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1999 Reader Survey enclosed in this issue

ED NURSING

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Inside

Enclosed in this issue:
Screening tests for alcoholism and drug abuse

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American Health Consultants® is
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Do you work with an impaired nurse? ED nurses are at higher risk

Drug, alcohol abuse are more common than most believe

When an emergency nurse at Loma Linda (CA) University Medical Center and Children's Hospital turned white as a ghost, broke into a sweat, and nearly passed out, she claimed to be suffering from a bad flu.

"Everyone accepted that explanation," says **Jill Pollock**, RN, executive director for critical care and emergency services nursing at Loma Linda. "Later, it became obvious the nurse had a substance abuse problem."

Working in the ED puts you at high risk for substance abuse, emphasizes Pollock.

"We are in a very stressful, chaotic environment on a continual basis. Part of wanting to alter your mood when you're addicted is about escaping," she explains. "Also, we are a helping profession; but when we're the ones who are hurting, we don't know how to take care of ourselves."

Denial is rampant when it comes to substance abuse, says Pollock. "Nurses tell themselves, 'I'm a nurse and a professional, and it would never happen to me. I can self-medicate and still be OK,'" she explains. "Also, we have easy access to medication. When we're exhausted from working double shifts, we may feel we need to take something to keep us going."

Special issue on substance abuse in nursing

This issue of *ED Nursing* features extensive coverage on substance abuse in nursing. The cover story reveals that up to 15% of nurses will develop a drug or alcohol problem in their careers. Inside the issue, we tell you how to approach a colleague when you suspect substance abuse, and a guest columnist gives you a detailed plan for a confrontation. We also give you reports on innovative alternative programs that can save an impaired nurse's license and offer the latest statistics on ED nurses and substance abuse. Charts in this issue include signs of alcohol and prescription drug abuse in nurses, characteristics of an impaired nurse, and screening tests for alcohol and drug abuse.

Don't miss reading this special issue of *ED Nursing!*

EXECUTIVE SUMMARY

Experts estimate that up to 15% of nurses will develop a substance abuse problem in their careers. A recent study revealed that ED nurses were three to five times more likely than nurses in women's health, pediatrics, and general practice to use marijuana or cocaine.

- Substance abusers are often bright, well-liked, hard working, skilled nurses.
- Avoid using alcohol or drugs to medicate bad feelings, such as fatigue or feeling upset.
- Warning signs for prescription drug abuse include overuse of prescription drugs, using them in ways they weren't intended, self-medicating with a controlled substance, and using a controlled substance for an extended period of time.

Estimates about impaired nurses reveal the problem is significant, says **Valerie Murchake Wright**, RN, MLHR, alternative program coordinator for the Ohio Board of Nursing in Columbus. "Based on estimates, we believe that 15% of nurses will have a drug problem at some point in their career. Chances are very good you are currently working with somebody who has a problem." **(See story on the latest substance abuse statistics, p. 83.)**

A recent study shows that ED nurses were three to five times more likely to use marijuana or cocaine, when compared with nurses in women's health, pediatrics, and general practice.[1] "The literature shows that drug use in nurses is at least as high as in the general population," Wright reports.

Here are some things to consider when confronting substance abuse in your ED:

• Don't subscribe to stereotypes.

Although attitudes are changing, there is still a serious misconception about substance abuse, says Pollock.

"There is an ongoing conflict as to whether substance abuse is a deviant behavior or an actual illness. It is a true illness, but as health care professionals, it's difficult to understand how this could happen to one of our colleagues," she explains. "We ask ourselves, 'How on earth could a nurse who is a caregiver and promotes health harm themselves?' That is unthinkable."

The impaired nurse doesn't usually fit the stereotype of an alcoholic or drug addict, Pollock emphasizes. "It's usually not the nurses who you may first suspect," she says. "Substance abusers are often bright, well-liked, hard working, skilled practitioners."

• Know the realities of loss of license.

The penalties for substance abuse aren't necessarily as severe as the impaired nurse believes, stresses **Liz Jazwiec**, RN, a Crestwood, IL-based consultant specializing in staffing issues.

"The myth is that if you're caught taking drugs as a health care worker, you lose your license automatically," Jazwiec says. "But in most cases, you won't lose your license if you take care of the problem and get treated." **(See story on alternative programs, p. 83.)**

Penalties may be minimal as long as the problem is caught early, explains Jazwiec. "With substance abuse, nurses are usually given the opportunity to recover. But if it goes unchecked or causes some grave consequences such as a bad outcome with a patient, then you can lose your job and your license," she says. "It's almost doing the nurse a favor if you point it out early."

Unfortunately, most impaired nurses don't get help until after they are fired, Jazwiec notes. "Until it gets to that point, the nurse doesn't get help, and things progress and it becomes a point of no return," she says. "Once the decision is made to terminate, they may get help and start fresh somewhere else."

Ignoring the problem is not doing an impaired nurse any favor, argues Jazwiec. "When a problem goes to the extreme, it can have sad and tragic consequences, such as losing jobs or losing lives," she explains. **(See related story and guest column on steps to take when you suspect an impaired colleague, p. 79 and p. 85.)**

If the nurse's drug problem harms a patient, there can also be serious legal ramifications for the hospital, Jazwiec notes.

• Avoid burnout.

"ED nurses have a high potential for burnout because they are working with trauma all the time, both psychological and physical. So they can become traumatized themselves," says **Madeline Naegle**, RN, CS, PhD, FAAN, associate professor at the division of nursing at New York University in New York City. "There is a strong connection between psychological trauma and substance abuse."

ED nurses need to nurture themselves, stresses

COMING IN FUTURE MONTHS

- Update on ACLS drugs
- Bring alternative medicine to your ED
- Create a trauma flow sheet
- How to deal with difficult physicians
- Use standardized conscious sedation form

Naegle. "You have to practice very good self care. That includes taking vacation time when you have it, relaxation, exercise, socializing, and hobbies," she says. "In the ED, you are constantly assaulted psychologically by upsetting events. So you need to find ways to refresh yourself and relieve the psychological strain."

Never use alcohol or drugs to medicate bad feelings, such as fatigue or feeling upset, says Naegle. "That sets up a pattern of malfunctional use which can get you into trouble," she warns.

• **Follow policies and procedures.**

Make sure department policies for keeping track of controlled substances are closely followed, Wright advises.

"If you have an ED where no one is following the rules, it's easier to steal drugs," says Wright. "That is the one area where the ED is more at risk than other departments. It's so hectic, the patients are in and out, and it may be more lax in how closely policies are followed."

• **Watch for warning signs in yourself.**

The following signs could mean you are developing an alcohol abuse problem, says Naegle:

— You are drinking more frequently.

— You find yourself looking forward to drinking.

— You consistently find yourself drinking more than you intended to.

— You mix alcohol with prescription drugs or marijuana.

— You drink more than five drinks in the course of an evening once a week or more.

Because ED nurses are at high risk for prescription drug abuse, it's important to closely monitor yourself for warning signs, recommends Naegle. "If you overuse prescription drugs, use them in ways they weren't intended, are self-medicating with a controlled substance, or using a controlled substance for an extended period of time without being evaluated by your care provider, you could be developing a problem," she warns.

• **Utilize state and national resources.**

"It's important that you use the resources of nursing specialty organizations and state organizations in addressing the problem of substance abuse," says Naegle. "However, people with a substance abuse problem are often very isolated and are not joiners, so they may not be members of any organization."

State nursing organizations also will help nonmembers, Naegle notes. "You can provide anonymous information, and they will give you a referral to contact," she says.

The state association is separate from the state Board of Nursing, Naegle points out. "Your professional organization is not required to report people with drug or alcohol problems," she says. "In addition, many states have diversion legislation which allows you to surrender your license voluntarily while in treatment and get it back when you get well."

Reference

1. Trinkoff A, Storr C. Substance use among nurses: Differences between specialties. *Am J Pub Health* 1998; 88:581-585. ■

When you suspect a colleague is addicted

Although attitudes are changing, there is still a stigma about substance abuse, notes **Jill Pollock**, RN, executive director for critical care and emergency services nursing at Loma Linda (CA) University Medical Center and Children's Hospital.

"When I was a staff nurse, I remember a colleague we respected and loved being taken away in handcuffs," she recalls. "That's like firing somebody who has diabetes. The main goal should be to get the nurse into treatment."

Here are steps to take when you suspect a colleague has a substance abuse problem:

• **Know and address warning signs of substance abuse.**

Be on the lookout for the following red flags, advises Pollock:

— a change in personality;

— being gone from the ED for a long time;

— lateness or calling in sick frequently;

— erratic behavior;

— mood swings;

— failure to pay attention to things they normally would;

— irritability;

— requesting the night shift.

"If we see a nurse moving slow and looking very pale, and the next half hour they're perked up and ready to go, we may not pay attention because we're so busy," says Pollock. "We work in such a hectic environment, but when we do sense something is wrong, we need to confront it immediately." **(See Checklist: Characteristics of an Impaired Nurse, p. 81; Signs and Symptoms of the Alcoholic Nurse, p. 82; Signs and Symptoms of the Drug-addicted Nurse, p. 83; and screening tests for alcohol and**

EXECUTIVE SUMMARY

Obvious warning signs such as irritability, tardiness, and mood swings are often ignored by colleagues.

- Nurses are reluctant to report suspicions about drug use, fearing they will destroy a colleague's career.
- Red flags to watch for include a change in personality, being gone from the ED for a long time, lateness or calling in sick frequently, erratic behavior, mood swings, irritability, and requesting the night shift.
- Trust your instincts as to whether a colleague has a problem; avoid denial.

drug abuse, inserted in this issue.)

• **Follow your instincts.**

Liz Jazwiec, RN, a Crestwood, IL-based consultant specializing in staffing issues, says, "Most of the time, everyone knows when someone has a substance abuse problem. But they try to deny it, just like they would in any typical family situation.

"As health care providers, we do know in our guts when something is not right. I don't think we are often surprised, but like any other close group, we try and pretend it's not there."

• **Be sympathetic.**

Too often, employers just want to get an impaired nurse dismissed and see them as a liability, says Pollock.

"But these nurses are good people; they just become ill," she emphasizes. "And they're not malicious or bad."

When a nurse leaves the ED to go into treatment, colleagues tend to be unsympathetic, Jazwiec urges.

"When a nurse who worked the night shift was found to have a serious drug problem, that nurse had to go into rehab for eight weeks," she recalls. "The staff was upset because they had to cover the nurse's shifts. I had to point out to them that the nurse isn't off on a vacation, taking it easy. When this occurs to somebody, it's absolutely devastating."

Realize that it's far harder to undergo treatment for drug addiction than to work additional shifts, Jazwiec notes.

"When this happens to a nurse and your facility stands behind them and doesn't fire them, you ought to be grateful that you're working for an employer that does that. Because at any time, it could be you or someone you are close to," she says.

• **Make sure impaired nurses know they're not alone.**

At Loma Linda, a peer support program enables nurses with a substance abuse problem to reach out to their colleagues to discuss their options.

"These are people who the ED nurses view as 'safe,' who will respect their confidentiality," says Pollock. "There are certain people who are helpful and listen well, who nurses feel comfortable approaching with concerns. A nurse in trouble with drugs is more likely to go to one of these individuals than the nurse manager."

Nurses can ask for help without revealing the problem, Pollock explains.

"They can at least test the waters and talk it out with someone safer than a supervisor. They can ask, 'If I had a problem, how would I go about getting help? I don't feel comfortable telling you what it's about, but please refer me,'" she explains.

• **Don't hesitate to share concerns about a colleague.**

Nurses fear they will devastate a colleague by reporting suspicions about drug use, says Pollock.

"In every class I teach, someone raises their hand and says, 'I cannot report somebody because I will ruin their life.' Yes, there is a possibility of that person losing their license, but that doesn't always happen," she stresses. "Our fear of confronting is one of the biggest obstacles we need to overcome."

Twenty states have alternative programs

Nurses may not realize that many states have a diversion board that allows impaired nurses to retain their licenses, notes Pollock.

"Five years ago, only eight states had an alternative program, and today there are 20. If you have a problem, you can enroll in a rigorous program and avoid having your license taken away as long as you comply," she says. **(See story on alternative programs, p. 83.)**

Care enough to confront, urges Pollock. **(See story, p. 82, and guest column, p. 85, on how to confront a colleague. Also see chart, Reaction of Colleagues, p. 84.)**

"Nurses may disappear from the ED for hours on end, but colleagues remain in denial," she says. "People are generally willing to believe anything, except the fact that the nurse has a problem with drugs or alcohol."

One ED nurse who had a substance abuse problem used to make excuses about having to go into the bathroom continually to change a dressing on a leg injury, Pollock recalls.

"We all accepted that explanation without questioning it," she says. "You need to really examine and look at what's going on around you. Don't accept excuses that don't make sense." ■

Checklist: Characteristics of an Impaired Nurse

Does your employee demonstrate the following characteristics? Check those that best describe the current situation.

I. Current Behavioral Patterns

Employee's appearance
- ❒ sloppy
- ❒ inappropriate clothing

Mood
- ❒ withdrawn
- ❒ sad
- ❒ mood swings, high and low
- ❒ suspiciousness
- ❒ extreme sensitivity
- ❒ nervousness
- ❒ frequent irritability with others
- ❒ preoccupation with illness and death (morbidity)

Actions
- ❒ physically assaultive (or threatening)
- ❒ unduly talkative
- ❒ exaggerated self-importance
- ❒ rigidity — inability to change plans with reasonable ease
- ❒ making incoherent or irrelevant statements on the job
- ❒ overcompliance with any routine (making it a ritual)
- ❒ frequent argumentativeness
- ❒ frequent outbursts of crying
- ❒ excessive amount of personal telephone time

II. Job Performance

Absenteeism
- ❒ multiple instances of improper reporting of time off
- ❒ excessive sick leave
- ❒ repeated absences following a pattern (Monday/Fridays)
- ❒ excessive lateness in the morning or upon returning for lunch
- ❒ peculiar and increasingly improbable excuses for absences
- ❒ high absenteeism rate for colds, flu, gastritis, general malaise, etc.
- ❒ frequent unscheduled short-term absences (with or without medical explanation)
- ❒ frequent use of unscheduled vacation time

"On the Job" Absenteeism
- ❒ continued absence from job location more than job required
- ❒ frequent trips to water fountain or restroom
- ❒ long coffee breaks

Accidents
- ❒ physical complaints on the job
- ❒ accidents on the job
- ❒ accidents off the job

Work Patterns and Production
- ❒ current work assignment requires more effort than previously taken
- ❒ work takes more time to produce
- ❒ difficulty in recalling instructions, understanding office procedures, etc.
- ❒ display of disinterest in work
- ❒ increased difficulty in handling complex assignments
- ❒ difficulty in recalling previous mistakes (although these have been brought to the employee's attention)
- ❒ general absentmindedness, forgetfulness
- ❒ alternate periods of high and low productivity
- ❒ coming to work in an intoxicated condition
- ❒ missed deadlines
- ❒ mistakes due to poor judgment
- ❒ outside complaints about the employee's work
- ❒ improbable excuses for these poor patterns
- ❒ carelessness

Employee Relations on the Job
- ❒ overreaction to real or imagined criticism
- ❒ wide swings in job morale
- ❒ borrowing money from co-workers
- ❒ unreasonable resentments against co-workers
- ❒ repeated and compulsive criticism of the company
- ❒ persistent requests for job transfer
- ❒ unrealistic expectation for promotion
- ❒ abrasiveness with others (managers and/or co-workers)

Work Related Relationships in the Company
- ❒ inappropriate behavior at company business meetings
- ❒ complaints from the community concerning the employee

III. Other

Things to look for:
- ❒ illogical or sloppy charting
- ❒ wears long sleeves at all times
- ❒ comes to work early and stays late for no reason — hangs around
- ❒ isolated; wants to work night shifts; lunches alone; avoids informal staff get-togethers
- ❒ elaborate excuses for behavior such as being late for work
- ❒ blackouts; complete memory loss for events, conversations, phone calls to colleagues; euphoric recall of events on the floor
- ❒ calls in to request compensatory time at the beginning of the shift

Suspicious Behavior Concerning Controlled Drugs
- ❒ consistently signs out more controlled drugs than anyone else
- ❒ frequently breaks or spills drugs
- ❒ purposely waits until alone to open narcotics cabinet
- ❒ consistently volunteers to be med nurse
- ❒ vials appear altered
- ❒ incorrect narcotic count
- ❒ discrepancies between patients' reports and other patients' reports on effective medications, etc.
- ❒ patient complains that pain medications dispensed by this nurse are ineffective
- ❒ defensive when questioned about medication errors
- ❒ too many medication errors

Source: Ohio Board of Nursing, Compliance Unit, Columbus.

Signs and Symptoms of the Alcoholic Nurse

1. More irritable with patients and colleagues; withdrawn; mood swings.
2. Isolated, wants to work night shifts, lunches alone, avoids informal staff get-togethers.
3. Elaborate excuses for behavior such as being late for work.
4. Blackouts; complete memory loss for events, conversations, phone calls to colleagues; euphoric recall of events on the floor.
5. Job shrinkage; does minimal work necessary.
6. Difficulty meeting schedules and deadlines.
7. Illogical or sloppy clothing.
8. Increasingly absent from duty with inadequate explanations: long lunch hours, sick leave after days off.
9. Calls in to request compensatory time at the beginning of the shift.

Source: Ohio Board of Nursing, Compliance Unit, Columbus.

How to confront one of your colleagues

You have a personal and professional responsibility to intervene if you suspect a colleague is abusing drugs, urges **Liz Jazwiec**, RN, a Crestwood, IL-based consultant specializing in staffing issues. "We all need to look out for each other," she stresses. "You will notice signs of substance abuse in a peer well before a manager will, because you work so closely together. Also, chances are if a nurse has a problem, they will mask it around a supervisor."

Here are some things to consider when intervening with a colleague:

• **Don't accuse.**

Describe behavior instead of being accusing, advises **Jill Pollock**, RN, executive director for critical care and emergency services nursing at Loma Linda (CA) University Medical Center and Children's Hospital.

"Approach it from the point of view of being really concerned," Pollock advises. "Point out a few behaviors you notice. Say something along the lines of, 'I've noticed you are so different; [you] used to be bubbly and happy, and now it seems like any little thing sets you off. Is there something I can do for you? Is there something that you need?'"

Typically a confronted colleague will give you excuses, but be persistent if you suspect abuse, advises Pollock. "The nurse may insist, 'I'm just having a tough time at home'" she says. "But if the staff nurse continues to see progressive behaviors, such as being gone for an hour at a time, people need to look at what is causing this person to be irritable."

• **Expect impaired nurses to deny the problem.**

"I've confronted many nurses about substance abuse, and almost all of them deny it. Very few have broken down and cried and admitted they need help, but that is a rarity," says Pollock.

"They deny it because they are so fearful that you are taking away their lifeline. They believe if they admit the problem, their life as they know it is over. "Understand that you could be saving a life, Pollock says. "Most nurses say, 'What if I falsely accused them?' But you need to consider what happens when they continue to use drugs," she urges. "It could result in the loss of their life or a patient's life."

• **Intervene early.**

"It's very appropriate to ask people we care about if there is a problem," says Jazwiec. "There's nothing wrong with having a frank conversation with that person and asking if they need help. You should do this as soon as you notice a problem."

"Early in my career, we terminated a nurse after a long period of time due to substance abuse," she says. "Six months later, the nurse came in as a DOA. That taught me that in that case, I was probably too understanding and too easy in the beginning and certainly didn't help matters by looking away."

• **Don't diagnose your colleague.**

"Don't label or diagnose their colleague, because you really don't know what the problem is," says **Madeline Naegle**, RN, CS, PhD, FAAN, associate professor in the division of nursing at New York University in New York City. "Never implicate someone or say they're using drugs, because it's not helpful to the situation. The best thing to do is identify a specific performance problem. Then the supervisor can refer this person to an employee assistance program or health service."

• **Refer the colleague for help.**

"If you don't intervene, the nurse will just go downhill and get sicker and you could lose a friend and colleague," says Naegle. "Suggest the person seek help from peer assistance program or on their own. Let them know it's really important to do something to improve their job performance."

• **Be positive.**

"Nurses may think they can't get well, but remind them that research has shown that health care providers do better in treatment than other people," Naegle explains.

• **Don't hesitate to go to a supervisor.**

Signs and Symptoms of the Drug-addicted Nurse

1. Extreme and rapid mood swings: irritable with patients, then calm after taking drugs
2. Suspicious behavior concerning controlled drugs:
   - Consistently signs out more controlled drugs than anyone else
   - Frequently breaks or spills drugs
   - Purposely waits until alone to open narcotics cabinet
   - Consistently volunteers to be med nurse
   - Disappears into bathroom directly after being in narcotics cabinet
   - Vials appear altered
   - Incorrect narcotic count
   - Discrepancies between patients' reports and other patient's reports on effective medications, etc.
   - Patient complains that pain medication dispensed by the nurse are ineffective
   - Defensive when asked about medication errors.
3. Illogical or sloppy charting.
4. Frequently absent from unit.
5. Comes to work early and stays late for no reason — hangs around.
6. Lavishly uses sick leave.

Source: Ohio Board of Nursing, Compliance Unit, Columbus.

"If you're not comfortable approaching the nurse directly, go to a supervisor and let them know what you've been observing," Jazwiec advises. "Say, 'I'm just concerned. She seems to get secretive or funny when dispensing meds, and that's not how she used to be.'" ■

The latest research on abuse by nurses

A recent study looked at prevalence of use of various substances in a sample of more than 4,000 nurses.[1]

"Understanding what the statistics mean is key to understanding the problem of substance abuse," says **Madeline Naegle**, RN, CS, PhD, FAAN, associate professor in the division of nursing at New York University in New York City. Here are several key findings:

• **Nurses do not misuse alcohol or illicit drugs any more than individuals in other professions.** "However, if you consider the fact that 8% to 10% of 2.2 million nurses have a drinking problem, that's a pretty significant number," she says.

• **Prescription drug use by nurses, at a prevalence of 7%, is higher than that of the general public.**

"There is a higher prevalence of misuse and abuse than the average person for prescription drugs, but not higher than physicians or pharmacists," notes Naegle. "Access seems to be a factor and create problems for people at risk for prescription drug abuse."

• **Critical care and ED nurses have a higher prevalence of prescription drug abuse than other nursing specialties.**

"The strains associated with ED nursing may result in unresolved psychological stress that needs to be relieved through healthier outlets."

Reference

1. Trinkoff A, Storr C. Substance use among nurses: Differences between specialties. *Am J Pub Health* 1998; 88:581-585. ■

Alternative programs can save your license

Alternative programs for chemically dependent nurses are the wave of the future, according to **Valerie Murchake Wright**, RN, MLHR, alternative program coordinator for the Ohio Board of Nursing in Columbus.

"There is a definite trend toward alternative programs as opposed to formal discipline," she says. "Currently, 20 states have an alternative program for nurses, and the number continues to grow."

All state boards of nursing are required to investigate

EXECUTIVE SUMMARY

Twenty states now have alternative programs that allow nurses to retain their licenses if they follow an approved program.

- A nurse's participation in an alternative program is confidential and is not reported to the national data bank.
- Impaired nurses agree to complete chemical dependence treatment, maintain abstinence from drugs and alcohol, and to provide regular progress reports to the alternative program.
- The programs protect the public by encouraging nurses to seek help for their addiction and to establish a drug-free lifestyle.

Reactions of Colleagues

The following feelings and reactions may be experienced by the fellow employees or colleagues of an impaired person:

1. Do you experience a sense of discomfort (embarrassment, sympathy, anger) in meeting an employee's spouse?
2. Do you have a sense of relief when an employee goes on vacation?
3. Do certain employees cause you "after workday worry?"
4. Do you pass over certain people in assigning tasks?
5. Is it easier to do an employee's assignment yourself just to be sure it gets done, and done right?
6. Is it easier to cover up than to make an issue of bad job performance?
7. Do you feel like you'd like to dig yourself a hole and pull it in after you because of the behavior of a certain employee at a company function?
8. Do you ever feel like a "pressure cooker" around certain employees, and you have to control yourself or you'll blow up?
9. Do you ever feel really sympathetic to the family problems of an employee and that if you made an issue of the bad job performance you'd be a jerk?
10. Do you ever feel it's none of your business because the employee's problems are personal?
11. Do you ever feel lied to or conned?
12. Are certain employees in your department so-called "accident-prone?"
13. Do you feel uneasy with an automatic raise for a certain employee?
14. Are you fearful of employees who evidence use of drugs other than alcohol?
15. Do you feel uncomfortable around an employee known to have serious financial problems?
16. Are you fearful of including a certain employee in a social function because you didn't know if she or he would fit in?
17. Have you noticed who usually is the bartender at the annual Christmas party?
18. Do you ever avoid talking to an employee about certain problems because you see some of those problems in yourself?
19. Have you ever said this? "That SOB! I can't believe a word he says."
20. Did you ever end up questioning yourself about a task you assigned that wasn't carried out properly?
21. Have you defended yourself on whether or not your instructions were specific?

Source: Ohio Board of Nursing, Compliance Unit, Columbus.

complaints about nurses, Wright explains. "Many of the complaints are about nurses with drug or alcohol addictions."

If the complaint is substantiated, a formal board action may be imposed against the nurse. "Actions can include a reprimand, suspension, or revocation of licensure," Wright explains.

All action taken by boards are considered public information and are reported to the national practitioner data bank, she adds.

Alternative programs were developed essentially as an "alternative to formal disciplinary action," says Wright. With alternative programs, the nurse is asked to sign a monitoring agreement that typically includes requirements to complete chemical dependence treatment, maintain abstinence from drugs and alcohol, and provide regular reports to the alternative program of their progress in recovery.

If the nurse successfully meets the terms and conditions of the alternative program agreement, the board will abstain from taking any formal action against the nurse's license. "A nurse's participation in an alternative program is confidential and is not reported to the national data bank," Wright says.

Impaired nurses may be unable to work for a lengthy period of time, she says. "Nurses need to be away from work in the early part of treatment. We have found that it's important for nurses to focus on their recovery. So it's not unusual for the board to say

SOURCES

For more information about confronting substance abuse in your ED, contact the following:

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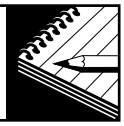
they can't work as a nurse for six months or more, depending on the circumstances," she explains. "When it comes to employment issues, we take into account the individual nurse and look at the whole picture."

Alternative programs create a structure to facilitate recovery and assist the nurse in returning to work once they have completed treatment.

"This structure allows boards to work with nurses as soon as there is knowledge of a problem," says Wright. "The programs protect the public by encouraging nurses to seek help for their addiction and to establish a drug-free lifestyle."

(Editor's Note: Nurses may obtain additional information about alternative programs in their state by contacting their state Board of Nursing or their state nurse's association.) ■

GUEST COLUMN



Plan for dealing with an impaired colleague

By **Colleen Bock-Laudenslager**, RN, MS
Bock-Laudenslager and Associates
Redlands, CA

If a colleague is demonstrating behavior that indicates impairment, dare to care! Concerning patterns may include: irrational thought processes, frequent medication errors, poor clinical judgment, tardiness, absenteeism, blaming others, mood swings, including withdrawal, and depression.

Recognize that the typical profile of an ED nurse makes us so vulnerable to impairment issues: the adrenaline rush, the caffeine infusions, the rollerblade work style, and working at more than two workplaces for the extra cash.

If you don't dare to care, then be aware as a nursing professional you are obligated to care. The Code for Nurses from the Washington, DC-based American Nurses Association suggests we are required to safeguard clients when health care is affected by incompetent, unethical, or illegal practice. Failure to adhere to the code of nurses places us in a position of censure, reprimand, and expulsion from a state's nursing organization.

The clinical nurse has a moral and ethical responsibility to report behavior that suggests impairment and a threat to the well-being of clients/patients. Critically observe the behavioral nuances of impaired colleagues, but reserve judgment. Listen to those peers. What are they trying to tell you? What are they trying to hide? Feel their sadness, and interact in a sensitive, professional manner. Consider these other suggestions:

• **Shake and shout.**

Denial is often the natural reaction with an impaired colleague. If you are aware of impairment issues with a peer, do something! When a nurse I worked with was showing signs of impairment, he offered me only a glimpse. I was too afraid it was none of my business, and I was afraid I wouldn't sustain healthy boundaries in the workplace. I did keep checking in to ask, "Are you OK?" But when he said yes, I took it as the correct answer. My gut told me otherwise.

If you dare to care and you are considering a confrontation of an impaired colleague, consult the impairment experts at your facility or your nurse management team. Remember, as nurses cozy with the caregiving role, we often enable our colleagues. It is so easy to be part of the tremendous emotional dysfunction and not report behavior truly unacceptable or concerning. Somehow our needs get wrapped up in their needs. It is at this point we are no longer helping them. Refer your colleague to the proper place for help. Set aside your role of chief counselor and problem solver. Encourage the peer to seek help from the institution's employee assistance program or counseling center.

• **Maintain the integrity of the airway.**

If you have the opportunity to minister to a colleague in a healthy dare-to-care way, keep the information to yourself. Talking about others creates a negative environment, especially concerning such sensitive subject matter. Don't gossip or discuss the peer's behavior with your colleagues. The end result is damaging and serves no purpose.

Talking about others creates triangles within a work unit and enhances tension and work distrust. If your impaired peers are open with you about their stories, create an environment of trust whereby baring their souls creates no risk for them. Keep your mouth shut to those not part of the confrontation team.

SOURCE

For more information about confronting a colleague with a substance abuse problem, contact the following:

- **Colleen Bock-Laudenslager**, RN, MS, P.O. Box 7303, Redlands, CA 92375. Telephone: (909) 798-4969.

I challenge the readers of this publication: If you or someone you know suffers from a substance, process, or relationship addiction, first know that there is hope. I encourage you to deal openly and honestly with these most difficult issues. Our addictions are killing us — both personally and professionally. Acknowledging our weakness may reflect strength. Allowing ourselves to be vulnerable to others offers us a clearer option of choosing to live. ■

Revamp how you address seizures — 4 new treatments

There are several new treatments for seizures that ED nurses should be aware of. Here are four:

• **Phosphenytoin.**

Andy Jagoda, MD, FACEP, associate professor at the department of emergency medicine at Mount Sinai School of Medicine in New York City, says, "The biggest concern is that a loading dose of a gram of phosphenytoin is a total volume of 20 ccs, and most nursing protocols don't allow nurses to administer more than 2 ccs IM. That has created a tremendous amount of concern for the nursing community."

Nursing protocols should be adapted to accommodate the recommended dosing, Jagoda says. "It can be given in a split dose, but can also be given in one site," he explains. "Other than a little bit of local irritation, most patients tolerate it very well."

• **Rectal diazepam.**

This is new on the market and is particularly valuable in children with recurrent seizures or clusters of seizures, says Jagoda.

"There have been some studies published in the last year showing that an IM dose of diazepam — because it's slowly released — can keep therapeutic levels for a prolonged period of time and minimize the recurrence of clusters."

If seizure disorders are treated at home, rectal dosing will allow parents to begin therapy before EMS even arrives, notes Jagoda. "In addition, when IV access needs to be established and the patient needs to be given an anticonvulsant, diazepam can be given rectally which makes it easier to administer. This is an option for someone not comfortable with IM dosing," he explains. "Another role for this may be in pre-hospital care, where providers may not be allowed to give IM dosing."

• **Intravenous valproic acid.**

"Valproic acid is a common antiepoleptic drug; but up until now, we've had no way of increasing patient's serum levels, short of slowly increasing their oral dose," Jagoda says.

Valproic acid can't be loaded orally because it causes a significant amount of GI upset, he explains.

"The IV route will allow us to manage these patients and give larger doses than we could give orally," Jagoda says. "It will enable us to increase serum blood levels in patients who are subtherapeutic and seize. This is being used in Europe to treat status epilepticus, but that is not a defined role for it in the states yet."

• **Prolonged post ictal period.**

When a patient who has had a seizure and has been given benzodiazene, the seizures will usually stop.

"Now, you have a patient who is lethargic, and you're faced with the question of why. Is it because of the drug — because the body has shut down after the seizure — or is there an infection we haven't recognized, such as meningitis?" he asks. "After most patients have seized, they have a period of being less responsive called the post ictal period, which can last from a few minutes to a few hours."

The patient may not be waking up because they are still seizing, says Jagoda.

EXECUTIVE SUMMARY

Phosphenytoin, rectal diazepam, intravenous valproic acid, and a prolonged post ictal period are all new treatments for seizure.

- There is a controversy over allowing nurses to administer phosphenytoin IM because of the loading dose volume.
- Rectal diazepam is effective in children with recurrent seizures or clusters of seizures, because of its slow release.
- IV administration of valproic acid allows larger doses to increase a patient's serum blood levels
- New evidence suggests many patients with a prolonged post ictal period may not be waking up because they are still seizing.

SOURCE

For more information on new developments in seizure management, contact:

- **Andy Jagoda**, MD, FACEP, Department of Emergency Medicine, Mount Sinai School of Medicine, One Gustave Levy Place, P. O. Box 1149, New York, NY 10029. Telephone: (212) 241-3870. E-mail: andy_jagoda@smtplink.mssm.edu.

"There is some evidence to suggest this isn't as infrequent as we once thought it was," he explains. "Nonconvulsive seizures just give the patient altered behavior symptoms, but the patient is still having a seizure."

New evidence suggests that 10% to 20% of patients treated for status epilepticus who stop having motor activity are actually still having seizure discharges in their brain, Jagoda notes.

"Nobody knows if this untreated seizure activity increased morbidity or mortality, but it's a very exciting area of future research."

In patients who have stopped seizing and are not waking up, among all the things that practitioners normally consider, also consider that they might still be seizing, says Jagoda. "Therefore, to make the diagnosis, you should probably get a bedside EEG," he advises. "Early consultation with an expert in seizure management is probably indicated." ■

Are you familiar with these 8 seizure myths?

There are several common misconceptions about seizure management, stresses **Gregory Henry**, MD, FACEP, chief of the department of emergency medicine at Beyer Memorial Hospital in Ypsilanti, MI. Here are eight:

• Myth 1: Febrile seizures in children are frequently a sign of a serious medical problem.

"Almost all febrile seizures in children are not due to a serious medical problem. One to 2% of kids will have those, and very few go on to be diagnosed as epileptic," says Henry.

However, childhood febrile seizures are a psychiatric emergency for the family, stresses Henry. "The near death-like appearance of the child is very frightening to the family," he says. "The family has many concerns and questions that need to be answered. So the nursing role in giving information and providing emotional support aspects is incredibly important."

• Myth 2: Febrile children need to be given continued anticonvulsants.

Virtually no febrile children need to have continued anticonvulsants, Henry maintains. "There's nothing in the literature that suggests that is useful," he says. "However, the family will want to know what to do, so nurses need to be schooled as to what the response should be. Discharge planning is more than half the battle in febrile seizures."

• Myth 3: A drug abuse panel isn't necessary with seizures.

"In young adults who have new onset seizures, we have to think about drug use, such as cocaine, alcohol, or stimulant drugs," Henry stresses. "It's worthwhile to carefully explore those areas, and don't be dissuaded by the history. A drug abuse panel is not unreasonable to get in any young person with seizures."

• Myth 4: All children with febrile seizures should be worked up for meningitis.

EXECUTIVE SUMMARY

Nurses should be aware of common misconceptions pertaining to seizure management.

- Almost all febrile seizures in children are not due to a serious medical problem.
- Virtually no febrile children need to have continued anticonvulsants
- A drug abuse panel should be ordered for any young person with seizures.
- There is no literature that shows that supplemental oxygen changes the length of a seizure.

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"There is very good data that suggests that if a child wakes up fairly quickly after a febrile seizure, and otherwise looks normal, they do not have worked up for meningitis," says Henry. "There is no higher incidence of meningitis in those kids."

• Myth 5: Put things in the patient's mouth so he or she wouldn't bite things.

This step is a waste of time, and it can be dangerous, says Henry. "All you need to do is keep the patient's head to the side, aspirate vomit, and [keep them from] hitting things," he says. "Keep them protected and cushioned, but don't hold them down too firmly, because they you can have so much force from the seizure [that] they break bones that way."

If they are not stopping quickly, then it is worthwhile to administer drugs, because prolonged seizing can cause inner cerebral damage, he says.

• Myth 6: Patient needs antiseizure medication instantly.

"If a seizure is going on for more than a couple of minutes, you may want to administer medicine, but almost all patients stop seizing," says Henry. "So the first thing you need to do is not fight with them to get an IV in. You need to protect them first, and then see if the seizures clear."

• Myth 7: Supplemental oxygen is necessary.

This seems like a good idea, but no literature that shows it changes the length of seizing, says Henry. "The problem is not the extraction of oxygen by the lung," he says. "It's a problem of the patient aspirating, and are they breathing regularly? So the breathing pattern of the patient should be observed."

• Myth 8: The newest antiseizure medications are the most effective.

"The old standbys, such as benzodiazepine drugs for the initial seizing episode, are still perfectly valid," says Henry. "If the situation calls for the sustained use of an antiseizure medication, Dilantin, Phenobarbital, and Tegretol are all still reasonable drugs to use."

More complex drugs should be used only if these basic drugs fail to work, says Henry.

"If simple drugs work, there is no reason to go to a fancier, more expensive drug," he advises. ■

CE Objectives

After reading this issue of *ED Nursing*, the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED Nursing. (See *Alternative programs can save your license* in this issue.)
2. Describe how those issues affect nursing service delivery. (See *Do you work with an impaired nurse? ED nurses are at higher risk* in this issue.)
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Revamp how you address seizures — 4 new treatments* and *Are you familiar with these 8 seizure myths?* in this issue.) ■