Managing people

Substance abuse in the OR: Saving lives through treatment, prevention

To outside observers, Mary Jones, RN, lived a charmed life: She was married to a bank owner, had 3 lovely children, and lived in a beautiful home overlooking a park. Colleagues in the OR where she worked enjoyed working with her. But Mary was hiding a secret: alcohol abuse. Over time, Mary started to become forgetful. She signed up for extra shifts, became a loner, and occasionally came to work with the alcohol on her breath. Staff would cover for her, attributing her problems to a recent divorce. No one could believe Mary had an addiction problem. To them, she didn’t fit their “profile” of an addict. Finally, Mary showed up inebriated and was taken to employee health services. She entered a treatment program and eventually returned to work. However, one day she came to work drunk and was terminated. Mary continued on a downward spiral until she died last year.

Although details have been changed for confidentiality reasons, Mary Jones is a real person. Her death left the staff and her manager feeling guilty and wondering if the outcome would have been different had they acted sooner.

“People need to speak up,” says Mary’s former manager.

Fortunately, most addicts successfully complete rehabilitation programs and don’t suffer Mary’s fate. What do those programs entail? And how can managers and staff contribute to a successful recovery?

Pathway to treatment

Cecil King, RN, MS, CNOR, a perioperative advanced practice nurse in recovery, says there are 3 stages of intervention. In early, and least likely, intervention, the clinician may choose to “cut back.” In the middle stage are clinicians who seek help on their own or with subtle pressure from others. Late intervention, which is involuntary, is often accompanied by legal, licensure, and financial complications.

Some addicts will vigorously deny their abuse problems even when faced with laboratory evidence.

“Sometimes you have to say, ‘If you’re not going for treatment, we’re going to terminate you,’” says King. “It’s tough love.”

The employee assistance program (EAP) is the first source of assistance for employees, but nurses often aren’t aware of them or fear them, says Marcia Rachel, RN, PhD, who worked at the Mississippi Board of Nursing (BON) for 17 years. “They don’t trust that the information will remain confidential.” Yet these can be valuable resources, says Jennifer Place, MA, CEAP, assistant director of workplace and EAP programs for Peer Assistance Services, Inc, in Denver, Colorado. Place provides case management for clinicians who seek help with addiction.

Depending on the situation, clinicians may begin with a residential (inpatient) followed by an outpatient program. King’s experience illustrates this combination approach: 10 days of detox, 28 days of inpatient treatment, and 6 months of outpatient therapy. Clinicians attend 12-step group programs, sometimes ones specifically designed for health care workers, and undergo random urine testing.

A recovery contract

“We put together a plan and hold them accountable,” says Place. Clients must sign a rehabilitation-monitoring contract with consequences, such as reporting to the client’s employer, if violations occur.
Union contracts may influence that agreement by giving additional protection to the impaired employee, says Nancy Brent, RN, MS, JD. For example, the agreement might require that a nurse still be paid even when suspended from his or her job for suspected substance abuse.

A nurse may enter a treatment program in several ways. The nurse may seek treatment on his or her own and if faced with a BON action, can state the treatment was undertaken voluntarily. The BON would use established criteria to evaluate the acceptability of the program.

Or the nurse practice act may include the possibility of the nurse entering treatment voluntarily under its established requirements of a treatment plan. For example, Ohio’s practice act contains specific requirements for the nurse to follow if this route is selected. In other cases, the BON may contract with companies like Place’s to provide these services.

Regardless of how treatment is obtained, if the recovery program is successfully completed, and the nurse adheres to any BON requirements concerning monitoring and continued aftercare once the treatment plan is complete, the nurse can return to the workplace.

The American Association of Nurse Anesthetists actively supports impaired certified registered nurse anesthetists (CRNAs) and provides links to treatment facilities on its website as well as a peer assistance hotline.

Physicians can turn to their state’s physician health program. These programs refer physicians to appropriate treatment and support and monitor recovery. Although addiction is a disease, it doesn’t absolve the person of responsibility. Treatment programs include new coping skills and understanding how to make appropriate choices. King gives the example of attending a function where alcohol is being served: “You have to ask yourself, do I have a legitimate reason for being at this event?”

Return to work

Most clinicians in recovery can return to work.

“Consequences such as loss of license and income are severe so they are highly motivated,” says Jackie Westhoven, RN, CEAP, EAP and workplace programs director at Peer Assistance Services, Inc.

But return doesn’t come without challenges. Managers’ concerns include whether the treatment worked and how to manage their relationship with the nurse and with the nurse’s coworkers.

Policy usually requires a fitness-for-work examination. Westhoven says the nurse’s counselor, the employee, and the manager work out the parameters and a contract for returning to work. Often nurses cannot handle narcotics for a specified time such as 6 months; for CRNAs this may be as long as 2 years. Urine testing is done on a random basis. Nurses must call in daily to a designated laboratory site to see if they need to be tested, and strict protocols for collecting the urine sample are followed.

The contract also includes factors such as increased supervision at work, more supervisory meetings, and restrictions for on-call duty. Westhoven says most contracts are at least 5 years, with restrictions easing as time progresses, and the nurse is doing well.

King says a good approach for the manager is to ask, “How can I support your return and recovery?” Be clear about expectations, be positive, and be fair. “Treat them with respect,” says Place. “This is not a bad employee.”

The issue of confidentiality

One major question is confidentiality. It’s difficult for news of the clinician’s “problem” not to leak out, leading to false rumors and tension among staff. Westhoven advises managers to see if the nurse is comfortable with sharing what’s going on with coworkers, saying something like, “I’ve been in treatment and need your help.” Westhoven says most nurses are usually willing to share, but if not, the information must remain confidential.

Brent reminds managers that in addition to HIPAA privacy protection, state and federal laws protect those receiving treatment for substance abuse. For example, not
only is disclosure about treatment prohibited, but redisclosure to a third party, even after consent is obtained from the patient for the initial disclosure, is prohibited without additional consent.

The American Disabilities Act (ADA) prevents discrimination against the clinician who is covered by the Act and in a treatment program, has successfully completed a treatment program, or is “regarded” as being a recovering clinician.

“If, as an example, they need time off to go to an AA meeting, managers probably need to ensure that that can happen under its duty to reasonably accommodate the individual,” Brent says.

She notes, however, that in recent years, the courts have narrowed the protections of the ADA. In several US Supreme Court decisions, the court has held that if treatment of an illness or condition can be “corrected” or “mitigated” by such things as medicine or devices (eg, eyeglasses), the person is no longer considered disabled and protected by the ADA. Therefore, if a clinician successfully completed a program, and part of the successful completion of the program is the requirement of taking a prescription medication that successfully prevents the individual from taking controlled substances or drinking, the clinician may not be covered under the Act because he or she may be seen as no longer disabled under these fairly recent Court decisions.

Your human resources and risk management departments are excellent resources to help you navigate this potential land mine.

Relapse is part of the disease, and the rate of relapse is high. “It takes time to change a life,” says Renae Battié, RN, MN, CNOR, director, intraoperative services, Swedish Medical Center, Seattle. Westhoven puts relapse into perspective saying, “Those with addiction don’t relapse any more than patients with diabetes or other chronic conditions who don’t follow their prescribed regimens.”

Monitoring may last from 2 to 5 years or more.

The staff’s role

Staff are usually the first to notice an impaired nurse or physician but are often slow to react. The manager can help staff to understand that they can’t be enablers. Staff (and managers) must stop denying the problem exists, hoping change will occur, protecting the person, covering poor performance, and worrying about hurting the coworker’s career.

When an impaired clinician is identified, staff may feel guilt, whether or not they were the source of the information. There is often sadness and shock that a coworker would engage in addiction patterns.

When the clinician returns to work, staff reactions may range from ostracizing the returning employee to overprotection. It’s up to the manager to set the tone and deal with inappropriate behavior from the staff, says Battié. “Watch for gossip and call staff on it when it occurs. You need to model the right behavior,” she says, acknowledging: “It can be an emotional roller coaster.” She suggests managers seek out their help from human resources for successful strategies.

Proactive education

Staff education programs on substance abuse can dispel myths and help clinicians understand the scope of the problem. Such programs include incidence, risk factors, and early signs and symptoms.

“You want to create a culture where people are encouraged to get help,” says Place. “The earlier the people get help, the more likely they will respond to treatment.”

It’s also important to help staff identify their own patterns of behaviors that may lead to addiction. “If people say, ‘I’ve had a tough day; I’m going out for drink,’” says King, “they need to understand that’s not appropriate coping.”

Saving a life

Battié, who is a friend of King, speaks with admiration of how far he’s come.

“He has had a tremendous amount of courage. It’s such a save for nursing and patients: We didn’t lose this very bright person. He’s a living reminder about how all the hard work is worth it to see lives restored and giving back to the professions.
in a positive way.” By acting promptly and assisting clinicians back into the workplace, managers can ensure fewer lives like Mary’s will be lost.

— Cynthia Saver, RN, MS

The first article in the series, “Substance abuse in the OR: Why managers should not ignore it,” appeared in the May 2008 OR Manager.

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References

Dunn, D. Substance abuse among nurses—defining the issue. AORN J. 2005;82:585-588;592-596.


Resources on addiction
Anesthetists in Recovery (AIR)
www.aana.com
Look under Resources, then Wellness and Peer Assistance.

American Society of Addiction Medicine
www.asam.org

American Academy of Addiction Psychiatry
www.aaap.org

International Society of Addiction Medicine
www.isamweb.org

International Nurses Anonymous
http://intnursesanon.org

International Nurses Society on Addiction
www.intnsa.org

Nurses in Recovery
http://brucienne.com/nir