



Peer Assistance Services

# **Substance Use Disorders: A Guide for Managers and Supervisors**

**by Peer Assistance Services, Inc. and Kate Ciluffo, RN  
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*Please contact Peer Assistance Services, Inc. for updated information and refer to your facility and the policies of your facility for specific information. This is only meant as a guide.*

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## **1) Introduction**

A 2001 study sponsored by The Robert Wood Johnson Foundation found the number one health problem (and most preventable) in the United States to be substance abuse. More deaths, illnesses, and disabilities result from substance abuse than any other preventable health condition. When substance abuse and dependence occur among healthcare professionals, there is added danger: the risk to patients receiving care from someone who is under the influence or thinking about being under the influence of mood-altering substances.

Healthcare professionals are not immune from the seduction of substances and are exposed to additional factors just because of their professions. Many healthcare professionals have easy access to drugs. They see people respond positively to prescribed medications and feel better. Health care professionals do have more information about drugs, but this knowledge can be accompanied by a confidence in their own knowledge to be able to “handle it.” It can be a slippery slope, from self-prescribing from the bathroom cabinet to borrowing a medication from patient stock to using medication that would be wasted anyway to diverting medication from patients. Practice impairment is characterized by the inability to carry out professional duties and responsibilities in a reasonable manner, consistent with acceptable standards. Since the early 1980s it has been recognized as a common and serious problem. The prevalence of substance use disorders (SUDs) among healthcare professionals is similar to the general population. The National Council of State Boards of Nursing states that approximately 15% of healthcare professionals struggle with SUDs at some point in their careers.

Substance Use Disorders, psychiatric, and physical conditions all have the potential to impair a healthcare professional’s ability to practice. However, literature recognizes that impairment due to SUD is most common. SUD is defined as a chronic, progressive, and fatal disease with a predictable course.

Tremendous progress has been made to educate healthcare professionals from all practice areas about the causes of impairment among colleagues, including the benefits of early recognition/intervention and the effectiveness of treatment. One of the most significant changes has been the development of programs of treatment and monitoring as an alternative to professional disciplinary action. This approach has become a win-win by both enhancing patient safety by early intervention and providing opportunity for rehabilitation and retention of valuable professionals.

## **2) Purpose of Handbook**

The purpose of the Handbook for Supervisors and Managers is to provide information on detection, prevention, and intervention of SUDs. Supervisors need to be prepared to deal proactively, through education, prevention and early detection, with SUD in staff members.

### 3) Peer Assistance Services, Inc.

Peer Assistance Services (PAS) is dedicated to quality, accessible prevention and intervention services in workplaces and communities, focusing on substance abuse and related issues. PAS is a statewide, non-profit organization founded in 1984.

### 4) Nursing Peer Health Assistance/Nurse Alternative to Discipline Program, Dental Peer Health Assistance Program, and Pharmacy Peer Health Assistance Diversion Program

PAS is a statewide alternative to discipline that provides comprehensive services to healthcare professionals who may be experiencing physical, emotional, psychological, substance use/abuse, or other personal problems. The objective is to protect the public and rehabilitate and return a healthcare professional to safe practice. It is a recognized peer health assistance organization under the Practice Act for dentists, nurses, and pharmacists. PAS contracts with The Colorado Board of Nursing, State Board of Pharmacy, and Board of Dental Examiners; license fees provide funding.

This handbook is geared towards substance use disorders. Please keep in mind that PAS helps healthcare professionals with a variety of problems, not solely substance use.

#### a) PAS provides:

- ◆ Assessment for RN's, LPN's, Advance Practice nurses, dentists, pharmacists, and student nurses, dentists, and pharmacists.
- ◆ Confidential alternative to the traditional disciplinary process.
- ◆ Provides early intervention.
- ◆ Aids in maintaining or re-entering profession.
- ◆ Comprehensive assessment, monitoring, and support services.
- ◆ Case management.
- ◆ Colleague-to-colleague intervention assistance.
- ◆ Network of resources and providers.
- ◆ Screening procedures with Norchem, a premier forensic lab with the latest technological advances in drug testing.
- ◆ Report to the Board of Nursing, Board of Pharmacy, or State Board of Dental Examiners within 24 hours of any practitioner unable to practice with reasonable skill and safety.
- ◆ Prevention education programs and workshops.
- ◆ On site presentations and exhibits.
- ◆ Provides a 24-hour, on-call staff member for telephone support.
- ◆ Management consultation.
- ◆ Return-to-practice guidelines.

## 5) Understanding SUDs

Addiction is a complex bio-psychosocial disease – it has biological, psychological, and social aspects. The word addiction is often used to describe a group of problems and is sometimes called drug addiction, alcoholism, substance abuse, and chemical dependence. All of these terms describe addiction to brain-rewarding chemicals. Increasingly, addiction is also used to describe many pleasure-producing, compulsive behaviors. Alcoholics Anonymous (AA) calls addiction cunning, baffling, and powerful. First steps in understanding SUDs involve formulation of factual concepts of what the disease is.

### a) Consider the following:

- ◆ SUDs are a legitimate disease like diabetes, epilepsy, or heart disease. Symptoms are clear and definable, it can be diagnosed accurately, and its progression is predictive.
- ◆ SUDs tend to magnify social and emotional problems rather than being the cause of them.
- ◆ SUDs are chronic diseases that can result in death.
- ◆ SUDs are characterized by “loss of control” over the amount the addicted person will drink/use. The addicted person may abstain for weeks, months, years, or the remainder of their life. However, “loss of control” is reactivated once drinking/using resumes.
- ◆ Dopamine plays a key role in a wide range of addictions, including those to heroin, nicotine, alcohol, and marijuana.
- ◆ SUDs are treatable. The disease can be controlled and prevented; persons can live full and productive lives without ever drinking/using again. A person’s psychological and emotional dependence on alcohol/drugs can be corrected.
- ◆ Discomfort, irritability, and sometimes excruciating pain occur when the alcohol/drug content in a person’s blood falls below the amount required to give them the feeling or effect that they strive to maintain; then, sobriety becomes difficult to obtain.

### b) It is also important to understand what SUDs are not

- ◆ It is not an illness like a headache, upset stomach, or having too much to drink.
- ◆ It is not caused by bad nerves or personality aberrations (although these problems may accompany dependency).
- ◆ It is not drinking or using all the time.
- ◆ Dependency does not occur because the person is bad.
- ◆ It is not a moral choice.
- ◆ No one plans to be addicted.

### c) Recovery means life adjustment

- ◆ Recovery from a SUD includes identification, intervention, treatment, aftercare, and life in recovery.
- ◆ The foundation of recovery is abstinence from alcohol and other drug use.

- ◆ SUD recovery is more than stopping alcohol and drug use; it means living a healthy, productive, and honest life while finding better ways to live.
- ◆ Even the most desperate with a SUD can usually regain control of their lives through hard work.
- ◆ Abstinence is necessary for recovery from a SUD, but abstinence alone is not sufficient for recovery.
- ◆ Recovery is a life-long process.

**d) SUD and Mental Illness**

- ◆ According to the National Drug Intelligence Center (NDIC), a serious mental illness frequently accompanies persons who suffer from chronic SUDs. This condition is known as a co-occurring disorder or dual diagnosis.
- ◆ Often, those suffering from a mental illness (often undiagnosed) will use drugs and/or alcohol to alleviate symptoms, also known as self-medication.
- ◆ SUDs and mental illnesses may exist independently, unrelated to one another.

**e) Special Challenges for Healthcare Professionals**

- ◆ High levels of job-related stress including long working hours.
- ◆ Emphasis placed on drugs as valuable tools of the trade.
- ◆ High level of knowledge regarding drugs yet inadequate knowledge about risks related to alcohol/drug use.
- ◆ Tendency to self-medicate.
- ◆ Tendency to assume signs of trouble can be identified.
- ◆ Easy access to controlled prescription drugs.
- ◆ Threat to career and professional license.
- ◆ Emotional jeopardy (shame and guilt) regarding acts of omission and commission.
- ◆ More likely than other health care professionals to be children of alcoholics.
- ◆ Working swing shift, nights, or rotating shifts leading to sleep deprivation, fatigue, and inconsistent sleep patterns.

**f) Risk Factors for SUDs**

◆ **Personal Risk Factors**

- Genetics; family history of SUDs.
- History of abuse

◆ **Environmental Risk Factors**

- Frequent exposure to alcohol and other addicting drugs.
- Living with a family that tolerates drug use and/or excessive alcohol use.
- Living in a community that tolerates addiction and its consequences.

### **g) Methods of obtaining drugs**

A variety of methods exist for procuring prescription drugs; examples are misusing legitimate prescriptions, diversion, “doctor shopping,” stealing, substitution, and forging prescriptions.

### **h) Identifying SUD**

Recognizing impaired practice can be difficult. Differentiating between the subtle signs of impairment and “stress” related behavior, common among all healthcare professionals at times, is challenging. Experts agree that the earlier a problem is recognized the better are the chances for rehabilitation and retention, whereas the later the problem identification 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.

Supervisors and Managers themselves must become knowledgeable regarding the most common indicators of a problem and they also have the professional responsibility to educate their staff about signs of impaired practice. When witnessed in isolation, many of these signs may be indicative of increased stress. However, when observed as a pattern, a more serious situation warranting corrective action is at hand. 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 staggering gait, slurred speech, witnessed diversion of drugs, and/or any serious error in patient care. In these situations, patient safety must be the first consideration. Remove the healthcare professional from patient contact and make sure the patient needs are addressed. Act in accordance with your institution’s policies and procedures, including reporting expectations and directing the healthcare professional to comply with drug testing procedures.

The following information has been collected to support investigation of suspected substance use and/or diversion. It is not unusual for problems to occur in a variety of situations, so managers should be alert for signs that may indicate that drug/chemical use is involved whenever problem practice occurs.

#### **♦ Organizational Indicators**

Planning for a variety of possible scenarios will increase the likelihood that you and your staff will be prepared to identify and deal with drug issues. It is better to plan for potential problems than to wait until you are facing an actual crisis. Lack of appropriate policies and procedures regarding controlled substances, or the failure to adhere to such guidelines, may be an indication of an environment where drug diversion may be present.

- ◆ Failure to keep Schedule II and selected III, IV, and V controlled substances locked at all times.
  - ◆ Leaving narcotic keys and prescription pads in plain view and unsecured.
  - ◆ Failure to limit those individuals having access to narcotic keys.
  - ◆ Signing out narcotics and carrying on person or leaving in unsecured location.
  - ◆ Carelessness in conducting end-of-shift inventory.
  - ◆ Failure to discard controlled substances appropriately, including failure to obtain witness to wasted substances.
  - ◆ Healthcare professionals sharing or revealing their controlled substances access code to automated drug dispenser.
  - ◆ Lax adherence to waste policies.
  - ◆ Lack of scheduled routine audits with the pharmacy department as a regular quality assurance activity.
  - ◆ Inadequate adherence to routinely scheduled pharmacy and/or Pyxis audits.
  - ◆ Key personnel not receiving pharmacy or Pyxis audit reports or not receiving audit reports in a timely fashion.
  - ◆ Lack of periodic policy review and staff in-service about SUD and drug diversion.
  - ◆ A culture of enabling may exacerbate a SUD.
- ◆ **SUD Indicators – Behavioral Signs**
- ◆ Tends to give more medications, always uses maximal dose.
  - ◆ Volunteers to give medications.
  - ◆ Exhibits an increased level of waste and breakage.
  - ◆ Shows strong interest in patient’s pain control, the narcotic cabinet and use of pain-control substances.
  - ◆ Requests to work evenings, nights, or weekends (shifts where there is less activity and supervision).
  - ◆ Exhibits increased anxiety, mood swings, inappropriate crying or anger.
  - ◆ Demonstrates problems interacting with peers and supervisors.
  - ◆ Exhibits forgetfulness or memory lapses.
  - ◆ Makes frequent trips to the bathroom or other unexplained, brief absences.
  - ◆ Disappearance into the restroom immediately after accessing narcotic cabinet.
  - ◆ Exhibits social avoidance.
  - ◆ “Job shrinkage” – the healthcare professional increasingly does minimum work necessary for the job.
  - ◆ Demonstrates absenteeism, tardiness, and increased use of sick leave.
  - ◆ Gives elaborate or inadequate excuses for tardiness or absence, including long lunch hours or use of sick leave immediately after days off.
  - ◆ Demonstrates difficulty meeting schedules and deadlines.
  - ◆ Illogical and erroneous charting.
  - ◆ Deteriorating handwriting.
  - ◆ Comments regarding marital, economic, health, employment or other problems.
  - ◆ Complains of frequent illness, minor accidents, and emergencies.
  - ◆ Changing patient assignments for no apparent reasons.
  - ◆ Leaves work frequently without explanation.

- ◆ Experiences rapid mood changes from irritation to depression to euphoria.
- ◆ Appears at work on days off or consistently comes to work early and stays late.
- ◆ Requests assignment that facilitates access to drugs.
- ◆ Elaborate implausible excuses for behavior.

◆ **SUD Indicators – Physical Symptoms**

- ◆ Shakiness and/or hand tremors.
- ◆ Slurred speech.
- ◆ Watery eyes dilated or constricted pupils.
- ◆ Diaphoresis.
- ◆ Unsteady gait.
- ◆ Runny nose.
- ◆ Nausea, vomiting, diarrhea.
- ◆ Weight loss or gain.
- ◆ Change in dress – suddenly wearing long sleeves or lab coats.
- ◆ Deterioration in grooming and increasing carelessness about personal appearance.
- ◆ Smell of alcohol on breath.
- ◆ Excessive use of breath mints, chewing gum, or mouthwash.
- ◆ Needle marks on arms.

**i) Narcotic Discrepancies Involving Suspect Healthcare Professionals**

The healthcare professional may consistently/frequently be involved in:

- ◆ Incorrect narcotic counts.
- ◆ Apparent alteration of narcotic vials.
- ◆ Patient reports of pain medication ineffectiveness.
- ◆ Discrepancy between patient reports and hospital records of pain medication (e.g., patient reports he takes pain medication only during the day; records indicate nighttime administration as well).
- ◆ Discrepancies in physician's orders, progress notes, and narcotic records.
- ◆ Large amount of narcotics wasted.
- ◆ Numerous corrections on narcotics records.
- ◆ Erratic patterns of narcotic discrepancies (may correlate with healthcare professional's work schedule).
- ◆ Significant variation on quantity of drugs required on a unit.
- ◆ Fails to obtain co-signatures.
- ◆ Defensiveness when questioned about medication errors.
- ◆ Frequently reporting medication spills or other waste.
- ◆ Volunteering to work with patients who receive regular or large amounts of pain medication.
- ◆ Forging other person's name or using another provider's DEA number.
- ◆ Excessive use of narcotics when others have not had to give patients as much medication.

Observing any combination of these behaviors with increasing regularity over a period of weeks or months or a serious indicator (error or overt sign of impairment) is a signal it is time to take appropriate action.

## 6) The Role of the Supervisor

### a) How Prepared Am I?

Consider the following when self-evaluating management of substance use disorders in the workplace:

- ◆ Do I have a basic understanding of SUDs as a disease that follows a specific course and progression with accompanying signs and symptoms?
- ◆ Do I know the most common indicators of SUDs?
- ◆ Do I know my workplace Policy and Procedure related to substance abuse? Does my workplace have one?
- ◆ What are my attitudes about SUDs? Am I supportive or are there barriers to helping a colleague?
- ◆ Do I know how to document a problem properly?
- ◆ Do I know my reporting responsibilities? Do I have a checklist of those I am required to report to?

#### Potential internal reporting responsibilities:

- a) Administration
- b) Human Resources
- c) Risk Management

#### Potential external reporting responsibilities:

- d) State Board of Nursing, Colorado Board of Dental Examiners, State Board of Pharmacy
  - e) Peer Assistance Services
  - f) Local Police
  - g) Food and Drug Administration: reportable when drug diversion, substitution, and/or tampering of any drug (controlled and non-controlled) occurs
  - h) Drug Enforcement Administration: reportable when drug diversion or theft of controlled substances occurs
  - i) Colorado Department of Public Health and Environment: reportable when deliberate drug diversion or theft of any drug (controlled and non-controlled) occurs
- ◆ Do I feel comfortable coordinating a reentry process for one of my healthcare professionals returning to work post treatment?
  - ◆ What resources are available to me as a manager in dealing with suspected or known healthcare professionals with a substance use disorder? What resources can help me and my staff learn more about addiction?

- ◆ Are educational in-services available for your staff? Education regarding SUD is crucial for early identification and intervention.

## **b) Impaired Practice: Reporting Responsibilities and the Supervisor**

When should the Board of Nursing, Board of Pharmacy, or Board of Dental Examiners be involved? It is essential that a manager be aware of statutory reporting requirements in their state. Contacts for reporting are found in the manual's appendix. Subsequent information highlights responsibilities of the manager when presented with an alleged diversion/theft of narcotics. The following information focuses mainly on SUD.

## **c) Considerations before a Confrontation**

PAS staff is available for consultation with supervisors and managers (or other referring parties) to discuss individuals who are seen as potentially impaired. PAS staff will assist the manager in developing a strategy for the situation. The consultation may include, but is not limited to, techniques for confronting the healthcare professional, proper documentation of the problem, and methodology in arranging a referral to PAS.

How much is “enough” to confront an employee regarding concerns about alcohol and/or drug use? This is a most challenging question for managers. Some signs and symptoms could have many different causes. Is it stress or behavior caused by other reasons or really a drug problem? Observing signs in isolation may be some other cause. Observing any combination of signs or patterns of occurrence of signs with increasing regularity, or a serious practice error or overt signs of impairment is a signal that it is time to act.

There are many factors to be considered in making these decisions. The most important factor is that of safety, for the patient, but also for the healthcare professional and the other health care team members. Some elements to consider in determining whether this is a safe place and time to practice include:

- ◆ The type of work environment.
- ◆ The level of supervision and interaction with other professionals.
- ◆ The intensity and stress of both physical and emotional aspects of the role.
- ◆ The access and exposure to drugs.
- ◆ The level of support for the professional.

There are many sources of information about substance use disorders. PAS is available for management consultation or information about SUDs. Another excellent source of information regarding your legal obligations is the State Board of Nursing, the State Board of Pharmacy, or the Colorado Board of Dental Examiners. The Johnson Institute in Minneapolis and well-known treatment centers such as Hazelden or Talbott Recovery have catalogs of products with written and audio-visual materials on the topic.

Local treatment programs and hospitals for substance use disorders employ professionals who can advise. Employee Assistance Programs (EAP) and Risk Management Departments are excellent sources of information and support. See Appendices A and B for resources.

#### **d) Initiating Action**

Before initiating action it is best to review facility policy and procedure. Solid policy and procedure is essential to ensuring patient safety and the consistent management of issues. Without clearly stated facility-wide policy and employee education, responses to problems are likely to result in inconsistent and unsystematic management. A haphazard approach places patients, employees, and the entire institution at risk.

Although specific language of policies and procedures may vary from facility to facility, a comprehensive policy for addressing fitness to practice concerns should 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 your own facility policy and procedure is essential prior to initiating an intervention.
- ◆ Close collaboration with Risk Management and Employee Assistance Program.
- ◆ Drug Free Policy awareness and application.
- ◆ Seamless collaboration between departments to ensure a consistent and fair approach.

The importance of proper documentation cannot be overstated. Instruct your staff to record clear, concise, objective data when documenting concerns. Stick to the facts; do not diagnose. The date, time, place, and situation of concern should always be documented. In addition, notations concerning action taken by the supervisor and subsequent follow-up should be included. For example:

*“On May 1, 2011, Davis Jones was observed sleeping on duty between 10-10:30 PM. When awakened he appeared drowsy but continued his charting until shift change.”*

As a supervisor it is your role to evaluate all documentation provided to you by staff and determine when and if sufficient concerns warrant formal action. In some cases you may request the help of a colleague in determining the best course of action to take. You may wish to consider utilizing a Performance Review Document (PRD) on an ongoing basis to track any concerns communicated. The PRD tool can make ongoing review of concerns easier and increase the ability to identify serious concerns and/or patterns. See the following example utilizing PRD for data collection.

**Performance Review Document      Staff Name: Davis Jones, RN**

<u>Date</u>	<u>Time</u>	<u>Behavior of Concern/Witness</u>	<u>Action and Follow Up</u>
5/1/11	10:00 PM	Davis Jones was observed sleeping on duty, when awakened he appeared drowsy, yet he continued shift without concerns.	Will f/u with JL on 5/28 regarding any further concerns.

J. Lowe (evening supervisor) made observation and report 5/18/01

In this situation the one concern documented may be only an isolated event noted in Mr. Davis' performance. However, further concerns documented on his PRD may depict a more serious pattern of problems. Ongoing documentation will assist greatly should counseling for corrective action be necessary. Proper documentation is crucial to a successful plan of action, especially in the case of impairment, with its subtle progression and chief characteristic of denial. When you suspect that a pattern of incidents may be emerging, it is helpful to seek validation and consultation of a supportive colleague with experience in effectively handling impairment issues. Consulting an employee assistance professional can also be a great resource for managers. The need for strict confidentiality in such situations cannot be overemphasized. Confidential resources, such as PAS, are available for confidential consultations. Often these resources can provide an expert opinion as to the documentation at hand and provide suggested intervention strategies.

**e) Confronting a healthcare professional**

Approaching a healthcare professional should be planned when there is sufficient indication that behavior and documentation is not within the expected norms. Facts should be objective and descriptive so that the professional is presented with concrete information. The planning and participation is often another critical responsibility of the supervisor. When confronting a healthcare professional, it is important not to just "react" to a situation, but to develop a careful "plan of action," including a referral to PAS before implementation.

Usually, the first step is to secure help and this is probably a policy of the health care facility. There are two primary reasons for this. First, the support and the witness of one or two others, from human resources or administration, are useful. Also, a group style is a much more powerful message and therefore more successful than if facilitated by an individual alone. Denial is the chief characteristic of all addictive diseases; therefore, it may be unrealistic to expect the healthcare professional 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 expectations of "instant acknowledgement." It is more common for the healthcare professional to deny the problem but demonstrate willingness to comply with an evaluation process in order to safeguard her employment and career. Once in a treatment process, denial fades and the process of admitting and accepting begins.

The supervisor should meet prior to the meeting with the team to review documentation, in house policy, and to determine the documented facts to be presented. The meeting should focus on documented facts of performance concerns along with supportive communication. Available options for a fitness-to-practice evaluation must be identified before the meeting is facilitated. Once all is in place, the identified healthcare professional is requested to join the group. Upon his/her entry he/she is asked to be seated and to listen to each of those present who are “here because we care and are concerned.” An honest, direct, and caring approach is recommended. The objective is to request that the healthcare professional refrain from practice and obtain a fitness-to-practice evaluation as soon as possible. Once he/she agrees to follow through with the evaluation plan, a referral to PAS is appropriate. It is helpful to contact PAS prior to the intervention for additional guidance.

**A referral to PAS will initiate a formal assessment to determine the type and setting for treatment and safety to practice guidelines.** Contact options for PAS are found in the appendix.

The final step is scheduling a meeting for all team members to debrief. This is a time for the intervention team to review 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 help sharpen skills for the future. The debriefing meeting is a good time to formulate documentation that summarizes who was present, what documentation was presented to the healthcare professional, their response, and outcome. At the close of the meeting members may begin to discuss return to practice considerations.

Supervisors should be aware that when a healthcare professional is confronted and realizes that their source of drugs is eliminated, there is an increased possibility of self-harm and/or suicide. If the problem is admitted, it is best to get the person into treatment immediately. If the healthcare professional is in denial, and especially if there are employment repercussions for the denial, they should not be left alone, but accompanied by family or friends.

### **Intervention Do's and Don'ts**

#### **Do's**

- ◆ Prepare a plan.
- ◆ Review documentation.
- ◆ Request help from others.
- ◆ Decide who will present what.
- ◆ Stick to job performance

#### **Don'ts**

- ◆ Just react.
- ◆ Intervene alone.
- ◆ Try to diagnose the problem.
- ◆ Give up.
- ◆ Use labels.

#### **f) Drug Testing**

- ◆ Drug testing policy should include a clear statement that employees are subject to drug testing for cause. Cause should be spelled out so that the employee understands that certain behaviors that suggest impairment will cause the employer to require drug testing.
- ◆ The policy should also include the confidentiality that will be maintained for the employee and how the employee will be apprised of the results.
- ◆ The policy should address the consequences of a positive drug test result and the options the employee will have.
- ◆ With a policy in place, you can direct a healthcare professional to be tested when the person exhibits behavior described in the policy – confusion, unsteady gait, inability to focus or manage expected performance, slurred speech or any other signs that could be consistent with impairment.
- ◆ Common tests for cause are generally a urine drug screen. A breath analyzer can be used if alcohol impairment is suspected.

#### **g) Supporting Staff in the Aftermath of Drug Diversion/Use**

Managing other staff members is one of the challenges facing the manager in this situation. Turn a traumatic situation into a learning opportunity by presenting information about SUD and diversion while offering opportunity for staff to express feelings and for sharing questions and concerns. Basic education on SUD and its prevalence in the healthcare profession can help dispel myths that view SUD as a moral weakness rather than a medical weakness. The privacy of the healthcare professional should be protected as much as possible but essential information should be made available on a need to know basis. There may be feelings of anger, hurt, betrayal, even guilt when a colleague is identified as having a drug problem. Other staff may feel used or put at risk because of their colleague's illness. The best approach is to be open and allow opportunity for expression of feelings to build support for the recovering healthcare professional.

When, or if, the healthcare professional returns to work, additional meetings may be useful for further sharing and education. Meetings like these are usually well received. Besides diffusing mistrust and misunderstanding, they also promote open communication and lessen the chance of enabling future problems. Staff members observe first hand a caring and professional approach to a colleague with SUD.

#### **h) Alternative Program versus Discipline**

Regulatory boards vary in their approaches to managing cases involving healthcare professionals with SUD. The following information provides an overview of what happens when a complaint is filed with the Board of Nursing.

PAS conducts assessments requested by the regulatory board. The assessment provides valuable information that assists the Board in evaluating the case and determining the possible basis for the identified behavior. Many persons with SUD also have mental health problems diagnosis. The assessor can present, if appropriate, recommendations for a therapeutic plan for the nurse. Treatment recommendations may be incorporated into a Board order as elements for monitoring or criteria toward re-entry requirements, but treatment should not be punishment.

## **7) PAS: Alternative to Discipline**

PAS is an alternative to discipline program that provides monitoring of participant healthcare professionals for public protection while giving them the opportunity to seek treatment and recovery in a non-disciplinary process. Treatment experts report that professional individuals who have careers riding on maintaining sobriety have higher rates of recovery.

Consider that PAS:

- ◆ Provides close monitoring of healthcare professionals who are impaired due to a substance use disorder to assure the public health and safety.
- ◆ Attempts to decrease the time between a healthcare professional's acknowledgement of a problem with a SUD and the time he/she enters a recovery program. Early entry into an appropriate recovery program allows the professional to practice in a manner that will not endanger public health and safety.
- ◆ Allows the healthcare professional who meets specified criteria to maintain an active license to continue employment. The benefit to the public is the earlier detection of problems and quicker intervention with close monitoring of healthcare professionals in recovery. The possibility of the avoidance of the notoriety of discipline can be an important factor in breaking through the denial associated with the disease.
- ◆ May reach healthcare professionals who are affected by SUD's but who are not being reached through the current disciplinary system.

PAS looks beyond violations to the causes of the behavior. If healthcare professionals are identified earlier and referred for treatment before practice is impacted, that is a benefit to the public. If recovering healthcare professionals are monitored stringently and watched for signs of relapse, that is a benefit to the public. If healthcare professionals who experience recovery are retained in the profession, they have a great deal to offer their patients and colleagues.

Holding professionals accountable for any behavior that violates grounds for discipline is one of the most critical responsibilities of the State Board of Nursing, the State Board of Pharmacy, and the Colorado Board of Dental Examiners. PAS assists these Boards by holding healthcare professionals accountable in an alternative manner. When the program is successful, everyone wins. When a professional cannot attain recovery, the Board is there to hold the individual accountable in the traditional manner.

PAS focuses on prevention of SUD. Education regarding SUD and identification of persons at risk is a major preventative tool. Professional nurturing, demonstrated by assisting peers in their roles as healthcare professionals, is also considered an important preventative factor. In order to promote professional nurturing, healthcare professionals strive to raise one another's consciousness of the needs of peers. PAS provides support of healthcare professionals in recovery and assists them to develop alternative coping mechanisms. PAS also advocates and supports healthcare professionals going through the discipline process.

PAS may recommend that a healthcare professional not practice for a period of time or they may agree to a non-practice status being written into his/her contract. A change in career direction may be in their best interest for a period of time until the healthcare professional is ready for return to practice.

PAS, in collaboration with the Board of Nursing, the Board of Pharmacy, and the Board of Dental Examiners, is an alternative model that offers the best balance between the protection of the public and the rights of the healthcare professional. Additionally, PAS provides consultation and educational services.

### **What does monitoring consist of at PAS and how does monitoring help ensure public safety?**

Each healthcare professional is assigned to a case manager at PAS.

- Case management is an array of services which includes assessment, service planning, referral, linkage to services, and monitoring. It is through the practice of case management, with review of progress and compliance, and regular client and community resource contacts, that the goals and objectives of a treatment and rehabilitation plan are supported. The comprehensive nature of a case management plan as part of the rehabilitation contract serves to make recommendations with individually tailored treatment goals and progress expectations that are specific to guiding a nurse through the process of recovery toward wellness and safe practice.

What is the definition of Safety to Practice?

- ♦ Ability to practice with reasonable skill and safety is based on the following criteria:
  - Ability to think critically, plan, organize, and prioritize
  - Ability to remember or concentrate
  - Ability to communicate effectively with health care team members
  - Ability to develop and maintain a therapeutic provider-patient relationship
  - Ability to respond appropriately to an emergency in the work place

Each healthcare professional working with PAS is asked to sign a Rehabilitation Contract

- ♦ The rehabilitation contract is an outline of the requirements agreed upon by the clients to assist in proving their safety to practice and guiding them towards wellness and recovery.

- ◆ Comprehensive case management services are based on the rehabilitation contract and include the following monitored items:
  - Abstinence from mood/mind altering substances
  - Contact with case manager
  - Participation in treatment
  - Individual and group therapy with reports
  - Practice Monitor and Supervisor reports
  - Random urine screens
  - Attendance at Peer Support Group meetings
  - Attendance at 12-step meetings and/or other mutual help groups with sponsorship
  - Compliance with relapse prevention plan
  - All necessary authorizations to release information kept current
  - On-going self-status reports
  - Immediate reporting of changes in employment, treatment, or residence

The case manager collects information from the above listed sources to help ensure that the healthcare professional is safe to practice. Safety Noncompliance occurs when PAS does not receive evidence that the client is safe to practice. Noncompliance in this context is reportable to the State Board of Nursing, State Board of Pharmacy, or the Board of Dental Examiners.

### **PAS Drug/Alcohol Testing**

- ◆ PAS may request urine drug/alcohol screens for reasonable cause.
- ◆ A narcotic discrepancy involving a healthcare professional participating in PAS is subject to a drug/alcohol test on the same day of the discrepancy. Your facility may request additional drug/alcohol screens in accordance with their policy.
- ◆ PAS will notify the healthcare professional and employer when positive screens are received. The healthcare professional must immediately cease practice and submit another drug/alcohol screen within four hours of notification from PAS.
- ◆ The healthcare professional returns to practice only upon clearance by the PAS case manager team or they may be referred to the board.
- ◆ PAS mandates random drug testing as one mechanism used to determine a healthcare professional's use of alcohol and/or drugs. Evaluation of participation in a recovery program is always used in conjunction with drug testing. Drug testing should never be used as the only indication of use or non-use, or a healthcare professional's ability to practice safely.
- ◆ PAS and/or the healthcare professional's employer reserve the right to determine specific drugs to be tested, as well as modify or change the number of drugs to be tested at any time.

## **8) Return to Practice**

Re-entry into practice is the ultimate goal of successful intervention and treatment of healthcare professionals with SUD. The key to a successful return to practice is careful and individualized reentry planning with monitoring to ensure safe practice and prompt detection of relapse behavior. There should be specific return to work requirements documented in a written contract, commonly known as a Practice Agreement/Return to Work Agreement. Common work restrictions include: narcotic restrictions, no nights, no float pool, no overtime, no staffing agencies, and may not practice as a manager or supervisor.

Also, experts advocate initiating a return to work conference to provide support, review expectations (including any practice restrictions), monitoring requirements, and to answer any questions. Involvement of not only the healthcare professional, staff, and manager, but also treatment representatives, human resources, EAP, and support persons assures that the plan is comprehensive and provides for patient safety. Copies of the Return to Work Agreement should be made for each person present at the meeting. There may need to be practice restrictions and information on how to work within these restrictions. Communicate details of the agreement to those who supervise the recovering healthcare professional.

### **a) Communication with PAS**

- ◆ One person should be assigned monitoring responsibilities of the healthcare professional; written evaluations should be submitted in a timely fashion.
- ◆ Notify PAS if concerned regarding healthcare professional's sobriety, competence, or ability to practice safely.
- ◆ Notify PAS immediately if healthcare professional's employment is terminated for any reason.
- ◆ Notify PAS if healthcare professional leaves employment voluntarily.

### **b) Indicators of Relapse**

SUD is a chronic illness. Like other chronic illnesses, it is characterized by periods of remission and exacerbation. In general, the relapse rate for healthcare professionals is lower than in the general population. This is due to the growth of supportive programs and strict state monitoring programs. Still, some healthcare professionals do relapse; knowing how to manage relapse in the workplace is crucial for both the safety of patients and well-being of the healthcare professional. A relapse is essentially a recurrence (exacerbation) of active disease. The signs of relapse mirror the signs described on page eight. If relapse occurs, signs will become apparent and will progress without intervention. In recovering healthcare professionals 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, withdrawing from recovery support people and meetings, isolating, resumption of denial thinking, and eventual substance use.

The same rule of thumb for usual employee performance assessment applies here. The supervisor should continue on-going monitoring of 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, steps to re-evaluate the healthcare professional's fitness to practice and/or removing them from practice should be initiated. Once re-evaluation is completed and fitness/stability is assessed, 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/treatment the chances of the healthcare professional re-entering recovery (remission) are great. Once one is stabilized and fitness to practice is determined, decisions about return to practice can be made. A clear policy regarding the management of relapse is extremely important and it should address areas of identification, documentation, intervention, referral for fitness to practice assessment/treatment, and parameters for return to practice.

## **9) Summary**

The supervisors and managers play a crucial role in the management of issues in the workplace. A manager who is knowledgeable, prepared, proactive, and compassionate is most successful. Reasonable policies, current knowledge, and a positive attitude set the climate for a work environment in which clear limits and collegial support coexist. The manager who fails to act, on the other hand, can make a significant negative impact on patient safety and the healthcare professional's well-being. Protecting patients while helping colleagues may best be accomplished by way of the age-old tenant of treating others, as we would wish to be treated.

# Appendix A

## Works Referenced

1. Substance Abuse – The Nation’s Number One Health Problem, (2001). The Robert Wood Johnson Foundation.
2. U.S. Department of Justice (2004). Drug Abuse and Mental Health Fast Facts.
3. Ramer, L.R. (2008). Using Servant Leadership to Facilitate Healing after a Drug Diversion Experience. *AORN*, 88, 253-258.
4. Chemical Dependency Handbook for Nurse Managers, (2001). The National Council of State Board of Nursing.

# Appendix B

## Resources

### **Reporting Resources:**

#### **Peer Assistance Services, Inc.**

2170 South Parker Road, Suite 229

Denver, CO 80231

303-369-0039

[www.peerassistanceservices.org](http://www.peerassistanceservices.org)

#### **Colorado State Board of Nursing**

303-894-2430

<http://www.dora.state.co.us/nursing>

#### **Colorado State Board of Dental Examiners**

303-894-7800

<http://www.dora.state.co.us/dental/>

#### **Colorado State Board of Pharmacy**

303-894-7800

<http://www.dora.state.co.us/pharmacy/>

#### **Drug Enforcement Administration**

720-895-4040

<http://www.justice.gov/dea/pubs/states/denver.html>

#### **US Food and Drug Administration**

Denver Regional Staff

303-471-1106, 303-674-1006, or 303-683-3640

#### **Colorado Department of Public Health and Environment**

<http://www.cdphe.state.co.us/hf/static/ncfocc.htm>

**Educational Resources:**

**Join Together**

<http://www.jointogether.org/>

**The National Center on Addiction and Substance Abuse (CASA) at Columbia University**

<http://www.casacolumbia.org/>

**American Nurses Association**

<http://www.nursingworld.org/>

**Colorado Nurses Association**

<http://www.nurses-co.org/>

**Colorado Dental Association**

<http://cdaonline.org/>

**Colorado Concerned Dentists**

<http://www.ccdinfo.org/>

**Southwest Pharmacist Recovery Network**

<http://www.swprn.org/>

**National Council of State Boards of Nursing**

<https://www.ncsbn.org/index.htm>

**National Institute on Mental Health**

<http://www.nimh.nih.gov/index.shtml>

**International Nurses Society on Addictions (IntNSA)**

<http://www.intnsa.org/>

**American Association of Nurse Anesthetists (AANA) Peer Assistance**

<http://www.aana.com/peerassist.aspx>

**National Institute on Drug Abuse (NIDA)**

<http://www.nida.nih.gov/>

**Substance Abuse & Mental Health Services Administration (SAMHSA)**

<http://www.samhsa.gov/>

**National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

<http://www.niaaa.nih.gov/>

**Hazelden**

[www.hazelden.org](http://www.hazelden.org)

**Talbott**

<http://talbottcampus.com>

**Substance Abuse – The Nation’s Number One Health Problem, (2001). The Robert Wood Johnson Foundation:**

<http://www.rwjf.org/files/publications/other/SubstanceAbuseChartbook.pdf>