Addressing Chemically Dependent Colleagues

Kathy Bettinardi-Angres, MS, RN, APN, CADC, and Stephanie Bologeorges, BA

Using a two-phase, mixed methods study, the authors investigated the practices of confronting and reporting chemically dependent nurses in the workplace. This article presents their findings. Quantitative data from 55 chemically dependent nurses at a treatment program for professionals provide a description of addiction variables and modes of entry into treatment. A content analysis of qualitative interview data from 30 practicing nurses yields perceptions and beliefs about confronting a chemically dependent colleague. The article also discusses barriers to reporting colleagues and resources for helping them. Finally, the authors make recommendations for educating nurses about addiction and viewing interventions not as confrontations but as acts of compassionate peer support.

Learning Objectives

- Recall at least two recommendations for improving the identification of and successful intervention for impaired nurses.
- State guidelines for helping and reporting nurses with chemical dependence.
- Identify barriers to helping and reporting an impaired peer.
- List warning signs of chemical dependence.

Treatment and aftercare of addicted nurses have improved greatly over the last 30 years, but the challenges of identifying impaired nurses and successfully intervening remain. This article presents findings from a two-phase, mixed methods study. Quantitative data from chemically dependent nurses in a treatment program are presented to describe addiction variables and modes of entry into treatment. A content analysis of qualitative interview data from practicing nurses yields perceptions and beliefs about confronting a chemically dependent colleague.

Estimates of the prevalence of dependence among nurses differ. The American Nurses Association (ANA) reports that about 10% of nurses are dependent on addicting substances, which is consistent with the estimated percentage of dependent people in the U.S. population. The video *Breaking the Habit: When Your Colleague is Chemically Dependent* (National Council of State Boards of Nursing, 2010) estimates that 15% of nurses are chemically dependent, and McDonough (1998) estimates that 20% of nurses use mood-altering drugs. Despite these astonishing numbers, some researchers believe substance abuse among nurses is underreported because of the ongoing stigma of chemical dependence (Monroe & Kenaga, 2010). No matter which number is correct, chemical dependence among nurses is a serious public health problem (Smith, Taylor, & Hughes, 1998).

Reporting Professional Misconduct

The ANA regards chemical dependence as a major problem and takes a proactive stance. The issues of substance abuse and chemical dependence are clearly addressed in the ANA's *Code of Ethics for Nurses*, under "incompetent, unethical, illegal, or impaired practice" (American Nurses Association [ANA], 2001). The code states that a nurse who is aware of such a practice has an ethical obligation to report it. Further, "concerns should be expressed to the person carrying out the questionable practice" before reporting to a higher authority, such as a supervisor (ANA, 2001). The recommended course of action is for nurses to confront colleagues directly about their chemical dependence because peers are among the first to recognize a colleague's impairment (Smith et al., 1998).

Other guidelines for reporting professional misconduct also emphasize discussing the behavior directly with the colleague. Dunn (2005b) recommends directly and caringly confronting an impaired colleague, surmising that initiating communication in a concerned manner will set the stage for honesty. This recommendation is consistent with the literature, which indicates that expressing compassion in a firm manner helps set the stage for an intervention (Smith et al., 1998).

Reports in the literature stress the need for education on identifying and responding to chemical dependence because nurses with such knowledge can confront peers with both confidence and understanding (Burman & Dunphy, 2011). Research shows that overall knowledge of chemical dependence is lacking in the workplace and that most nurses are unable to identify the signs and symptoms (Lillibridge, Cox, & Cross, 2002; Pullen & Green, 1997). This lack of knowledge results in inadvertent enabling, failure to document, and failure to report (Smith et al., 1998).

Research on other health professionals with similar ethical obligations has identified the failure to report colleague misconduct as a serious problem (Baggio, Duffy, & Staffelbach, 1998). In one study, more than a third of physicians did not support peer reporting of an impaired colleague. The most frequently cited reason was the belief that someone else was taking care of the problem (DesRoches et al., 2010). Though no empirical studies have been conducted, personal accounts from nurses contain a similar belief. Nurses also report fear of repercussion or retaliation, fear of a lack of administrative support, and uncertainty regarding what to report or the consequences of not reporting (Burman & Dunphy, 2011; Dunn, 2005b; Smith et al., 1998; Taylor, 2003).

A litany of research on chemical dependence in nursing has been disseminated, but little evidence exists on the mechanisms for successful interventions. Additionally, although the code of ethics mandates that nurses address impaired practice with "the person carrying out the questionable practice" (ANA, 2001), nurses who do so face significant individual and systemic challenges (Burman & Dunphy, 2011). Yet, little empirical research on barriers to reporting any form of colleague misconduct, including chemical dependence, appears in the literature. The question for the nursing profession is this: Does a gap exist between our guidelines and recommendations for reporting chemical dependence and our actual practices?

In an attempt to answer this question, we used a two-phase, mixed methods study to investigate the means used for successful interventions and the likelihood that nurses will report their impaired colleagues.

Phase 1 of the Study

The aim of phase 1 was to better understand variables related to chemical dependence in nurses, including the drugs of choice, the question of I.V. use, and the percentage of nurses diverting drugs. In this phase, we also intended to investigate the modes of entry into treatment and the percentage of nurses that enter treatment based on colleague referral.

Participants

Participants included all 55 nurses admitted to a residential outpatient addiction treatment program for professionals in Chicago in the last 2 years (N = 55). The sample included 49 registered nurses (RNs), two certified registered nurse anesthetists (CRNAs), two advanced practice registered nurses (APRNs), and two licensed practical nurses (LPNs).

Twelve nurses (21.8%) were from intensive care units (ICUs); twenty-five (45.5%) were from medical-surgical settings, including operating rooms and emergency departments; four (7.3%) were psychiatric nurses; three (5.5%) were from nursing home and home health care settings; one (1.8%) was from the military; one (1.8%) was from family practice and nine (16.4%) were unemployed. (See Table 1.)

TABLE 1

Demographics

	N	Valid %
Gender		
Male	5	9.1
Female	50	90.9
Credentials		
Registered nurse	49	89.1
Certified registered nurse anesthetist	2	3.6
Advanced practice registered nurse	2	3.6
Licensed practical nurse	2	3.6
Work settings		
Intensive care unit	12	21.8
Medical-surgical, emergency department, operating room	25	45.5
Psychiatric	4	7.3
Nursing home, home health care	3	5.5
Military	1	1.8
Family practice	1	1.8
Unemployed	9	16.4

Procedure

Retrospective reviews of patient charts were conducted to collect demographic and descriptive data on addiction variables and modes of entry into treatment. All data were entered and coded into Statistical Package for the Social Sciences version 18.0 for descriptive analyses.

Addiction variables included the following:

- Type of nursing credential (coded as RN, CRNA, APRN, or LPN)
- Workplace (coded as ICU, medical-surgical, psychiatric, nursing home/home health care, military, family practice, or unemployed
- Drug of choice (coded as alcohol only, drug use only, or both alcohol and drug use)
- Drug availability in the workplace (coded as yes or no)
- I.V. users (coded as yes or no)
- Drug diversion from the workplace (coded as yes or no).

To determine the modes of entry into treatment, we reviewed the admission, intake, and referral forms of each nurse. Five types of referral were identified: workplace, legal, self-referral, psychiatric, and therapist or physician. Workplace referrals included referrals from the employer, an employee assistance

program (EAP), or the licensing board. Legal referrals included referrals from any part of the judicial process, such as a referral from the patient's attorney. Self-referrals included individual admissions of the need for treatment and admissions prompted by friend or family member concerns. Psychiatric referrals were referrals following treatment for a primary psychiatric problem, such as a suicide threat or attempt. Therapist and physician referrals were referrals made by individual counselors and physicians that had already established relationships with the nurses as patients.

Results

Of the 55 nurses, 11 used only alcohol (20.0%); 25 used only drugs other than alcohol; and 19 used both alcohol and other drugs (34.5%). Thus, 80% were using at least one substance illegally. Additionally, 22 nurses were I.V. drug users (40.0%), and all but two used syringes from their workplace. Of the 55 nurses, 40 used substances that could readily be obtained from their workplaces, such as hydrocodone, Demerol, and Percocet. Of these 40 nurses, 26 were diverting drugs from their workplace.

The most common referral sources were the workplace (60%), self-referral (14.5%), and legal (10.9%). EAPs and human resource departments were common sources of workplace referrals. In most of these cases, nurse managers reported suspicions to human resources. Nurses agreed to treatment to save their jobs, preserve their licenses, or avoid legal ramifications.

Discussion and Limitations

The demographic breakdown of our sample with regard to workplace environment was consistent with other studies that found higher rates of substance abuse among nurses in critical care, emergency, oncology, and psychiatry settings (Trinkoff & Storr, 1998). Rather alarmingly, 65% of nurses who abused a substance available at their workplace were diverting their drug of choice. Thus, in most cases, other nurses and their patients were exposed to these nurses while they were impaired.

Not one nurse in the sample entered treatment because of an intervention by a colleague, even though colleague intervention or referral is the approach recommended in the literature (e.g., Dunn, 2005a) and the ANA code of ethics (ANA, 2001). This lack of intervention not only enables addicted nurses in the workplace, it compromises the workplace legally and financially. Our findings suggest that peer referral or intervention does not frequently take place, although a limitation of this study is the inability to determine the reason.

Phase 2 of the Study

The aims of phase 2 were to investigate the perceptions and attitudes of practicing nurses regarding confronting a colleague suspected of being chemically dependent and to explore the reasons for not confronting such a colleague. Phase 2 was intended to extend the findings on barriers to confrontation among other health-care professionals to nurses.

Participants

Participants were 30 RNs from various departments of a large Chicago hospital who consented to take part in a brief discussion on chemical dependence in the nursing profession. The sample included three nurses from an ICU setting, twenty-three from medical-surgical units, three from psychiatric units, and one administrative nurse.

Procedure

Each nurse participated in a semistructured interview about confronting a colleague suspected of being chemically dependent. Each nurse was asked three standard questions:

- "If you suspected a colleague was using or abusing alcohol or other drugs, would you be comfortable addressing your suspicion with that colleague?"
- "If you suspected a colleague was using or abusing alcohol or other drugs, would you report your suspicion? If so, to whom would you report?"
- "What are some reasons that would prevent you or your coworkers from confronting a chemically dependent colleague?"

Follow-up questions and prompts were used when appropriate, and qualitative responses were recorded to look for trends in the data using content analysis.

Results

Most nurses in our sample (57%) reported that even if they were suspicious that a peer was using drugs or alcohol, they would not want to confront him or her. Commonly cited reasons included: "I would be afraid [the colleague] might react in a way that would harm me"; "I would be fearful of possible retribution or retaliation"; "I would feel like I was being a tattle-tale"; "I wouldn't want to be the one responsible for jeopardizing [a colleague's] job"; "I'm not sure I trust my own observations or instincts to confront [a colleague]"; and "I know I'm not an expert in chemical dependence and think it would be better dealt with by someone who is."

One young ICU nurse said she would have mixed feelings about what to do because it would be a complicated situation. In general, she said she would not do anything if a nurse's addiction did not affect his or her job performance—that is, if the nurse was coming to work and getting the job done. She also stated she was too busy in the ICU to handle this sort of situation without having direct evidence. Medical-surgical nurses shared this view. A few said the demands of their jobs already had them spread too thin. One remarked, "I already have enough patients on my floor to take care of. I don't need another one." Many nurses said they felt confident a supervisor would intervene without them having to say anything.

When nurses were asked if they would report their suspicions, and if so to whom, the vast majority (80%) said they would report suspicions to a supervisor. A few said they would also contact the human resources department or the licensing board; two said they would keep their suspicions to themselves.

Some nurses revealed that they had been in this situation or they knew of a colleague who had been chemically dependent. One nurse said she faced the situation three times. She also said that a coworker died on the unit with a needle in her arm. According to this nurse, she would have no problem confronting a colleague because she has seen the harm dependence can cause to nurses and patients. She added that she is close to retirement and her experience and age give her more confidence than she had years earlier. Other nurses reported telling their supervisors about their suspicions without ever confronting the colleague. In retrospect, two more experienced nurses said they should have raised their concerns directly with the colleague. For some nurses, the decision to report a colleague to a supervisor was made easier by having tangible evidence, such as discrepant counts of controlled substances.

An interesting trend emerged from the interviews: Many of the nurses who said they would be comfortable confronting a colleague had worked a number of decades in nursing. Without hesitation, these nurses said they would confront an addicted nurse and report their observations to a supervisor. Their extensive experience gave them personal knowledge of and regret for not intervening in the past. Other nurses who said they would bring the issue to their supervisor cited the fear of losing their own license and concerns about patient care and safety as their reasons.

Discussion

Only 57% of RNs in our sample reported being comfortable addressing the issue of chemical dependence with a suspected colleague, despite the ANA's ethical guidelines. The reasons for not confronting a colleague were similar to those given by physicians for not reporting colleague misconduct (DesRoches et al., 2010). Many nurses echoed the physicians' belief that someone else, namely a supervisor, was taking care of the problem (DesRoches et al., 2010). This finding is particularly disturbing because peer reporting and referral are key mechanisms for identifying impairment in health-care professionals.

The fact that some nurses would report a colleague is significant because it suggests an inherent yet informal reporting mechanism that seems to be useful. Our quantitative data from phase 1 are consistent with this trend: The majority of nurses entered treatment through workplace involvement (60%), and most of the time, a supervisor or nurse manager initiated the process. Our content analysis indicates that nurses with extensive experience (20 years or more) are more likely to confront a colleague. Thus, education and experience with chemical dependence seem to be the underlying factors that cause a nurse to address the issue with a peer.

TABLE 2

Signs and Symptoms of Chemical Dependence in the Workplace

- Withdrawal from peers at the workplace
- Frequent or long breaks
- Increased or unexplained absences or tardiness
- Elaborate excuses for simple problems
- Gradual decline in work performance
- Consistently signing out or wasting more narcotics than peers
- Inappropriate choices of drugs or dosages for patients
- Patients who complain of inadequate pain relief
- Inordinate amount of time around drug supply areas
- Mood swings
- Difficulty with authority figures
- Forgetfulness, confusion, lack of concentration
- Dishonesty, even in unimportant matters
- Frequent illnesses and complaints of chronic, unrelieved pain
- Tremors, shakiness, diaphoresis, GI problems, and runny nose
- Overt signs of alcohol or drug use, such as the smell of alcohol on the breath
- Inappropriate intoxication at social functions
- Frequent job changes
- Preference for shifts with less supervision and more access to drugs
- Desire to work overtime or extra shifts
- Pinpoint or dilated pupils or glassy eyes
- Sleeping at inappropriate times or being abnormally hyperactive
- Relationships with physicians who may prescribe medication
- Significant family problems
- Incomplete charting and practice errors

Barriers to Helping an Impaired Peer

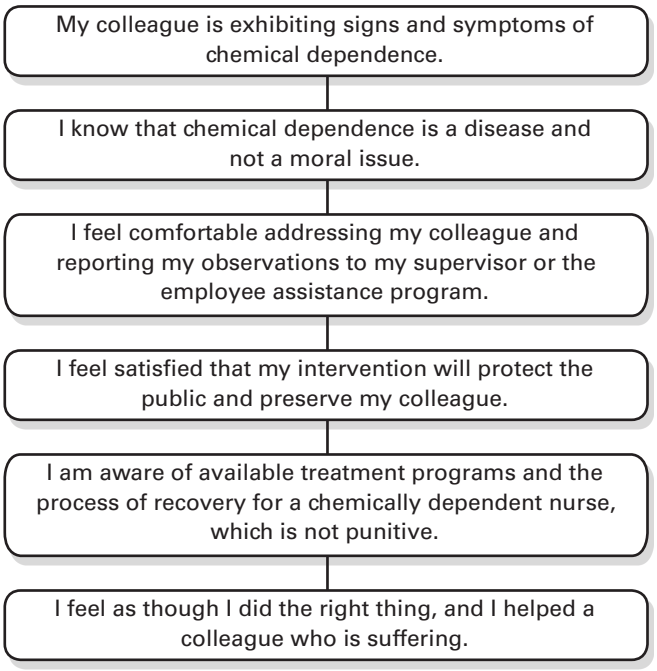
The quantitative and qualitative findings in this article suggest that collegial confrontation for chemical dependence among nurses is lacking. In addition to the reasons cited in phase 2, certain barriers may contribute to the reluctance to confront a peer.

One barrier is the overall lack of knowledge of chemical dependence in the workplace, which continues to be cited as a problem in the literature (e.g., Lillibridge et al., 2002). Supervisors and managers who are not knowledgeable may fire an addicted nurse rather than acknowledge his or her addiction as a disease and refer them for treatment. Once fired, impaired nurses cannot use their EAP or insurance benefits to assist in their recovery, and this lack of support may make the difference between receiving help and not receiving help. Supervisors were often cited as the persons to whom nurses report chemical de-

FIGURE 1

Compassionate Intervention

Understanding that substance dependence is a disease allows nurses to see chemically dependent colleagues as peers who need treatment and to see intervention as an act of compassion. The optimal line of thinking would be similar to the one below.



pendence in the workplace, even though several nurses in phase 2 reported knowing of supervisors who fired addicted nurses or gave them the option to resign. In such cases, the supervisor's lack of knowledge only drives the problem further underground without protecting the public or helping the nurse.

Another barrier is the lack of a clear protocol for intervention, even though the literature cites the advantage of having uniform and accessible protocols for all nursing staff and management (Angres, Bettinardi-Angres, & Cross, 2010). Without an established action plan, nurses are ill equipped to intervene on behalf of their impaired colleagues.

The lack of peer caring in the workplace has also been cited in the literature as a barrier (Lillibridge et al., 2002). Despite the fact that compassion is "the hallmark of the nursing profession," it often does not translate into empathy for the addicted nurse (Monroe, Pearson, & Kenaga, 2008). The ANA requires "nurses in all roles" to advocate for and support impaired colleagues to ensure they receive adequate treatment and "access to fair institutional and legal processes." Unfortunately, both the literature and individual testimonies point to a deviation from this paradigm. Changing the work climate to one of compassion for peers will demand a "kind of mind-training," according to noted author and theologian Karen Armstrong (2011). She argues that living the Golden Rule is the key to the successful future of mankind and that being more compassionate requires a conscious effort to refrain from inflicting undue pain on others and to transcend selfishness. Such compassion in the workplace would create a climate for nonjudgmental clarity and an impetus for protecting peers and patients from harm. With conscious efforts to adopt a mindset of universal compassion in nursing, the negative perceptions of reporting colleague impairment could be reduced, thus promoting identification of and intervention for chemically dependent nurses. Nurses may be an ideal population to begin this radical movement because compassion is already instinctive in the profession.

Finally, the term *confrontation* itself seems to be a barrier. The idea of confronting a colleague with a suspicion of substance abuse is daunting to most nurses. Using a term such as *helping, assisting,* or *addressing* may set the stage for more compassionate action. The thought of confronting a colleague with a suspicion of chemical dependence does not generate positive emotions that allow a nurse to feel her actions are helpful or meaningful.

Need for Education

To address the issue of chemical dependence, we need education at all levels. Understanding chemical dependence as a potentially lethal biogenetic disease can decrease the stigma associated with addiction. Enhancing our knowledge of warning signs and symptoms, existing support systems in the workplace, available treatment options, and return-to-work issues will provide a set of tools for compassionately intervening and addressing chemical dependence in peers.

As research indicates (e.g., Pullen & Green, 1997), a lack of knowledge of the signs and symptoms of chemical dependence keeps colleagues from making informed observations and addressing the issue with a peer or reporting the disease to a supervisor. For a list of warning signs and symptoms specific to the workplace, see Table 2.

The workplace must have a protocol for addressing and reporting chemical dependence, and nurses must be made aware of it. Nurses value the assurance of confidentiality between reporter and authority figure. They must feel they can communicate their observations without fear of reprisal and with the confidence that both the public and the nurse will be protected.

Many nurses are unaware of available resources. Most hospitals and some patient-care organizations have EAPs, which can help addicted nurses obtain treatment covered by their insurance. Unfortunately, many nurses do not know of these programs or do not understand their benefits. EAPs facilitate a quick transition from workplace to treatment and from successful treatment to re-entry into the workplace. An alternative-to-discipline (ATD) program allows nurses to recover and resume nursing without the threat of license revocation or incarceration, as long as they

follow the recommendations of the treatment and ATD programs (Darbro, 2011).

If nurses understood addiction and knew of these support systems, they might feel more comfortable intervening. Figure 1 illustrates an appropriate line of thinking for interventions. Lowell & Massey (1997) developed a decision-making tree that is more detailed than Figure 1, which is intended to empower nurses to report a colleague, not to provide detailed instructions on implementing an intervention.

Nurses and nurse managers also must have up-to-date knowledge of pharmacologic advancements that can aid in returning an addicted nurse to work. Drugs such as naltrexone and Vivitrol (the injectable form of naltrexone) help block the cravings and the physiologic and psychological responses to the addictive substances. In the field of addiction medicine, these drugs are groundbreaking advancements that can help nurses in recovery and offer an employer an additional line of defense in protecting the public and preserving the nurse.

Recommendations

Our recommendations are as follows:

- Emphasize education on chemical dependence, starting in nursing school. A required course on chemical dependence must be part of the curriculum in all nursing programs, and a required module on chemical dependence must be part of nursing orientation in the workplace.
- Establish and actively communicate clear protocols for confidential reporting of chemical dependence in the workplace.
- Establish nurse's well-being committees in the workplace. Committee members must be professional peers with the knowledge and compassion to help nurses in trouble.
- Create a climate of compassion for peers and patients in the nursing profession.

Summary

With education about chemical dependence and compassion for each other, nurses can provide support and understanding for chemically dependent colleagues from intervention to their reentry into the profession.

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Ce

CE Posttest

Addressing Chemically Dependent Colleagues
If you reside in the United States and wish to obtain 1.8 contact hours of continuing education (CE) credit, please review these instructions.

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Contact hours: 1.8
Posttest passing score is 75%.
Expiration: July 2014

Posttest

Please circle the correct answer.

1. Which statement about the prevalence of chemical dependence among nurses is correct?
a. The American Nurses Association (ANA) estimates the prevalence of chemical dependence in nurses to be 5%.
b. The ANA estimates the prevalence of chemical dependence in nurses to be 25%.
c. Some researchers believe chemical dependence in nurses is overreported.
d. Some researchers believe chemical dependence in nurses is underreported.

2. The ANA's estimate of the percentage of nurses who are chemically dependent is:
a. consistent with estimates for the U.S. population.
b. higher than estimates for the U.S. population.
c. lower than estimates for the world population.
d. consistent with estimates for the world population.

3. Which statement about chemical dependence in nurses and the ANA's *Code of Ethics for Nurses* is correct?
a. The code does not address chemical dependence.
b. The code is being revised to address chemical dependence.
c. The code states nurses have an ethical obligation to report chemical dependence.
d. The code states nurses have a legal obligation to report chemical dependence.

4. If a nurse suspects chemical dependence in a colleague, current recommendations state he or she should:
a. share his or her concern with the person suspected of dependence.
b. immediately report the person suspected of dependence to the supervisor.
c. gather information about other nurses' opinions before taking action.
d. avoid sharing his or her concerns with the person suspected of dependence.

5. Based on the authors' findings, which statement about peer intervention is correct?
a. Peer intervention does not frequently occur.
b. Peer intervention occurs in one-third of cases.
c. Peer intervention occurs in about half of cases.
d. Peer intervention occurs in the majority of cases.

6. In the authors' study, what percentage of nurses reported that even if they suspected chemical dependence, they would not want to confront their colleague?
a. 33%
b. 42%
c. 57%
d. 76%

7. According to the authors' study, a nurse is most likely to report suspicions of a colleague's chemical dependence to whom?
a. Supervisor
b. Board of nursing
c. Police
d. Human resources

8. According to the authors' study, who is most likely to confront a colleague about chemical dependence?
a. A manager in an intensive care unit
b. A staff nurse with 23 years of nursing experience
c. A clinical educator with 5 years of nursing experience
d. A staff nurse in the perioperative setting

9. Which statement is most consistent with productive intervention for chemically dependent nurses?
a. Chemically dependent nurses should be incarcerated.
b. Chemically dependent nurses should lose their licenses immediately.
c. Chemical dependence is a moral issue and not a disease.
d. Chemical dependence is a disease and not a moral issue.

10. Which of the following suggests chemical dependence in a nurse colleague?
a. Shorter break times
b. Reduced absenteeism
c. Patients complaining of inadequate pain relief
d. Effective communication during meetings

11. Which of the following would prompt a nurse to talk with a colleague about chemical dependence?
a. Two job changes over the past 5 years
b. Increased ability to concentrate
c. Logical excuses for simple problems
d. Dilated or pinpoint pupils

12. A common reason nurses do not confront colleagues about chemical dependence is:

a. a belief that someone else is taking care of the problem.
b. a disinterest in the effects on patient care.
c. an understanding that confrontation is not appropriate.
d. a desire to protect the nursing profession.

13. Which of the following terms does not help set the stage for more compassionate intervention?

a. Helping
b. Assisting
c. Addressing
d. Confronting

14. Which statement would be important to include in an education program on chemical dependence?

a. A resource is the organization's employee assistance program.
b. A protocol should not be used, so approaches can be individualized.
c. If you suspect chemical dependence in a colleague, the first step is to notify the state board of nursing.
d. Alternative-to-discipline programs have not helped return chemically dependent nurses to work.

15. Which drug helps block the cravings associated with chemical dependence?

a. Naltrexone
b. Valium
c. Vitamin C
d. Dilantin

16. Research on nurses' knowledge of chemical dependence shows that:

a. The resources for chemical dependence are well known.
b. Overall knowledge of chemical dependence is lacking.
c. Nurses are able to identify signs of chemical dependence.
d. Nurses are able to identify symptoms of chemical dependence.

17. According to the authors' study, which is the most common source of referrals for treatment of chemical dependence?

a. A colleague
b. Attorney
c. Workplace
d. Self

18. In the authors' study, what percentage of nurses abusing a substance available at work were diverting it?

a. 25%
b. 40%
c. 52%
d. 65%

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Recall at least two recommendations for improving the identification of and successful intervention for impaired nurses.

1 2 3 4 5

- State guidelines for helping and reporting nurses with chemical dependence.

1 2 3 4 5

- Identify barriers to helping and reporting an impaired peer.

1 2 3 4 5

- List warning signs of chemical dependence.

1 2 3 4 5

Rate each of the following items from 5 (very effective) to 1 (ineffective):

2. Were the authors knowledgeable about the subject?

1 2 3 4 5

3. Were the methods of presentation (text, tables, figures, etc.) effective?

1 2 3 4 5

4. Was the content relevant to the objectives?

1 2 3 4 5

5. Was the article useful to you in your work?

1 2 3 4 5

6. Was there enough time allotted for this activity?

1 2 3 4 5

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PLEASE DO NOT SEND CASH.

Mail completed posttest, evaluation form, registration form, and payment to:

NCSBN
c/o Beth Radtke
111 East Wacker Drive
Suite 2900
Chicago, IL 60601-4277
Please allow 4 to 6 weeks for processing.