Overdose Policy

Turas Training

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1. Policy Statement

TURAS is committed to ensuring that the health and safety of service users is a paramount consideration in all activities of the service. We believe that timely and appropriate staff intervention can reduce the risk of serious health implications or death through overdose.

2. Purpose

2.1. To outline a standard process for staff to follow if they suspect an overdose.
2.2. To ensure preventative measure are in place to reduce the risk of overdose to the service user group.

3. Scope

3.1. This policy applies to TURAS staff, volunteers and locum staff working within the organisation or on outreach. The level of intervention in regards to overdose will be determined by the levels of training of the staff member.

4. Glossary of Terms and Definitions

4.1. Overdose: in general overdose referrers to an excessive use of a drug, resulting in adverse reactions ranging from mania or hysteria to coma or death. In the instance of this policy the term overdose referees to a reduction in consciousness and respiratory function leading to a risk of lose of health or life.
4.2. First Aid: emergency treatment administered to an injured or sick person before professional medical care is available. Individuals should have first aid training before performing CPR as part of a first aid intervention.
4.3. Goof: state of altered consciousness that may result in reduced responsiveness and lack of awareness to environment.

5. Principles

5.1. The risk of overdose should always be taken seriously.
5.2. Any service users who are suspected of consuming psychoactive substances should be monitored while on the premises as an overdose can occur for a period after substances have been taken.
5.3. If staff suspect an overdose they should always engage with the service user as described within the protocols.
5.4. If an ambulance is called and a service user decides not to avail of medical help this decision should be respected. There should be no negative consequences as a result of refusal to accept pro-offered medical services.

6. Roles and Responsibilities

6.1. It is the responsibility of all staff to act to the level of their training in regard to suspected overdose. In all cases suspicion of overdose should be responded to immediately.
6.2. Managers should monitor overdose prevention strategies, and ensure that relevant staff have appropriate and up to date first aid training.

7. Recognising Overdose

7.1. Most overdoses set in over the course of hours, as a person's body slowly shuts down and breathing becomes more labored (in opioid overdose). Additionally, repeated use of a drug over hours or days overwhelms normal cardiovascular function (in the case of stimulant drugs). Therefore the role of monitoring individuals who are at possible risk of overdose is very important. When monitoring, the following are signs of overdose risk:
    7.1.1. Depressants: awake but cannot speak; slow heartbeat and pulse, slow breathing, blue lips and/or fingernails; gurgling, raspy breathing, choking sounds, passing out, throwing up, pale face, limp body.
    7.1.2. Stimulant Poisoning: extreme agitation or anxiety, foaming at mouth, very rapid heartbeat, pulse, elevated body temperature, quick, shallow breathing; chest pain, pressure; choking or

gurgling sounds, throwing up (note that stimulant poisoning can turn into stimulant overdose).

7.1.3. Stimulant Overdose: suddenly collapsing or passing out, shaking, seizure, heart attack, and stroke.

7.2. If staff observe signs of potential overdose the person should be monitored as described in point 8. If this is not possible the individual should be encouraged and facilitated to attend, or accompanied to medical services.

7.3. If the individual insists on leaving without medical attention they should be encouraged not to be alone and if possible, some information and/or support should be provided by staff to the person accompanying them.

8. Procedures – Monitoring and Responding to Overdose

8.1. If staff suspect that a service user has consumed drugs prior to entering the premises or while on the premises they should monitored. In general monitoring means noting where the individual is and ensuring that they are not left alone in a room for periods of time without being checked on every 20 minutes or so. An individual who has taken drugs may 'goof' which will necessitate staff taking pro-active monitoring to ensure the individual has not gone into an overdose and requires medical attention. When monitoring, the following processes should be followed:

8.1.1. Staff should monitor that the individual is breathing, if the individual is not in a position where this can be monitored (i.e. they are slumped forward), then the person will need to be spoken to ascertain consciousness. They should be asked to move into a comfortable position where staff can keep an eye on them by monitoring breathing. Ideally the service users should be moved into a recovery position to ensure that airways are clear. If the service user does not wish to move then a staff member should speak to the individual and get a response every ten minutes. If the individual is frustrated by this, the reasons should be explained and the other option of moving position explained. If there is no verbal response, then;

8.1.2. The staff member should ask the individual to move part of their body to acknowledge that they can hear. If this does not occur:

8.1.3. A small amount of physical discomfort should be inflicted, i.e. pulling the ear lobe, rubbing knuckles across the chest. The purpose of this is to rouse the individual. If they do not respond:

8.1.4. The emergency services should be contacted on 112 or 999. If possible one staff member will call emergency services while another member engages in first aid. The operator should be told the following:

8.1.4.1. The exact location of the building, including street address and any landmarks

8.1.4.2. The phone number of the organisation

8.1.4.3. Any information pertaining to the overdose, for instance what drugs have been taken if this known.

8.1.5. If the staff member is trained in first aid then the following steps should be undertaken:

8.1.5.1. If the individual at the scene is not trained in first aid, once the ambulance is called they should get a staff member who is trained to assist the individual until the ambulance arrives.

8.1.5.2. The first aider should check to make sure that the environment is safe, i.e. ensure there are no needles in the vicinity or any other dangers.

8.1.5.3. The service user should be moved into a lying position on their back to facilitate further assistance:

8.1.5.4. The staff member should check the airway and tilt the individual's head back by pushing their chin towards the ceiling to open the airway.

8.1.5.5. The worker should check for breathing, by lowering their face to the service user's mouth and listening / feeling for breath. If there is no breath and they are trained they should begin CPR. Current guidance (Aug 2010) is that there should be two breathes for every thirty compressions. CPR should be continued until the arrival of the ambulance.

8.1.5.6. If the individual is breathing then the first aider should put them in recovery position and monitor. A body scan may be undertaken to ensure that no other injuries are apparent.

8.1.6. While waiting for an ambulance a causality sheet should be completed (appendix I). This form will assist the ambulance staff provide the most effective treatment. The sheet should be filled in by a trained first aider and given to the ambulance staff on arrival.

9. Prevention

9.1. Environmental Management

9.1.1. The service has a no drugs use on the premises policy and all service users will be informed of this, however as a low threshold service staff will also be aware that the rules may be broken and that services users may use drugs. In this instance the organisation has a duty of care to those attending the service. To reduce the risk of overdose staff will undertake the following:

9.1.1.1. The use of toilets will be monitored, if anyone spends longer than 5 minutes in the toilet, staff will knock on the door and ask for a verbal response. If there is no response the door will be loudly knocked and the person called to; if there is still no response then the door will need to be physically forced open. At all times the service user should be communicated with in case they are roused and able to respond.

9.1.1.2. No service user will be left alone and unchecked for more than 20 minutes after having knowingly consumed drugs.

9.2. One-to-One Sessions

9.2.1. All service users will be offered one-to-one harm reduction information on how to reduce the risk of overdose. Follow up will be undertaken within a month, where possible, to check retention of information and to assist in application of the information to lifestyle.

9.2.2. Particular attention will be paid to ensure people in the following higher risk groups have one-to-one harm reduction sessions and follow up (It should be noted that individual with combinations of the following have a higher risk):

9.2.2.1. history of overdose
9.2.2.2. heavy drinking
9.2.2.3. soon to be realised from prison
9.2.2.4. high levels of intoxication or drug use
9.2.2.5. on ARV drugs
9.2.2.6. using sedatives and opiates
9.2.2.7. recently stopped methadone maintenance programme or not on programme
9.2.2.8. poor health
9.2.2.9. long history of injecting
9.2.2.10. reduced tolerance due to break in drug use

9.2.3. Overdose prevention information will be given in the following sessions / environments (state how and when information is delivered, i.e. in initial key working sessions and every 6 months following this, at exchanges people will be periodically given information in a 1-2-1 discussion, in group sessions every six months a session will be dedicated to overdose prevention etc).

9.2.4. All interventions will be backed up by resources as required. Overdose prevention resources are to be found by using first aid and calling emergency services.

9.2.5. Staff will look out for any informal opportunities for overdose prevention information to be offered / discussed.

9.2.6. Following an overdose on the premises staff will conduct a post overdose session to debrief, and discuss strategies to avoid overdose in the future. In this scenario the issue of suicide and intentional overdose should be raised. If this is the case then the intervention should be managed as described in the suicide policy.

9.2.7. A brief record of all individual1-2-1 overdose prevention interventions will be kept (in service user file, or on a separate sheet etc)

9.2.8. Managers will maintain reviews / audits / checklists to ensure that all services users have relevant service users have received appropriate overdose supports and interventions, this will have particular relevance to people in categories listed in point 9.2.2.

9.3. Group Educational Sessions

9.3.1. Group sessions on overdose prevention will be run every 4 months.

9.3.2. The following will be undertaken to maximise the trainings effectiveness:

9.3.2.1. Sessions will have clear aims and objectives.

9.3.2.2. Sessions will cover preventing self overdose and responding to another persons overdose. The organisation aims for all service users to be aware of how to put someone in the recovery position and how to call for assistance.

9.3.2.3. Creative and participative ways of learning included in session plan

9.3.2.4. Services users will be informed of the session

9.3.2.5. There will be the possibility of 1-2-1 follow up where required

9.3.2.6. Where possible there will a retention session planned for a month following the initial session to record retention of information.

9.3.2.7. Where possible the service will monitor individual / group risk behaviours to ascertain change and retention of information following group training.

9.3.3. Group overdose sessions will always be run before Christmas breaks (and occasions of high risk, holidays etc.

9.3.4. Prison based sessions, will always include overdose prevention sessions.

9.4. Staff materials and Resources

9.4.1. The following materials may be of us in training, trainers should be familiar with all material prior to planning one-to-one or group sessions. see hyperlinks:

9.4.1.1. Excellent and thorough Overdose Prevention Guide and Training Manual, HRC, Harm Reduction Coalition. USA. http://harm.live.radicaldesigns.org/downloads/Overdose%20Prevention%20.pdf

9.4.1.2. Excellent information resources, policy guides, training resources and posters on overdose. Exchange Supplies. U.K http://www.exchangesupplies.org/shopsect_publications_and_dvds.php

9.4.1.3. Resources for services users including DVD / YouTube clip on recovery position Harm Reduction Works. UK. http://www.harmreductionworks.org.uk/6_booklets/overdose.html

Appendix I: Casualty Information Sheet

To be completed following a first aid intervention that requires emergency services.

1. General Casualty Information: *complete as much as possible.*

Date: / Time:
Victim's name: _____ _____ *male* *female*
Age: _____
Victim's phone number: _____
Your name:_____Signature:_____
Your phone number: _____
Consented to treatment: *Yes* *No*
Guardian Consented *Minor without Guardian*
Unconscious
Are you aware of any allergies:_____
Are you aware of any pertinent history:
_____
_____
Last meal taken:_____
Event that lead to accident/illness:
_____
_____
First aid treatment received:
_____
_____

2. Vital Signs: *Complete vital signs every 10 minutes until Ambulance arrives.*
Use over page if required and note clearly.

Time	Level of Consciousness 1) **a**lert (A) 2) responds to **v**erbal cue (V) 3) responds to **p**ain (P) 4) **u**nresponsive (U) *Measured through interaction*	Heart Rate 1) full/weak. 2) regular /irregular. (normal adult = 60-80/min) *Measured by counting pulse*	Respiratory Rate 1) laboured shallow/deep 2) regular /irregular (normal adult = 12-20/min) *Measured by counting breathe.*	**Capillary Refill** (normal = less than 2 secs) *Measured by pressing nails watching colour return.*	Skin Colour and Temperature 1) Hot/warm/cold 2) Pink/pale/blue *Measured by observation and touch with back of hand to forehead.*	Pupillary Reaction Normal = equal and reacting to light. If not please specify. *Measured by observation.*

orirst aid: