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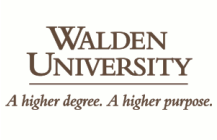

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Management Strategies to Address the Substance-Impaired Healthcare Professional in the Workplace

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Walden University

College of Management and Technology

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Anna Smith

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Walden University
2019

Abstract

Management Strategies to Address the Substance-Impaired Healthcare Professional in the Workplace

by

Anna M. Smith

MSN, University of Louisville, 1992

BSN, Spalding University, 1984

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

March 2019

Abstract

Healthcare professionals who practice while impaired by alcohol or drugs endanger the well-being of patients. In the workplace, the substance-impaired healthcare professional poses challenges for healthcare leaders who are responsible for the provision of safe patient care and safe work environments. The purpose of this multiple case study was to explore management strategies used by some healthcare organizational leaders to address the substance-impaired healthcare professional in the workplace. The conceptual framework for this study drew upon the legal and ethical concepts of due diligence. Data collection consisted of surveys of 40 managers and supervisors, and 3 senior leaders, semi structured interviews of executive leaders from one large hospital, and a review of company documents. A software program was used to organize the data for analysis. Five themes emerged that yielded 6 possible strategies that leaders could use to address the substance-impaired healthcare professional in the workplace: an affective healthcare business model, healthcare leader training, monitoring and surveillance systems, synergistic integration of work and life balance, and legal and ethical incident reporting. These research findings may contribute to positive organizational and social change by reducing the risk patients have from substance-impaired healthcare professionals.

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Dedication

To my mother, Virginia Smith, thank you for your devotion and support through the years. To my father, Robert Smith Jr. and my brother Robin Smith, though both are deceased, you remain steadfastly in my heart. To my family and friends for their unwavering encouragement and the continual question “are you done yet”? To Patty who provided continual belief in my ability to complete this journey. Thank you for the multiple ways you demonstrated tangible support. To those who played an active role in the achievement of a doctoral degree, please accept a heartfelt thank you for your love, guidance, and support.

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Section 1: Foundation of the Study

Healthcare includes both the business and the practice of patient care. Healthcare organizations must keep patients free from harm (Rundio, 2013). Healthcare professionals including nurses, physicians, and pharmacists, who practice or perform duties while impaired by alcohol or other chemical agents, may place patients at risk for harm, jeopardizing the business and the practice of the healthcare organization. In this research, I explored management strategies used by some healthcare leaders to address healthcare professionals, who practice or perform duties while substance-impaired predisposing patients to harm.

Background of the Problem

Estimates reveal that eight to 15% of healthcare professionals abuse or misuse drugs or alcohol (Goggans, Landfair, Ohlenik, & Michalakes, 2013). According to the American Hospital Association (2013), healthcare professionals are the caregivers responsible for the health and well-being of the population. A healthcare professional with education, training, and certification or licensure systematically provides medical care following prescribed protocols and procedures (Rundio, 2013). A professional body accredits healthcare professionals upon completing a course of study. A government agency provides a license to practice a health-related profession such as dentistry, nursing, medicine, pharmacist, physical therapist (Baldisseri, 2009). The epidemiology of the impaired healthcare professional is broad, affecting all genders, socioeconomic status, educational background, culture and geographic location (Rundio, 2013).

Competency is the hallmark of the healthcare profession and is requisite for the health, safety, and welfare of patients (Burton, 2014). The American Hospital Association (AHA) describes safe nursing and medical care as a distinguishing characteristic of healthcare organizations. Accrediting organizations such as the Hospital Consumer Assessment of Healthcare Providers and System Organizations financially penalize hospitals failing to provide safe patient care (AHA, 2013; McNeil, 2012).

The healthcare industry is concerned about substance impairment as it potentially diminishes competency and decreases the ability of the healthcare professional to practice according to accepted professional standards. Substance impairment may result from substance use, abuse, or dependency (Georgiou, 2013). Employment of substance-impaired healthcare professionals contributes to poor employment success rates, increased safety, and quality risks, and potential increased harm to patients (Kunyk, 2015; Fusion, 2014). Healthcare organizations are responsible for protecting the public from harm in the work setting by creating strategies for addressing healthcare professionals who practice while substance-impaired (Rundio, 2013). Leaders within healthcare organizations sometimes fail to recognize substance-impaired healthcare professionals (Kinkle, 2015). Despite the evidence of the prevalence of substance abuse and the negative effect on healthcare organizations, there is scant evidence to inform healthcare leaders about strategies used to address substance impairment in the workplace.

Problem Statement

Estimates reveal approximately 10% to 15% of all healthcare professionals will misuse drugs or alcohol at some time during their career Approximately 10% of nurses, 8% of physicians and 15% of pharmacists abuse alcohol or drugs at some time during their career (Goggans et al., 2013). The cost of drug diversion and substance abuse is approximately $78.5 billion a year including $11 billion in healthcare costs for drug treatment and drug-related medical consequences (Florence, Zhou, Luo, & Xu, 2016; O'Neill & Cadiz, 2014). The general business problem is some healthcare organizations put patients at risk for significant injury or death when healthcare professionals provide patient care while under the influence of drugs or alcohol. The specific business problem is that some healthcare leaders may lack management strategies to identify and address the substance-impaired healthcare professional in the workplace.

Purpose Statement

The purpose of this multiple qualitative case study was to explore what management strategies were used by some healthcare organizational leaders to address substance-impaired healthcare professionals in the workplace. The population included approximately 40 managers and supervisors who supervise healthcare professionals and who work for a healthcare organization in the Commonwealth of Kentucky, United States. Managers and supervisors received questions administered in a survey questionnaire format. Three executive leaders were interviewed using a semi structured interview process designed to elicit their lived-experience for addressing the substance-

impaired healthcare professional. The executive leaders did not receive the qualitative survey questionnaire sent to the managers and supervisors. I reviewed organizational documents for relevant information. According to Yin (2018), interview methods include an observation aspect to enhance the research and a discussion with the interviewed participants. Implications for positive social change include the identification of management strategies to identify and manage the substance-impaired healthcare professionals in hospitals.

Nature of the Study

I selected qualitative research method with a case study design was for this study. Qualitative analysis relies on the skill, vision, and integrity of the researcher doing the analysis (Frels & Onwuegbuzie, 2013). Qualitative research aims to gather an in-depth understanding of reasons, actions, and behaviors of human interaction while the quantitative method focuses on the what, when, or where of a phenomenon and may not readily lend to understanding human behavior in situations (Baden-Savin & Major, 2013). The intent of this study was not to develop or test a theory, but rather to explore management strategies used by some healthcare leaders to address issues that affect the efficient delivery of healthcare when dealing with substance-impaired healthcare professionals in the workplace.

Interpretivism and constructivism form the basis for qualitative research (Anfara & Mertz, 2014). Qualitative researchers seek to deepen an understanding of human behavior by investigating the why and how of decision making (Bryman, 2006). Decision

making is the study of identifying and implementing alternatives based on the values and preferences of the decision maker. Decision making is a central management activity (Cottrell, 2012).

Qualitative researchers seek to identify a single concept or phenomenon, to validate and interpret the data, and to study an event within the context or setting by interacting with the participants (Frels & Onwuegbuzie, 2013). Qualitative research includes situational questions designed to explore knowledge of a phenomenon or theory (Anfara & Mertz, 2014; Prowse, 2013). This qualitative study consisted of situational questions designed to explore management strategies used by some organizational leaders to address the substance-impaired healthcare professional in the workplace.

In contrast, the measurement of quantity used in quantitative research connects empirical observation with measurable outcomes (Anfara & Mertz, 2014). Quantitative data is any data in the numerical form such as statistics or percentages. The quantitative researcher asks specific, focused questions and collects a sample of statistical information from participants to answer questions. This type of research prohibits understanding the subjective nature of management strategies and healthcare professional impairment (Anfara & Mertz, 2014; Frels & Onwuegbuzie, 2013).

A case study, a form of qualitative research, is useful for exploring or explaining analysis of groups or events such as managers and supervisors in a healthcare setting (Yin, 2018). Case studies help researchers explore how leaders used or applied underlying principles, knowledge, and skill about substance-impaired healthcare

professionals (Yin, 2018). Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems studied holistically by one or more method (Thomas, 2011). I reviewed human resource policies and procedures, employee assistant procedures, education and training documents, and other approved forms of documentation in this study. These documents facilitated the understanding of healthcare leaders who managed substance-impaired professionals in the hospital setting.

Research Question

The central research question was: What management strategies do some healthcare leaders use to address the substance-impaired healthcare professional in the workplace? The conceptual framework of due diligence grounded the interview questions that I used to elicit answers from participants as they relate to this topic (Starr, 2015). Due diligence refers to the care a reasonable person should take before entering into an agreement or a transaction with another party (Violette & Shields, 2007). The concept of due diligence applies to organizations who seek to provide a safe and effective workplace environment. The basic concept of due diligence in this context extends the idea of safe practice linking healthcare leaders, healthcare professionals, and healthcare organizations.

Questions for Participants

Survey Questionnaire for Manager and Supervisor Participants

Forty managers and supervisors who supervise healthcare professionals in daily operations received a six-question survey questionnaire. The questions were designed to

explore managers and supervisors' knowledge of management strategies related to policy and procedure, education, practice, identification and management of the substance-impaired healthcare professional. The questions were as follows:

1. What management strategies do you use when addressing the known or suspected to be a substance-impaired healthcare professional?
2. Describe how your preparation as a leader regarding your organization's management strategies regarding the substance-impaired healthcare professional?
3. Describe the management strategy or process for drug testing the suspected impaired healthcare professional in your organization who is actively providing patient care?
4. What management strategies do you use to support a healthcare professional enrolled in a substance abuse recovery program?
5. What management strategies do you use to monitor a substance-impaired healthcare professional returning to the work environment?
6. What additional information would you like to add?

Interview Questions for Executive Leader Participants

Four questions were designed to explore the executive leaders' knowledge of management strategies related to policy and procedure, education, practice, identification and management of the substance-impaired nurse or physician. leaders hold positions such as chief executive officer, chief of nursing and chief of operations as defined by the

organization's job description. The executive leaders received a study participation letter. The questions were as follows:

1. What management strategies do you use when addressing the known or suspected to be impaired nurse or physician?
2. What methods do you use for educating managers and supervisors on strategies when addressing the impaired nurse or physician?
3. What strategies do you use to manage reentry into practice for healthcare professionals after completing a substance impairment treatment program?
4. What additional information would you like to add?

Conceptual Framework

Due Diligence

This study was framed through the conceptual lens of due diligence as it applies to organizations who seek to provide a safe and effective workplace. The concept of due diligence applies to organizations who seek to provide a safe and effective workplace and served as a framework for this study (Starr, 2015). Due diligence refers to the care a reasonable person should take before entering into an agreement or a transaction with another party (Violette & Shields, 2007). The concept of due diligence is both a legal and an ethical concept (Starr, 2015).

Due diligence, created mainly from American securities laws, can impose liabilities on the issuers of securities sold within the public domain (Engle, 2012; Tizen & Aneidere, 2011). American courts address obligations in some instances in which the

parties behaved responsibly and tried to meet the disclosure standard of laws. Due diligence extends beyond underwriting transactions and can include duties of careful investigation for reasons when the parties want to be reasonably informed about the material aspects of a transaction (Bottger & Barsoux, 2012). Organizations require the ability to make informed decisions with reasonable information and transactions concerning involved parties (Engle, 2012: Sawyer, 2013). Healthcare leaders govern the principles, ethics, and operations of the business, inclusive of healthcare professionals, who practice in their organization. Healthcare leaders evaluate, investigate, and monitor the competence, capacity, and expertise of the healthcare professional (AMA, 2017).

Corporate responsibilities address the ethics, behavior, and due diligence of an organization. Due diligence prescribes the ethical and humane treatment of individuals within a business setting (Engle, 2012). Healthcare leaders, who adhere to the ethical aspects of the organization's values, mission, and purpose, seek to provide safe practice environments (Collins, 2012). According to the AMA (2013), healthcare professionals who practice while under the influence of a chemical substance violate the ethical and humane treatment of patients and family members and violate the ethics of the healthcare institution or hospital. The public has a right to expect healthcare professionals such as RN's to maintain professional competence as demonstrated through a high-level of the knowledge, abilities, and judgment (ANA, 2014). The ANA's position iterates that employers have a responsibility to provide an environment conducive to competent

practice (ANA, 2014). Figure 1 presents the interrelationships of the ethical and legal aspects of due diligence as applicable to healthcare leaders.

Figure 1. Due diligence concepts as applied to healthcare leaders. Healthcare leaders exercise reasonable steps to ensure that a healthcare business such as a hospital meets ethical and legal obligations which avoid harm to other persons or their property during transactions such as the provision of care, A. Smith, 2017. No copyright.

Operational Definitions

The operational definitions of key terms that I used in this study are as follows:

American Hospital Association (AHA): The leaders of this professional healthcare organization ensure the delivery of quality healthcare provided in hospitals and healthcare networks (AHA, 2013).

American Medical Association (AMA): The members of this professional organization promote the art and science of medicine for the betterment of public health. Members advance the interests of physicians, encourage the well-being of patients, support public health, and lobby for favorable legislation for physicians. The AMA organization established the medical standards of practice as well as the Code of Medical Ethics (AMA, 2017).

American Nurse Association (ANA): The members of this professional organization govern nursing policies which protect, promote, and optimize health, prevent illness and injury, and alleviate suffering through the diagnosis and treatment of human response in the care of individuals, families, communities, and populations (ANA, 2014).

Drug diversion: The transfer of a prescribed drug or controlled substance from a lawful to illegal distribution. The National Institute for Drugs Abuse (NIDA) categorizes controlled substances into five schedules referred to as I, II, III, IV, and V. According to the Controlled Substances Acts schedule, I and II drugs require severe restrictions in the United States. Schedule, I and II drugs, have a high potential for abuse and may lead to severe psychological or physical dependence (National Institute on Drug Abuse, 2014).

Drug-free work program and policy: The organizational programs and policies which restrict employees from working while using any substance, legal or illegal, which could cause impaired performance. Comprehensive programs may vary in structure but often include leadership training, employee education, employee assistance and drug testing (Elmer, 2012).

Healthcare leader: The individuals within the selected organization who are administratively responsible for ensuring the continuation of daily business operations, inclusive of the safe and uninterrupted delivery of care to patients (AMA, 2017).

Healthcare professional: The requirement for specialized knowledge, training or skills and can embrace a broad array of professional practices including, but not limited to, nurses, physicians, and pharmacist (ANA, 2014).

Healthcare organization: A hospital or institution which provides medical, surgical or psychiatric care and treatment for the sick or injured. Hospitals require staffing and equipment to provide diagnostic and therapeutic services which support the functions of the specific or assigned mission (AHA, 2013).

Psychometric testing: Psychometric tests are used as a standard and scientific method to measure an individual's mental capabilities and behavioral style (Wright, 2014).

Substance abuse: A demonstrated pattern in which an individual consumes a controlled substance, alcohol, or other chemical agents in amounts harmful to themselves or others. The term has a wide range of definitions, including the use of a psychoactive

drug or performance-enhancing drug, for non-therapeutic or non-medical effect (ANA, 2014; Starr, 2015).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are accepted as real or at least plausible even though unverifiable (Frels & Onwuegbuzie, 2013). In conducting this study, I assumed that leaders of the organization subject to this inquiry were well-versed in strategies used to address the impaired healthcare professional in the workplace. This assumption proved to have constraints as not all leaders could articulate this knowledge. I found the data collected from my sample group of healthcare leaders was reasonably representative of healthcare leaders within similar healthcare settings.

Limitations

The limitations of a research study include the influences or weaknesses the researcher cannot control (Cottrell, 2012). In qualitative research, certain limitations may hinder the ability to generalize the findings to the broader population. One weakness of my study was the subjective nature of the study which proved challenging to interpret (Cottrell, 2012). Some participants had negative experiences, which may have biased their perceptions of impaired healthcare providers. My study was confined to one hospital setting. Other hospitals may have different processes and policies in place which may influence the results.

Delimitations

Delimitations are choices made by the researcher and describe boundaries set for the study (Cottrell, 2012). Delimitations include issues or concerns not covered in the literature review of the study (Cottrell, 2012). Selection criteria for the study included participants 21 years of age or older and those who held the job description of a leader in the selected organization. Only participants able to read and who understand the English language received the case study questions. The concept of due diligence is assumed to be a useful framework for understanding the implication of the phenomenon substance-impaired healthcare professionals within the selected organization. Delimitation factors of the study included (a) the confinement of the study to an acute care hospital, (b) the population size and (c) the communication method used with the participants.

The Significance of the Study

Contribution to Business Practice

The health and well-being of nurses and physicians and other healthcare professionals are the focus of studies (Oreskovich et al., 2015; Shanafelt & Noseworthy, 2017). Several studies focused on numerous issues including quality of life, burnout, and medical errors; substantive studies regarding leadership skill for addressing the substance-impaired nurse or physician in the workplace are lacking. Leaders who address the healthcare professional demonstrating substance-impaired behavior while at work may prevent the actual or potential adverse outcomes or injury to patients and lessen the interruption of daily healthcare operations.

Understanding the phenomenon of how leaders address the substance-impaired nurse or physician may promote a productive and safe work environment. The absence of a strategy for managing substance impaired healthcare professionals could negatively influence the effectiveness of a hospital (Collins, 2012). Healthcare leaders must be more concerned with protecting the health of their patients than their brand.

Implications for Social Change

Positive social change is a deliberate process of creating and applying strategies and actions to promote the worth, dignity, and development of individuals, communities, organizations, and institutions (Kinkle, 2015). This study potentially fostered positive social change by identifying strategies to manage substance-impaired healthcare professionals in hospitals (Kunyk, 2015). Further, impaired healthcare professionals may leave the workforce because of depression, anxiety or feelings of guilt and worthlessness (O'Neil & Cadiz, 2014). This study may assist healthcare leaders in (a) supporting the impaired provider's feelings of self-worth and dignity after treatment, and (b) providing a safe work environment for patients and providers.

A Review of the Professional and Academic Literature

My goal for this literature review was to (a) present this study in the context of the healthcare leadership strategies in literature, (b) justify the need for the research, and (c) build or extend existing research literature. The review of the literature for the study included a wide range of seminal books, journals, and research studies. The primary

sources of the literature review were peer-reviewed journal articles, dissertations, books, professional websites, and federal government publications.

I obtained peer-reviewed journal articles from Google Scholar and the following Walden University research databases: ABI/Inform, Business Source Complete, Science Direct, PubMed and the National Institute of Health provided relevant information for the study. A significant component of a viable organization is the maintenance of a quality workforce to conduct business (Sawyer, 2013). An in-depth review of database searches used words and phrases. Word searches included: *ethics, due diligence, healthcare organizations, healthcare workers, professional practice, leadership, employment screening, background checks, and social media. Additional terms included chemical impairment, drug diversion, substance abuse, peer health programs, reentry, drug testing, addiction, prevalence, identification and education, detection, prevention and recovery,* and *blood-borne infection.* Functional terms included *impairment, chemical impairment, chemical or alcohol dependency,* and *substance abuse*. The search strategies yielded more than 100 studies analyzed for this project.

Research regarding healthcare organizational leaders, management strategies, and substance impairment reflects a multidisciplinary review. Accordingly, different concept definitions and explanations of substance impairment exist in the literature. The understanding of this literature review may be challenging because of the complicated relationship between organizational leadership, management strategies, and substance impairment. Much of the literature did not cover implications of and methods for

exploring management strategies used by some healthcare leaders to address the substance-impaired healthcare professional in the workplace. Seemingly a holistic, qualitative case study would likely represent both a meaningful contribution to the literature and promote this research design to gain insights into management strategies used by some healthcare organizational leaders addressing the substance-impaired healthcare professional in the workplace.

Organization of the Literature Review

The literature review is organized to address the major components of the due diligence conceptual framework. The components reviewed included (a) the legal and financial implications and (b) the ethical and moral implications of the substance-impaired healthcare professional in the workplace. I examined literature regarding management strategies used by some healthcare leaders. I conclude the literature review with a summary of findings.

Legal and Financial Implications

The Mayo Clinic, a Rochester, Minnesota-based health system, experienced an increase in costly patient infections in at least three of its facilities related to healthcare workers who stole or diverted narcotics intended for patients. The workers subsequently partially injected the narcotic into themselves then used the same now-contaminated needles/syringes to inject the remainder into their patients (Berge, Dillon, Sikkink, Taylor, & Lanier, 2012). The infectious outbreaks were consistent with revealed gaps in prevention, detection and response to addicted nurses, physicians and healthcare workers

in other U.S. healthcare facilities (Schaefer & Perz, 2014). Mayo responded by developing rigorous training and prevention programs related to the occurrence of substance impairment. Unfortunately, several newspaper articles highlighting the initial lack of oversight appeared in the *Minneapolis Tribune*. As a result, the famous Mayo Clinic health system was found liable and experienced negative fiscal effects and decreased credibility with the public and in the healthcare community (Berge et al., 2012). Another case in Nevada involving a substance-impaired nurse awarded $524 million in combined compensatory and punitive damages to two patients who contracted HCV because of the improper handling and administration of an intravenous sedative drug. Cross-contamination occurred when the nurse repeatedly used the same vial intended for sole use on multiple patients during procedures (Berge & Lanier, 2014). The plaintiff's attorney placed culpability on the healthcare workers, the healthcare company, and the affiliated professional insurance plan of the healthcare workers (Miller & Feeley, 2014).

Employment tests and screening strategies. Human resource (HR) departments use a combination of processes to sift the myriad of applicants received on a routine basis (Bateson, Wirtz, Burke, & Vaughan, 2014). Traditional screening processes include telephone or face-to-face interviews with HR specialists, managers, and supervisors (Cottrell, 2012). The standard HR process seeks to quickly and efficiently review candidates, screen out significant numbers of unsuitable candidates, and target the smaller, better-qualified pool to undergo the costlier personalized steps of the screening

process (Bateson et al., 2014). Pre-employment screening in the hiring process is especially important in the healthcare industry, in which financial damages and lawsuits affect hospitals because of negligent hiring (Mar & Tingle, 2012). Employers are increasing testing and screening procedures because of security concerns, concerns regarding workplace violence, and safety and liability issues (Bateson et al., 2014). Human resources and hiring managers should have a variety of testing tools at their disposal (Draper, Hawley, McMahon, Reid, & Barbir, 2014). The selected pre-employment hiring strategy is dependent upon the organization's human resource policies and procedures and the organization's business needs, goals and objectives (Hughes, Hertz, & White, 2013).

The Employment Equal Opportunity Commission agency of the United States Government enforces federal employment discrimination laws (EEOC, 2014). The EEOC Employer Best Practices for Testing and Selection allows businesses to incorporate a variety of pre-employment strategies to ensure efficient and effective screening (EEOC, 2014). Employment selection tests must adhere to the American with Disabilities guidelines and assessments individualized based on the work setting, the requirements of the position and the individual's present ability to safely perform the essential job functions (EEOC, 2014).

Pre-employment tests include industry and job-level specific categories (Hughes et al., 2013). Employers seek to increase their effectiveness and accuracy of choosing employees who can assist the organization to achieve their strategic goals, maintain a

competitive edge against like businesses, and help the organization remain cost-effective in hiring selections and while minimizing employer liability (Hughes et al., 2013). Many companies conduct pre-employment testing before or as a part of the interview process (Menendez, 2010). EEOC Governing Laws allow pre-employment tests that are unbiased and support Title VII employment guidelines. Title VII provides employment testing as long tests do not discriminate based on race, color, religion, sex or national origin (EEOC, 2014).

The EEOC recommends the following regarding pre-employment tests:

(a) employers should ensure tests or selection procedures remain predictive of success,

(b) employers are responsible for keeping abreast of current changes in job requirements,

(c) employers should update test specifications and selection procedures accordingly (Wright, 2014).

Tests or selection procedures can be a useful management tool if those administering the tests maintain proficiency in both application and scoring integrity techniques (EEOC, 2014).

Intuition and decision making. Intuition is a complicated decision process few researchers have empirically investigated and defined (Glockner & Witteman, 2010; Gore & Sadler-Smith, 2011). Intuition is not a homogeneous concept, but a label used for different cognitive mechanisms (Slaughter, Christian, Podaskoff, Sinar, & Lievens,

2014). Research by Miles and Sadler-Smith (2014) revealed under complex conditions and uncertain outcomes, time-pressured managers sometimes rely on intuition and judgment when selecting employees which can lead to good or bad decision-making. Slaughter et al. (2014) found manager reliance on intuition in the employee screening process ambiguous and subjective and recommend further research regarding implications.

The use of technology as an employment tactic. HR and the relationship to changes in the economy, globalization, and the shift in diversity create new demands for organizations such as increased an increased reliance on information technology (IT); Stone, Deadrick, Lukaszewski, & Johnson, 2015). IT innovations continue to transform how organizations recruit, select, motivate and retain employees (Stone et al., 2015). Technology advancements, inclusive of websites and job boards, continue to change the way HR professionals perform their work. Despite the changing relationship between IT and HR, opportunities remain regarding the effectiveness of computers and telecommunications devices used to collect, store or disseminate data for business purposes (Stone et al., 2015).

Job boards in healthcare. IT consultant Jeff Taylor launched the first job board, *Monster.com,* in 1994 and quickly produced a world-wide effect in the sourcing of job candidates (Bateson et al., 2014). The growth in job boards dramatically increased the number of candidates per position in the United States (Bateson et al., 2014). HR healthcare employers state that online job boards are more efficient than corporate

websites in filling most of their positions across the board in 20 of 26 job categories (Healthe Careers Network, 2015). The application of due diligence and the use of job boards may have adverse outcomes. The use of job boards in healthcare is challenging because of the static communication processes used to make information available to applicants regarding online jobs. Managers and supervisors do not have the opportunity to interact or clarify the nature of the job resulting in an impersonal, passive and artificial distance between applicants and organizations (Stone et al., 2015).

David Kwiatkowski, a former health worker, is serving 39 years in a maximum-security federal prison for his role in the hepatitis outbreak in hospitals. depicts how he used job boards to gain employment in seven different states and various healthcare settings throughout years. The agencies that placed him included Maxim, Advance Med, and Springboard. Kwiatkowski described how previous terminations on more than one occasion failed to prevent his ability to gain employment time and again by using job boards. He further explained how one separation resulted from a substance abuse incident which left him unresponsive after he self-injected a stolen narcotic. This severe event required resuscitative measures by the hospital to save his life. Job boards placed him in numerous facilities including Johns Hopkins Hospital, Maryland General, Temple University, Arizona Heart, Kansas Hays Medical Center, and the University of Wisconsin Hospital and Clinics (Eichenwald, 2015). Kwiatkowski, infected with hepatitis C, exposed numerous patients to the potentially fatal disease by using narcotic injections on both himself and his patients during procedures. The Center for Disease Control and

Prevention (CDC) recommended some 12,000 patients be tested because of their contact with Kwiatkowski's blood (Eichenwald, 2015). According to Kwiatkowski, drugs were plentiful in hospitals and hospital leadership never reported his drug use to appropriate authorities even when he tested positive for drugs. The employing hospitals allowed him to resign or terminated his employment. The use of job boards, the implications of patient safety, and leadership responsibility remain an area for future research.

Founded in 2002, LinkedIn is the most extensive business-oriented social networking site and reached 200 million global member milestones in 2013 (LinkedIn, 2013). Hiring professionals increasingly use sites such as LinkedIn as their primary or sole job-posting site (Root & McKay, 2014). One problem with these sites is subscribers do not represent the national or global job-applicant pools. Social media business-oriented sites can help employers attract top talent though legal pitfalls such as discrimination can occur. A survey questionnaire revealed lower percentages of Latino and African American users per capita (Bates, 2013). Another recognized limitation of the professional networking site is the limited amount of information usually obtained only through face-to-face interviews (Bates, 2013).

Students of a southeast College of Business used social media sites when seeking employment. Researchers examined participants for what they thought employers preferred when creating an attractive social media profile. Students reported employers considered posts about the applicant's use of drugs, alcohol, or sexual activities were potentially detrimental to recruitment. Students stated that they do not post content or

block content they would not want an employer to see. Further research regarding how hiring managers use material deemed essential for the evaluation of job applicants is recommended (Root & McKay, 2014). The research did substantiate the use of job boards or professional networking sites and the ability to prevent or detect potential substance abusers

Psychometric testing. Hiring managers may use psychometric tests to screen the applicant's cognitive skills, work skills, physical and motor abilities, personality, emotional intelligence, language proficiency and even integrity (Wright, 2014). Tests such as psychometric or personality tests should not take the place of management judgment and continual assessment of their utility (Wright, 2014). Traditional screening processes may enhance outcomes when combined with psychometric sifting tests at the start of the recruitment process (Bateson et al., 2014).

Psychometric tests measure a candidates' suitability for a role and may include personality tests, skills tests, and aptitude tests. According to the Community Standards for Drug Screening and Background Checks (2013) employers may administer or test applicants via a computer within the employer's testing area using un-proctored Internet testing (Wright, 2014). The computerized system compares each applicant's traits to the traits for success on the job and generates a report based on how well each applicant matches the ideal profile for a job (EEOC, 2014). My organization used psychometric testing as part of the evaluation of applicants including Registered Nurses and physicians. A critical reduction in viable applicants resulted in an abandonment of psychometric

testing. The lack of viable applicants produced by the testing method affected the organization's ability to hire enough employees needed for successful daily operations (A. Smith, personal communication, March 14, 2014). While benefits are evident with psychometric testing, the negative aspect of being cited as language barriers, test anxiety and unfamiliarity can create a false negative of an applicant's ability (EEOC, 2014). Psychometric tests may contain biases of diverse cultural backgrounds (Wright, 2014). The research was inconclusive regarding the use of psychometric analysis and the ability to predict or identify substance impairment in the healthcare setting.

Background checks. Few employers consider background checks a superfluous formality of selecting and retaining employees (Gardner, Lewis, & Keaveney, 2008). Employers perform background checks as an industry standard. The Society for Human Resource Management (SHRM) found 96% of employers conducted background checks of applicants, up from 66% in 1996 (Hughes et al., 2013). Business entities have a legal duty to perform due diligence in the employment relationship, which includes a reasonable effort is taken to ensure the provision of a safe environment for the consumer (Sawyer, 2013). Information regarding the benefit of employment screening in the healthcare industry supports the importance of hospital leadership to implement a background check program as a part of the organization's due diligence (Hughes et al., 2013). Employers can legally seek information related to the person's work history, education, criminal record, financial history, medical history, or the use of social media via background checks (EEOC, 2014). Tests require an individual's consent and must

comply with federal laws protect applicants from discrimination (EEOC, 2014). Organizations who use background checks as a form of due diligence should inform applicants what the background check consist of, how is used and is protected (Hughes et al., 2013). Some organizations use background checks specific to security-sensitive positions such as senior-level administrator positions or for those who have responsibility for patient care or child care (Hughes et al., 2013). Only a third party contracted by the organization or by Consumer Reporting Agencies should provide background checks performed for pre-employment purposes (EEOC, 2014). The Fair Credit Reporting Act (FCRA) regulates state and local laws concerning CRA's (Hughes et al., 2013). In 2012 the EEOC issued guidance to employers discouraging blanket policies which categorically disqualify candidates based solely on criminal background histories. An increasing number of states are opting out of asking job-seekers about their criminal background in applications (Zeidner, 2014). Healthcare organizations can face serious risks to patient and employee safety, fines, and penalties for unknowingly hiring sanctioned or unlicensed nurses or physicians (Starr, 2015).

A useful background screening program for the healthcare professional includes checks for a criminal history of endangering patients, drug theft and abuse (Kentucky Board of Nursing, 2014). In 2013, The Dallas Fort Worth Hospital Council Foundation became the first program to mandate Community Standards for Drug Screening and Background Checks. The standards provide guidelines for drug screenings, background checks, and immunizations in the North Texas region for schools and hospitals/healthcare

agencies (Community Standards for Drug Screening & Background Checks, 2013). Little quantifiable research exists regarding the effectiveness of background checks as a source predictor of present or future substance abuse (Hughes et al., 2013).

Drug screens and alternatives. Employers may use various alcohol and drug testing processes such as pre-employment, routine and for-cause testing (Mar & Tingle, 2012). Hospitals often screen applicants to prevent or minimize lawsuits because of negligent performance (Mar & Tingle, 2012). Employment screening in the healthcare industry is highly regulated. Law does not require drug testing, and drug testing policies may be vague on procedural details and confidentiality (Sawyer, 2013). Healthcare organizations may choose not to perform drug or alcohol screening because of complex testing procedures, concerns about the individual's legal rights and the time it takes to obtain results when competing for available talent (Mar & Tingle, 2012). Employers who utilize drug or alcohol screens need not apply the same drug screening package for every position but should maintain consistency for everyone screened for the same or similar job (Sawyer, 2013). Pre-employment drug screens and for-cause drug tests on employees are a form of due diligence. Employees who care for patients and are substance or alcohol-impaired may put patient and employee safety at risk. This risk could potentially result in negligence or malpractice claims (Mar & Tingle, 2012).

In November 2014, a vote on California's Proposition 46 failed to pass. The proposition required physicians in the state to be randomly drug tested and to report fellow physicians who may be impaired by drugs or alcohol. Those found to be impaired

while on duty would be disciplined (Ejnes, 2014; McCarthy, 2014). Proposition 46, the Medical Malpractice Lawsuits Cap and Drug Testing of Physicians Initiative, mandated the discipline (McCarthy, 2014). The initiative proposed an increased cap on economic damages, such as those for pain and suffering, incurred by a patient because of an impaired physician, with medical malpractice settlements from $250,000 to $1.1 million (Ejnes, 2014). An essential aspect of Proposition 46 required hospitals to institute drug and alcohol testing of physicians at random and after adverse events. Positive test results would result in the immediate temporary suspension of the physician's license. The statute applied to any employed physician contracted to admit patients to a hospital or healthcare organization.

Those in opposition to the proposition stated the initiative would make the results of a physician's test available for criminal and civil litigation which could have the deleterious effect of less reporting by colleagues or reduce the number of physician referrals to monitoring programs (Pham & Pronovost, 2014). Ejnes, a California physician, refuted the usefulness of Proposition 46. Ejnes contended the proposal lacked specificity regarding the time frame for investigations to occur to determine physician impairment and that the proposition excluded other healthcare providers such as nurses or pharmacist. Ejnes further claimed the proposition was not specific regarding random testing of physicians and risk stratification. He maintained the proposition could increase cost and potentiate false-positive results because of vague guidelines regarding how random selection would occur. Ejnes noted "discrimination could occur because the

initiative failed to define what constitutes an adverse event; and the proposition lacked clarity regarding the role of hospital administration and the medical staff in testing oversight" (Ejnes, 2014, p.912).

Pham and Pronovost (2014) supported Proposition 46 provision for drug testing when adverse events especially those resulting in a patient's unexpected death occurred. Testing would be limited to the immediate setting of occurrence which would enable vetting of the logistics, risks, and benefits of such a program (Pham & Pronovost, 2014). While identification of impaired physicians through random drug testing would occur, "the bigger role of the proposition was to support the rehabilitation of physicians rather than punishment through possible civil and criminal liability" (Pham & Pronovost, 2014, p.913). Some states do not offer Physician Health Programs or rehabilitation programs for impaired physicians which could support a stronger case for Proposition 46.

Many high-risk industries such as airlines or nuclear power plants examine critical events when they occur (Ejnes, 2014). The directly involved individuals were tested for alcohol and other drugs (Banja, 2014; Pham, Pronovost, & Skipper, 2013). Mandatory drug or alcohol testing for physicians in unexpected death cases does not routinely occur in healthcare. Most states use a peer review process often governed by physician health programs to identify physicians with impaired performance; on the other hand, these programs vary in their authority, mandates, reporting requirements, authority (Pham et al., 2013). In many hospitals, reliable data must exist and be available in a hospital before initiating an investigation (Ejnes 2014; Pham et al., 2013).

A survey of 205 family medicine residency programs' practices relating to drug testing of medical students and incoming residents found most programs required testing. Programs not performing mandatory drug and alcohol screening believe the cost-benefit ratio as highly questionable (Bell, Semelka, & Bigdell, 2015). Alcohol and drug testing create a humiliating violation of privacy, is unlikely to detect substance abusers, and drug tests are subject to sabotage and false-positive and false-negative results (Pham & Pronovost, 2014). Employers are not legally liable in the absence of a drug-testing program. Some employers claim substantial legal costs incurred in defending their programs against wrongful dismissal claims. Employers claim the benefit to risk is not proven (Pham & Pronovost, 2014). Health institutions could improve patient safety and employee's wellbeing by implementing less invasive policies like encouraging employees to speak up when system operators notice work behaviors threaten, harm or create peril (Banja, 2014).

Along with nurses and physicians, other healthcare professionals such as pharmacist, experience problems with substance-related impairment as well. Pharmacists are another at-risk healthcare group for substance impairment (McLaughlin et al., 2013). To identify standard mechanisms of prescription drug diversion by pharmacists Merlo, Cummings and Cottler (2014) surveyed 32 pharmacists (71% male) who were monitored by their state professional health program (PHP) because of admitted substance-related impairment. Participants in this study revealed many ways they diverted drugs in their work setting such as taking expired drugs no longer and awaiting disposal, assuming

responsibility for inventory management, forging prescriptions and collecting patients' unused medication. Efforts to address the problem of prescription drug abuse and diversion by pharmacists may safeguard the patients served by those pharmacists (Merlo et al., 2014). Organizational leadership cannot exclude the effect on patient safety posed by impaired healthcare professionals such as a pharmacist. Further research may lead to understanding the implications of the role of leadership and the supervision of pharmacists in the healthcare setting (McLaughlin et al., 2013).

Adverse events in healthcare are complex and multi-factorial (Merlo, 2014; Oreskovich et al., 2015). Merlo (2014) sought to understand how high-levels of work-related stress, occupational access or secondhand exposure to commonly abused drugs, personality characteristics, long working hours and lack of self-care contributed to substance impairment in the healthcare professional. Merlo identified overarching problems faced by substance-impaired healthcare professionals including the vilification of impaired professionals, the limited understanding of the substance addictions and treatment modalities and the lack of support for individuals to obtain the care they need. The findings of the study recommended random drug testing as a comprehensive initiative to improve wellness among healthcare professionals (Merlo, 2014). The research supported leadership's role in developing an environment that retains high-valued employees avoids potential litigation and prevents catastrophic events within the healthcare system afforded by random drug-screening.

The Maryland Department of Public Health and Mental Hygiene report found regional staffing agencies are mostly unregulated nationwide and lack diligence related to drug screen testing on individuals they refer to hospitals for employment. Multiple employers who are unaware of the employee's substance addiction history (Maryland Department of Health and Mental Hygiene, 2013) may hire impaired healthcare workers. What the prevalence of healthcare organizations who use temporary nurse staffing (TNS) is increasing because of the nursing shortage (Mazurenko & Perna, 2015; Birnbaum, 2014). The research suggests the use of TNS may decrease service quality and negatively affect organizational outcomes; the study was inclusive regarding differences between substance impairment in the TNS group when compared with nurses who were actual employees of healthcare organization (Mazurenko & Perna, 2015).

Leaders are responsible for addressing risks which jeopardize the safety of the organization, the employees, and the public's welfare. To avoid legal difficulties, pre- and post-employment drug screens need to be relevant to the job functions as well as the skill sets necessary to perform those essential functions successfully (EEOC, 2014). Birnbaum (2014) cites the increasing change in the licensing and regulatory oversight of staffing agencies used by many hospitals. This change resulted in healthcare workers, including nurses and physicians, across the country tested for drugs by the company and not the actual hospital or facility. While many businesses require a pre-employment drug screen, research related to the utility as a predictive tool to determine present or future potential for substance impairment in the healthcare professional remains undetermined.

Substance abuse in the healthcare setting. Healthcare organizations provide for the process of the diagnosis, treatment, and prevention of physical or mental impairment (AHA, 2013). Practitioners in allied health, medicine, nursing and other areas such as dentistry deliver healthcare. Healthcare refers to the provision of primary care services inclusive of the administration of pain controlling medication (Mar & Tingle, 2012; Kinkle, 2015).

Impaired nurses and physicians may begin by taking a patient's medicine and substituting the medication meant for the patient. Substance-impaired nurses or physicians may replace saline for injectable drugs such as Demerol or morphine sulfate resulting in inadequate pain control for their patients (Goggans et al., 2013). Theft of narcotics intended as pain relief for patients by surreptitious replacement of drug with other fluids, while depriving patients of optimal care, further predisposes the patient to blood-borne pathogens such as HIV or HCV if the healthcare worker is infected (Birnbaum, 2014). The act of substance abuse and the impaired employee can be devastating to a health organization (Collins, 2012).

An incident involving an anesthesiologist resulted in the first case of its type regarding a hospitals duty to protect patients related to the credentialing of a physician (Sanford, 2009). The evidence found at Lakeview Regional Medical Center, Dr. Berry's previous employer, terminated the physician for putting patients at significant risk. The report described Dr. Berry as reporting to work in an impaired physical, mental, and emotional state rendering him incapable of providing care. The former hospital failed to

disclose the physician's known Demerol drug abuse habit and as a result, the new employer, Kadlec Medical Center, unknowingly hired the physician and allowed him to operate on patients. Ms. Jones, a healthy thirty-one-year-old mother of three, suffered massive, irreversible, incapacitating brain damage while undergoing a short, uncomplicated surgery at Kadlec with Dr. Berry as her anesthesiologist. Two days after the event, the pharmacy director analyzed the computer software program used to track narcotic practice in the operating room and found several discrepancies related to Dr. Berry. Upon being confronted the physician admitted he had withdrawn and used a significant amount of Demerol from the medication dispensing cabinet. He admitted to substance-impaired during Ms. Jones' surgery. The patient's family undertook high-level lawsuits against both hospitals and the physician for failure to adequately protect Ms. Jones (Sanford, 2009).

Financial damages and lawsuits for healthcare organizations increased because of the actions of impaired healthcare professionals in the work environment (Anderson, 2018; Martanegara & Kleiner, 2003). A 176-page public health vulnerabilities report revealed severe defects in hospital practices and licensing board processes which allowed a few determined healthcare workers to evade detection of impairment (Maryland Department of Health and Mental Hygiene, 2013). The report addressed the legal case of a David Kwiatkowski; an HCV infected healthcare worker, who stole and used syringes containing fentanyl intended for patients. Kwiatkowski, who is serving 39 years in prison, injected himself with the fentanyl and refilled the same needles with saline. The

used syringes which contained particles of his infected blood, as well as a substitute solution, subsequently used in patient care procedures. The single act of this addicted healthcare pre-disposed 7,000 patients in eight states to hepatitis (Maryland Department of Health and Mental Hygiene, 2013). To date 46 patients developed HCV, two died, and one suffered severe liver damage.

The patients potentially exposed to HCV were contacted, tested and will be monitored for years to come (Maryland Department of Health and Mental Hygiene, 2013). The report states employees reported to administrative leaders their suspicion of Kwiatkowski's substance abuse and his impaired behavior; concerns included the presence of slurred speech, profuse sweating, bloodshot eyes, and disheveled appearance, foaming at the mouth, and erratic behavior. Unfortunately, the investigative action did not occur (Maryland Department of Health and Mental Hygiene, 2013). The public health vulnerabilities report further cites additional outbreaks of HCV traced to narcotic theft and tampering by other healthcare workers throughout the state. Exeter Medical Center, a facility which employed Kwiatkowski, has multiple class action lawsuits filed against the organization many of which are still in progress (New, 2013).

In healthcare settings, the act of drug diversion and substance impairment present significant concerns. Healthcare settings require rapid and efficient surveillance and detection programs to prevent adverse events (Poklis, Mohs, Wolf, & Poklis, 2016). Preventable adverse events (PAEs) are the third leading cause of patient death in healthcare (James, 2013). Hospitals have a special duty of care toward patients (AHA,

2013). Patients because of their illness or condition are vulnerable to violence, abuse, theft, and other acts, hospital leadership is encouraged to execute due diligence in their hiring process (Anderson, 2018; Markey & Tingle, 2012). Substance abusing employees effect hospitals when negative publicity related to the pain and suffering caused to victims and their families occurs. The AHA speaks to the delivery of safe and effective care and how the provision of the right care at the right time in the correct setting is the core mission of hospitals across the country. Leaders within the hospital setting are responsible for the quality of care routinely provided every day (AHA, 2013). Healthcare in the United States can be challenging at the individual provider level, the system level and the national level (James, 2013). Factors such as increased production demands in cost-driven institutions, the shortage of physicians and nurses, the lack of organizational transparency, and the failure to report medical errors increase the risk of PAE's by substance-impaired providers (Anderson 2018; James, 2013). The propensity for patient harm related to substance abusing providers curtails when hospitals efficiently ensure the mission of their business (James, 2013).

Hospitals rely on the ethics of physician and their sworn oath to provide competent medical care (Meffert, 2009; Parry, Brooks &Early, 2018). The American Medical Association (AMA) used to reprint a translation of the Hippocratic Oath. Many physicians entering the medical profession still adhere to the oath (Meffert, 2009). The pledge, embedded in the AMA Code of Medical Ethics, is used as an expressed warranty of the medical profession to "first not harm" (American Medical Association, 2013). The

AMA Code of Medical Ethics articulates the enduring values of medicine as a profession. The Code links theory and practice, ethical principles and real-world dilemmas in the care of patients (American Medical Association, 2013). Alcohol and drugs impair performance and, directly or indirectly, increase risks for error (Pham & Pronovost, 2014). Removing the impaired physicians from the work setting reduces the possibility of harming patients (Pham et al., 2013).

Despite efforts to improve patient safety medical injuries such as infections still occur (Anderson, 2018; James, 2013; Pronovost & Wachter, 2013). Hospital leaders and boards often monitor error reporting data over time, assuming the trends reflect changes in safety and reporting trends. Patients' safety measures should help to address risks or events at single points in time and help identify rare events or harm such as medication errors or infections which may be related to drug diversion. To be valid rate-type measures must define and identify at-risk populations within hospital settings in real time (Pronovost & Wachter, 2013).

The records at the Centers for Disease Control and Prevention related to outbreaks of infections from drug diversion by healthcare personnel in U.S. healthcare settings were reviewed to describe protocols and public health actions of prevention (Schaefer & Perez, 2014). Information compiled included types of infections, healthcare settings, and specialty of the implicated professional, kind of medications, mechanism of diversion, number of infected patients, and the number of patients with potential exposure to bloodborne infections, and the resolution of the investigation. Six outbreaks occurred

over a ten-year period from 2004 to 2013. In each of the outbreaks, the healthcare worker was infected with HCV exposing nearly 30,000 potential patients to bloodborne infections. Each patient required notification and initial and subsequent testing. Implicated healthcare professionals included three technicians, three nurses and one nurse anesthetist. Tampering with injectable controlled substances was the common mechanism of diversion. Four outbreaks involved tampering with syringes or vials containing narcotics. The outbreaks revealed gaps in prevention, detection, and response to drug diversion and chemically impaired healthcare workers. Recommended actions included assessment of harm to patients, consultation with public health officials when tampering with injectable medications was suspected, and prompt reporting to enforcement agencies (Schaefer & Perez, 2014).

Many hospitals have policies for processing-controlled substances in place. Some hospitals decreased problematic substance abuse by employing special programs and hiring individuals well versed in substance abuse detection. Some program controls such as video surveillance flag and reveals issues on which to focus. Medication accounting systems can run selective reports detailing provider usage when doing an investigation. Organizations utilize these reports to develop internal practice and compliance with external regulatory board and reporting requirements (New, 2013). Useful systematic improvements in pharmacy handling and distribution of controlled substances add costs to organizations such as additional labor expenses, cost of camera surveillance, testing of wasted narcotics. The result is inconsistency in robust surveillance systems (Berge &

Lanier, 2014). Since these systems passively decrease access to drugs, leadership should continue to monitor additional surveillance processes including the use of unique RN sign-on username and passwords when accessing medication dispensing cabinets. Another RN witnesses single bin entry by one RN, and two users should witness, and waste medications not administered to patients as ordered (New, 2013). Ultimately, no single method or system prevents drug diversion. Substance-impaired nurses or physicians continually devise ways to circumvent systems and obtain and abuse drugs in the healthcare setting (Berge & Lanier, 2014). Best practices recommend hospital leaders implement diversion response teams to investigate missing narcotics and to work closely with a pharmacist to review diversion concerns (New, 2013). Other best practice measures include implementing surveillance technology which can help flag and reveal issues to focus on and the development of a diversion committee to evaluate the effectiveness of a hospital's medication management system (Howison, Ewa, McLennan, Ferreira da Silva, & Herbsleb, 2015; New, 2013).

Impaired nurses can become dysfunctional in their ability to provide safe, appropriate patient care (KBN, 2014). The ANA issued a position statement describing substance abuse as fraudulent activity and as a blatant misuse of prescribed drugs intended for patient care. The position statement further recognized the presence of dysfunction related to alcohol and other substance use or psychological problems interferes with judgment and the delivery of safe care (ANA, 2014). Nurses have easier access to medication than many other professionals as an inherent nature of their job

functions (Kinkle, 2015). Nurses may be predisposed to substance. Addiction is a disease, but the addicted nurse must be accountable for their actions when working (Miller, Kanai, Kebritchi, Grendell, & Howard, 2015). The substance-impaired healthcare professional should seek help for their addiction and be removed from the patient care setting until completing a diversion treatment program (Miller et al., 2015). Some reasons were given as to why nurses continue to work while substance-impaired include the enabling behavior of their peers. Staff members often make excuses to rationalize their colleague's behavior; they desire to protect him or her and are hesitant to be the whistleblower (Kinkle, 2015). Nurses may experience a sense of professional betrayal, frustration or powerlessness when they become aware a colleague may be impaired (McCulloh, Nemeth, Sommers, & Newman, 2015; Starr, 2015). Many substance-impaired nurses are unidentified, unreported, and untreated and continue to practice impairment including signs and symptoms (Kinkle, 2015). Nurses should be aware they have an ethical and legal responsibility to report a nurse co-worker suspected of substance abuse to management (Bettinardi-Angres & Garcia, 2015). Managers and leaders have the responsibility to protect patients, support staff and maintain high standards of care throughout the organization (Berge et al., 2014; Georgiou, 2013).

For nurses to recognize and treat addiction nurses need to know the signs and symptoms of substance impairment. Awareness of the signs and symptoms of substance impairment is the initial step for identification and treatment. Early recognition and

intervention in the workplace protect patients and results in better outcomes for the impaired nurse or physician (Kinkle, 2015).

Many impaired nurses and physicians encountered in the workplace abuse everyday medications as well as street drugs (Fusion, 2014). The American Nurses Association Code of Ethics for Nurses states registered nurses are the premier advocates for the delivery of safety and quality patient care. The Code of Ethics describes how nurses must uphold standards of professional practice and safeguard public welfare. An impaired nurse is unable to provide the minimum standards required for safe practice. Nurses impaired by drugs or alcohol may neglect patient care, commit costly medication errors and place their organization at risk (ANA, 2014; O'Neil & Cadiz, 2014).

State boards are the most important regulatory agency for handling diversion sanctions although specific sanctions may vary among individual states (ANA, 2013). For instance, the California Medical Association disbanded their Peer-Review program for impaired physicians even though nurses and physicians are encouraged to self-report their illegal use of drugs and their substance impairment to their respective regulatory body (KBN, 2014; Pham & Pronovost, 2014). Self-reporting viewed as an ethical and moral duty, temporarily removes the impaired individual from the patient care environment thus protecting patients, colleagues, the nursing and medical profession and the community from unsafe practice (KBN, 2014). If self- reporting does not occur, the organization's leadership may report the substance-impaired healthcare professional to

the appropriate regulatory agency and remove the substance-impaired individual from direct patient care contact (O'Neil & Cadiz, 2014).

A cross-sectional study on the prevalence of alcohol abuse and dependence among practicing surgeons found 28.78 % of those surveyed had a score on the Alcohol Use Disorders Identification Test Version C (AUDIT-C) consistent with abuse. The validated tool included questions about practice characteristics, demographic information, burnout, depression, career satisfaction, substance use, malpractice suits, and medical errors. Approximately 15.4% of the 7197 respondents had an AUDIT-C score consistent with alcohol abuse or dependence with an even higher score for female surgeons (Oreskovich et al., 2012). Surgeons reporting a medical error in the last three months were more likely to have abuse or dependence (odds ratio 1.45, $p<.001$). The rate of alcoholism among practicing physicians mirrors the population of 10%-15% although the exact prevalence among physicians is unknown (Fusion, 2014; Oreskovich et al., 2012). Available data comes from licensing boards, mortality studies, hospital statistics, treatment programs and training programs (Oreskovich et al., 2015). Data about substance abuse among physicians-in-training in medical residency programs are limited but suggest the use of benzodiazepines, such as valium, is prevalent among age-matched peers, whereas the use of alcohol is similar between the two groups (Fusion, 2014; Cottler et al., 2013). I could not find any reasons to provide insight into why physicians-in-training were more likely to use the drug benzodiazepine instead of other narcotic substances.

A national study regarding physician burnout in the United States compared physicians with workers in other fields (Shanafelt et al., 2012). The physician specialty explored disciplines differences by using the American Physician Masterfile and surveyed a probability-based sample of the United States population for comparison. Burnout using validated instruments examined work-life balance satisfaction. Of 27,276 physicians who received an invitation to participate, 7288 (26.7%) completed a questionnaire using the Maslach Burnout Inventory (MBI). This tool assesses the frequency and intensity of perceived burnout among persons in the helping professions.

Results of the MBI revealed 45.8% of physicians reported at least one symptom of burnout. Burnout by specialty demonstrated a substantial difference between specialties with the highest rates among physicians at the front line of care including family medicine, internal medicine, and emergency medicine. When compared with the probability-based sample of 3,442 working adults, physicians were more likely to have symptoms of burnout (37.9% versus. 27.8%) and to be dissatisfied with work-life balance (42.2% versus. 23.2%) ($P< .001$ for both) (Shanafelt et al., 2012). The study found burnout is more common among physicians than among other workers. The results further concluded burnout might erode professionalism, influence quality of care, increase the risk of medical errors, and increase problematic chemical abuse. The research presents important implications for hospital leadership regarding physician burnout and work-life balance (Shanafelt & Noseworthy, 2017; Oreskovich et al., 2015; Shanafelt et al., 2012).

Physicians in the United States were surveyed again in 2014 to assess their level of burnout and work-life satisfaction using The Burnout Inventory tool (Shanafelt et al., 2015). Of the 35, 922 physicians who received the survey 6880 (19.3%) completed it. The results of this showed 3,680 (54.4%) physicians reported at least one symptom of burnout in 2014 compared with 3310 (45.8%) in 2011. Satisfaction with work-life balance also declined in physicians for the same time periods. A pooled multivariate analysis adjusted for age, sex, relationship status, and hours worked in a week. The study revealed physicians remain at an increased risk for burnout and more than half of the physician's experience were less likely to be satisfied with work-life balance (odds ratio, 0.68; 95% CI, 0.62-0.75; $p<.001$) (Shanafelt et al., 2015). Leaders and managers should be aware of burnout as an at-risk factor when designing drug-free workplace programs and policies to address chemical impairment in the workforce.

Occupational Safety Hazards Association (OSHA) works closely with the U.S. Department of Labor's Substance Abuse and Mental Health Services (U.S. Department of Health and Human Services, 2016). OSHA governs how employers ensure their health and safety plans and enhance workplace drug prevention. OSHA recommends organizations establish drug-free workplace Programs and policies which allow leaders to be consistent in managing employees suspected of or confirmed to be abusing substances. OSHA urges employers and employees to collaborate on the program's design including implementation of standards and acceptable codes of behavior. Drug-free Workplace Programs and policies include a statement of purpose and program objectives. The

program explains illegal substances, possession, and use, indications for random or event-based drug testing, how impaired employees are managed, how discipline occurs. Leaders use drug-free workplace programs and policies to address concerns including the conditions of continued employment, the seriousness of the violation inclusive of any past infractions. The program should include the employees 'rights and confidentiality aspects of the investigation. OSHA further recommends employers routinely train employees, managers, and supervisors to identify impaired behavior, substance abuse, and appropriate intervention. OSHA estimated costs of business-related employee substance abuse to diminish more than $100 billion from American companies yearly. OSHA estimated 38 to 50 % of workers' compensation claims were related to substance abuse in the workplace with substance abusers filing three to five times as many workers' compensation claims. Medical costs for substance abusers are 300 % higher than non-abuser medical expenses. Absenteeism rates are higher for those who abuse substances with a projection of eight days or more a year (OSHA, 2016). These statistics hold significant financial and productivity implications for any business including hospital leaders who must ensure uninterrupted operations essential for patient care.

Signs and symptoms of substance impairment. Impaired nurses or physicians are not always readily recognized (Miller et al., 2015). Leaders may not recognize specific signs and symptoms exhibited by nurses or physicians who take extra precautions to avoid detection. In a Baylor Healthcare System case, found several patients harmed because of an impaired cocaine-using surgeon (Fusion, 2014). Thomas

and Siela (2011) described common behaviors exhibited by the impaired nurse or physician. Behaviors included withdrawing from peers, taking frequent bathroom breaks, frequently disappearing while on duty, exhibiting a gradual decline in work performance, consistently signing out more narcotics than peers and increasingly labile moodiness with frequent, unexplained anger and overreaction to criticism. A document published by The National Council of State Boards of Nursing (2013) on substance use disorders portray symptoms of substance impairment as challenging to differentiate from stress-related behaviors but describe changes in behavior, physical appearance and drug diversion as possible cues (Burton, 2014; New, 2013). Signs indicative of substance impairment vary and may or may not be easily recognized (see Figure 2).

AANA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Signs & Behaviors: If You See Something, Do Something

Early identification of the **signs and behaviors** associated with substance use disorder and drug diversion reduces the risk of harm to patients and providers

Impairment	Drug Diversion
Behaviors • Severe mood swings, personality change • Elaborate excuses • Frequent or unexplained tardiness, work absences, illness or physical complaints • Underperformance or inconsistent work performance • Difficulty with authority • Poorly explained errors, accidents or injuries • Wearing long sleeves when inappropriate • Confusion memory loss, and difficulty concentrating or recalling details and instructions • Visibly intoxicated • Refuses drug testing • Ordinary tasks require greater effort and consume more time • Unreliability in keeping appointments and meeting deadlines • Relationship discord (e.g., professional, familial, marital, platonic) **Signs** • Physical indications (e.g., track marks, bloodshot eyes) • Deterioration in personal appearance • Significant weight loss or gain • Blaming others for own problems and shortcomings • Discovered comatose or dead	**Behaviors** • Consistently uses more drugs for cases than colleagues • Frequent volunteering to administer narcotics, relieve colleagues of casework, especially in cases where opioids are administered • Consistently arrives early, stays late or frequently volunteers for overtime • Frequent breaks or trips to the bathroom • Heavy wastage of drugs • Drugs and syringes in pockets **Signs** • Patient has unusually significant or uncontrolled pain after anesthesia • Higher pain score as compared to other providers • Inappropriate drug choices and doses for patients • Missing medication and prescription pads • Drugs, syringes, needles improperly stored • Signs of medication tampering, including broken vials, returned to the pharmacy • Carelessness, mistakes or errors in judgment • Frequent financial problems • Multiple or erratic changes in jobs or positions

Figure 2. These signs and behaviors may be indicative of possible workplace drug problems. *Addressing Substance Use Disorder for Anesthesia Professionals* position statement and policy consideration, July 2016, p.16. Retrieved from www.AANA.com/Addressing SUD. Reprinted with permission.

The list elicits the potential behavioral signs and symptoms which may vary by situation and by the impaired individual. Leaders should scrutinize behavior changes such as making an excessive number of mistakes, including medication errors; and physical signs such as diminished alertness, confusion or increasing isolation from a colleague (Fusion, 2014; Starr, 2015). Healthcare leaders should investigate when patients complain of ineffective pain relief after receiving a narcotic. The impaired provider may substitute medication and divert a patient's pain medication to themselves (Kinkle, 2015). Cares, Pace, Denious, and Crane (2015) examined the context and perceived consequences of substance abuse among nurses. A secondary goal examined the barriers and opportunities for earlier identification and treatment of these issues among nurses, their colleagues, and employers. Active participants in a peer health assistance program received anonymously mailed surveys questionnaires. The survey questionnaires asked about drug-related behaviors in the workplace; behavioral cues regarding early identification of substance use and mental illness; perceptions of barriers to seeking assistance; and strategies for preventing substance abuse problems. Almost 302 nurses (60%) responded to the survey questionnaire. Nearly half (48%) reported drug or alcohol use at work, and two-fifths (40%) said their competency level was affected by their substance impairment. Barriers to seeking treatment for substance abuse and mental illness included fear, embarrassment, and concerns about losing their nursing license. More than two- thirds of the respondents thought their problem could be recognized earlier. Involved nurses recommended leaders and nurses' in professional training receive

education on signs of impairment as a prevention strategy and to earlier identification of risk factors (Cares et al., 2015). Symptoms can only be experienced by the impaired individual, whereas signs are observed by other people (Cares et al., 2015).

Substance abuse among nurses has been recognized and researched by nurse leaders as a threat to patient safety, but little research has focused on student nurses' perceptions of impaired nurses. Boulton and Nosek (2014) conducted a quasi-experimental study to explore the perceptions of 79 student nurses' attitudes toward substance-impaired nurses using a two-group, pretest-posttest design. The student nurses completed The Perception of Nurse Impairment Inventory (PNII) at the beginning of their junior year of nursing school before receiving formal education about substance impairment. The researchers who conducted this study repeated the PNII before, and after participants received training. A control group of sophomore students who did not receive chemical impairment education completed the PNII. A repeated measures analysis of variance was used to measure the differences between the two groups of students. Students who received the training chose more compassionate responses on the PNII and were more likely to report a nurse's or manager and supervisor is responsible addressing, investigating, supporting and guiding the impaired nurse to access professional care (Boulton & Nosek, 2014). The researchers of who performed that study found even after exposure to education, participants in both groups perceived themselves to be unable to recognize and support an impaired nurse. The ability to acknowledge contributing factors to impairment was not significant. Results of the study found

students held mistrust of administrators' ability to be helpful regarding the impaired nurse. Findings from this study are useful for schools of nursing, hospitals and healthcare employers to improve training in the early identification of substance-impaired nurses. These data support the need for further research regarding prevention and early identification of co-existing disorders in nurses in the healthcare setting (Cares et al., 2015).

Research regarding anesthesia providers and the risk of abuse of controlled substances is well documented (Bettinardi-Angres & Garcia, 2015; Rose, Campbell & Skipper, 2013; Sanford, 2009). Factors examined over a five-year period included participant demographic factors, outcomes, and preventative measures for substance abuse among nurse anesthesia students. An electronic survey sent to 111 program directors of accredited nurse anesthesia programs in the United States, provided insight into nursing students. Twenty-three programs (response rate=21.7%) reported data related to 2,439 students. Sixteen incidents of substance impairment reported a five-year prevalence of 0.65%. Opioids were the most reported drug of choice (n=9). Approximately half of the incidents revealed no predisposing factors. Students reported voluntary entry into treatment (n=10), dismissal from the program (n=7), loss of nursing license (n=2), and one death. The schools performed pre-employment background checks, and drug testing for cause were the most commonly reported screening practices while wellness promotion programs and education regarding substance impairment were the common prevention strategies. The prevalence of substance impairment was lower

among student registered nurse anesthetists as compared with certified registered nurse anesthetists. A significant association noted a lack of dispensing control and the prevalence of propofol or opioid abuse, suggesting dispensing systems may pose as means to prevent or deter substance abuse (Bozimowski, Groh, Rouen, & Dosch, 2014).

Ethical and Moral Implications

Ethics and morals used interchangeably. Ethics refers to the standards provided by an external source such as codes of conduct in the workplaces while morals refer more to an individual's choices and principles (Flite & Harman, 2013). A code of ethics frequently incorporates values and professional standards. Professional values form the basis for ethical practice (Flite & Harman, 2013). The impaired healthcare professional may violate core moral principles of beneficence (do good) when they practice while substance-impaired (Starr, 2015). The substance-abusing nurse or physician often realizes the increased risk for patient harm but may resist entering a treatment program until mandated by court order or as a requirement by management for continued employment (Fusion, 2014; Starr, 2015). Impaired nurses or physicians are more likely to steal from employers and are also more likely to have workplace accidents and higher absenteeism rates (Starr, 2015).

Drug-free workplace programs and policies. Many states provide reduced Worker's Compensation insurance rates for businesses who provide comprehensive drug-

free workplace programs and policies (Elmer, 2012). Many healthcare leaders establish and maintain

drug-free work workplace related to the nature of the business (Markey & Tingle, 2012). Leaders use the Drug- Free Workplace programs and policies to direct organizational standards regarding the unlawful manufacture, distribution, dispersion, possession, or use of a controlled substance in the workplace (Drug- Free Workplace Advisor, 2014). Employees who under a prescribed controlled substance may be allowed to work if the prescribing medical provider indicates they can work and if they are exhibiting no unusual symptoms of behavior (Drug-Free Workplace Advisor, 2014). Drug-free work environments provide education to employees Regarding the serious harm that can result from substance impairment in the workplace. Drug-free workplace processes rarely mandate drug testing rather they highly suggest drug testing for cause such as suspicious behavior or workplace incidents occur. Organizations who choose to perform drug testing must have policies in place which describe how, when and where drug testing will occur (Drug-Free Workplace Advisor, 2014).

The Controlled Substance Schedules describes a chemical or drug as illicitly used drugs or prescription medications regulated by a government and designated as a controlled drug in the United States (Controlled Substance Schedules, 2014). Substance classification depends on whether the controlled substance has accepted medical use in treatment in the United States, the relative abuse potential, and the likelihood of causing dependence when abused. Title 21 Code of Federal Regulations (Controlled Substance Act, 2014) publishes

an updated list of scheduled drugs annually. The control of drugs through law exists to protect people from the possible addictive and impairing nature of these drugs and the potential harmfulness of these drugs to individuals and society (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013). Healthcare facilities should have systems to comply with drug laws, deter controlled substance abuse and promptly identify and address its occurrence (Monroe et al., 2013). Such systems are multifaceted and require close cooperation among multiple stakeholders including risk and safety programs, human resources and hospital leadership (Maryland Department of Health and Mental Hygiene, 2013). Hospitals leaders should have a broad-based appreciation of the dangers impaired healthcare professionals create for patients, employees of healthcare facilities, and employers (Monroe et al., 2013). Many substances impaired healthcare professionals may also use over-the-counter medications every day in the work-place (Monroe et al., 2013). Over-the-counter drugs do not require a prescription nor are they classified as controlled substances. An exception would be U.S. state laws governing the dispensing of over-the-counter medicines such as pseudoephedrine-based products used to illegally manufacture the stimulant methamphetamine (Controlled Substance Schedule, 2014). This study excludes the implications of over-the-counter medications.

The substance-impaired healthcare professional. Healthcare professionals who have untreated addictions may compromise patient safety and endanger the welfare of the healthcare professional (Kunyk, 2015). Early detection of the substance-impaired healthcare professional is encouraged to protect public safety, increase treatment for

substance addiction, provide early intervention for the impaired individual and support a safe return to practice (Georgiou 2013; Smith, 2013). Responses should be supportive, non-punitive, and provide treatment options which allow a return to the work setting (Kunyk, 2015).

Eighty-two percent of nurses have not notified their employers that they have a substantial impairment because of shame or embarrassment, 53% had concerns about to the effectiveness of intervention programs and the ability to return safely to the work environment (Kunyk, 2015). Organizational leaders must shape the values of the organization and acknowledge contributing factors which may potentiate substance impairment including emotional or psychiatric elements (Kunyk, 2015).

Substance impairment may exist simultaneously or independently of another medical diagnosis. The prevalence of co-morbidity examined in a study of impaired nurses. Results revealed 60% of the nurses demonstrated a comorbid psychiatric illness which is significantly higher than in the population (Rojas, Jeon-Slaughter, Brand, & Koos, 2013). The healthcare provider groups found substance-impaired healthcare professionals who had a psychiatric component experienced higher relapse rates and necessitated a more complicated course of treatment (Rojas et al., 2013). Further research is needed to understand the effect of substance impairment, comorbidity issues, relapse, and intervention and treatment programs (Rojas et al., 2013).

Substance-impaired physicians pose significant consequences for patient safety and public health (Merlo, Singhhakant, Cummings, & Cottler, 2013). To understand

reasons why physicians abuse prescription medications or alcohol Merlo et al., (2013) interviewed 55 physicians (94.5% male) monitored by their state physician health programs for problems relating to alcohol and drug abuse. Participation was anonymous and consisted of discussions transcribed from nine separate focus groups lasting 60-90 minutes each. Qualitative analyses were conducted to examine themes. Participants described several reasons for substance impairment. Issues identified included managing stressful situations, reducing physical pain, controlling emotional or psychological distress, avoiding withdrawal symptoms and recreational purposes. Some physicians (69%) reported lifetime misuse of prescription medications and others (84.2%) said lifetime abuse of alcohol. The study recognized the small population as a limitation. The study did not examine the effect of the substance-impaired physician, and patient care. Further research is recommended to understand the reasons why physicians self-medicate, the implications of career-related stress and the need for knowledge of physician impairment by other physicians.

Medical specialties of anesthesiology, emergency physicians, and psychiatry appear to have a higher than expected substance use than their peers (Bozimowski et al., 2014; Rose et al., 2013). A study by Rose et al., (2013), compared Emergency Physicians (EPs) to other physicians in treatment for substance abuse or impairment. The study used the dataset from a 5-year, longitudinal, cohort study involving 904 physicians with a history of substance-related impairment. The study compared fifty-six emergency physicians to 724 other physicians. Outcomes variables included rates of relapse,

successful completion of monitoring, and return to clinical practice. EPs had a higher than expected rate of substance impairment with an odds ratio of 2.7 confidence interval: 2.1-3.5, $p<0.001$. The study required random drug testing of physicians throughout the 48 months of the physician health program participation (PHP). While monitored by the PHP 13% of the EPs had at least one positive drug test compared to 22% of the other physicians, the difference was not significant (p=0.13). Of the three outcome variables measured EP's had similar rates of success on variables compared to the other physician cohort although not statistically better. The higher rate of substance impairment for EP's found in this study is essential given the significant patient care implications and the potential adverse physical, psychological and legal consequences of impaired EPs (Rose et al., 2013; Cottler et al., 2013).

Approximately 8-15% of healthcare professionals misuse alcohol or drug substances at some point in their lifetime which statistically mirrors the public statistics (Goggans et al., 2013; Baldisseri, 2009). Few studies have examined the risk factors associated with initiation of substance abuse and the development of substance impairment among healthcare professionals (Merlo, Lopez, & Conwell, 2013). An exploratory study recruited healthcare professional attendees at a conference for healthcare professionals in recovery (Merlo et al., 2013). In this study, 105 healthcare professionals (80% male) ranging in 24-68 (M= 47.1 years, SD=10.2) completed a self-report questionnaire. The questionnaire assessed age at first use, education level at first use, means of access to substances upon first use, the order of substance use initiation,

and reasons for early and continued substance use. The respondents consisted of physicians (51%), pharmacists (19.2%), dentists (11.5%), physician assistants (5.8%), and various other allied health professionals (12.7%). Results demonstrated 73.2% of the professional's used tobacco, 90.4% used alcohol, and 64.4% used other drugs before beginning professional school. Reasons for substance initiation included curiosity, peer influence, and availability. Reasons for continued substance abuse were found to be addiction and stress management. A limitation of the study was the relatively small participant population and the confinement of the study to one state. Female healthcare professionals were underrepresented.

Despite the flaws, the investigation is still useful regarding addiction among healthcare professionals. The results explored the onset of substance use among health professionals who proceeded to develop a substance impaired practice. Additionally, the authors sought to understand why healthcare professionals have higher success rates with addiction treatment programs when compared with the public. Merlo (2013) recommended further research to identify and provide intervention regarding high-stress situations.

Intervention and treatment programs. Healthcare professionals with identified substance-impaired issues may sign a contract with a PHP voluntarily to avoid sanctions such as job loss, licensure revocation and other legal matters (Rose et al., 2013). Some treatment programs use as an alternative to discipline (ATD) (Smith, 2013). The goal of a PHP or ATD program is to protect patients and to safely return the healthcare

professional to the workforce (Kinkle, 2015; Yellowlees et al., 2014). The length of time in a treatment program for professionals varies from 6 to 12 weeks depending on the requirements of the program (Bettinardi-Angres & Garcia, 2015). In 2009 approximately 12,060 employed nurses were newly enrolled in some form of disciplinary or ATD monitoring programs across the United States (Monroe et al., 2013). Data indicate the likelihood of successful treatment outcomes is higher with early implementation of treatment (New, 2013). The National Council of State Boards Nursing (NCSBN) estimate approximately 70% of nurses who seek treatment successfully return to practice (NCSBN, 2011). Nurse ATD programs aim to protect the public from the harm of impaired practice; nurses also receive support while in early recovery from substance abuse as they re-enter the practice setting (O'Neil & Cadiz, 2014). An ATD approach mandates "a contract, expectation to complete appropriate treatment, participation in a support group, random drug screenings, workplace monitoring, and abstinence from controlled substances" (Smith, 2013, p.466). An alternative to entry into an ATD is entering a Peer Assistance Program (PAP). A PAP program has the same goal as an ATD. A PAP assists the substance-impaired healthcare worker through recovery and supports their return to the healthcare environment (Smith, 2013). Hospitals often have ATD, or PAP programs help in the recovery process (Monroe et al., 2013). Strict adherence to the program is required to ensure an individual's professional license is not revoked (Rundio, 2013).

The Federation of State Physician Health Programs consists of 42 states. The states monitor abstinence, relapse, and compliance of employed physicians who reported substance-impaired issues. ATD allow nurses in treatment to continue working while observed for safe practice (Cadiz, O'Neil, Schroeder, & Gelatt, 2015). Most PHP's involve continuous monitoring for five years (Yellowlees et al., 2014; Cottler et al., 2013).

A limited epidemiological research study of lifetime substance abuse and dependency compared physicians enrolled in a PHP with those in a population seeking treatment for substance impairment (Cottler et al., 2013). Participants included 99 physicians referred to the PHP because of suspected impairment. Referred physicians age, gender, and education status-matched comparison group from the National Epidemiologic Survey Alcohol and Related Conditions (NESARC) Wave 1 in a 1:1 ratio. Physicians undergoing monitoring in the PHP were more likely than the matched population to meet criteria for alcohol, opiate, and sedative abuse. Physicians were less likely to report the use of those substances than the population. Implications of this study enforce leadership's role in management strategies which identify and address the substance-impaired nurse or physician in the healthcare setting.

Among physicians, anesthesiologists have a higher incidence of substance impairment and risk relapse upon return to the practice setting as compared to an anesthesiologist who left the specialty (Bozimowski et al., 2014). Similarly, certified registered nurse anesthetists (CRNAs) also have a substantial risk for substance

impairment because of their direct access to potent drugs and their expert knowledge of pharmacology (Bettinardi-Angres & Garcia, 2015). A study of recovering CRNAs identified how their challenges were uniquely different than the standard registered nurse population. CRNAs may require a more detailed approach for treatment and reentry to practice. This research recognized the importance of established guidelines and recommendations for a consistent approach to treatment and practice reentry for CRNAs. Promoting a culture of patient safety is the goal when addressing the substance-impaired CRNA.

The authors offered numerous recommendations for employers in developing a successful return for the recovering CRNA. One suggestion for employers included determining a mandatory time away from the practice of anesthesia noting 98% of relapses occur within the first two years of recovery with the first two months proving the most critical. Results of this study included insight into how leaders and managers could increase the likelihood of successful treatment and return to practice for recovering CRNAs (Bettinardi-Angres & Garcia, 2015). Results from this study were consistent with a qualitative inquiry by Wright, McGuinness, Schumacher, Zwerling, and Moneyham (2014) which explored protective factors against relapse for practicing nurse anesthetists in recovery from opiate substance impairment. An open-ended question format was used to allow participants to describe individual experience factors. The protective factors were found to be external and personal to the recovery process. The study examined individual elements such as time away from practice and organizational leadership

involvement in the situation. Personal factors included removing the obsession to use, maintaining inner strength and envisioning the ability to work again safely (Wright et al., 2014).

Worksite monitoring of nurses in early recovery from substance abuse presents a challenge to the employer but is necessary for public protection from unsafe nursing practice (O'Neill & Cadiz, 2014). Worksite monitoring should be conducted by those who are competent to assess the performance of the returning nurse (O'Neill & Cadiz, 2014). Specialized education of managers and supervisors and who monitor nurses in disciplinary or ATD programs is a necessary component of public protection (O'Neill & Cadiz, 2014). Specialized training related to monitoring programs is value-adding to administrators because it improves managers and supervisor's knowledge and skills and identifies practical and empirical processes can increase worksite monitor program effectiveness (Kunyk, 2015; O'Neill & Cadiz, 2014). Managers and supervisors and who received training demonstrated a mean change in knowledge, training utility, self-efficacy, and confidence to supervise nurses enrolled in an ATD program (Cadiz et al., 2015). Worksite monitoring should be conducted by a nurse who is competent to assess the general performance of the nurse returning to work. The returning nurse must meet the standards of care set forth by the NCSBN (2011). According to the NCSBN, any nurse with any level of manager and supervisory authority such as a nurse manager, the charge nurse, or the nurse administrator can accept responsibility for monitoring the returning nurse.

Cadiz et al. (2015) stress the need for educating leaders as worksite monitors of nurses in ATDs as an essential public safety measure. Without specialized education managers and supervisors may lack the awareness to recognize the early signs of impairment or know how to intervene when a nurse's performance is unsafe (O'Neill & Cadiz, 2014). The long-term effect of manager and supervisors monitoring has been linked to subordinates' perceptions of manager and supervisor knowledge and their ability to detect substance use and substance impairment (Cadiz et al., 2015).

The issue of re-entry into practice is often the initial concern raised by the impaired nurse or physician when being referred to intervention and treatment program (Srivastava, 2018). Stigma may be associated with the impaired medical professional's return to the healthcare work environment (Cook, 2013). Nurses with substance abuse disorders who perceive a decreased level of organizational support from their employers have a propensity for relapse (Kunyk, 2015).

Leaders play an essential role in the early recognition of the substance-impaired healthcare professional and how after treatment reentry or returning to the organization occurs (O'Neil & Cadiz, 2014). To achieve the best possible outcomes for involved, managers and leaders must promptly identify potential substance impairment and intervene appropriately (Starr, 2015). Intervention should be implemented by professionals who are trained and experienced in the required techniques as defined by the organizational policies (Kunyk, 2015). Many healthcare professionals demonstrated they could be safely returned to their practice after treatment for substance impairment

(Oreskovich et al., 2015). Supportive work environments begin with leadership knowledge of impairment and recovery and monitoring programs such as ATD or PHP. Responsible leaders develop understanding and transparent cultures which support patient safety (Cook, 2013).

Recovery and re-entry. Full disclosure, support from colleagues, and participation in ATD or PHP are the tenets of successful reentry programs (Valdes, 2014; Yellowlees et al., 2014). Gaps exist in the literature concerning the length of treatment, reentry contracts, workloads, work settings, and the success of individualized treatment methods enforcing the importance of managers and leaders in the governance of the entry process of the recovered substance-impaired healthcare professional. Evaluations of individuals entering ATD or PHP programs demonstrate high engagement with treatment, increasing rates of completion and sustained abstinence years after treatment (Yellowlees et al., 2014).

Re-entry into practice is a difficult and challenging task (Valdes, 2014). Recovering healthcare professionals may have a difficult time gaining employment after disclosing impairment issues even after successful completion of treatment programs (Burton, 2014; Valdes, 2014). Factors of successful re-entry into practice include establishing back-to-work contracts random drug testing, requiring regular attendance at support meetings and restriction from patient care for determined timeframes (Valdes, 2014). Education of healthcare administrators, leaders and staff about the nature and effective treatment of substance impairment and dependency, policies, and programs are

needed to make public a caring and supportive attitude necessary for successful return and reentry outcomes (Valdes, 2014).

Transition

The reader was afforded a discussion about how leaders identify and address the substance-impaired healthcare professional in the workplace in Section 1. I presented the background of the problem, introduced the implications of the impaired healthcare professional, and the propensity of occurrence. Throughout the review of the literature, I presented commonly abused drugs, predisposing factors, the benefit and risk of drug testing, alternative treatment programs and the potential effect on healthcare organizations relating to interruption of daily business operations. Related concepts discussed the increased potential for lawsuits related to patient harm; and the diminished confidence in the eye of the community and customer and the effect on a hospital's competitive edge in the healthcare market. This review depicts for the reader the importance of effective leadership within the organization and the responsibility of preventing detrimental patient care business outcomes. Numerous studies advocate for or against random drug testing as means to enhance employee wellness and patient safety. Another section of the review includes research studies addressing substance-impaired healthcare professionals including nurses, physicians, and pharmacist. Epidemiological research and data on substance impairment among healthcare professionals and the work setting are limited mostly because of a lack of methodological constraints (Cottler et al.,

2013). Studies had limitations and recommended further research with larger samples for broader application. Studies did not inform or were limited regarding best practices for management strategies and decreasing the incidence of the substance-impaired healthcare professional. Throughout the review of literature defined the rationale for the use of qualitative versus quantitative or mixed methods.

Section 2: The Project

Section 2 of this study includes an outline of the scholarly foundation for the research design and method used to answer the research question. The outline includes (a) a restatement of the purpose of this study, (b) a discussion of the researcher's role, (c) a description of participant strategies for conducting the study, (d) additional information on the study population, and (f) a discussion on the project's ethical considerations. This section also includes the process for data collection, describes the data instruments and explains the data collection techniques and data analysis. I conclude Section 2 with information for establishing reliability and validity for this study.

Purpose Statement

The purpose of this multiple qualitative case study was to explore what management strategies were used by some healthcare organizational leaders to address the substance-impaired healthcare professional in the workplace. The selected population included approximately 29 managers and supervisors who supervise healthcare professionals and who work for a healthcare organization in the Commonwealth of Kentucky, United States. Managers and supervisors received questions administered in a survey questionnaire format. Three executive leaders were interviewed using a semi structured interview process designed to elicit their lived-experience for addressing the substance-impaired healthcare professional. The executive leaders did not receive the qualitative survey questionnaire sent to the managers and supervisors. I reviewed organizational documents for relevant information. According to Yin (2018), interview

methods included an observation aspect to enhance the research and a discussion with the interviewed participants. Implications for positive social change included the identification of management strategies to identify and manage the substance-impaired healthcare professionals in hospitals (Kunyk, 2015).

Role of the Researcher

I was the central researcher for this qualitative case study. My responsibilities in this role included the development of the research question, selection of a conceptual framework, selection of the research participants, data collection through fieldwork, data analysis and coding, and the dissemination of the findings (Zhang & Creswell, 2013). My qualitative research employed numerous techniques in my collection of the data (Baden-Savin & Major, 2013; Freeman, Gregen, & Josselson, 2015). My qualitative research took place in a natural and less formal setting as opposed to a laboratory or controlled setting (Anfara & Mertz, 201; Moustakas, 1994).

I initiated data collection upon approval of the Walden Institutional Review Board (IRB). I used email to communicate information related to the study and to invite the targeted population to participate in my research study (see Appendix A). The research community is increasing the use of electronic media to supplement paper-based informed consent processes when conducting research (Earley, 2014). A survey questionnaire and informed consent were administered to the targeted managers and supervisors through SurveyMonkey, an Internet-based program (see Appendix B).

My research further included conducting semi structured interviews with three executive leaders using an interview protocol (see Appendix C). I used the interview protocol as a guide to ask the interview questions and to maintain procedurally consistent technique throughout each interview. Each interview document included a heading consisting of the date, time, place, and interviewee number. The process of interviewing each of the executive leader research participants began with a greeting and a brief preamble of the interview process. After an explanation of the study I explained the informed consent document. Each executive leader signed the form and returned it to me. Each research participant received a signed copy of the informed consent form. I thanked them for their participation and explained how their participation would add to the richness of my study. I described the estimated time involved in conducting the interview, allowed them to see the interview questions, and asked if they had any concerns I could address. The participants were made aware they were under no obligation to participate, no compensation would be provided, and how they could withdraw from the study. I reiterated the potential value of the research study to healthcare leaders. During the discussion, the participant understood he or she could stop participating in the interview at any time. After the interview, if the participant decided not to participate, the informed consent document contained instructions for removing themselves as a participant in the study. I explained to the participant all data collected would be stored for five years in a secure file cabinet in my house and destroyed after 5 years. The informed consent document included the Walden University approval number

(08-11-17-0350406) and Walden University contact information should the participant want to ask about the status of the study. To ensure participants' identities remain confidential, I used an assigned number for each participant's interview form, and no individual or organizational names are used in the study. I am the only person with to access to the signed informed consent document.

I used the interview protocol as a guide for conducting qualitative research throughout the interview process. Asking questions according to the interview protocol helped to mitigate interviewer bias by addressing the central research question. I based my interview protocol on Yin's (2018) five skills for evidence gathering: ask good questions, be a good listener, stay adaptive, have a good understanding of the issues, and avoid biases. I transcribed the interviews verbatim to help mitigate bias in collecting and analyzing data. The interview portion of this research study in conjunction with the survey questionnaire helped to further my understanding of the participants' lived experiences.

Participants

Qualitative research conducted in the field allows direct interaction with the people studied and learned content-specific knowledge regarding a study's central research question (Anfara & Mertz, 2014). My multiple case study design incorporated the subjectivity of the participants' frame of reference and their interpretation and social experiences (Yin, 2018). The participants in this study were healthcare leaders who had hierarchical responsibility for managing healthcare professionals. The healthcare leader is

responsible for managing the care delivered within the hospital. A component of the qualitative research study is the identifying and selecting the most appropriate participants for a study (Yap & Webber, 2015). The participants in this study were healthcare leaders consisting of managers, supervisors, and executive leaders in a specific healthcare facility. The sample was composed only of those involved in the daily supervision of healthcare professionals. Participant criteria were further limited to healthcare leaders with at least 1 year of leadership experience in managing and supervising healthcare professionals.

I have a current professional relationship with an executive leader who served as my community liaison and provided permission for the study to be conducted at their facility. Permission from the executive leader to perform the study was predicated upon obtaining Walden IRB approval. The executive leader appointed a secretary in the HR department to assist me in locating policies, and historical and current documents. The same secretary helped facilitate contact with the managers and supervisors through email. The secretary did not participate in the research. I alone selected the individual participants. The potential research participants received an introductory email in which I introduced myself, provided basic information about the research and included a request to participate (see Appendix A). Approximately 40 leaders in the organization fit the research criteria which allowed for the formation of a participant pool (Gentles, Charles, Ploeg, & McKibbon, 2015). Managers and supervisors were asked to participate in the research study by completing a survey questionnaire. I invited three senior leaders

accountable for the delivery of safe and effective patient care to participate in one-on-one interviews. All three executive leaders acknowledged the request and participated in the research study. Interviewing the executive leaders served to enhance data collected from the managers and supervisors. Collecting data from two separate research participant groups assisted with data saturation and promoted a more in-depth understanding for my research study (Gentles et al., 2015).

This qualitative study involved a case study element to explore the firsthand experiences of managers and supervisors regarding their lived experiences of managing impaired healthcare professionals in the healthcare organization. I emailed the informed consent and the survey questionnaire to managers and supervisors using SurveyMonkey, an internet-based platform (see Appendix B). The managers and supervisors received an explanation of the research study and provided implied consent by clicking on the link. Upon clicking on with the survey-questionnaire the link the participant could complete and submit the survey questionnaire. The executive leaders research participants contributed to the research study by participating in a semi structured individual one-to-one interview. Each interview included an explanation of informed consent and addressed the maintenance of privacy and confidentiality.

An Internet-based research survey questionnaire is a useful qualitative and quantitative tool used to gain quick access to many respondents (Keusch, 2014; Wagner & Hubbard, 2014). Researchers have successfully used SurveyMonkey for qualitative and quantitative surveys and questionnaires (Keusch, 2014; Symonds, 2011). I utilized

SurveyMonkey, an Internet-based platform, to capture the responses and opinions of the managers and supervisors. The qualitative survey questionnaire was formulated to specifically illicit responses related to the central research question. I constructed single statement open-ended questions which permitted the participants to describe their feelings and develop a description of the topic. All survey participants received the same questions, asked in the same order. The SurveyMonkey Web Link function interfaced with the informed consent and the survey questionnaire Managers and supervisors received the informed consent by email; after reading the informed consent they accessed the survey questionnaire by clicking on the link entitled "Manager and Supervisor Survey Questionnaire." Those who elected to participate completed the open-ended questionnaire and selected finish which returned the survey questionnaire to the Collector Response. I activated the Collector Response setting in SurveyMonkey, which afforded the ability to collect the survey responses directly to my account. I set the Collector Option to prevent a participant from submitting more than one survey questionnaire. The Anonymous Responses function in SurveyMonkey kept respondents from being singularly identifiable in the survey results. The Anonymous Responses function in SurveyMonkey ensured the participant's confidentiality by downloading data directly to a Microsoft Excel spreadsheet. Excel is a program that allows the user to enter, modify and perform functions on sets of data (Cokley & Awad, 2013).

The audiotaped interview session began with an exchange of pleasantries, casual discussion of the project's goals, and an information regarding my experience and

credentials. My knowledge and experience in the healthcare field assisted with establishing interviewer credibility with the participants (Farago, Zide, & Shahani-Denning 2013; Yin, 2018). Effective communication can affect interviewing success. I carefully controlled my modes of speech to promote optimal responses from each participant (McDermid et al., 2014). Responsive interviewing with the participants enabled follow-up questions to flow organically (Grossoehme, 2014). The interviews produced rich narrative data in which the words of the participant provided the contextual perspective needed for this qualitative study (McDermid et al., 2014).

Research Method and Design

In this qualitative multiple case study, I focused on strategies healthcare leaders may use to manage impaired healthcare professionals in the workplace. A case study allows for multiple levels of abstraction and the potential to identify emerging themes (Gentles et al., 2015). I used concepts of due diligence as a conceptual framework for the exploration of the central question. I reviewed due diligence strategies from the (a) the legal and financial implications and (b) the ethical and moral implications.

Research Method

Researchers are encouraged to compare the differences between research methods and to determine the study method best suited for the study (Gentles et al., 2015; Yin, 2018). I considered three research methods for this study including qualitative, quantitative, and mixed methodologies (Frels & Onwuegbuzie, 2013; Gentles et al.,

2015). The qualitative research method integrates the observer and the observation by embracing varying philosophical assumptions, strategies of inquiry, and methods of data collection, analysis, and interpretation (Anfara & Mertz, 2014). The use of qualitative data provided insight into participants' reflections and afforded organizational context; qualitative research is thought to be the most flexible of the various experimental techniques as it encompasses a variety of accepted methods and structures (Anfara & Mertz, 2014; Frels & Onwuegbuzie, 2013). The aspects of qualitative research allowed my research to take place in a natural setting of a hospital.

I employed multiple methods of data collection to incorporate the participants' perspective in exploring the research questions. Yin (2018) suggest quantitative research is less flexible for understanding a participant's perspective. Quantitative inquiry focuses more on counting and classifying features and the use of statistical models and figures to explain observations (McDermid et al., 2014). Numerical, trending or longitudinal data does not readily capture the richer exploration of the lived experience necessary for this study (Anfara & Mertz, 2014). The mixed methods approach is gaining popularity as a form of research (Frels & Onwuegbuzie, 2013). Mixed method research uses both qualitative and quantitative data to inform each other and produces insight and understanding of a singular approach cannot produce (Zhang & Creswell, 2013). The mixed method approach was not appropriate for this study as trends, or numerical data are absent in exploratory design for reasons previously explained (McDermid et al., 2014). Quantitative and mixed-method designs are less likely to align with the

exploratory nature of participant self-expression. After comparing methodologies, I selected qualitative research as the most appropriate for exploration of strategies used by some healthcare leaders. (Freeman, Gregen, & Josselson, 2015; Grossoehme, 2014; Yin, 2018).

Research Design

I considered three research designs: ethnography, phenomenological, and case study. After examining the goals and methods associated with each, I selected the most appropriate research design for my study. Ethnography is a descriptive account of the way of life in a society and means to write or represent a culture (Marshall & Rossman, 2011). Ethnographers typically spend extended time in the places or cultures in which they conduct research, often forming lasting bonds with people (Marshall & Rossman, 2011). Ethnography was not an optimal choice for this research study as ethnographic studies may yield to cultural norms, actions, behaviors, or social compositions not useful to explain or address the specific business problem of my research question (Reeves et al., 2013). Typically, phenomenological studies use the perspective of an individual or the individual experiences of people groups (Gentles et al., 2015). Phenomenological studies explore individual lived experiences through multiple in-depth interviews within like-population. This design is limited in that it does not encourage the gathering of information from publicly available documents which I found useful for my study (Marshall & Rossman, 2011). I reviewed and then dismissed the use of a

phenomenological study. Researchers use case studies to examine persons, events, decisions, periods, projects, policies, institutions, or other systems (Houghton, Casey, Shaw, & Murphy, 2013). Case studies can be explanatory, exploratory, or descriptive. Exploratory multiple case study was selected for this qualitative inquiry as the most useful in a fluid research environment

Managers and supervisors received a survey questionnaire; the executive leaders participated only in interviews and did not receive a survey questionnaire. The survey questionnaires and the interview questions consisted of specific, open-ended questions, a technique frequently used in qualitative research (Keusch, 2014). Before initiating the data collection process, the potential participants received an email which explained the research project, an invitation to participate and how data would be collected (Carman, Clark, Wolf, & Moon, 2015). The invitation letter included (a) my name, university affiliation and email address and credentials; (b) the purpose of the study; (c) the study's participant eligibility criteria; (d) the risks and benefits of the study; and (e) the contact details in case respondents need any additional information (Farinde, 2014) prior to initiating the process.

I administered a pilot questionnaire by email to a small group of five people from my target group of managers to provide feedback regarding question structure and content. The small group returned their feedback regarding the survey questionnaire (McDermid, Peters, Jackson, & Daly, 2014). The feedback was used to modify the survey questionnaire and clarify the questions for the participants. The final study does not

include the pre-test results. A survey questionnaire can provide a systematic process for gathering meta-data and formulating the meta-database on a specific topic (Howison et al., 2015; Stone et al., 2015). I emailed the supervisors and managers a self-administered survey questionnaire using an Internet-based tool (SurveyMonkey, 2016; Keusch, 2014). Wagner and Huber (2014) suggested the timing of questionnaire administration and the inclusion of early and late responders is essential to increasing data collection. The managers had three opportunities to complete and return the survey questionnaire; after the initial request to participate, an electronic reminder was sent in four- week and in six-week increments. Providing additional prompts to both early and late responders assisted in increasing the collection rates (Keusch, 2014). Participants who chose not to participate simply deleted the email and were not asked why they chose not to participate.

The semi structured interview is qualitative data collection strategy in which the researcher asks questions about a topic using pre-determined open-ended questions (Yin, 2018). To explore the lived experience of executive leaders in the organization, I performed in-person semi structured interviews utilizing a written interview guide. The open-ended questions permitted the participants to elaborate on responses (Baden-Savin & Major, 2013). The interviews were audiotaped, and I alone reviewed the tapes to ensure completeness and accuracy of the recorded data, The used of field notes can help in identifying potential research ideas (Baden-Savin & Major, 2013). I took field notes during my review of historical and current documents, human resource policies and

procedures, employee assistant records, education and training files, or other approved forms as appropriate (Gentles et al., 2015).

I excluded federally protected classes from this qualitative study excluded (Yap & Webber, 2015). Participants were able to ask me questions regarding the purpose of the research, the research process, and how to withdraw him or herself from the from the study if they so choose. I received one question from an interview participant who asked if impairment included emotional issues as well as substance issues? I clarified that the study specifically addressed substance impairment only. No participant contacted me by phone or email with questions or concerns regarding the research or research process. The executive staff asked for copy of the final study upon approval by my university. I will honor the request.

Population and Sampling

Researchers address issues or questions of value to groups of individuals known as a research population (Houghton, 2013). A researcher makes assumptions about a population or group of people. Defining populations depends on the context of the research study (Yin, 2018). The population for this study included two groups of leaders. Managers and supervisors comprised one group and executive leaders comprised the second group. Both groups directly or indirectly supervise healthcare professionals in a selected health care organization. As suggested by Carman, Clark, Wolf, and Moon (2015) only relevant segments of the population should comprise the focus of data

collection. I selected leaders in the organization who have a lived experience related to the central research question; and excluded leaders within the organization whose job description excluded the supervision of healthcare professionals. The specific sample of the population should be enough for exploring and understanding the research questions within the study. Sampling refers to a process or method used to select a portion of the population for the study sample (Carman et al., 2015). Yin (2018) explained how qualitative research reflects non-probability and purposive sampling rather than probability or random approaches.

I used purposeful sampling techniques to identify the appropriate leaders in the organization who manage healthcare professionals. The targeted organization employs approximately 2500 people; approximately 150 employees have management or supervisory responsibilities. I specifically selected a sub-group of approximately 40 managers and supervisors who manage healthcare professionals in daily operations to receive the survey questionnaire. Additionally, I conducted semi structured interviews with three executive leaders to assist with data saturation. The three executive leaders did not receive the survey questionnaire. The semi structured interviews proved useful in getting the story behind the participant's experiences and promoted a deeper understanding of the central question. Yin (2018) suggested that the use of a typical case purposive sampling method is to ensure the qualifications of participants. The sample size included the available number of leaders in the organization who specifically met the inclusion study criteria.. Data collection included a review of official job descriptions to

understand how the organization defined the specific requirements of the leadership role. I examined job descriptions for specific requirements such as years of experience, education, and licensure or certifications and the responsibility of supervising healthcare professionals. Those who did not supervise healthcare professionals were excluded from the sample. The purposeful sampling criteria for participants was further deduced to having at least one year in the organization in a middle management role or an executive role.

Purposeful sampling relies on the availability of participants with characteristics specific to the focus of the study, which are easily accessible to the researcher (Carman et al., 2015; Palinkas et al., 2013). I discussed the need for a case purposive criterion of the participants with the executive staff to ensure I would have access to the targeted qualified personnel for the study. My purposeful sample was limited by the number of managers and supervisors, and executive leaders who meant the inclusion criteria. Sampling in qualitative research is flexible and often continues until data saturation occurs (Gentles et al., 2015). Data saturation is realized when data becomes repetitive, and no new information is obtained (Gentles et al., 2015; Yin, 2018). For this study, saturation depended on the quality of the interviews, the number of available participants, and the ability to perform purposeful sampling (Carman et al., 2015; Grossoehme, 2014). The data collected from the interviews, the qualitative survey questionnaires and the information from the organization's documents enhanced data saturation. During the interview process I noted repetitive information inferring the best opportunity to reach

data saturation. Data saturation is an elusive concept with few definitive guidelines (Palinkas et al., 2013). There is no pre-determined formula or number at which data saturation is complete Gentles, et al., 2015 (Yin, 2018). The observance of data saturation assists in facilitating the transparency and credibility of my research. I concluded my document review when I observed no new coding or information opportunity. A deeper understanding of the participants' perspective assists to achieve data saturation. Triangulation of data sources inclusive of questionnaires, interviews, and a review of organizational current and historical documents contributed to data validity, reliability, credibility, and saturation.

Data collection for this study occurred once I obtained Institutional Review Board approval by the Walden Institutional Review Board for Ethical Standards and Research. Participants received related information about the study electronically. Managers and supervisors implied informed consent by accessing and submitting a survey questionnaire. The executive leaders signed the informed consent before participating in the interview. Participants were informed about the potential risks and how the study could benefit healthcare leaders.

Ethical Research

Incorporating ethical principles assisted with preventing or reducing harm to participants. The Belmont Report offers a consistent approach to the protection of human subjects regarding beneficence, justice, and respect for persons (The Belmont Report,

1979). The study incorporated the ethical principles identified by Bell and Bryman (2007). Before collecting interview data, I received approval from the Walden University Institutional Review Board (08-11-17-0350406) regarding the collection of data through the administration of a survey questionnaire and semi structured interviews. Both collection methods protected the privacy and rights of all participants in this study. Additionally, I completed training and obtained a certificate from the National Institute of Health's (NIH) Office of Extramural Research regarding the protection of the rights of research participants. My final study will include the Walden IRB approval number to ensure I complied with ethical standards regarding human participants. I minimized any potential or known harm, danger and privacy risks to participants personally, behaviorally, or intellectually. The study did not capitalize on or induce monetary benefits to the participants throughout the research process.

This study offered no incentives for participation. Participants included in the follow-up interviews had the opportunity to read and ask questions before the initiation of the interviews. Participants were aware of voluntary participation, and that they could withdraw from the study without penalty. No participants withdrew from the study. Participants were made aware that if they withdrew from the study before publication I would destroy all information collected, including notes, recordings, survey questionnaires, or interviews. Agreement to participate indicated the participant understood the terms as explained in the consent form regarding the study. I maintained the participant's confidentiality throughout the study. The participant information

collected from the survey-questionnaires are stored in an encrypted file to maintain confidentiality after the study. Information retrieved or obtained from interviews are locked in a file drawer for five years. I explained to the participants data associated with this study is stored in a secure location. I will destroy all data after five years.

Data Collection Instruments

The goal of the data collection process was to amass enough information from which to understand and develop a response to the research question (Yin, 2018). Common sources of data collection in qualitative research include survey questionnaires, interviews, observations, and reviews of documents (Earley, 2014). Collection of data for this research occurred through survey questionnaires, semi structured interviews and a review of the organization's current and historical documents. The request to participate was sent in an email to potential research participants (see Appendix A). The managers and supervisors received the informed consent with the attached survey questionnaire link concurrently (see Appendix B). I conducted semi structured interviews with three executive leaders using an interview protocol (see Appendix C). I am the only individual who collected and analyzed the data from the semi structured interviews, the survey questionnaires and the review of the historical and current documents.

Approximately 40 managers and supervisors have the responsibility for supervising healthcare professionals at the designated facility located in the Commonwealth of Kentucky, USA. This select group of managers and supervisors

received the survey questionnaire by email and accessed the informed consent and survey questionnaire by clicking on the link. The SurveyMonkey Web Link function interfaced the informed consent overview and the survey questionnaire concurrently. Those who elected to participate completed the open-ended survey questionnaire and selected the finish box to return the survey questionnaire to the Collector Response. The Collector Response setting in SurveyMonkey afforded the ability to collect responses directly to my account. To achieve my goal of a minimum 50% response rate, I emailed a reminder to stimulate participation to all the managers and supervisors (Gentles et al., 2015). The managers and supervisors had three opportunities to complete and return the survey questionnaire; the initial request to participate and an electronic reminder which was sent in four- week and in six-week increments (Keusch, 2014). The Anonymous Responses function in SurveyMonkey kept respondents from being singularly identifiable in the survey results and prevented IP tracking. All personal data such as first or last names were excluded. The Anonymous Responses function in SurveyMonkey further ensured the participant's confidentiality by downloading data directly to a Microsoft Excel spreadsheet. Excel Microsoft is a program which allows the user to enter, modify and perform functions on sets of data (Cokley & Awad, 2013).

To enhance data richness, I conducted semi structured interviews with three executive leaders. The executive leaders held organization were directly accountable for the delivery of safe and effective patient care. The interview tends to be the most common source of data in qualitative studies (McDermid et al., 2014). I explained and

collected the informed consent document on the day of the interview, 15 minutes before the start of the interview. After obtaining consent from each executive leader I conducted individual one-on-one semi structured interviews in a confidential environment within the facility. The questions allowed the interviewee to respond succinctly or to pursue a relevant idea in detail. Semi structured interviews promote two-way communication (McDermid et al., 2014). The information obtained from the interviews promoted a deeper exploration of the participants lived experiences, beliefs or motivations on specific matters related to the research question (Grossoehme, 2014). My field notes assisted in collecting and organizing and analyzing the data. Another part of the data collection included a review of the organization's relevant documents. The review of documents, the policies and procedures, increased my understanding of the participants' lived experience and provided further context for the exploration of the research question.

Data Collection Technique

Yin (2018) encourages the use of multiple data collection technique. I utilized data from various sources including a survey questionnaire, one-on one semi structured interview, and generated field notes consisting of a review of appropriate organizational current and historical documents. To collect data from the managers and supervisors I used SurveyMonkey, an Internet based platform, to administer a survey questionnaire. To collect data from the executive leaders I conducted one-on-one semi structured interview utilizing an Interview Protocol. I generated and collected field notes by reviewing the appropriate organization's historical and current documents such as human resource

policies and procedures, employee assistant records, and education and training files. Yin (2018) maintained that developing field notes based on data from source-appropriate documents and historical records provides for valid data. My review noted several procedural policies were not site-specific to the hospital; they were generated at the corporate level and were not located with the hospital-based policies. By collecting data through survey questionnaires, semi structured interviews, and generated field notes I achieved a more though exploration of the research.

Researchers must remain neutral when administering questionnaires or performing interviews (Anfara & Mertz, 2014). I followed my Interview Protocol (see Appendix C) to conduct the one-to-one semi structured interviews. I used the Interview Protocol consistently throughout each interview to ensure a neutral approach to the interview questions and procedures. Each interview form included a heading with the date, time, place, and interviewee number. Procedurally, my Interview Protocol outlined how to conduct the interview. After explaining the informed consent, the participant signed and returned the form to me. The participants were informed of their rights as explained in my informed consent document. I allowed the participant to ask questions regarding the process or the interview. I placed the recording equipment on the table and then initiated the interview.

The executive leader's secretary assisted me in organizing convenient dates and times according to the individual executive leader's schedule. She further assisted me in securing a confidential meeting room within the facility to conduct the one-on-one

interviews with the three executive leaders. As recommended by Grossoehme (2014), the private room was away from the immediate work area of the executive suite which assisted in minimizing work distractions. I initiated the interviews by greeting the participant and making them feel comfortable by exchanging a minimum of conversation. I explained to each participant why I selected them to participate in my research study. The criteria included based t their experience, qualifications and their role within the organization. I walked the participant through the informed consent document explaining the interview would be recorded, the approximate time required for the interview, their rights and confidentiality, handling, storage, and eventual destruction of the interview data as well as the purpose of the study. After the participant signed the form I made a copy of the form and provided a copy to the participant. I am the only person with access to the original signed informed consent document. After obtaining informed consent I started the semi structured interviews as described in the Interview Protocol Guide (see Appendix C).

As described in the Interview Protocol, I recorded the interviews to assist in accurately capturing the participants' responses. The Livescribe Smart Pen 3 and Sony Linear PCM MP3 were used for the purpose of recording each interview. I experienced equipment failure in my second interview. The use of both recording devices minimized the impact of equipment failure during the interview. The interviews lasted approximately 40-75 minutes using a narrative approach. A disadvantage to conducting a recorded interview is that participants might not be comfortable participating in a voice-

recorded interview (Doody & Noonan, 2013). One participant was initially uncomfortable being recorded but began to reax as the interview progressed. I utilized member checking to mitigate bias in collecting the data (Palinkas et al., 2013). Member checking may result in interviewing the participant again or repeating the responses to clarify concepts or clarify the interpretation of participant data input (Frels & Onuwuegbuzie, 2013). I conducted follow-up member checking with the executive participants to review analysis of the recorded data. The interview participants expressed appreciation for the opportunity to have their responses validated for accuracy, reliability, and correct interpretation of the data. Yin (2018) suggest the use of data source triangulation by using multiple data sources. I included four sources of research, the survey questionnaires, the semi structured interviews, the review of the related current organization's documents and the review of the historical and archived organization's documents. Developing data source triangulation takes more time, energy, structure, and discipline than single source data collection but yields a broader understanding of the research.

Data Organization Techniques

Qualitative data is non-numerical information and includes responses gathered through interviews, observations, focus groups, or open-ended survey questionnaires (Zhang & Creswell, 2013). I collected data from survey questionnaires, recorded semi structured interviews as well as reviewed and collected data from current and historical

organizational documents. I followed Yin's (2018) technique on collecting data from documents. The completed personal interviews and notes remained in a secure folder until the data analysis phase. The survey questionnaire data was exported from the Collector Response of my SurveyMonkey instrument into a spreadsheet on my personal computer. I scanned the field notes generated from the current and historical documents on to my personal computer.

I utilized use the electronic software NViVO to help me track, organize and code all collected data. NViVO software is specifically designed for qualitative data analysis and storage of (a) raw data files from the interviews, (b) field notes, (c) themes, (d) concepts, and (e) survey questionnaire data. I utilized NViVO to store ideas during and after completion of the study (Bazeley & Jackson, 2013). I used the Livescribe Smart Pen 3 and Sony Linear PCM MP3 to record and store each interview After each interview, I reminded the participant that recorded data would be stored in a secure location and destroyed after five years. I transcribed the recorded interviews into text and stored the data onto my personal computer. Adhering to Yin's (2018) procedure for maintaining data integrity all data remain secured on my personal computer. My computer is password protected and I am the only one that has the password. I have intrusion software on my computer to prevent unauthorized access of stored data.

Bazeley and Jackson (2013) found analysis and data organization to be the essential components of theme recognition. I rechecked raw data to ensure the integrity of the data prior to transcription and analysis. After transcription of data, I used NViVO

software on my password protected computer to assists in reviewing, storing, and organizing the collected data. The NViVO software is helpful in extracting, coding and identifying themes (Maher, Hadfield, Hutchings & Eyto, 2018). I developed an assigned code such as MGL1 through MGL29 for manager and supervisor survey questionnaire responses, and EL1, EL2, EL3 for the three executive leader interview responses to enhance anonymity.

I developed the list of descriptive codes based on concepts in my conceptual framework and literature review. The participants associated with this study were informed that all observation notes, questionnaires, and recordings would be destroyed by me. I secured all transcribed data, written notes, interview tapes, and personal notes in a locked file cabinet. The participant information collected from the survey-questionnaires remains stored on an encrypted file to maintain confidentiality after the study. Information retrieved or obtained from personal notes will remain locked in a file drawer for five years. After five years, I will destroy all collected data.

Data Analysis

Qualitative data analysis involves the identification, examination, and interpretation of patterns and themes in textual data (Freeman et al., 2015). My first step for analyzing the qualitative information was to reduce or simplify the data for analysis (Freeman et al., 2015). Because of its verbal nature, simplification was challenging. Data analysis is contingent upon the type of data gathered. I collected qualitative data from

survey questionnaires, recorded semi structured interviews, reviews of current organizational documents, as well as historical organizational documents. The survey questionnaire responses were downloaded to an Excel spreadsheet and I imported the data into NViVO. I personally transcribed the recorded interviews into text. and stored the transcription on my computer. I scanned the field notes onto my personal computer. I uploaded the transcribed interview text and scanned my field notes for data analysis using the NViVO computer software. NViVO helps users organize and analyze non-numerical and unstructured data (McNiff, 2016). The process of data analysis in qualitative research involves the evaluation of the resulting data by working with the data, breaking the data down, synthesizing data, and searching for themes or patterns to discover the critical or relevant data elements (Freeman et al., 2015). I used the NViVO tools to classify, sort and arrange information. I developed descriptive codes by identifying the most basic information from the raw data based on the concepts found in the conceptual framework and literature review (see Appendix D). NVIVO® was helpful for examining relationships in the data, counting frequencies of words and querying key words. I linked relevant data to form patterns across data sets. I followed Yin's (2018), approach of listing all relevant data and preparing a composite of the data. I used the NViVO software tools in further classifying passages of text into defined nodes. Nodes consist of related material or data sets and assist with identifying emerging patterns and ideas (Maher et al., 2018). Based on the pattern of the data sets I identified key themes. Methodological triangulation of data collected through the survey questionnaire, the semi structured

interviews and the review of the organization's legal current and historical documents served to substantiate the information gathered during data collection process. I correlated the key themes with information found in the literature review and in the conceptual framework. The identified key themes were predicated upon and viewed through the lens of the concepts of due diligence.

Reliability and Validity

Reliability

Reliability is the assurance the researcher's approach is consistent and replicable (Babbie, 2010). I ensured reliability of data throughout the study. Analytical procedures, accounting for personal research method by documenting procedures. Maintaining a detailed protocol provided consistency. Procedures and interview protocols are consistent with implementation and application. Consistency in the application of these methods helps control researcher bias. Reliable research inquiry should ultimately allow an independent researcher to arrive at similar or comparable findings (Lakshman, 2013). I ensured consistency and trustworthiness in my research method. Methods to ensure trustworthiness included literature comparisons and member checking with randomly selected participants. A professor and researcher in the field of addiction medicine who provides managerial responsibilities for two hospital-based pharmacies provided the expert review. Member checking helped to ensure the interpretation of the participant interview statements were accurate (Grossoehme, 2014).

Validity

Validity is the precision with which the findings accurately reflect the data and the researcher's approach measures what it stated it would (Yin, 2018). An exploratory case study is suitable for revealing cause and effects processes by using systematic comparison and exploration (Byrne, 2013). Data collected from survey questionnaires and semi structured interviews comprised the main basis for data collection. Member checking the interviewed participants further support validity by ensuring the accuracy of my interpretation of the interview statements (Grossoehme, 2014). I performed member checking by reviewing the transcribed interviews with the executive participants. This enhanced accuracy prior to subjecting the transcripts to formal coding and analysis.

Janssen and Stube (2014) discussed the use of interview notes and the use of a clear audit trail and summaries in creating a dependable, confirmable, process accurately presents the participant's perspectives. Trustworthiness, consistency, and applicability assist in achieving neutrality or confirm-ability (Janssen & Stube, 2014). I endeavored to reflect a neutral and accurate accounting of the participant's experience. The participant's experiences form the basis for data regarding management strategies used by healthcare organizational leaders to identify and address impaired healthcare professionals in the workplace.

I ensured consistency of findings by using different data sources and collection methods to assist with the integrity of the collected data (Byrne, 2013). The findings of

this study are specific to the healthcare community. Transferability of qualitative research to a different setting can be difficult and may require a broader context (Keane, Lincoln, & Smith, 2013). The judgment of the reader and future researchers determine the transferability of the findings of this research.

Transition and Summary

My qualitative, exploratory case study was designed to identify any themes derived from the data. The study provided a thorough description of the themes which explored the multiple perspectives of the participants or the detailed individual descriptions to support the themes. The conceptual lens of due diligence framed this inquiry and supported the research question and the in-depth case study.

In Section 2, I outlined the methodology, the design, and restated (a) the business problem, (b) purpose, (c) data collection process and the role of the researcher, and (d) any potential relationships with researchers and participants. Additionally, (a) access strategies, (b) ethical protections, (c) data retention plan for the inquiry, (d) justification for the research method, and (e) a research design for this study were presented. I concluded Section 2 by discussing matters relating to the (a) population and sampling, (b) ethical considerations, (c) instruments for data collection, (d) data collection techniques and organization, (e) data analysis, and (f) reliability and validity of the results of this study.

In Section 3, I present the research findings, analysis, conclusions, and implications for professional use. I developed themes related to the conceptual framework and literature review. My study explored strategies used by some healthcare leaders to identify and address substance impairment in the workplace. I conclude Section 3 with further research recommendations, reflections, and opportunities for extending knowledge for leaders in the healthcare arena.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore the management strategies used by some healthcare organizational leaders when addressing and managing the substance-impaired healthcare professional in the workplace. To facilitate my research, I conducted a review of relevant literature and recruited managers, supervisors, and executives from a specific healthcare organization to participate in the study. Managers and supervisors received a survey questionnaire and the executives participated in individual interviews. I reviewed documents and observed the suitable operations and business characteristics of the organization.

In this section contains the analysis of the collected data and the six emerging themes of this research. The themes may prove beneficial to other healthcare leaders in similar-sized organizations for the development of specific and effective strategies to address the impaired healthcare professional in the work environment. This section also includes observations concerning the applications for professional practice, implications for social change, and further research recommendations.

Presentation of the Findings

The central research question was: What management strategies do some healthcare leaders use to address the substance-impaired healthcare professional in the workplace? One hospital owned by a national healthcare company comprised the data

collection. The concept of due diligence served as a framework and a foundation for developing the survey questionnaires and the interview questions.

A purposive sample was selected. The review of the organization's job descriptions provided a basis for understanding the manager, supervisor, and executive leadership positions. The managers and supervisors were required to have a minimum of a bachelor's degree while executive leaders were required to have a master's or doctoral degree. Two of the three executive leaders possessed doctorates. All managers, supervisors, or executive leaders' participation criteria included having at least 1 year of experience in their leadership position and direct or indirect responsibility for managing healthcare professionals in daily operations.

I emailed 40 hospital managers and supervisors a request to participate in an internet survey questionnaire. Twenty-nine managers and supervisors completed the survey questionnaire for a 73% response rate. Some participants did not respond to every question. I emailed a separate request for a face-to-face interview with three executive leaders. The executive leaders did not receive the internet survey questionnaire. All three executive leaders, or a100%, responded affirmatively to the request. The executive leaders participated in individual, semi structured follow-up interviews regarding their lived experience with strategies to address the substance-impaired healthcare professional in the workplace. Each executive leader participant reviewed and clarified responses during the interview and had the opportunity to review the transcripts of their interview. This process served to increase the reliability and validity of the interview responses.

My data also included a review of relevant documents including four current and six historical organization documents. The review of these documents increased my understanding of policies, education and training, employee assistance programs, hospital reporting requirements, and other information applicable to management of substance-abuse within the organization and within the national healthcare company. After conducting the data collection process, a thematic analysis included the transcribed interviews, the survey questionnaire responses, and the review of the relevant documents of the organization. Many of the policies and processes were developed at the national level and implemented across the network of the individual hospitals. I used a broad spectrum of data sources encompassing current and historical documents, reviewed literature, and data collected from participant survey questionnaires and interviews for triangulation and analysis. The IP address tracking and email address tracking was disabled to assist in keeping survey questionnaire responses anonymous.

In general, participants appeared comfortable expressing their lived experience and conveying knowledge of current or retrospective events related to the survey questionnaire or interview questions. MGL2 stated, “It concerns healthcare leaders when we are work with someone who may be substance-impaired; we have to intervene appropriately on behalf of our patients. It can get ugly quick because usually their initial response, when confronted, is denial.” This participant went on to describe an occurrence when:

> I had to tell an on-call doctor that I was concerned he was impaired. Upon his arrival, I could smell something on his breath, and I was pretty sure I smelled alcohol. Other's smelled it too. His behavior was erratic, and his appearance was off. I could not allow him to perform surgery until the concern was investigated. As the manager of the case, I asked if he had been drinking before coming in and he said no. I was uncomfortable for me, but I know I did the correct thing by intervening. We must maintain a culture of safety for our patients no matter what.

Three MGL and two EL participants indicated they had not directly managed a substance-impaired provider scenario. The three MGL participants expressed apprehension in how to deal with such a situation effectively. MGL10 stated "I think this is a very important subject-- we should have training on this. I've not had to deal with this yet, and I'm not sure I would know what to do."

I identified the survey questionnaire and interview data. The survey questionnaire responses were uploaded directly from the survey questionnaire platform into NViVOPro11. The interview responses were transcribed and entered the same computer-assisted qualitative analysis program. Interview and survey questionnaire responses comprised a coding tree. The process was reviewed to ensure congruency between the data and the coding schema. The NViVO software program proved valuable for creating nodes, exploring patterns, and identifying emerging themes from both the interviews and the survey questionnaires. The themes derived from the data along with the various perspectives from participants revealed the leaders' recognition of the substance-impaired

healthcare professional in the workplace and the need to protect patients from harm. All participants discussed concerns about working with an impaired professional and detailed concerns 64 times across all survey questionnaire responses and interviewees. This finding was consistent with research by James (2013) who described the potential for patient harm when care is provided by a substance-impaired professional. Executive responses included words such as safety, patient harm, apprehensive, concern, and at-risk. Manager and supervisor responses frequently used words such as stress, concern, diversion, substance-abuse, training, education, and patient safety. The difference in verbiage between the executive leaders and the supervisors and managers may indicate that the executives were concerned about the risk to the organization, while the managers and supervisors were more focused on how the staff were affected.

After the successful completion of the collected data and qualitative analysis, six consistent themes emerged for exploring the complex phenomenon of management strategies and the impaired-healthcare provider. This subsection contains a discussion of these six themes: (a) selective application of policy, (b) managerial training on the indications of substance impairment, (c) monitoring and surveillance support, (d) reentry into work environment, (e) synergistic integration between work and life, (f) managerial training on the legal and ethical implications of reporting.

Theme 1: Selective Application of Policy

A review of policies such as substance impairment, substance abuse, EAP, and training processes confirmed the existence of workplace policies related to my topic. The manager and supervisor survey questionnaire responses reflected a lack of a clear understanding of the organization's published substance-abuse policies. Confusion and uncertainty was expressed regarding when, where, or how to apply such policies. MGL responses included discussion of how substance abuse and related policies were sometimes situationally applied and were apprehensive about access to clear and accessible policies. Eleven MGL participants stated factors such as the gravity of the occurrence or the type of substance involved, either drugs or alcohol, could influence how policies were applied. MGL5 detailed how "the time of occurrences like weekend or weekday, or day shift or night shift determine what happens; the leaders with the most knowledge of policies tend to be on days." EL participants noted that workplace policies for nurses and other employees, including substance abuse policies, were separate from those of physicians. The EL participants expressed how all substance abuse and related policies ascribed to the goal of a safety-first culture for patients and employees. El1 expounded on "the Employee Assistant Program policy and how human resources supported treatment for substance impaired healthcare workers." EL2 stated that, "impaired physicians were not handled through the hospital's EAP as most were considered contract labor and not actual employees of the hospital. Physicians issues are usually addressed through the medical staff office, not through the hospital's human

resource.” MGL responses regarding EAP were nondescript with only two MGL’s fully noting the role of human resources, EAP, and having knowledge of the separateness of physician policies. I did not see any physician substance-impairment policies in my review of documents.” Two EL leaders described their role in daily operations related to drug diversion or suspected substance impairment and did not express the same apprehension about policy application but rather expressed an elevated level of satisfaction with policy and application.

The finding regarding the selective application of policy contradicts research. Consistent and easily retrievable policies promote quick intervention on behalf of the impaired colleague. Easily accessed policies assist managers and supervisors in protecting patients from physical or emotional harm related to impaired healthcare providers (Valdes, 2014). The theme regarding the selective or inconsistent application of policy was discussed 31 times by MGL participants and six times by EL participants, for a total of 37 times, which was 20% of participant responses (see Table 1).

Table 1

The Frequency of Times Selection Application of Policy Discussed

Participant ID	Times discussed	% of Coverage
MGL1	1	8%
MGL2	5	12%
MGL3	2	35%
MGL4	4	17%
MGL13	4	26%
MGL12	2	15%
MGL17	4	22%
MGL20	3	7%
MGL26	2	9%
MGL28	2	34%
MGL29	2	20%
EL1	3	45%
EL2	1	17%
EL3	2	27%
Participant's equivalent percentage numbers	37	20%

Theme 2: Managerial Training on the Indications of Substance Impairment

Signs and symptoms of substance-impairment manifest in diverse ways. Factors include the type of substance, the amount, and the method. Healthcare organizations generally provide resources such as workplace health policies with information related to signs and symptoms of substance abuse (Kinkle, 2015). MGL participants described how consistent education is vital in recognizing the diverse signs and symptoms indicative of suspected or actual substance-impairment. MGL5 stated,

> I have not had to deal with an impaired professional. I heard something in orientation about what to do but nothing more. I think we need more training. We have to be alert and take appropriate action when impaired practice jeopardizes patient care.

Both managers and executive leaders expressed that nurses and other healthcare professionals have unique workplace stressors such as demanding workload, long work hours, fast-paced decision-making, or repeated exposure to death. MGL10 commented on staffing shortages, increasing patient to provider ratios, increasing patient acuity, long work hours such as back-to-back 12-hour shifts all serve to make healthcare a highly stressful vocation.

Five managers and one executive leader noted the need for education describing the challenges in recognizing subtle signs of impairment and stress-related behaviors. One manager described how she attended an educational offering provided by the

organization related to impairment and learned about behavior changes, physical signs and when to have a heightened awareness of the potential for drug diversion. This participant stated all healthcare leaders needed to attend similar training. EL2 stated that "individuals may avoid detection by using extra precaution. I dealt with an impaired provider who always chewed gum, used mints and mouthwash to mask the smell of alcohol." The finding for education regarding substance impairment is consistent with Bana (2014) who emphasized the need for consistent education regarding signs and symptoms of substance impairment. Bana further specified that when employees think their manager and supervisors know how to detect substance abuse and do something about it, the potential for substance abuse decreases. Managerial training on the indications of substance impairment was discussed 21 times by MGL participants and seven times by EL participants, a total of 28 times, which equates to 22% of participant responses (See Table 2).

Table 2

The Frequency of Training on the Indications of Substance Impairment Discussed

Participant ID	Times Discussed	% of Coverage
MGL2	2	19%
MGL4	3	11%
MGL5	5	41%
MGL8	3	22%
MGL10	4	38%
MGL22	4	30%
EL1	2	18%
EL2	3	15%
EL3	2	26%
Participants' equivalent percentage numbers	Total: 28	Average: 22%

Theme 3: Monitoring and Surveillance Support

NIDA (2014) proposes that any healthcare facilities with controlled substances on their premises are at risk for diversion and the potential for substance abuse. Eighteen

MGL and EL participants described that surveillance and monitoring processes were in place. Some described the process of how technology was helpful while others spoke to the development of quality assurance processes and committees which provided over site audits of drug diversion events. MGL2 described participating in a multidisciplinary internal drug diversion and compliance committee. “Our role is to investigate and resolve suspicious medications issues such as drug diversion.” The members consist of healthcare professionals including physicians, pharmacist, nurses, and anesthetist. EL1 further defined the pharmacy department’s role in that they “review specific activity reports regarding the monitoring and surveillance of medication usage data.” These reports revealed the type and number of narcotics accessed and administered in the patient care units. EL3 described:

> I heard about several issues of diversion and the possibility of an impaired RN in a patient care area. I asked the pharmacy to increase random audits on those who had accessed certain narcotics at a rate higher than the norm. We limited access to our automated dispensing machines, increased end of shift reconciliation of narcotic balances, and implemented the use of fingerprint identification.

Georgiou (2013) and Smith (2013) described how early detection through monitoring and surveillance of narcotic discrepancy helps to protect public safety, increase treatment for substance addiction for an impaired healthcare professional, and support the impaired individual’s safe return to practice. This finding was consistent with

current research regarding surveillance and monitoring systems that support organization policies, procedures, record keeping, and guidelines for periodic and random audits (Banja, 2014, OSHA, 2016). Monitoring and surveillance support were discussed 14 times by MGL and four times by EL for a total of 18 times which was 18 % of participant responses (see Table 3).

Table 3

The Frequency of Times Monitoring and Surveillance Support Discussed

Participant ID	Times Discussed	% of Coverage
MGL1	2	20%
MGL2	2	18%
MGL10	3	22%
MGL14	3	39%
MGL20	4	42%
EL1	2	16%
EL2	1	12%
EL3	1	9%
Participants' equivalent percentage numbers	Total: 18	Average: 18%

Theme 4: Reentry into Work Place

Many substance-impaired healthcare professionals receive treatment and return to the workforce (O'Neil & Cadiz, 2014). Healthcare organizations can consult with or obtain guidance through professional licensing boards such as the ANA or the AMA when developing reentry procedures. These professional boards address the ethical implications of how or when to recommend additional treatment and give forth guidelines for how to support the reentry process. Managers and supervisors, and executive leaders in this study unanimously reflected the returning individual must be healthy and recovered before assuming full duties. Leaders reflected reentry should include full license capacity including the administration of narcotics to patients. This finding was consistent with Bettinardi-Angres and Garcia (2015) who describe how returning to full duty is in keeping with current practice. The MGL stance demonstrates a supportive work environment for the reentry of a health professional's back into the work environment. Managers and supervisors commented that every situation is unique and described how ultimately the returning individual is accountable for their reentry process. Seventeen managers and supervisors described multiple methods used to support the reentry of a healthcare professional. Managers and supervisors reflected ambiguity about their role in providing reentry support. For example, MGL 5 explained:

> I have a critical role to ensure the provision of safe patient care. My role in working with the person who is reentering the workforce is one of support.

> However, I do not have the time to devote to monitoring and looking at multiple scenarios to ensure the provider is performing safely. I must rely on everyone to help monitor that safe practice is occurring; MGL 9 commented on the difficulty in recognizing unsafe practice related to impairment. Sometimes I may just be seeing that the person is tired or stressed and read the situation wrong because I'm hypervigilant because I know the person's history. Whose job is it really to monitor these individuals? I would like guidance on how to support a reentry process—it's not cut and dry.

The above statement is consistent with research revealing recovery is more than just a treatment program. It encompasses a process of change in which the involved person strives to make healthy choices and accepts ownership for their welfare (O'Neil & Cadiz, 2014). Managers supported random drug testing as a way of monitoring for relapse albeit leader responses were inconsistent regarding how this would occur, who would be responsible for the testing and monitoring, how long or how frequently drug testing should be performed, and who should have knowledge of the results. I did not see this clearly articulated in my review of documents. An individual demonstrating a substance-impaired relapse would present a unique challenge and require immediate leadership involvement. Reentry into the workplace was discussed 11 times by MGL and three by EL for a total of 14 times which was 17% of participant responses (see Table 4).

Table 4

The Frequency of Times Reentry into Work Environment Discussed

Participant ID	Times Discussed	% of Coverage
MGL1	1	9%
MGL3	1	6%
MGL5	2	30%
MGL8	2	26%
MGL9	3	45%
MGL14	1	11%
MGL19	1	15%
EL1	1	10%
EL2	1	8%
EL3	1	12%
Participants' equivalent percentage numbers	Total: 14	Average: 17%

Theme 5: Synergistic Integration between Work and Life Balance

The MGL participants described a myriad of factors such as long work hours, overtime, and heavy patient work assignments as contributing to the incidence of

substance-abuse by healthcare professionals. The EL group addressed issues related to work and life integration. One EL participant described:

> Leaders should periodically observe healthcare professionals and the delivery of care. Healthcare leaders can stay aware of how employees are dealing with the effect of environmental work stressors by periodically walking or rounding through the workplace. Leaders can check on and observe employees, equipment and the status of ongoing work. As leaders talk to employees, they observe first-hand any anomaly in the work environment or any untoward behavior that may be exhibited by an employee.

Starr (2015) supports leader presence stating leaders should periodically and regularly visit the work environment. According to Starr leaders can gather relevant information by conversing first-hand with workers. According to the MGL group leader presence promotes early detection of environmental or personal stressors which may pre-dispose healthcare professionals to substance impairment. The EL group supported and encouraged leader presence but did not have a developed format for how this should occur or how the observations would be acted upon if needed. The MGL group identified several environmental stressors inclusive of the lack of peer compassion in the workplace, the stress related to meeting the continual and overwhelming needs of patients and their families, and poor job satisfaction and low morale.

The MGL group discussed how environmental factors could potentiate succumbing to substance impairment for the healthcare professional. Compassion or empathy as a response to knowledge of an addicted colleague was mentioned four times by the MGL group. Nevertheless, the MGL participants were adamant that a substance-impaired colleague should not provide care as patient harm could occur. Once identified, removal from the work environment should occur. The EL group expressed how compassion is necessary when managing the impaired professional. The EL group further related how substance abuse is an individual choice and that potential consequences could result. EL3 explained the following:

> We see substance impairment as an addiction and treat it as a disease much like other diseases. Substance abuse and impairment are to be managed with appropriate treatment inclusive of supportive measures just as other diseases and treated with specific interventions. We recognize that healthcare can be very stressful. Our leaders recognize the relationship between the well-being of the worker and the negative or positive affect on business outcomes. We need to be vigilant regarding the occurrence of substance impairment in the work environment. Creating a culture of safety is our top priority. We must also acknowledge the tendency of substance impairment to occur and encourage the impaired individual to enter treatment.

The responses from the MGL group did not specifically identify synergistic integration of work demands and life balance as a factor for the impaired healthcare

professional. This finding contradicts Shanafelt et al. (2015) research which reflected that healthcare providers are at risk for excessive use of narcotics or alcohol related to burnout, high work demands, and stressful work environments. Physicians specifically were less likely to be satisfied with how high workloads and the effect on their personal life. The study cautioned that healthcare leaders should be vigilant regarding environmental or personal stressors such as burnout or high work demands as healthcare professionals may resort to using alcohol or narcotic substances to manage stressors. Synergistic integration with work demands and life balances were discussed 15 times by MGL and three times by EL for a total of 18 times, which was 19% of participant responses (see Table 5).

Table 5

The Frequency of Times Synergistic Integration Between Work Demands and Life Balance Discussed

Participant ID	Times Discussed	% of Coverage
MGL1	2	20%
MGL3	2	18%
MGL10	3	22%
MGL11	3	39%
MGL21	4	42%
EL1	2	16%
EL2	1	12%
EL3	1	9%
Participants' equivalent percentage numbers	Total: 18	Average: 19%

Theme 6: Managerial Training on the Legal and Ethical Implications of Reporting

The organization's policy provided information regarding how to act upon any actual or suspicion of a healthcare professional's substance-impaired behavior. The sixth theme to emerge from the data analysis was that the manager and supervisor knowledge regarding the reporting process was lacking. Seven MGL participants recognized the

responsibility to report but were apprehensive about the process and how and what happens when identifying the substance-impaired healthcare professional. Feelings of loyalty, guilt, and fear often prevent healthcare workers from reporting to their manager and supervisors (New, 2013). Four MGL participants were uncertain when and how reporting should occur per the organization's policy. One MGL participants said they would keep their suspicion to themselves. This finding is concerning since reporting and referral are instrumental in identifying impairment in healthcare professionals. Only two MGL participants stated they would not hesitate to report a situation to their director or a human resource leader and could define the process. One MGL participant that had been in their position with the organization for only one year stated the following:

> I know reporting is the right thing to do, but I'm concerned about backlash from the person if the individual found out that I reported them. Sometimes it's best to let someone else take care of it. I know of a situation where someone reported a doctor, and they were very concerned that the doctor would find out who reported him and tried to have them fired.

This finding is consistent with research that found a correlation between years of experience and comfort level with reporting a suspicious colleague (New, 2013). More experienced leaders were quicker to report than inexperienced leaders. The knowledge deficit of the GL participants revealed an inconsistent understanding of reporting requirements, the organization's policies and board regulations regarding reporting

requirements. Eight MGL participants reflected a level of knowledge of how to report a comparable impaired professional such as a nurse reporting another nurse. The MGLs' was uncertain about the reporting requirements for dissimilar health professionals such as how a nurse would report a doctor or a pharmacist demonstrating behavior consistent with substance-impaired behavior. Questions included to whom would they report? How would it be handled? Could they make an anonymous report or did reporting require their name and be involved in the investigation? EL participants collectively reflected that reporting did occur within the institution but acknowledged that frequency could be under-reported as new leaders and staffs were sometimes hesitant to report related to lack of knowledge. EL3 continued by stating:

> When we receive reports of suspected drug-related activity, we immediately analyze the occurrence and look for trends that might isolate a pattern such as time of day, the day of the week, the narcotic diverted, who accessed the medication drawer and why what patients may have been affected and so on. Trended information is acted upon on a case by case basis. We ensure periodic training for our managers and supervisors regarding when and how to report and ensure they realize their responsibilities in doing so. Newer or less experienced managers or staff may lack the understanding of reporting requirements which comes from experience in dealing with substance impaired scenarios. Inexperience could affect the amount of reporting within the organization.

The EL participants did not reflect the MGL concerns or lack of knowledge of the organization's substance abuse policies. Managers and supervisors spoke to various aspects of the organization's policy but failed to articulate the total reporting process clearly. The MGL participants collectively voiced confusion regarding EAP and the referral process. This finding is in direct contrast with James (2013) and Pronovost and Wachter (2013) who found healthcare leaders who are confident in the reporting process are quicker to report substance-impairment and in so doing protect the patient and the organization. The act of reporting serves to expedite the needed intervention, care, and treatment needed by the impaired healthcare professional. One EL response reflected that substance impairment is not the only impairment to be concerned about and described concern for mental and emotional health. The managers and supervisors spoke to other concerns such as their need for being updated when new licensing board regulations occur or when laws regarding the substance-impairment change.

The executive leaders stated that substance-impairment policies were uniform and accessible to all staff. Four MGL participants explained that policies were electronically stored, sometimes difficult to access, and not always updated concurrently. I noted that organizational policies and medical policies regarding substance impairment were stored in separate locations and not readily accessible. Difficulty finding policies could be potentially challenging for managers and supervisors and potentially delay a manager's ability to intervene in dire situations. Any delay in reporting an impaired healthcare

professional in the workplace places jeopardizes patient safety and places an organization at legal and financial risk (Mar & Tingle, 2012).

The ELs responses recognized that prompt reporting is a necessary safeguard which assists in helping healthcare organizations maintain a safe practice environment, meet legal responsibilities, adhere to professional licensing boards, and prevent potential financial liability related to patient harm. Legal and ethical implications of reporting were discussed ten times by MGL and four by EL for a total of 14 times which was 20% of participant responses (see Table 6).

Table 6

The Frequency of Times Managerial Training on the Legal and Ethical Implications of Reporting Discussed

Participant ID	Times Discussed	% of Coverage
MGL1	2	20%
MGL5	2	18%
MGL10	3	22%
MGL17	2	39%
MGL22	1	42%
EL1	2	16%
EL2	1	12%
EL3	1	9%
Participants' equivalent percentage numbers	Total: 14	Average: 20%

Applications to Professional Practice

This study was an initial exploration of possible strategies that may be used by some healthcare leaders in hospital organizations to address the substance-impaired

healthcare professional in the workplace. The findings reveal the participants' perspectives on both the positive and negative aspects of their current policies and processes. Leaders of similarly sized healthcare organizations who read this research can be informed regarding the far-reaching considerations of substance impairment and specifically that of the impaired healthcare professional in the work environment. Ultimately, the reader may, because of this research, be better equipped to craft an optimal plan for the specific requirements and conditions of their organization. The finding indicates that healthcare leaders, to varying degrees, utilize numerous strategies to manage the substance-impaired healthcare professional. The findings document the need for the development of consistent and effective strategies for managing the impaired healthcare professional in the workplace. My research further indicates how healthcare leaders might inconsistently apply organizational policies related to knowledge deficits, experience, confidence, and subjective understanding. Management strategies identified in this study may assist healthcare leaders to prevent some financial and legal problems for their hospitals. Substance abuse does not discriminate. OSHA (2016) estimates drug costs to employers at $81-100 billion annually. The findings of my study may further benefit other industry leaders regarding workplace health and safety issues associated with worker impairment from alcohol and other drugs.

Implications for Social Change

The findings of this qualitative multiple case study could undergird positive social change by improving the dissonance of conflicting attitudes, beliefs or behaviors in managing the impaired healthcare professional. One role of healthcare leaders is to monitor and observe an individual's practice and to implement immediate intervention when performance fails to meet safe and effective patient care standards (O'Neil & Cadiz, 2014). Positive social change is a deliberate process of creating and applying strategies and actions to promote the worth, dignity, and development of individuals, communities, organizations, and institutions (Kinkle, 2015). The management strategies identified in this research might provide additional guidance to healthcare leaders as they direct the daily operations of a healthcare environment. Health reform conversation continues as incumbent healthcare leaders become better corporate citizens who affect positive change. The exploration of suggested strategies may allow healthcare leaders to promote a learning environment for elucidating strategies to manage the substance-impaired healthcare professionals in hospitals. Feelings of guilt, worthlessness, depression, and anxiety often result in impaired healthcare professionals leaving the workforce at a time when most hospitals are in critical need of these positions (O'Neil & Cadiz, 2014). Healthcare leaders who recognize the cascading ill-toward effects of substance impairment can promote positive social change by supporting the impaired provider's feelings of self-worth and dignity after treatment while ensuring a safe work environment for patients, employees and the community.

Recommendations for Action

The six important themes that emerged from this research include (a) selective application of policy, (b) managerial training on the indications of substance impairment, (c) monitoring and surveillance support, (d) reentry into work environment, (e) synergistic integration between work and life, and (f) legal and ethical implications of reporting. Each theme should be a managerial consideration when promulgating management strategies regarding the impaired healthcare professional in the workplace. Healthcare leaders have the responsibility to protect patients, to support staff and to maintain high standards of care throughout the organization (Berge et al., 2014; Georgiou, 2013). Many leaders are unaware of the number of healthcare professionals who are addicted and may practice while impaired by drug, alcohol or both (Goggans et al., 2013). EL1 stated:

> Substance-impaired nurses or doctors who perform patient care tasks in the workplaces are more prevalent than we appreciate. We are uncomfortable talking about it, so we compartmentalize it and foster unintentional harm to the impaired provider by not getting them appropriate intervention. We potentially place our patients in harm's way, compromise the organization credibility and risk the financial viability of our organization.

MGL6 described the following:

> I want to work in an environment that keeps me and my patients safe. I don't want to worry about the individuals I work with or oversee. If we have the right culture, good knowledge of policies, and leadership support, substance-impairment is less likely to occur. My role is important in helping to shape that culture.

After a thorough review of the current literature, I was unable to find previous studies which addressed the specific purpose of this research. Individuals participating in this topic affirmed the importance of improving current practice for managing the substance-impaired health care provider. Based on my initial study, I determined five strategies which to enhance current processes when managing substance-impaired healthcare providers in the workplace. The recommended strategies are intrinsic to the legal and ethical concepts of due diligence.

I recommend executive leaders act as change agents to develop a comprehensive strategy to address the problem of managing the impaired healthcare professional in the workplace. Defining a consistent business and comprehensive business model is critical to the successful revision of the fragmented process that exists today. Current practices can be subjective and open to interpretation depending on the work setting, leadership experience, and even the healthcare professional involved. Inconsistent processes pose considerable legal and ethical risks for healthcare organizations. Subsequent harm to patients would be difficult to defend if managers and supervisors were to point to the subjectivity of policy application. The challenge in locating policies and the lack of ongoing efforts to provide enough education regarding this topic is a serious deficit. A

lack of legitimately defined processes further predisposes an organization to operational and financial risks. The development of an all-inclusive, sustainable healthcare business model would incorporate, and be consistent with, the legal and ethical constructs of due diligence. A sustainable business model consists of generalizable policies and procedures and should mitigate confusion for healthcare leaders who manage substance-impaired healthcare professionals (Goggans, 2013). Organizations should consistently adhere to a reasonable, prudent practice of defined policy and procedures. Doing so readily positions the organization to defend itself in the event of untoward outcomes. A comprehensive business model would provide equitable, consistent application of practice for all healthcare professionals.

I suggest executive leaders ensure mandatory training and retraining of healthcare leaders on policies regarding recognition, indications, and symptoms of substance impairment and its manifestation in the workplace. Leaders, managers, and supervisors should be afforded regular and continual training and retraining to increase knowledge of risk factors. The information assists the healthcare leader to ensure transactions between patients and providers are appropriate and provided in a safe and efficacious manner. Again, this adheres to the legal and ethical principles of due diligence. Managers and supervisors often have the firsthand knowledge of healthcare professional's performance but may not always understand what to do about behavior indicative of substance-impairment. Executive leaders should ensure managers and supervisors receive an educational needs assessment to determine deficits in knowledge

and understanding of substance abuse, impairment, diversion activity, and related topics. Subsequent training would address any knowledge deficits to ensure managers and supervisors are competent and confident in all aspects of managing an impaired healthcare professional. Organizational healthcare leaders should obtain training and retraining regarding their legal and ethical responsibilities to customers, suppliers, employees, and communities as it relates to their social responsibility to stakeholders. All leaders should attend annual mandatory professional development ongoing training regarding substance impairment, diversion, addiction, and related subjects. Initial and ongoing licensure requirements should include the completion of continuing education hours regarding the substance impaired healthcare professional, recognition of signs and symptoms, and state-required reporting standards.

I recommend developing a comprehensive strategy for the provision of monitoring and surveillance resources which support the early detection and identification of substance abuse or diversion in the workplace as this is consistent with the legal and ethical aegis of due diligence. Leaders need to receive expedient feedback regarding narcotic discrepancies and information trended from these reports. My findings indicate that many times, managers and supervisors never receive information back from reports they submitted regarding discrepancies or diversion activity. Managers and supervisors cannot manage if they do not know the outcomes of submitted reports. Closing the feedback loop and giving information regarding relevant, current events increases the ability to manage daily operations and mitigate risk-exposure for the

organization. Leaders in organizations that can financially do so should incorporate current technology such as AI, retina or finger scanning which supports monitoring and surveillance processes as these systems provide synchronized institutional usage and access to narcotics. Reports generated from these systems should be disseminated to managers and supervisors. Managers and supervisors who are aware of medication administration discrepancies can supervise more affectively. Suspicious transactions should be investigated immediately to promote a culture of safety. Leaders should ensure managers and supervisors receive training related to accessing, interpreting and trending data from these systems. Managers and supervisors should receive ongoing training regarding appropriate narcotic storage, dispensing and disposal or waste procedures.

Healthcare professionals may be subject to a concomitant affect of the stress and caring for ill or injured people day after day. The provision of this subsequent stress may place them at risk for mental illness and substance abuse unless they have healthy coping mechanisms. The ethical principles of due diligence encourage leaders to carry out the legal and economic aspects of a business. I advise leaders to develop programs supportive of work and life integration Leaders who understand the demands healthcare professionals face during patient care transactions are positioned to create a caring, supportive culture throughout the organization. Leaders who establish well-being committees in the workplace help ensure support all employees, especially healthcare providers. Starr (2013) described how many leaders are unaware of the available resources such as EAP and ATD programs which may assist the impaired healthcare

professional to shift from workplace to treatment and experience positive reentry to the workplace after treatment. Healthcare leaders need to understand their role and responsibilities in confidently addressing an impaired colleague with knowledge and compassion. I suggest that monitoring and surveillance strategies support the early detection and identification of substance abuse or diversion. These strategies should define the responsibilities of the individual in recovery, the role of the manager or manager and supervisor, and the role of peers or colleagues and how to address a relapse after treatment. Leaders are to be afforded knowledge regarding other chemical assistance detox resources. Leaders need to have initial or basic information about potential financial assistance and other supportive measures which may assist the impaired colleague receiving treatment.

The development of clear protocols for intervention provides guidance as to when and how to intervene on behalf of an impaired healthcare professional. Researchers **(**Ejnes, 2014; Pham & Pronovost, 2014; Pham et al., 2013) explained how a lack of uniform protocols impedes the ability to report results in a failure to protect patients and the public. Without clearly defined reporting processes managers and supervisors are ill-equipped to intervene on behalf of the impaired healthcare professional. I propose the development of consistent reporting practices that conform to the legal and ethical standards defined by licensing boards, state regulations, and national standards of practice in relation to reporting practices. Reporting protocols must be fair, ethical and equitably applied to all regardless of their role. All levels of leadership should receive

training and retraining regarding the ethical and legal responsibility to report a co-worker who demonstrates behavior or physical symptoms indicative of substance impairment. Protocols must be actively communicated and disseminated to every level of leadership to ensure the promotion of a culture of safety (Paradiso, 2018). Preserving confidentiality in reporting of substance-impaired healthcare professionals is critical or employees who may be fear reprisal and hesitate to report.

Incorporating a drug reporting telephone line with a dedicated number is a fair innovation used by corporate compliance hotlines to support the anonymous ability to report. The managers and supervisors of this study demonstrated a lack of knowledge regarding standards, regulations, and requirements which mandate reporting drug diversion activity. Managers and supervisors were able to articulate internal reporting processes such as working with the human resource department. Managers and supervisors demonstrated a knowledge deficit regarding mandatory reporting to external agencies, I.E., state licensing boards, police, or the DEA. I suggest incorporating education regarding both internal and external mandatory reporting requirements into ongoing substance-impairment training for all healthcare leaders. Further, education and training effectiveness should be validated through pre and post-test processes and provide education and training on an ongoing basis. The proposed five strategies and implementation actions are summarized below in table 7:

Table 7

Recommended Strategies and Implementation Actions

Recommended strategies	Recommended implementation actions
Healthcare business model	• Assess and develop a sustainable healthcare business model to unify substance abuse practice; • Assess current business policies and practices regarding impaired providers; • Develop uniform and generalizable policies, procedures, and protocols; • Ensure all policies are accessible to all leaders always.
Healthcare leader training	• Increase awareness of risk factors: provide training and retraining on signs and symptoms of substance impairment inclusive of behavior and physical changes; • Increase managerial competence: perform a needs assessment with of managers and leaders to determine knowledge deficit, design and provide ongoing training to address deficits; • Implement mandatory professional development regarding substance impairment, diversion, addiction, and related subjects.
Monitoring and surveillance systems	• Investigate technology such as Artificial Intelligence (AI), eye or finger scanning that can detect institutional usage and patterns; ensure unique login and passwords when accessing medication dispensing cabinets; • Provide expedient feedback regarding discrepancy reports to lessen risk exposure.
Synergistic integration of work and life balance	• Participate in professional membership groups, such as licensing boards, PAC's or professional networks which provide the most current and relevant practice information; • Define the responsibilities of the individual in recovery, the role of the manager or manager and supervisor, and the role of peers or colleagues; • Ensure leaders know EAP, ATD, and other chemical assistance detox resources; • Provide knowledge regarding financial assistance and other supportive measures which may assist the impaired colleague receiving treatment;

	• Provide training regarding pharmacologic advancements to assist the return of addicted providers.
Legal and ethical of reporting	• Define clear protocols for when to intervene on behalf of an impaired healthcare professional. • Develop and actively communicate clear protocols for confidential reporting of substance-impaired healthcare professionals • Provide training regarding the ethical and legal responsibility to report a co-worker who demonstrates behavior or physical symptom indicative of substance impairment; • Incorporate a drug reporting line into corporate compliance hotlines to support the ability to keep reporting anonymous; • Provide education regarding standards, regulations, and requirements which mandate reporting drug diversion activity to external legal agencies, I.E., state licensing boards, police, DEA.

A copy of this study was sent to the senior leadership of the organization to inform them of my findings and recommendations. I shared the results of the study in educational forums with the managers and supervisors as deemed appropriate by the executive staff. Upon executive approval, a copy of the study will be sent to the corporate level and the new-business owners so that strategies may be appreciated and disseminated on a larger level. The study findings and recommendations are to be shared with other researchers both locally and across the nation in healthcare and non-healthcare sectors as the study may prove beneficial to an array of leaders irrespective of the setting. I intend to publish this study for the broader community with the assistance of my chair and institutional resources. Finally, I will publish the extant research in academic journals and professional business and healthcare publications.

Recommendations for Further Research

The study's limited size and scope require further research to explore reasons given as to why nurses, physicians, pharmacist, and other healthcare professionals continue to work while substance-impaired. Research is needed to examine how peer behavior may enable impaired providers (Bell et al., 2015). Staff members often make excuses to rationalize their colleague's behavior; they desire to protect him or her and are hesitant to be the whistleblower (Kinkle, 2015). Reporting the colleague can assist in protecting patient safety and in gaining help for the impaired colleague (McCulloh et al., 2015). Research by Cares et al. (2015) reflects the perspective of substance-abuse and addiction as a disease process. A growing body of research support the idea of treating substance-impairment with biologic or physiologic methods much like other diseases. Viewing the act of substance-impairment in the workplace as punishable crime is changing albeit suspension or loss of employment is still a standard outcome. EL3 stated that "some countries do not even report diversion to a regulatory board; however, in this country, we are severe in how we handle impaired providers." Both the MGL and the EL participants described that while many factors contribute to substance-impairment, the addicted provider must be accountable for their actions in the workplace. Miller et al. (2015) supported the stance that healthcare providers are accountable for their practice and the delivery of safe patient care. Finally, leaders should address the knowledge deficit that exist regarding how healthcare leaders deal with the significant implications of the impaired provider. I recommend in-depth research to understand how healthcare

leaders manage the impaired healthcare professional in the workplace and to ameliorate organizational effect.

Reflections

The impetus for this study grew out of my 25-plus year of healthcare leadership in an array of public and private healthcare environments. I witnessed firsthand the leader inconsistencies in managing impaired healthcare providers. My lack of knowledge allowed me to make mistakes and errors of omission in assessing and managing substance-impaired healthcare professionals. I desire to improve my understanding of the varying practice and processes which exist and if possible to determine if singular, consistent processes or strategies could reduce incongruencies in the management of impaired healthcare providers regardless of their professions in the workplace. Also, policies vary from organization to organization and from state to state. Unified processes could potentially provide a more effective process for healthcare leaders who manage impaired healthcare professionals.

As I started researching the organization's documents and conducting my survey questionnaires and interviews for this study, I quickly found I was the first one to explore this specific subject. Additionally, while due diligence is a term often used in the business realm, I did not see any previous application to the business of healthcare and leadership. This study required a varied amount of knowledge and experience in the healthcare field as a leader and as a provider. My unique skill set afforded me the opportunity to

constructively communicate with organizational leaders on both the executive level and the management leaders who are "in the trenches." I had to obtain authorization to conduct the study at the corporate level and the organizational level; the Walden University IRB and the health business corporate compliance office. I came to understand that this study could have broader implications beyond healthcare leaders. In the words of EL3, "this is a bigger conversation than chemical impairment in healthcare since impairment can manifest in other business milieus."

I additionally recognized that impairment could present in other destructive ways. While we care for others, we are not always a very healthy profession. Indeed, one leader asked me "how do you define impairment? Does this study address social media addiction which can affect work environments or dependence on highly-caffeinated drinks such Red Bull which is readily used to help stay awake during long shifts or the taking of multiple smoke breaks and so forth?" I explained the succinct parameters of this study while acknowledging the opportunity for future research.

Furthermore, I had to understand the topic and be comfortable exploring a subject that is sometimes not openly acknowledged by healthcare leadership. I had to know the appropriate questions to ask, as well as how to present those questions. My professional alliances and credibility, and my knowledge of professional licensing requirements and accrediting agencies afforded me the opportunity to research two diverse groups using multiple data collection methods.

The Doctor of Business Administration (DBA) academic process was far different than I anticipated. I did not appreciate the challenges such as the amount of time and effort required. My topic evolved throughout feedback from my chair, my professional colleagues and the exploration of my concept of due diligence. Even my community partner experienced a change. One week before my Walden IRB approval, the hospital site was sold resulting in a restructuring of several leadership positions. With these changes, the ability to perform my study became even tenuous and required renegotiating my research request with new leaders. My entire DBA program proved a significant learning opportunity requiring fortitude and flexibility.

Conclusion

"It always seems impossible, until it's done" (Mandela, 2011). Corporations have accountability to those groups, individuals, and stakeholders that they can affect. Corporate social responsibility is germane for healthcare leaders as most consumers and job seekers consider how businesses deal with their environmental, social and economic effect. Today's consumers demand high-quality products and services. Given the sheer size and power of most healthcare organizations, healthcare leaders have an enormous capacity to influence initiatives positively, policies, and practices which inherently align with the mission of the healthcare industry.

Based on the research data, healthcare professionals are not immune to the growing opioid crisis (Rundio, 2013). The specific business problem is that some

healthcare leaders may lack management strategies to address the substance-impaired healthcare professional in the hospital setting. This study was framed through the conceptual lens of due diligence as it applies to organizations who seek to provide a safe and effective workplace (Starr, 2015). The concept of due diligence provided both a legal concept and an ethical concept (Starr, 2015). Based on the analysis of data, I presented five strategies that healthcare leaders may use to address and manage the impaired healthcare provider in the workplace.

Healthcare leaders who govern with honesty and transparency recognize the serious implications of the impaired healthcare professional in the workplace. By developing and implementing one or all five recommended strategies, healthcare leaders may be more successful in reducing the variation in strategy application that currently exists. Virtually every member of the community could experience a healthcare need at some point in their life. Leaders are charged to promote a positive effect on community, social and environmental wellbeing. The recommendations of this research present a supportive platform for healthcare leaders who manage impaired healthcare professionals in the workplace. Healthcare leaders can positively influence the conflicting attitude, belief, and practice regarding the impaired healthcare professional. This research can have a direct impact on the creation of safer work environments for employees and patients and the reduction of legal and financial culpability throughout healthcare organizations.

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Appendix A: E-mail Manager Supervisor

Letter of Request to Participate in the Survey Questionnaire

Date:

Dear Healthcare Leader:

My name is Anna Smith, and I am a doctoral candidate at Walden University. I am working towards completing my Doctorate in Business Administration degree in healthcare. I am conducting a doctoral research study on management strategies used by some healthcare leaders who supervise substance-impaired healthcare professionals in daily operations.

Because of your success and experience in the healthcare field, I invite you to participate in an internet-based survey questionnaire. The survey questionnaire regarding the substance-impaired healthcare professional in the work environment requires about 20 minutes or less to complete.

This study will not afford any monetary compensation for your participation. For participation in the study, you may receive a summary of the findings, which will allow you to learn innovative best practices and possibly assist in the management of substance-impaired healthcare professionals.

Thank you for your consideration in participating and helping me to complete this study. Your contribution and expertise can make a significant contribution to academic research industry standards. If you have any questions, please feel free to call me at _____

Best regards

Appendix A: E-mail Letter of Request to Participate

Executive Leader Interview

Date:

Dear Healthcare Leader:

My name is Anna Smith, and I am a doctoral candidate at Walden University. I am working towards completing my Doctorate in Business Administration degree in healthcare. I am conducting a doctoral research study on management strategies used by some healthcare leaders who supervise substance-impaired healthcare professionals in daily operations.

Because of your success and experience in the healthcare field, I invite you to participate in an individual interview for about 60 minutes or less regarding the substance-impaired healthcare professional in the work environment. Throughout the interview, you will have the opportunity to review and clarify responses which may increase the interview time.

This study will not afford any monetary compensation for your participation. For participation in the study, you may receive a summary of the findings, which will allow you to learn innovative best practices and possibly assist in the management of substance-impaired healthcare professionals.

Thank you for consideration for participating and helping me to complete this study. Your contribution and expertise can make a significant contribution to academic research industry standards. If you have any questions, please feel free to call me at _____. If you agree to participate, I will contact you to arrange and schedule interview times.

Best regards,

Appendix B: Manager and Supervisor Leader Survey Questionnaire

These are the questions administered in a survey questionnaire format to at least 40 leaders in the organization who supervise healthcare professionals in daily operations:

1. What management strategies do you use when addressing the known or suspected to be impaired healthcare professional?
2. Describe how you prepared as a leader regarding your organization's management strategies regarding the substance-impaired healthcare professional?
3. Describe the management strategy or process for drug testing the suspected impaired healthcare professional in your organization who is actively providing patient care?
4. What management strategies do you use to support a healthcare professional enrolled in a substance abuse recovery program?
5. What management strategies do you use to monitor a substance-impaired healthcare professional returning to the work environment?
6. What additional information would you like to add?

Appendix C: Executive Leader Interview Protocol and Interview Questions

Leader Interview Protocol

The interview protocol addresses both the interview questions and the interview procedures. The open-ended interview questions support additional inquiry as indicated and help enable a thorough understanding of the participants lived experiences regarding management strategies used to identify and address substance-impaired healthcare professional in the workplace. Procedurally, the interview protocol includes a script of what will be said before each interview, a script for the conclusion of the interview, how to collect informed consent, and prompts to assist the interviewer in gathering the information of interest. It includes instructions concerning the reading of the questions, how to conclude the interview, and how to deliver an appropriate thank-you statement at the end of the interview. The interview protocol thus forms a procedural guide for conducting qualitative research throughout the interview process.

Institution: _____

Interviewee Number (Title and Name): _____

Interviewer:

Introductory Process

Thank you for your agreeing to participate.

This is the informed consent document devised to meet our human subject requirements. The form explains aspects of your participation including: information is confidential, your participation is voluntary, and you may stop at any time if you feel uncomfortable, and no intended harm or injury will occur.

Please read the informed consent document. Please keep a copy for your files.

As stated in the informed consent document the interview will be audiotaped. You may observe me taking notes during the interview; the notes facilitate my later recall and are used in conjunction with the recorded information. Only I will be privy to the tapes and notes which will be transcribed for my research.

The interview will last approximately 60 minutes. During this time, I will ask you five questions in a one-on-one confidential interview environment, as specified in the executive leader informed consent. I will pace our time together to provide optimal response time to the questions. I will periodically repeat or clarify your responses and allow you to share information to enhance understanding of your responses during or after the completion of the interview. This process known as member checking may add 30 minutes to the interview timeframe.

Explanation to Executive Leader Participant of Research Study

You were selected to speak with me today because of being identified as an individual within the organization with at least two years of executive leadership experience in healthcare. You may have specific insights to share regarding this topic.

My research topic seeks to explore the experience of healthcare leaders regarding strategies used by some healthcare leaders to manage the substance-impaired healthcare professional. My interest is to explore how leaders identify and address the substance-impaired healthcare professional in the workplace. My study does not aim to evaluate techniques or experiences. Rather, the goal is to explore management strategies and to learn how leaders affect healthcare practice hopefully.

Interviewee Background:

How long have you been in your present position at this institution_____?

How many total years of experience do you have at the executive level _____ _?

Briefly describe your role or responsibilities as it relates to your executive leadership position

_____?

Briefly describe your responsibilities for the delivery of safe and effective patient care in daily operations_____.

What motivates you to use innovative techniques or strategies in performance of your role_____?

Interview Questions for Executive Leader Participants

I will use the following questions to interview three executive leaders within the healthcare organization. Questions will explore the executive leader's knowledge of management strategies related to policy and procedure, education, practice, identification and assessment of the substance-impaired nurse or physician. The executive leader will hold the position of vice president, chief medical officer, or chief nursing officer as defined by the job description and must have at least two years of executive level experience.

1. What management strategies address the substance-impaired healthcare professional in the work environment?
2. What are the methods used for educating managers and supervisors on strategies to address the impaired healthcare professional?
3. What strategies are used to manage reentry into practice for healthcare professionals after completing a substance impairment treatment program?
4. What additional information would you like to add?
5. Post Interview Comments and Observations:

Closure- Thank the participant. Answer any questions regarding a study they may have.

Date: _____ Time: _____

Appendix D: Descriptive Codes and Nodes

I performed a cursory aggregation using initial descriptive codes to analyze the data (Yin, 2018). The initial descriptive codes were extracted from my conceptual framework and my literature review. Based on the pattern of the data sets I extrapolated nodes and key themes. The initial descriptive codes are competence, consistent processes, culture, education, standards, and reentry.

Competence: A high-level of the knowledge, abilities, and judgment (ANA, 2014).

Consistent Processes: A required element of the process in agreement with other facts or with typical or previous behavior (AMA, 2017).

Culture of Safety: Ethical and transparent culture of safety supportive of patient care; the sum of what hospitals do in the pursuit to protect patients (Cook, 2013).

Documents: Written, printed or electronic materials furnishing information or evidence of a legal or official process (Earley, 2014).

Education/ Training/ Experience: Provision of general knowledge, instruction, training, or study; imparting information and/or instructions to improve the recipient's performance (Bana,2014).

Standards/ Practice: Healthcare leaders govern the principles, ethics, and operations of the business, inclusive of healthcare professionals, who practice in

their organization. To evaluate, investigate, and monitor the competence, capacity, and expertise of the healthcare professional (AMA, 2017).

Reentry/ Practice: Factors include establishing back-to-work contracts random drug testing, requiring regular attendance at support meetings and restriction from patient care for determined timeframes (Valdes, 2014).