

Dealing with substance abuse

Anyone can fall prey to substance abuse. But when a nurse becomes addicted to drugs or alcohol, it's not just the user who is in danger. Patients' lives are put at risk, and other staff members can be put in risky situations.

Unfortunately, this happens all too often. Research tells us that substance abuse is the number one reason for disciplinary action by state boards of nursing (Sullivan and Decker, 2001). The American Nurses Association has estimated that as much as eight percent of nurses in the U.S. use alcohol or drugs enough to impair their professional judgment while on duty.

Hopefully, you're not part of that statistic—but some of your colleagues may be. That makes it your issue, too, because a nurse's first duty is to safeguard patients. Obviously, an impaired nurse is not fulfilling that duty. But nurses who notice another nurse's impairment and look the other way are also failing to safeguard patients. Both of these behaviors can be considered negligent—and can lead to malpractice suits.

Despite the risks to patients, nurses may be reluctant to report a colleague's suspected substance abuse. They may feel it's disloyal, they may feel guilty, they may even be afraid of adversely impacting a colleague's career. Often they worry that the substance abuser will lose his or her nursing license and, consequently, his or her job.

However, most healthcare organizations now support the disease model of addiction, which maintains that addiction warrants treatment, not disciplinary action. This model, while not universally accepted, is reinforced by clinical research and has been endorsed by a growing number of government and medical bodies, including the Office of National Drug Control Policy (ONDCP) and the American Medical Association.

Of course, despite the growing acceptance of the model, it's still important to protect yourself in this situation. Be sure to thoroughly document suspected abuse, keeping your observations objective, concrete, and as confidential as possible.

Your responsibilities

If you are a staff nurse, you have an obligation to report impaired nursing to your manager immediately. In addition, document your actions and the actions of the other parties in a notebook, just as you would record your actions and a patient's actions in the patient chart when providing nursing care: include date, time, full names of those involved and objective details of what occurred with direct quotes if pos-

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sible. Only document and report events you have witnessed firsthand. Keep a copy for yourself even if you are asked to provide the information to management. This will help demonstrate that you fulfilled your duty even if management does not follow through properly.

If you are a nurse manager, you have a heightened responsibility. Supervisors and managers who don't act on known or suspected substance abuse among their staff can be sued for negligent supervision. Nurse managers must be able to recognize substance abuse problems and handle them appropriately, as well as ensure that their staff nurses know how to respond.

As a nurse manager, it's also important to ensure that your staff is thoroughly trained to recognize the signs of substance abuse among their colleagues and to know what to do when they have suspicions.

Staff training should emphasize that addiction is an illness that requires treatment, not a moral failing, and it should clearly outline the steps the facility would take to address the situation. When staff nurses know that colleagues with substance abuse problems will receive help instead of disciplinary

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Patients with low literacy skills—what is your duty?

So much of risk management depends on written documentation. But what happens when your patient can't understand what is written, due to low literacy skills, limited English proficiency, or both?

These situations require resourcefulness and flexibility. The techniques you use to ensure understanding will vary depending on the circumstances. For example, patients who cannot read at all will require a different approach than patients who read at a low level. Your primary duty is to protect the patient—so you need to do whatever you can to help patients understand the care that is being delivered and any instructions for self-care once they have returned home.

If you are aware that the patient does not read at all, read the appropriate printed materials aloud to him or her, using simple language and avoiding medical terminology and acronyms. Speak clearly and encourage questions. Whenever possible, use drawings or other visual aids to convey information. If a family member is available, it may be helpful to involve him or her in the conversation; family members are likely to be more familiar with the patient's commu-

nication style and level of understanding. If the patient is literate in another language, see if your facility provides patient education materials in that language, if an interpreter is available or if a family member can interpret for the patient.

When you've completed educating the patient, ask him or her to repeat back the information to verify understanding. This "teach back" communications technique is recommended by the American Medical Association, The Joint Commission and the National Quality Forum. If the information includes self-care procedures, like insulin administration or wound care, ask the patient to "show back," or demonstrate, the technique. In an in-patient setting, have patients demonstrate how to use the call button to request assistance, for example. In an out-patient setting or following discharge, place a telephone call to the patient the next day to reinforce understanding and answer any questions he or she may have.

Since nurses aren't always aware of patients' literacy levels, it's best to take a "universal precautions" approach. Using these communications techniques in every patient encounter can help ensure

understanding, increase compliance and prevent errors. Even patients with adequate literacy skills can have difficulty understanding medical terminology and processing home care instructions. Make sure that patient forms and instruction sheets are written in simple, plain language without medical jargon or abbreviations. For example, write or say "after meals" instead of "postprandial."

Whatever techniques you use, be sure to document the details, including dates and times of the patient's situation and your efforts carefully to ensure understanding. Note the names and relationships of family members you communicated with, the specific information you reviewed with the patient and/or family members, and the "teach back" and "show back" processes you and the patient went through. If a problem arises, you need to be able to demonstrate that you did all you could to communicate appropriately with the patient.

Sources:

"What Did the Doctor Say?": Improving Health Literacy to Protect Patient Safety 2007 The Joint Commission.

Partnership for Clear Health Communication at the National Patient Safety Foundation http://npsf.org/askme3/PCHC/what_can_provid.php, accessed 3/25/08.

Protecting your patients from physical abuse

Addressing suspected abuse can be a challenge. As a nurse, your duty is to observe, intervene and protect. All three of these elements come into play when you suspect that a patient is a victim of abuse—and failing to fulfill these duties can be considered negligence.

First, you need to know how to recognize (observe) the signs of abuse. Physical signs can include unusual or recurring scratches, bruises, bite marks, skin tears, or welts; bilateral bruising (bruises on opposite sides of the body); burns; and fractures or sprains. The patient's behavior can also be a sign; when asked about the injury, the explanation may be incompatible with the physical evidence, or the patient's body

language may indicate that he or she is not being truthful. Patients may seem passive and withdrawn, and show little reaction to pain.

The intervening and protecting roles aren't just your nursing duty; in some cases, these actions are also mandated by law. Nurses are considered "mandated reporters," meaning that they are required by law to report certain types of abuse. All U.S. states have mandatory reporting laws in place for child abuse, and most states now have similar laws concerning elder abuse. However, the definitions of what constitutes abuse still vary state-to-state. Laws about domestic violence (now often referred to as "intimate partner violence" or IPV) are even more disparate; most at least require that homicidal threats are reported to law

enforcement authorities. As a practicing nurse, it is your responsibility to know your state's laws about abuse reporting.

You should also know your facility's policies and procedures for reporting suspected abuse. Of course, all policies and procedures must comply with the state's reporting requirements; your facility may require additional steps to ensure the protection of the patient, staff members, and the facility. Policies and procedures may include protocols for screening for abuse, assessing patient danger and seeking assistance and protection for the patient.

Nurses should be extra vigilant in documenting physical and behavioral signs of abuse and the conversations they have with potential abuse victims. This is particularly important in cases of intimate

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partner violence, where reporting may not be mandated and the patient may ask the nurse not to report. Scrupulous documentation is the best way to respect the patient's wishes while still demonstrating your commitment to your duty to intervene and protect.

Documentation should include a description of the event in the patient's own words, a body diagram with descriptions and locations of the injuries; behavioral observations; and, if possible, photographs of the injuries. You'll also want to complete a lethality assessment with the patient; this can help the patient

recognize the severity of the problem and help you determine if reporting is legally required.

Reporting suspected abuse protects your patients and yourself. It's the best thing you can do to help the patient avoid further injury—or worse.

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Walton-Moss, Benita and Campbell, Jacquelyn C. "Intimate Partner Violence: Implications for Nursing" *Online Journal of Issues in Nursing*, 7 (1); 2002. <http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/Number1January31/IntimatePartnerViolence.aspx>, accessed 3/26/08.

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action, they may be more likely to report their suspicions. Also, make sure your staff is aware of applicable policies and procedures, local laws and state board of nursing regulations, so that they know their actions and the actions of impaired colleagues can impact their careers and the facility for which they work.

Preventing improper access

Policies and procedures can help prevent improper access to drugs on the job, and highlight abuses as they occur. There are a number of ways that nurses gain access to drugs while at work: staff physicians write prescriptions for them; nurses divert PRN medications from patients, forge prescriptions, back date medical records, alter orders, or sign out medications for discharged or transferred patients. Having strong, clear medication management policies and procedures in place makes it more difficult for nurses to obtain drugs on the job, and makes it easier to detect discrepancies. The strength of your facility's policies and procedures in this area can also be a factor in a lawsuit; inadequate attention to the issue can be interpreted as negligence.

Many facilities have a controlled substance committee, which tracks, reports and investigates all discrepancies in medication inventory. All controlled substances are monitored by nursing unit, work shift, and individual. This type of analysis allows trends to appear that might be missed by simply tracking one variable.

Staff nurses and nurse managers can often recognize those patterns, too.

Incorrect narcotics counts, altered vial labels, large medication waste reports, and patients reporting ineffectiveness of pain medication can all be signs of abuse in a unit. On a personal level, mood swings, absenteeism or lateness, requesting shifts where nurses work in isolation, and frequent trips to the bathroom can all be signs that a nurse has a problem.

Managing the risk of substance abuse in your setting is much the same as managing other types of risk: work in the best interest of your patients, develop and follow strong policies and procedures, and document carefully. By managing this risk effectively, you will not only keep your patients safe from harm, you can help keep yourself safe from a lawsuit.

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Risk Management Case Study: Avoiding Medication Errors

A 79-year-old woman was admitted to the hospital through the emergency department after a TIA. Her primary care physician gave telephone orders to a floor nurse for her maintenance medications, which included four milligrams of Reminyl taken in an oral solution twice a day for mild dementia. The nurse mistakenly wrote the order for Risperdal, an antipsychotic medication, and the hospital pharmacy filled the order as written.

On the second day of her stay, the nurse on duty documented that the patient appeared lethargic and had slurred speech. Staff nurses through several shifts continued to administer four mg of Risperdal twice a day for a total of three days, while the patient's condition deteriorated. On the fourth day of the patient's stay, the error was discovered and Risperdal was discontinued. Soon after, the patient experienced acute renal failure. The patient died two days later.

The woman's adult children filed a suit claiming negligence in the administration of the wrong drug and failure to recognize the error for several days. The case was settled out of court for \$500,000.

LESSONS LEARNED:

Verify oral orders. When receiving verbal orders, either in person or over the phone, read the order back to the physi-

cian before proceeding. Note in the patient's chart that the order was taken verbally and that you repeated it back to ensure accuracy. Your facility may have additional policies and procedures about verbal orders; familiarize yourself with them and follow them to the letter.

Remember the five rights. In this case, the staff nurses who administered the drug after the order believed they were delivering the right drug to the right patient at the right dosage at the right time. But the error might have been avoided if a nurse had considered the "right reason." Risperdal carries a warning against its use in elderly patients, particularly those with dementia, and can increase the risk of stroke and TIAs. The patient's age alone should have been a warning; a further look at her chart to discover her diagnosis of early stage Alzheimer's would have been a red flag. Nurses are expected to be familiar with any drug they administer. In this case, that "R" could have saved a life.

Fulfill your duty. Nurses are expected to recognize the special needs of populations that are at higher risk for medication errors, like the elderly. Part of being familiar with a drug is knowing the potential side effects and signs of toxicity. In this case, a nurse might have recognized the patient's lethargy and slurred speech as an early sign of Risperdal toxicity.