Identifying substance use disorder in nursing

By Suzanne Alunni-Kinkle, BS, RN, CARN

Substance use disorder (SUD) in nursing is more common than many believe. The American Nurses Association (ANA) estimates that 6% to 8% of nurses have a drug or alcohol problem that impairs their practice.[1] Others estimate that nurses abuse drugs and alcohol at the same rate as the general population, which is between 10% and 15%. This means that as many as one in 10 nurses may be experiencing an unidentified and untreated SUD.

How can you take action to support colleagues and ensure better outcomes for your patients and nurses?

Occupational hazards

Nurses have easier access to medication than many other professionals because of the nature of their job. Nursing can be a stressful occupation because of negative patient outcomes, rotating shifts, and high patient-to-nurse ratios. The lack of education in schools of nursing and healthcare organizations about the prevalence of SUD, its signs and symptoms, and how to address the problem also puts nurses at increased risk.

Nurses may be susceptible to SUD because of ingrained beliefs that they're invulnerable. Nurses often see themselves as caregivers and not as patients needing care. They tend to self-diagnose and self-medicate, believing they "need to work" and that this justifies their drug use.

One of the biggest reasons why nurses continue to work despite an SUD is the enabling behavior of their peers. Other staff members will rationalize their colleague's behavior, make excuses, and cover for him or her. Peers tend to look the other way out of loyalty or fear of being a whistleblower. Often, staff members will discuss the nurse's suspected condition among themselves; however, the nurse doesn't receive help and continues working while impaired.

An obligation to act

The ANA Code of Ethics addresses SUD in nursing.[1] Code 3.6 states that the nurse must be vigilant to protect the public and intervene when a colleague's practice appears to be impaired. Recent updates to Code 3.6 place the burden on nurses to extend care and compassion to colleagues in recovery and those who experience job disruption due to SUD. The code advocates for nurses to receive appropriate services and support for their return to work.

As nurse leaders, we not only have the responsibility to protect patients and support our staff, but we must educate our staff about SUD and how to recognize its signs as well. Nurses should also be acquainted with state mandatory reporting laws that hold colleagues responsible for harm to patients if they fail to report a coworker they suspect has an SUD.[2]

Nurse leaders should work to implement nonpunitive SUD reporting policies and procedures.[3] A transparent policy increases the likelihood that nurses will report suspected impairment in the workplace. Reporting colleagues need to be viewed as supportive and not punitive. An environment that encourages early recognition and intervention leads to increased public safety and better outcomes for all involved.

Red flags

Indicators of impairment are often conflated with symptoms of stress; therefore, it can be challenging to distinguish between the two. (See *Table 1.*) The signs and symptoms of SUD may also vary depending on the nurse's drug of choice, typically alcohol

or prescription medication. Common behavioral signs include a disheveled appearance, isolation, and mood swings. Nurses abusing alcohol will frequently use excessive amounts of mouthwash, gum, and mints to mask the smell of alcohol. Symptoms of alcohol abuse include tremors and excessive absenteeism or tardiness.

A nurse who's diverting drugs, on the other hand, will come to work daily because of access to medication. This nurse may offer to help administer medication to other staff members' patients, volunteer to work late, and work overtime. This nurse may also stop by the unit on days off.

Patients may complain of ineffective pain relief and you may see excessive cancellations of opioids in the automated medication dispensing system, excessive administration of as needed pain medications, and unsigned opioid wastage. Occasionally, the nurse will disappear from the unit for long periods of time and may spend copious amounts of time in the bathroom or around the medication cart.

Steps to take

Objective documentation, including observations of physical appearance, is essential and should focus on a nurse's ability to offer care. Knowing the nurse's baseline performance is critical. If patient safety is at risk, the nurse needs to be removed immediately.

If action is warranted after the documentation is reviewed, nurse leaders should plan an intervention. Ideally, there should be two people at the intervention to support the nurse and serve as witnesses. Focus the intervention on the documented facts and conduct it in a private, confidential setting to protect the nurse. Provide a referral to an alternative to discipline program (if one exists in your state) and treatment options.[4] The ultimate goal is to protect patients and return the nurse to the workforce.

Although it's common for a nurse to deny the allegations, some nurses experience relief when confronted because their lie is over. Most nurses will comply with the recommendation to avoid loss of license or any public action/discipline taken on their license. Nurses in an alternative to discipline program may be asked to refrain from practice or temporarily inactivate their license until deemed safe to practice.

After a nurse successfully completes the recommended treatment and complies with the state monitoring program, nurse leaders should advocate for and support the nurse's return to work. According to the National Council of State Boards of Nursing, approximately 70% of nurses who seek treatment successfully return to practice. The nurse in a state monitoring program will have a return to work agreement, which includes approved area of nursing, limitation of hours worked per week, restrictions on opioid handling if any, and required direct supervision and performance reporting. The nurse returning to work will continue to have random testing while under the monitoring agreement. It's vital for the nurse manager to have knowledge of the nurse's enrollment in a monitoring program and information on the contents of the return to work agreement.

Safety above all

Awareness of the signs and symptoms of SUD is the first step in identification and intervention. Early identification of SUD in the workplace protects patients and results in better outcomes for the nurse, along with retention for the profession. SUD is treatable and nurses can and do safely return to the workplace. NM

Table 1: Common red flags

Behavioral signs	Physical symptoms	Diversion behaviors
• Nodding off or napping • Unkempt/deterioration in appearance • Slurred speech • Smell of alcohol on breath; excess use of mints, gum, mouthwash, or hand sanitizer • Frequent, long trips alone; eats alone • Unexplained absences • Frequent tardiness	• Irritability • Diminished alertness/memory lapses • Uncontrolled anger or crying • Frequent mood swings • Defensiveness	• Volunteers for overtime, stays late • Comes into work on days off/vacation • Often volunteers to administer medications • Has discrepancies in medication counts • Excessively administers as needed pain medications • Has frequent patient complaints about ineffective pain relief • Has large amounts of opioid wastage

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