Understanding Chemical Dependency Among Nurses

A Guide for Nursing Administrators

Missouri Nurses Association
Organized 1906

Peer Assistance Committee

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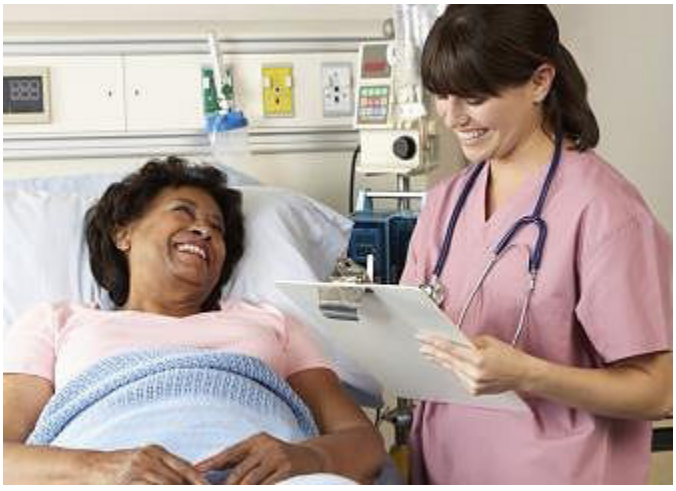
INTRODUCTION

As the problem of substance abuse increases within the general population, it also increases among professionals.

Every state, including Missouri, has established regulations to control the practice of nursing. The Missouri Department of Economic Development and the Missouri State Board of Nursing are mandated by state legislation to protect the public: the health care consumer. This responsibility is implemented through the licensing and regulation of designated professionals by individual boards. Over the last decade the Missouri Board of Nursing, as well as other professional boards, has experienced an increase in the number of cases for review and disciplinary action concerned with the use of drugs/alcohol or psychological/psychiatric conditions.

Across the nation, special programs are being developed to assist physicians, dentists, pharmacists, veterinarians, nurses and others whose practice is impaired due to the use of drugs and alcohol. Recent estimates are that one in seven nurses in the United States are alcoholics or addicts.



The Missouri Nurses Association has prepared this reference manual to assist the nursing administrator in understanding and coping with the many problems that arise when a nurse on staff is suspected of being drug- or alcohol-dependent. Identification, intervention, and referral for treatment, along with adequate safeguards for patients and other staff members, are the critical elements of sound policy for the management of chemical dependency problems or impairment in the workplace.

Suggestions for identification and management of the problems of substance abuse in this manual are based on recommendations from national symposiums on the chemically dependent nurse, current literature, and the combined experience of resource persons working directly with the problem over many years. We trust this manual will be of value to nurses in Missouri, particularly those in administrative positions, as we address the very serious problems surrounding substance abuse in our profession.

MISSOURI NURSES ASSOCIATION

Position Statement
Chemical Dependency and the Nursing Profession

The problem of substance abuse is recognized to be on the increase in the general population and among professionals. In the last decade the Missouri State Board of Nursing (MSBN) and other professional boards have experienced an increase in the number of cases for review and disciplinary action concerned with the use of drugs and alcohol. Statistics indicate that one out of seven nurses will experience a problem with drugs or alcohol. All too frequently, their nursing practice as well as their nursing license is jeopardized.

The Missouri Nurses Association believes that chemical dependency is a treatable disease. Through awareness and education nurses whose practice is affected by the use of drugs or alcohol can be assisted.

Identification, timely and effective intervention, and referral for treatment are necessary components in the management of chemical dependency in the workplace. These three steps can contribute to the restoration of the nurse to health, maintenance of the standards of nursing practice, and adherence to the Code for Nurses that ensures the public safety.

The Missouri Nurses Association recognizes its professional responsibility to colleagues and to those they serve. The Missouri Nurses Association believes it should continue to take leadership in responding to the needs of the chemically dependent nurse. Therefore, the Missouri Nurses Association will continue to provide information on the issue of substance abuse among nurses to the nursing profession and other health care providers.

The Missouri Nurses Association believes it is the professional responsibility of the Association to establish mechanisms for dissemination of information that include significant educational and research activities and legal and ethical issues that relate to the impaired nurse.

The Missouri Nurses Association believes it should collaborate with the Missouri State Board of Nursing in addressing the problems associated with chemical dependency in nurses.

The Missouri Nurses Association believes nursing administrators and other employers of nurses should offer appropriate treatment in lieu of or prior to disciplinary action if deemed necessary. Chemical dependency should be managed in the same manner as other health problems including the provision of options for continuing or subsequent employment. If dependent nurses seek help in an approved rehabilitation program, it may not be necessary to report offenders to the MSBN.

To reiterate, chemical dependency is treatable. Appropriate effective treatment can save a nurse's life, career, and license.

Missouri Nurses Association Peer Assistance Committee, approved by the Missouri Nurses Association Board of Directors April, 2009.

CHAPTER 1

CHEMICAL DEPENDENCY: THE DISEASE CONCEPT

Chemical dependency is a controllable disease. The single greatest obstacle to the treatment of this disease is attitude: the attitude of the person with a chemical dependency; the family, friends, and employer; and society at large. The misconception persists that chemical dependency is not a disease but rather a behavior problem that is either psychological, ethical, or moral in nature.

Consider if you will: It is rare that neighbors increasingly avoid and mistrust a fellow human being simply because he has heart trouble or is a victim of crippling arthritis. Nor do families feel humiliated or try to conceal that a family member is ill. Nor do police commonly put such unfortunate persons in jail if their illness causes them to fall or to display other symptoms of an acute attack while in a public place. Yet all of these are typical responses to the person with chemical dependency.

Why is this so? We all tend to fear, avoid, and sometimes even to despise that which we do not understand. The sight of an intoxicated person weaving erratically down the street or the addict lying disheveled in a stupor arouses responses of either revulsion and alarm, or scorn and contempt in the majority of people. Seldom does such a spectacle generate compassion. It is still easy to find communities in the United States where the standard treatment for chemical dependency is jail.

Chemical dependency is a disease. But do we as nurses believe this? Or do we believe that being an addict or alcoholic is a symptom of some grave mental disorder, a poor pattern of behavior, or the habitual response of a morally and ethically weak character. None of these is accurate. Chemical dependency is a disease.

WHAT IS A DISEASE?

Medical and nursing literature agree that a disease can be identified by five specific characteristics: (a) a disease has identifiable signs and symptoms; (b) it follows a predictable and progressive course which, if left untreated, may lead to death; (c) it produces consistent anatomical and/or physiological alterations; (d) its cause or causes may not be known; and (e) it is a primary condition, not merely a symptom.

IDENTIFIABLE SIGNS AND SYMPTOMS OF CHEMICAL ADDICTION

Alcoholics and addicts "use" compulsively, inappropriately, illogically, and often uncontrollably, Though fully intending to “have just one," often they will "use" until passing out. Once they have started "using," they are unable to guarantee their subsequent behavior.

Tolerance for the drug changes. Regardless of the drug, be it alcohol or Demerol or whatever, the quantity which once induced a happy glow no longer brings forth that glow and increasing amounts of the drug are needed.

Blackouts are experienced. Users actually forget the events of hours or even days during which they have used, and may arrive at places without any idea of how they got there. Phone calls are made and lengthy conversations are held without recall. They may have even performed complex but routine tasks for others without full awareness.

Withdrawal syndrome is experienced when the drug is reduced or eliminated. This condition results from a pendulum-like swing of the involuntary nervous system, going from the depressed state induced by the drug, to the hyperactive state that follows when the depressive influence is removed after several hours of abstinence. The physical condition deteriorates and such physical deterioration include malnutrition, insomnia, persistent headaches, sexual impotence, difficulties with vision, terrifying dreams, and stomach and heart trouble. Personal hygiene is neglected and interest in personal appearance is lost.

Psychological well-being deteriorates and is evidenced by loss of interest in hobbies and other accustomed leisure activities, loss of interest in work, and decreasing willingness to accept normal responsibilities. Inappropriate and exaggerated mood swings occur. There are also increased feelings of shame, guilt, helplessness, and hopelessness. Isolation and impaired communication skills result in a further deterioration of psychological well-being.

Sociocultural and financial conditions deteriorate. Marriage, relationships, spiritual needs, community, and work all become less important. Chemically dependent persons seem to lose interest in anything that is not directly related to their supply of drugs. As they become more withdrawn, their position gradually shifts from being an asset to their family and community to that of an increasing detriment and burden. Dimly they realize this and feel further guilt and shame.

PREDICTABLE AND PROGRESSIVE COURSE

Alcoholism usually begins with the occasional drink taken to relieve tension, to blunt either physical or psychological pain, to heighten pleasure, to facilitate social interaction, or just to become one of the group. Soon the alcoholic's drinking pattern differs from the purely social drinker. Alcoholics usually drink more frequently and in greater quantities than non-alcoholics. They often experience considerable pride in their ability to "drink their companions under the table."

Drug addiction may begin with the recreational use of alcohol, followed by the smoking of marijuana, and then gradual progression into other street drugs. Addicts use because they enjoy the way the drug makes them feel. Many people become addicted to prescription drugs given to them by their physician for relief of pain, insomnia, anxiety or depression. A transition can take place somewhere in the course of treatment when these patients begin taking more medication than prescribed until at some point they begin to feel like they cannot function without their drug.

ANATOMICAL AND PHYSIOLOGICAL CHANGES

Any organ of the body may be altered in structure or function by the continued use or abuse of alcohol and drugs. It has been known for at least a century that continued excessive use of alcohol produces changes in the liver. Since the advent of electron microscopy, researchers have observed changes in both the structure and behavior of the cells of the heart, bones, blood cells, and central nervous system as a result of chemical use and abuse.

UNKNOWN CAUSE

Many alcoholics and addicts with long records of drunkenness and addiction have experienced effective treatment and have gone on to reestablish happy, productive, and chemically free lifestyles. This is accomplished without knowing the exact cause of the disease. Even though the exact cause of chemical dependence is still unknown, the treatment of the disease remains the same: total abstinence from all mood-altering drugs.

A PRIMARY CONDITION

Chemical dependency is a primary condition in itself, not merely a symptom of some underlying disorder. The choice of drugs is wide and varied, including alcohol, street drugs, and controlled prescription drugs. An overwhelming number of chemically dependent persons whose drug of choice is alcohol become trapped in the disease as they follow the norms for social drinking. An equal number of chemically dependent persons who choose drugs other than alcohol started using drugs as part of their socialization into adulthood.

The American way of life almost dictates that every person indulge routinely in social drinking. Although social drinking may be a harmless and pleasurable experience for many people, for the unsuspecting 14% of our population who have a predisposition for alcoholism, the results may lead to torment and eventual disaster. It is now known that these people have a genetic "switch" that alcohol can "flip"—sometimes even after one drink. The alcoholic cannot drink either socially or harmlessly. Rather than being a pleasant, social lubricant as it is to a great majority of people, alcohol is a diabolic and insidiously toxic poison to the alcoholic. If these individuals continue to drink, they will eventually manifest the progressive symptoms of this disease.

The chemically dependent person who chooses drugs other than alcohol cannot take any mood-altering chemicals. The chemically dependent person uses drugs to alter his or her mood. Many of these people started using recreational drugs in order to be accepted by and to identify with their peers. However, they cannot sustain using drugs on only a recreational basis. They eventually manifest signs and symptoms of the disease of chemical dependency.

OBSTACLES TO THE DIAGNOSIS

With the seven recognizable signs that signal the development of chemical dependency, why is this disease not more quickly and more frequently diagnosed? First of all, there is the issue of shame. Neither chemically dependent persons nor their families are easily prepared to accept a diagnosis of chemical dependency because societal attitudes are still clouded with many myths and deep-seated convictions that chemical dependency is due to moral weakness or personality defects. It is secretly believed that if the individual would only brace up and be a stronger person, he or she could stop altogether.

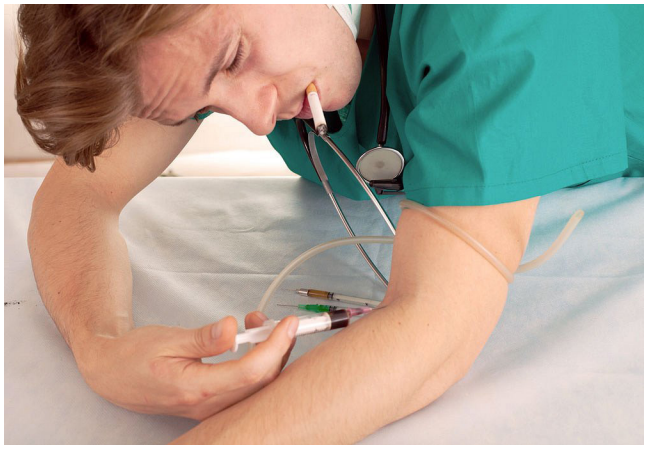
Then there is lack of awareness. Chemically dependent persons may be truly unaware of the significance of their symptoms. They may fail to realize that their morning shakiness is a symptom of withdrawal, induced by having used the night before. In addition, these individuals have a complex system of coping mechanisms including extensive use of denial—denial that they have a problem, denial that it is affecting their lives or the lives of others adversely, and denial that they need help.

Finally, there is a lack of knowledge. Chemical abuse has been a criminal offense on the statutes of almost every municipality in the United States. This results in putting sick people in jails, where many of them endure unnecessary physical pain, and even death A handful of states have officially decriminalized alcoholism and have set up a number of facilities to treat the disease of alcoholism. However, many states have yet to do the same for those dependent upon other drugs.

Old attitudes, old beliefs, and old prejudices die hard. Much of our population still harbors a mixture of fear and contempt in their attitude towards those who are chemically dependent. As long as these attitudes persist, chemically dependent persons cannot get the community understanding and support which they desperately need—yet which we do provide to the victims of other illnesses.

Chemical dependency is a disease. It remains for all of us to act, with knowledge, compassion, and commitment in conformity with that truth. Chemical dependency can be treated and arrested, thus restoring millions

of Americans, including nurses, to happier, more productive lives. How much of this is actually accomplished depends in great measure on what we as a community of nurses in Missouri think and believe about the disease.



CHAPTER 2

RECOGNITION OF THE PROBLEM OF SUBSTANCE ABUSE

Employers are encouraged to prepare to deal with the very difficult issue of substance abuse before problems occur. Substance abuse by health professionals creates both legal and ethical concerns for the employing agency.

Individuals under the influence of alcohol and/or other drugs have diminished skills of observation and communication, delayed reaction times, and impaired abilities to make judgments. It is clear that the impact of this problem is far-reaching, affecting not only the life of the abuser, but also affecting patients, fellow employees, the image of the agency in the community, and the cost of health care.

Recognizing that an employee has a problem with substance abuse involves acknowledging that the problem exists, recognizing certain clues, and analyzing the scenario presented. Managing the chemically dependent nurse involves policy development, knowledge, skill, and a willingness to address the issue.

Experts suggest that alert supervisors automatically observe clues that an employee may be abusing substances in the course of supervising work performance. Job performance will inevitably deteriorate. At that point, management's efforts at correction may be focused only on the resulting behaviors and not their causes, in order to deal with the problem. However, case histories reveal that many chemically dependent nurses go undetected and continue working into the advanced state of addiction (e.g., 2,000 mg. Demerol per day). Most of these nurses have no difficulty relocating and obtaining references that may only vaguely suggest family or health problems. It is not uncommon to find that nurses with substance abuse problems hold positions of responsibility.

The following are clues that depict typical employment behaviors and histories that are associated with the substance-abusing nurse. As demonstrated, some behaviors are individually specific to the abuse of alcohol and to the abuse of other drugs; others are common to both alcohol and drug abuse. Each situation is unique and symptoms vary with the drug of choice, but there are more similarities than differences.

PROFILE OF THE CHEMICALLY IMPAIRED NURSE

The following signs and symptoms can be observed in the nurse who is chemically impaired. A formerly healthy, competent professional nurse may exhibit the following changes:

Physical Signs and Symptoms:

- General deterioration of physical appearance
- Weight loss
- Tremors
- Disheveled, unkempt appearance, or always a perfect appearance
- Slurred speech
- Rhinorrhea (runny nose)
- Flushed face

- Bruising
- Itchy nose
- Wounds or sores that are not healing
- Tics
- Sudden drowsiness
- Watery eyes, dilated, or constricted pupils
- Diaphoresis (sweating)
- Nausea, vomiting, diarrhea
- Unsteady gait
- Smell of alcohol on the breath
- Memory loss, inability to concentrate
- Evidence of blackouts

Behavioral Signs and Symptoms:

- Wears long sleeves all the time
- Frequent reports of illness, minor accidents, and emergencies
- Elaborate or inadequate excuses for tardiness or absences
- Emotionally labile/overreacts to situations
- Exhibits mood swings, paranoia, irritability, depression, or euphoria
- Makes suicidal threats and/or attempts
- Belligerent, short-tempered
- Increasing isolation from colleagues, family, and friends, or always wanting them around because the addict is suspicious of them
- Exhibits poor judgment
- Frequent complaints of marital and family problems
- Complaints from others about the nurse's alcohol/drug use
- Complaints from peers about the nurse's poor performance
- Strong interest in patients' pain control
- Request for night shifts
- Difficulty meeting schedules and deadlines
- Inconsistent stories
- Obsessive-compulsive organization

Psychological Characteristics:

- Needs to be needed
- Helper
- Caregiver
- Controlling
- High-achiever
- Unrealistic expectations of self
- Denies vulnerability to the disease
- Denies feelings to maintain professional image
- Feels responsible for failures beyond personal control
- Suffers from lack of recognition or acceptance of recognition
- Exhibits superhuman efforts to cope with frequent crisis
- Raised in an alcoholic/drug addicted home
- Underlying psychiatric illness such as Bipolar Disorder or Depression

Added Risk Factors for Nurses:

- Occupational hazard in dealing with drugs
- Great knowledge of drugs
- Self-medicates but believes s/he can avoid addiction
- Colleagues are physicians who write prescriptions/samples
- Lack of recognition for value of work
- Feels guilt and responsibility for clinical failure
- Must exhibit superhuman effort to cope with patient crisis
- Disturbed sleep patterns due to 24-hour profession

Employee Profile:

- Absenteeism
- Tardiness
- Decreasing quality of performance
- Works overtime/appears on off-days
- Frequent errors in documentation or lack of documentation
- Illegible handwriting
- Spends extended periods in bathroom
- Returns late from breaks
- Disappears into the restroom immediately after accessing narcotics cabinet
- Strong interest in patients' pain control and narcotics cabinet
- Administers narcotics to patients who otherwise require little medication
- Medicates other nurses' patients/offers to do PRN medications
- Unusual narcotic waste
- Consistently signs out more narcotics than other nurses
- Patients complain medications dispensed by this nurse are ineffective
- Disorganized or very organized
- Numerous job changes or internal transfers in the past 5 years
- Frequent geographic changes for unexplained reasons
- Exhibits reluctance to undergo pre-employment physical
- Exhibits reluctance to authorize reference check from most recent employer
- Working or applying for position inappropriate for qualifications

DRUG FACTS FOR NURSES

Nurses are as vulnerable as anyone else to becoming chemically dependent. In fact, nurses have a 50% greater incidence of developing chemical dependency than the general population. This can be attributed to heredity, education, training, and accessibility to drugs that are not commonly available. Of the 115,000 nurses in Missouri, one out of seven will use alcohol and/or other drugs and become dependent. Chemical dependency is a treatable disease. If treatment is begun early, the nurse has a better chance for a successful recovery. Your intervention is the first step in that recovery process.

Following is a list of mood-altering drugs and the effects commonly associated with their use. This information may help you to recognize when someone is using these substances. It is important to remember, however, that sometimes individuals who have certain medical conditions may exhibit behavioral symptoms commonly associated with drug abuse. It is important to send the person exhibiting such behaviors to an emergency room or medical facility of the agency's choice for evaluation.

MOOD-ALTERING DRUGS

DRUGS	POSSIBLE EFFECTS
Narcotics	Euphoria Drowsiness Respiratory Depression Constricted Pupils Nausea
Depressants	Slurred Speech Disorientation Drunken Behavior without Odor of Alcohol Drunken Behavior Due to Alcohol Intake
Stimulants	Increased Alertness Excitation Euphoria Increased Pulse Rate & Blood Pressure Insomnia Loss of Appetite
Hallucinogens	Delusions Hallucinations Poor Perception of Time & Distance
Cannabis	Euphoria Relaxed Inhibitions Increased Appetite Disoriented Behavior

CHAPTER 3

MANAGEMENT OF THE PROBLEM OF CHEMICAL DEPENDENCY IN NURSES

Due to the increased incidence and serious ramifications of chemical dependency among nurses, management should prepare a specific plan prior to the immediate and often emotional situation in which decisions must be made.

POLICY DEVELOPMENT

It is recommended that the agency develop a committee to review both written policy and current unofficial practices affecting management of substance abuse. Membership on the committee should include representation from upper level management and staff, including recovering nurses. It is important for recovering nurses to be able to maintain confidentiality and anonymity which are extremely important in a 12-Step Recovery Program. If management is decentralized, representatives from each area should be included.

The committee should have the authority to make decisions or recommendations regarding insurance benefits, sick leave, employee assistance programs, and employee health services. Policies of employment, evaluations, promotion, and termination should be reviewed by the committee. Differences in the way cases have been handled in the past should be discussed. Agency routines and practices which are conducive to drug diversion should be immediately changed as these may be viewed by abusers as open invitations to continue their habit at the institution.

Following a review of existing policies, the committee's task is to develop a written policy which may include:

1. Recognition of addiction as a health problem affecting job performance and the welfare of the employee.

2. Statement of belief that addiction is a treatable disease, a condition from which one can be rehabilitated.

3. Agreement to treat the disease of addiction as any other employee health problem.

4. Assurance of confidentiality of records with the exception of any necessary mandatory reporting.

5. Assurance that requesting or undergoing evaluation and/or treatment will not affect job security especially with an Open Door policy encouraging those who want help prior to demonstration of impairment.

6. Outline modes of safe transportation for employees who demonstrate impairment while on duty and need to be transported for evaluation and/or treatment.

7. Identification and description of conditions under which an employee's position or role would be affected.

8. Outline of necessary communication channels for reporting complaints related to possible abuse.

9. Description of requirements and documentation necessary for various actions, including issuing ultimatums or conditions of continued employment, transfer, termination, and re entry. Use caution with ultimatums or they may not work.

If serious problems arise in formulating such a policy, the following strategies may be useful in stimulating the desired changes:

1. Engage a professional expert consultant.

2. Sponsor the attendance of administrators at a seminar on addiction designed for managers.

3. Invite a recovering nurse to speak on his/her experience.

4. Hold small group discussions to facilitate re-examination of feelings and values influencing management of this problem.

5. Contact MONA's Peer Assistance Program.

When a policy is developed, awareness of the problem can be increased by sharing the policy (in whole or in part) with the staff and including it in new employee orientations. "Knowing the score" may encourage employees to seek help as needed.

Research indicates that the attitudes of non-addicted nurses toward this problem are even more negative than those of the general population. These negative attitudes must be dealt with before effective policy can be implemented. We are cautioned not to become "an army that shoots its wounded." The substance abusing nurse can be effectively rehabilitated to re-enter the work force.

PREVENTION

Agency procedures should be reviewed to determine whether they are providing a favorable climate for the chemically dependent nurse. Suggestions for preventing drug diversion include:

1. Use single unit dosage containers and individual patient billing rather than stock supplies and multiple dosage vials.

2. Develop precise procedures to handle patient's personal medications on admissions and surplus medications on discharge

3. Use medicine storage rooms and medication prep areas which are open and easily observable.

4. Eliminate or rotate the role of "medication nurse."

5. Periodically review narcotic records (preferably computerized) to establish averages and identify irregular patterns of use.

6. Limit the number of persons handling narcotic keys.

7. Eliminate laxity in narcotic counts and waste procedures and reiterate the importance of actually witness ing counts and procedures; don't just initial it.

8. Establish and enforce policies on borrowing narcotics from other units when the pharmacy is closed.

EDUCATING PERSONNEL

A vital key to the success of intervention in the workplace is the education of nursing managers. Training about

specific signs/symptoms, intervention, enabling (as a barrier to intervention), and specific policies and procedures is essential. Training relating to these issues should be provided for staff personnel through orientations, brown bag sessions, and regularly scheduled offerings.

DEALING WITH THE PROBLEM

At some time you will be faced with the problem of working with a nurse you may suspect is chemically dependent. Regardless of how well you have screened and educated your staff, established policies on substance abuse, and incorporated preventive measures, it will take all of your skill as a manager to balance your responsibility to the patient, the chemically dependent employee, and to the institution.

EMERGENCY MEASURES

When observations suggest that patient safety is endangered by intoxication or incoherent behavior, the nurse should be sent home on sick or personal leave with a conference scheduled for the following day. The nurse should not be allowed to return to duty until the problem is resolved.

OBSERVATION AND DATA COLLECTION

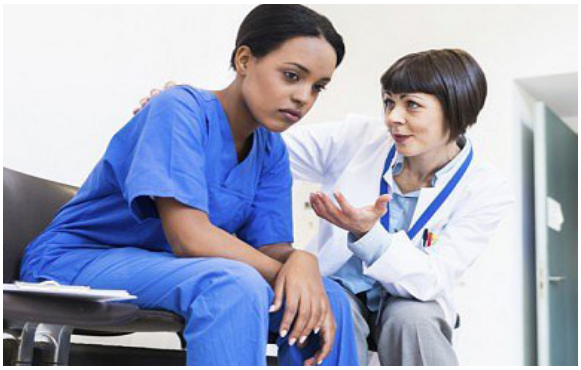
The suspicion that a nurse is abusing drugs or alcohol generally arises from a series of observations rather than from an isolated instance. When this occurs:

1. Don't panic, but do act. Over-reacting may create additional problems, but patients must be protected and legal rights assured. Over-reacting may also cause the nurse to quit and seek employment elsewhere. The only thing you can do wrong is to do nothing.

2. Document carefully. All reports and direct observations of questionable behavior should be recorded with dates, times, names of observer/reporter, nurse in question, description of circumstances, any action taken, and the nurse's response. Notes should be factual; data should be objective.

3. Increase the observation/supervision of the nurse. As unobtrusively as possible, examine the nurse's notes and narcotic records and talk to patients and other staff regarding patient care. (See "Working with Staff" below).

4. Consider reassignments. Do not "enable" the nurse to continue her/his problem by giving easier assignments or schedules. However, if it is feasible, a change in unit or shifts may help in evaluating the situation, particularly if a similar situation recurs. The nurse's resis tance to a change that reduces opportunity and accessibility of drugs may also be significant.



WORKING WITH STAFF

Only those staff members who really need to know should be informed. Quietly and matter of factly, enlist their help. Emphasize that it is only a concern and work to prevent problems that commonly occur (gossip, a witch hunt attack, over-protection, anger and guilt over "ratting" or ruining someone's life, attempts to act as the nurse's therapist, and divided opinions). Without proper administrative support, the staff can destroy the workplace

PRIOR TO INTERVENTION

It is often helpful to consult with the MONA Peer Assistance Program prior to intervention. Often, assistance

regarding suggestions for the plan of action and Peer Assistance Program-approved treatment resources can be provided. We at MONA are interested in supporting nurses in obtaining the help they need. We encourage you to call if we can be of further assistance: 573-636-4623, extension 228.

INTERVENTION/MOTIVATION

Determining the timing of the intervention with the nurse involved is sometimes difficult. Motivating the nurse to seek help is apt to be more effective as you have more data and can involve people who truly care about the nurse in the intervention. It is advisable to have a recovering nurse assist. Intervention/motivation is easily the most difficult aspect of the process and even experienced persons sometimes fail to achieve the goal of getting the nurse "out of practice and into treatment."

Guidelines to intervention/motivation are:

1. Allow sufficient time. Arrange a conference when there is plenty of time for all to express their feelings. Don't allow interruptions or take phone calls. Provide a comfortable environment.

2. Use a partner. Be sure to have at least one person present when you talk to the nurse. "Two heads are better than one" definitely applies to this problem. This team approach provides moral sup port as well as some one with whom to validate your actions and compare impressions. If possible, ask for the assistance of a recovering nurse who can empathize with the nurse being con fronted, cut through the inevitable denial (you can't con a con), and offer living proof that recovery is possible. Or, you may ask a friend of the nurse or a co-worker involved in the data collec tion to join you for this conference.

3. Introduce the issue. Indicate an existing problem and express concern. This may begin in a number of ways, such as:

   "I've asked you here to discuss some problems that have come to my attention. I'm concerned about your job performance."

   "You've been one of our best nurses, and although nothing serious has happened, some changes seem to be taking place. The staff is concerned about your health."

   Be objective. Report your data to the nurse objectively:

   "You've been absent three days and late twice."

   "Two patients have complained about not getting relief from their analgesics."

   "I notice that you always seem tired and don't dress as neatly as you did before."

   "When I phoned, your speech was slurred."

4. Focus on job performance. Although you may have heard through the grapevine some additional data that are influencing your perceptions (e.g., that he or she really ties one on every Saturday night), stick to your role of supervising job performance. Do not cloud this issue with side events or attempts to change values or lifestyles.

5. Wait for a response. Offer an opportunity for response. Examples: "I wonder if you're ready to talk about this problem" "Has this happened to you before?" "I wonder if something is wrong." "What happens when you try to decrease your pain meds?"

6. Listen to the nurse's story. Do not accept lies, elaborate excuses, promises to do better, sob stories, pleading, or accusations of mistreatment. Do not argue, become defensive or judgmental. After all, denial and anger are the most common reactions to intervention and should be expected. Do listen to feelings, stresses which may be contributing, and any indications of readiness for help.

7. Stick to the issue. Refocus on the immediate problem, not its causes. Getting too deeply into personal problems can be counter-productive at this point. At this point your partner may take over, you may reiterate your position, or state your impression of the data which you have already presented. This should be worded carefully.

8. Avoid terms such as alcoholic, addict, or junkie. The use of these terms during an intervention may heighten denial.

9. Use "I" messages to share your own feelings or interpret their actions rather than an authoritative diagnosis.

   Supervisor: *Do not say, "You're an alcoholic."*
   Say: "I'm concerned that you may have an alcohol problem."

   Nurse: "Oh, it's mouthwash."

   Supervisor: "It smells like alcohol. I'm feeling there's a connection between what I smell and the fact that you are behind in your work," or "I'm afraid that you're using drugs."

   Nurse: "Why on earth would you say that?"

   Supervisor: "I just have that feeling..." or "we highly suspect...."

10. Suggest a plan. Simply offering help is not effective. If you have done your homework, you have some solutions to offer: a revised schedule to provide time off, general information regarding treatment programs, insurance and agency policies, an appointment at a treatment center ("I know a place where they can help you") and the name and number of the MONA Peer Assistance Program.

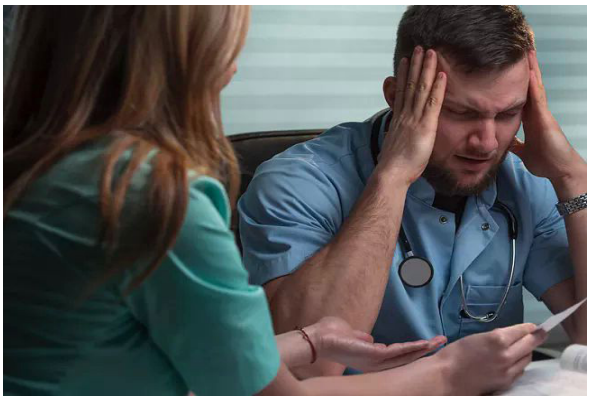
11. Apply pressure. Statements such as "It's going to catch up with you sooner or later," or "We can't risk patient care" may be effective, but more often the nurse seeks treatment only when the consequences of not doing so are greater than the fear of doing so, i.e., when job and/or license are directly threatened. This is usually a stronger motivator than concern for personal health.

    Clear any ultimatums with administration before using them. Identify choices for correcting the problem. Be very clear and firm regarding expectations, consequences, and time limits.

12. Document the meeting. Document the time of the meeting, who was present, and the agreement that has been reached as well as stipulations and consequences if the agreement is not followed.

13. Follow up or follow through. If the nurse agrees to treatment, follow up to be sure of his or her follow-through. Some managers use a contract in which the nurse agrees to treatment compliance. Do not offer chance after chance or allow the nurse to resign and take the problem to another institution. If you are unable to motivate him or her to seek help, follow through on the consequences agreed upon.

REFERRAL



It is usually best not to admit the employee as a patient in the agency where employed. Before making a treatment referral, investigate facilities and services available. The more specifically the program applies to the situation, the more effective it appears to be. A program designed for substance abuse is usually preferable to a general psychiatric unit or psychiatrist. Many programs are primarily designed for drugs or alcohol, although they may accept both. Programs that have treated nurses and other medical professionals are most effective. Call the MONA Peer Assistance Program for approved treatment resources in your area utilized for chemically dependent nurses. Also, providing the nurse with information on the Peer Assistance Program is very helpful. This is a very frightening time for the nurse and reassurance, support, and providing information is vital.

IF THE NURSE REFUSES ASSISTANCE

It is your professional obligation to report your concerns to the Missouri State Board of Nursing (MSBN): 573-751-0681.

CHAPTER 4

CODEPENDENCY

Codependency is a term that refers to the maladaptive and/or immature responses, behaviors, and feelings exhibited by someone who is in a relationship with a person who is chemically dependent or has some other serious dysfunction or addictive disease (e.g., compulsive gambling, compulsive lying, workaholism, sexual addiction, chronic illness, chronic pain, etc.). Many professionals consider codependency a disease that is treatable. In fact, there are a growing number of chemical dependency treatment programs that offer a separate treatment program for the codependent.

The major symptoms of codependency are a self-esteem that relies on how much the person feels needed by others and the person's ability to control others. Codependents assume responsibility for others, often neglecting themselves and their needs. They often become involved in unhealthy relationships with chemical-dependents, or with those who exhibit other seriously dysfunctional behavior. Such relationships cannot meet even normal needs. Codependents have unrealistic expectations of themselves and others that cannot be met. As a result, the codependent is consistently disappointed and frustrated, experiences anxiety, often gets depressed, may develop compulsive traits, and rely on denial as a defense mechanism to keep functioning. If these feelings and behaviors continue without treatment, the codependent can become debilitated to the point of being unable to function. There are many sources available for those who desire more detailed information about codependency. Call MONA to find out more.

The profession of nursing is especially appealing to individuals whose self-esteem rests on their ability to take care of others. Considering that care-taking is one of the major traits of the codependent, it explains why a significant number of nurses are codependent. A behavior that the codependent nurse may exhibit is diverting drugs for the use of others. Such a nurse may not be chemically dependent him- or herself, but will divert drugs for friends or relatives who are chemically dependent or in need of analgesics because of uncontrolled pain. If a nurse is found to be diverting drugs for others, s/he must be confronted and offered the same treatment options as the nurse who is chemically dependent. Failure of the nurse to enter treatment should result in notification to the MSBN.

CHAPTER 5

REPORTING A COMPLAINT TO THE MISSOURI STATE BOARD OF NURSING

IMPORTANCE OF REPORTING

For the protection of your colleagues, yourself and your institution, suspicions of abuse should be shared. Liability increases when nurses suspected of abuse are retained on staff. In addition to the increased legal liability of keeping an impaired nurse on staff, "keeping the secret" is not in the best interest of the nurse. It may be confused as permission to continue abuse. Watch for a request to turn to you as confident or therapist, or an indication that the suspect thinks you can be manipulated, do not care, or are incapable of dealing with the situation. "Keeping the secret" allows the disease to progress towards the fatal stage.

Since drug diversion has been considered a felony criminal act of theft, many nurses have been reported to the police, arrested, and prosecuted through the criminal justice system. Unless a large volume of drugs is involved with evidence of trafficking, this action is of questionable benefit and usually unnecessary.

The Missouri Tort Reform Law RSMo 383.105, 383.110 went into effect January 1, 1987. As a result of this law, the Missouri State Board of Nursing (MSBN) promulgated a rule known as the Mandatory Reporting Rule. This rule requires hospitals, ambulatory surgical centers, and temporary nursing staffing agencies to report to the MSBN any final disciplinary action taken (not just for chemical dependency) against a Graduate Practical Nurse (GPN), Licensed Practical (LPN), Graduate Nurse (GN), and Registered Nurse (RN). Disciplinary action is defined in section 383.130, RSMo as any final action taken by the board of trustees or similarly empowered officials of a hospital or ambulatory surgical center, or owner or operator of a temporary nursing staffing agency, to reprimand, discipline, or restrict the practice of a health care professional.

Only such reprimands, discipline, or restrictions in response to activities which are also grounds for disciplinary actions according to the professional licensing law for that health care professional shall be considered disciplinary actions for purposes of this definition.

The only exemption to this rule is if a nurse is alcohol- and/or other drug-impaired and the employer is willing to take an active role in assisting and monitoring the nurse. In other words, if you as the employer are willing to confront the nurse regarding your suspicions, see to it that the nurse receives an evaluation for chemical dependency by a chemical dependency professional and follows the professional's recommendation(s), and allow the nurse to continue to work with an employment contract in place, you do not have to report this nurse to the MSBN. If the employer is not willing to take such an active role in the chemically impaired nurse's recovery from this disease and termination or resignation in lieu of termination results, this must be reported to the MSBN. By law, this report must be made within 15 days of the final disciplinary action.

REPORTING PROCESS TO THE MISSOURI STATE BOARD OF NURSING

Complaints may be filed by anyone with knowledge of the alleged violation. A complaint MUST BE IN WRITING and SIGNED by the person(s) filing the complaint. A complaint must allege a violation of the Nursing Practice Act. A detailed description of the alleged behavior which violates the Nursing Practice Act must also be provided in the complaint. The complaint should also include any documentation which supports the allegations. To determine if the incident may be a violation of the Nurse Practice Act (NPA), you may review Section 335.066, RSMo, at http://www.pr.mo.gov/nursing.asp.

The written complaint should include the following:

- Correct spelling of the nurse's full name (first and last).
- A detailed summary of each alleged violation of the Missouri NPA. Include the date of each alleged incident and the name of the patient involved. If the incident involves medication, include the name of the medication. Be very specific in describing the events.
- List witnesses to the incident(s) and contact information for each.

The person named in the complaint will be notified of this complaint and be given a copy of the complaint.

CONFIDENTIALITY
Based on State law, the Board cannot guarantee confidentiality of a complainant's identity. The complaint should be based on first-hand observations and/or personal knowledge and not hearsay statements obtained from others.

If the complaint is being submitted under the Mandatory Reporting Rule, this information must be received within 15 days of the final disciplinary action.

DISPOSITION OF THE COMPLAINT
The Investigations Administrator reviews the information submitted and determines if the Board has jurisdiction, if the complaint contains sufficient information to investigate, and if a violation of the Nursing Practice Act has potentially occurred. If so, the case is assigned to a Board investigator. The investigator interviews both the complainant and the licensee. Information is gathered from relevant sources, such as patient and personnel records. After all available information is collected, both positive and negative, the investigator prepares a report for the Board to review. If the Board has no jurisdiction or a violation of the Nursing Practice Act is not alleged, an investigation is not conducted and the complainant will be notified by mail.

HOW LONG DOES AN INVESTIGATION TAKE?
On average, an investigation takes three months to complete.

WHAT HAPPENS AFTER THE INVESTIGATION?
The Board of Nursing reviews the investigative report and decides how to proceed. The Board considers alleged violations based on the merits of each case and potential danger to the public. The threshold for imposing discipline is a violation of the Nursing Practice Act. If the Board finds that insufficient evidence exists or that no violation of the Nursing Practice Act occurred, the Board will take no action against the nurse. If a violation of the NPA occurred but the Board decides not to seek formal disciplinary action, the Board may issue a letter of concern, which is not considered a disciplinary action. The Board may decide to refer the case to legal counsel to file a formal complaint with the Administrative Hearing Commission seeking disciplinary action against the licensee. In all three situations, the complainant will be notified in writing of the final disposition of the complaint. The Board meets only four times per year and significant delays may occur during the legal process.

CAN MY COMPLAINT BE KEPT CONFIDENTIAL?
No. Based on state law, the Board cannot guarantee confidentiality of a complainant's identity.

WHAT INFORMATION IS AVAILABLE CONCERNING THE STATUS OF A COMPLAINT?
Section 620.010.14(7), RSMo, states, in part, "...complaints, investigatory reports, and information pertaining to any person who is an applicant or license ... are confidential and may not be disclosed to the public or any member of the public, except with the written consent of the person whose records are involved." No information can be released until formal disciplinary action has been taken. Because investigations and legal cases differ in complexity, duration, and priority, no definite timeframe can be given as to when the complaint process will be completed for any individual case. Generally, cases take a minimum of six months from beginning to end, while others may continue for years. Pursuant to Section 620.010.14(7), RSMo, the Board cannot give you any information on the rationale or basis for the Board's decision.

CAN A NURSE WHO HAS BEEN DISCIPLINED BY THE BOARD CONTINUE TO WORK AS A NURSE?
If the discipline is censure or probation, the nurse may continue to practice. If the Board suspends the nurse's license for a period of time, the nurse may not practice until the period of suspension is completed. A licensee may not practice nursing while their license is revoked. One year after the effective date of the revocation, the licensee may re-apply for a license with the Board of Nursing.

IS DISCIPLINARY ACTION PUBLIC INFORMATION?
Yes.

DISCIPLINING A LICENSE
Disciplinary action taken by the members of the MSBN can include censure, probation, suspension, revocation, or a combination thereof. Disciplinary decisions are considered public information and are published in the MSBN's quarterly newsletter.

Censure of a license is equivalent to a one-time discipline making the situation and decision of the MSBN open to the public. There is no on-going correspondence or monitoring done on a nurse who has been censured.

Probation means the nurse can continue to function as a licensed nurse with certain stipulations as indicated by the MSBN. An example of stipulations placed on the license of a chemically impaired nurse can include meeting with the MSBN members and/or staff, submission of a completed employer evaluation form, counselor update letter, and evidence of regular attendance at 12 step meetings (AA/NA/CA, etc.). Failure to comply with these terms could result in further discipline on the license. According to the Missouri Nurse Practice Act, this disciplinary term shall not exceed 5 years.

Suspension of a license means a nurse may not work in the capacity of a licensed nurse. The Missouri Nurse Practice Act states a term of suspension shall not exceed 3 years. The nurse can be expected to comply with conditions such as, while on probation, meeting with the members of the MSBN and supplying required documentation. Failure to comply with these terms could result in further discipline on the license.

Revocation is the permanent removal of a license. This person may not work in the capacity of a licensed nurse. The nurse must wait one year to reapply. In order to obtain a license to practice, the person must submit to the MSBN an application to sit for the licensing exam, be granted permission by the members of the MSBN to sit for the exam, and successfully pass the licensing exam. While this process seems impossible, there have been a number of Missouri nurses who have been successful in completing these requirements.

Disciplinary terms may be combined. For example, a license may be suspended for 3 years followed by 5 years probation.

The members of the MSBN take several things into account when considering the disciplinary terms. For example, due to the time delay between receipt of a complaint and actual discipline, the nurse may have completed an in patient treatment program for chemical dependency, be active in one or more 12-step groups, and be involved in "aftercare" or individual outpatient counseling. This type of information is utilized by the MSBN when making a disciplinary decision.

The process of disciplining a nursing license can result from the signing of a Settlement Agreement or issuance of a Disciplinary Order. Generally, the first step in disciplining a license is requesting MSBN's legal counsel to draw up an agreement stating the cause for discipline and discipline terms which is signed by the nurse and the MSBN Executive Director. Signature of this agreement waives the nurse's right to have a hearing before the Administrative Hearing Commission (AHC). Once the required signatures are obtained on the Settlement Agreement, the disciplinary terms apply.

If the nurse and the Board cannot agree to a Settlement Agreement, the Board will file a complaint with the AHC. The AHC has jurisdiction over a broad range of administrative and regulatory cases, including all the licensing boards. It is not unusual for a case to take a year to be heard. The nurse does not have any discipline on his/her license during this period of time and is able to work in the capacity of a licensed nurse without restrictions by the MSBN.

At the conclusion of the case, the AHC Commissioner issues his/her decision as to whether the MSBN has authority to impose discipline against the license in question. If the Commissioner rules in favor of the MSBN, the MSBN schedules a disciplinary healing for the next regularly scheduled MSBN meeting. The nurse has the right to appear at that hearing and present testimony and/or evidence concerning the appropriate discipline. At the conclusion of that hearing, the MSBN will make its decision as to discipline. Either party may appeal the AHC decision. The nurse may appeal the disciplinary decision of the Board.

The nurse may offer settlement terms to the MSBN at any point in the process of issuance of discipline. The nurse may tell the MSBN s/he would agree to alternate disciplinary terms or cause(s) for discipline. It is the MSBN's discretion to agree or not agree with the offered terms.

In the fiscal year 2007-2008, 33% of the cases the board closed were chemical dependency-related. The same was true in 2006-2007. Due to the growing concern by the members of the MSBN, alternative methods for dealing with chemically impaired nurses are under consideration by the MSBN.

If you have questions about the material presented in this chapter, please feel free to contact the MSBN office at 573-751-0068.

CHAPTER 6

RE-ENTRY FOR THE RECOVERING CHEMICALLY DEPENDENT NURSE

There probably is not an experienced director of nursing nor a nursing supervisor who has not faced the situation where an outstanding nurse is found to be chemically dependent. Nurses have moved from job to job because their supervisor or peers have failed to conform their behavior. Reluctance may stem from fear of having to report this nurse to the MSBN. The irony of this situation is that the MSBN encourages the employer to intervene to prevent reporting of the recovering nurse to the MSBN. The Mandatory Reporting Rule, promulgated in response to the Tort Reform Law, states if the employer is willing to perform an intervention and monitor the recovering nurse's treatment and recovery program via an employment contract, the nurse DOES NOT have to be reported to the MSBN for possible discipline.

Terminating chemically dependent nurses without providing intervention, treatment, and monitoring options is costly to the nurse involved, the employer, and the profession. According to LaGodna and Hendrix (1989), the cost to the employer for early counseling by the nursing supervisor, an institutional investigation, termination, reporting to and participating in proceedings of the MSBN, conducting conferences with the remaining staff, and hiring a replacement totals $17,867.00. The cost to the chemically dependent nurse for lost income and court proceedings totals $31,953.00. The professional regulatory agency's cost for investigation and hearing of this termination is estimated at $4,300.00.

The total estimated cost per nurse is $54,120.00 (LaGodna and Hendrix, 1989). Of this figure, 59% of the cost is borne by the nurse, 33% by the employer, and 8% by the professional regulatory agency. These figures demonstrate the value of retaining nurses whose practice has been compromised by chemical dependency, avoiding the cost of turnover, and the loss of experienced practitioners.

Returning to employment in nursing is usually the primary goal of a chemically dependent nurse's intervention and treatment. As the employer of a recovering nurse, you should begin planning for this nurse's return to work as soon as the nurse enters treatment. Initially, the employer should consider their facility's policy regarding professionals in recovery and your commitment to providing the best situation for the recovering nurse to work in. Conferences may be held with this nurse's peers to teach them about chemical dependency and recovery, and to allow them to express their feelings.

As the recovering nurse prepares for discharge from treatment, the employer may be asked to participate in a conference to discuss the treatment team's recommendations and develop an employment contract. Many programs will recommend the recovering nurse not have access to mood-altering drugs for a minimum of six (6) months to one (1) year. MONA recommends a minimum of six months without access to controlled substances once the nurse returns to work. Following this six-month period, conferences with the immediate supervisor and treatment professional are recommended prior to authorizing return to administering controlled substances. Often, employers feel they cannot continue to employ a nurse who cannot have access to controlled drugs. However, the recovering nurse may develop a system where treatments and administering controlled drugs may be exchanged to make a more equal patient assignment. For example, the recovering nurse's peer will assume responsibility for administering any controlled drugs to the recovering nurse's patient(s), and the recovering nurse will assume responsibility for treatment of the peer's patient(s). Other units may assign the charge nurse with the responsibility of administering controlled drugs to the recovering nurse's patients.

Not all recovering chemically dependent nurses are ready to return to the clinical area at the completion of treat-

ment. Some nurses may be encouraged to assume other positions until additional recovery time is achieved. Once again, the benefit is retention of an experienced professional and providing support to the nurse. Developing a return-to-work contract outlining expectations regarding guidelines and work standards can be an effective re-entry tool.

Only those persons who really need to know should be informed of the nurse's illness and recovery. Many recovering nurses will initiate a discussion or peer meeting and be comfortable about this. Anxiety of the re-entering nurse may center on who to tell, who to turn to in time of need, handling narcotic keys and drugs, social events with alcohol, holidays, and negative comments about patients who abuse. An atmosphere of friendly support is helpful, along with the recognition and understanding that the commitment of sobriety must be a lifelong, daily priority.

RETURN-TO-WORK GUIDELINES

Experience has demonstrated that the following recommendations provide the structure and support necessary to help the chemically dependent nurse remain in recovery, ensure quality care for patients, and decreased liability for the employer. These guidelines should be used in conjunction with the return-to-work contract see samples in Appendix A).

1. Assign the recovering nurse to the day shift if possible. Other shifts are acceptable pending careful evaluation of the circumstances, i.e., familiarity of co-workers on the shift with the fact that the nurse is recovering. Shift rotation is highly undesirable.

2. Avoid “PRN," "floating," or overtime. The nurse should work only on regularly assigned units, and should not be used for coverage on other units. Overtime is not recommended. This, however, is negotiable up to eight hours in any two-week period, dependent upon individual and/or situation.

3. Assign to a unit with little or no drug availability whenever possible. However, if this is not possible, utilize a "buddy system," with the recovering nurse giving additional nursing care in exchange for administration of mood-altering medications.

4. Facilitate employee's return to work by staff education about alcoholism and drug addiction among health care professionals. If the recovering nurse is returning to a unit where s/he was identified as chemically dependent, it is therapeutic to have a session to allow peers an opportunity to express feelings of guilt, anger, betrayal, relief, etc.

5. Avoid high stress areas such as ICU, ER, L&D for six months to one year. Some exceptions may be considered, i.e., returning to an area where the recovering nurse is already known and accepted, and/or are the primary areas of the nurse's expertise.

6. Recommend witnessed random drug screen testing. Most treatment centers recommend such testing. However, the final decision to do so should be based upon recommendations from the treatment facility. If such testing is to be a part of the recovery process, it should be stipulated in the return-to-work contract.

RETURN-TO-WORK CONTRACT

Developing a return-to-work or employment contract should be done by the employer, but contain the treatment team's discharge recommendations for the recovering nurse. The contract should address the following issues:

1. Abstinence from all mood-altering chemicals.

2. Regularly received documentation confirming attendance and participation in aftercare and/or outpatient counseling sessions.
3. Agreement to attend and participate in a specified number of 12-step meetings per week.

4. Compliance with any additional recommendations from the treatment team.

5. Agreement not to use any prescribed medications without approval of a designated primary physician who is aware of the recovering nurse's history and knowledgeable about chemical dependency.

6. Agreement to submit random urine or blood samples upon request of the employer.

7. Information regarding the consequences of non-compliance with the contract and resignation from the facility.

8. Information regarding timeframes for duration and review of the contract.

Agreement to the return-to-work contract sets up an open communication for the employer, counselor and recovering nurse. The contract allows the participants to know ahead of time their responsibilities, and what the consequences of non-compliance are. It should be clearly stated in the contract that failure to comply with the contract terms will result in termination and reporting of the nurse to the MSBN.

The immediate supervisor should make contact with the Peer Assistance Program staff to discuss re-entry and to obtain additional information.

Intervening and monitoring a recovering chemically dependent nurse provides a cost savings to the employer, allows the facility to keep an experienced nurse on staff, and provides support and encouragement to the nurse throughout the recovery process.

CHAPTER 7

RELAPSE

Chemical dependency is a chronic progressive disease. During the process of recovery, relapse can occur. Relapse results in additional problems for both the chemically dependent nurse and the nurse administrator and leads to examination of attitudes and feelings about the relapse and what has transpired.

If the nurse administrator has been working with the nurse for a period of time, the nurse administrator may feel angry and frustrated and want to give up. One reaction is for the nurse administrator to mentally conclude that because the nurse drank or used, the situation is hopeless and that the nurse should be terminated. On the other hand, the nurse administrator may have the attitude that occasional relapse is to be expected. With this attitude the nurse administrator is, in a sense, giving permission to the recovering nurse to relapse. Neither of these attitudes are helpful.

Relapse should be viewed with the same degree of concern as an attempted suicide. There are no rational reasons for relapses. Signs, symptoms, and attitudes which alert the nurse administrator to a recovering nurse who is at high risk for relapse include:

- Negative attitudes "I just don't care."
- Inability to face daily job-related stress and problems that may arise (repression of feelings, i.e., inability to express anger appropriately)
- Denial: "If I just quit using, everything would be perfect."
- Feeling powerful: "I can handle it."
- Decreased attendance at support groups
- Increased use of excuses for failure to follow through with treatment recommendations
- Isolation from and avoidance of coworkers and others
- Return of dysfunctional behavior and thinking

It is extremely important that the nurse administrator does not become judgmental. It is equally important that the nurse administrator remains objective and provides hope if the nurse truly desires sobriety. There are times when the nurse may relapse despite the nurse administrator's support. It is important that nurse administrators avoid the trap of feeling they are responsible for the relapse. No one is so powerful as to cause or prevent someone else from drinking or using. The nurse administrator's role is one of providing help and assistance, and it is the recovering nurse's responsibility to work his or her own program of recovery.

CONCLUSION

The Missouri Nurses Association has a commitment to promote awareness regarding the problems of substance abuse among nurses as well as provide resources and support for those who are chemically dependent. Activities are being directed to educate nurses and those who employ nurses as well as to suggest alternatives to disciplinary proceedings.

Both MONA and the MSBN recognize the value of developing an appropriate alternative to disciplinary proceedings when dealing with the chemically impaired nurse. Therefore, MONA and MSBN have joined in a collaborative effort to work toward that goal. UNDERSTANDING CHEMICAL DEPENDENCY AMONG NURSES: A GUIDE FOR NURSING ADMINISTRATORS (2nd Edition) is a continued effort to assist nursing administrators to confront the complex problem of chemical dependency in the workplace. It is hoped this manual will provide safeguards for patients and optimal care and resources for the nurse. Again, for further information or assistance, please call the Missouri Nurses Association: 573-636-4623.

APPENDIX A

Sample 1

OREGON NURSES ASSOCIATION
Sample Return to Work Agreement

This agreement constitutes the conditions for return to work or continuing to work and the continuation of employment for _____(Name)_____.

Each requirement listed below must be adhered to or disciplinary action, including termination, may result.

Conditions which must be met for continued employment:

1. You must meet all the standards for successful completion of the duties of your job. (List any deficiencies here with a closing statement such as: "Any failure to meet minimum standards shall result in termination.")

2. You will be subject to random drug/alcohol testing during the next 12 months. A positive test will result in immediate termination.

3. You will adhere strictly to the probationary requirements stipulated by the Oregon State Board of Nursing.

4. You will be placed on six months probation at which time administration will determine permanent status or extension of probation.

5. Any violation of this Return To Work Agreement may result in your termination.

_____ _____
Supervisor/Manager Date

I have read this Return To Work Agreement. By signing this document, I am acknowledging its terms and agreeing to the terms as set forth. I understand that any future violations covered in this document are grounds for immediate termination. Further, I understand that I can be disciplined, up to and including termination, should I violate other Hospital policy or rules not specifically addressed in this agreement. In consideration of continued employment, I agree to the terms of this agreement.

_____ _____
Employee Date

CONFIDENTIAL WHEN FILLED IN

APPENDIX A

Sample 2

THE JEWISH HOSPITAL OF ST. LOUIS
Employee Assistance Program
Agreement Between Employee and Jewish Hospital

_____ agree to the following terms as a condition to my continuing employment at Jewish Hospital. This agreement will apply for a period of two years, beginning on _____ and ending on _____.

1. If it should be determined that I am using any mood altering chemicals, (except under the direction of a physician who will keep the Employee Assistance Program informed as to reason and specific period of time), I will be immediately terminated and reported to the State Board of Nursing.

2. I agree to cooperate in any random urine check requested by Jewish Hospital. The results will be sent to the Employee Assistance Program. If at any time mood altering substances are found, I will be immediately terminated and reported to the State Board of Nursing.

3. I agree to follow a treatment prescribed program designed by the E.A.P. including attendance in AA, aftercare and regular meetings with the E.A.P. Coordinator. I will be responsible for giving documentation of attendance to the Employee Assistance Program and if I do not comply, either in attendance and/or documentation, I will be immediately terminated and reported to the State Board of Nursing.

4. If I should voluntarily terminate from Jewish Hospital, I agree to keep the Employee Assistance Program informed as to my compliance with prescribed program of aftercare, my address and place of employ ment. I further agree to inform my new employer of my condition and request my new employer to keep the Employee Assistance Program at Jewish Hospital informed of my progress. Unless other arrange ments are made which are mutually agreeable to the new employer and the Employee Assistance Program at Jewish Hospital, if the above conditions are not met, I will be reported to the State Board of Nursing.

The terms of this agreement have been explained to me and I have read and I understand the consequences and terms of this agreement.

_____ _____
(Employee Signature) Date

_____ _____
(Director of Nursing Jewish Hospital) Date

_____ _____
(EAP Coordinator Jewish Hospital) Date

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APPENDIX A

Sample 3 (cont.)

TERMS AND CONDITIONS OF RETURN TO WORK AGREEMENT

1. I agree to abstain completely from mood-changing chemicals except as prescribed by my primary provider, to notify my designated worksite monitor of such prescriptions, and to provide such documentation as may be required to verify a prescription.

2. I agree to provide a urine/blood sample* for drug screen, to be obtained in the presence of a qualified witness if the employer has documented reason to believe that I may be unfit for duty. The cost of the laboratory test shall be the responsibility of the employer. Positive urines will be cause for immediate assessment by my supervisor, Director of Nursing, and myself. Relapse may or may not result in termination. I will comply with peer assistance program drug screening requirements at my expense.

   *Note: During the course of this agreement, it is understood by the principals that no poppy seed products or herbal supplements will be ingested.

3. I agree to execute consent forms and/or medical authorization forms required for designated worksite monitor, treatment center, and/or statewide peer assistance program to obtain information and records needed to monitor my compliance with this agreement.

4. I understand that my continued employment depends not only on meeting the terms of this agreement, but also on the satisfactory performance of my job. My employer will monitor my job performance and an unsatisfactory performance evaluation may be grounds for my termination consistent with the general employment criteria for all employees.

5. I understand the responsibilities of my job and am capable of meeting those responsibilities. I agree to notify my designated worksite monitor if at any time I believe I am not capable of performing any of my required job functions.

6. I agree to meet with my clinical supervisor to review my performance and discuss any difficulties I may be having:

   Six weeks after execution of this agreement:_____
   and every _____ weeks thereafter for a period of _____ months.

   *Note: The Peer Assistance Committee recommends that these meetings be scheduled as follows: at 3, 6, 12, 18 and 24 months after employment. However, individual circumstances may warrant a different schedule.

7. The employer agrees to maintain this Agreement and other information relating to my chemical dependency in a confidential file separate from my personnel records. If I successfully complete this Agreement, the employer agrees to expunge this Agreement and all other reference to my chemical dependency from the employment records. This paragraph does not preclude the employer from making any appropriate entry in my personnel file.

_____ _____
Employee Name Employer Name

_____
Nurse's Representative
(Collective Bargaining Representative)

APPENDIX A

Sample 3 (Cont'd)

RESTRICTIONS ON PRACTICE

1. Experience of recovering nurses indicates that the successful recovering nurse's return to practice needs to be in a work environment supportive to recovery. The restrictions listed below are ones that have proven to be the most successful in providing this support.

2. The parties agree to the following restrictions. Each restriction should be initialed by the parties to indicate acceptance.

RESTRICTIONS (check only those that apply and initial below)

	Employer	Nurse	Representative
a. Day shift is preferred, but 3-11 shift is acceptable based on careful evaluation of the circumstances, i.e. staffing patterns, familiarity of co-workers with nurse's dependency, availability of daytime support/ group/therapy/aftercare meetings. Nurse will not work 11-7 shift for a minimum of one year.	_____	_____	_____
b. Shift rotation will not be permitted, i.e., must work the same shift, either days or evenings continually for one year.	_____	_____	_____
c. The nurse will work only on regularly assigned, identified, predetermined units and will not be used for coverage on other units, e.g. "PRN" or "floating" for one year. It is preferred that staff on the unit be knowledgeable and willing to work with a recovering nurse.	_____	_____	_____
d. The Nurse will not work any overtime or on call assignment for first six (6) months. After six (6) months, overtime and on-call assignments must be mutually agreed upon by employer, representative, and nurse.	_____	_____	_____
e. The nurse agrees not to work for multiple employers for one year.	_____	_____	_____
f. The nurse will not do private duty nursing or engage in any type of self-employed practice for one year.	_____	_____	_____
g. The nurse will not accept employment with temporary or supplementary agencies/registries/services, home health care, or other isolated areas of practice for one year.	_____	_____	_____
h. Access to mood-altering medications will occur only as mutually agreed upon by the nurse, employer, and representative.	_____	_____	_____

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APPENDIX B

TITLE 4 DEPARTMENT OF ECONOMIC DEVELOPMENT
DIVISION 200 STATE BOARD OF NURSING, CHAPTER 4 GENERAL RULES

4 CSR 200 4.040 MANDATORY REPORTING RULE

1. The Board of Nursing shall receive and process any report from a hospital or ambulatory surgical center concerning any final disciplinary action against a nurse licensed under Chapter 335 or the voluntary resignation of any such nurse against whom any complaints or reports have been made which might have led to disciplinary action.

2. Reports to the Board shall be in writing and shall comply with the minimum requirements as set forth in section 383.133.2 and this rule. Such information shall include, but not be limited to:

   a. The name, address and telephone number of the person making the report;

   b. The name, address and telephone number of the person who is the subject of the report;

   c. A brief description of the facts which gave rise to the issuance of the report, including the dates of occurrence deemed to necessitate the filing of the report;

   d. If court action is involved and known to the reporting agent, the identity of the court, including the date of filing and the docket number of the action;

   e. A statement as to what final action was taken by the institution; and

   f. The Board of Nursing will assume that all reports received from hospitals or ambulatory surgical centers will be treated as under 383.133.

3. Any activity that is construed to be a cause for disciplinary action according to section 335.066 RSMo (1986) shall be deemed reportable to the Board. Nothing in this rule shall be construed as limiting or prohibiting any person from reporting a violation of the Nursing Practice Act directly to the State Board of Nursing.

4. In cases where a nurse voluntarily submits to an employee assistance program or to a rehabilitation program for alcohol or drug impairment, this action is exempt from the reporting requirement provided that participation in the employee assistance program or rehabilitation program is a part of the nurse contract with the nurses current employer.

5. In response to a written or verbal inquiry from a hospital or ambulatory surgical center regarding reports received by the Board regarding a specific nurse, the Board shall provide the following information:

   a. Whether any reports have been received.

   b. The nature of each report.

   c. The action which the Board took on each report or if the Board has taken action on the report.

6. Each report received shall be acknowledged in writing. The acknowledgement shall state that the report is being reviewed by the Board or is being investigated and shall be referred to the Board or an appropriate Board subcommittee for consideration. The institute shall subsequently be informed in writing as to whether the report has been dismissed by the Board, or is being referred to legal counsel for filing with the Administrative Hearing Commission, or for other legal action. The institution may be notified of the ultimate disposition of the report excluding judicial appeals.

Auth: chapter 335, RSMo (1986). Original rule filed August 5, 1987, effective November 12, 1987. Amended: filed January 8, 1988, effective April 28,1988.