TEXAS HOSPITALS:
A DESCRIPTION AND ASSESSMENT OF THEIR POLICIES TOWARD NURSES WHO ARE CHEMICALLY IMPAIRED

BY

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CHAPTER ONE

INTRODUCTION

Chemical dependence is an issue that has received a lot of coverage in the media for many years. Much of the media coverage addresses the illegal use of illegal drugs purchased illegally on the street. Another aspect of the issue of chemical dependence is the use of legal drugs either in excess or for inappropriate purposes. The health professions are vulnerable to the abuse of legal drugs. Doctors, pharmacists, dentists, nurses and veterinarians are at risk of becoming chemically dependent due to their access to drugs; their knowledge of the effects of drugs; and the stresses of their professions.

Nurses who become chemically dependent most often become dependent on legal drugs. The Texas Peer Assistance Program for Nurses (TPAPN) gathers information regarding the drug of choice of program participants. Registered nurses participating in this nurse recovery program most often report Demerol, alcohol or morphine as their drug of choice. The use of Demerol and morphine may have been initiated during a legal course of treatment with the medication.

In my position as Supervising Investigator for the Texas Board of Nurse Examiners, I have become familiar with cases involving registered nurses who have become chemically dependent. These

nurses' chemical dependence has resulted in the nurses violating the Texas Nurse Practice Act and facing disciplinary action by the Board of Nurse Examiners. In my position, I have also become familiar with the Texas Peer Assistance Program for Nurses. TPAPN offers a rehabilitative alternative to disciplinary action for nurses with chemical dependence problems. Nurses who successfully remain in recovery from chemical dependence through participation in TPAPN do not have disciplinary action taken against their license to practice nursing in the State of Texas.

CASE EXAMPLES

A couple of case examples are presented here to illustrate the manifestations of chemical dependence in the nursing profession and the types of cases that are referred to the Board of Nurse Examiners and TPAPN.

> Example #1 - A nurse working in an intensive care unit does not return from her scheduled lunch break. In searching for the nurse, it is discovered that one of the employee restroom doors is locked and there is no response to knocking on the door. Hospital security is called to gain entry into the restroom. Inside the restroom is a nurse. The nurse is unconscious. A tourniquet is tied on her left arm. The needle of a syringe is still in her arm. After vital signs are checked, the nurse is transferred to the emergency room for treatment. The nurse had diverted Demerol from the narcotic supply of her employer for her own use to satisfy her craving for the drug.

Example #2 - A staff nurse working on a telemetry unit is found by the charge nurse staring at a monitor. The monitor alarm is sounding. The staff nurse is not responding to the alarm. The charge nurse asks the staff nurse why she has not responded to the alarm. The staff nurse turns her head and mumbles something that is unintelligible. The charge nurse responds to the alarm.

Upon return to the telemetry monitor station, the charge nurse assesses the staff nurse. The charge nurse observes that the staff nurse has a glazed look in her eyes, her speech is slurred and her words do not make sense. The charge nurse finds another nurse to take over the duty at the telemetry station.

The charge nurse and the night supervisor take the staff nurse to an office to confront her about her inappropriate behavior. The staff nurse tells the other nurses that she has back pain and that she is tired She has been working full-time on the night shift at this facility and about 24-30 hours per week, as needed, at another facility because she is a single parent with three children to support. She states she is just tired from trying to work so many hours while not feeling well. Upon further questioning, the staff nurse finally admits that she has taken morphine from the facilities narcotic supply because her back was hurting. She did not call in sick or ask to leave after reporting to work because she needs the money she can earn during the shift.

These examples are typical of the complaints that are received by the Texas Board of Nurse Examiners and the referrals that are received by TPAPN. The Board and TPAPN receive such complaints and referrals each day.

CHEMICAL DEPENDENCE AND THE NURSING PROFESSION

Chemical dependence is described by Kabb as "When alcohol or drug use is causing continuing problems in one or more areas of an individual's life, such as problems at home, on the job, physically or legally" (1984, p. 19). Chemical dependence is an occupational hazard of the nursing profession. Nurses are at risk of becoming chemically dependent because of the presence of several factors. Risk factors include:

1. The practice of nursing is a stressful career.
2. Nurses are taught about the wonders which drugs can produce.
3. Nurses see the positive effects of drugs on their patients.
4. In many practice settings, nurses have ready access to drugs which are not readily available to the general population.

The care provided by or managed by a nurse may be critical to the recovery and/or survival of a patient. The practice of nursing while under the influence of mood altering chemicals such as alcohol or narcotic drugs may impair a nurse's ability to function at a minimal acceptable level. The impaired nurse may make errors in judgement or fail to provide care as ordered. These errors or failures may expose the patients assigned to the nurse's care to risk of harm.

Nurses employed in general hospitals work in a highly stressed environment. These nurses also have more access to the drugs that are commonly abused by nurses, than nurses working in other practice settings such as rehabilitation hospitals, psychiatric hospitals, nursing homes, home health agencies and medical clinics.

Impaired nurses are often allowed to continue practice or enabled by their peers or supervisors. Impaired practice may put patients at risk of physical or psychological harm. Impaired practice may also put a nurse's employer at risk of liability claims and financial loss.

In 1984, the American Nurses Association (ANA) reported the findings of their "Task Force on Addictions and Psychological Dysfunctions" (ANA, p. 5). This task force addressed the issue of chemical abuse. They encouraged the development of systems of services for nurses who are chemically dependent or at risk of becoming chemically dependent to ensure that they can remain in their chosen profession and not expose patients to risk due to impaired nursing practice.

PURPOSE OF THE STUDY

Studies have not been published which identify the services that hospitals have implemented to address the problem of chemical dependence in the nursing profession. The purpose of this study is to identify the services that Texas general hospitals have in place to:

1. educate nurses about the risks and the problems related to chemical dependence;
2. identify and intervene when chemical dependence may be impairing nursing practice;
3. refer nurses suspected of impaired practice due to chemical dependence;
4. support nurses through treatment for chemical dependence; and
5. facilitate re-entry into the workplace and monitor the practice of nurses recovering from chemical dependence.

The study will gather information about the services offered to nurses who are or are at risk of becoming chemically dependent through the administration of a survey to nurse administrators currently employed by general hospitals in Texas. Nurse administrators were selected as the units of analysis because they are in a position which should make them knowledgeable of the policies of the employing hospital.

CHAPTER SUMMARIES

Chapter Two will summarize the current literature on the issue of nurses and chemical dependence. Much of the literature focuses on factors enabling nurses to become chemically dependent, defining chemical dependence and describing the manifestations of chemical dependence on the practice of nursing. Finally, the conceptual framework for the study will be presented.

The research setting will be described in Chapter Three. The roles of the Board of Nurse Examiners, TPAPN and hospitals with respect to dealing with the issue of chemical dependence in nurses will be described. These roles will be categorized as preventative, rehabilitative or punitive.

Chapter Four will describe the methodology used to gather information for this study. Survey research methodology will be explored for appropriateness to the research question. The survey instrument, the population, the sampling frame, and the sample will be described. The operationalization of the study will be discussed.

The survey results will be presented in Chapter Five. The results will be presented in their initial groupings of educational, identification and intervention, referral, treatment or return to work monitoring and also re-grouped as preventative, rehabilitative or punitive.

Chapter Six will review the results of the survey and offer summary comments regarding the results. Suggestions for future study will be presented.

CHAPTER TWO

REVIEW OF LITERATURE

Chemical dependence may impair the ability of a nurse to function in his or her professional role. Impaired nurses are often allowed to continue practice or enabled by their peers or supervisors. Impaired practice may put patients at risk of physical or psychological harm. Impaired practice may also put a nurse's employer at risk of liability claims and financial loss.

A review of current literature was performed to identify the thrust of prior research on the subject of nurses and chemical dependence. The findings of the literature review are summarized here to provide a basis of the need for this study and to justify the inclusion of certain items in the survey instrument. After reviewing the literature, the conceptual framework for this study will be described.

DEFINITION OF CONCEPTS

Chemical Dependence

Chemical dependence is described in the literature as dependence or addiction "to a mood-altering substance" and need for the "substance, physically and/or psychologically to survive" (Sullivan, 1990, p. 33). In 1984, Kabb described chemical dependence as: "When

alcohol or drug use is causing continuing problems in one or more areas of an individual's life, such as problems at home, on the job, physically or legally" (1984, p. 19). Kabb's definition is commonly cited in other articles addressing chemical dependence in the nursing profession. Lachman describes "Chemically dependent nurses [as] individuals who are unable to meet the professional code of ethics and standards of practice because of alcoholism or addiction to a mood-altering drug" (1988, p. 34).

Addiction and substance abuse are other terms used synonymously with chemical dependence in the literature. Lee describes addiction as having "recognizable symptoms that include compulsive, uncontrollable use of drugs/alcohol; changes in tolerance for the drug of choice; withdrawal symptoms when the drug is absent; disintegration of support systems; and possibly, premature death if the addiction progresses without interruption" (1990, p. 190). Substance abuse is defined by Naegle as "compulsive, repetitive use of a drug despite detrimental social, physical, and psychological effects" (1988, p. 2)

Since this research is focused on impaired nursing practice due to chemical dependence, a hybrid definition of chemical dependence will be used which incorporates the main concepts described in the literature. Chemical dependence will be defined as the compulsive and continuing use of drugs (including alcohol) for purposes other than medical necessity, which negatively impacts or impairs a nurse's ability to carry out his/her professional responsibilities.

Impaired Practice

According to Valentine, "A nurse is labelled impaired when an alcohol or drug abuse problem fosters unsafe, unprofessional, or potentially negligent on-the-job behavior." (1988, p. 45). The American Nurses Association objects to the labelling of the nurse as impaired, but refers to the practice being impaired. According to the American Nurses Association, "Nursing practice is impaired when the individual is unable to meet the requirements of the professional code of ethics and standards of practice because cognitive, interpersonal, or psychomotor skills are affected by conditions of the individual in interaction with the environment." (ANA, 1984, p. 2-3). Caroselli-Karinja and Zboray state that practice is impaired "when substance abuse interferes with the delivery of safe nursing care and/or personal well being" (1986, p. 14). Patrick describes impairment "as dysfunctional job performance behavior attributed to chemical abuse or dependence" (1984, p. 99). For the purposes of this research we will focus on the impairment of practice, as it is the impairment of practice that puts patients and employers at risk.

Enabling

The word enabling is used here to describe the behavior of co-workers which allows the chemically dependent nurse to continue detrimental behavior. Kabb described typical enabling behaviors on a nursing unit. Co-workers will "cover poor job performance, not report early stage drug discrepancy suspicions, cover last-minute

schedule changes, and protect their co-worker, hoping that he or she will get some help for the problem" (1984, p. 19). A nurse may view his/her enabling behaviors as helping behaviors.

Often a nurse does not make the connection between the problems of a co-worker and chemical dependence until the co-worker can no longer function on the job at a minimal acceptable level. When a co-worker has become a friend, the worker that should perhaps see the signs of chemical dependence will often times go through denial, thinking that his/her friend could not or would not be a substance abuser. Even when job functioning begins to significantly deteriorate, the co-worker will continue in his/her denial rationalizing that his/her friend or peer is just going through a temporary stressful time and will return to the former level of functioning on the job.

According to Patrick, "Although nurses see themselves in the role of patient advocate, many do not view advocacy for the health and well-being of co-worker nurses in the same light. . . . In the place of peer assistance is a co-conspiracy of silence and cover-up that prevents early intervention and promotes a continuation or exacerbation of impaired behavior" (1984, p. 103). Evidence that Patrick's assertion holds merit is seen in the expression of many nurses that they will not report a co-worker's impaired behavior because they do not want to have the co-worker's nursing license put at risk of being revoked.

Sullivan found that recovering nurses "warned against enabling a dependent colleague to continue use by not confronting him or her with the a drug abuse problem" (1988, p. 794). Through employee and supervisor training and education, co-workers and supervisors can learn to recognize the signs of chemical dependence and manifestations in impaired practice. They can learn that intervention and rehabilitation are effective tools in assisting nurses to enter a program of recovery and return to the practice of nursing.

RELATIONSHIP BETWEEN A NURSING CAREER AND CHEMICAL DEPENDENCE

Stressors in Nursing

The stressors in the nursing profession are relevant to this research because there is evidence that job stress is often a precursor to chemical dependence in nurses. "Poplar found that one of the basic reasons for drug dependency among nurses was work pressure that was too demanding both physically and emotionally. . . [Smith and Seymour found that] . . . 78 percent of chemically impaired nurses did not use drugs prior to their nursing career" (Certo-Guinan and Waite, 1991, p. 52).

A career in nursing can be very stressful, especially if a nurse is working in a hospital setting. Kobberberger and Zboray identified the following "stressful situations in nursing:

1. Young [or inexperienced] nurses dealing with reality shock in the workplace.

2. Nurses working nights, rotating shifts, weekends, and holidays.

3. Mothers, many of whom are sole providers for their families balancing career and child care responsibilities.

4. Pressures of cost containment and 'down-sizing' in hospitals.

5. A physician-dominated health care system.

6. Repeated exposure to death, dying, and illness.

7. 24-hour responsibility for patient care.
(Kobberger and Zboray, 1985, p. 6-7)

A study of stress in hospital nurses was reported by Keane, Doucette and Adler in 1985. One purpose of their study was to "identify some factors associated with burnout" (1985, p. 231). They found the "three most common answers" to a question regarding what nurses least liked about their jobs were: 1) too heavy patient load; 2) work hours (inflexible schedules and night shifts); and 3) interference from physicians. (1985, p. 234). They concluded "that nurses who experienced higher levels of burnout perceived that failure on the job was due to factors over which they had no control" (1985, p. 235).

In 1985, Norbeck reported finding "relatively high levels of psychological distress" (1985, p. 230) in a sample of critical care nurses. She suggested that "job-stress and job-related strain may affect physical and mental health outcomes" (1985, p. 225).

A 1987 study of health professionals including pharmacists, physicians and nurses was conducted "to assess job stress among three diverse groups of health professionals" (Wolfgang, 1988, 24). The results showed:

> . . . that nurses reported the highest levels of stress. . . . Nurses and pharmacists perceived more frequent stress in the supervision of coworkers, lack of recognition from other health professionals, poor advancement opportunities, inadequate feedback on job performance, and the inability to use all of one's abilities on the job. (Wolfgang, 1988, p. 25).

Professional stresses are identified by Roth as: "1) overwork, inadequate salaries and under recognition; 2) family responsibilities; 3) sleep deprivation, call schedule, strenuous workload, changing schedule and 4) exposure to pain and socioeconomic deprivation" (1987, p. 92).

Sullivan found in a survey of nurses that 90 percent of the respondents "ranked nursing as highly or fairly stressful." The respondents ranked the causes as "1) excessive workload;. . . 2) handling illness and death; and 3) dealing with supervisors and physicians" (1988, p. 792).

Hence, stress is a part of the nursing occupation. From the studies reviewed, the stress factors identified are common to nurses working in a general hospital setting. Unfortunately, stress increases the likelihood that a nurse will become chemically dependent. These findings support the assertion that nurses working in general hospitals are vulnerable to becoming chemically dependent.

Attitudes Toward Drugs

A common theme in the literature suggests that nurses' perceptions of drugs and drug use are different than the perceptions of those who do not have the same knowledge and experience with the effects of drugs. Lee states:

> Nurses . . . view drugs differently than the general public. . . . [They] recognize the value of drugs and the positive effects drugs can have on patients. . . . [They] believe they are invulnerable to addiction and other dangers associated with drugs (1990, p. 190).

Nurses are vulnerable to drug abuse, according to Roth, because they associate "analgesics and other psychoactive chemicals with pain and stress reduction. Drugs are seen as a solution to discomfort and as a coping mechanism . . ." (1987, p. 92). Lachman states: "Nurses learn that drugs are an acceptable means of altering negative feeling states. Drugs become acceptable to use for medical and psychological pain" (1988, p. 35).

Nurses with their knowledge of physiology, disease and medications are vulnerable to either self-diagnosing or clever enough to describe a set of symptoms for which the desired medication is an appropriate course of treatment. The physiologic causes of complaints of migraine headaches and back pain are not easily diagnosed and treated. Real or imagined complaints of this sort often begin a nurse on a course of substance abuse which manifests in chemical dependence.

Patrick states that "The nurse may feel overly confident in the safety in self-prescribing drugs for various physical and emotional problems. . . . It is generally easy to contact a colleague physician, describe a variety of personal symptoms, suggest or ask for a specific drug, and to receive the prescription without ever being seen by the physician writing the script" (1984, p. 101-103). The beliefs of nurses about the effects of drugs facilitates the initiation of substance abuse that can lead to chemical dependency.

Access to Drugs

Nurses who begin abusing drugs usually use drugs that are used in the work setting or alcohol. The drug used in the work setting that is most commonly abused by nurses is Demerol, a synthetic opiate. Addiction to Demerol has similarities to addiction to heroin, in that, the abuser usually develops an ever increasing need or craving for the drug as dependence continues. Other drugs commonly abused by nurses include morphine, Vicodin, codeine, Valium, Stadol, Nubain, Xanax and Dilaudid. Often the drug of choice reflects the unit of employment. For example, Demerol and morphine are commonly used on post-surgical patients and are often abused by nurses working in medical/surgical units.

The three most common sources of drugs (other than alcohol) for nurses who are chemically dependent are: 1) diversion of medications prescribed for patients; 2) obtaining unnecessary prescriptions from physician colleagues; and 3) passing forged prescriptions. It is easy access that helps enable nurses to slip into a pattern of drug abuse that often leads to chemical dependence.

According to Lachman, "Inadequate and insecure monitoring systems for controlled drugs and tranquilizers provide opportunities for individuals to divert drugs to their own use." It is easy for nurses to obtain "prescriptions from physician colleagues" (1988, p. 35).

Use of Drugs

Robbins states that "The combination of high stress and easy accessibility of drugs in nursing should alert health care leaders that chemical dependency is an occupational hazard" (1988, p. 22). Since high stress and easy accessibility to drugs are factors which are both present in the general hospital setting, nurses working in general hospitals should be educated about and reminded of their vulnerability to chemical dependence due to their choice of practice setting.

A study of "the process through which nurses become chemically dependent" conducted by Hutchinson found that "as a result of physical and/or psychological pain nurses who became chemically

dependent embarked on a trajectory of self-annihilation" (1986, p. 196). The stages of self-annihilation are: 1) experiencing relief from pain by use of drugs; 2) commitment to drug use for pain relief; and 3) compulsion to use drugs, where the drug use becomes the goal, not the relief from pain (1986, p. 198-199). The abuse of Demerol by a large number of chemically dependent nurses exposes them readily to this trajectory of self-annihilation as Demerol does relieve pain and once dependent on Demerol, the abuser normally requires increasing amounts of Demerol to satisfy cravings. A continued increase in the amount of Demerol used may result in the death of the abuser.

PREVALENCE OF CHEMICAL DEPENDENCE IN THE NURSING PROFESSION

Estimates of the prevalence of chemical dependence in the nursing profession are widely varied. The range of estimates is that from 2 to 20 percent of nurses are chemically dependent. Sullivan surveyed "over 500 nurses residing in 19 states" and reported that "6 percent answered affirmatively to two of four standard diagnostic questions for potential or actual chemical dependency" (1990, p. 33). Sikora estimates that "some 16,000 of the 200,000 (about 8 percent) [registered] nurses and licensed vocational nurses in Texas are dependent on alcohol or addicted to drugs" (1988, p.24).

Trinkoff, Eaton and Anthony studied "the prevalence of substance abuse among registered nurses" and found 32.9 percent of the nurses responding to their survey had engaged in illicit use of drugs (1991, p. 172). Hickman, Finke and Miller performed a pilot

study of alcohol and drug use of nurses. They found that 90.6 percent of their respondents had used drugs or alcohol "in the month preceding the questionnaire" (1990, p. 15). Some of the respondents "even admitted to working in the hospital under the influence of chemical substances" (1990, p. 15). Neither of these studies attempted to determine what percent of those who had engaged in use of or illicit use of drugs or alcohol were chemically dependent.

Although the actual prevalence of chemical dependence among nurses is unknown, the practice of nursing while impaired due to use of drugs or alcohol exposes patients and employers to risks. Therefore, even a 2 percent level of chemical dependence in the nursing profession is of concern.

RELATIONSHIP BETWEEN THE CHEMICALLY DEPENDENT NURSE AND HIS/HER EMPLOYING HOSPITAL

Risks to Patients

Nurses are responsible for providing care to patients that can be critical to recovery and/or survival. If chemically dependent, a nurse's ability to practice may be impaired. This impairment may affect cognitive skills and result in errors in nursing judgment. This impairment may affect motor skills and limit a nurse's physical ability to care for patients. Impaired nursing practice may expose the nurse's patients to risk of harm. Impaired practice may result in:

1. errors in the administration of medications and treatments;

2. failure to administer medications and treatments;

3. failure to assess a patient's condition and appropriately respond to changes in a patient's condition; and

4. appropriation of medications.

No studies were found which reported research directed at determining how many patients are put at risk by the continued practice of chemically dependent nurses. In 1988, Sullivan did a survey of nurses in recovery and found that "about one-fourth" of the recovering nurses that responded to her survey "said they had been negligent in their care of patients due to their abuse problem" (1988, p. 792).

Risks/Costs to Employers

No studies were found which reported the financial cost to employers for liability claims resulting from the impaired practice of a nurse which resulted in patient harm. Vernon cites the potential for liability of employers for the "negligent hiring or negligent retention" of employees that may put patients at risk of harm. (1988, p. 28).

The issue of personnel costs is addressed in the literature. Studies have been conducted to identify the costs that are borne by an employer that allows a nurse to continue practicing while

chemically dependent. Lachman states that:

> It is estimated that an alcoholic employee costs the employer approximately 25 percent of his or her annual salary per year, if a hospital has 1,000 employees with an average salary of $20,000 and 6 percent of these employees have an alcohol problem, the cost of not dealing with these employees is $300,000 a year (1988, p. 40).

LaGodna and Hendrix (1989) estimated the cost to the employer "caused by a critical care nurse with a late recognized problem of impaired practice" to be $17,867.00. The costs included were: 1)lost productivity; 2)internal investigation; 3)termination; 4)reporting to and participating in the State Board of Nursing disciplinary process; 5)conferring with the nurse's coworkers and 6)replacement of the terminated nurse. (1989, p. 14-15).

Robinson is cited as estimating "that the cost to a hospital with a staff of 1,100 nurses is over $1.7 million per year, if one assumes that 10 percent of the nurses are impaired and productivity is decreased by 20 percent" (Hickman, et al, 1990, p. 14). Sullivan estimates that replacement costs are conservatively $3,000 per employee "including advertising, recruitment, interviewing, selection, orientation, and training" (1986, p. 179).

The exposure to liability claims, loss of productivity and the personnel costs associated with having to replace chemically dependent nurses coupled with other costs related to providing medical care which have been escalating, provide a challenge to a hospital to minimize exposure to these costs.

Need for Hospital Sponsored Services

For years there has been a greater demand for nurses than the available supply. One of the drains on the supply has been the discarding of nurses who have become chemically dependent. Robbins states that "Studies show that 90% of impaired health care professionals (IHCP) going through a residential treatment program have a successful recovery and that 85% of people who seek treatment can return to the workforce as productive employees" (1988, p. 20). Since nurses are in great demand and hospitals are the major employer of nurses, it is in the interest of the hospital industry, to develop education, identification, treatment and re-entry services for nurses that are chemically dependent.

Hospitals may be fostering chemically dependent nurses and increasing their potential liability and financial loss by not developing programs to deal with chemically dependent nurses. Lack of employee education and the enabling behaviors of co-workers may delay the identification of chemically dependent nurses.

SERVICES THAT HOSPITALS CAN OFFER TO NURSES THAT ARE OR AT RISK OF BECOMING CHEMICALLY DEPENDENT

Education

Hospitals need to educate their staff in the warning signs of chemical dependence; the dangers of chemical dependence to impair practice and put patients at risk; and the institution's policies for dealing with chemically dependent nurses. It is through education

that co-workers will become more willing to act to help a chemically dependent co-worker. Employee education is also an important tool to inform employees of the benefits available through the hospital for those who are chemically dependent or at risk of becoming chemically dependent.

Supervisor training on the identification of the chemically dependent nurse, intervention and referral programs and reincorporation of the recovering nurse into the work setting can be crucial to salvaging the careers of nurses. Once in recovery many nurses can return to the practice of nursing and ease the stress of the shortage of supply of nurses.

Employee Discipline

Termination from employment of a nurse that is chemically dependent without an opportunity for treatment and re-entry to employment is a poor response to the problem of chemical dependence. Since nurses are in demand, a chemically dependent nurse who is terminated by an employer can easily go on to a new employment setting and continue drug use. This perpetuates the exposure of patients and employers to the risks of impaired practice. Handley points out another problem with the job change of a chemically dependent nurse. Nurses may also have insurance coverage terminated when it is needed for treatment (Handley, 1991).

As an alternative to termination, some employers place employees suspected of or admitting to chemical dependence on a suspended or

probationary status conditioned upon the employee's agreement to cooperate in evaluation and treatment programs. This less severe approach, may provide the incentive an employee needs to seek treatment.

Hospitals may also involve hospital security or law enforcement agencies in dealing with nurses that are chemically dependent. This approach may be used when a nurse appropriates medications from the hospital. The involvement of law enforcement agencies can result in the filing of criminal charges. Since the drugs stolen are most often classified as controlled substances, the nurse may be charged with a felony offense. Conviction of a crime, whether it is a felony or a misdemeanor, may subject the nurse's license to discipline by the state licensing agency.

Intervention

Intervention is a method of confronting a person suspected to be chemically dependent and encouraging the person to seek evaluation for chemical dependence. An intervention is appropriate when sufficient evidence of chemical dependence has been gathered and a relationship between chemical dependence and deficiencies in job performance can be clearly identified and expressed. Handley states that:

> . . . intervention is specifically designed to use surprise to decrease the denial typical of alcohol and drug abuse. The intervenor does not diagnose; rather they present information and recommend professional evaluation(1991, p. 479).

Interventions are usually conducted with a number of people in attendance including, for example, a supervisor, one or more co-workers, a human resource professional and a representative of an employee/peer assistance program. The person who is the focus of the intervention is confronted with deficiencies in job performance. Drug abuse is suggested as the cause of the deficiencies. Intervention is a compassionate approach that raises the subject's threshold of pain and facilitates breaking the subject's denial that he/she has a chemical dependence problem. The subject is encouraged to seek evaluation and treatment. The subject may be required to have an evaluation and, if warranted, receive treatment prior to returning to work or face termination from employment.

Employee Assistance Programs

Lachman describes an [employee assistance program] EAP as "a system designed to provide professional care to employees whose job performance is or may be affected by personal problems such as alcoholism, emotional difficulties, stress, and drug dependency" (1988, p. 40). She states that: "less than 50 percent of the hospitals in this country have in-house assistance . . . through an employee assistance program" (1988, p. 38).

Sullivan states that "An employee assistance program identifies chemically dependent employees, performs or assists with intervention, refers the employees to the appropriate professionals, and assists with reentry into the work force" (1986, p. 179). The benefits of an employee assistance program to an administrator, manager or supervisor are articulated by Kabb as "the administrator can focus on his or her area of expertise-job performance-yet motivate the employee to obtain help for the personal problems that may be causing the poor performance. . . . An EAP counselor is able to identify the cause of the personal problem, refer to appropriate resources for help, and provide follow-up to both the individual and the employer" (1984, p. 21).

It may not be economically feasible for small hospitals to maintain an in-house employee assistance program. There are freestanding employee assistance programs that will contract with employers to provide employee assistance services. A small hospital in a rural area may not have access to a freestanding employee assistance program.

Return to Work Contracts

Return to work contracts are designed to allow a nurse recovering from chemical dependence to return to work under conditions that are conducive to continued recovery. The return to work contract ensures that the employer is aware of the fact that the nurse is in recovery and that restrictions are placed on the

nurse's practice to enhance the success of the nurse in maintaining his/her sobriety while returning to the practice of nursing.

Robbins describes a model "Monitored Treatment Program" that involves the hospital, a hospital employee health nurse and a peer assistance program in monitoring a nurse during his/her re-entry to practice after treatment for chemical dependence. The key components of her model program include a written contract which addresses: 1) stress reduced work environment; 2) limits on access to controlled drugs; 3) drug screening; 4) family involvement; and 5) support group meeting attendance (1988, pp. 22-23).

Sullivan states "A 'return to work' contract should be formulated by the institution and signed by the reentering nurse, his or her supervisor, and the EAP coordinator. All parties must understand that if any stipulation is violated, termination will result." (1986, p. 200).

The unpublished results of a study done by Alexander, Bunker, Reed and Marks found that:

1. 96 percent of recovering nurses on return to work contracts (RTWC) were employed in nursing;
2. 65 percent of recovering nurses not on RTWC were employed in nursing; and
3. nurses on RTWC reported that their chemical dependency was discovered in the workplace significantly more often than those not on RTWC (undated, p. 1)

The return to work contract is beneficial to the employer and the recovering nurse in that it signifies a commitment on the part of both parties to work toward salvaging the nurse's career and assist the nurse in maintaining a program of recovery that will ensure that he/she can practice safely.

Peer Assistance Programs

Peer assistance programs utilize volunteer nurses to assist in the intervention of nurses whose practice is impaired; offer referrals for assessment and treatment; assist a nurse in re-entering practice and monitor a nurse's practice after re-entry. Peer assistance programs for nurses have been established in most states. The programs vary somewhat from state to state but have common characteristics. Most programs are based in a professional organization rather than in an employing institution. In many states a nurse who successfully completes a peer assistance contract and remains in recovery is not subject to having permanent disciplinary action taken against his/her license.

PRIOR RESEARCH

American Nurses Association Study

In 1984, the American Nurses Association (ANA) reported the findings of a "Task Force on Addictions and Psychological Dysfunctions". The report states: "The health care industry has lagged behind other industries in providing employee services that

address the misuse of alcohol and other drugs" (ANA, 1984, p. 5). In 1975, only 10 percent of existing substance abuse programs were "in the combined areas of business, education, social services and health services" (ANA, 1984, p. 5).

The ANA task force identified outcome measures that could be used to determine if appropriate systems have been developed and implemented to address the issue of chemical dependence in nurses. The suggested outcome measures are:

1. Change in the number of nurses reviewed by the state board of nursing and referred for treatment.
2. Decrease in the number of actions on licensure.
3. Increase in the number of health care agencies with policies and procedures related to impaired practice;
4. Increase in the number of health care agencies with identification and referral systems;
5. Establishment of health care benefits for diseases of addiction; and
6. Establishment of organizational clearinghouses. (ANA, 1984, p. 16).

Outcome measure #1 implies and outcome measure #2 clarifies that a desired outcome is fewer nurses being reported for review by the state board of nursing and more nurses being referred for treatment. Outcome measures #3, #4, and #5 are focused actions that health care agencies, including general hospitals, should take to address the problem of chemical dependence in the nursing profession.

Survey of Directors of Nursing - Florida Hospitals

No prior research was found that was specifically directed at identifying the services offered by general hospitals to nurses that are or are at risk of becoming chemically dependent. In 1986, Certo-Guinan and Waite surveyed directors of nursing of Florida hospitals "to identify the role of Directors of Nursing in the State of Florida in identification, intervention and referral of chemically dependent nurses in their institutions" (1991, p. 52). Some of the items of their survey instrument assessed attitudes of the respondents while others did request responses to questions regarding the services utilized by the respondent's hospital to deal with chemically dependent nurses. Their findings included:

1. 93 percent refer chemically dependent nurses for treatment;
2. 37 percent of the facilities had written policies and procedures for managing alcohol-dependent and drug-dependent nurses;
3. 74 percent of facilities had health insurance plans that provide payment for alcohol and/or drug abuse inpatient treatment;
4. 52 percent required a written return-to-work contract for recovering nurses;
5. 40 percent had written policies regarding drug screening;
6. 44 percent paid the cost of drug screening;
7. 56 percent required recovering nurses to attend aftercare groups; and
8. 18 percent had policies regarding the handling of relapses (1991, p. 53-54).

The results of this survey indicate that hospitals, at least in the State of Florida, have not uniformly implemented comprehensive programs to provide for the identification, treatment and re-entry of chemically dependent nurses.

CONCEPTUAL FRAMEWORK FOR THIS STUDY

After determining that the purpose of this study would be to identify services offered by Texas general hospitals to nurses who are or are at risk of becoming chemically dependent, a list of specific services was developed. The ANA outcome measures, the Florida Study, and my personal knowledge of services that some Texas hospitals offer were used to develop the list. The list of identified services is presented in Table 2.1.

Table 2.1

CATEGORIZATION OF SERVICES

SERVICE	CATEGORY*
Employee Education	
Employee seminars/training regarding the nursing profession and chemical dependence	PR
Distribution of literature regarding the nursing profession and chemical dependence	PR
Supervisor/Manager Training on:	
Identifying the chemically impaired nurse	PR
Supervising a nurse in recovery	R
Urine/Blood Drug Screens	
Pre-employment	PR
Random for all nurses	PR
Suspicion of use/impairment	R
Nurses with a history of chemical dependence	P
Nurses returning to work after treatment for chemical dependence	R
Mandate Nurse Reporting of:	
Suspected theft of drugs	P
Suspected drug use/impairment	P

SERVICE	CATEGORY*
Employee Discipline	
Termination from employment	P
Suspension from employment	P
Placement on probationary employment status	P
Refer Nurse Suspected of Misuse/Drug Theft to:	
In-house intervention program	R
In-house employee assistance program	R
In-house peer assistance program	R
Outside/contract employee assistance program	R
Texas Peer Assistance Program for Nurses (TPAPN)	R
Board of Nurse Examiners/Vocational Nurse Examiners	P
Hospital security	P
Law enforcement agency	P
Employee Benefits	
Paid leave of absence	R
Leave of absence without pay	R
Insurance coverage for:	
Inpatient treatment	R
Outpatient treatment	R
Aftercare	R
Individual/group psychotherapy	R

SERVICE	CATEGORY*
Employee benefits formally explained to employees	PR
Substance abuse treatment an optional benefit (cafeteria plan)	PR
Hiring and Retention	
Hire employees with a prior history of chemical dependence	R
Utilize return to work contracts for nurses returning to work after treatment for chemical dependence	R
Hire nurses under TPAPN contract	R
Retain nurses under TPAPN contract	R
Hire nurses under orders of a nursing board	R
Retain nurses under orders of a nursing board	R

*Category

PR = Preventative
P = Punitive
R = Rehabilitative

Education services were chosen for inclusion in the list because through employee education hospitals may derive the most benefit for the cost of these services. Education of nurses about their vulnerability to substance abuse may deter some nurses from becoming caught in the trap of substance abuse. Education about the behaviors that may manifest in the practice of a substance abusing nurse will assist supervisors and peers in identifying nurses needing intervention at an earlier stage of their chemical dependence. Informing nurses about employee benefits such as employee assistance programs, peer assistance programs and insurance coverage for treatment programs may be the impetus that some nurses need to seek help on their own or encourage a peer or subordinate to seek help.

Urine/blood drug screens are an effective method of detecting whether or not nurses are using drugs that have not been legitimately prescribed or that may impair ability to practice nursing safely. The possibility of being requested to give a urine or blood sample for screening at anytime, may deter both nurses who have not had a chemical dependency problem and nurses recovering from chemical dependence from using.

Mandatory employee reporting of suspected drug theft or drug use/impairment may facilitate earlier intervention of nurses that are abusing drugs. This may get a nurse into treatment at an earlier stage of the addiction process. It may also assist in protecting patients from risk of harm that may result when a nurse practices in an impaired state.

Referring nurses suspected of impairment to employee assistance programs or peer assistance programs may assist in the breaking of a nurse's denial that he/she has a chemical dependence problem. If the referral results in evaluation, even if the nurse is not chemically dependent, another underlying problem that is resulting in failing job performance may be identified.

Referring nurses to a licensing board, hospital security or a law enforcement agency may result in administrative or criminal sanctions. These authorities' actions may finally break a nurse's denial or remove a nurse from practicing if he/she continues to deny a chemical dependence problem that is impairing ability to practice nursing safely.

Employee benefit programs may assist nurses in receiving treatment and getting into a program of recovery or they may assist the nurse in relieving other physical or emotional stresses that can facilitate the initiation of chemical dependence. Offering leaves of absence and insurance coverage for treatment may allow a hospital to salvage the career of a nurse. This is especially important while the supply of nurses is less than the demand.

Hiring or retaining nurses in the initial period of recovery or with a prior history of chemical dependence increases the labor pool of nurses that are available to a hospital. Return to work contracts should be utilized for nurses in the early stages of recovery to facilitate the continuing recovery of a nurse and minimize the hospital's exposure to liability if the nurse relapses and continues

to practice while impaired.

This is an initial effort at determining what services are offered by Texas general hospitals to nurses who are or are at risk of becoming chemically dependent. The list of services identified for use in this study may not be exhaustive. The list should be useful though, to determine if services are being offered to nurses employed in Texas general hospitals.

After reviewing the list of identified services, it became apparent that each service had a primary purpose that could be described as preventative, punitive or rehabilitative. For the purpose of this research, these terms are defined as:

Preventative - measures to keep an event from occurring

Punitive - measures to penalize or punish

Rehabilitative - measures to restore to a former state

Each of the identified services was categorized according to the primary purpose of the service. It is recognized that most of these services could have a secondary purpose or situationally have a different primary purpose. The categories for the purposes of this study are listed in Table 2.1.

In an ideal world, if effective preventative services could be relied upon to keep all nurses from becoming chemically dependent, there would be no need for punitive or rehabilitative services. Since there are no preventative services that are guaranteed to prevent a nurse from becoming chemically dependent, punitive and rehabilitative services are also needed in a complement of services.

Punitive services may serve as the key to breaking strong denial in some chemically dependent nurses. Rehabilitative services may be the keys which allow many chemically dependent nurses to get into a program of recovery and make a successful return to practicing their chosen profession.

CONCLUSION

In 1984, the American Nurses Association identified a need for hospitals to become more involved in the identification, treatment and re-entry to practice of chemically dependent nurses. The literature reviewed shows that there has been much emphasis on identifying factors that may contribute to nurses becoming chemically dependent. There is information about warning signs, appropriate treatment and models of re-entry to practice. There is little research to determine if hospitals have been responsive to the need for institutional involvement in the identification and treatment of nurses whose practice is impaired by chemical dependence.

Based on the information gathered from the literature review and the lack of studies to identify services offered by hospitals for those who are or are at risk of becoming chemically dependent, a list of possible services was developed. These services were categorized as preventative, punitive or rehabilitative so that in addition to identifying what services are being offered, a description of the thrust of those services can also be presented. With this information as background, the next chapter will describe the

selected research setting and Chapter Five will describe the methodology utilized in identifying services offered by Texas hospitals to nurses who are or are at risk of chemical dependence.

CHAPTER THREE

THE RESEARCH SETTING

As stated in the literature review chapter, it seems logical that approaches to dealing with nurses that are or are at risk of chemical dependence fall into three categories preventative, punitive and rehabilitative. No one approach is necessarily exclusively type cast into one of these three categories. In looking at the research setting, I will describe the State Board of Nurse Examiners' role in regulating the practice of professional nursing; the Texas Peer Assistance Program for Nurses' (TPAPN) role with nurses who are chemically dependent and briefly describe the general hospital setting in which many nurses practice and become chemically dependent. The categorical nature of the role of each of these institutions will be discussed.

STATE REGULATION OF THE PRACTICE OF PROFESSIONAL NURSING

Nurses are regulated in each state under state statutory authority. State enabling statutes bear many similarities but also have differences. Since the focus of this study is Texas, I will describe the regulatory environment in the State of Texas.

The terms registered nurse and professional nurse are used interchangeably. Registered nurses are licensed by the Texas Board of Nurse Examiners. Vocational nurses are licensed by the Texas

Board of Vocational Nurse Examiners. These licensing boards operate independent of one another under separate enabling statutes. Texas is one of only five states that maintains separate regulatory boards for registered nurses and vocational nurses. Both boards are required, by statute, to regulate the practice of their licensees in the interest of protecting the public. In the interest of public protection both boards have the authority to take disciplinary action against licensees who violate the enabling statutes.

There are currently 131,015 (FY 1992) professional or registered nurses (RNs) and 74,540 (FY 1992) vocational nurses (LVNs) licensed by the State of Texas. Registered nurses differ from vocational nurses in the amount of education that is required for qualification to sit for a licensing examination. Registered nurses must complete a two year associate degree program, a three-year diploma program, a four-year baccalaureate degree program or a two or three year entry level master of science in nursing program (for persons with a non-nursing undergraduate degree) prior to being eligible for the licensure exam. Vocational nurses must complete a one year educational program prior to becoming eligible to sit for the licensure examination.

Based on self-reports by registered nurses during the license renewal process, of the nurses who reported their place of employment 58,405 of 83,870 or 69.6 percent of the RNs reporting their place of employment are employed in hospitals.

Most of the literature that was reviewed for this paper was specifically directed toward the practice of registered nurses. Some of the literature does not distinguish between type of nurse licensure. For the purpose of this paper, I will focus on the regulatory environment that exists in Texas for registered nurses with the understanding that the regulatory environment for licensed vocational nurses in Texas is similar to that for registered nurses.

The Board of Nursing Examiners operates under the authority granted in Articles 4513-4528, Revised Civil Statutes of Texas, as amended. "The mission of the Board of Nurse Examiners is to protect and promote the welfare of the people of Texas, by ensuring that each person holding a license as a registered professional nurse (RN) in the State of Texas is competent to practice safely" (Board of Nurse Examiners, 1992).

The primary role of the Board of Nurse Examiners in dealing with chemically dependent nurses is punitive. The Board of Nurse Examiners is granted the authority to discipline its licensees by Article 4525, Revised Civil Statutes of Texas, as amended. This article titled "Disciplinary Proceedings" grants the Board the authority to issue a warning, a reprimand, a reprimand with stipulation, suspend a license, suspend and probate the suspension of a license or revoke a license of a nurse who violates the Nurse Practice Act or the rules that have been promulgated pursuant to that Act. One of the specific provisions of the statute, Article 4525(a)(8) prohibits:

> Intemperate use of drugs or alcohol that the board determines endangers or could endanger patients. Intemperate use includes but is not limited to practicing professional nursing or being on duty or call while under the influence of alcohol or drugs. (Nurse Practice Act, 1992).

The Board of Nurse Examiners has an investigative staff to investigate complaints against RNs. The investigative process involves gathering evidence; reviewing evidence to determine if the evidence supports a violation of the practice act or rules and recommending disposition. When the evidence will support a finding that a nurse has violated the practice act or rules, unless there is compelling mitigating evidence, the nurse will be disciplined by the licensing board.

Disciplinary action may be agreed to by the nurse through a consent or agreed settlement or the matter may be heard at a public disciplinary hearing by an administrative law judge who later issues a proposed order of discipline. All discipline, whether agreed to or ordered by an administrative law judge, is subject to approval of the licensing board.

Disciplinary action by the board may restrict or prohibit the practice of nursing. The action by the licensing board is a matter of public record and is disseminated to employers of nurses. The disciplinary action against a nurse becomes a permanent part of his/her licensure record. For these reasons, disciplinary action is categorized as punitive.

A board disciplinary action may require a nurse to work under limitations and monitoring of his/her practice through the imposition of stipulations or probationary conditions. The issuance of a reprimand with stipulations or suspension with probation conditions is a punitive action with a secondary objective of rehabilitation. Typical stipulations or probation conditions include:

1. Requiring the nurse to notify his/her employer that he/she is under an order of the board.
2. Requiring the nurse's employer to submit performance reports.
3. Requiring the nurse's employer to perform random drug screens and report the results to the board.
4. Requiring the nurse to participate in individual therapy.
5. Requiring the nurse to attend self-help support group meetings
6. Limiting the number of hours and shifts a nurse can work.
7. Limiting the nurse to working on only non-critical care units.
8. Requiring the nurse to work under the supervision of another registered nurse.
9. Prohibiting the nurse from working in independent practice settings such as home health.
10. Prohibiting the nurse from the use of alcohol or controlled drugs
11. Prohibiting the nurse from administering controlled drugs.

The Board of Nurse Examiners also performs some educational functions regarding nurses and chemical dependence through articles in the Board's newsletter and discussion of the issue of chemical dependence at speaking engagements. Statutorily mandated duties coupled with fiscal constraints, limit the capacity of the Board to perform educational functions regarding chemical dependence and the nursing profession.

TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

There is conflicting opinion as to whether or not punitive action is an appropriate method of dealing with nurses who suffer from the addictive disorder of chemical dependence. In recognition of this conflict, not only for nurses but for other licensed professionals, the Peer Assistance Act was passed into Texas State law by the 69th Legislature in 1985.

Under the authority granted in the Texas Health and Safety Code, Chapter 467, Vernon's Texas Codes Annotated, entitled "Peer Assistance Programs", the Board of Nurse Examiners and the Board of Vocational Nurse Examiners contract with the Texas Nurses Foundation to provide the Texas Peer Assistance Program for Nurses (TPAPN). The purpose of TPAPN is to assist nurses whose practice is impaired by chemical dependence or mental illness in their recovery to allow for their safe return to the practice of nursing. TPAPN provides a rehabilitative alternative to punitive disciplinary action by a nurse licensing board.

> The philosophy of TPAPN is that a nurse should not lose his/her job or license due to chemical dependency or mental illness without first being offered the opportunity for education, treatment, and recovery. It is also the philosophy of TPAPN that a nurse whose mental illness or chemical dependency prevents her or him from practicing nursing at an acceptable level should not be allowed to practice. (TPAPN, 1992)

Article 4525a. Professional Nurse Reporting, Revised Civil Statutes of Texas, as amended, requires the reporting of violations of the Nurse Practice Act to the Board. Under Article 4525a., Sec. 8, a nurse who is impaired or suspected of being impaired due to chemical dependence may be reported to TPAPN in lieu of being reported to the Board.

A nurse who is reported to TPAPN; contracts with TPAPN; successfully completes a TPAPN contract and remains in a program of continued recovery is not referred to the Board of Nurse Examiners and no disciplinary action is reflected on the nurse's permanent licensure record. A usual TPAPN contract with a chemically dependent nurse is for a two year period. Examples of contract requirements are: The nurse must

1. receive treatment for substance abuse;
2. abstain from of mood-altering substances;
3. submit to random drug screens;
4. attend support group meetings; and
5. sign a return to work agreement which sets out terms and conditions of employment.

A nurse's compliance with a TPAPN contract is monitored by his/her employer, a system of volunteer advocates and TPAPN employed case managers.

Since chemical dependence is a disease of relapse, a nurse who was referred to TPAPN by a third party and relapses once or twice, while under a TPAPN contract may be allowed to sign a new contract in lieu of being referred to the licensing board for disciplinary action. The licensing board has approval authority over allowing nurses who were referred to TPAPN by a third party, as an alternative to referring the nurse to the Board, to continue in TPAPN after relapses.

If a nurse who was referred to TPAPN by a third party fails to comply with the conditions of the TPAPN contract he/she is referred to the appropriate licensing board and subject to the disciplinary process. To encourage self-referrals to TPAPN, a nurse who self-refers to TPAPN is not reported to the Board if he/she is non-compliant with a TPAPN contract.

From the inception of TPAPN in 1987 through calendar year 1991, 1,227 RNs had been referred to TPAPN for suspected chemical dependence. By the end of 1991, 283 RNs had successfully completed TPAPN contracts and 464 RNs had been referred back to the Board of Nurse Examiners for disciplinary action.

Although the primary function of TPAPN is rehabilitative, their secondary function is educational. TPAPN provides education about chemical dependence to nurses through workshops, a newsletter and

video tapes. As with the Board of Nurse Examiners, TPAPN's provision of educational services is limited by the required duties of contracting with and monitoring nurses in recovery and by fiscal constraints.

Since TPAPN is required to refer contract non-compliance of nurses who were referred by third parties to the licensing board, this duty can be categorized as punitive in nature. Although this duty is punitive it is crucial to the goal of keeping nurses from practicing who can not function in a practice setting at a minimal acceptable level.

THE GENERAL HOSPITAL ENVIRONMENT

General hospitals employ RNs to manage the day to day care of their patients. Patients in a general hospital require round the clock care by medical professionals.

The RN plays a key role by ensuring that the orders of physicians are carried out either by him/herself or by staff with lower levels of education and training. The RN plays a critical role in assessing the condition of a patient and the patient's response to medications. The RN must have the knowledge and skills needed to effectively collaborate with the physician who is directing the care of the patient but has infrequent contact with the patient and to intervene when the patient's condition changes requiring immediate action.

Because of the key role that the RN plays in the care of patients and an inadequate supply of RNs, hospitals are often put in a position of hiring almost any RN that applies for employment. They do not have the luxury of choosing from many qualified candidates. Hence, hospitals often hire nurses who may already be chemically dependent.

Because of the inadequate supply of RNs, hospitals often will pressure their RN employees to work additional hours. Due to the nature of the work, patients cannot be left without an RN to manage their care. Thus, if there is an inadequate supply of RNs to fill the round the clock requirements to meet patient care needs, RNs are often asked to work double shifts, work extra shifts or work twelve or sixteen hour shifts. The RN that succumbs to the pressures of the hospital to work extra hours, puts his/herself under additional stress and, as was learned from the literature review, puts his/herself at risk of using drugs to manage that stress.

There are 399 general hospitals in the State of Texas. As noted earlier from the self-report of RNs renewing their licenses, 58,405 registered nurses reported working in hospitals. It is unknown how many of the RNs working in hospitals are working in the 399 general hospitals.

Hospitals play differing roles in the categories of prevention, rehabilitation and punishment. The results of the survey will indicate if and how general hospitals in Texas have chosen to provide services for nurses who are or are at risk of chemical dependence.

CONCLUSION

The roles of the Board of Nurse Examiners in disciplining the chemically dependent professional nurse in Texas and TPAPN in enabling the rehabilitation of nurses who become chemically dependent are clear. The roles that general hospitals have chosen to deal with nurses that are or are at risk of chemical dependence are unknown. With this glimpse at the research setting, the methodology for collecting information about the services that Texas general hospitals have chosen to provide will be described in the next chapter.

CHAPTER FOUR

METHODS

The review of current literature on chemical dependence and the nursing profession did not reveal studies done to identify services offered by hospitals to nurses who are or are at risk of becoming chemically dependent. After completing the literature review, it became apparent that a study to identify services offered by hospitals would collect information that is lacking in the literature.

Due to constraints of time and money, it was necessary to focus the study on an identifiable subset of all hospitals. Information collected by TPAPN regarding the drugs of choice of registered nurses shows that narcotic analgesics such as Demerol and morphine are the most frequently reported drugs of abuse. These drugs are most easily accessible to nurses working in general hospital settings. Therefore, general hospitals in Texas were selected as the focus of the study.

METHODOLOGY - SURVEY RESEARCH

A review of methodologies revealed that survey research methodology was appropriate for the research purpose because it allows for "collecting original data for describing a population too large to observe directly" (Babbie, 237). The most efficient method

of gathering information is the self-administered questionnaire that is mailed to persons who have knowledge of the presence or absence of services in their employing hospitals.

SURVEY INSTRUMENT

Six questions requesting demographic information were placed at the beginning of the survey instrument. These items requested:

1. type of hospital;
2. ownership of hospital;
3. is hospital part of a multi-hospital system;
4. hospital bed capacity;
5. location of hospital (city); and
6. the position title of the respondent.

The response categories for type of hospital and type of ownership are those used by the Texas Hospital Association. Type of hospital was requested so that if an error was made in sampling and a hospital other than a general hospital was included in the sample, the response could be eliminated from the results of the survey.

The remaining questions on the survey instrument included the services identified in Table 2.1. Table 4.1 shows the location of each of the services on the survey instrument.

Table 4.1

LOCATION OF SERVICES ON SURVEY INSTRUMENT BY TOPIC

	TOPIC	QUESTION NUMBERS
1.	Employee Education	7,8
2.	Supervisor/Manager Training	9,10
3.	Urine/Blood Drug Screens	11,12,13,41,42
4.	Mandated Nurse Reporting	14.15
5.	Employee Discipline	17,18,19
6.	Referrals of Suspected Drug Misuse/Theft	16,20,21,22,23,24,25,26
7.	Employee Benefits	27,28,29,30,31,32,33,34
8.	Hiring and Retention	35,36,37,38,39,40

On the survey instrument, items were sub-divided into five sections: 1) educational services, 2) identification services, 3) referral services, 4) employee benefits and 5) return to work monitoring. (Refer to the survey instrument in Appendix A).

Respondents were asked to answer yes, no or unknown as to the presence or absence of each service in their employing facility. At the end of each of the five sections a space was provided for the respondent to list any additional services offered by his/her employing hospital. At the end of the survey instrument a space was provided for general comments.

The categorization of each item as preventative, punitive or rehabilitative did not appear on the survey instrument. The location of each category of service on the survey instrument is shown in Table 4.2.

Table 4.2

LOCATION OF SERVICES ON SURVEY INSTRUMENT BY CONCEPT

CONCEPT	QUESTION NUMBERS
Preventative	7,8,9,11,12,33,34
Punitive	14,15,17,18,19,24,25,26,41
Rehabilitative	10,13,16,20,21,22,23,27,28, 29,30,31,32,35,36,37,38,39, 40,42

PRE-TEST

After drafting the survey instrument, I asked two of my work colleagues to review the survey instrument. One is a research assistant who has more training and experience in doing research than I. The other is an investigator who is a graduate student who has taken courses in research methods and who performs field investigations which might make him more aware than I, of services offered by hospitals.

The suggestions of my colleagues were incorporated into the survey instrument and a pre-test of the survey instrument was completed by sending the instrument to nine nurse executives and the director of TPAPN. Seven of the nurse executives returned the survey instrument with no suggestions for additional survey items. The director of TPAPN provided suggestions to improve the survey instrument after review by himself and his staff. Three additional survey items were added at the suggestion of the TPAPN director.

POPULATION AND SAMPLING FRAME

The Texas Hospital Association gathers information about all hospitals in Texas, not just member hospitals. According to the Texas Hospital Association, there are 399 general hospitals in Texas. The Texas Hospital Association has an affiliate organization, the Texas Organization of Nurse Executives. This organization has 533 members, most of whom are currently practicing in a hospital setting.

Members of this organization were selected to sample.

A list of mailing labels in zip code order for members of the Texas Organization of Nurse Executives was obtained from the Texas Hospital Association. The list of 533 was reviewed and nurse executives that did not work in general hospitals were deleted. If more than one nurse from the same general hospital was on the list, one was selected for inclusion in the sampling frame and the others were deleted. Hence, the policies of individual hospitals should be represented only once in the responses. The resultant list included 189 names and addresses of nurse executives working in Texas general hospitals. The list of 189 was the sampling frame used in the study. The hospitals represented by these nurses were the units of analysis for this study.

One hundred nurse executives were selected for the sample. They were selected by choosing every third name from the zip code ordered list until one hundred names had been selected. This selection method was used to ensure that there would be statewide geographic representation in the sample.

DISTRIBUTION AND RETURN OF THE SURVEY INSTRUMENT

The survey instrument was mailed to the 100 nurse executives on September 19, 1992. A self-addressed stamped envelope was included with each survey to facilitate the return of the survey instrument and enhance the response rate. A cover letter was included explaining the purpose of the research and requesting that the

respondent mail the completed survey form by October 1, 1992. (See Appendix A).

Fifty-four completed surveys were returned. All of the respondents indicated that they were employed in general hospitals so all responses were included in the data to be analyzed.

ANALYSIS OF DATA

Univariate analysis is the appropriate analysis for examining the results of this survey. Frequency distributions were generated to summarize the respondent's answers to each of the survey questions. Frequency distribution is defined by Babbie as "A description of the number of times the various attributes of a variable are observed in a sample" (Babbie, Glossary, G3). Since the purpose of the study was to describe the services that exist in the general hospital setting, this is the appropriate depth of analysis. The frequencies were translated into percentage distributions for presentation in the tables of the findings.

CONCLUSION

The purpose of this study is to explore unknown territory. Survey research methodology with univariate analysis is an effective method for gathering information about an unknown area of study. The findings of the survey will be presented in the next chapter. In the final chapter conclusions will be drawn from the findings.

CHAPTER FIVE

RESULTS

The results of the survey are presented and discussed in this chapter. The demographic data are presented first. The responses to the survey questions regarding services are presented and discussed first in the categories as they appeared on the survey form: education, identification and intervention, referral, employee benefits and return to work/monitoring. Respondent's comments are incorporated into the presentation and discussion. The questions and the responses are then presented and discussed regrouped into the categories of preventative, punitive and rehabilitative.

DEMOGRAPHIC DATA

One hundred surveys were mailed to nurse executives who are members of the Texas Organization of Nurse Executives. Fifty-four completed surveys were returned. All of the respondents indicated that they were currently employed in a general hospital. Demographic information about type of ownership of the employing hospitals, whether the hospital is a part of a multi-hospital system, and hospital bed capacity are shown in Tables 5.1 through 5.3. The locations of the hospitals are found in Appendix B.

Ownership Type

The ownership type of the hospitals is shown in Table 5.1. The categories are those used by the Texas Hospital Association.

Table 5.1

OWNERSHIP OF HOSPITAL

	NUMBER	PERCENT
Church	9	16.7
Non-Church Non-Profit	15	27.8
Association	0	0
Corporation	9	16.7
Individual	1	1.9
Partnership	2	3.7
City	3	5.6
City-County	0	0
Community MHMR	0	0
County	4	7.5
Federal	1	1.9
Hospital Authority	1	1.9
Hospital District	6	11.1
State	1	1.9
Other	2	3.7
TOTAL	54	100

Twelve of the fifteen ownership types were represented. The largest three categories were church (16.7 percent), non-church, non-profit (27.8 percent) and corporation (16.7 percent). The three ownership types that were not represented were association, city-county and community MHMR. Community MHMR was not expected because MHMR stands for mental health and mental retardation. It is unlikely that a MHMR hospital would be classified as a general

hospital. It is unknown how many, if any, general hospitals in Texas are owned by an association or a city-county.

Multi-hospital System

A multi-hospital system is an owner that owns more than one hospital. It is expected that hospitals having a common owner would offer the same or similar services for nurses that are or at risk of chemical dependence. The status of the hospitals is shown in Table 5.2. Almost 60 percent of the respondents work in a hospital that is not part of a multi-hospital system.

Table 5.2

MULTI-HOSPITAL SYSTEM

Yes	23	42.8
No	31	57.5
TOTAL	54	100

Bed Capacity

The bed capacities of the hospitals are shown in Table 5.3. All of the bed capacity categories were represented. Over half of the responses (51.9 percent) came from hospitals with a bed capacity of 149 or less.

Table 5.3

HOSPITAL BED CAPACITY

	NUMBER	PERCENT
49 or less	7	13.0
50-99	12	22.2
100-149	9	16.7
150-199	4	7.4
200-249	7	13.0
250-299	4	7.4
300-349	4	7.4
350-399	1	1.9
400-449	1	1.9
450-499	2	3.7
500 or more	3	5.6
TOTAL	54	100

Location of Hospital

The cities where the hospitals are located are listed in Appendix B. At least 43 different cities were represented. Two respondents did not list the location of their hospital. Small cities such as Quitman with a population of approximately 2000 and large cities such as Houston with a population of about two million were represented. Cities from all geographic areas of the state were represented.

Position Title of the Respondent

The position title of the respondent was requested to verify that the respondents were currently employed by a hospital. All of the respondents did supply their position titles. The titles were varied and are not reported here.

Summary

The demographic data is presented to describe characteristics of the hospitals that are included in the findings that follow. No attempt was made to determine if the hospitals included in the responses to the survey are representative of the population of general hospitals in Texas.

RESULTS REPORTED BY TOPIC

Education Services

Education services are designed to provide information. Some of the benefits of education services include:

1. They may deter a nurse from engaging in substance abuse.
2. They may heighten the awareness of a nurse who is already abusing and encourage him/her to seek help.
3. They may encourage peers of a chemically dependent nurse to stop enabling behaviors.

4. They may assist supervisors in identifying a chemically dependent nurse at an earlier stage of addiction.

5. They may assist supervisors in facilitating the successful re-entry and continued recovery of a nurse who has received treatment and is ready to return to work.

The responses to the questions about educational services are presented in Table 5.4. The responses indicate that more than half of the hospitals do offer employees education services regarding chemical dependence. Training about the nursing profession and chemical dependence is offered by 60.4 percent. Literature on the nursing profession and chemical dependence is distributed by 64.2 percent of the hospitals.

Supervisor training is not as common as general employee training. Supervisor training on identifying the chemically dependent nurse is offered by 57.7 percent of the hospitals. Less than half of the hospitals (42.3 percent) offer supervisors training to assist them in supervising a nurse in recovery.

There were no "unknown" responses to the questions about educational services. This indicates that the respondents are aware of their hospitals' training programs on the subject of chemical dependence.

Table 5.4

EDUCATION SERVICES

(Percent Distributions)

	YES	TOTAL RESPONSES
Employee seminars or other training programs	60.4	53
Distribution of literature	64.2	53
Supervisor training - identifying the impaired nurse	57.7	52
Supervisor training - supervising a nurse in recovery	42.3	52

The comments of three respondents (See Appendix C) indicate that the employee assistance program is a source of educational services regarding chemical dependence. One respondent also identified TPAPN as a training source. Of interest, one person commented that working with chemically dependent patients was an educational service. This work may heighten the awareness of nurses of the physical and emotional manifestations of chemical dependence and have a deterrent affect.

All of the education services listed on the survey are offered by about half of Texas general hospitals. The literature suggests that education can reduce the initiation into chemical dependence. It can also provide for earlier identification and intervention when a nurse does begin a path toward chemical dependence through the abuse of substances.

Identification and Intervention Services

Identification and intervention services are mechanisms that a hospital may use to stop a nurse who is abusing drugs/alcohol from providing patient care while in an impaired state. Stopping impaired practice lessens the chances that a patient will suffer harm as the result of impaired practice and lessens the hospital's exposure to liability claims.

The survey results as shown in Table 5.5 indicate that most hospitals use some or all of the identification and intervention services listed on the survey questionnaire. Only random drug screens for all nurses and termination from employment are used by less than half of the hospitals.

There were no "unknown" responses to the questions on drug screens and mandatory reporting. This indicates that hospitals have made a conscious decision to use or not use these services.

Table 5.5

IDENTIFICATION AND INTERVENTION SERVICES

(Percent Distributions)

	YES	TOTAL RESPONSES
Pre-employment drug screens	67.9	53
Random drug screens - all nurses	28.8	52
Random drug screen - suspicion of use/ impairment	76.9	52
Mandated reporting - suspected theft of drugs	94.2	52
Mandated reporting - suspected use/ impairment	92.3	52
In-house intervention program	53.8	52
Termination from employment	39.1	46
Suspension from employment	62.2	45
Probationary employment status	69.6	46

About two-thirds of the hospitals require pre-employment drug screens and about three-quarters require random drug screens upon suspicion of use/impairment. Random screens for all nurses are used by less than a third of the facilities.

Respondents reported that over 90 percent percent of their facilities mandate reporting of suspected theft of drugs suspected drug use/impairment. The only comment on these questions was that reporting is "not mandated but nurses do this voluntarily with suspicion".

In-house intervention programs were reported as present in about half (53.8 percent) of facilities. Comments related to intervention indicate that seven of the facilities use TPAPN and employee assistance programs in the the identification and intervention process. The utilization of TPAPN is shown in the next section of "Referral Services" to be 98 percent. The absence of an in-house intervention program in about half of the hospitals does not indicate that intervention services are not provided by those hospitals.

Employee disciplinary actions of termination were reported by 39.1 percent of respondents; suspension by 62.2 percent of respondents and placement on probationary status by 69.6 percent of respondents. Of note, 6.5 percent of the respondents did not know if their hospital terminated chemically dependent nurses. The ten comments regarding employee discipline indicate that the use of discipline is situational. Suspension or placement on probation were indicated as more likely if the nurse enters a treatment program. The responses to the three questions about employee discipline and the comments of respondents suggest that a majority of hospitals are not immediately discarding nurses who may have a chemical dependence problem.

Identification and intervention services provide a second line of defense for hospitals when educational services have not been effective in preventing substance abuse. The results discussed above, show that a majority of hospitals have established a second line of defense.

Referral Services

When a nurse is suspected to be or known to be abusing chemical substances, referrals to services outside the employing unit may be needed. Referrals may be to employee assistance and peer assistance programs for evaluation and, if needed, for treatment. Referrals may also be to regulatory or law enforcement agencies for administrative or criminal sanctions. Table 5.6 describes referral services used by the hospitals. Almost all of the hospitals in the survey refer nurses for evaluation and treatment. Over 90 percent make referrals to the nursing boards for administrative sanctions. Less than one-third refer nurses to law enforcement authorities for criminal sanctions.

Table 5.6

REFERRAL SERVICES

(Percent Distributions)

	YES	TOTAL RESPONSES
In-house employee assistance program	43.1	51
In-house peer assistance program	36.5	52
Outside/Contract employee assistance program	45.1	51
Texas Peer Assistance Program for Nurses (TPAPN)	98.1	53
Nurse licensing board	92.2	51
Hospital security	27.5	51
Law enforcement agency	26.5	49

Almost all of the hospitals use TPAPN as a referral service. Over 90 percent refer chemically dependent nurses to the nursing boards. Comments of three respondents indicate that referrals to the nursing boards are not made if the nurse enters TPAPN. The results confirm that these hospitals are using TPAPN to assist nurses into a program of recovery that will allow for their return to the practice of nursing. They also suggest that hospitals are complying with statutory provisions that mandate the reporting of nurses not fit to practice, to TPAPN or the nursing boards.

Respondents indicated that almost 90 percent of their facilities have in-house employee assistance programs (43.1 percent) or outside/contract employee assistance programs (45.1 percent). Only about one-third of the hospitals have in-house peer assistance programs. The existence of TPAPN may lead hospitals, especially smaller hospitals, to have no need to develop an in-house peer assistance program.

Less than one-third of hospitals report chemically dependent nurses to hospital security (27.5 percent) or to law enforcement agencies(27.5 percent). Two respondents indicated that referrals are made to law enforcement only if theft is involved and three indicated that it "depends". Of interest, 5.9 percent of respondents did not know if they refer chemically dependent nurses to hospital security and 10.2 percent did not know if they are referred to local law enforcement.

Few other referral services were identified in the comments of the respondents. One person stated that referrals are made to various treatment centers. Another listed referrals to a local drug and alcohol council and to attend AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) meetings.

Employee Benefits

The availability of employee benefits may be a factor in a nurse's decision to seek evaluation, treatment and follow-up care for chemical dependence. Knowing that insurance benefits will pay for part or all of mental or physical health care services and that a job is waiting after services have been received, may also assist a nurse in making the choice to admit to a chemical dependence problem and seek treatment.

The survey questions about employee benefits revealed that a number of respondents did not know if insurance benefits and/or leaves of absence were available to chemically dependent nurses. Refer to Table 5.7 and note that the "unknown" responses to these questions range from 3.8 percent to 16 percent. In addition, two to four of the respondents did not answer some or all of these questions. If the nurse executives responding to the survey do not know the answers to these questions, it is likely that staff nurses are even less likely to know if these benefits are available.

Table 5.7

EMPLOYEE BENEFITS

(Percent Distributions)

	YES	UNKNOWN	TOTAL RESPONSES
Paid leave of absence	34.6	5.8	51
Leave of absence without pay	84.3	5.9	51
Insurance coverage for:			
Inpatient treatment	84.6	5.8	52
Outpatient treatment	88.5	3.8	52
Aftercare	58.0	16.0	50
Indiv./group psychotherapy	70.6	9.8	51
Benefits formally explained	90.4	3.8	52
Employees offered substance abuse treatment - optional benefit	19.2	7.7	52

Only about one-third (34.6 percent) of the hospitals offer paid leave of absence for treatment and recovery. Nine of the respondents clarified their response to this question by indicating that employees may use accrued benefit time. Leave without pay is offered by 84.3 percent of the hospitals. One respondent commented that leave without pay is only offered if the employee is in an outside (treatment) program.

Insurance coverage for inpatient and outpatient treatment is available in over 80 percent of the hospitals. Coverage for individual/group psychotherapy is less available. Seventy percent of the hospital's insurance benefits include psychotherapy. Almost ten percent of the respondents did not know if their insurance benefits include psychotherapy. The literature indicates that stress and self-treatment for emotional or mental illness often lead to chemical dependence. The access to psychotherapy through available insurance benefits may allow nurses to seek treatment before they embark upon self-treatment.

Insurance coverage for aftercare was indicated as available in only 58 percent of facilities. Another 16 percent, indicated that they did not know if insurance coverage for aftercare is available to employees of their hospital. Aftercare assists a person in recovery to stay in recovery. Access to aftercare treatment is often included in payment for a comprehensive inpatient or outpatient treatment program. The respondents may not be aware of its inclusion in their hospital's insurance benefits.

Employee benefits are formally explained to employees in most of the hospitals. The high "unknown" responses to the questions about insurance coverage suggests that information on benefits available for treatment of chemical dependence are not uniformly addressed in the explanation of benefits.

Optional benefit packages (cafeteria plans) are offered by only about 20 percent of the hospitals. Since most of the hospital's

insurance plans include coverage for chemical dependence treatment, there may be no need to offer optional benefits.

Return to Work/Monitoring Services

The literature suggests that 85 percent of chemically dependent nurses can receive treatment and return to practice. Hospitals need policies to guide their hiring and monitoring of nurses that are returning to work after treatment. The responses to the survey questions on return to work and monitoring services are in Table 5.8. The "no" and "unknown" responses are included in this table because of their frequency.

The results suggest that a hospital is twice as likely to hire a nurse under TPAPN contract (84.3 percent) than a nurse under a nursing board order (42.9 percent). In addition to only 42.9 percent indicating that they would hire a nurse under a board order, about one quarter of the respondents did not know if their hospital would hire a nurse under a board order and 10 percent (5) did not respond to the question. This suggests that a nurse seeking employment while under a board order will have difficulty finding a job. A past history of chemical dependence is less of an impediment to employment than a board order. About three-quarters of the hospitals will hire a nurse with a history of chemical dependence. Respondents' comments regarding hiring employees with a history of chemical dependence indicate that such hiring is situational, dependent upon such things as drug screens or whether the nurse is part of a structured program.

Table 5.8

RETURN TO WORK/MONITORING SERVICES

(Percent Distributions)

	YES	NO	UNKNOWN	TOTAL RESPONSES
e employees - history chemical dependence	78.3	19.6	2.2	46
lize return to work tracts	80.8	17.3	1.9	52
e nurses under TPAPN tract	84.3	11.8	3.9	51
ain nurses under TPAPN tract	92.3	5.8	1.9	52
e nurses under nursing rd orders	42.9	30.6	26.5	49
ain nurses under nursing rd orders	60.0	16.0	24.0	50
dom drug screens - nurses h history of chemical endence	60.0	36.0	4.0	50
dom drug screens - nurses urning to work after atment	82.7	11.5	5.8	52

The majority of the hospitals do have monitoring services. Most hospitals require return to work contracts (80.8 percent) and random drug screens (82.7 percent) for nurses returning to work after treatment for chemical dependence. Seven (7) respondents commented that they use random drug screens as required by (return to work) contracts. A nurse with a history of chemical dependence will be subjected to random drug screens by more than half of the hospitals.

RESULTS REPORTED BY CONCEPT

Preventative

Preventative services attempt to keep a nurse from becoming chemically dependent. The results as shown in Table 5.9, indicate that a majority of hospitals do have preventative services in place. Reasons for the absence of the two services that are not offered by a majority of the hospitals are suggested. The cost of doing drug screens could be a factor that affects a hospital's decision to not require random drug screens for all nurses. As stated previously, the inclusion of chemical dependence treatment in a basic insurance package may negate the need to offer it as an optional benefit.

Although a majority of hospitals offer preventative educational services and pre-employment drug screens about one-third or more of the hospitals do not offer any or all of these services. Since preventative services are less costly than rehabilitative services and likely to keep some nurses from practicing while impaired, these findings suggest that more hospitals should consider offering preventative services.

Table 5.9

PREVENTATIVE SERVICES

(Percent Distributions)

	YES	TOTAL RESPONSES
Employee seminars or other training programs	60.4%	53
Distribution of literature	64.2	53
Supervisor training - identifying the impaired nurse	57.7	52
Pre-employment drug screens	67.9	53
Random drug screens - all nurses	28.8	52
Benefits formally explained	90.4	52
Employees offered substance abuse treatment - optional benefit	19.2	52

Punitive

Punitive Services aim to penalize or punish a nurse for chemical dependence. The results of responses to questions categorized as punitive are in Table 5.10. Again because of the frequency of "no" and "unknown" responses, they have been included in the table.

The most punitive measure is a criminal sanction. Referral to hospital security and/or a law enforcement agency are used by only about a quarter of the hospitals. Ten percent of respondents did not know if their hospital refers nurses to law enforcement agencies and another ten percent did not respond to the question. This low rate of use suggests that hospitals are not interested in pursuing criminal sanctions against a nurse with a chemical dependence problem.

The next most punitive measure of termination from employment is used in only about 40 percent of the respondents who answered the question. Six and one-half percent of the respondents did not know if their hospital terminates chemically dependent nurses from employment. Eight of the survey respondents (17.4 percent) did not answer the question. The literature states that termination is not an effective way to deal with chemically dependent nurses because they will likely continue drug use and gain employment in another healthcare setting.

Most hospitals require reporting of suspected drug theft (94.2 percent) and of suspected use or impairment (92.3 percent). Although this is a punitive measure, the mandate of such reporting is in the interest of the hospital, as nurses stealing drugs may be stealing the drugs for personal use. Impaired practice due to drug use does expose the hospital's patients to risk of harm. Although this measure may have the punitive impact of removing the nurse from duty

and a possible resultant loss in pay, in many hospitals the nurse will be given the opportunity to seek treatment and return to work in lieu of facing immediate termination from employment.

Table 5.10

PUNITIVE SERVICES

(Percent Distributions)

	YES	NO	UNKNOWN	TOTAL RESPONSES
Mandated reporting - suspected theft of drugs	94.2%	5.8%	0%	52
Mandated reporting - suspected use/impairment	92.3	7.7	0	52
Termination from employment	39.1	54.3	6.5	46
Suspension from employment	62.2	33.3	4.4	45
Probationary employment status	69.6	28.3	2.2	46
Referral to nurse licensing board	92.2	5.9	2.0	51
Referral to hospital security	27.5	66.7	5.9	51
Referral to law enforcement agency	26.5	63.3	10.2	49
Require random drug screens nurses with history of chemical dependence	60.0	36.0	4.0	50

Employee discipline is used to deal with chemically dependent employees. Hospitals use suspension (62.2 percent) or placement on probationary status (69.6 percent) more often than termination (39.1 percent). Respondent's comments indicate that the application of employee discipline is dependent upon the situation, especially dependent on whether or not the employee is involved in a treatment program.

Referrals to the nursing boards were reported by most (92.2 percent) respondents. This high number of yes responses may be due to the mandatory reporting requirements in the statutes governing the practice of nursing in Texas.

Requiring random drug screens for nurses with a history of chemical dependence was reported by 60 percent of the respondents. This high percentage indicates a lack of confidence that nurses in recovery will maintain their recovery.

The punitive services that are reported as used by about two-thirds or more of the hospitals are mandatory reporting, suspension, probation and referral to the nursing boards. These punitive services are the least severe and often are used to force a chemically dependent nurse to receive treatment so they can safely re-enter practice.

Rehabilitative

Rehabilitative services are directed to restoring a chemically dependent nurse to a former state of good health. The majority of Texas general hospitals do offer rehabilitative services to address the issue of chemical dependence (See Table 5.11). Of particular note is the use of TPAPN. Respondent's reported that 98.1 percent of the hospitals refer nurses suspected to be chemically dependent to TPAPN; 92.3 percent will retain nurses under a TPAPN contract and 84.3 percent will hire a nurse under a TPAPN contract. In addition to utilizing TPAPN; 88.2 percent of the respondent's reported that their hospitals have in-house or outside/contract employee assistance programs; in-house intervention programs (53.8 percent); in-house peer assistance programs (36.5 percent); and utilize return to work contracts (80.8 percent). These are all services that are similar to those offered by TPAPN.

Most hospitals offer insurance coverage for inpatient treatment (84.6 percent) and for outpatient treatment (88.5 percent). Insurance coverage for individual/group psychotherapy is offered by 70.6 percent and for aftercare by only 58 percent. The availability of insurance benefits for substance abuse treatment can be a key rehabilitative approach to getting nurses into treatment and keeping them in a program of recovery.

Table 5.11

REHABILITATIVE SERVICES

(Percent Distributions)

	YES	TOTAL RESPONSES
Supervisor training - supervising a nurse in recovery	42.3	52
Random drug screen - suspicion of use/ impairment	76.9	52
In-house intervention program	53.8	52
In-house employee assistance program	43.1	51
In-house peer assistance program	36.5	52
Outside/Contract employee assistance program	45.1	51
Texas Peer Assistance Program for Nurses (TPAPN)	98.1	53
Paid leave of absence	34.6	51
Leave of absence without pay	84.3	51
Insurance coverage for:		
Inpatient treatment	84.6	52
Outpatient treatment	88.5	52
Aftercare	58.0	50
Indiv./group psychotherapy	70.6	51

Table 5.11 (cont.)

	YES	TOTAL RESPONSES
Hire employees - history of chemical dependence	78.3	46
Utilize return to work contracts	80.8	52
Hire nurses under TPAPN contract	84.3	51
Retain nurses under TPAPN contract	92.3	52
Hire nurses under nursing board orders	42.9	49
Retain nurses under nursing board orders	60.0	50
Random drug screens - nurses returning to work after treatment	82.7	52

Leave of absence without pay is available in 84.3 percent of facilities for employees needing treatment for chemical dependence. This is an important complement to insurance coverage for treatment, as it provides an additional incentive for a nurse to commit to treatment and recovery knowing that there is still a job they can return to after treatment. Paid leave of absence is available in only about one-third of the hospitals. According to the comments of the respondents, paid leave is usually for the period of time that the nurse has accrued benefit days for vacation and sick leave.

Random drug screens are utilized by most hospitals upon suspicion of use/impairment (76.9 percent) and for nurses returning to work after treatment (82.7 percent). Drug screens may identify a nurse who needs treatment. They may have a deterrent affect for a nurse in recovery who knows that he/she could be asked to submit to a drug screen at any time. This knowledge alone is sufficient to keep some nurses from making the decision to use drugs or alcohol.

Supervisor training on supervising a nurse in recovery is reported to be offered by only 42.3 percent of the respondent's hospitals. Since appropriate supervision is an important element in the success of a recovering nurse's return to work, more hospitals should consider adding this to their training programs.

Only 42.9 percent of hospitals hire nurses under orders of a nursing board and only 60 percent report retaining nurses under orders of a nursing board. Although these percentages are much lower than the responses to the similar questions regarding TPAPN, they are not unexpected. Many of the nurses who are disciplined by the nursing board have had the opportunity to receive treatment and return to work under a TPAPN contract. They have either chosen not to participate in TPAPN or been unsuccessful in maintaining their recovery and been referred to the licensing board by TPAPN. Also of note, were the percentages of respondents who did not know if their hospital would hire a nurse under orders of a nursing board (26.5 percent) or retain a nurse under orders of a nursing board (24 percent).

The hospitals which do not hire or retain nurses under orders of a nursing board may not feel confident that these nurses are likely to succeed in a program of recovery forced upon the nurse as a condition of continued licensure. This or some other reason discourages hospitals from hiring or retaining nurses under orders of a nursing board when so many will hire and retain TPAPN participants.

The responses to questions that have been categorized as rehabilitative indicate that a majority of hospitals have developed a complement of rehabilitative services to assist a nurse from the identification of a chemical dependence problem through treatment and to facilitate the nurse's return to work in an environment that is supportive of his/her continued recovery.

SUMMARY

The reported results of the survey show that the majority of Texas hospitals do offer services to nurses who are or at risk of becoming chemically dependent. The results also show that the hospitals offer a variety of services in the categories of preventative, punitive and rehabilitative. Suggestions for further study based on the results of this research will be presented in the next chapter.

CHAPTER SIX

SUMMARY AND CONCLUSIONS

The purpose of this study was to identify the services offered by Texas general hospitals to nurses who are or at risk of becoming chemically dependent. The study was conducted to look at whether or not Texas general hospitals have, as the 1984 ANA Task Force recommended, implemented a complement of services that offer chemically dependent nurses an alternative to being fired from their place of employment and possibly discarded from the nursing profession through the loss of their professional license.

The return of fifty-four of the one hundred surveys mailed to the sample was a good return rate. The demographic data reported by the respondents showed that responses were received from locations throughout the state from large urban cities to small rural cities. The ownership types and bed capacities of the hospitals were also varied. Although no attempt was made to analyze how representative the respondents were of the whole population of 399 general hospitals, it appears that a cross section of the Texas general hospitals were represented in the responses.

The findings that are reported in Chapter Five suggest that Texas general hospitals do offer an array of services for nurses who are or are likely to become chemically dependent. One finding that

was particularly encouraging was that 98 percent of the hospitals do refer nurses suspected of being chemically dependent to TPAPN. TPAPN is the type of program that the ANA Task Force was suggesting would be a beneficial alternative to governmental regulatory disciplinary action against chemically dependent nurses.

It is also encouraging to note the number of facilities that will hire or retain nurses that have become chemically dependent, received treatment and are in a program of recovery. Through enabling rehabilitation rather than enabling continued chemical abuse hospitals and nurse peers can assist in salvaging the careers of nurses. This is particularly important in the current nursing shortage environment.

Although over half of the respondents reported that their hospitals offer employee training regarding chemical dependence the finding that about 40 percent do not offer training would suggest that hospitals can do more preventative service work by offering more educational programs to employees. Another area of concern is that only slightly more than half offer training to supervisors on identifying the chemically impaired nurse and less than half offer supervisor training on supervising a nurse in recovery. Since it was reported that 92.3 percent of hospitals mandate the reporting of suspected drug use or impairment, the provision of additional educational services would enhance the knowledge base of employees who are expected to report suspicions of drug use/impairment.

The use of drug screens in hospitals seems to be geared toward prevention and rehabilitation. The preventative use of pre-employment drug screens was reported by 67.9 percent of respondents. The rehabilitative use of drug screens is evidenced by 76.9 percent using drugs screens upon suspicion of use/impairment and 82.7 percent requiring random drug screens for nurses returning to work after treatment.

The utilization of referral services whether in house or with outside agencies appears to be the norm for hospitals. Other than TPAPN, which is utilized by most all hospitals, 88.2 percent reported having in-house or contract employee assistance program and 92.2 reported that they make reports to the nursing boards. The least utilized referral resources were hospital security and law enforcement agencies. The thrust of referrals appears to be toward rehabilitative resources.

The questions related to employee discipline showed that termination is least likely to be used, with suspension or placement on probation more likely to be used. The infrequent use of termination as a means of disciplining an employee with a chemical dependence problem is consistent with the recommendations of the ANA Task Force that health care employers should provide rehabilitative services. Comments of respondents suggest that the decision to terminate a chemically dependent employee is often affected by the willingness of the employee to get treatment.

More than 80 percent of the hospitals are reported to offer insurance coverage for inpatient or outpatient treatment for chemical dependence. Coverage for aftercare and individual/group psychotherapy are less available with 58 percent providing coverage for aftercare and 70.6 percent providing coverage for individual/ group psychotherapy. It is noteworthy that 16 percent of respondents did not know if aftercare coverage was included in their insurance benefits and 9.8 percent did not know if individual/group psychotherapy would be covered. This implies that hospitals may need to do more employee education regarding available insurance benefits.

Another look at the services as recategorized as preventative, punitive or rehabilitative shows that the services offered by hospital fall into all of these categories. This suggests that the proper utilization of services from all three categories is the approach that makes the most sense for hospitals. Certainly, preventative efforts if successful will save the hospital money in terms of personnel costs and possible liability costs. Rehabilitative services can serve the purpose of salvaging the careers of nurses whose skills are in demand due to a shortage of available registered nurses to fill positions. Finally, punitive services or measures may be needed for nurses who maintain strong denial of a chemical dependence problem and whose continued practice may expose patients to risk of harm.

IMPLICATIONS FOR FURTHER RESEARCH

This study was an initial attempt to identify what services hospitals offer to nurses who are or are at risk of chemical dependence. Due to constraints of time and money only a sample of Texas general hospitals were studied. It would be interesting for the same or similar studies to be conducted in other states or nationwide. It would be interesting to compare the level and types of services offered by Texas general hospitals to those in other states. With other studies available for comparison, a better sense of how Texas general hospitals are doing would become apparent. It would be interesting to find out if hospitals have, in fact, in the eight years since the ANA report was published increased the number and types of services that they offer. It would also be interesting and useful for further research to evaluate the effectiveness of the services being used. Are the services accomplishing their intended goals? Are they preventing some nurses from becoming chemically dependent? Are nurses receiving treatment maintaining a long-term recovery program?

Although survey research methodology was appropriate for this study, it does leave the researcher with questions that are unanswered. Since there was no personal contact with the respondents, the responses to questions which were answered with comments such as "depends" could not be clarified. An approach suggested for further study would be face to face indepth interviews with nurse managers or executives to allow for follow-up questions to

clarify responses.

Another approach to further research might be to perform document analysis of the policies and procedures that hospitals have in place that address the issue of chemical dependence. The document analysis might reveal more information regarding the situational use of services.

APPENDIX A

September 19, 1992

Dear Nurse Manager:

My name is Kathleen Lamm. I am a graduate student at Southwest Texas State University majoring in public administration, with a career support area of health care administration. The final requirement for my degree program is an applied research project.

My applied research project is a descriptive study of the services currently offered by Texas hospitals to nurses who may be at risk of or are chemically dependent. Information is being collected through the enclosed survey instrument. The information collected will be reported in a summary format. No individual respondents or hospitals will be identified in the report of findings.

Please take a few minutes to complete the survey instrument. Any comments would be appreciated. Please mail the completed survey form by October 1, 1992. A return envelope has been enclosed for your convenience.

Your assistance is appreciated. If you would like a copy of the results of my study, please indicate so and include your name and address on the survey form or on a separate sheet of paper. If you have questions, please feel free to contact me at 512-251-6607.

Sincerely,

Kathleen S. Lamm
1709 Peridot Road
Pflugerville, TX 78660

Enclosures

QUESTIONNAIRE REGARDING SERVICES OFFERED TO NURSES WHO ARE AT RISK OF OR ARE CHEMICALLY DEPENDENT

A. DEMOGRAPHIC INFORMATION

1. TYPE OF HOSPITAL: (CHECK ONE)

___ GENERAL
___ CANCER
___ ALCOHOLISM/CHEMICAL DEPENDENCY
___ EYES, EARS, NOSE AND THROAT
___ OBSTETRICS/GYNECOLOGY
___ PEDIATRIC
___ PULMONARY/HEART DISEASE
___ VENTILATOR DEPENDENCY
___ GENERAL OSTEOPATHIC
___ CHEST DISEASES
___ COLLEGE INFIRMARY
___ GERIATRIC
___ ORTHOPEDIC
___ PSYCHIATRIC
___ REHABILITATION
___ OTHER (SPECIFY) _____

2. OWNERSHIP OF HOSPITAL: (CHECK ONE)

VOLUNTARY
___ CHURCH
___ NON-PROFIT, NON-CHURCH

INVESTOR-OWNED
___ ASSOCIATION
___ CORPORATION
___ INDIVIDUAL
___ PARTNERSHIP

GOVERNMENTAL
___ CITY
___ CITY-COUNTY
___ COMMUNITY MHMR
___ COUNTY
___ FEDERAL
___ HOSPITAL AUTHORITY
___ HOSPITAL DISTRICT
___ STATE

___ OTHER (SPECIFY) _____

3. IS THIS HOSPITAL A PART OF A MULTI-HOSPITAL SYSTEM? ___YES___NO

4. HOSPITAL BED CAPACITY: (CHECK ONE)
___49 OR LESS ___50-99 ___100-149
___150-199 ___200-249 ___250-299
___300-349 ___350-399 ___400-449
___450-499 ___500 OR MORE

5. LOCATION OF HOSPITAL(CITY)_____

6. YOUR POSITION TITLE_____

PLEASE IDENTIFY THE SERVICES THAT ARE OFFERED BY THE HOSPITAL AT WHICH YOU ARE CURRENTLY EMPLOYED. ALL QUESTIONS ARE SPECIFICALLY RELATED TO SERVICES THAT ADDRESS THE ISSUE OF CHEMICAL DEPENDENCE.

B. EDUCATIONAL SERVICES

7. EMPLOYEE SEMINARS OR OTHER TRAINING PROGRAMS REGARDING THE NURSING PROFESSION AND CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

8. DISTRIBUTION OF LITERATURE REGARDING THE NURSING PROFESSION AND CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

9. SUPERVISOR TRAINING ON IDENTIFYING THE CHEMICALLY IMPAIRED NURSE ___YES ___NO ___UNKNOWN

10. SUPERVISOR TRAINING ON SUPERVISING A NURSE IN RECOVERY ___YES ___NO ___UNKNOWN

PLEASE LIST OTHER EDUCATIONAL SERVICES RELATED TO CHEMICAL DEPENDENCE THAT YOUR HOSPITAL PROVIDES:

_____

_____

C. IDENTIFICATION AND INTERVENTION

11. PRE-EMPLOYMENT DRUG SCREENS	___YES	___NO	___UNKNOWN
12. RANDOM DRUG SCREENS FOR ALL NURSES	___YES	___NO	___UNKNOWN
13. RANDOM DRUG SCREEN UPON SUSPICION OF USE/IMPAIRMENT	___YES	___NO	___UNKNOWN
14. MANDATED NURSE REPORTING OF SUSPECTED THEFT OF DRUGS	___YES	___NO	___UNKNOWN
15. MANDATED NURSE REPORTING OF SUSPECTED DRUG USE/IMPAIRMENT	___YES	___NO	___UNKNOWN
16. IN-HOUSE INTERVENTION PROGRAM	___YES	___NO	___UNKNOWN
17. TERMINATION FROM EMPLOYMENT	___YES	___NO	___UNKNOWN
18. SUSPENSION FROM EMPLOYMENT	___YES	___NO	___UNKNOWN
19. PLACEMENT ON PROBATIONARY EMPLOYMENT STATUS	___YES	___NO	___UNKNOWN

PLEASE LIST OTHER IDENTIFICATION AND INTERVENTION SERVICES UTILIZED IN YOUR HOSPITAL:

_____

_____

D. REFERRALS TO:

20. IN-HOUSE EMPLOYEE ASSISTANCE PROGRAM	___YES	___NO	___UNKNOWN
21. IN-HOUSE PEER ASSISTANCE PROGRAM	___YES	___NO	___UNKNOWN
22. OUTSIDE/CONTRACT EMPLOYEE ASSISTANCE PROGRAM	___YES	___NO	___UNKNOWN
23. TEXAS PEER ASSISTANCE PROGRAM FOR NURSES (TPAPN)	___YES	___NO	___UNKNOWN
24. BOARD OF NURSE EXAMINERS/ VOCATIONAL NURSE EXAMINERS	___YES	___NO	___UNKNOWN
25. HOSPITAL SECURITY	___YES	___NO	___UNKNOWN
26. LAW ENFORCEMENT AGENCY	___YES	___NO	___UNKNOWN

PLEASE LIST ANY OTHER TYPES OF REFERRALS YOUR HOSPITAL MAKES OF CHEMICALLY DEPENDENT NURSES:

_____

_____

E. EMPLOYEE BENEFITS

27. PAID LEAVE OF ABSENCE	___YES	___NO	___UNKNOWN
28. LEAVE OF ABSENCE WITHOUT PAY	___YES	___NO	___UNKNOWN

7. INSURANCE COVERAGE FOR:

29. INPATIENT TREATMENT ___YES ___NO ___UNKNOWN

30. OUTPATIENT TREATMENT ___YES ___NO ___UNKNOWN

31. AFTERCARE ___YES ___NO ___UNKNOWN

32. INDIVIDUAL/GROUP PSYCHOTHERAPY ___YES ___NO ___UNKNOWN

33. ARE EMPLOYEE BENEFITS FORMALLY EXPLAINED TO EMPLOYEES? ___YES ___NO ___UNKNOWN

34. ARE EMPLOYEES OFFERED SUBSTANCE ABUSE TREATMENT COVERAGE AS AN OPTIONAL BENEFIT (CAFETERIA PLAN)? ___YES ___NO ___UNKNOWN

PLEASE LIST ANY OTHER EMPLOYEE BENEFITS YOUR HOSPITAL OFFERS TO CHEMICALLY DEPENDENT NURSES:

_____

_____

F. RETURN TO WORK/MONITORING

35. HIRE EMPLOYEES WITH A HISTORY OF CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

36. UTILIZE RETURN TO WORK CONTRACTS FOR NURSES RETURNING TO WORK AFTER TREATMENT FOR CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

37. HIRE NURSES UNDER TPAPN CONTRACT ___YES ___NO ___UNKNOWN

38. RETAIN NURSES UNDER TPAPN CONTRACT ___YES ___NO ___UNKNOWN

39. HIRE NURSES UNDER ORDERS OF A NURSING BOARD ___YES ___NO ___UNKNOWN

40. RETAIN NURSES UNDER ORDERS OF A NURSING BOARD ___YES ___NO ___UNKNOWN

41. REQUIRE RANDOM DRUG SCREENS FOR NURSES WITH A HISTORY OF CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

42. REQUIRE RANDOM DRUG SCREENS FOR NURSES RETURNING TO WORK AFTER TREATMENT FOR CHEMICAL DEPENDENCE ___YES ___NO ___UNKNOWN

PLEASE LIST ANY OTHER RETURN TO WORK/MONITORING SERVICES YOUR HOSPITAL UTILIZES FOR CHEMICALLY DEPENDENT NURSES:

_____

_____

GENERAL COMMENTS: _____

_____

_____

_____

_____

APPENDIX B

Location of Hospital	Frequency
Amarillo	1
Angleton	1
Beaumont	1
Bedford	1
Brownsville	1
Bryan	1
Dallas	3
Denison	1
Dumas	1
El Paso	1
Electra	1
Floresville	1
Fredricksburg	1
Ft. Worth	2
Galveston	1
Gatesville	1
Georgetown	1
Harlingen	1
Houston	3
Irving	1
Jacksonville	1
La Grange	1
Linden	1
Lufkin	1
Mission	1
Missouri City	1
Monahans	1
Muleshoe	1
Nederland	1
Orange	1
Paris	2
Pasadena	1
Quitman	1
Round Rock	1
San Angelo	1
San Antonio	3
Sheppard Air Force Base	1
Sweetwater	1
Temple	2
Terrell	1
Tomball	1
Victoria	1
Waco	1
No City Listed	2
TOTAL	**54**

APPENDIX C

RESPONDENT'S COMMENTS

Educational Services (Questions 7-10)

Supervisor training (#9 and #10) could be provided as needed.

Other educational services

1-services are offered through larger facilities.

2-impaired nurse counselor also supports and teaches allied health students.

3-employee assistance program and peer review

4-employee assistance program and TPAPN

5-one week orientation to all med/.surg. supervisors

6-EAP (Employee Assistance Program) Committee

7-inservices only - video tapes/outside speakers

8-Working with patients with chemical dependency, detox and inpatient CD treatment

Identification and Intervention Services (Questions 11-19)

Termination, suspension or placement on probation (#17-#19)

1-depends on situation/ circumstances (X3),

2-only if-non-responsive to intervention,

3-sometimes termination or suspension, yes to placement on probation

4-suspended or placed on probation until referred to TPAPN or BNE

5-termination depends,

6-termination if refuses help, suspension or probation depends on situation,

7-suspension if in treatment,

8-depends on nurses willingness to enter rehab

Mandated reporting of suspected drug theft, use/impairment (#14-#15)

1-not mandated but nurses do this voluntarily with suspicion

Other identification and intervention services

1-TPAPN referral (X4)

2-TPAPN assistance in training, counselling and identification hospital employee assistance program (X3)

3-nurse peer review,

4-inpatient treatment

5-admission to CD inpatient/outpatient program (X2)

6-counselling

Referral Services (Questions 20-26)

Referral to board (#24)

1-Do not refer to Board if in TPAPN

2-Refer to Board if refuse TPAPN

3-Prefer TPAPN-this step last resort

4-depends

5-if appropriate

Referral to law enforcement (#26)

1-only if theft involved (X2)

2-depends on situation (X3)

Referral to hospital security (#25)

1-if behavior warrants

2-depends (X2)

Other referral services

1-various treatment centers

2-local drug and alcohol council, attendance at AA or NA meetings

Comment

-In-house employee assistance program - not formal, no department for this service due to hospital size

Employee Benefits (Questions 27-34)

Paid leave of absence (#27)

1-if sick or other benefit time has accrued (X7)

2-use of benefit time then leave of absence without pay (X2)

Leave of absence without pay (#28)

1-if no benefit days (X2)

2-only if in an outside program

Insurance coverage (#29-#32)

1-limited

2-inpatient and outpatient treatment for alcohol

3-employee insurance can be optional if employee spouse has coverage

4-employee benefits are explained formally in orientation and annually in writing

Return to Work/Monitoring Services (Questions 35-42)

Hire employees with a history of chemical dependence (#35)

1-depends

2-if they will be part of our structured program

3-never experienced

4-depending on drug screens

5-currently no, but would consider

6-we have not been in this position

Hire nurses under TPAPN contract (#37)

1-not tested yet

Hire or retain nurses under a board order (#39-#40)

1-depends on situation

2-not been requested to do so (X2)

Random drug screens-nurses with history of chemical dependence (#41)

1-only upon suspicion (X2)

2-under contract guidelines

3-just like all employees

Random drug screens for nurses returning to work after treatment for chemical dependence (#42)

1-during TPAPN contract (X5)

2-under contract guidelines

Comments

-Drug screening and support meeting requirements are followed according to TPAPN or Board requirements

-We have no chemically dependent nurses at this facility. We would have to treat them on a case by case basis.

-Questions #35-#42-how would you know? no one volunteers this information

-TPAPN is utilized

-Questions #37-#40-haven't had the opportunity, but would

-Random drug screens for all employees in pre-identified key positions

-Generally will only take them back under TPAPN Contract; have on occasion allowed board stipulations

General Comments

1-Failure to abide by substance abuse policy after treatment for chemical dependence results in termination.

2-Managers must learn the monitoring standards required on their own. Occasionally will be sent to a TPAPN workshop.

3-In over 25 years of nursing and working in many facilities across the US I have only run across 2 chemically dependent nurses. I think you time might be better spent studying how DRGs, insurance payments, Medicare affect the cost of running a hospital. The affect of the ADA on the hospitals. The affect of the new laws concerning health care workers who test HIV positive in the hospital. The reasons why hospitals are going under. How the suit-society is affecting health care cost. We all realize that chemical dependency is always a risk in health care. I think you will find it is much more of a problem in physicians than nurses, either way if its one or one thousand per per hospital it is a problem. I am for rehabilitation and returning to work but as I've said earlier each case has to be evaluated individually, to do otherwise is unfair to the employee and the employer.

4-Of course everyone with a chemical dependency is treated on an individual basis depending on past history, etc. We have had a better contract completion rate with in-house employees rather than outside hires. It just seems to have worked better for us on the average a better recovery rate.

5-A lot of the answers to these questions depend on individual and circumstances.

6-In the three years I have held this position there have been nurses under BNE orders and TPAPN contract. There have been no applicants presenting for employment with CD history. I support giving people a chance, under guidance and protection of state agency or other supervision.

7-I have had positive experiences with TPAPN over the past 8-10 years and have worked with 10-12 nurses on contract after treatment. Since I've been here only 5 months, there is much about this system (both written and unwritten policies) that I do not know. However, I remain committed to the peer assistance program and will gradually change internal policies to be more compatible with TPAPN.

8-Limited insurance coverage for CD.

9-Our facility is an active duty military hospital who does not "hire on" known abusers. However, we do treat those with alcohol problems and return them to duty with periodic monitoring. Substance abusers are administratively discharged form active duty after treatment.

10-I have only faced this issue twice during my tenure. One applicant was unable to work 12 hour shifts. The other case is current and pending TPAPN recommendations.

11-We have a reputation locally and with the Board for being fair, open minded and supportive of impairment issues; local advocates send nurses here to apply; we recently supported an individual through the tedious reinstatement process for licensure.

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