Recognizing Impairment in the Workplace

Presented by Clinical Learning 2021

This course meets the Florida Board of Nursing 2.0 contact hour requirement, meant to be completed after 08-01-17 and every other biennium (every 4 years) thereafter.

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Description

Designed to instruct nurses on how to protect patients and assist colleagues who are struggling with substance use disorder (SUD). Nurses will review legal and ethical professional obligations, gain a better understanding of the disorder, and learn how to encourage successful recovery outcomes.

Objectives

1. Clarify substance use disorder and signs of impairment in the healthcare environment.
2. Examine the role of the employer in promoting patient safety and providing assistance.
3. Determine the steps for mandatory reporting when impairment is suspected.
4. Explain the treatment programs available to support impaired practitioners.
5. Describe the successful recovery from substance use disorder and return to practice.

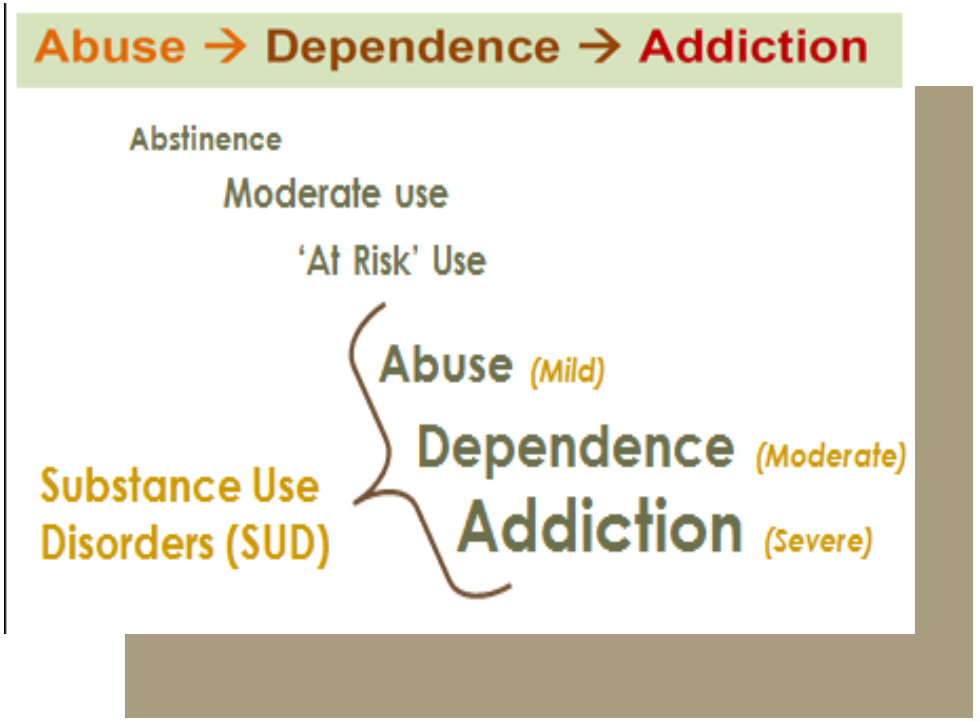
Terminology

The term impairment, as used in this module, relates to addiction or abuse of alcohol or other drugs. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms chemical dependency, substance abuse, substance dependence, or substance addiction. Instead it refers to substance use disorders, which are defined as mild, moderate, or severe. Substance use disorder is defined as the recurrent use of alcohol and/or drugs, causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder (SUD) is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. In terms of the health professional, the implications include placing patients at risk.

The following is a list of the most common substance use disorders in the United States.

Most Common SUDs:

- **Alcohol** *Use Disorder (AUD)*
- **Tobacco** *Use Disorder*
- **Cannabis** *Use Disorder*
- **Stimulant** *Use Disorder*
- **Hallucinogen** *Use Disorder*
- **Opioid** *Use Disorder*



Definitions

Hitting Bottom: A state of unbearable suffering which provides the motivation to change.

Impaired Nurse: Nurses are considered impaired when alcohol or drug use affects their cognitive, interpersonal, or psychomotor skills to the point where they can no longer satisfy their professional code of ethics or standards of practice.

Mild or Moderate Substance Use Disorder (formerly called substance abuse or chemical dependency): A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences.

Phenomenon of Craving: According to the book Alcoholics Anonymous, once an alcoholic takes alcohol into their system, it becomes virtually impossible for him (or her) to stop drinking.

Recovery from mental and/or substance use disorders: This is a process of change through which individuals practice *abstinence* and improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Severe Substance Use Disorder (formerly called addiction or alcoholism): The *mental obsession* with, and *compulsive use* of, mood-altering, addictive substances despite adverse consequences. *Denial* is one of the hallmarks.

Substance Use Disorder (SUD) (formerly called alcoholism, addiction, abuse, dependency): Defined as the misuse of, dependence on, and addiction to alcohol or to legal or illegal drugs, or both. SUD occurs along a continuum, a range of severity from "problem" through abuse, dependence, and addiction.

Substance Use Disorder in Healthcare

> ***"There is no medical cure, but recovery is possible."***

Healthcare workers are not immune to the risks of developing substance use disorders such as those related to alcohol, opioids, cocaine and marijuana. According to the 2011 report by the National Council of State Boards of Nursing (NCSBN), the prevalence of substance use among United States nurses is the same as that of the general population, affecting about *10 percent* of the total population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Additionally, a report in Current Psychiatry states that physicians have rates of addiction that are the same as those of the general population (Mossman, 2011). By the time the substance use disorder is apparent on the job, the disorder has progressed to the level of addiction, or severe substance use disorder.

Whether substance use disorder is due to legal or illegal drugs- and alcohol is a drug- it is a complex disease with serious physical, mental, emotional, financial and legal consequences. It can affect anyone regardless of age, occupation, economic circumstances, ethnic background or gender. *Alcohol* is the drug of choice for the general population, but nurses have increased access to controlled substances, contributing to a higher incidence of dependence on them. Substance use disorder is a progressive, chronic, and ultimately fatal disease that can be classified in a myriad of ways. For example, it is a *biological and mental illness; a harmful, destructive behavior; a dysfunctional emotional response; and a spiritual and social concern*. There is no medical cure, but recovery is possible. The earlier a nurse with substance use disorder is identified and treatment is started, the sooner patients are protected and the better the chances are of the nurse returning to work.

Signs of Impairment

To work while impaired means that one is working under the influence of a substance, mental or emotional condition, or physical illness that causes that person to not function at the level of acceptable practice. However we focus here on SUD, which can quickly lead to deterioration in performance. Since the early 1980s, impairment has been recognized as a common and serious problem in healthcare by the American Nurses Association.

The nurse manager and coworkers may miss the signs of SUD because of societal stereotypes, biases, and the stigma associated with addiction and alcoholism. Substance use disorders come prepackaged with shame, secrecy, and guilt. Health professionals are perhaps better equipped than the general population to keep their substance use well hidden. After all, many of us associate addiction and alcoholism with unemployment, homelessness, lack of education, and perhaps low income. It's no wonder we consider other explanations when a nurse exhibits SUD behaviors. In fact, many nurses with SUD are unidentified, unreported, untreated and continue to practice, endangering both patients and themselves. Loyalty, guilt and fear often prevent a nurse from reporting a coworker to the nurse manager, but all nurses have a professional and ethical responsibility to report in order to ensure the safety of patients and possibly save the life of the nurse or physician. Prompt reporting will serve as a safeguard to prevent patient harm, and will help the nurse receive immediate care and treatment. Once a report has been made with the nurse manager or Human Resource department and patient safety is at risk, action by the manager should *be taken immediately*.

It's not always easy to recognize unsafe practices in a nurse with a SUD. It can be difficult to differentiate between the subtle signs of impairment and stress-related behaviors. Three domains to examine are behavior and attitude changes, physical signs and possible drug diversion. These observations also serve as the basis for reporting the possible impairment of a coworker. When nurses are abusing pain medication and are unable to obtain them legitimately, they may turn to the workplace to access narcotics.

> ***"Loyalty, guilt and fear often prevent a nurse from reporting a colleague to the nurse manager."***

Signs of Impairment

Changes in Job Performance

- Being missing from the unit for extended periods
- Frequent trips to the bathroom
- Arriving late or leaving early
- Making mistakes, including medication errors

Attitude Changes

- Blaming vague 'personal problems' for poor performance
- Decreased concern for patient well-being
- Increased absence from functions or duties
- Patient complaints about care and bedside manner
- Indifference to telephone calls or patient needs
- Inappropriate verbal or emotional responses

Impaired Behaviors

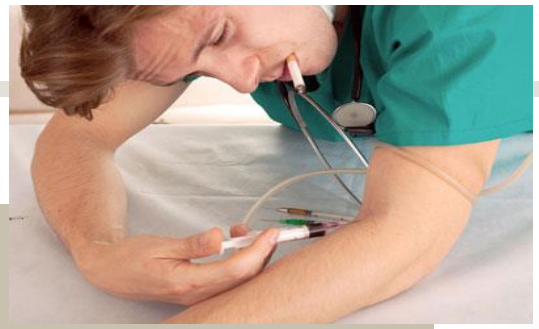
- Confusion, memory loss, and difficulty concentrating
- Difficulty with authority
- Elaborate excuses
- Frequent or unexplained tardiness, absences, illness
- Ordinary tasks require greater effort
- Poorly explained errors, accidents or injuries

Physical Changes

- Appearing sleep-deprived
- Neglectful of appearance
- Increasing isolation from coworkers
- Diminished alertness, confusion, memory lapses

Signs of *Diversion*

- Altered medication orders
- Reports of ineffective pain relief from patients
- Incorrect controlled substance counts
- Large amounts of controlled substance wastage
- Numerous corrections of medication records
- Very high narcotics usage
- Refuses drug testing (*Immediate dismissal*)
- Severe mood swings, personality changes
- Underperformance
- Visibly intoxicated
- Wearing longs sleeves when inappropriate



Reporting Impairment

When reporting signs and symptoms of impairment, *objectivity* is essential. Do not offer opinions, recommendations, or suspicions. Instead, be factual and unemotional, as in the e-mail examples on the next page.

In the acute care setting, we fulfill our duty to report possible signs of impairment by notifying the nurse's leader, or in the case of impaired physician, the chief medical officer. The report should always be in writing or electronic, as in an e-mail or through an incident report. Since the confidentiality of the healthcare provider must be protected, leaders are not obligated to share private information regarding outcomes or actions taken. The leader and entity is responsible for investigating and referring to the Board of Nursing or Medicine if impairment exists.

In the case where no action is taken and patient safety continues to be compromised, you may report directly to the specific state board. Note that although our primary commitment is to protect the health, safety, and rights of the patient, we are also obligated to assist the impaired nurse. The *stigma* of substance abuse is a major reason nurses and other healthcare professionals are hesitant to admit to and seek help for the treatment it requires.

Your documentation may save the life of the impaired nurse, physician, and/or patient. Leaders are not in the position to directly observe for signs of impairment; they depend on all of us to report observations. We are required to report when patients are at risk; failing that, we may be subject to disciplinary action by the Florida Board:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition.

(k) **Failing to report** to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board; however, if the licensee verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the licensee is required to report such person only to an impaired professionals consultant.

Reporting Examples

Jenny Nightingale, BSN, RN, CMSRN
Coral Gables Hospital
Methodist Health South Florida

Janet_Jackson@MethodistHealth.net
Manager, Telemetry Unit 16

5/16/2019

Dear Nurse Manager,

While working with Florence Smith last night (May. 16, 2019), I noted that she seemed distracted and easily confused, with frequent trips to the bathroom. I received complaints from two of her patients who stated that "I haven't seen her all night". When I questioned her about it, she said she was nauseated and not feeling well. I noted drops of blood on the sleeves of her sweater. Her speech was mildly slurred and slow; I did not smell alcohol on her breathe and she was not stumbling. I offered to find coverage so that she could go home, but she adamantly refused. When the nursing supervisor completed the narcotics count this morning, there were unexplained discrepancies. Unfortunately she had already punched out and gone home.

Sincerely,

Jenny Nightingale

Jenny Nightingale, BSN, RN, CMSRN
Coral Gables Hospital

FLORENCE SMITH, MSN, RN-BC
CORAL GABLES HOSPITAL
METHODIST HEALTH SOUTH FLORIDA
PHONE: (555) 555-0125 | FSMITH@METHODISTHEALTH.NET

July 3rd, 2020
Nurse Manager, Telemetry 16
Coral Gables Hospital

Dear Janet:

Twice this week I have worked with Jenny Nightingale in the overflow unit (12-12-20 and 12-13-20). Both mornings I smelled alcohol on her breathe and person. When I shared this observation with her, she said she had been out late drinking with friends and then took a sleeping pill. She complained of a bad headache, but after several trips to her locker she became animated although the smell of alcohol remained. One of the patients noticed it as well. Otherwise her behavior was normal and she seemed to take good care of the patients.

I just wanted to let you know, just in case.

Sincerely,

Take Care,

Florence

The ‘Disease’ of Substance Use Disorder

> ***“We miss the signs because of societal stereotypes, biases, and the stigma associated with SUD.”***

We can begin to understand addiction by calling it a disorder rather than a disease. The term ‘disease’ implies that it can effectively be treated using a traditional medical approach. According to Chapter 458 of the Florida Statutes, “practice of medicine” means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition. This applies to the medical aspects of substance use disorder, such as the patient hospitalized for an accidental overdose, detoxification, esophageal varices, cirrhosis, or injuries sustained while driving under the influence. Unfortunately it doesn’t apply to the ***recovery*** from substance use disorder. These patients return to the hospital again and again in a cycle of self-destruction, resulting in frustration for those who care for them. For many of us, these experiences form the basis of opinions and stereotypes of what someone with substance use disorder behaves like and looks like, which is usually ‘not like me’. We are misled by appearances.

Substance use disorder does not discriminate. No one aspires to addiction or alcoholism, but it happens to people in all walks of life whether rich, poor, young, old, college educated or unschooled. It affects people of all races, cultures, sexual orientation, and lifestyles. It is not a moral issue but rather a combination of genetics, environment, upbringing, mental outlook, emotional maturity, coping skills, defense mechanisms, and spiritual development. It is not caused specifically by what happens to a person in life, but rather their dysfunctional response to life itself. It is not an issue of individual weakness or immorality.

Typically substance use disorder develops along a continuum, but whether it is classified as mild, moderate, or severe, it is all the same disorder. It is a chronic, progressive, and ultimately fatal disorder fueled by denial. Relapses are common, whether days or years apart. The majority of teenagers try drinking as a rite of passage into adulthood; we all play with fire when we choose to drink. There is no one cause of SUD, therefore there is no single treatment. Let’s look at what might set the stage for SUD development.

Remember learning about Maslow's Hierarchy of Needs in nursing school? According to Maslow, lower needs must be met before the individual will strongly desire or become able to fulfill the secondary or higher level needs. To ultimately achieve *self-actualization*, all the lower physical and safety needs as well as the need to belong and to have one's life matter in the world (self-esteem) must be present. In the absence of physical safety – due to war, natural disaster, family violence, childhood abuse, mental illness, alcoholism, etc. – people may re-experience *post-traumatic stress disorder*. Children who grow up without having their most basic physical or safety needs met are prone to anxiety disorders as adults. Those who never experience a sense of belonging or sense of self may suffer mood disorders such as depression. Anyone who has ever observed children who cling to abusive parents witness how strong the need for love and belonging can be. Many people become susceptible to loneliness, social anxiety, and clinical depression in the absence of this love or belonging element. Some people look to get these needs met through a drink or drug, and the relief they find is profound. Unfortunately, because of the tolerance that develops, the 'solution' becomes problematic. Normal people with good self-esteem, a sense of belonging, and a purpose in life may enjoy a drink, but it's not a life-changing event. For them, drinking may enhance sociability, but does not have to serve to make life more bearable.

In 2015, the American Nurses Association published an updated version of the Code of Ethics for Nurses with Interpretive Statements.

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

3.6 Patient Protection and Impaired Practice

Nurses must protect the patient, the public, and the profession from potential harm when practice appears to be impaired. The nurse's duty is to take action to protect patients and to ensure that the impaired individual receives assistance. This process begins with consulting supervisory personnel, followed by approaching the individual in a clear and supportive manner and by helping the individual access appropriate resources. The nurse should extend *compassion and caring* to colleagues throughout the processes of identification, remediation, and recovery. Care must also be taken in identifying any impairment in one's own practice and to seeking immediate assistance.

Nurses must follow policies of the employing organization, guidelines outlined by the profession, and relevant laws to assist colleagues whose job performance may be adversely affected by mental or physical illness, fatigue, substance abuse, or personal circumstances. In instances of impaired practice, nurses within all professional relationships must advocate for appropriate assistance, treatment, and access to fair institutional and legal processes. Advocacy includes supporting the return to practice of individuals who have sought assistance and, after recovery, are ready to resume professional duties.

If impaired practice poses a threat or danger to patients, self, or others, regardless of whether the individual has sought help, nurses must report the practice to persons authorized to address the problem. Nurses who report those whose job performance creates risk should be protected from retaliation or other negative consequences. If workplace policies for the protection of the impaired nurses do not exist or are inappropriate- that is, they deny the nurse who is reported access to due legal process or they demand resignation- nurses may obtain guidance from professional associations, state peer assistance programs, employee assistance programs, or similar resources.

> ***"The nurse should extend firm compassion and caring to colleagues throughout the processes of identification, remediation, and recovery."***

Bobbie's Story

No one was more surprised than me to find myself in the IPN at 36 years old after 15 years of being an ICU and ED nurse. Here's my story, as told many years later:

I was born in a middle class neighborhood in a rural New England town. I was the second of five children and always believed I had a good childhood. My parents were born to farmers and did not get beyond high school. **My mother was emotionally unstable** *and prone to hysterics and depression; my father was stoic and never really expressed his emotions. He was a daily whiskey drinker, but he never appeared drunk. He went to work every day, never complaining. My mother was difficult and hard to please, and I assumed my father drank because of her. He died of liver failure at age 58, never able to accept his obvious alcoholism. I had always looked up to him, and had never thought of him as alcoholic either. After all, alcoholics are disgusting and homeless, right? Not gracious and dignified like my dad (or so I thought).*

I was obsessed with reading and did well in school. I was shy and liked to be by myself, although I did join the marching band. I never drank or drugged because I always felt like I needed to have my wits about me to stay safe (because of my mom, I realize now). I liked the feeling of being in control. I went to technical school after graduation to become an LPN, then soon after married my first boyfriend- an alcoholic/drug addict. I thought I could help him change, but I failed. He died in a motorcycle accident at 27 years old just a few weeks before his daughter was born. Shamefully, I felt relief because I didn't have to worry about his drinking and drugging anymore. I was working in a critical care unit at the time, and **kept my husband's alcoholism a secret** *from coworkers. No one knew about our chaotic home life, including my own parents.*

A couple of years later I married again, this time to a successful but mentally ill man. I went back to school and earned a BSN. I loved being a nurse and couldn't imagine doing anything else.

I became obsessed with my weight, running 25 miles a week. I learned how to pretend that my life was great. I never could ask for help and always felt alone. I wanted everyone to look up to me and think I had my act together.

When I was thirty I had minor surgery and sent home with pain pills. **Those pain pills made me feel better than I had ever felt in my entire life**. *The opioids made me feel happy, energetic, optimistic, and joyful. (Since being in recovery I often feel that same sense of euphoria, but without the help of pain meds.) I never realized that by suppressing my feelings- especially those of anger and fear- I also suppressed any feelings of satisfaction and love. Once I experienced that high from the pain pills, there was no turning back. Gradually I began stealing pills from the narcotics drawer, as my tolerance increased and I needed higher doses to get the same effect, until I needed the drugs just to feel normal. When I starting diverting and injecting IV morphine, I crossed what is called the 'invisible line', into addiction. This means that once I started, the craving for more became unbearable and uncontrollable. I couldn't stop until I injected everything I had, which was frightening. My* **self-hate became intense** *as I struggled to pretend I was okay.*

After six months of feeling trapped I took a position as critical care educator, thinking if I didn't have access to the drugs, I would be okay. I was depressed and miserable during this time. Then one day I was asked to help cover a few hours in the ED as a staff nurse, and soon found myself injecting morphine in the bathroom. I remember thinking that this time it would be fine, that I just needed 'something to take the edge off', ridiculous as that now sounds. The charge nurse tried to talk to me, but I left abruptly. My husband was out of town and my kids were sleeping over my sister's house. The next morning I was intervened on and sent to treatment, which I believe saved my life. I was deeply ashamed, yet at the same time relieved.

I had always had the sense that there was something really wrong with me, but I never dreamed it was addiction. Denial is an incredibly powerful- yet completely unconscious- ego defense. I did not know I was lying to myself. The first step in my recovery was to be honest and face the truth; **I was emotionally maladjusted and self-destructive**. *I had to 'hit bottom', which meant realizing that I couldn't live with the drugs, yet I couldn't live without them either. I understand completely now why my alcoholic/drug addict patients are so self-centered. The substance takes over their lives and makes all the decisions. I found I had to let my guard down enough to admit I was suffering so that I could begin to heal.*

My outside life today still looks pretty much the same, but my inner life is completely different. I apply the spiritual principles of the 12 step group I belong to and I am at peace with myself and the world. I can connect with others in a way I never dreamed of and have found meaning and purpose in sharing my experience, strength, and hope. So many people are suffering and dying from this disorder every day, so I do what I can for those who are able and willing to recover. It may seem strange, but I feel blessed to have become addicted because of my life today. I am glad I don't have to drink or take mind or mood-altering drugs (prescribed or not) to be able to live life on life's terms.* **I'm free!**

***The spiritual principles of 12 step programs are HONESTY, FAITH, COURAGE, INTEGRITY, WILLINGNESS, HUMILITY, GRATITUDE, LOVE, UNITY, & SERVICE.**

Alternative-to-Discipline Programs

As of 2016, virtually all state nursing boards refer the nurse with substance use disorder to an alternative-to-discipline program providing treatment and rehabilitation (Monroe, et al., 2013) in order help retain valuable healthcare professionals. In 2002, the American Nurses Association (ANA) recommended that all state nursing boards adopt alternative programs, shielding the nurse actively being monitored and engaged in recovery from disciplinary action.

The ANA and other professional associations report that a minimum of 10% of nurses are affected with substance abuse and mental health problems that can impact the ability to practice safely. As nurses, we are fortunate to practice nursing in a state that has a program to assist nurses with both mental health and substance abuse conditions. The Intervention Project for Nurses (IPN), an "alternative to discipline" program, offers support, referral for evaluation, coordination of appropriate treatment, and follow-up monitoring. The majority of nurses who receive assistance through IPN do so without disciplinary consequences or public notice on their nursing license, hence the term "alternative to discipline."

> ***"Substance use disorders come prepackaged with shame, secrecy, and guilt."***

Virtually all alternative programs adhere to the following criteria:

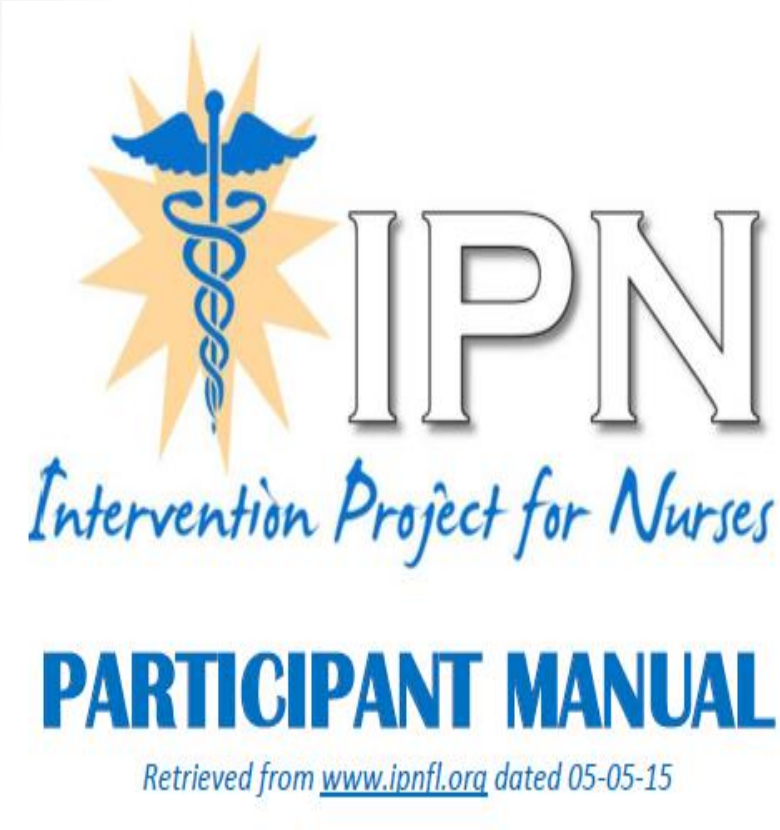
- ✓ Completion of a drug or alcohol treatment program.
- ✓ Restrictions on handling and administering narcotics for six months to one year or more, if applicable.
- ✓ Conservative work hours (no on-call, no overtime for 6-12 months, no night shifts, and no weekends.
- ✓ Mandatory daily call-in for random urine and/or hair follicle drug/alcohol screening for up to five years.
- ✓ Weekly documented support group meetings with other healthcare providers for 2-5 years.
- ✓ Documented weekly attendance of at least three Alcoholics/Narcotics Anonymous meetings for 2-5 years.
- ✓ Monthly self-progress reports to an IPN case manager.
- ✓ Disclosure to the employer and supervision while at work.

Referrals to IPN generally come from employers who identify a nurse who either has a positive pre-employment drug screen without a valid prescription, a drug or alcohol related arrest (driving while intoxicated), situations involving diversion, or behavioral signs of impairment. In other cases, courageous nurses may call for help themselves despite fear about what will happen. However, upon learning they are "not alone" there is often relief from the shame and secrecy the participant has been living with.

Once IPN is notified, the first step involves an evaluation to determine 'fitness to practice' and whether treatment, counseling, and monitoring are appropriate. Should there be a need for some form of treatment, IPN case managers will help coordinate resources that can appropriately assist the nurse. IPN acts as a liaison between the individual nurses and the treatment provider or program.

Nurses who participate in IPN attend weekly nurse support groups with other nurses in IPN; currently there are 150 nurse support groups in Florida. The sense of belonging and shared experience is most often cited by participants as most valuable to ensuring success. Facilitators are IPN trained, and in addition to providing education and support, keep up with attendance and progress of each nurse.

Once the nurse returns to nursing practice, IPN receives performance updates from the immediate supervisor which help establish ongoing safety to practice. IPN consistently tracks an 80% successful completion rate where everyone benefits. Patient care is protected from unsafe nurses while nurses are provided much needed help and support. *Note: A separate program, the Professional Resource Network, provides similar services for all other health practitioners other than nurses. PRN and IPN operate under contract to the Department of Health Division of Medical Quality Assurance.*



Admission to IPN by Order of the Board of Nursing

Board mandated IPN participation that is a "stayed suspension" of the nursing license or CNA license is considered discipline. This means the license has been suspended; however, the suspension will be lifted (stayed) when the Board office is notified of active status by IPN. The suspension will remain "stayed" as long as the IPN participant is compliant with all terms and conditions required by IPN. This allows a disciplined (suspended) nurse or CNA who is complying with IPN and who has been approved by IPN to return to practice. Failure to comply with the terms of IPN participation will place the nurse or CNA in violation of the Board Order, with subsequent termination from IPN and a report made to the Department of Health (DOH). The fact that discipline occurred by the Board will be part of the nurse's permanent record and will be available to future nursing employers.

- IPN seeks to protect and keep confidential the identity and personal information of program participants.
- IPN does not charge a monitoring fee for participation; however, a small urine drug screen administrative fee is collected as part of the drug screen total cost. There is an annual fee of $50.00 for the Relapse Prevention Program. You are responsible for all fees related to IPN participation including, but not limited to evaluation(s), treatment and continuing care (e.g., nurse support group fees, aftercare, therapy, etc.) as required by your IPN Monitoring Contract.

P.O. Box 49130 • Jacksonville Beach, FL 32240 • phone: 904-270-1620
To make a referral and/or confidential consultation: Call IPN @ 1-800-840-2720

Participant Manual continued on the next several pages……

EVALUATION AND MONITORING

The first step in your IPN entry process was completion of a thorough evaluation to determine treatment need(s) and monitoring specifics. IPN assisted you in obtaining an evaluation with an IPN approved evaluator. Once your evaluation was completed, IPN assisted you in accessing treatment as recommended. Upon completion of appropriate treatment your individualized monitoring program was determined. This is outlined in your IPN Monitoring Contract. Ongoing monitoring generally includes attendance at support groups and nurse support group, random drug screening, and completion of quarterly monitoring reports. IPN is responsible for monitoring both fitness to practice and progress in recovery.

EMPLOYMENT

When returning to work, you must:

A. Get approval from IPN for you to return to nursing employment.
B. Inform your prospective employer of your IPN participation when accepting any position.
C. Provide your employer with a copy of your IPN Monitoring Contract.
D. Have direct supervision by another licensed healthcare professional who is:
   - □ Aware of IPN participation.
   - □ Working on the premises or same unit
   - □ Readily available to provide assistance
E. Submit in writing to the IPN name of employer and immediate supervisor.
F. Obtain approval from IPN prior to starting employment or making any changes in nursing position.
G. You must inform IPN of any changes in employment immediately via phone and/or email.

Generally, upon return to practice, you may NOT:

A. Be self-employed in the healthcare field or work for multiple employers.
B. Work more than forty (40) hours per week.
C. Work for a staffing agency, in SUD treatment, home health settings or float to areas not supervised by your manager.

IPN “Return to Work” criteria used by treatment providers when assessing return to practice are:

- Stability in Recovery
- Support Systems
- Problem-solving ability
- Cognitive functioning & Judgment
- Ability to psychologically cope with stressful situations
- Decision making ability in a crisis

CONTROLLED SUBSTANCE/NARCOTIC ACCESS

In order to facilitate the recovery process and as a safety measure within the clinical setting, the IPN may require that participants refrain from dispensing controlled substances until approval is given by the IPN. Please see your individualized IPN Monitoring Contract, Part 1.

1. Generally, IPN participants may not have access to or administer any controlled substances for a minimum of twelve (12) months. An IPN participant who does not adhere to this requirement is subject to termination from IPN and a report will be made to DOH/FBON (Florida Board of Nursing).

2. Specifically, if it is stated in your IPN Monitoring Contract that your narcotic access is restricted, you may not have access to, administer, witness, waste, to include titrating, any controlled/locked (Schedules I-V) medication that is mood/mind-altering, for a period of one (1) year after you return to clinical nursing. You may not have access to any narcotic or controlled/locked drug that is mood/mind-altering via any automated narcotic delivery system (PYXIS or Sure-Med, etc.), hold the narcotic keys or count narcotics during this time. You must adhere to proper procedure to regain your narcotic access privilege.

3. IPN participants who refrain from clinical practice during the first twelve (12) months of IPN participation will have narcotic access restricted for a twelve (12) month period when returned to clinical practice.

4. After working for 1 year (12 months) in clinical practice and submitting four (4) favorable Work Performance Evaluations, the participant will be eligible for review for reinstatement of narcotic/controlled substance access.

REQUIRED MEETINGS AND MONITORING REPORTS

1. The Work Performance Evaluation and the Progress Evaluation provide IPN with ongoing evidence of your compliance and progress. It is your responsibility to inform your quarterly evaluators (work supervisor, Nurse Support Group Facilitator and treatment providers) of the dates when your reports are due in the IPN office. These evaluations are due every three (3) months (January, April, July and October) by the due date on the front of your IPN Monitoring Contract. It is strongly recommended that you retain a copy of all submitted paperwork for personal records and mail all required paperwork electronically. Failure to attend required meetings and submit reports when due will result in noncompliance, possible refrainment from practice and may result in your termination from IPN.
2. If required, attendance at Mutual Support Group meetings is specified in your IPN Monitoring Contract. IPN encourages you to develop a mutual support system within a group that is knowledgeable about substance use disorders or the issues that have caused problems in your life. This support system must:
    - Be readily available/accessible
    - Meet the times per week you are required to attend
    - Have a structured meeting format with a leader
    - Promote personal growth

3. Historically, twelve-step meetings fulfill these needs for the majority of IPN participants. In the event you would like to discuss alternative meetings, please contact your Case Manager.
4. Attendance at Weekly Nurse Support Group meetings is effective immediately unless otherwise directed by your IPN Monitoring Contract. Please give your Facilitator a copy of your Monitoring Contract. This meeting is required and may not be changed without the approval of IPN and the present Facilitator. You are required to participate in the structured monthly Relapse Prevention for Nurses (RPN) continuing education program provided to you by your Nurse Support Group Facilitator and IPN.
5. Attendance is required at aftercare therapy and/or other requirements as individualized per Monitoring Contract.
6. Employer Report is used in the assessment of your work performance by your immediate supervisor.
7. Facilitated Support Group Report provides an assessment of your general behavior, appearance, and progress.
8. Quarterly Evaluation form completed by any treatment provider of the nurse at the request of IPN.
9. Meeting Attendance Log of all 12-step and/or mutual support meeting(s) is done electronically.
10. Self-Report is required quarterly on all participants and must be done electronically.

USE OF MOOD-ALTERING CHEMICALS

1. IPN participants in abstinence Monitoring Contracts *are expected to remain free* of all mood-altering, controlled, or addictive substances to include alcohol, over-the-counter drugs and prescription drugs.
2. If there is a medical need for the use of any mood-altering chemical, you are required to inform your IPN Case Manger as soon as possible, either when prescribed or the next business day. You must submit a fully completed Medication Report form to IPN.
3. In the event a random drug screen is positive and you have not informed IPN of your medication use as required, your use of the medication will likely result in an evaluation.
4. You are to refrain from providing patient care when using any prescribed mood-altering medication until authorized to return to practice by IPN. A negative urine drug screen is required prior to return to patient care.
5. Medically necessary, frequent, or extended use of any mood-altering medications will require that an IPN approved addictionist be involved in your case to monitor your medication management.

THE LONG TERM USE OF MOOD-ALTERING MEDICATIONS FOR PSYCHIATRIC CONDITIONS

In rare cases a participant may require a mood-altering medication and/or controlled substance for the treatment of an ongoing chronic psychiatric condition. IPN encourages the participant who does not have a substance abuse and/or dependency diagnosis and who has been prescribed a mood-altering medication on a long-term basis for a psychiatric disorder, to look for non-addictive alternative medications if possible. If the continuing use of the mood-altering medication is required as determined by their treating physician, the IPN strives to ensure that the practitioner can practice with reasonable skill and safety with no harm to the public while taking the medication.

Given the disease concept of addiction as defined by the American Medical Association and the numerous non-addictive medication options, IPN does not support the use of mood-altering substances for the treatment of psychiatric conditions in IPN participants who also have a substance abuse and/or dependency diagnosis.

Relapse Considerations

SUD is chronic, non-curable illness characterized by periods of remission and exacerbation. In general, the rate of relapse among nurses is lower than in the general population because of the supportive programs and strict monitoring. *More than 75%* of the nurses who participate in the IPN program fully recover and successfully return to work. Usually nurses who are unable or unwilling to recover tend to give up nursing entirely. Unfortunately, not all are capable of recovery and some nurses do indeed relapse. If a nurse is unable to recover, action must be taken to protect patients.

Knowing how to manage relapse in the workplace is crucial for both the safety of patients and well-being of the recovering nurse. A relapse is essentially a recurrence (exacerbation) of active disease, and the signs of relapse are the same as the signs of impairment described earlier. If relapse occurs, signs will become apparent and will progress without intervention. In recovering nurses, there is usually a behavioral change noted before a break in abstinence occurs. Behavioral changes include such things as taking on more than one can reasonably handle, over-extending, complaining of pain, withdrawing from recovery support people and meetings, isolating, the return of denial thinking, and eventual substance use.

The same rule of thumb for usual employee performance assessment applies here. The nurse manager should continue ongoing 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 nurse's fitness to practice and to remove the nurse 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 nurse re-entering recovery (remission) are great. Once the nurse is stabilized and fitness to practice is determined, the 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. For confidential consultation and more information, please contact Intervention Project for Nurses (IPN) at (1-800) 840-2720.

Return to Work

Maintaining substance use disorder requires secrecy, isolation, and self-deception. In contrast, recovery from substance use disorder involves correction of thinking, behavioral change, and honesty with self and others. Full recovery must be holistic, encompassing all aspects of an individual's life. When offering support, it is helpful to recognize how vulnerable and exposed the returning nurse might feel. Here are some helpful tips:

- □ Be open and welcoming. SUD is not catching!
- □ View SUD as a treatable disorder and provide encouragement.
- □ Acknowledge that struggling with SUD is difficult.
- □ Be hopeful and optimistic.

"Welcome back! I know you've had a rough time, but it's so good to see you again."

What NOT to say:

- □ "It's not right what you're doing to your family."
- □ "You have everything going for you."
- □ "Stop wasting our time."
- □ "You need to grow up."
- □ "Think about your kids."
- □ "You're just being selfish."

Do I Drink Too Much? Self-Test

1. Do you try to avoid family or close friends while you are drinking?
2. Do you drink heavily when you are disappointed, stressed or have a quarrel?
3. Can you handle more alcohol now than when you first started to drink?
4. When drinking with others, do you try to have a few extra drinks they won't know about?
5. Do you sometimes feel uncomfortable if alcohol is not available?
6. Do you sometimes feel a little guilty about your drinking?
7. Has anyone expressed concern or complained about your drinking?
8. Do you often want to continue drinking after your friends say they've had enough?
9. Do you usually have a reason for the occasions when you drink heavily?
10. When you're sober, do you sometimes regret things you did or said while drinking?
11. Have you tried switching brands or drinks to control your drinking?
12. Have you sometimes failed to control or cut down on your drinking?
13. Have you ever had a DUI (driving under the influence of alcohol) violation?
14. Are you having more financial, work, school, and/or family problems from drinking?
15. Has your physician ever advised you to cut down on your drinking?
16. Do you sometimes have a little drink or tranquilizer in the morning to stop the shakes?
17. Have you recently noticed that you can't drink as much as you used to?
18. Do you sometimes stay drunk for several days at a time?

If you answered ‘yes’ to more than 4 questions, you are at risk for developing a problem with alcohol. To evaluate your use of drugs, go to the following website:
National Council on Alcoholism and Drug Dependence (NCADD) *Retrieved from* ***https://www.ncadd.org/***

If you think you might have a problem with alcohol or drugs:

- Ask for help. Addiction is an illness; you need help to recover. 12 Step mutual support groups, treatment programs, counselors, and substance abuse nurse organizations can help, but not if you don't ask.
- Don't wait until you resort to stealing, cheating, or lying to feed your addiction. Get help early. Your supervisors and peers will respect you for your efforts.
- Protect your nursing license. By getting help and staying clean, you protect what you have worked so hard to earn, in a profession you are proud to be in.
- Become an advocate. Help other nurses in your community with addiction issues. As stated previously, over 10 percent of nurses are addicted to drugs or alcohol.

The End

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