assessment of the nurse’s ability to work safely and ensure competence to practice. Fitness for duty can be determined by negative drug screens or by performance-based measures such as neuropsychological examinations. This policy can guide the manager in what steps to take if the manager suspects an employee is impaired, what data to collect, determine what are the lines of communication, confidentiality and legal issues. The policy can also address what to report, when to report and who to go to with the report (Ohio Nurses Foundation, 2008).

Although the specific language of the policies and procedures may vary from facility to facility, a comprehensive policy for addressing fitness-to-practice concerns can encompass the following areas:

- pre-employment and probable cause drug testing
- fitness-to-practice evaluations
- documentation expectations
- intervention procedures
- in-house and external reporting requirements
- return-to-practice guidelines (including relapse management)
- reviewing the facility’s policy and procedures (this is essential prior to initiating an intervention)

It is essential to develop written policies and procedures for handling a situation where a nurse is chemically impaired or in a case of diversion long before it actually occurs, in order to ensure that all suspected employees are treated the same and communication to coworkers is consistent. Management can be notified to gain support and to ensure the agency policy and procedure is followed for the safety and rights of all concerned (Raia, 2004).

Policies and procedures can also be established for the prevention of impairment and diversion. For example, all nurses must know the policy and procedure for accepting deliveries of controlled substances from pharmacies and for the safe disposal of controlled substances, including disposal at the time of a patient’s death. If there is a prevention plan in place, then all employees and potential employees can be made aware of it and it can be regularly reviewed with current employees.

**Prevention of Diversion**

The importance of being proactive in the prevention of diversion of drugs in the workplace cannot be emphasized enough. To prevent diversion, the institution must first establish standardized methods of documenting and handling controlled substances. Any staff members who handle controlled substances must be appropriately monitored and the seriousness of the facility’s diversion program must be communicated to staff (Sobel, 2005). Diversion prevention must be supported throughout the organization with every employee being held responsible for diversion prevention.

The first step in reducing diversion is to let everyone in the organization know that a diversion prevention program is underway, controlled substances are being monitored and that diversion is being taken seriously by management. Education can even begin during orientation and continue as part of ongoing competency training. Revisiting a facility’s system for medication accountability to determine its vulnerability is strongly encouraged (Shumaker & Hickey, 2006). The facility’s goal is to engage in ongoing prevention. Sources of drug diversion must be tackled head-on without impeding the legal availability of opioid analgesics, the practice of medicine or patient care (Stokowski, 2008).
Most health care facilities report drug diversion as a result of an incident (such as a patient reporting that he did not receive his pain medication or a nurse is found in a bathroom unconscious from an overdose of narcotics). Regular audits of automated drug dispenser reports (such as Pyxis machines) must be conducted on a routine basis (Colorado Board of Nursing, 2003). Regular monitoring of medication records can greatly reduce or prevent these incidents. One way to reduce drug diversion in a health care facility is to prohibit the nurses from sharing or revealing their controlled substances access code to other nurses.

**Regular Monitoring as Prevention**

Nurses must be regularly monitoring how drugs are administered and how total or partial non-administered doses are discarded and documented.

They must be aware of and check for the following red flags:

- one nurse documents the administration of more PRN medications than other nurses
- the patient is not on the unit at the time the dose is documented
- the dose was signed out from the narcotic supply but not documented in the medication administration record or the nurse’s notes
- the nurse medicates another nurse’s patient
- the nurse says he/she was too busy or forgot to obtain a witness to discard the controlled substance
- the nurse signs out a larger dose of controlled substance when the ordered dose is available, then signs that the remaining medication was discarded or wasted
- the nurse says a controlled substances access code was shared with another nurse
- controlled substance withdrawal times do not correspond to administration times
- patients are reporting that the pain medication ordered does not relieve their pain on the nurse’s shift
- there are inaccuracies of the controlled substance count when a particular nurse works
- controlled substances are signed out for a patient who has no order for them
- times and amounts of controlled substances signed out are not authorized by physicians’ orders
- the staff signatures or initials appear to be forged

Reviewing documentation is one way to determine if a nurse is diverting medications but the medications themselves must not be overlooked. Nurses need to also check actual medications to ensure that liquid medications have a normal color, odor and consistency.

If there is any concern about any medication, the nurse manager must ensure that a pharmacist inspects the medication and a determination can then be made about whether testing by a chemical or forensic lab is indicated. If it is, a sample of the medication can be sent to a chemical or forensic laboratory. It is helpful if someone also witnesses that the sample sent to the lab came from the bottle of medication in question. The nurse manager can save the bottle with the remaining medication for evidence.

Nurses can also regularly inspect controlled substance packaging for possible drug substitution. A pharmacist must inspect any medications that are returned to the facility by a nurse, such as if a nurse says they took the missing controlled substance home in their pocket by mistake. Again, a determination can be made about whether testing by a chemical or forensic lab is indicated.
**Internal Investigations**

The following are recommendations for conducting an internal investigation for alleged drug diversion at a health care facility.

These recommendations can supplement any facility procedures already in place:

- do not destroy any documents that contain information about possible impairment or drug diversion
- ensure that investigative documents can be found by another administrative nurse in the investigating nurse’s absence (including pertinent medical records)
- document observations about the nurse (such as appearance, gait, speech, pupils, mood swings)
- obtain witness statements in writing and ensure that they are dated, timed and signed
- if the nurse admits to diverting, obtain the nurse’s admission in writing with a witness present
- ask the nurse to document what drugs were diverted, within what time period and how the diversion occurred
- ensure that all documents are dated, timed and signed with the staff member’s full name and title
- refer the nurse for a urine drug screen and a Breathalyzer test or blood test for alcohol, pursuant to facility policy (these are essential components of an investigation of drug diversion, drug or alcohol impairment)
- take actions to ensure the safety of patients and other staff (such as suspension or administrative leave)

After reviewing the results of the internal investigation, notify the required agencies, review the board’s reporting rules and establish an intervention plan. This plan may include a referral to an alternative to discipline program, a back-to-work agreement, a complaint to the board of nursing or all three. The nurse manager can then meet with the nurse, present the plan and proceed as indicated by the nurse’s response (Colorado Board of Nursing, 2003).

It is imperative that the investigative and review processes are consistent. Accusations of bias and conduct-targeting investigations can easily occur when the methodology is erratic and not reproducible (Siegel, 2007). However, judgment is still a key factor that is guided by experience in the process (Siegel, 2007). The more experience one gains in the investigative process, the easier it is to recognize patterns of diversion that raise red flags of suspicion and can help narrow down and focus the investigation (Siegel, 2007).

**Managing the Nurse with a Substance Use Disorder**

Nurse managers play a fundamental role in recognizing and managing nurses whose practice is impaired due to a substance use disorder. Due to the potential negative impact on patient and co-worker safety, an impaired practice can be addressed proactively in a systemized manner rather than in a blaming mode (Kohn, Corrigan, & Donaldson, 2000). To be proactive, a manager must be adequately prepared for the tasks at hand. An assessment of personal risk factors and a level of competence and comfort in addressing impairment due to a substance use disorder among colleagues is a necessary first step.

Staff can also reflect on the following important points in order to be better prepared:

- have a basic understanding of a substance use disorder as a primary disease, their course and signs or symptoms
- know the most common indicators of unsafe nursing practice due to a substance use disorder
know the workplace’s policies and procedures pertaining to medication administration, wastage and inventorying of controlled substances
know who the resources are in-house and externally regarding substance use disorder in any nursing staff
recognize personal attitudes about substance use disorders as supportive or as a barrier to helping a colleague
know how to document a problem properly
feel confident in personal intervention skills (if a problem requires action, know the personal reporting responsibilities as they pertain to hospital administration, board of nursing and state alternative or peer assistance program)
feel capable to coordinate re-entry to practice process for any staff nurses
recognize the value of practice restrictions, workplace exchange and workplace monitors for such nurses
know the signs of relapse or exacerbation of substance use disorders and how to respond appropriately

Nurse managers may be better able to intervene earlier and more proactively by assessing their preparedness both personally and professionally with nurse employees who are suspected of having a substance use disorder. Additionally, by following best practices nurse managers have the potential to assist their institutions in attaining significant financial savings when it comes to nurse employees identified with substance use disorders. In an unpublished study (Van Doren & Bowling, 2007) it was estimated that Baylor University Medical Center in Dallas, Tex. saved over four million dollars in turnover cost avoidance of RNs identified with a substance use disorder and certain psychiatric disorders over an eight-year period. Baylor worked to retain nurses whenever possible rather than summarily terminating them. Through the proactive advancement of education, identification, intervention, re-entry to practice and policies and procedures system-wide Baylor administration was able to help save the lives and careers of many employees as well as money.

Allowing for the possibility of nurses to seek treatment for their disease and resume practice whenever prudent becomes a win-win approach for employee and employer alike, enhancing patient safety through early intervention while providing the opportunity for rehabilitation and retention of valuable professionals. Such options also permit the workplace to give up its claim of immunity to nurses with addiction when in truth they have only succeeded in terminating nurses identified with substance use disorders (Kelly & Mynatt, 1990).

Identification of a Substance Use Disorder

Recognizing an unsafe practice in a nurse who has a substance use disorder can be difficult. Differentiating between the subtle signs of impairment and stress-related behavior, common among all nurses at times, is challenging. Experts agree that the earlier a problem is recognized the better the chances are for rehabilitation and retention, whereas the later the problem is identified the greater the chance of practice-related concerns. Escalating impairment is indicated by impaired cognitive functioning and memory, diminished alertness, altered motor skills, impaired judgment, difficulty making decisions and an inability to cope with stressful situations. The workplace is the source of most referrals to alternative programs (Duke & Zsobar, 1995; Smith, Taylor, & Hughes, 1998; Talbott & Wilson, 2005), therefore it is important to address the malignant denial that can exist in the health care setting and in health care professionals (Hanks & Bissell, 1992).
Nurse managers must become knowledgeable regarding the most common indicators of a problem. They also have a professional responsibility to educate their staff about signs of unsafe practice. When witnessed in isolation many of these signs may be indicative of increased stress. However, when observed as a pattern over time a more serious situation warranting corrective action becomes apparent. Keep in mind that even a single indicator may be significant enough to warrant immediate intervention. These signs may include the smell of alcohol and other overt indicators such as a staggering gait, slurred speech, witnessed diversion of drugs or any serious error in patient care.

Signs of a substance use disorder generally fall into three major categories: job performance, personality and mental status, and diversion of drugs from the workplace. Hughes & Smith (1994) offer the following lists of these most common warning signs:

**Job Performance**
- excessive use of sick time, especially following days off (most common in alcohol abuse or dependency)
- absence without notice or last-minute requests for time off
- long breaks or lunch hours
- frequent or unexplained disappearances from the unit (at work but not on the job)
- job shrinkage (a nurse increasingly does the minimum work necessary for the job)
- increasing difficulty meeting schedules or deadlines
- sloppy or illogical charting
- excessive number of mistakes (frequent medication errors or errors of judgment in patient care)
- smell of alcohol on breath
- excessive use of breath mints, chewing gum or mouthwash
- elaborate implausible excuses for behavior
- denial that a problem exists (DENIAL = Don’t Even Notice I Am Lying)

**Personality and Mental Status**
- inappropriate verbal or emotional responses (such as snapping at colleagues, uncontrolled anger or crying, unusual silences, irritability or frequent mood swings during the course of the shift)
- diminished alertness, confusion or frequent memory lapses (appearing dazed or preoccupied)
- increasingly isolates self from co-workers by eating alone, avoiding informal staff get-togethers or requesting a transfer to the night shift

**Diversion**
- consistently volunteering to be the medications nurse
- often signing out more controlled drugs than co-workers
- greater number of pulls or more frequent administration of controlled drugs (identified through inventory of electronic drug-dispensing system)
- frequently reporting medication spills or other non-administered or partial-dose medications
- failing to obtain co-signatures
- reports reflecting excessive use of PRN medications
- discrepancies in end-of-shift medication counts
- evidence of tampering of vials or other drug containers
- reports of the nurse waiting until no one is around to open the narcotics box or cabinet
• disappearing into the bathroom after opening the narcotics box or cabinet
• an increase in patients’ complaints of unrelieved pain
• defensiveness when questioned about medication errors
• consistently coming to work early and staying late
• volunteering to work with patients who receive regular or large amounts of pain medication
• observing any combination of these behaviors with increasing regularity over a period of weeks or months
• occurrence of a critical incident (error or overt sign of faulty nursing practice) is a signal it is time to take appropriate and immediate action

**Identifying and Investigating Reports of Impaired Practice**

Unfortunately, many health care professionals do not receive the appropriate intervention and treatment due to the lack of proper identification of a dependency problem (Nebraska Health and Human Services Regulation & Licensure, 2005). It is essential for nurse managers to understand what a substance use disorder is so that they are able to recognize the problem earlier, intervene more effectively and so they can educate all staff members so that they too will recognize the problem. The time spent at work and the interactive nature of nursing practice means that substance abuse issues in nursing are usually first noted by staff members.

In extreme cases, it is the board’s responsibility to remove a nurse from practice when the nurse has violated a professional standard for safe and competent practice (Raper & Hudspeth, 2008). However, the information gleaned during the licensure or renewal process is extremely valuable but limited in scope because it does not address the greater issues of identifying problems that occur during the licensure cycle (Raper & Hudspeth, 2008). Boards rely upon reports of these offenses from nurse managers, chief nursing officers and nurse co-workers.

Identification of traits that are apparent in the nurse with a substance use disorder is a necessary step in creating a safe nursing environment. The second step is to incorporate modifications in personal behavior and professional practice in order to identify any hazard promptly and minimize its potency whenever possible. Taking this kind of a proactive approach is essential in order to identify risk markers before the appearance of an adverse event. Ongoing monitoring for these traits may prompt a nurse to make a lifestyle change, which may decrease the likelihood of becoming substance-use dependent (Quinlan, 2003).

The most critical component in identification of a substance use disorder is to know the performance baseline from which a person normally functions (Nebraska Health and Human Services Regulation & Licensure, 2005). Negative behaviors and practices that clearly move away from the individual’s performance baseline are common indicators of a substance use disorder (Nebraska Health and Human Services Regulation & Licensure, 2005). Several steps can be followed when a manager suspects an employee has a problem with a substance use disorder, which can be clearly delineated in the facility’s policies and procedures.

Obviously, it is necessary to assess and observe the nurse’s behavior and appearance. At least two people can conduct the assessment. The person who is assessing the nurse benefits from the support of another nurse and the second person can serve as a witness. The nurse’s patients can also be assessed in order to ensure that they have received their correct medications and have received adequate pain medication pursuant to physician’s orders (Colorado Board of Nursing, 2003). This may include obtaining an order for a urine drug screen for the patient from whom a drug may have been diverted to determine if the patient received the drug or if another drug was substituted for the ordered medication (Colorado Board of Nursing, 2003).
Documentation is essential to the process for potential future actions. Documentation includes, but is not limited to: trends in absenteeism and tardiness, incident reports, written complaints, charting reviews, opiate record discrepancies and evaluations. It is best to document any issues at the time a problem or incident occurs. Over a period of time the manager may be able to see patterns emerge as a result of careful documentation. A nurse manager, though, cannot wait until a crisis occurs in order to look back over the problems or incidents that may have occurred during the past year. A nurse manager can look for any patterns such as absenteeism after a scheduled weekend off, tardiness or leaving work early and habitual episodes of extended lunches or break times (Ohio Nurses Foundation, 2008).

Employees can help by documenting problems on a day-to-day basis and look for patterns in behavior. According to the Ohio Nurses’ Foundation (2008), co-workers can include the following detailed information:

- specific periods of time and dates
- specific places
- persons involved (participants or observers)
- resources for additional information (chart documentation, lab data, X-ray and any additional reports)
- actions taken
- participants’ responsiveness
- outcomes

If there is suspicion that a nurse may have a substance use disorder problem, then the staff can be alerted to look for patterns when reviewing the reports. The staff is in a good position to look for the following signs of a substance use disorder in the reports or complaints:

- multiple complaints of appearance
- liability of mood
- interpersonal problems with patients, staff or family
- patient complaints
- frequently absent from the unit or workplace while on duty
- charting review

When reviewing the nurse’s charts the Ohio Nurses’ Foundation says to look for:

- accuracy
- timeliness of entries (late entries)
- coherence (incomplete thoughts or statements)
- inappropriate terminology unexplained changes in handwriting (illegible writing if usually neat)
- opiate and medication records

Look for discrepancies such as:

- ordering medications from the pharmacy prior to the refill date
- orders for patients who have died or been discharged
- inaccurate opioid counts
- increases in charted medication administration of mind-altering drugs without appropriate cause
- unexplained changes in route of administration
- noncompliance for observing wastage of opiates
- frequent breakage or wasting of opiates
Substance Use Disorder in the Workplace

- patient reports of decreased pain relief on specific shifts despite record of medications administered
- patient comments regarding not receiving pain medication administration even though it was reported or charted
- discrepancies in the provision of controlled substances in the records of automated medication systems
- discrepancies in the provision of controlled substances through automated medication systems
- inconsistent performance evaluations
- changes in the evaluation of job performance over time with no apparent cause
- an inconsistent work history
- the way the nurse deals with others
- the ability of the nurse to take or provide feedback

Facilities must not shy away from utilizing urine screens in order to detect and prevent diversion and substance use at work. It is recommended that health care facilities establish written agreements with temporary staffing agencies to ensure that nurses who are employed by those agencies will be required to submit to urine drug testing at the request of the health care facility (Colorado Board of Nursing, 2003). The agreement can state that staff from the temporary staffing agency will come to the health care facility at times designated by the health care facility staff. The health care staff will escort the agency nurse to the collection site or lab for testing for a urine drug screen or a breathalyzer or both tests as determined by the health care staff.

Such agreements are necessary because nurses from temporary staffing agencies are seldom required to submit to drug screening. Health care facilities believe that the agency nurse is not their responsibility. However, not all staffing agencies interview the nurse about a substance abuse or diversion incident in a timely manner or require a drug screen. Therefore, many nurses with a substance use disorder who are employees of temporary staffing agencies are allowed to work in multiple facilities until someone takes responsibility for reporting them to the board.

It is also common for a nurse who is an employee of a health care facility to allege that a staffing agency nurse diverted narcotics when, in fact, the nurse who is a regular employee may have diverted the narcotics. If the identity of the nurse who diverted the narcotics cannot be ascertained, other measures can be taken. Start by identifying who had access to the narcotic stock on all three shifts and require those nurses, all nurses or all staff to submit to urine drug testing but only if the policy of the facility supports the intervention.

Recommendations for drug testing include:
- always escort the nurse with a substance use disorder to the collection site
- ensure that the chain of custody is preserved
- do not allow the nurse with a substance use disorder to drive home
- request that the lab use an expanded professional panel when testing the nurse’s urine. Specify on the lab form what substance was diverted to ensure that the lab tests for that specific substance (For example, synthetic opiates are not included in routine drug panels. Therefore, if Demerol is missing and opiates is checked on the lab form, the specimen will not be tested for Demerol)
- ask the lab to test for the lower limit of quantification of all controlled substances requested on the lab request form (not just the standard cutoff levels)
• obtain the drug screen even if the nurse claims to have a valid prescription (Ask for quantified testing that will establish if the nurse is taking the medication as prescribed or supplementing the amount from facility-controlled substance stock.)
• require written verification of the prescription by the nurse’s health care provider
• refer the nurse for a fitness-for-duty evaluation to ensure that the medication is not interfering with critical thinking skills such as memory or concentration (Neuropsychological testing may be indicated to assess for cognitive impairment.)
• require a breathalyzer or a blood alcohol level in addition to a urine drug screen if the nurse presents with the odor of alcohol (Breathalyzers must be administered or blood alcohol levels drawn as soon as possible because alcohol is metabolized so quickly by the body.)
• establish a urine drug screen policy and a relationship with a collection site and laboratory that has agreed to collect and test samples according to the health care facility’s urine drug screen policy
• establish a plan for intervention on any shift and educate staff regarding the plan (For example, collection sites usually close in the evening. Consequently, the plan can include information such as where a nursing supervisor can send a nurse for drug testing on evening and night shifts, who will cover for the nurse, who will escort the nurse to the collection site or emergency department and how transportation will be paid.)
(Colorado Board of Nursing, 2003)

**Documentation During a Workplace Intervention**

Facilitating an intervention is already difficult but without adequate documentation it becomes almost impossible. The workplace has a poor track record of identifying and intervening with nurses who have a substance use disorder and that makes it even more critical to be well-trained and well-informed about intervention strategies (Beckstead, 2002; Crosby & Bissell, 1989). The importance of proper documentation cannot be overstated. Instruct the staff to record clear, concise and objective factual data when documenting concerns. It is a nurse manager’s role to evaluate all documentation provided by staff and determine when and if sufficient concerns warrant formal action. In some cases the nurse manager may request the help of a trusted colleague or supervisor in determining the best course of action to take. Something as simple as written or typed notes based on anecdotal communications are useful in order to keep track of ongoing concerns. It is important to maintain some minimum organization of your notes such as the name of the staff member of concern, names of witnesses and their titles, or if they are patients the date, time and nature of their concern and the action or follow-up that was taken.

Once all of the information has been reviewed, the nurse manager who suspects a nurse with signs of a substance use disorder can compile his/her findings. In doing so, the nurse manager can consider whether or not there is a pattern of behaviors that suggest the nurse may have a problem with substance use disorder or even some other issue. The nurse manager may want to keep in mind that patterns of a substance use disorder vary depending on the stage of disease, the substances used and the nurse. There may be only one sign and symptom or many signs and symptoms. If there is any suspicion that there is a problem, the nurse can also elicit the assistance of the immediate supervisor (Ohio Nurses Foundation, 2008).

Ongoing documentation will assist greatly if counseling as part of a corrective action becomes necessary. Proper documentation is crucial to a successful plan of action, especially in the case of substance use disorder impairment with its subtle progression and chief
characteristic of denial. If a nurse suspects that a pattern of incidents may be emerging, the nurse can seek validation and consult with a supportive colleague who has experience in effectively handling a substance use disorder.

Consulting an employee assistance professional can also be a great resource for managers. However, the need for strict confidentiality in such situations cannot be overemphasized. Confidential resources outside the health care setting may also be available and may include staff within a statewide peer assistance program or alternative to discipline program. Often these resources can provide an expert opinion about the documentation that has been gathered and suggest intervention strategies. With sufficient resources and support, nurse managers can better prepare to play the role of an intervention coordinator and proceed with confidence.

If the nurse is obviously under the influence of mind-altering chemicals in the work setting the manager must immediately deal with the issue. Patients are always the first priority, which means the nurse manager must immediately remove the suspected nurse from the unit or department, obtain a drug screen and evaluate the need for emergency treatment (medical or psychiatric). If immediate treatment is needed, transport the nurse to the emergency room. Once the emergency is stabilized, the plan of action can be developed to deal with the problem (Ohio Nurses Foundation, 2008).

**Action Plan**

Next, the nurse manager must develop a plan of action for an intervention to effectively deal with the problem. Ideally, the manager will have time to work on this over several days. Once the nurse manager has developed a plan, the manager can rehearse what needs to be said and how to best present the information.

The nurse manager must act immediately if a nurse has demonstrated unsafe practice or is at risk for harming others. Remove the nurse from the patient care area and get the nurse to a safe, secure place. Check to make sure the nurse does not need emergency medical or psychiatric treatment. Or if the nurse is able to provide a drug screen, proceed with a test. If the nurse is not in immediate medical or psychiatric crisis, begin the intervention. If the nurse is not on-site, determine the best time to confront the nurse. This might be the next time the nurse is scheduled to work or at a planned meeting. Interventions work most effectively when the nurse is unaware of the intent of the meeting. It must be kept in mind that a nurse with a substance use disorder may not appear for a meeting if it is suspected that a confrontation about behavior is going to take place.

Ideally the most experienced and knowledgeable person in the disease of substance use disorder and intervention is the leader of the intervention. Usually the manager, supervisor and other staff providing relevant data about behaviors also attend the intervention. A union representative may be present if the nurse is in a collective bargaining unit or has been asked and requests representation. Sometimes colleagues may be asked to provide information. In addition, human resources or employee health or EAP may be present. It is also possible that a representative of the pharmacy, pharmacy board, security department or members of the police may attend.

An intervention provides the opportunity for the manager to present data to the nurse regarding the suspected substance abuse and for the nurse to explain the behavior in question. To prevent potential retaliation by a nurse with a substance use disorder, the names of people who have contributed information about behaviors can be kept confidential and not released to the nurse. Information about evaluation and treatment options need to be presented. Consequences of failure to follow through with the evaluation or treatment need
to be identified such as a loss of job or potential criminal charges. It is suggested that an agreement between the employer and employee to address the problem within a specific time frame be completed.

A confidential but safe place needs to be identified and reserved. Make arrangements for a medical leave of absence and staff coverage during the nurse’s absence. In preparation for an intervention, safety is a prime consideration for the nurse and all members of the intervention team. The nurse is facing a crisis in his/her life. It includes the threat of loss of license and livelihood with possible loss of income, legal involvement, inpatient treatment and family upheaval. Another significant loss is the mood-altering chemicals that have made the nurse dependent. In order to protect all parties involved, the manager needs to find a secure area for the intervention such as an office or a conference room where they will not be interrupted but will have some privacy for the nurse in order to protect confidentiality. Someone not involved in the intervention but who is nearby can be informed so that if security needs to be called, they can do so. The manager needs to consider having security in the room during the intervention if they are aware that the nurse carries weapons such as a knife or gun. The manager can also ask the nurse prior to beginning the intervention if he/she currently has anything in his/her possession that could harm anyone.

In addition, the manager can consider the nurse’s home status. Arrangements will need to be made if there are pets or children who will need care and after-school arrangements if the nurse goes directly to treatment or evaluation. Contact a spouse or family member after the intervention. These situations may interfere with the nurse’s willingness or ability to go directly to treatment or evaluation. The nurse manager may realize that there is a high risk of suicide at this time and can create a plan to ensure that the employee is not left alone at any time during the intervention and post-intervention periods. Remember that the intervention, while supportive and with the nurse’s well-being in mind, is still a confrontation. This is a time of crisis and family or a designated friend needs to know that the nurse cannot be left alone until the nurse is admitted into a treatment facility (Ohio Nurses Foundation, 2008).

While planning the intervention process the manager should be mindful of the rights of the nurse. Most nurses do not know that they have any legal rights. If the nurse is accused of drug theft, diversion or impairment while on duty, the manager can make the nurse aware that criminal or administrative legal action could occur. The nurse can also be advised to seek legal representation (Ohio Nurses Foundation, 2008).

Refusing treatment or being unreceptive to intervention such as a drug screen is a time of high risk. Information can be given about accessing treatment resources including employee assistance programs if a nurse refuses treatment.

Treatment for a substance use disorder does work and nurses in recovery can re-enter the workplace safely when treatment and monitoring is instituted. A nurse who is known and being monitored can be a safer practitioner than a nurse who may have a substance use disorder and goes undetected. Early termination from work actually decreases the likelihood that they can access benefits tied to employment and therefore access treatment. Termination from work minimizes the opportunity for treatment.

Zero tolerance policies resulting in automatic termination do not serve the community because the nurse with an active substance use disorder is just being passed on to another facility and that drives the issue underground. It also leads to nurses hiding and minimizing their own symptoms. In addition, blanket termination policies contribute to the stigma of addiction.
Pressure to enter treatment from employers is often the best opportunity for nurses to enter treatment and recovery. Giving a nurse a second chance is a misnomer or inaccurate term. The next ethical step in the progression of workplace intervention is to offer options to the nurse. Some options are to put the nurse on administrative leave with or without pay and give the nurse time to utilize health benefits to enter treatment and get into a solid recovery program before returning to work. Utilizing a return-to-work agreement in the workplace is highly predictive or supportive of a successful re-entry into the workplace.

**Implementation**

An intervention can be planned once it is determined that sufficient documentation exists to support concerns of unsafe practice. The planning and participating in an intervention is often another critical responsibility of the nurse manager. It is important for the nurse manager to consider all aspects of the work environment that are likely to be impacted. Forecasting the nurse’s absence from the practice area and preparing the staffing and scheduling needs will make the transition easier for co-workers whether it is a temporary leave or a termination. Administration must be informed to garner support for the intervention and to assess the potential for retention. Human resource personnel need to be involved along with the administration in order to determine such things as the available benefits or leave time.

Prior to holding the actual intervention it is important to not just react to the situation but instead to develop a careful plan of action, which is the intervention, before the implementation. Usually, the first step is to secure help. In fact, it is never recommended to do an intervention alone, no matter what your confidence level. There are two primary reasons for this. First, the support and the witness of others are extremely useful and necessary to help create enough momentum to accept the need for assessment. Also, a group style intervention is a much more powerful message and therefore has been found to be more successful than an intervention facilitated by an individual. Denial is the chief characteristic of all addictive diseases. It is unrealistic to expect the nurse with a substance use disorder to ask for help. A solid denial system is part of the active disease of addiction. Understanding this will help lower frustration and decrease any expectation of instant acknowledgment. It is more common for the nurse with a substance use disorder to deny the problem but demonstrate willingness to comply with an evaluation process in order to safeguard employment and career. Once in a treatment process the denial normally fades and the participant can begin the process of admitting and accepting his/her part. For these reasons a group intervention is most suitable for chipping away at denial and providing additional support to both the nurse manager and identified nurse than attempting to intervene one-on-one with just the nurse.

The use of a private setting in a group format for the intervention is essential. Interveners can meet prior to the actual intervention to review documentation, in-house policy and to determine the documented facts to be presented by each intervener. Just as important as establishing the facts, interveners can also be ready to emphasize how the nurse’s behavior has caused them to feel such as disappointed, hurt or worried. A course of action can also be determined (termination, reporting to a regulatory agency) in case the nurse refuses assistance. All of the interveners need to be informed of the possible consequences for the nurse such as retention or termination and a consensus achieved by all regarding the possible administrative actions.

One aspect that can’t be overlooked is the possible risk of harm, whether it is self-inflicted or done to others during the course of an intervention. For this reason, whenever possible security and a safe transport needs to already be put into place. Security must be informed
that an employee counseling session will be occurring and that there may be a potential for physical harm. The nurse can be accompanied by security personnel or a responsible and knowledgeable professional after the intervention but while still on the workplace property and preferably transferred to a responsible family member, significant other or provided a taxi to an awaiting assessment. Failing this, local law enforcement (911) may need to be called especially if there is potential for public endangerment by the nurse from driving a vehicle on the roadways. Remember that a nurse who may demonstrate unsafe practice at work is just as likely to be unsafe if allowed to drive off the property.

The intervention can focus on documented facts of concerns about performance along with supportive communication. Available options for a fitness-to-practice evaluation must be identified before the intervention is facilitated. It is usually best not to reveal the exact nature of the meeting because a nurse who is tipped-off as to the nature of the meeting could build up a defense mechanism and end up refusing help. A for-cause drug test can also be included within the intervention process whenever policies permit. It is essential to ensure that the for-cause drug test includes any medications diverted or other substances and that a responsible professional of the same sex is available to provide an observed urine drug test.

Once all is in place, the identified nurse is requested to join the group. Upon the nurse’s entry the nurse is asked to be seated and asked to listen to each of those present who are there because they care and are concerned. An honest, direct and caring approach by interveners is recommended. The objective of the intervention is to request that the nurse refrain from practice and obtain a fitness-to-practice evaluation as soon as possible. A referral to the state diversion program may be appropriate once the nurse agrees to follow through with the evaluation plan. Usually this contact is best made in the presence of the nurse, especially if the nurse manager has reviewed the nurse’s eligibility for the program beforehand. This method of offering a non-punitive alternative to the nurse has been referred to as benevolent coercion and is considered an effective and beneficial option for all involved (Hanks & Bissell, 1992).

**Practical Tips**

**Do:**
- prepare a plan
- review documentation
- request help from others
- ensure security is readily available
- decide who will present what
- expect denial
- conduct a for-cause drug test
- provide for safe transport
- report as necessary to state alternative program and/or board of nursing
- debrief with interveners
- leave the nurse with a sense of hope that they are a good human being deserving of help
- ask the nurse to listen to everyone before responding to interveners
- stick to the job performance
- have evaluator options ready

**Don’t:**
- just react
- intervene alone
- try to diagnose the problem
- expect a confession
- give up
- use labels
Follow-Up

After the nurse is referred and a formal evaluation is conducted, then decisions regarding the need for treatment, its type, setting and safety to practice can be made with the help of the evaluation team.

With any intervention a debriefing meeting can be scheduled for all intervention team members. This is a time for the team to review intervention strategies and look at what worked best and least. A debriefing meeting allows members to share personal feelings and reactions about an experience that is often intense and emotional. It will also help sharpen skills for future opportunities that require intervention. The debriefing meeting is a good time to formulate documentation that summarizes who was present at the intervention, what documentation was presented to the nurse and the nurse’s response and outcome. At the close of this meeting members may begin to discuss return-to-practice considerations.

As a final step to the debriefing it is important to inform staff of the incident in a summary manner with everyone informed of the outcome to the intervention.

Return to Practice

A recovering nurse’s return to practice also requires planning and the oversight of this process by the nurse manager is indispensable. There are many things to consider once a nurse is determined to be safe to return to practice. These include developing return-to-practice guidelines often written in what is known as a return-to-work contract. Experts also advocate initiating a return-to-work conference to provide support, review expectations (including any practice restrictions), monitor requirements and to answer any questions. There are typically two meetings that need to occur with the nurse’s return: an administrative meeting that involves confirming accommodations (practice restrictions) per the Americans with Disabilities Act as well as reviewing and signing the return-to-work contract; and a clinical meeting with co-workers that involves identifying the nature of the alternative program and the restrictions involved along with the need for possible work exchange.

The prospect of returning to work is anxiety provoking for the recovering nurse and often the nurse manager as well. Discussing the plan for the nurse’s return prior to the nurse’s actual return will decrease misunderstanding and potential problems later. Possible participants in the administrative return-to-work conference can include, besides the recovering nurse and nurse manager, the identified nurse monitors who will be responsible for oversight of the nurse’s practice, a representative from human resources, an administrative representative, an employee assistance representative, as appropriate, a supportive peer or work buddy and a representative from the alternative program. The written return-to-work agreement can be prepared and copies made for each person present at the meeting.

The National Council of State Boards of Nursing (2001) recommends that return-to-work contracts stipulate the following:

- the length of the contract
- the plan for treatment (if the contract is signed at the time the nurse’s dependency is first detected) and aftercare
- practice restrictions, such as no overtime and prohibiting administration of narcotics for a period of time (Six to 12 months unless there is evidence of drug diversion, prescription fraud or harm to a patient. Then the restriction must be 12 months with no access.)
- random drug screening requirements
- mandatory attendance at support group meetings for nurses with substance use disorders
• professional standards that the nurse’s job performance must meet
• provision for periodic evaluation meetings with direct supervisor
• steps to be taken in the event of relapse
• consequences of failure to comply with contract stipulations
• regular reports from supervisors or work-site monitors

Practice restrictions can be managed in a number of creative ways. A system for labor exchange is a prime example. This allows for specific tasks to be exchanged ahead of time with a designated buddy who will be assigned to work in tandem with the recovering nurse. The recovering nurse is usually prohibited from administering controlled substances early in the return-to-work period and so a labor exchange allows a buddy to administer all controlled substances for the recovering nurse while the recovering nurse completes one or more of the buddy’s agreed upon assigned tasks. An arrangement like this puts planning in the forefront, promotes teamwork and removes the burden of others having to accommodate the returning nurse. Additionally, such a work arrangement may help lessen the feelings of shame, of being different and of not carrying a full load by the recovering nurse.

Another important area to consider when preparing for a nurse’s return to work is the response of co-workers. If the identified nurse is returning to the same unit the staff members are probably already aware of some of the circumstances precipitating the nurse’s leave of absence. As a way to minimize rumors, it is important to set up a time to hold the clinical return-to-work meeting so that the professional staff who have a legitimate need to know can openly talk about their concerns. Questions can be answered in a general way to provide necessary information to staff members while at the same time ensuring confidentiality. This may be an appropriate time to initiate staff education as well. Basic education on substance use disorders and its prevalence in the nursing profession can help dispel myths that view substance use disorder as a moral weakness rather than a medical illness. All practice restrictions and possible work exchanges can be discussed in the clinical return-to-work meeting. This is also an opportunity for the nurse, especially if returning to the same practice area, and for co-workers to express their gratitude and make any brief comments as to their acknowledgement of their disease and the need to re-establish trust and healing over time. Additional meetings may be useful for further sharing and education once the nurse returns to work. Meetings like these are usually well received. Besides diffusing mistrust and misunderstanding, they also promote open communication and may decrease the chance of enabling behaviors occurring in the future.

In general, the ongoing management of the returning, recovering nurse can be no different than that of other employees. During any period in which access to controlled substances is in effect it is vitally important that the nurse manager ensure that all staff with a need to know be informed of this restriction. This would include any nursing float or agency staff. However, the nurse manager must also participate in the development of the return-to-work agreement and the subsequent return-to-work conference. The nurse manager will also likely have to compile regular, written performance summaries if the recovering nurse is participating in a statewide monitoring program.

It is important not to expect perfection as it may take the nurse a little while to regain a sort of comfort level upon return. Open communication providing support, clear expectations and regular feedback is crucial to success. Any concerns in performance can be communicated without delay along with expectations for improvement.
Indicators of Relapse

A substance use disorder is a chronic illness. Like other chronic illnesses, it is characterized by periods of remission and exacerbation. In general, the rate of relapse among nurses is lower than in the general population. This is due to the growth of supportive programs and strict state monitoring programs. Still, some nurses do relapse. Knowing how to manage relapse in the workplace is crucial for both the safety of patients and well-being of the nurse. A relapse is essentially a recurrence (exacerbation) of an active disease. The signs of relapse mirror the warning signs of a substance use disorder. If relapse occurs, the signs will become apparent and will progress without intervention. In recovering nurses there is usually a behavioral change noted before a break in abstinence occurs. Behavioral changes include such things as taking on more than one can reasonably handle, over-extending one’s self at the expense of recovery and coping activities, withdrawing from recovery support people and meetings, isolation, resumption of denial and an eventual return to drug or alcohol use. Relapse requires a re-examination of the return-to-work contract.

The same rule of thumb for the usual employee performance assessment applies here. The nurse manager can continue ongoing monitoring of the recovering nurse’s job performance, document concerns and take action when warranted. Any concerns must be addressed proactively. If performance concerns do not improve after performance counseling or if serious signs are observed the steps to re-evaluate the nurse’s fitness to practice and to remove the nurse from practice can be initiated. Once re-evaluation is completed and fitness or stability is assessed the next steps can be determined. It is important that this entire process be handled in a non-punitive way. With early recognition of relapse signs and appropriate intervention or treatment, the chances of the nurse re-entering recovery (remission) are great. Decisions about return to practice can be made once the nurse is stabilized and fitness to practice is determined. A clear policy regarding the management of relapse is extremely important and it can address areas of identification, documentation, intervention, referral for fitness-to-practice assessment or treatment and parameters for return to practice.

Reporting Nurses with a Substance Use Disorder

Chief nursing officers are often in the position of making decisions that have regulatory implications. Chief nursing officers are responsible for ensuring that nurses under their direction are properly licensed and practicing safely within the appropriate scopes of practice or authorized duties as outlined by state law and regulations. Therefore, it is important for these nurses to develop both an understanding of the complexities of regulation and a working relationship with the board of nursing and nurse substance use disorder monitoring programs (Hudson, 2008). It is recommended that chief nurse orientation programs be developed in order to educate nurse managers about nursing regulation and to include such components as the mission, the scopes of practice for licensees, information about investigations, mandatory reporting for nurses and the board of nursing’s program for nurses with a substance use disorder. Boards of nursing can be actively involved in these orientation programs. Research supports the need for further education and guidance for reporting workplace practice issues by nurses, which enhances public safety (Maxfield et al., 2005).

Most complaints that end up being investigated by a board are filed by nursing administrators, either chief nursing officers or nurse managers (Raper & Hudspeth, 2008). Without understanding all of the ramifications of disciplinary processes and the requirements to protect the rights of the nurse that are guaranteed under the U.S. Constitution, the final decision of the board can be totally different than anticipated and thus disappointing to
the reporting nurse administrator (Raper & Hudspeth, 2008). The complainant nurse could perceive the decision as wrong and the board as unsupportive and dismissive of his/her efforts to alert the board to a problem nurse. This unhappiness with the outcome does little to strengthen the relationship between the board and the nurse administrator.

An initial step in resolving this problem is to create a better understanding by nursing administrators of the legal procedures that guide disciplinary processes and the board. Education for nurse managers about relevant state laws and rules regarding the practice of nursing and the disciplinary process will provide more effective reporting and higher levels of satisfaction with board disciplinary decisions (Raper & Hudspeth, 2008). Although state laws mandate certain reports to the board by nurse managers, a law that most managers are familiar with, a more in-depth understanding of the law and the reasons for the mandatory reporting laws will likely ensure that reporting occurs and provide the manager greater comfort and acceptance with the board’s complaint review process. For example, research reveals that for public safety reasons it is better to report a nurse if unsafe practice or diversion is suspected than to fail to report (Dunn, 2005).

**Reporting Guidelines to Boards of Nursing**

Many states have mandatory reporting statutes or rules and the nurse manager may face action by the board for failing to report misconduct of subordinates. Regardless of the existence of such requirements there is a moral responsibility to the public to report nurses who pose a threat to patient safety. The high demand for nurses can result in a manager, who discharges an unsafe nurse without reporting to the board or taking other appropriate action, passing the problem on to the next manager and at-risk patients.

It is important to know whether reporting a nurse to an alternative program truly fulfills the nurse’s obligation to report misconduct to the board. There may be confidentiality restrictions on the alternative program’s ability to pass complaints on to the board.

Nurses can examine their state’s laws with respect to reporting other health care professionals. Support & Klein (2008) suggest that when reviewing the laws, the nurse look for the following:

- a definition of reportable events or situations
- a description of level of suspicion (must there be first-hand knowledge or is reason to believe or suspicion enough)
- direction about who to report to
- exceptions from duty to report
- consequences for failing to report

Nurse managers can work with their state board of nursing to ensure that there is a mandatory reporting law or rule in place for nurses. Mandatory reporting can require a complaint or information to be submitted to the board even if a complaint or information was filed or is going to be filed with the state’s alternative to discipline program. Such a requirement would ensure that the board knows who is in the program.

**Filing Complaints to the Board of Nursing**

Nurse managers must be familiar with both state and federal requirements for reporting drug diversions. Health care facilities or individuals can also make a report. Health care facilities are responsible for reporting but not for filing charges. The crime is against the state. Some state statutes protect those who report diversion or theft of controlled substances to law enforcement from civil lawsuits. Therefore employers and professionals can be made
Substance Use Disorder in the Workplace

aware of their legal obligations to report diversion to appropriate criminal or administrative authorities without the threat of being sued.

Nurses and nursing management will need to know how to access a board of nursing complaint form, how to fill it out completely, who to send the completed form with supporting documentation to, and who to call if there are any questions about the form or the complaint process. All documentation must be legible.

The following information is necessary:

- the nurse’s name including a middle name and any other names used by the nurse if known
- the nurse’s license number and date of birth
- the nurse’s address

If submitting documents from a patient’s medical record, highlight information that supports the complaint, especially automated drug dispenser reports or pharmacy records. Give specific details of the incident to answer the following questions:

- what happened?
- who was involved?
- when did it occur?
- how was it discovered?
- where did it occur?
- was there a witness?

Controlled substance diversions also require the following information:

- what drugs were diverted?
- did the nurse divert for self-use?
- did the nurse demonstrate unsafe behavior while on duty?
- did the nurse falsify patient records?
- was the nurse arrested for obtaining controlled substances by fraud or deceit, or for possession of controlled substances?
- did the nurse undergo drug testing?
- what were the results?
- was the drug test done as part of a random drug testing procedure or as part of an investigation for diversion of controlled substances?
- inclusion of all relevant documentation to the complaint, (such as drug screen results or witness statements)

(Colorado Board of Nursing, 2003)

Traditional Discipline and Alternative Programs

The nurse can be aware of whether regulations exist regarding a referral to alternative programs and the existence of mandatory reporting laws or regulations. Some states have rules that allow nurses to report directly to the nurse assistance program in lieu of a formal complaint to the board as long as certain conditions are met. Nurses can work with their state boards to implement rules that require a complaint or information to be submitted to the board even if a complaint or information was filed or is going to be filed with the state’s alternative program. Such a requirement would ensure that the board knows who is in the program. It would also ensure that nurses who were previous alternative program participants (something which may be unknown to the supervisor) are not funneled into the program again when discipline is probably more appropriate. Perhaps most importantly, it eliminates the possibility of a supervisor making a referral to the alternative program
and failing to follow up to verify that the nurse did in fact enroll. The basic requirements and what is expected of the nurse participant are the same regardless of whether the nurse is in the alternative programs or the discipline program. Therefore, a co-worker does not need to have any hesitation in filing a complaint with the board as opposed to reporting the alternative program for fear that the requirements for the nurse would be stricter. Both types of participants are required to sign a contract.

Nursing management can contact the board of nursing for a listing of alternative programs and develop an open and ongoing relationship between the alternative program manager and nursing management whether or not laws and rules exist regarding alternative programs. This relationship will assist in getting nurses with substance use disorder–related issues the help they need.

Nursing management would be well advised to make contact with their state’s alternative programs before facing the difficult and stressful situation of reporting a nurse with signs of a substance use disorder. These programs often maintain materials and can provide assistance to nursing management on how to handle such situations. Additionally, they often offer educational programs for management and staff.

It is important for nursing management and staff to know the regulations governing these programs, what these programs consist of, what their role will be in the monitoring of employees and the importance of continuous contact with the program coordinator and other personnel. A nurse manager who also has a greater understanding and good grasp of the interworking of the board of nursing, has knowledge about existing substance use disorder assistance programs as well as about the nursing statutes and regulations will be better equipped to educate other nurses about such things. Boards of nursing can assist nursing management in developing comprehensive educational programs for nurses.

Guidelines for nursing management:
- manage their own personal stereotypes of addiction and nurses with a substance use disorder
- develop and foster a climate of transparency and support for all nurses
- encourage nurses to break the code of silence
- educate about the disease of addiction
- manage the controversial and emotional issue of addiction among all workers
- support a Just Culture and create an environment that encourages reporting as a necessary part of reducing the stigma, maintaining transparency, rehabilitating the nurse and protecting the public
- implement and utilize workplace intervention strategies for handling substance use disorder issues
- institute educational, training and counseling programs on substance use disorder issues, bullying and lateral violence
- establish policies and procedures on substance use disorder, bullying and lateral violence
- apply them consistently and follow through

Summary
It is incumbent upon all parties engaged in the management and monitoring of nursing practice to educate themselves about substance use disorder issues. These parties must further work together to identify, document, report and generally work together to reduce complaints related to any substance use disorders in the workplace. In addition, alternative programs and boards of nursing can be cognizant of their potential role in impacting these issues through various educational materials and resources.
The nurse manager is in a unique position to play a primary role in carrying out policies and practices designed to timely address any substance use disorders in the workplace. A nurse manager who is knowledgeable, prepared, proactive, sets clear limits and is compassionate is likely to be more successful with a staff whose practice may be unsafe due to a substance use disorder. The nurse manager who fails to act, who has a poor attitude or has unrealistic expectations can make a significant negative impact on the safety and morale of patients, co-workers and the identified nurse. Protecting patients while helping colleagues may best be accomplished by treating others as we would wish to be treated. It is critical to understand that a substance use disorder is a disease and is not a matter of will. Intervention is conducive to a better environment for patients, staff and management and for healthier outcomes for the nurse.

References


