse area thoroughly with clean water.
3. Apply bleach solution.
4. Leave the bleach solution on the surface for at least 20 minutes.
5. Let air dry, or wipe with a clean disposable towel.

Please note that this sanitizer will lose its strength easily. It may be kept for two weeks if it is stored in an airtight container and kept away from the light. If you are cleaning a mess that involves body fluids or you are disinfecting a potentially contaminated area, it is best to mix a fresh solution. Use caution on metal; if the solution is found to be corrosive, a different sanitizer should be chosen.⁴⁸

Surfaces and Appliances

All surfaces and appliances need to be carefully and regularly cleaned and sanitized to prevent the sharing of bacteria or other germs. Good practices governing both the timing and the techniques of these procedures are described below.⁴⁹

The following surfaces should be cleaned and sanitized **before and after each use**:

- Counters
- Worktables
- Cutting boards

⁴⁸ Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

⁴⁹ The following lists have been adapted from MAFRP, *Effective Practices Project*, 2005; and from Toronto Public Health (TPH), *Food Handler Certification Program*, 4th Edition, 2004, page 27. Available at: www.toronto.ca/health/foodhandler/pdf/fh_document.pdf.

Surfaces that are touched regularly by a large number of people should be cleaned and sanitized **at the end of each drop-in day**. These include:

- Door knobs / door handles
- Windows and window latches
- Taps in bathroom
- Toilet seats and toilet handles
- Sinks
- Light switches
- Telephones
- Furniture (where possible; it is a good practice to have chairs made of material that can easily be wiped down, e.g. vinyl)

The following appliances should be cleaned and sanitized **after each use**:

- Dishwasher strainer
- Sinks
- Can openers
- Blenders and food processors
- Stove tops

The following are to be cleaned **immediately when there is a spill and thoroughly at least once a month**:

- Ovens
- Dishwashers
- Cupboards, drawers, shelves
- Refrigerators
- Oven fan hoods

Microwaves should be cleaned immediately when there is a spill and thoroughly at least once a week. **Freezers** are to be cleaned immediately when there is a spill and thoroughly at least twice per year. Freezers are to be emptied out monthly; food should not be stored for over one month.

Dishes and Utensils

In some drop-ins, plastic cutlery and paper or Styrofoam cups and dishes are used. This helps small-scale drop-ins with smaller kitchen facilities provide food in a sanitary way; however, the toll this takes on the environment can be severe. It is a good practice for drop-ins to look into funding sources for a more environmentally sustainable system (for example, money is available through the Health and Safety branch of the City of Toronto's Homeless Initiatives Fund for dishwashers and other appliances).

All dishes and utensils used in cooking should be washed in the dishwasher, if you have one.

If you are washing dishes by hand, you should follow this procedure:⁵⁰

1. Sort, scrape, and pre-rinse dishes.
2. Wash dishes with warm water and detergent.
3. Rinse with clean water (the water should have a minimum temperature of 43 degrees Celsius).
4. Soak the dishes for a minimum of 45 seconds in:
 - A 100 mg/Litre chlorine solution at a minimum temperature of 24°C (see **Appendix 5H.1**), OR
 - Clean water at a minimum temperature of 77°C.
5. Change sanitizing water frequently to maintain its temperature and/or to maintain its concentration of bleach.
6. Sanitize sinks, taps, and faucets after washing dishes.
7. Allow dishes to air dry rather than using a towel to dry them.

Ideally, a **three-compartment sink** should be used – one compartment for washing, one for rinsing, and one for sanitizing. If you do not have a three-compartment sink, washing and rinsing may be done in the same compartment, but sanitizing must always be done separately – whether in a different sink compartment, or in another basin or container.

Kitchen Linen

It is a good practice to change kitchen linen at least once a day and as required throughout the day. Do not use cloths designated for washing utensils, food preparation areas, or serving surfaces for any other purposes.⁵¹

Bathrooms

Toilets and flushing handles should be cleaned and sanitized at least once a day, and the toilet paper supply should be checked daily. Bathroom sinks and countertops should be cleaned and sanitized at least once per day. Bathroom floors should be swept or vacuumed daily and mopped with cleaner when obviously dirty.⁵² The frequency of these cleanings and checks may increase if you have a high volume of participants coming through your drop-in.

ATTACHMENT:

- **Appendix 5H.1 – Bleach and Water Solutions**

⁵⁰ Adapted from TPH, *Food Handler Certification Program*, pages 53-56, and from MAFRP, *Family Support Health and Safety Toolkit*, 2005.

⁵¹ MAFRP, *Family Support Health and Safety Toolkit*, 2005.

⁵² *Ibid.*

Appendix 5H.1 Bleach and Water Solutions

Source: #1: Toronto Public Health (TPH), “Fact Sheet: Bleach and Water for Disinfecting,” 2 April 2003 (poster available for download at: www.toronto.ca/health/sars/pdf/sars_disinfecting.pdf); #2: TPH, *Breaking the Chain*, March 2006, page 30 (document available for download at: www.toronto.ca/legdocs/2006/agendas/committees/hl/hl060410/it009.pdf); and #3: TPH, *Food Handler Certification Program*, 4th Ed., 2004 (available at: www.toronto.ca/health/foodhandler/pdf/fh_document.pdf).

BLEACH AND WATER SOLUTIONS

#1 Everyday Cleaning Bleach and Water Solution

Use:

For disinfecting surfaces such as:

- Counter tops;
- Sinks, faucets, and toilets;
- Building fixtures, including door handles and telephones; and
- Toys.

Preparation:

Mix 1 teaspoon of household bleach with 2 cups of water. (The ratio is about 99 parts of water with one part bleach.) Be careful not to spill on your skin.

#2 Extra-Strength Cleaning Bleach and Water Solution

Use:

For cleaning-up surfaces where there are bodily fluids (e.g. blood) or other contamination (not skin).

Preparation:

Mix nine equal parts of water with one part bleach. Be careful not to spill on your skin.

#3 Dishes Sanitizing Bleach and Water Solution

Use:

For sanitizing dishes after they have been hand-washed using detergent and rinsed.

Preparation:

Mix 100mg of bleach with one litre of water at a minimum temperature of 24 degrees Celsius in a clean sink compartment or separate container. Let dishes soak for a minimum of 45 seconds.

SUBSECTION 5I

Safe Storage

Dishes and Utensils

When putting away the clean dishes and utensils, examine them carefully. Rewash any soiled items and discard any damaged items. Store knives, spoons, and forks in clean containers with the handles all pointing in one direction to avoid hand contact with eating surfaces.⁵³ Store glasses and cups upside-down on a clean, sanitized, and dry surface, and store all dishes on clean shelves or in clean cabinets. All utensils and dishes, including paper service, must be protected from contamination.⁵⁴

Cleaning Materials

Staff should be familiar with the requirements of the Workplace Hazardous Material Information System (WHMIS).⁵⁵

Soap, detergents, sanitizer, and any other washing solutions should be clearly labeled and kept in a locked cupboard if possible. Dry floor mops should be shaken outside after every use and laundered when noticeably dirty. Sponge mops should be hung with the head up and the handle down to dry. The sponge head should be rinsed in a sanitizing solution and wrung out once a week. Rag mops should be hung head up to dry and laundered once a week.⁵⁶

Garbage

Handling, storing, and disposing of waste material safely is important in maintaining a clean facility and preventing the spread of disease.

Good practices include the following:⁵⁷

- Make separate garbage containers available in the washrooms, kitchen, eating, and program areas.
- Keep garbage containers tightly covered and away from food.
- Ensure that program sites have enough covered metal or durable plastic containers for all garbage and waste materials.
- Ensure indoor garbage containers are waterproof and have a tightly fitting lid, preferably operated by a foot pedal.
- Plastic liners must be used in garbage containers.

⁵³ Toronto Public Health (TPH), *Food Handler Certification Program*, 4th Edition, 2004, page 56. Available at: www.toronto.ca/health/foodhandler/pdf/fh_document.pdf.

⁵⁴ Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

⁵⁵ See www.e-laws.gov.on.ca/DBLaws/Regs/English/900860_e.htm for the WHMIS regulation in the Ontario Health and Safety Act. See also www.ccohs.ca/oshanswers and www.labour.gov.on.ca/english/hs/whmis for answers to frequently asked questions about the regulation.

⁵⁶ MAFRP, *Family Support Health and Safety Toolkit*, 2005.

⁵⁷ Adapted from *ibid.*

- Dispose of garbage daily and insert a new liner in the container. Garbage must not be left overnight in the kitchen area or wherever food is kept.
- Clean and sanitize containers once a week and whenever there is a leak or containers are visibly soiled.
- Keep outside garbage areas clean and sanitary, minimizing odours.
- Follow proper recycling methods.

When disposing of garbage, make sure never to touch it with your hands or any other part of your body – for example, don't put your foot inside the container to stamp it down, or reach in with your hand to push it down (even if you are wearing gloves). Containers may contain dangerous or contaminated materials such as sharps. If a container is overflowing, use tongs (or some other type of tool) to move excess garbage from one bag to another.⁵⁸

Pest Control

Pests such as cockroaches, flies, mice, and rats contribute to the spread of dirt and disease in food areas.

A pest control program including the following points should be in place:⁵⁹

- **Keep all areas clean** – It is important to clean, not just the tops of counters and other surfaces (as described above), but also behind for stationary equipment and shelving. Items must be stored on racks or shelves at least fifteen centimeters (6 inches) above the floor.
- **Exclude pests** – Screen doors and windows. Caulk and fill all holes and crevices.
- **Eliminate all breeding and nesting areas** – Keep storage areas clean and free of unused equipment. Eliminate any food and water source such as food scraps, spillage, or water leaks. If possible, store all food in sealed containers.
- **Check goods received for infestations** – Dried food must be inspected for food infesting pests, their eggs and larvae. Examples are moths, beetles and worms
- **Reporting** – Make sure to report any sightings of pests or infestations.
- **Disposal** – Properly dispose of any dead pests immediately
- **Pest control services** – Look up the number of a local licensed pest control company and include it on the list of emergency contact numbers by the phone.

⁵⁸ TPH, *Breaking the Chain: Infection Prevention and Control for Homeless and Housing Service Providers*, March 2006, page 27. Available at:

www.toronto.ca/legdocs/2006/agendas/committees/hl/hl060410/it009.pdf.

⁵⁹ Adapted from TPH, *Food Handler Certification Program*, pages 60-61.

SUBSECTION 5J

Food and Nutrition

Drop-in centres need to ensure that the food and snacks they provide for participants are nutritious and take into account health issues and respect individual preferences.

Obtaining Food

Obtaining food is one of the major difficulties faced by drop-ins. Fresh and nutritious food can be expensive, and most drop-ins must rely on donations.

Food donations come from three main sources:

- 1. The general public** (through food drives and Daily Bread);
- 2. Local businesses** that develop relationships with their neighbourhood drop-in and regularly send over surplus food; and
- 3. Charitable organizations** (like Second Harvest) that pick up excess, unused, or recently expired perishable foods from grocery stores, food manufacturers, hotels, and caterers and redistribute them to social service agencies.

The two main challenges to relying on donated food are **consistency** and **quality**. In the first instance, it is difficult to ensure consistent amounts of particular food staples, particularly when attempting to plan meals for hundreds of people in advance. In the second instance, donations often consist of expired foods that are no longer saleable.

Some drop-ins refuse to accept **expired food** from these organizations on the grounds that, if it is not fit for general consumption, it is not fit for anyone's consumption and should not be served to socially marginalized people who often have poor health and compromised immune systems. An alternative strategy to accepting expired food donations is to accept only surplus food donations. This may be achieved through developing friendly relationships and formal partnerships with local merchants who can vouch for the quality of the food they pass on.

Other drop-ins argue that expiry dates always err on the side of caution, and that market demands for fresh food are often based on aesthetics or taste rather than health concerns. For example, most people would eat day-old bread, but few would pay full price for it in a store. It is important, of course, to examine the food that is donated and determine whether or not it is still good; **a basic rule of thumb is to not serve anything that you would not eat yourself.**

Fruits and Vegetables

It can be a challenge to include healthy portions of fruits and vegetables in the meals served. Canada's Food Guide to Healthy Eating recommends that people eat 5 to 10 servings of vegetables and fruit every day. The health benefits of this diet are high; people who eat five or more servings of fruit and vegetables as part of a balanced diet each day have a reduced risk of developing heart disease, hypertension, some types of cancer, diabetes, and other chronic diseases.⁶⁰ It is also important for people whose immune systems are already compromised to eat healthy food.

A “serving” is defined as:⁶¹

- 1 medium-sized vegetable or fruit;
- 125 mL (½ cup) of raw, cooked, or canned vegetables or fruit;
- 250 mL (1 cup) of raw, leafy vegetables, such as salad;
- 50 mL (¼ cup) of dried fruit; or
- 125 mL (½ cup) of 100% fruit or vegetable juice.

There are many challenges to drop-ins who want to serve fruits and vegetables:

- 1. Stable sources of food.** For drop-ins who do not have stable funding for meals and rely heavily on donated items, it is difficult to get large quantities of fresh produce (see “Obtaining Food” above).
- 2. Cost.** Fresh fruit and vegetables can be expensive. Buying **in-season** Ontario fruits and vegetables can greatly reduce the cost, as can shopping at **farmers’ markets** rather than grocery stores. Toronto Public Health provides a list of seasonal and year-round farmers’ markets, with a chart indicating the availability of local produce by month at: www.toronto.ca/health/vf/vf_your_barriers.htm. Certain vegetables and fruits – such as potatoes, squash, cabbage, apples, and pears – are still locally available and relatively inexpensive out of season and throughout the winter. Finally, **frozen or canned options** are still nutrient-rich and are often cheaper than fresh produce.⁶²
- 3. Taste preferences.** Many participants who are simply uninterested in eating fruits or vegetables, and may push them to one side on the plate. If this is a concern at your drop-in, it is a good practice to purée vegetables and make them part of the sauce, stew, casserole, or chili that you are preparing.

⁶⁰ Toronto Public Health (TPH), Invite Us Along: Fruit and Vegetable Campaign, “5 to 10 a day; Are you getting enough?” (www.toronto.ca/health/vf/vf_5to10.htm) and “What are YOUR barriers to getting enough vegetables and fruit?” (www.toronto.ca/health/vf/vf_your_barriers.htm).

⁶¹ TPH, “5 to 10 a day; Are you getting enough?”

⁶² TPH, “What are YOUR barriers to getting enough vegetables and fruit?”

Special Diet Needs

It is a good practice to think about the diversity of participants and their special food requirements. Some participants may not be able to eat food such as pork or beef due to **religious restrictions**; others may have **allergies** or other food sensitivities; others may have **health conditions** like diabetes or AIDS that require particular attention to nutritional balance and food preparation; others may be **vegetarian**.

With vegetarians, drop-ins often respond with a “**double-double**” approach – two servings of the starch, two servings of the vegetables – rather than plan separate meals. The drawback to this approach is that it may not provide adequate protein or nutritional balance. However, most drop-ins report only a very small minority of vegetarians and inadequate resources to cook separate meals.

One solution is to work out an agreement with local grocery stores or small businesses to donate frozen vegan and vegetarian entrées. These can be kept in the freezer for long periods of time, and quickly heated up when a participant requests a vegetarian option. This approach can be taken whenever there are infrequent requests for special diets.

Whenever there are one or more individuals with special needs who regularly access the drop-in, it is a good practice to take these needs into account when preparing the main meals. For example, if cooking a pot of chili, pour some into a smaller container and add chickpeas, then add meat to the bigger pot.

Allergies

Although you cannot plan for every allergy that a potential drop-in participant may have, it is a good practice to avoid some of the most common and most dangerous items linked to food sensitivities. For example, use vegetable oil when cooking rather than peanut oil.⁶³ Servers should be aware of which ingredients were used in the preparation of the meal so that if a participant asks, the servers can respond appropriately and a potentially hazardous situation can be avoided. If a person has a severe allergic reaction, call 911.

Food Storage

Dry goods should be stored at least fifteen centimeters (6 inches) above the floor to make it more difficult for pests to access them. It is a good practice to store bulk items (e.g. cereals or rice) in re-sealable jars, since the cardboard or plastic packages they come in may be easily gnawed through. These practices not only protect dry goods from pests, but also protect them from flooding or spilled water (for example, from a mop bucket). Food should not be stored in the same area as possible sources of contamination (for example, cleaning supplies). Items should be checked regularly for expiry dates and thrown away as needed.

Please read the sections below on temperature control and cross-contamination for a discussion of proper storage of perishable goods such as meat and dairy products.

⁶³ TPH, *Food Handler Certification Program*, 4th Edition, 2004, page 26. Available at: www.toronto.ca/health/foodhandler/pdf/fh_document.pdf.

Food Preparation

It is recommended that all staff handling food and, ideally, all volunteers handling food, take the Toronto Public Health Food Handler Certification Program. You can call 416-338-FOOD for more information.

The Good Practices Toolkit extracts and summarizes some of the basic protocols for safe food preparation from Toronto Public Health's *Food Handler Certification Program*, but this should not be understood as a substitute for the training provided by TPH or the full discussion contained in the original document (available online at www.toronto.ca/health/foodhandler/pdf/fh_document.pdf).

Temperature Control

Most food poisonings occur because hazardous foods were improperly stored, giving pathogenic bacteria a chance to grow. Toronto Public Health defines pathogens as “harmful micro-organisms that can cause disease in humans” and hazardous food as “food that is able to support the growth of pathogenic micro-organisms or the production of toxins.” This includes dairy products and meat, especially poultry and ground meats.

Although food-borne illness is one of the most common diseases affecting people, it often goes untreated. Symptoms can include mild stomach discomfort, vomiting, diarrhea and, in some cases, death. Illness can occur within one hour to several days after consuming the contaminated food.⁶⁴

The Danger Zone

“The danger zone” is the temperature range between 4 and 60 degrees Celsius (4°C to 60°C). This is the temperature range that allows bacteria to multiply fast enough to cause food-poisoning. When preparing or serving meals, do not allow hazardous food to remain in the danger zone for more than two hours. If you are using steam tables, cover food to keep the heat in, and regularly check that the temperature is above 60°C using a thermometer.⁶⁵

Using the Thermometer. To check the internal temperature of food, use the following procedure.⁶⁶

1. Insert a probe thermometer into the thickest part of the food. Be careful to ensure that it does not touch the pot, container, or bone (if meat); this will give a falsely high reading.
2. Clean and sanitize the probe after each use and before inserting it into the next food item.

⁶⁴ *Ibid.*, pages 31, 11, and 16.

⁶⁵ *Ibid.*, page 32.

⁶⁶ *Ibid.* page 31.

Before checking temperatures, it is important to calibrate your thermometer to ensure that your reading is accurate:⁶⁷

1. Fill a medium-sized glass with ice. Add water to ice. Place thermometer in glass.
2. Wait 3 minutes. Stir water occasionally.
3. After 3 minutes, thermometer should read 0°C (32°F).
4. If not, leave probe in ice water.
5. Using pliers or a small wrench, turn the adjustable nut on the back of the thermometer head until the needle reaches 0°C (32°F). You may need to add more ice.
6. Wait 3 minutes. Stir occasionally. Readjust the nut if required for the needle to read 0°C (32°F).

Refrigeration. Each refrigerator and freezer must be equipped with a reliable thermometer to ensure that proper temperatures are maintained. In general, food should be kept at a temperature below 4°C (outside of the danger zone). Frozen food should be stored at temperatures below -18°C. Hazardous food stored below -20°C for 7 days, or below -35°C for 15 hours will kill parasites and their eggs. Pathogenic bacteria do not grow at temperatures below -18°C, but will survive. Do not allow food to cool to room temperature before storing it in the refrigerator; cool food quickly using shallow pans of cold water or an ice bath.⁶⁸

Cooking Food Thoroughly. Different types of hazardous foods have different cooking and reheating temperatures. See **Appendix 5J.1** for a chart.

Leftovers. Foods that have been frozen and allowed to thaw should not be refrozen unless cooked first. Food should be reheated to at least 74°C. Drop-ins that provide participants with leftover food to take away with them should educate people about safe food storage. One approach is to ask people to sign a waiver when they take food with them that indicates their understanding that food needs to be stored under specific conditions (e.g. in a freezer or fridge) and eaten within a specific timeframe.

Hand-Washing

Staff should wash their hands thoroughly before preparing food. The kitchen should be equipped with a hand-washing sink. If it is not, drop-ins should prioritize seeking the funding to install one. Ensure paper towels are available to dry hands; do not use linen towels.⁶⁹ Hand-washing posters should be posted in the drop-in; posters are available for downloading and printing from the Toronto Public Health web site.⁷⁰

⁶⁷ *Ibid.*, page 67.

⁶⁸ *Ibid.*, pages 32-33 and 36.

⁶⁹ Metro Association of Family Resource Programs (MAFRP), *Effective Practices Project: Family Support Health and Safety Toolkit*, prepared by Leslie Wright, Novita Interpares Limited, 2005.

⁷⁰ TPH, "Handwashing:" www.toronto.ca/health/sars/pdf/sars_handwashing.pdf.

The following hand-washing procedure should be followed by all staff and volunteers:⁷¹

1. Use liquid soap and warm running water.
2. Wet your hands and add soap.
3. Rub your hands vigorously for fifteen seconds.
4. Wash all surfaces, including the backs of hands and between fingers.
5. Rinse your hands well under running water.
6. Dry your hands thoroughly with a single-use towel.
7. Turn off the taps with a single-use towel and dispose of it in waste container.

Cross-Contamination⁷²

It is important to prevent contact between food that is ready to eat and raw food, pathogenic bacteria, or chemicals. Such cross-contamination can make prepared food unsafe to eat.

Cross-contamination can be avoided through:

- Washing hands before and after handling food;
- Making sure cutting boards, knives, and equipment are cleaned and sanitized after they come in contact with hazardous food;
- Using plastic cutting boards for meat rather than wooden cutting boards (it is more difficult to sanitize the wooden surface and pathogenic bacteria may become trapped in its cracks);
- Storing cooked or ready-to-eat food in a separate refrigerator or on a shelf in the fridge above raw food;
- Covering all food and drinks inside the fridge;
- Labeling chemicals and cleaning products and storing them away from food;
- Using specially designated surfaces for foods (for example, using a separate cutting board for meat exclusively); and
- Ensuring that tabletops are free of dents, chips, and cracks.

ATTACHMENT:

- **Appendix 5J.1 – Temperatures for Cooking and Reheating Hazardous Food**

⁷¹ This procedure has been adapted from TPH, *Breaking the Chain*, page 103, and MAFRP, *Family Support Health and Safety Toolkit*, 2005.

⁷² TPH, *Food Handler Certification Program*, pages 37-38.

Appendix 5J.1 Temperatures for Cooking and Reheating Hazardous Food

Source: Toronto Public Health (TPH), *Food Handler Certification Program*, 4th Edition, 2004, pages 34-35. Available at: www.toronto.ca/health/foodhandler/pdf/fh_document.pdf.

COOK FOOD THOROUGHLY

Hazardous Food Item	Cooking °C (°F) for 15 seconds	Reheating °C (°F) for 15 seconds	Additional comments
Poultry: Whole	82 (180)	74 (165)	Make sure poultry is fully cooked; do not partially cook poultry and finish cooking it at a later time. Poultry is one of the most common sources of food-borne illness. Assume all poultry is contaminated with pathogenic bacteria (e.g. Salmonella and Campylobacter).
Poultry: <ul style="list-style-type: none"> • Other than whole poultry • All parts of ground poultry • All parts of ground meats that contain poultry 	74 (165)	74 (165)	
A food mixture containing poultry, egg, meat, fish or another hazardous food	74 (165)	74 (165)	
Pork and pork products	71 (160)	71 (160)	
All parts of ground meat , other than ground meat that contains poultry	71 (160)	71 (160)	Cook hamburger all the way through, making sure the juices run clear and the meat is brown or grey. Ground meat is very dangerous as the pathogens (e.g. E. coli 0157:H7) are mixed throughout the meat mixture in the grinding process.
Fish	70 (158)	70 (158)	