ORIGINAL ARTICLE

Nurses' substance use disorder in disciplinary procedures: A retrospective document analysis

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Abstract

Aim and objectives: To describe nurses with substance use disorder (SUD) in authority disciplinary actions.

Background: Nurses with SUD risk patient safety. Research evidence on the identification of nurses' SUD and related management procedures is currently sparse.

Design: Retrospective document analysis of decisions related to SUD in nurses' disciplinary actions.

Method: Decisions on nurses ($N = 171$) made by the Finnish National Supervisory Authority for Welfare and Health in Finland during 2007–2016 were used as data. An electronic extraction sheet was developed for data collection including variables ($N = 34$), of which 18 were analysed in this study with descriptive statistical methods and chi-squared statistics. The study reported in accordance with the STROBE checklist for cross-sectional studies.

Results: The mean age of the nurses was 43 years (SD 8.7). The most mentioned reasons for notifications leading to disciplinary actions were substance abuse with working while intoxicated and drug theft. The most mentioned intoxicants used were medicines and alcohol. On average, the first disciplinary decision was given at 6.4 months (SD 3.9) and the final decision was given at 17.9 months (SD 13.1). The most common decision was restriction of the right to practice.

Conclusion: The results supported findings from previous decades and different continents, showing similar trends are prevalent globally and continue today. In future studies, countries' registers of nurses with SUD could be used to clarify the profile of nurses and develop appropriate procedures. Qualitative studies could be conducted to investigate to shed light on concealment of the phenomenon.

Relevance to clinical practice: There is a need for early identification, intervention and referral to treatment as well as effective protocols for reducing nurses' risks of disciplinary actions related to SUD. It is important to be aware of the signs and symptoms of SUD and training for this is needed.

KEYWORDS
employee discipline, nurses, patient safety, risk management, substance-related disorder

1 | INTRODUCTION

Substance use disorder (SUD) has been shown to have both short- and long-term influences on nurses' health, presence and safe work performance, jeopardising patient safety and the quality of care (Kunyk et al., 2016). It harms the reputation of the nursing profession and reduces the trust in the health care system (Matthias-Anderson & Yurkovich, 2016). Therefore, early identification of SUD is important.

SUD refers to substance abuse and dependence caused by various substances (Robinson & Adinoff, 2016). It manifests as behavioural signs, physical symptoms and diversion behaviours (Alunni-Kinkle, 2015) with multifactorial pathogenesis or reasons (Dittman, 2008; Toney-Butler & Debra, 2022). Individual nurses are responsible for their ability to work (ICN, 2021), but organisational protocols are necessary for the identification and intervention of recognised risks or adverse events (Bettinardi-Angres & Bologeorges, 2011). In addition, disciplinary authorities are responsible for investigating the most severe cases (Cronquist, 2013). Violations related to nurses SUD have been shown to be a leading background factor in disciplinary investigations (Dahn et al., 2014; Hudson & Droppers, 2011; Morelock, 2017). However, little is known about how nurses' SUD is identified in organisations and what kind of nursing management procedures are carried out in disciplinary investigations of it.

2 | BACKGROUND

The prevalence of SUD has been estimated to range from 5%–20% among the nursing population (Mumba & Kraemer, 2019). Nurses' SUD has been reported to occur at the same level as the general population (Kunyk, 2015). SUD has been connected to substance use already in nurse degree education (Boulton & O'Connell, 2017).

Nurse peers have a key role in reporting impaired practice and professional misconduct, with an ethical duty to take appropriate action (Alunni-Kinkle, 2015; ICN, 2021). Colleagues confronting SUD issues have found this to be challenging, but confidential reporting with clear protocols helps nurse peers in early detection and intervention (Bettinardi-Angres & Bologeorges, 2011). Nurse leaders have responsibility to intervene early to signs of nurse employees' SUD (Alunni-Kinkle, 2015). However, they need knowledge to recognise nurses' SUD, as well as to educate other staff about signs of it. Written policies regarding managing SUD in the workplace are essential to define protocols for early identification, intervention and referral to treatment (Bettinardi-Angres & Bologeorges, 2011). If procedures in the workplace are sufficient, cases are referred to the supervisory authority, which investigates cases with hearing procedures, culminating in a decision with disciplinary outcomes (Brous, 2012). Disciplinary decisions may include revocation, suspension, probation, censure, limitations, monetary fines and negative action such as reporting as the statutory grounds of discipline (Eisenmann, 2020).

At international level, approximately 0.5% (Azuri et al., 2014; Kunyk & Deschenes, 2019) to 2% of nurses are disciplined annually (Dahn et al., 2014). SUD is one of the main reasons for disciplinary actions towards nurses together with patient integrity violations, nursing

What does this paper contribute to the wider global clinical community?

- Study provides a description of registered nurses (RNs) with substance use disorder (SUD)-related violations in a Nordic country based on national regulatory authority disciplinary decisions. Earlier studies of RN disciplinary actions have mainly been conducted outside of Europe in northern America and Australia, and they have focused on nurses' violations, disciplinary procedures and recidivism. Most of them are from a previous decade. They do not provide knowledge of the factors that characterise nurses with SUD.

- The study produces new knowledge and updates previous knowledge. Results support earlier findings of disciplined nurses from previous decades and different continents, showing that similar effects are prevalent globally and still apply today. Results can be used in the development of effective protocols for early identification, intervention and referral to treatment among nurses with SUD.

process mistakes and nursing incompetence (Papinaho et al., 2019). The majority of studies were conducted in North America (Davis et al., 2014; Kunyk & Deschenes, 2019) and Australia (Chiarella & Adrian, 2014). In previous studies, nurses' SUD and drug-related violations were described as improper handling of drugs, such as writing illegal or unauthorised prescriptions, dispensing or administering medications and diversion of controlled substances (Dahn et al., 2014; Kenward, 2008). In addition, nurses have been found to have taken drugs with patients (Chiarella & Adrian, 2014), carried out the sale of drugs (Kenward, 2008) and driven under the influence of drugs (Zhong et al., 2009). The average age of nurses with SUD requiring a disciplinary process has been shown to vary from 40 (Kenward, 2008)–50 years (Hudson & Droppers, 2011). Male nurses are disproportionately disciplined more often than female nurses (Hudson & Droppers, 2011; Kenward, 2008; Zhong et al., 2009). A history of criminal conviction has been shown to be related to recidivism in SUD-related violations (Davis et al., 2014; Waneka et al., 2011; Zhong et al., 2009).

Previous studies have mainly focused on nurses' violations, disciplinary procedures and recidivism (Papinaho et al., 2019). There is a need for further knowledge of the factors that characterise nurses with SUD in disciplinary processes to strengthen early intervention methods in nursing leadership. To the best of our knowledge, this is the first study in a Nordic country focusing on registered nurses (RNs) with SUD-related violations as the main reason for disciplinary procedures providing descriptive information of these nurses.

3 | AIM

The aim of this study was to describe Finnish RNs with SUD in authority disciplinary actions. Such knowledge is needed to develop methods

for early recognition of SUD for nursing supervisors and the work community.

The main research questions were as follows:

1. What information is documented about the educational and professional history of nurses with SUD?
2. What kind of drugs do nurses with SUD use and how is the disorder manifested in the workplace?
3. What are the violations for notifications and disciplinary decisions of nurses with SUD?

4 | METHOD

4.1 | Design

This study was a descriptive, retrospective document analysis (Bowen, 2009) using decision documents of RNs who received disciplinary actions for SUD.

4.2 | Research context

In Finland, professionals working as RNs ($n = 73500$; Finnish Nurses Association) are supervised regionally by regional government agencies and nationwide by the National Supervisory Authority for Welfare and Health (Valvira) which operates under the Ministry of Social Affairs and Health. Valvira has a wide right of access to information and documents concerning the investigated healthcare professional and their professional activities. These documents include case notifications, reports from the professional's workplaces and healthcare giver, reports of medications prescribed for the professional and by whom, determination of the professional capacity and state of health or skills, and the professional's own explanation and hearing statement (National Supervisory Authority for Welfare & Health, 2019, 2021).

The Supervisory Board of Social and Health Care Professionals in Valvira deals with and decides on matters concerning the restriction and loss of right to practice, revocation of a licence and prohibition of the use of a professional title, as well as matters concerning the recovery of the right to practice, right to use a professional title and items of discipline (National Supervisory Authority for Welfare & Health, 2016). The number of decisions the board made regarding nursing professionals increased from year 2009 ($n = 38$)–2014 ($n = 119$). In subsequent years, the number of decisions was around 100 and was 108 in 2018 (National Supervisory Authority for Welfare & Health, 2020).

4.3 | Data collection

Data for this study were obtained from registers of Valvira. Inclusion criteria of disciplinary decisions of Valvira regarding RNs for this study were as follows: 1) the nurse had a registered nurse degree, and 2) the case related to SUD. In this study, information from decision papers from 1 January 2007–31 December 2016 was used. The study was the first phase of a larger follow-up study, which aims to analyse National Supervisory Authority's documents retrospectively every ten years. All the disciplinary decisions related to substance use disorder of nurses were included in this study. The disciplinary decision files were non-electronic, including the complaint or notification and investigation and decisions papers. In this study, we used information from decision papers and, where necessary, explanatory documents to clarify the content. The number of documents/nurse in this study varied between 1–47 (mean 14 documents).

An electronic extraction sheet, based on previous research (Cares et al., 2015; Kunyk, 2015; Wright et al., 2012) and in discussion with experts in Valvira, was developed to collect the data. In total, 34 items with open fields were used to record the data. Information on each RN's disciplinary decision was entered into the extraction sheet manually. If an RN had received several decisions, information from all of them was collected in the record. The extraction sheet was modified by clarifying items after handling four decisions and again after 23 decisions to better suit data collection. The utility of the electronic extraction sheet was tested and confirmed in a pilot study conducted on the decisions ($n = 68$).

In total, 324 decisions regarding 204 RNs were entered in the extraction sheet by three researchers. Of these RNs, 171 (83.8%) had decisions related to SUD and their background and status factors, professional status and history, education and educational history, use of drugs and manifestation in the workplace, and disciplinary decisions were analysed in this study.

4.4 | Analysis

Descriptive analyses were used and included crude numbers (n) and frequencies (%). Chi-squared statistics were used to evaluate relationships between categorical variables. To examine differences in continuous variables between two groups, independent sample t-tests were used. A P-value ≤ 0.05 was set as significant. IBM SPSS v.27.0 (New York, USA) was used for the analyses. The study reported according to STROBE guidelines for cross-sectional studies (File S1).

4.5 | Ethical considerations

The study was conducted according to the ethical principles of research (ALLEA, 2017) according to Finnish legislation (Act on the Openness of Government Activities, 1999; Data Protection Act, 2018). The permission for data collection was granted by National Supervisory Authority for Welfare and Health (Valvira), and with this type of documentary data, the ethical review statement is not needed (Finnish National Board on Research Integrity, 2019). The researchers committed with a non-disclosure agreement and research-related data protection guidelines issued by Valvira.

Confidential and sensitive material was processed only in situ at the premises of Valvira at pre-agreed times. The documents were

not scanned or copied, but the data were read, selected and written into the electronic extraction sheet on a computer. The decision files were submitted from archive to the researchers by a representant of the supervisory authority according to a preliminary plan. Data for the electronic extraction sheet were gathered by anonymising all identification information, including the subjects, which were assigned numbered codes. The collected data were stored on an encrypted external storage that was kept in a locked state. Disposal of the data followed Valvira´s instructions.

5 | RESULTS

In total, 171 RN disciplinary decisions related to substance abuse were analysed. The majority of nurses (81%) were women. The mean age of the nurses at the time of the decisions was 43 years (SD 8.7). Most of them were nurse employees (85%), worked in the health care sector (72%) and a public organisation (77%). The most common working specialty was older care and nursing homes (21%). However, the specialties in hospital were most often mentioned as the employment setting. Over half (53%) the nurses had a current criminal proceeding relating to the current disciplinary process or another reason being dealt with at the same time. Some of the nurses had a criminal history (19%). Of the nurses, 24% had been diagnosed with mental health problem and 11% with SUD. Almost half (46%) of the nurses had been diagnosed with both a mental health problem and SUD (Table 1).

5.1 | Nurses' educational and professional history

Over half (62%) of the nurses had a nursing degree alone. Of the nurses, 23% had an additional vocational degree. Problems during nursing school were not commonly mentioned in the decisions. Over half of the nurses (57%) had a work history of two or more employers. The mean duration of employment contract with the current employer was 5.3 years (SD = 7.8 years). Thirteen per cent of nurses had previously been a subject of a disciplinary procedure (Table 2).

5.2 | Nurses' intoxicant use and its manifestation in the workplace

Nurses used the following intoxicants: medicines (51%), alcohol (25%) or a combination of both (18%). The intoxicant use manifested in the workplace as working while intoxicated (47%), drug theft (37%) and a change in behaviour (13%; Table 3).

5.3 | Reasons for notifications and the disciplinary decisions

Several reasons for the notifications received by nurses were documented. The most mentioned reasons were substance abuse with

working while intoxicated and drug theft. The neglect of tasks, working hours and instructions also received several mentions (Table 4).

TABLE 1 Background characteristics of nurses ($n = 171$)[a]

	Mean (SD)	*n*	%
Age, years	42.9 (8.7)		
<35		36	21.3
35–44		55	32.5
45–54		60	35.5
≥55		18	10.7
Gender			
Women		139	81.3
Men		32	18.7
Occupation			
Nurse		146	85.4
Head nurse		14	8.2
Organisation			
Public		131	76.6
Private		36	21.1
Sector			
Health care		113	71.5
Social services		45	28.5
Specialisation			
Primary care		21	12.3
Older care and nursing homes		35	20.5
Cancer and internal medicine, surgery		25	14.6
Mental health, substance abuse treatment		17	9.9
Maternity, women, children		14	8.2
Emergency care, intensive care, anaesthesia		28	16.4
Criminal history			
Yes		32	18.7
No		139	81.3
Current criminal proceeding			
Yes		90	52.6
No		81	47.4
Diagnoses			
Mental health		41	24.0
SUD		18	10.5
Mental health and SUD		78	45.6
Neurological		3	1.8
Musculoskeletal		6	3.5

[a]If a variable contained a class 'other' or 'not mentioned', these were not reported.

TABLE 2 Educational and professional history of nurses (n = 171)

	Mean (SD)	n	%
Qualification			
Nurse		106	62.0
Nurse and vocational degree		40	23.4
Nurse and midwife or public health nurse or other		25	14.6
Problems during nursing school			
Yes		7	4.1
No		164	95.9
Duration of current employment contract, years	5.3 (7.8)		
<1		63	38.9
1–5		48	29.6
>5		51	31.5
Working history			
1 employer		50	36.8
2 or more employers		77	56.6
Temporary agency work		9	6.6
Previous disciplinary processes			
Yes		22	12.9
No		149	87.1

TABLE 3 Nurses' intoxicant use and the manifestation of intoxicant use at the workplace

	n	%
Intoxicant[a]		
Medicines[b]	89	50.9
Alcohol	43	25.1
Alcohol and medicines	28	17.5
Alcohol, medicines and drugs	5	2.9
Medicines and drugs	3	1.8
Alcohol and drugs	2	1.2
Drugs[c]	1	0.6
Manifestation at the workplace[a]		
Working while intoxicated	71	46.8
Drug theft	56	36.8
Disorganised or tired or strange behaviour	19	12.5
Omission of duties or shifts	6	3.9

[a]Several mentions per nurse possible.
[b]Medicines affecting the central nervous system and analgesics.
[c]Cannabis, amphetamine, heroin or ecstasy.

Nurses had on average 1.8 reasons for notifications (SD 1.1); 75 nurses (44%) had one reason documented, 57 (33%) had two reasons documented; and 39 (23%) had three or more reasons documented.

A total of 275 disciplinary decisions were given to nurses (Table 5). On average, the first decision was given at 6.4 months (SD 3.9) and the final decision was given at 17.9 months (SD 13.1). The most common decision regarded restriction of the right to practice.

Nurses with a previous disciplinary process (n = 22) did not have significantly different current decisions compared to nurses without previous processes. Nurses who had undergone a previous disciplinary process had shorter processing times (mean 15.0 months) compared to nurses without a previous process (mean 18.3 months). However, the difference was not statistically significant. Nurses with a criminal history had slightly longer processing times (mean 19.6 months) than nurses without a criminal history (mean 17.4 months). Nurses with a criminal history had most often prohibition to practice as a disciplinary decision (47%). However, the decisions did not differ significantly from those of nurses without a criminal history.

6 | DISCUSSION

Earlier studies of RN disciplinary actions have mainly been conducted in northern America and Australia and they have not focused on RNs with only SUD-related violations. Most of the studies are from a previous decade. Our study provides a description of RNs with SUD related violations in a Nordic country based on national regulatory authority disciplinary decisions, updates previous knowledge of the phenomena and provides new knowledge. Although research evidence of some personal and working characteristics of nurses with SUD has accumulated globally, this has not led to the research-based development of early identification and intervention methods. Different countries have different registers of nurses with SUD, and these could be used more thoroughly to clarify the profile of nurses with SUD and to identify ways to develop evidence-based interventions and protocols in workplaces.

TABLE 4 Reasons for notifications (n = 328)

	n	%
Reasons[a]		
Substance abuse and working while intoxicated	124	72.5
Drug theft	90	52.6
Neglecting duties, working hours and instructions	54	31.6
Inappropriate behaviour at work	24	14.0
Forged patient records	13	7.6
Lack of professional skills	9	5.3
Decreased work ability	8	4.7
Failure to follow a restriction of the right to practice and duty to report	4	2.4
Risking patient safety	2	1.2

[a]Several mentions per nurse possible.

TABLE 5 Disciplinary decisions (*n* = 275)

	n	%
Disciplinary decisions[a]		
Restriction of the right to practice	72	42.1
Prohibition to practice a profession	65	38.0
Written warning	59	34.5
Removal of professional rights	49	28.7
Duty to report to the National Supervisory Authority for Welfare and Health	30	17.5

[a]Several mentions per nurse possible.

The study found that there were relatively more men than women in disciplined nurses compared to the general nursing population in Finland being in line with previous studies (Chiarella & Adrian, 2014; Hudson & Droppers, 2011; Kenward, 2008). The average age of disciplined RNs was slightly over forty, which was similar to the average age of the Finnish RN population and that found in previous studies of disciplined nursing professionals (Kenward, 2008; Zhong et al., 2009). The manifestation of SUD at work within middle-aged nursing professionals mirrors the severity of the disease, which might continue for years before emerging as signs in the workplace. This may be because of poor tools and processes for the early identification of the problem in the workplaces. Research is needed of persons with SUD history to identify patterns of concealing behaviour. It is also important to explore how work communities and nurse leaders respond to concerns of SUD in order to develop tools to support early identification.

Working while intoxicated puts patients at risk and impairs collaboration with co-workers. Drug diversion may lead to a patient's inadequate treatment of pain and cause drug confusion (Alunni-Kinkle, 2015). Knowledge of chemical dependence is needed to identify, intervene and refer to assessment and treatment at the earliest possible stage. Use of drug and alcohol screening that provide objective information, in addition to subjective interpretation of intoxicated behaviour, could facilitate intervention. According to this study final disciplinary decisions were on average given at one and half years. The length of processing time affects not only the RNs themselves but also their work communities. If the RNs are not dismissed, it increases the uncertainty and concern about employee's future among nurse leaders and peers. In the absence of temporary disciplinary decisions, there is a risk that RNs may continue to compromise patient safety. Further studies are needed to identify the most supportive and non-stigmatising practices during the processing time from notification to decision.

Over half of the disciplined RNs had two or more employers in their working history. Frequent job changes could be a sign of chemical dependence requiring closer monitoring (Bettinardi-Angres & Bologeorges, 2011). In the studied RN population, one third of nurses had a current employment contract of under one year. However, about five years was the average time in the workplace when disciplinary processes began. In the preceding years, nurses

with SUD may daily threaten patient safety and the quality of nursing. Although nurses with SUD represent a marginal group, their behaviour may daily affect numerous patients, co-workers and leaders. Thus, the problem may have severe consequences. The length of time when SUD remains unnoticed illustrates the challenges in identifying, addressing and intervening in this disorder.

Half of RNs in this study had a current criminal proceeding and 19% of RNs had a criminal history, which was overrepresented compared to the proportion of Finnish healthcare professionals having a criminal record. Having a history of criminal conviction has been shown to be a risk factor for recidivism (Davis et al., 2014; Zhong et al., 2009). It is important to support SUD recovery with person targeted methods and develop effective monitoring protocols to reduce the risk of recidivism.

Having a previous disciplinary process did not differentiate the decisions compared to RNs without a previous process, but it was connected to shorter processing times. RNs with a criminal history had slightly longer processing times than RNs without a criminal history. In comparison, Azuri et al. (2014) described an average time from complaint to resolution as about two years, and Clevette et al. (2007) concluded that nurses with a prior criminal conviction were disciplined sooner than nurses without.

Most often, disciplined RNs worked in healthcare settings in hospitals, consistent with the findings of previous studies (Azuri et al., 2014; Davis et al., 2014; Hester et al., 2011). Nurses' substance use varies between specialties and has been found to be highest in oncology, adult critical care and emergency units (Trinkoff & Storr, 1998), which mirror the specialties of RNs with SUD in the present study. These specialties may be highly stressful and have good availability of drugs, which are risk factors of SUD (Darbro & Malliarakis, 2012). However, in our study, the most common working specialties of RNs with SUD were older care and nursing homes, where notifications for inappropriate behaviour were given. These specialty areas have been found to have an increased prevalence of SUD among nurses (Mumba & Kraemer, 2019). Vulnerable patients and a lack of close supervision of daily work may make it difficult for nurse peers and nurse leaders to monitor and identify signs of SUD as well as address it at an early stage. However, it was reassuring in this study that the working communities in older care were sensitive enough to intervene when inappropriate behaviour could cause harm to patients. It is important to be aware of the behavioural signs of SUD that may lead to misconduct and endanger patient safety. Peers should have courage to speak up and report those signs. However, this requires knowledge of the signs of SUD, which is achieved through training.

In this study, 24% of RNs had mental health related diagnoses and almost half of the nurses had SUD and mental health problems at the same time. This result is in line with previous findings, which showed that mental illnesses are associated with an increase of co-occurring SUD (Drake et al., 2007). Thus, these RNs may have had a relationship with healthcare services that could have identified SUD and prevented them from working under the influence of substances.

The effect of SUD on work ability should be identified. Risks of working under the influence of drugs or alcohol should be discussed with nurses when assessing work ability. Further research is needed to assess whether RNs with SUD have sufficient assessments, which are the best interventions to support work ability, and how the collaboration with superiors can be supported in these cases.

A quarter of RNs in this study had an additional vocational degree, such as Licensed Practical Nurse, Midwife or Public Health Nurse. This was four time higher than in previous studies (Kenward, 2008; Zhong et al., 2016). Supervisors were marginal in this data. Problems during nursing school were not commonly mentioned in Valvira's decisions in this study. It is still worth noting that nurse students with a criminal history, including substance related violations, are more likely to engage in subsequent professional misconduct (Smith, 2013). Evaluations and treatments for substance abuse in nursing school should be documented for use after graduation to examine possible SUD-related violations at work (Averette, 2020).

7 | STRENGTHS AND LIMITATIONS

The involvement of several data collectors may affect the reliability of the data. However, the researchers of the present study had opportunity to discuss choices in a timely manner and to make decisions together on the content to be congruent. Although document analysis can include quantitative and qualitative components (Dalglish et al., 2020), the diversity of the data made it difficult to select relevant content for the extraction matrix, particularly when the documentation related to decisions that were not strictly structured and included lot of pages on each research subject. Documents were prepared by various officials to inform decisions and not for research purposes. However, the data could be considered reliable because it contained information from diverse legally eligible documents.

8 | CONCLUSION

We examined RNs disciplinary decisions related to SUD with background factors, professional status and history, education and educational history, use of drugs and its manifestation in the workplace. The results of this study support earlier findings of disciplined nurses from previous decades and different continents, showing that similar effects are prevalent globally and still apply today. However, this knowledge was not used for the development of early identification and intervention methods. In future studies, countries' different registers of nurses with SUD could be used to clarify the profile of these nurse and develop appropriate interventions and protocols. Qualitative studies should also be considered among nurses with SUD and work communities to shed light on concealment of the phenomenon.

9 | RELEVANCE TO CLINICAL PRACTICE

The study provides knowledge and perspectives of Finnish RNs with SUD for nurse leaders and peers based on a national supervisory authority's disciplinary decisions. Although the results cannot be generalised, this information is needed for early identification, intervention and referral to treatment, as well as for the development of effective protocols to reduce nurses' risk of disciplinary actions related to SUD. It is important to be aware of the signs and symptoms of SUD for earlier identification and intervention. This requires nurse leaders to know each employee's history, to monitor their performance at work, to consult other employees and to know the operating protocol. Training nurse leaders and employees to identify signs of SUDs is important. Already in the prelicensure state, it is important to raise SUD issues in discussions of well-being at work and occupational safety curricula.

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