Substance Abuse and Misuse Identification and Prevention: An Evidence-Based Protocol for CRNAs in the Workplace

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Healthcare providers are susceptible to substance abuse, and anesthesia personnel are some of the most vulnerable. Substance abuse is the principal cause of professional impairment for Certified Registered Nurse Anesthetists (CRNAs), with 1 of 10 experiencing addiction to drugs or alcohol. Despite this problem, there is no standardized screening protocol for the identification of substance abuse or misuse for CRNAs. The purpose of this evidence-based protocol is to provide a standardized approach for the prevention and early identification of substance abuse and misuse in the practicing nurse anesthetist. An evidence-based protocol was created for workplace prevention of substance abuse and misuse. This article addresses the need for a protocol by including occurrences of accidents and injuries, consequences to anesthesia practice and patient care, costs, and the culture in an anesthesia group or department. Components of the protocol are formation of a committee, risk assessment, clear workplace policy, annual continuing education, annual supervisor training, drug screening of anesthesia personnel, pharmacy accountability, and access to treatment. The article describes the protocol and provides supplemental information to aid in implementation at other anesthesia departments. Substance abuse among CRNAs is a complex issue. This protocol is only an attempt to abate this problem.

Keywords: Prevention, substance abuse, substance misuse.

The healthcare community is not immune to the opioid crisis sweeping the nation. There has been a steady increase in investigating activity from the US Drug Enforcement Administration (DEA) on substance use and diversion in hospitals. Although the DEA’s emphasis is on organized crime, over the past several years, the focus has also included hospitals. Massachusetts General Hospital and Tufts Medical Center both received, for cause, unannounced visits from the DEA. Fines for hospitals found to be noncompliant with diversion identification and prevention have been in the millions of dollars. In 2015, Massachusetts General Hospital was fined $2.3 million over controlled-substance diversion by nursing staff.1

In 2006, there were 17.9 million adults in the United States who admitted to using illicit drugs while maintaining a full-time or part-time job.2 The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 8% of employees have used illicit drugs within the past month, 3% meet the criteria for substance use disorder, 3% have used illicit drugs while at work, 9% of employees have worked with a hangover, and 7% of employees drank alcohol during a workday.2 In 2007, the Centers for Disease Control and Prevention reported that prescription narcotic abuse cost employers in the United States $26 billion due to ineffective work or absenteeism.3 The National Safety Council (NSC) found that employees who use drugs are 2 to 5 times more likely to be absent, late, quit, or be fired within the first year of employment; be violent; receive an injury; or require workers’ compensation.4 Additionally, workers with a substance use disorder miss nearly 50% more workdays than do employees on average.4

The United States spends $35 billion a year treating substance use disorders but spends $85 billion a year managing injuries, illnesses, and infections related to them.5 In circumstances of turnover, injury, or absenteeism, the cost falls to the employer, and these costs are estimated to be up to $4,000 a year for each employee.5 Specifically, turnover can cost an employer approximately 25% of an employee’s salary, and estimates are up to $140 billion a year for US business owners.5 More difficult to define monetarily is a loss of reputation to an anesthesia group or department and the risk of patient harm. In 2016, approximately 2,900 patients were in jeopardy of HIV, hepatitis B, and hepatitis C exposure because of a surgical technician diverting syringes from anesthesia workspaces.1

Substance abuse is the principal cause of anesthesia personnel professional impairment.6 Approximately, 1 of 10 nurse anesthetists experience addiction to drugs or alcohol.7 The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) no longer recognizes the terms substance abuse or dependence but instead, recognizes substance use disorder in a varying scale of symptoms present.8 In this article, substance abuse refers to someone...
who would meet mild criteria for a substance use disorder in the DSM-5, and misuse is the inappropriate use of a substance, such as diversion or prescription misuse. Nurse anesthetists (nurse anesthetists, student registered nurse anesthetists, anesthesiologists, and anesthesia residents) are healthcare providers most susceptible to substance abuse and misuse. Nurse anesthetists are vulnerable to substance abuse for several reasons: accessibility, knowledge of use, lack of screening, solitary performance at work, ease of diversion, and lack of accountability by employers.

Additionally, there are factors that contribute to the culture of stigma and fear of reporting substance abuse among anesthesia providers: negative consequences for employment, loss of wages, anxiety regarding confidentiality, risk of losing one’s license, financial strain of treatment, fear of legal problems, conflict among primary relationships, denial of a problem, false belief of the ability to control substance use, and ignoring the problem in others. Beliefs in a group or organization shape the approach to substance abuse prevention and identification. The culture of an anesthesia group influences the way that Certified Registered Nurse Anesthetists (CRNAs) behave and what determines social norms. To modify the mindset that substance abuse is shameful to one of care will require fundamental transformations in the culture of CRNAs in the workplace. There is no comprehensive, evidence-based framework that changes culture in a healthcare workplace, but healthcare policy and literature propose that a culture change occurs through leadership, teamwork, and placing the patient at the center of care. To change the beliefs and attitudes regarding substance abuse, education and training are necessary, but they are not solely sufficient. There are 10 core values for an effective workplace culture: person centeredness, open communication, high support with high challenge, stakeholder involvement, teamwork, leadership development, evidence-based development, lifelong learning, positive attitude toward change, and safety. Addressing substance abuse and misuse in the workplace addresses all 10 of the core values by fostering care toward the CRNA for improved patient safety.

To change the culture from one that punishes or ignores to a culture of care and treatment, it is important that the core values of the anesthesia group or department are known to all CRNAs. This will encourage and challenge CRNAs in the organization to reflect these values in patient care and through interactions with team members. An anesthesia group or department must have a shared vision of care that puts the patients and the employees at the center. To do this, transformational leadership is necessary that will preserve the well-being of the CRNA, cultivate collaborative and innovative ways to work, and demonstrate a willingness to adapt as evaluations and feedback are given. A culture change is addressed throughout this protocol because it is necessary to change all aspects of the anesthesia workplace to decrease the shame and stigma of substance abuse.

**Substance Abuse and Misuse Identification and Prevention Protocol**

The Substance Abuse and Misuse Identification and Prevention (SAMIP) Protocol is an evidence-based approach for anesthesia groups or departments. There are 3 goals of the SAMIP Protocol. The first goal is to identify CRNAs with the potential for abuse or misuse early. If the SAMIP Protocol could prevent a CRNA from substance abuse or misuse, the risk for professional impairment by CRNAs might decrease. The second goal is to recognize CRNAs with a substance use disorder and provide directions to gain access to treatment. By establishing easy-to-follow reporting and treatment instructions, the risk for harmful outcomes for the CRNA and compromised patient care may decrease. The third goal is to decrease the stigma associated with substance abuse/misuse by changing the culture from one of punishment to one of care and concern. By instituting annual education and training, CRNAs’ knowledge of this disorder will increase, and those with substance use disorders may have easier access to treatment.

There are 8 components of the SAMIP Protocol: formation of a committee, risk assessment, clear workplace policy, annual continuing education, annual supervisor training, drug screening of anesthesia personnel, pharmacy accountability, and access to treatment (Table). The SAMIP Protocol has not been evaluated and is presented here as a potential opportunity to improve a well-documented problem.

- **Formation of a Committee.** Substance abuse and misuse by CRNAs can affect an entire facility. A SAMIP committee (SAMIP-C) should be formed to perform the following duties: maintain or develop policies for prevention and identification; track and examine data for suspected misuse or diversion; manage annual education for CRNAs, direct annual training of supervisors; be responsible for reporting diversion events in compliance of state or federal law; ensure that CRNAs with substance abuse disorders are enrolled in the employer-sponsored assistance program (ESAP) and given access to treatment; oversee preemployment, random, and for-cause drug screening; collaborate with pharmacy for accountability; and perform routine and random risk assessments. If applicable, the SAMIP-C should standardize practices across facilities.

It is important to note that the SAMIP-C will reflect an administrative function, not for diagnosis or treatment. Members of the committee should include a diversity of professions reflecting the anesthesia group: CRNAs, anesthesiologists, anesthesia assistants, anesthesia technologists, administrators, human resources staff, compli-
ance officers, and risk management specialists and/or security personnel. The SAMIP-C will be the foundation for a culture shift in the anesthesia group. Members of the committee should consider appointing an operating room (OR) pharmacist manager to join. The pharmacist would report to the committee suspicious behaviors, any changes in ordering of controlled substances, auditing reports, and any other information pertinent for the committee to monitor. The pharmacist member would not be privy to confidential information such as CRNAs sent for drug testing or treatment. Members of the committee should also consider involving upper management leadership, such as the chief nursing officer or the chief medical officer. Participation of higher leadership would provide collaboration, knowledge, and experience to the SAMIP-C while elevating the importance of the committee's work. Members of the SAMIP-C should meet quarterly and ad hoc if there is suspicion of diversion, positive drug screens, self-reporting, and other needs.

The committee should delegate a chairperson responsible for the implementation of the SAMIP Protocol. The chair of the SAMIP-C will conduct the meetings, support supervisor training, engage in brief interventions with supervisors as necessary, analyze pharmacy reports, and be a representative for the SAMIP-C on other committees. The chair will be responsible for reporting to other committees but always abide by confidentiality. The committee will be accountable for the implementation of the SAMIP Protocol.

- **Risk Assessment.** A risk assessment is an evaluation of the workplace to address trends, potential hazards, and the culture surrounding substance abuse and misuse in the workplace. The goal is to evaluate the workplace's potential risks if a hazard occurs. It is unlikely that one person will understand the entire group or workplace; therefore, the SAMIP-C will be responsible for the initial risk assessment. The prevention and identification of substance abuse and misuse will be more successful with shared responsibility and cooperation among committee members. A risk assessment should first be conducted to determine the CRNA's needs and the employer's ability to meet these needs. By first assessing the risks and needs, specific vulnerabilities regarding substance abuse and misuse can be identified. These can include employee morale, the anesthesia group's public image, productivity, absenteeism, and patient safety.

The following questions could guide the SAMIP-C's risk assessment. (1) Is substance abuse or misuse a problem or concern in our workplace? Are we creating a culture of care for our employees and our patients? These questions assess the organizational culture and employee work-life balance. (2) What could happen to employees, patients, OR staff, or other anesthesia employees if substance abuse or misuse occurs in our workplace? This question not only assesses safety and security concerns but also addresses absenteeism, turnover, and productivity. (3) What do we do as an anesthesia group or department if a CRNA reveals that he or she has a substance use disorder? This question evaluates protocols in place, gaps in knowledge, and approach to

<table>
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| Committee formation | • Chairperson  
• Members of anesthesia group  
• Pharmacist liaison |
| Risk assessment | • Identify gaps in the workplace.  
• Conduct routine risk assessments to assess new risks for the committee to address.  
• Make random, unannounced visits to areas with use of commonly abused or diverted drugs. |
| Policy development | • Substance abuse policy  
• Return to practice policy |
| Clear workplace policy | • AANA Position Statement  
• Employer sponsored treatment program |
| Annual continuing education and training | • Supervisors  
• Employees |
| Drug testing | • Preemployment  
• Random  
• For cause |
| Pharmacy accountability | • Employer sponsored treatment program |
| Access to treatment | • Employer sponsored treatment program |

Table. Substance Abuse and Misuse Identification and Prevention Protocol
treatment. (4) What resources do we have available to employees with substance use disorders?18 This question addresses the cost of treatment and what is available in the community. (5) How are we preventing substance use disorders and misuse in our employees?18 This question again focuses on the culture of the organization.

The initial risk assessment could identify gaps in the workplace and guide the SAMIP-C on prioritizing implementation. Routine risk assessments should occur within a set period to assess new risks for the committee to address. Additionally, random risk assessments should include unannounced visits to areas with use of commonly abused or diverted drugs, for example, the OR pharmacy, procedural areas, locations where medications are being wasted or disposed, and individual OR setups. This would allow the committee members to understand drug transactions, vulnerabilities in controlled-substance interactions, and whether procedures and policies are being followed and are reasonable.17,19

- **Clear Workplace Policy.** In 2016, the AANA released a position statement for the creation of a workplace substance abuse and drug diversion policy that addresses 9 components: (1) promotion of healthy behaviors and a safe, stigma-free work environment; (2) identification of the consequences of substance abuse and misuse; (3) education on individual risk factors; (4) identification of common signs and behaviors of substance abuse and misuse; (5) implementation and utilization of diversion prevention tactics; (6) application of drug testing that includes anesthesia drugs; (7) steps to manage and verify positive drug screens of current CRNAs; (8) delineation of reporting processes through a chain of command, authorities, and/or licensing boards; and (9) access to treatment with a contract for a safe return to practice.20 The AANA position statement does not specifically address treatment as an employer responsibility. An ESAP is necessary in the substance abuse policy, to provide a culture of care.

The SAMIP-C will be responsible for writing and establishing a policy if nonexistent, and the SAMIP-C should analyze the policy annually to determine if additional procedures or revisions are needed. The workplace policy should have clear language regarding the SAMIP Protocol. All CRNAs should be aware of the constituents and purpose of the SAMIP-C, risk assessment procedures, requirements for substance abuse education and training, requirements and procedures for drug screening, and the availability of treatment resources. CRNAs should acknowledge the policy on their date of hire, annually, and as any changes are made to the policy. The workplace policy should be written from a perspective of care for both CRNA employees and patient safety to remove the culture of fear and punishment.21

- **Annual Education.** In the literature, substance abuse prevention is rooted in education. However, there is no accepted module or standard in nurse anesthesia training programs or state licensing boards.22,23 Most states defer to the professional credentialing organization for the quality and quantity of continuing education credits and do not require dedicated credits on substance abuse prevention.22 Currently, the National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA) does not require any mandatory education on substance abuse, prevention, or wellness of the CRNA.24 West Virginia's Board of Nursing is the only state that requires diversion training for the maintenance of licensure.22

The workplace for the CRNA provides a critical opportunity to address substance abuse prevention and identification. In the workplace, education should be geared toward patient safety, personal health, and work performance. The workplace offers a prime location to address stress management, healthy coping mechanisms, burnout prevention, financial planning, risk of suicide, nutrition and weight loss, and nonviolent communication, all of which encompass preventive measures and improvement of culture.21 Every employee should be well versed on how to report a colleague if necessary. Additionally, if counseling sessions are available through the ESAP, it is important that all employees are aware, not just CRNAs requiring treatment.25

Although substance use disorder is classified as a disease of the brain, stigma is associated with the disorder, which can be perpetuated by healthcare professionals' mistreatment of patients with substance use disorders. Mistreatment of these patients can cause CRNAs to conceal their own abuse or misuse from colleagues.26 Education should address stereotypes and encourage others to evaluate their opinions regarding substance abuse, misconceptions concerning treatment, and return to practice. These discussions could decrease the stigma and foster a culture of care and support among CRNAs.26 There is a lack of opportunities for practicing nurse anesthetists to address and accept substance abuse as an occupational hazard. To change this culture, there should be avenues in the workplace to share ideas for system improvement and offer support to others. By creating healthier CRNAs, the organization creates a safer environment for patients as well.21,26

- **Annual Supervisor Training.** Supervisors are often the responsible party for annual training required in an anesthesia group. Supervisors can be a key component for prevention and identification of substance abuse and misuse in CRNA employees. However, many supervisors lack the training required to provide this support in the workforce. Annual training for supervisors should include the substance abuse and misuse policy, which includes drug screening; specific signs of substance abuse related to job performance, personality, and mental status changes; and diversion tactics.27 A supervisor should also be aware of confidentiality importance, the procedure if a CRNA is under the influence, his or her
role in an intervention, the procedure if a CRNA reports a colleague, and the chain of command for reporting a suspected CRNA. 18,26

An adaptable evidence-based protocol for substance abuse and misuse for CRNA supervisors is Screening, Brief Intervention, and Referral to Treatment (SBIRT). The supervisor would assess the CRNA for risky substance use (S), engage in a brief conversation (BI), and then refer the CRNA for additional services (RT). 28 The SBIRT model has been adapted outside the healthcare field to universities, web-based models, and workplaces. It is within the responsibility of a CRNA supervisor to help identify CRNAs with substance use disorders, but it would not be the supervisor’s duty to perform an intervention, refer the CRNA to treatment, or manage a CRNA in an ESAP. Supervisors have the unique ability to set the tone of the anesthesia group. Until more stringent policies and procedures are required and implemented, supervisors can be responsible for developing a culture of transparency, care of colleagues and patients, and prevention of substance abuse and misuse.

• Drug Screening. Alcohol and drug testing in the workforce are controversial, with conflicting evidence on the legality, ethics, and cost-effectiveness. In 1988, the federal government instituted mandatory drug testing for all safety-sensitive occupations, specifically transportation. 29 Benefits of testing include reducing risks to the health of employees, increasing safety in the workplace, thwarting workplace injuries, improving employee well-being, increasing the production process, enhancing public confidence in the workplace, and an improved medical fitness of employees, which will reduce healthcare costs. 29 Potential harms of testing include unreliability of testing, possible false-positives, possible false-negatives, damaged relations of the employee and employer, underreporting of negative events that would lead to testing, and increased cost. 29

It is important to address numerous features of drug testing in the substance abuse policy. These include the frequency with which CRNAs will be tested, the protocol for testing of CRNAs, testing facilities allowed for collection, type of drug test (urine, blood, saliva, and/or hair) used, allowable timeframe to report for testing, allowable timeframe to wait for results, how CRNAs will be notified for testing, steps taken after a positive test result, whether ethyl glucuronide (EtG) testing (a urine test for recent consumption by detecting ethanol’s breakdown into ethyl glucuronide) will be completed and what level will trigger consequences, who will pay for the test, whether a CRNA will be permitted to work while awaiting results, and if the wait period differs depending on the type of test requested (random vs for cause). 21,25,26,30 The SAMIP-C, with collaboration from employee health and legal departments, should determine the specific panel of drugs to be tested and at which intervals. 31 If there are no employee health services to determine a panel, commonly diverted drugs including anesthesia drugs (eg, propofol) should be screened. 31

Urine screens are the most common test for detecting substance use; however, many substances might not be detected because of their short elimination half-life in urine. 32 Alternative specimens such as saliva and hair are gaining attraction in the workforce. Currently, urine is the only approved method for workplaces that are covered by federal guidelines. 3 There is no federal law that regulates drug testing in the private sector, and due to this, the states regulate drug testing in the workplace. Saliva testing can be completed on-site, but it can only detect drug use that happened within the past few days. 3 Hair testing will detect long-term use, but it does not cover a recent period since it takes time for hair to grow. 3 The specific type of specimen collected should be determined by the needs of the anesthesia group and the SAMIP-C. A case could be made that a hair specimen is applicable for preemployment testing due to the wide window of detection, and urine would be most appropriate for random and for-cause testing. However, a hair test may not be possible for every employee, and it is considered an invasive, expensive investment for a potential employee. 21,25

There are 3 categories for timing of drug testing: preemployment, random, and for cause. Hiring should be contingent on a negative preemployment drug screen. 21,25 Potential employees should sign acknowledgement that employment is contingent on a negative drug screen and that any disclosure of legally prescribed drugs will remain confidential. Privacy, testing procedures, and chain of command should be conducted according to the Department of Health and Human Services’ mandatory guidelines. 3 Random drug screening should be assigned in a nondiscriminatory manner and addressed in the workplace policy. CRNAs should be aware of the practice and frequency of random drug screens. Random drug screening may deter substance misuse since CRNAs will be unaware of the testing time, and it could decrease the first-time use of controlled substances. 20 Random drug screening is often not completed because anesthesia groups and department are concerned of its punitive perception. Education should be completed to shift this perception from one of punishment to one of care and protection. If random drug screening could prevent first-time use, then CRNAs and patients are potentially safeguarded from dangers of substance abuse and misuses in the workplace.

For cause drug screens are administered when misuse or abuse is reported or suspected. 20 Anesthesia critical incidents that warrant a for-cause drug test should be determined by the SAMIP-C, but some examples include taking a controlled substance off campus, unaccounted for controlled substances, all sentinel events, falling asleep while administering anesthesia, more than 2 controlled-substance discrepancies in a week for a full-time
employee, multiple errors that deviate from the standard of care, evidence of neglect, abandonment, or poor attention while administering anesthesia, and visible evidence of medication tampering.21,25 While many of these incidences could occur as a result of substance abuse or misuse, they could also ensue without inappropriate use of substances. It is important to label the drug test as a cause of an action, not as a punishment of the action. By providing transparency through a standardized protocol of when a for cause drug test is completed, a culture of care for the CRNA and patient will be fostered.

• Pharmacy Accountability. It is crucial that the pharmacy responsible for dispensing controlled substances to nurse anesthetists be involved in substance abuse identification and prevention in the workplace. Pharmacists can provide quantitative data through reports and anesthesia records, but also qualitative data through interactions with CRNAs in the distribution process. The SAMIP Protocol outlines a risk assessment in the anesthesia group or department; however, the OR pharmacy should consider its own risk assessment to identify gaps and support multidisciplinary involvement.

The Centers for Medicare and Medicaid Services (CMS) outline several standards for pharmacies in the Conditions of Participation for Hospitals: secure medication handling, auditing for diversion, and safety in storage.33 Current and accurate records must be kept for the acceptance and return of all scheduled drugs (42 CFR 482.25(a)(3)). The American Society of HealthSystem Pharmacists (ASHP) surgery and anesthesia practice guidelines recommend record keeping for the following: controlled substances dispensed, returned, and disposed; controlled-substance inventories, and use by providers.34 The person responsible for auditing the anesthesia records should be clearly delineated in the substance abuse policy.19 The ASHP recommends that the inventory for controlled substances should be verified daily and that random audits of the inventory occur by a pharmacy staff member who does not work in the surgical pharmacy area.34 There is no standardization for the auditing of controlled-substance use in anesthesia records. Ideally, all anesthesia records are audited daily, but at least, the ASHP recommends random audits of anesthesia records to match the amount of controlled substance used.34 Pharmacists, specifically pharmacies for ORs, often base auditing practice on the amount of staff and the culture of pharmacy practice. The SAMIP-C should be familiar with the pharmacy’s auditing practice in order to collaborate and recommend improvements for identification and prevention in the facility.21

All scheduled drugs are required to be kept in a secure area, locked when appropriate, and with limited access to authorized personnel.33 Pharmacists and pharmacy staff members need familiarity with CRNAs’ management of controlled substance after leaving the pharmacy, specifically how CRNAs transport, store, and dispose of controlled substances. Pharmacists, pharmacy staff members, and the SAMIP-C must hold CRNAs accountable to CMS regulations by enforcing that no controlled substances are placed in pockets or personal belongings, or are carried outside areas of operation, such as bathrooms or cafeterias. Pharmacists and pharmacy staff must ensure that controlled substances are not left in unsecure locations such as unlocked anesthesia carts or locked boxes that are transportable, and do not use resources that require keys that could become misplaced or stolen.

Controlled substances require an independent witness to verify the waste and disposal. Often, this occurs between 2 healthcare providers, such as a registered nurse and a CRNA. If the procedure for obtaining controlled substances involves a pharmacist or pharmacy technician, wastage should occur in the same procedure.21,25 Wastage between a CRNA and pharmacist would allow for the waste to be documented within the view of cameras and remove any diversion potential that could arise by wasting the substance in a remote location.21,25 Cameras are for the protection and security of all employees: pharmacy staff, OR staff, and CRNAs.16 The ASHP recommends that cameras be placed in locations of high risk: where access can be obtained without radiofrequency identification tags or biometric means, remote locations (radiology suites, endoscopy rooms, etc) away from the pharmacy’s control, and in areas where diversion is suspected.34 The location and functionality of the cameras will be important for the SAMIP-C to note on risk assessments.

Pharmacists must regularly monitor for how drugs are administered, documented, and discarded. The following could serve as markers for pharmacists to closely monitor and communicate to the SAMIP-C: CRNAs who routinely administer more controlled substances than others; hypervigilance with charting of waste, counts, or anesthetic records; controlled substances removed from multiple locations for one patient; a CRNA administering controlled substances to another’s patient; using a larger vial of controlled substance when a smaller vial is available, then wasting the remaining medication; sharing access codes for controlled substances; CRNA signatures or initials that appear to be forged; frequent dropping or wasting of controlled substances due to damage; and controlled substances administered to patients not currently in the perioperative area or to false patients.16,21,25,26 Gaps for the OR pharmacists to consider include how to monitor CRNAs who move between facilities, such as a float pool; how to attest that auditing reports are being monitored; and allowable timeframe from recovery room to waste and return at the pharmacy.16,21 An OR pharmacist will be an integral member of the SAMIP-C to provide the committee with data necessary for identification and prevention.

• Access to Treatment. Substance abuse and misuse is listed as one of the leading workplace issues of healthcare
personnel, but there is a large treatment gap, with only 22% of workplaces having policies to address substance use disorder. The creation and maintenance of a workplace culture that supports the emotional and physical health of CRNAs is integral for employee well-being. Most health insurance plans offer incentives for physical health, and emotional health with substance abuse prevention could be integrated with these plans. Employer-sponsored assistance programs could provide resources, education, access to treatment services, and counseling. Implementation of an ESAP would ensure that every employee has access to support should they require it. An ESAP should include a set of professional services that improve the overall health of employees and apply knowledge of the profession to provide mental health support for personal issues (eg, marital, family, financial). Anesthesia groups or departments could encourage yearly checkups with a primary care provider for management of physical health, but also with a counselor or therapist through the ESAP for the encouragement of emotional health. Focusing on the emotional and physical well-being of employees speaks to the culture of care among an anesthesia group or department.

The NSC maintains that it is in the employer’s best interest to offer employee assistance programs for confidential access to treatment, and ESAPs are a cost-effective option. Findings on the efficacy of corporate health and productivity report that employee assistance programs have positive returns on investment and that 90% of all Fortune 500 companies offer these programs. Public Law 91-596 (Occupational Safety and Health Act) states that employers are accountable for employees’ health, safety, and welfare. This includes the responsibility of employers to minimize safety risks with the potential to harm employees, or workplaces can be found liable for the actions of employees who may be working under the influence. Providing ESAP to CRNAs communicates a culture of care.

Evaluation

After implementation of the SAMIP Protocol, evaluation of the protocol will determine whether the interventions have been effective. The goal of evaluation is to collect findings to improve the SAMIP protocol for continued use. Before implementation, an assessment of the anesthesia group should be completed to determine a baseline for data among current CRNAs. Data such as morale, beliefs toward substance abuse, absenteeism, turnover, open workers’ compensation claims, and CRNAs in substance abuse treatment, should be collected before the implementation of the protocol.

After execution of the protocol, it will be important to determine whether the SAMIP goals were met. The evaluation should determine whether the education and training were effective, strengths and opportunities of improvements, and justification for the continuation of substance abuse prevention and identification. Education effectiveness could be assessed through the administration of Likert scales. These evaluations could be given to CRNAs before and after the completion of education or training to assess whether CRNAs have a better comprehension of risks, improved knowledge on reporting and policy, and/or a changed outlook regarding the importance of reporting and access to treatment. Data collected before implementation of the protocol could be compared to determine whether there is improvement in turnover, absenteeism, disciplinary actions, or workers’ compensation claims. Data specific to drug testing could determine rates and classifications of positive screens, events that led up to a for-cause drug screen, and employee satisfaction toward testing. Additionally, the SAMIP-C could form a focus group of CRNAs to gain additional support or ideas to improve the SAMIP Protocol. The SAMIP-C would be responsible for the evaluation of the protocol, improvements identified in evaluation, and the refinement of the goals for prevention and identification.

Cost of Implementation

Costs associated with implementation of the SAMIP Protocol include time and money. It will take time to gain upper management support to form a committee dedicated to the prevention and identification of substance abuse and misuse. After the committee is formed, the protocol will require committee members to be away from patient care or other job duties to perform a risk assessment, develop policies and procedures, and train and educate employees. The SAMIP Protocol will be an ongoing process that needs a dedication of time from employees and management to be executed. Drug testing could be a new cost for an anesthesia group or department, and the cost will vary by the specific test and sample chosen. The Society of Human Resources Management estimates that most employers spend between $30 and $50 for a urine test. Additionally, annual education will be required as a component of the protocol. There is currently a lack of for-credit wellness education specifically for anesthesia providers; however, there are many free health promotion and wellness education programs that would foster the development of a caring culture in the anesthesia group or department. More continuing education modules specific to anesthesia providers are needed.

Conclusion

Workplace substance abuse prevention is a relatively new field of research and health promotion strategy with many legislative and ethical implications. The SAMIP Protocol is designed to assist anesthesia groups or departments in addressing substance abuse and misuse in the workplace. The goal of this protocol is prevention through early identification, increased access to treatment, and an improved
culture of care. Substance use disorder among nurse anesthetists is a complex issue with varying degrees of manifestations. Although the SAMIP Protocol is an evidence-based approach for the prevention and identification of substance abuse and misuse, it is only an attempt to abate this problem in the anesthesia community. Anesthesia groups or departments are encouraged to adapt these tools and resources with local addiction specialists to further guide prevention and identification of substance abuse and misuse in the workplace. As more anesthesia groups and departments adapt and evaluate a standardized approach, more evidence-based literature can be developed to further prevent substance abuse and misuse in the CRNA.

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