

Analysis of Complaints and Discipline Against Licensed Nurses

Introduction

The need to analyze the nursing profession's use of professional discipline and its relationship to the number and type of complaints brought against licensed nurses is a responsibility of a regulatory entity such as the Alabama Board of Nursing. Its mission statement is literally to "safeguard the public's health, safety and welfare by adopting and enforcing legal standards for nursing education and nursing practice" (Alabama Board of Nursing, 2006). Part of safeguarding the public's health is conducting research in areas of regulation.

Regulation

According to the Alabama Board of Nursing Administrative Code, reporting of unsafe nursing practice is mandatory and, in fact, failure to report illegal, substandard, unethical, unsafe, or incompetent nursing practice is itself a violation which is worthy of disciplinary action (Alabama Board of Nursing Administrative Code, Rule 610-X-8-.03 (6) (y)). Patients, members of the public, health care organizations, physicians, other nurses, or employers of a nurse can file a complaint with Alabama's Board of Nursing, although the complaint must be in writing in order for the Board to pursue an investigation. The exception to this mandate is the self-reporting of a violation of the Alabama Nurse Practice Act.

Complaints are received on a variety of offenses which may be considered to be professional misconduct, including:

- impaired behavior at work
- medication errors resulting in patient injury or death
- false charting
- positive drug screen results
- refusal of a nurse to submit to a for cause drug screen
- representing oneself as a nurse or an advanced practice nurse without the benefit of proper credentials or licensure
- patient abandonment
- violation of professional boundaries
- falsification of employment records
- patient abuse and exploitation and
- substance abuse.

Substance abuse in nurses can produce an entire separate category of offenses which may lead to discipline being levied against a nurse's license, such as probation or even revocation. It is estimated that at least 10% of the nursing population has alcohol and/or drug abuse problems, and six percent of licensed

nurses have substance abuse issues serious enough to interfere with their ability to practice safely (Dunn, 2005). The Alabama Board of Nursing's mandatory reporting rule requires that such impaired professionals be reported to the Board in order to protect the public from unsafe care delivered by a practitioner who is neither mentally nor physically competent to deliver care. When a nurse remains silent and fails to report an impaired colleague, he or she is permitting that nurse to provide substandard care to patients. The nurse's ethical duty to protect the public is violated. In reality, though, nurses consistently fail to carry out this duty for a variety of reasons. Dunn (2005) described a study in which 91% of nurses surveyed responded that they would report an incident which either harmed a patient or put a patient at risk of injury. However, only about half of the nurses had actually reported all of the incidents they had observed.

Even beyond the mandatory reporting required by the Alabama Board of Nursing regulations is the public accountability required by Professional Codes for Nurses and Nurse Practice Acts. The earliest code for nurses is believed to be the one composed by Lystra Gretter in 1893 while serving as principal of the Farrand Training School for Nurses in Michigan. Based on the Hippocratic Oath, it became known as the "Florence Nightingale Pledge". An official code of ethics for nursing was adopted in 1950 by the American Nurses Association. Currently, the American Nurses' Association's *Code for Nurses with Interpretive Statements*, formulated in 1985, serves as the nursing profession's public expression of nurses' ethical values and duties. The Code specifically requires nurses to be accountable for the prevention or alleviation of potential harm that could befall a patient, while acting as a safeguard for the public when health and safety are threatened by another nurse's incompetent, unethical, or illegal practice. Furthermore, the National Federation of Licensed Practical Nurses (2006) provided its Code for Licensed Practical/Vocational Nurses on its website. The Code specifically requires the LPN to take "responsible actions" when there is unprofessional conduct by a peer or other health care provider. Another LPN organization, the National Association of Practical Nurse Education and Service, has its Code of Ethics posted on its website. This code specifically charges the LPN with the promotion and protection of the "physical, mental, emotional and spiritual health of the patient and his family" (National Association of Practical Nurse Education and Service, 2004).

Although the disciplinary processes implemented for violation of the Nurse Practice Act vary from state to state, the structure of the basic process is consistent. Common components of most Boards of Nursing are found in Table 1, while elements of a Nurse Practice Act in most states are displayed in Table 2

Table 1

Common Components of most Boards of Nursing (Flook, 2003)

1. Defines and enforces the minimum requirements for safe nursing practice
2. Sets licensing requirements and validates credentials of licensees.
3. Outlines and implements procedures for receiving, investigating, and resolving complaints involving licensees; outlines and implements procedures for appropriate disciplinary actions.
4. Defines standards of conduct for licensees, including protection of the public against unsafe and unethical behaviors
5. Interprets and enforces the Nurse Practice Act in that state.
6. Approves nursing education programs.

Table 2

Elements of a Typical Nurse Practice Act (Flook, 2003)

1. Standards of nursing practice
2. Standards of professional conduct for licensees
3. Professional licensed nurse reporting requirements
4. Disciplinary procedures
5. Supervisory role and criteria for delegation
6. Continuing Education requirements
7. Licensee name and address notification requirements
8. Process and requirements for initial licensure as well as licensure renewal
9. Advanced practice requirements and scope of practice
10. Structure and authority of the Board of Nursing

A complaint is initially filed against a nurse when it is submitted in writing to a state’s Board of Nursing. In Alabama, once the Board receives the written complaint, a case is opened and docketed in the Board’s licensing database; the complaint is subsequently reviewed by the Executive Officer. Unless the complaint was initiated by an anonymous party, a letter acknowledging receipt of the Complaint is sent to the complaining party. Upon receipt of the complaint, the Executive Officer determines if the case should be closed due to insufficient evidence, if the complaint is invalid and without merit, or if the complaint is worthy of investigation. If an investigation will be pursued, a written notice of investigation is sent to the nurse. In Alabama, any documents necessary for complete investigation of the complaint are subpoenaed prior to an investigator receiving the file. If an investigator is assigned to determine if enough evidence exists to potentially charge the nurse with a violation of the Nurse Practice Act, he will interview witnesses, review submitted documents, and compile all evidence for the case file. The Alabama Board of Nursing employs two nurse consultants in the Legal Division, one of whom will be assigned the case to review and then provide a recommendation which is then scrutinized by the Board’s attorney. The Board’s attorney reviews all of the evidence as well as the nurse consultants’ recommendation and then decides how to proceed with the case.

In Alabama, acceptance of a settlement offer (also referred to as a consent order) precludes the nurse being required to attend a formal public hearing to discuss his or her case before a hearing officer. However, when a charge of misconduct on the part of the nurse cannot be resolved through a settlement offer, a formal hearing is usually convened. In other states, the hearing may take place before a panel appointed by the Board of Nursing and the nurse's guilt may be determined by panel vote (Malugani, 2000).

In Alabama, the Board's attorney prosecutes the case, the nurse consultant or investigator who provided recommendations on the case testifies, and the Hearing Officer subsequently provides a discipline recommendation to the Board. The hearing is conducted in accordance with the *Alabama Administrative Procedures Act*. Once discipline occurs, the name and license number of the nurse are posted on the Board's website under a heading corresponding to the appropriate action taken. Once there is an Order of the Board, the information becomes available for public scrutiny.

Boards of Nursing are required to report disciplinary actions to three federal databanks, the Healthcare Integrity Protection Databank (HIPDB), the National Practitioner Databank (NPDB), which have merged into one entity, and the Office of Inspector General (OIG). The OIG receives notification of a nurse's license being revoked or suspended and then makes the determination if the nurse should be excluded from providing care to Medicare and Medicaid patients. If such an exclusion occurs, it usually is for an indefinite time period. If the nurse's license is reinstated prior to the end of the five year time period, the nurse must petition the OIG for removal of the exclusion. Along with reporting to the federal databanks, most Boards of Nursing report disciplinary action to NurSys, the databank of the National Council of State Boards of Nursing. This allows the disciplinary action to be available for other Boards of Nursing to review (Alabama Board of Nursing, 2005).

Literature Review

As will be shown in the findings obtained from this study, substance abuse plays a significant role in the accumulation of both complaints and discipline brought against licensed nurses. Domino, Hornbein, Polissar, Renner, Johnson, Alberti, and Hankes (2005) conducted a study examining the risk factors for relapse in physicians who had been diagnosed with substance use disorders. It was noted that 25% of individuals included in the study had had at least one relapse, with the drug of relapse being the initial drug of choice for 85% of cases. Family history of substance use, use of a major opioid, and the presence of a coexisting psychiatric disorder all were statistically significant predictors of relapse. Alcohol was the substance most frequently abused, with fentanyl being another frequent drug of choice. The risk of relapse was almost doubled when a major opioid was the drug of choice. When opioid use, dual psychiatric

diagnosis, and family predisposition were all present the risk of relapse increased 13-fold. Psychological factors which were found to contribute to relapse were persistent denial, failure to accept the existence of the disease, dishonesty, stress, overconfidence, and withdrawal (Domino, Hornbein, Polissar, Renner, Johnson, Alberti, and Hanks, 2005).

In a related study, Collins, McAllister, Jensen, and Gooden (2005) surveyed anesthesiology training programs regarding their experiences with chemically dependent residents over a ten-year period of time. The authors noted that anesthesiology appears to be the specialty with the largest percentage of impaired physicians. Despite this information, only 16% of the responding programs routinely performed substance abuse screening in the selection process and only 15% required pre-employment urine toxicology testing. Of the chemically dependent anesthesiology residents identified during the survey period, less than half were successful in completing anesthesiology training. The authors also noted that anesthesiology residents undergoing treatment for dependency cited drug availability as the major determinant of their choice of professional path (Collins, McAllister, Jensen, and Gooden (2005).

Finally, Kenna and Wood (2004) investigated the prevalence of substance use by pharmacists, nurses, dentists, and physicians. They found that nurses reported the highest rate of the use of cigarettes, marijuana, pain relievers, and sedative-hypnotics of the four groups of participants. Nurses reported themselves to be involved in "heavy drug use" more than any other group, with heavy drug use being defined as use on five or more occasions within the past month. In terms of family stability, the group of nurses participating in the study, 89.5% female, had more than three times the rate of divorce of the other groups participating and also were more than four times as likely to be involved in a cohabitation relationship (Kenna and Wood, 2004).

Findings

Analysis of Complaints Brought Against Licensed Nurses

The entire complaint data for the time period of October 1, 2001 to September 30, 2006 was analyzed. It consisted of 5237 logged complaints. It was found that 170 nurses had had two or more complaints brought against them during this time period, providing a recidivism rate in terms of multiple complaints of 3.25%. Of the 170 "repeat offender" nurses, 22 were RNs (12.94%), 106 (62.35%) were LPNs, and 42 (24.71%) had initially been licensed as an LPN prior to becoming an RN. Of the 106 LPNs who made up the majority of the repeat offenders, 31 (29.25%) ultimately surrendered their licenses, either before or after the filing of an administrative complaint.

Table 3

Statistical Breakdown of 170 Repeat Offender Nurses: Complaints (October 1, 2001-September 30, 2006)

RNs	Percentage of total Nursing Population	LPNs	Percentage of total Nursing population	Initial Licensure as LPN prior to Licensure as RN	Advanced Practice Approval	Males	Females	Foreign Educated
22 (12.94%)	.035%	106 (62.35%)	.170%	42 (24.71%)	2 (1.18%)	21 (12.35%)	149 (67.65%)	0

The 170 “repeat offender” nurses were further analyzed according to other criteria. Of the group, 21 were male (12.35%). Of this group of 21 male nurses, 11 were LPNs. This is reflective of the significance of the LPN population in the entire “repeat offender” nursing population. One of the male “repeat offenders” was an Advanced Practice Nurse (4.76%), five were RNs (23.81%), five had been licensed as an LPN prior to becoming licensed as an RN (23.81%). The one Advanced Practice male nurse had been initially licensed as an LPN.

The 170 “repeat offender” nurses were also analyzed according to Advanced Practice status. Of the group, two were Advanced Practice nurses (1.18%). One APN was male and the other was female. The male APN had two separate complaints which had been brought against him; one was cleared, and the other resulted in a letter of admonishment. Both the letter of closure and the letter of admonishment are considered to be non-disciplinary means of resolving an investigated complaint. The female APN had two separate complaints brought against her; one was resolved with a consent order, and the second resulted in a letter of admonishment.

Ultimately, the results of the analysis show that the highest rate of recidivism in terms of complaints filed against licensed nurses is among female LPNs who are not internationally educated. This information is summarized in Table 3.

The complaint data was further analyzed in an attempt to determine the educational background of nurses cited in the total number of complaints. Of the total number of licensed nurses who sustained a complaint against their licenses during the time period from 2001 until 2006, 39.05% were RNs. When these RNs were reviewed according to their educational background, it was found that 21.60% of licensees were Associate-degree prepared, 10.19% were Bachelor’s-degree prepared, 63.42% had a certificate or diploma in nursing, and 4.79% had a Master’s degree in nursing. It is significant that although Alabama has a predominant number of Associate-degree prepared RNs, the greatest number of complaints was brought against RNs who possessed a certificate or diploma in nursing. It may be inferred that this group of RNs could be older than the average practicing RN.

In comparison to the analysis of RNs, it was also found that of the total number of licensed nurses who sustained a complaint against their licenses during the time period from 2001 until 2006, 60.95% were LPNs. When these LPNs were reviewed according to their educational background, it was found that 1.18% of licensees had an Associate's degree, .57% had a Bachelor's degree in nursing, 91.94% had a certificate in Practical Nursing, 5.39% had a diploma in Practical Nursing, and .99 % had a Master's Degree in Nursing. Since the predominant method of preparing LPNs in Alabama is through the issuing of a certificate in Practical Nursing upon completion of a plan of study, it is not surprising that the majority of licensees who had complaints filed against them were certificate-prepared. The numbers of LPNs who had Associate's or Bachelor's degrees in nursing as well as Master's degrees may be nurses who were originally licensed as LPNs and subsequently acquired additional nursing education to become an RN.

The complaint data were also analyzed in an attempt to determine the number of licensed nurses who may have entered the nursing profession with evidence of pre-existing chemical dependency issues. Since it is likely that a licensee entering the profession with preexisting chemical dependency issues would sustain a substance abuse-related complaint against his or her license within the first year of obtaining licensure, all nurses who had sustained such a complaint within the first year of licensure as a nurse in Alabama were reviewed rather than only applicants. For the purpose of analysis of the data, the definition of "evidence of pre-existing chemical dependency issues" was defined as a substance abuse-related complaint which was sustained within the first year of licensure. Of the five groups of licensed nurses separated according to educational backgrounds, none of the Master's-prepared nurses were found to exhibit evidence of pre-existing chemical dependency issues, while 6.45% of the Bachelor's-prepared nurses were found to show evidence of such issues, in comparison to 5.73% of the Associate-prepared nurses and 1.54% of the Diploma-prepared nurses. These numbers are significant when the number of Bachelor-prepared nurses is considered in comparison to the much larger number of Associate-prepared nurses in Alabama. While Associate-prepared nurses sustain more than twice the number of complaints as Bachelor's-prepared nurses in Alabama, Bachelor's-prepared nurses sustain a higher percentage of complaints related to evidence of pre-existing chemical dependency issues prior to entering the profession. When the total number of complaints related to substance abuse since 1992 was analyzed, it was found that 87 out of the total 231 complaints involved exam applicants (37.66%). This finding may provide evidence that some individuals are entering nursing with pre-existing substance abuse issues.

Analysis of Discipline Brought Against Licensed Nurses

The discipline data for the time period of October 1, 2001 to September 30, 2006 was analyzed. It consisted of 2900 logged complaints which resulted in

discipline brought against a licensed nurse. Of this number, it was found that 168 nurses had two or more incidents of discipline during this time period, providing a recidivism rate in terms of multiple disciplinary incidents of 5.79%. Of the 168 cases of multiple discipline, 75 were RNs (44.64%), 75 were LPNs (44.64%), and 18 (10.71%) had initially been licensed as an LPN prior to becoming an RN. One male LPN who was foreign-educated was noted to have sustained discipline related to illegal practice, although he was not a repeat offender.

The 75 RNs who experienced more than one incident of discipline against their licenses were further analyzed according to other criteria. Of the group, 18 were male (24%). This is a significant percentage when considered in light of the small percentage of male nurses currently practicing in Alabama as well as nation-wide. According to the Health Resources and Services Administration (2004), 5.9% of all licensed RNs in the nation in the year 2000 were male. In Alabama, in comparison, 6.98% of all RNs licensed to practice nursing were male (Alabama Board of Nursing, 2006). Of the previously mentioned group of 18 male nurses, none were Advanced Practice nurses and none had been foreign-educated. However, 13 out of the 18 “repeat offender” RNs were disciplined for either substance abuse or violations of the Voluntary Disciplinary Alternative Program (72.22%). It may be inferred from this information that male RNs practicing in Alabama are at substantial risk of sustaining at least two incidents of discipline, with at least one of those incidents being substance abuse-related. Of the 57 female RNs sustaining more than one incident of discipline against their licenses, none were Advanced Practice nurses and none had been foreign-educated. Their violations included:

- Substandard Practice: 13 RNs (22.81%)
- Voluntary Discipline Alternative Program violations: 4 RNs (7.02%)
- Probation Violation (after having sustained discipline previously): 6 RNs (10.53%)
- Illegal Practice: 1 RN (1.75%)
- Substance Abuse: 33 RNs (57.89%)

Analysis of the 18 nurses who had initially been licensed as an LPN prior to becoming an RN showed that two were male (11.11%). Of the 18 nurses, 16 sustained at least one incident of discipline which was related to either substance abuse or a VDAP violation (88.88%). None were foreign-educated and none were Advanced Practice nurses. This data confirms the significant role that substance abuse frequently plays in discipline recidivism in RNs.

The 75 LPNs who experienced more than one incident of discipline against their licenses were also analyzed in depth. Of the group, seven were males (9.33%), a rate which is almost half of the number of male RN “repeat offenders”. Although not as high a percentage as that of male RNs, this number still is quite significant. None of the seven male LPNs were foreign-educated. When the violations which led to the discipline of the male LPN “repeat

offenders” were analyzed, it was found that two (28.57%) were related to substance abuse, and two (28.57%) were related to illegal practice. It may be inferred from this data that male LPNs in Alabama, while not as high risk for discipline recidivism as male RNs, are still at risk for discipline related to either substance abuse or illegal practice. Of the 68 female LPNs sustaining more than one incident of discipline against their license, none were foreign-educated. Their violations included:

- Illegal Practice: 7 LPNs (10.29%)
- Probation Violation (after having sustained discipline previously): 7 LPNs (10.29%)
- Voluntary Discipline Alternative Program violations: 1 LPN (1.47%)
- Fraud/Deceit: 1 LPN (1.47%)
- Arrest/Conviction: 1 LPN (1.47%)
- Substance Abuse: 26 LPNs (38.24%)
- Substandard Practice: 25 LPNs (36.76%)

It is also significant to note that Advanced Practice nurses rarely become “repeat offenders”, thus attesting that the level of their integrity as a subsection of the nursing population may well match their increased level of education and professional training. This information is summarized in Table 4.

Table 4

Statistical Breakdown of 168 Repeat Offender Nurses: Discipline (October 1, 2001-September 30, 2006)

RNs	Percentage of total nursing Population	LPNs	Percentage of total Nursing population	Initial Licensure as LPN prior to Licensure as RN	Advanced Practice Approval	Males	Females	Foreign Educated
75 (44.64%)	.120%	75 (44.64%)	.120%	18 (10.71%)	0	27 (16.07%)	141 (83.93%)	0

The discipline data were further analyzed in an attempt to determine the educational background of nurses cited in the complaints. Of the total number of licensed nurses who sustained discipline of their license during the time period from 2001 until 2006, 40.38% were found to be RNs. Of the RNs who experienced discipline, 22.62% were Associate’s degree-prepared, 8.74% were Bachelor’s degree-prepared, 54.17% had either a certificate or a diploma in Registered Nursing, and 14.37% had a Master’s Degree either in Nursing or a related field. These findings echo those found upon analysis of the RN complaint data in a similar manner.

In comparison to the RN discipline data, it was found upon analysis that LPNs accounted for 59.62% of the licensed practitioners who experienced discipline. Review of this group of LPNs’ educational backgrounds showed that 1.71% possessed an Associate’s Degree in Nursing, 97.69% possessed a

certificate of diploma in Practical Nursing, and .65% had acquired a Master's degree in Nursing or a related field.

The discipline data were also analyzed in an attempt to determine the number of licensed nurses who may have entered the nursing profession with evidence of pre-existing chemical dependency issues. For the purpose of analysis of the discipline database, the definition of "evidence of pre-existing chemical dependency issues" was defined as sustaining discipline designated as "substance abuse", "VDAP violation", or "arrest/conviction-drug" within the first year of attaining licensure. It is important to note that a VDAP agreement is not possible if the licensee has sustained a felony conviction or does not admit his or her substance abuse. Of the five groups of licensed nurses separated according to educational backgrounds, 1.45% of the Master's-prepared nurses were defined as receiving discipline of their license due to evidence of pre-existing chemical dependency issues, while 18.84% of the Bachelor's-prepared nurses were disciplined due to such issues, in comparison to 39.13% of the Associate's-prepared nurses and 14.49% of the Diploma-prepared nurses. Furthermore, 23.19% of LPNs received discipline related to evidence of pre-existing chemical dependency issues while 2.90% of nurses whose educational background could not be determined from information provided received such discipline. Thus, it appears that while Bachelor's-prepared nurses sustain a higher percentage of complaints related to evidence of preexisting chemical dependency issues, a higher percentage of Associate's-prepared nurses actually receive discipline related to these issues. This may be a direct result of Alabama's large population of Associate's-prepared nurses composing a majority of the RNs working in direct care positions where controlled substances are easily accessible.

As previously mentioned regarding complaint data, though this analysis is significant concerning discipline, it does not provide definitive evidence for the existence of pre-existing substance abuse issues prior to practitioners entering the profession. However, it does offer the suggestion that such issues exist.

Recommendations

Once findings have been presented and interpreted, recommendations can be made. The findings indicate that LPNs may be at higher risk than RNs to have a complaint brought against them. This may be related to the various sources of most complaints brought against LPNs, as shown in Table 5. Note that the source of the highest percentage of complaints for RNs is the ABN staff, whereas for LPNs, it is employers or co-workers. LPNs tend to work in large numbers in the long-term care section of the health care industry, which is highly regulated and surveyed by the State Public Health Department. Complaints could potentially be brought against an LPN as a result of a nursing home's poor performance on a State survey or because a nursing home resident is injured.

Table 5

Source of Complaints Received in 2005 (Alabama Board of Nursing, 2006)

Complaint Source	No. of RNs	Percentage	No. of LPNs	Percentage
ABN Staff Initiated	224	37.58%	73	21.66%
Anonymous Report	31	5.20%	16	4.75%
Consumer	9	1.51%	6	1.78%
Employer/Co-worker Report	116	19.46%	115	34.12%
Endorsement Application	14	2.35%	6	1.78%
Exam Application	6	1.01%	15	4.45%
Law Enforcement	4	.67%	2	.59%
Other Agency	38	6.38%	68	20.18%
Patient/Family Report	14	2.35%	4	1.19%
Reinstatement Application	16	2.68%	6	1.78%
Renewal Application	11	1.86%	1	.30%
Self-Report	112	18.79%	24	7.12%

Male LPNs, although small in number in terms of the overall nursing population, made up 12.94% of the total number of “repeat offender” nurses who had more than one complaint brought against their licenses. These findings, along with the large number of complaints initiated by employers and co-workers, can be used to show a need for facilities to provide remedial instruction to their LPN populations regarding the Nurse Practice Act and their scope of practice. The orientation period for new graduates, in particular new LPNs, may need to be lengthened to ensure safe practice (Floyd, 2003). Floyd further recommended that each new graduate be assigned a preceptor to incorporate theory into practice (2003). However, this recommendation should be expanded to include training for all preceptors to ensure that they are equipped to assess the learning style of their new graduate: problem-solving, task-centered, or experience-based. Practice settings which are dominated by LPNs, such skilled nursing facilities, city jails, correctional facilities, and physicians’ offices, should be closely supervised to prevent an increase in complaints from occurring due to lack of adequate supervision and sufficient leadership. Skilled nursing facilities in particular could benefit from close supervision because of the detailed regulations which govern their activities.

Regarding discipline, findings show that RNs and LPNs appear at equal risk of receiving discipline brought against their licenses. Male RNs appear to be at particularly high risk of receiving discipline related to substance abuse. This finding supports the need to emphasize the existence of Employee Assistance

Programs in facilities. While foundering in the midst of the nursing shortage, facilities may simply choose to “look the other way” when confronted with a nurse who is using inappropriate self-medication as an ineffective coping method. Colleagues who enable nurses through a failure to report must realize the necessity of quickly reporting the impaired nurse to the Board of Nursing, thus allowing the nurse to be given the option of entering treatment in a timely manner, rather than waiting until a patient’s life becomes jeopardized. Support groups for male RNs who may opt to use drugs or alcohol to cope with the high level of stress associated with critical care practices settings must be implemented, maintained, and encouraged in-house (Hilton, 2005).

Of particular risk of receiving discipline related to substance abuse are nurses who were initially licensed as an LPN and then subsequently were licensed as an RN. Having seen the need for further education, these nurses are obviously older than new graduates and have already been subjected to the stress level present in today’s health care environment. They may reject alcohol as an inappropriate coping method even while abusing prescription antidepressants or pain medications. This finding speaks to the need for vigilance on the part of the nurse manager and a willingness to confront a colleague who is clearly impaired (Kramer, 2004).

Finally, evidence exists that the Associate’s-prepared nurse is the population at highest risk to receive discipline related to the evidence of pre-existing chemical dependency issues. This speaks to the need for this group of nursing programs specifically to increase its vigilance in detecting symptoms of substance abuse and inadequate coping skills in students long before they graduate and attempt to cope with real world stressors.

Ultimately, though, the question remains: What, if anything, can be done to prevent recidivism in both accumulation of complaints and discipline of nurses? The answer may lie in detecting the seeds of chemical dependency in nursing students. Clark (2006) has noted that chemical dependency is so common among nurses that it has been described as an occupational hazard of the profession. Many nurses who abuse substances reported that they initiated the practice during their nursing education. Clark has emphasized the need for students to be aware of the prevalence of substance abuse within the nursing profession, the legal and ethical ramifications of both abuse and drug diversion, and the proper way to respond if a colleague shows evidence of impairment. Clark noted that nursing schools should have a clear policy for dealing with substance abuse that is consistent both with the policies of the parent university and the regulations of the State Board of Nursing. Analysis of the websites of the 37 Registered Nurse programs in Alabama revealed that 12 of them (32.43%) have distinct policies on drug testing of nursing students. Of the 25 Practical Nurse programs in Alabama, four (16%) were found to have such policies readily available for review on their websites. Clark provided suggestions for nurse

educators to prepare them to possibly intervene with a student suspected of substance abuse. They include:

- Examine personal attitudes toward substance abuse.
- Become informed about the incidence and prevalence of chemical dependency within nursing education and the profession.
- Examine ways to decrease stress within nursing education programs; teach self-care to mitigate the effects of escalating stress and burnout as part of the curriculum.
- Review university and program policies regarding substance abuse and become an active participant in policy revision and development.
- Base policy on an understanding of substance abuse as a treatable disease (2006).

Recognizing the significance that chemical dependency plays in the accumulation of multiple complaints and incidents of discipline brought against a nurse allows us to infer that preventive measure should begin not merely in the nursing education program itself but even prior to college entry, in the high school system. Yu (2001) found that college students' alcohol consumption was significantly influenced by alcohol consumption in high school, particularly during the senior year of high school. This means that education of high school and even junior high school guidance counselors and teachers on the recognition of the symptoms of substance abuse and the proper avenue for intervention should be seen as a priority for state Departments of Education.

This recommendation is confirmed by the findings of Lazarus and Moracco's 2000 study involving 50 nurses identified as substance abusers. When interviewed, the nurses who engaged in substance abuse in the form of drug use admitted to initial procurement of illicit drugs during adolescence. Drugs were obtained from friends, using money or substances pilfered from family members. Drug use in adulthood usually began after an emotional crisis, physical pain, or the development of an association with a drug user (Lazarus and Moracco, 2000). It may be inferred from this that early recognition of a student who demonstrates signs of possible substance abuse while still in junior high school or high school may allow for preventive measures to be implemented that would curtail recidivism in the student's professional nursing career later in life.

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