

MEDICAL-SURGICAL NURSES' EXPERIENCES
CARING FOR PATIENTS WITH SUSPECTED
OPIOID USE DISORDER

by

ANGELA W. BRIDGES

NIRMALA EREVELLES, COMMITTEE CHAIR
BECKY ATKINSON
ALICE MARCH
JOANN OLIVER
LINDA OLIVET

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ABSTRACT

Opioid use disorders (OUDs) are epidemic in the United States. Individuals with undisclosed OUDs are commonly encountered in general hospital settings. Many studies confirm negative attitudes of healthcare professionals towards patients with substance use disorders (SUDs), especially nurses. Current evidence suggests negative attitudes of healthcare professionals are associated with negative outcomes for this patient population.

This qualitative study examined medical-surgical nurses' experiences caring for patients with suspected OUDs. Study findings included that nurses could remember little or no content on SUDs from nursing curricula. It was through experiences caring for actual OUD patients that enabled nurses to identify patients who may have an OUD.

Identification of those suspected of OUD was based on frequent and/or bogus admissions, identifying Dilaudid as the drug of choice, setting phone alarms for the next opiate dose, rating all pain as severe, patient behaviors suggesting little or no pain, and a range of negative behaviors. Attitudes towards suspected OUD patients were largely negative and based on acting out behaviors and disruption of unit routines.

Nurses had mixed feelings over the patient's report of pain versus behaviors and assessment findings suggesting little or no pain. Consequently, a common pain management strategy was limiting opiates. Additionally, nurse-patient relationships were limited and nonproductive at best. Nurses were discouraged from caring because they felt they were not making a difference in the underlying problem; furthermore, giving pain medications made them feel they were drug dealers rather than healers. Paradoxically, most nurses did not engage in

actions that might have validated the underlying OUD and the development of a treatment plan. Facilitation of treatment or referral may have enhanced nurses' self-esteem and improved the outcome for this patient population.

Study recommendations included the addition or enhancement of content related to SUDs, especially OUDs, in nursing curricula and staff training in acute care settings. Care may be improved in hospital settings through collaboration with physicians and administration to reduce opiate prescribing and the establishment of brief screening, intervention and referral processes.

DEDICATION

“I can do all things through Christ who strengthens me.” Philippians 4:13

This dissertation is dedicated foremost to God who has heard my prayers and the many prayers said on my behalf. Secondly, it is dedicated to my loving and very patient husband Alton who has listened to and comforted me during stressful times. Thirdly, I dedicate this dissertation to my children and grandchildren who have been my constant cheerleaders and prayer partners.

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CHAPTER I:
INTRODUCTION

There are many complex problems in healthcare today including the challenges of opioid addiction and pain management. While challenging in themselves, these conditions conjoined magnify the negative impact on patients, their families, society, and the healthcare industry. It is especially troubling for nurses who find themselves caught between the need to manage the patient's report of pain and the healthcare maxim of *primum non nocere*, a Latin phrase meaning *first, do no harm*. The following scenario illustrates the dilemma of nurses when they suspect a patient's report of pain is coupled with opioid addiction.

Susan is a registered nurse who works on a busy medical-surgical unit. Having received a shift report 45 minutes ago, she is busy rounding on her six patients when she pauses to respond to a call light. As she enters the room of Ms. Levin, a 38-year-old female admitted with lower back pain, Susan notices that she is talking and laughing on her cell phone. Ms. Levin glances at Susan, places her hand over the receiver and whispers, "bring me something for pain." Susan begins to elicit a more detailed assessment of Ms. Levin's pain. Exasperated with the questions, Ms. Levin places her caller on hold and snaps, "My pain is a 10; it is hurting in the same place it always hurts. It has been three hours since my last OxyContin. Please hurry, the last time I had to wait nearly 45 minutes." Before Susan could leave the room, Ms. Levin was back on the phone while munching on a cookie. Susan recalls comments by the off going nurse at shift change, "She is demanding and will run you ragged; you better get her pain med pronto or she will flip out." Susan leaves the room in dread.

This scene plays out in a variety of ways multiple times daily across America and forms the basis for this study. As in the above scenario, there is the suspicion of opioid addiction unwittingly supported in the guise of a chronic, painful condition. That said, it is certainly true that patients who are addicted to opiates can experience legitimate, physical pain and have a right to have their pain managed. However, the concerns for those suspected of addiction juxtaposed with the nurse's awareness of legal, moral, and ethical responsibilities of patient care including pain management. The investigator became aware of this issue about six years ago while talking with staff nurses during a workshop discussion activity. Nurses revealed they struggled to form relationships with "pain" patients. Upon further questioning, the investigator realized that the nurses were referring to patients they believed were feigning pain in an attempt to obtain opiates. This internal tug of war is a real issue for nurses who want to do the right thing for their patients concerning pain management and the possibility of addiction. The meanings that nurses make of their experiences caring for the suspected OUD patient is the phenomenon of interest explored in this study.

Substance Use Disorders and Related Issues

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in brief defines substance use disorders (SUDs) as "problematic pattern of substance use leading to clinically significant impairment or distress" (National Institute on Drug Abuse, 2016, para. 3). The DSM-5 no longer uses substance abuse and dependence terminology, but SUDs, defined in terms of mild, moderate and severe (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Specific substance use disorders represent the drug causing the disorder such as opiate use disorder (OUD) or alcohol use disorder (AUD). See detailed definitions under *Definitions* at the end of this chapter.

SUDs are widespread in the United States. An estimated 21.5 million Americans ages 12 and older were classified with a SUD in 2014 (SAMHSA, 2015). The abuse of opioids was responsible for 500,000 deaths in the United States from 2000-2014; opioid related deaths hit record levels in 2014 with a staggering increase of 14% in just one year (Centers for Disease Control and Prevention [CDC], 2015). Second only to marijuana, opioid abuse is epidemic in the United States with Americans consuming 80% of the world's prescription opioids (Manchikanti, Fellows, Ailinani, & Pampati, 2010).

The Pain Connection

Much attention is devoted to the issue of opioid use disorder (OUD) with commentary and interventions primarily focusing on nonmedical use, diversion, dishonest prescribing, and overdose (Beauchamp, Winstanley, Ryan, & Lyons, 2014). Historically however, opioids are used to manage pain, a high priority in contemporary healthcare. Pain management is important and improves postoperative recovery with subsequent decreased length of stay, lower readmission rates, and overall cost savings for both patients and the health care systems (Glowacki, 2015). For those suffering from chronic pain, adequate pain management improves the quality of life.

There are many definitions of pain; two of the most common are defined. The International Association for the Study of Pain (2017) defines pain as “an unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage” (para. 2). Margo McCaffery's definition, first published in 1968 and widely quoted and published in health literature, states that “Pain is what-ever the experiencing person says it is, existing whenever he says it does” (Pasero & McCaffery, 2001, p. 73). The latter somewhat vague definition is often cited in healthcare literature and seems to direct current pain

management. Regardless of the definition, pain is a subjective experience that often has no physical findings. The assessment and management of pain depends upon the patient's story. Unfortunately, deceit is often a ploy of those with OUD mitigating the most useful tool in pain management, the patient's narrative of their pain history (Baily, Hurley, & Gold, 2010).

For decades, inadequate pain management has been a major health concern in government and healthcare entities who emphasize the need for better pain control (Booker, 2015; Glowacki, 2015). In the updated Medicaid provision of the 1997 Balanced Budget Act (H.R. 2015, Section 4704), severe pain was cited as a measure for emergency care. The Institute of Medicine (IOM) released a report in 2011, *Future of Nursing and Relieving Pain in America*, that emphasized the need for quality pain management, pain education, and research. The 106th United States Congress passed Title VI, Section 1603, of H.R. 3244 announced the year 2000 as the "Decade of Pain Control and Research" (Gallagher & Chief, 2000). In 2009, the National Pain Care Policy Act (H.R. 756/ S.660) was passed as part of the Affordable Care Act of 2010 (Meghani, Polomano, Tait, Anderson, & Gallagher, 2012).

Pain relief is a human right (Brennan, Carr, & Cousins, 2007). Patient satisfaction and healthcare reimbursement are dependent on adequate management of pain (Adams, Bledsoe, & Armstrong, 2016). In 2001, the Joint Commission (TJC), an accrediting body of healthcare entities, released standards devoted to meeting patients' pain needs (Berry, 2000). Consequently, various health care entities responding to the standards began to refer to pain as the "fifth vital sign" (Baker, 2016). Answering the call to improve pain management and support education and research, a number of professional organizations have evolved which include the American Society for Pain Management Nursing, the American Pain Society, the International Association for the Study of Pain, and the American Academy of Pain Management. Additionally, there are

a number of professional journals devoted to the topic of pain including *PAIN*, *Pain Medicine*, *Pain Practice*, *The Journal of Pain*, and *Pain Management Nursing*.

Problem Statement

Because of the opiate epidemic in the United States, it is not surprising that individuals with OUDs are encountered in general hospital settings. Studies have shown SUDs are stigmatized and that healthcare professionals in general have negative attitudes toward SUD patients. This is especially problematic for OUD patients who may not disclose their addiction on admission for fear of judgment or other reasons. Additionally, studies indicate that healthcare professionals, including nurses, have had limited pre-licensure or workforce training. There is scant research, however, especially in the United States, on the experiences of nurses working on medical-surgical units caring for SUD patients in general or OUD patients specifically. Furthermore, of those studies, none related specifically to nurses' experiences caring for those suspected of OUD. Therefore, the investigator was interested in whether the same issues, attitudes, and experiences existed among nurses caring for patients suspected of an OUD on medical-surgical units.

Purpose of the Study

Given the dilemma of pain management and patient behaviors alluding to opioid addiction, the purpose of this study was to broadly explore and make meaning of medical-surgical nurses' experiences caring for suspected OUD patients. Using semi-structured interviews, the investigator drilled down to mine a more a specific understanding of nurses' experiences as broadly articulated in the research questions. The questions were based on a qualitative study by Neville and Roan (2014) discussed later in the literature review.

Research Questions

This study included the following research questions:

1. What are the thoughts, feelings or perceptions of medical-surgical nurses for patients with suspected OUDs;
2. How do the thoughts, feelings or perceptions of medical-surgical nurses influence relationships with and the care given to patients; and
3. What are the implications for the nurse-patient relationship and nursing education?

Significance of the Study

Findings from this study illuminated gaps in knowledge that may inform nursing education and health care training. They may also improve processes to identify patients who may have an OUD and the ways and means to improve care of all OUD patients. Lastly, the hope is that the study findings will increase healthcare organizations' awareness of the opioid epidemic, barriers to providing care, and the need for screening and referral. Ultimately, these adjuncts may improve outcomes of OUD patients and nurses' attitudes and satisfaction caring for this patient population.

Study Background

Opioids, the Answer to Pain

Some suggest that the current opioid epidemic was predictable based on the generous dispensing of opioid prescriptions for any kind of pain in the 19th and early 20th centuries (Beauchamp et al., 2014). Physicians in the 1980s became more comfortable with opioids for pain based on reports signifying a low probability for inadvertent or iatrogenic addiction (Bailey et al., 2010; Beauchamp et al., 2014). *A New England Journal of Medicine* reported that addiction in hospitalized patients receiving narcotics with no prior history of addiction was very

rare (Porter & Jick, 1980). Another study concluded that narcotics can be safely used as alternative pain management for patients with non-cancer related pain (Portenoy & Foley, 1986). However, these studies had serious limitations such as small sample size and the treatment of acute pain rather than chronic (Bailey et al., 2010). A systematic review by Minozzi, Amota, and Devoli (2012) concluded the evidence related to opioid dependence in adults with no prior abuse history was inadequate to implicate opioid analgesics as a significant risk factor for developing dependence. However, McAuliffe (2013) challenged their findings citing that most studies in Minozzi et al.'s review were irrelevant, did not meet the author's inclusion criteria, contained limited information to judge quality, and was inaccurately reported.

Another angle of addiction less explored is how some people transition to nonmedical use and dependence in spite of their intent to use the medication as prescribed. This iatrogenic addiction, defined by the 2006 109th Congress, is an addiction developed from the legally prescribed and use of an opioid analgesic by an individual with no previous history of any addiction (Office of National Drug Control Policy Reauthorization Act, 2006). Beauchamp et al. examined several studies from the 1980s reporting addiction rates from 0.03% to 0.1% in hospitalized patients with no prior addiction history. A 2008 review of studies from 1966-2006 involving chronic pain patients receiving opioid therapy indicated a 3.27% abuse/addiction rate as compared 0.19% for preselected chronic pain patients receiving opioids with no prior addiction (Fishbain, Cole, Lewis, & Rosomoff). Another 2007 review of studies from 1966-2005 involving chronic back pain patients receiving opioids indicated a prevalence of lifetime SUDs ranging from 36-56% leading the investigators to conclude that SUDs are common in chronic back patients taking opioids (Martell et al., 2007) A large study examined the long-term use of analgesics from 1997-2008 and found that opiate naïve patients 66 years and older who received

a opioid prescription within seven days postop were 44% more likely to become long-term opioid users as compared to those who were not prescribed opioids (Alam, Gomes, Zheng, Mamdani, Jurlink, & Bell, 2012).

Other Drivers of Pain Management and Addiction

In concert with research proclamations of opioid safety, pharmaceutical companies began aggressively marketing their opiates (National Institute on Drug Abuse [NIDA], 2014). Some marketing practices were investigated. Purdue Pharm and top executives pleaded guilty in 2007 to criminal charges for misleading physicians, patients and the FDA about the risks of OxyContin addiction (Vivian, 2011).

Compounding the pain management/addiction issues, the Federation of State Medical Boards pushed boards for punitive actions against physicians for inadequate pain management (Gounder, 2013). Potentially, issues such as this and the fact that patients can go on a website and rate their satisfaction with the doctor may have influenced more prescription dispensing. Regardless, as prescription painkiller sales escalated, they paralleled the number of opioid overdose deaths between 1999-2010 (Beauchamp et al., 2014).

Another suggested contributor to the opioid epidemic is the laser focus on patient satisfaction (Adams et al., 2016). In 2006, the Centers for Medicare and Medicaid Services enacted a survey, the *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS), to assess healthcare quality and the patients' perspectives of their healthcare experience (Centers for Medicare and Medicaid Services, 2017). Among the variables measured are questions related to pain management such as "how often did the hospital staff do everything they could to help you with your pain?" Adams et al. argued that this question is linked to the Joint Commission's stance on pain management that has promoted the belief that a patient

should experience no pain. Based on survey responses physicians and hospitals are penalized (i.e., reduced reimbursement) when patients' expectations for pain management are not met.

Little has been done to curb the opioid epidemic; however, some actions have occurred to decrease dependence. For example, the pharmaceutical industry supported by the FDA, developed narcotic formulas containing abuse-deterrent properties (Alexander, Mannion, Weingarten, Faneilli, & Stilles, 2014). Additionally, many states have implemented prescription drug monitoring programs (PDMPs) designed identify misuse and diversion of controlled substances (Beauchamp et al., 2014).

The Toll of Opioid Addiction

Adding to the significance of opioid epidemic is the staggering death toll. From 2000-2014, 500,000 Americans died from overdose related deaths and most were related to opioids (Centers for Disease Control and Prevention [CDC], 2015). In fact, from 2002 to 2015, there was a 2.8-fold increase in deaths from all opioids. From 2002-2011, there was a 1.9-fold increase in deaths related to prescription opioids although the death rate has been stable since then (NIDA, 2017). The increase in prescription opioid deaths corresponds to the striking increase in opioid sales from 1999 to 2010. Patients' susceptibility to overdose could not have changed significantly during that time; what did change was their exposure to opioids (Dowell, Kunins, & Farley, 2013)

Another impact of all drug abuse is its costliness with an estimated \$740 billion spent annually on direct and indirect costs such as crime, health, and lost productivity. The healthcare costs associated with prescription opioids in 2013 was estimated at \$26 billion with overall related costs estimated at \$78.5 billion (NIDA, 2017). Although the direct and indirect costs are

expensive, the pain and misery experienced by the abuser, and destruction of families and other relationships are incalculable.

ODU Patients in Hospitals and Staff Attitudes

Given the prevalence of OUDs, it is not surprising that these patients periodically require admission to hospitals. Unfortunately, patients do not often report their OUD upon admission. This presents many challenges for all healthcare professionals, especially nursing who has more contact with them than other healthcare providers do. These challenges include forming therapeutic relationships to OUD persons often depicted in life and popular media as criminals, lazy, and immoral. As contemporary society stigmatizes addiction, healthcare professionals are also susceptible to this problematic thinking (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013).

Erving Goffman is credited with early insights related to stigma, a phenomenon which occurs when a person has an attribute that is different and negatively construed leading to discrediting or devaluing that person. Goffman noted that stigma was often associated with mental disorders, addiction, homosexuality, and other traits or conditions (Lloyd, 2013). Stigma may be experienced in several ways: social or public, self, and structural (Livingston, Milne, Fang, & Amari, 2011). Public stigma is the phenomenon of large social groups supporting stereotypes about stigmatized groups and acting against them. Self-stigma refers to the loss of self-esteem and self-efficacy when people ascribe to and assume social stigma. Structural stigma references policies, procedures, and rules of institutions that limit rights or opportunities for stigmatized groups (Corrigan, Kerr, & Knudsen, 2005). A health-related stigma exists when individual or groups are negatively judged and excluded based on a socially unacceptable health problem (Weiss, Ramakrishna, & Somma, 2006).

Several studies suggest that SUDs are stigmatized more than other health problems and others indicate that stigma is used as a tool to discourage unhealthy behaviors. Negative stigmatizing attitudes of certain behaviors (i.e., substance use during pregnancy) are culturally supported and associated with immorality and criminality, especially concerning illegal substances. For example, heroin use is not only morally condemned but also classified as criminal rather than a health issue (Livingston et al., 2011).

SUDs are linked to a host of other stigmatizing conditions (i.e., HIV/AIDs, mental illness), unsafe behaviors (i.e., sharing needles, impaired driving) and social complications (i.e., poverty, crime). In effect, through association, SUD persons inherit culturally-accepted stereotypes that encompass the condition. These stereotypes are challenging to refute as there is some degree of accuracy related to the stereotypes (Livingston et al., 2011). Other factors that promote stigma is the belief that SUDs are within the control of the SUD person which further increases negative judgement and intolerance (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

Global and national studies have identified negative attitudes of many healthcare professionals toward SUD patients (Brener, Hippel, & Kippax, 2007; Gilchrist et al., 2011; McLaughlin, McKenna, & Leslie, 2000). Negative attitudes and stigmas are significant as they influence the experience of illness, seeking treatment, and treatment compliance. Further, attitudes and behaviors of healthcare professionals toward patients with stigmatized conditions can impact the quality of care (Ahern, Stuber, & Galea, 2007; Weiss et al., 2006). In a 2013 systematic review, the authors examined healthcare professionals' stigmas towards patients with SUDS and the outcomes to healthcare delivery. Among their findings were that negative staff attitudes moderated patients' feelings of empowerment and related treatment outcomes.

Healthcare professionals were less engaged with the SUD patient and more task-oriented in their approach to care (van Boekel et al., 2013). Patients with SUDs who are in pain are at risk for poor pain management because of behaviors that are interpreted as ‘drug seeking’ (Morley, Briggs & Chumbley, 2014). Some studies indicated there is discrimination and judgement even from staff working in drug treatment programs. The impact to the SUD patients was incompleteness of treatment programs (Brener, von Hippel, von Hippel, Resnick, & Treloar, 2010) and high levels of enacted, perceived, and self-stigma among drug users with IV drug users feeling more judgement as compared to non-IV drug users (Luoma et al., 2007).

Negative attitudes of healthcare professionals in general are associated with: stereotypical factors related to patient violence and manipulation (McGillion, Wanigaratne, Fienmann, Godden, & Bryne, 2000), perceptions that SUD patients are responsible and can control their addictions (Brener, von Hippel, Kippax, & Preacher, 2010), lack of organizational role support such as expert consultation to acute care staff caring for SUD patients (Ford, Bammer, & Becker, 2009), and inadequate staff education (Happell, Carta, & Pinikihana, 2002; McLaughlin et al., 2006; McGillion et al., 2000). Factors associated with positive attitudes of health care professionals have been related to more contact with SUD patients such as in drug treatment facilities (Brener et al., 2007) and previously mentioned role support. There are few studies, however, that specifically examine attitudes and general experiences of medical-surgical nurses who frequently encounter patients with the actual or suspected comorbid condition of OUD. These studies will be detailed in the next chapter.

Conceptual Framework

As the investigator was interested in understanding the meaning medical-surgical nurses’ make of their experiences caring for suspected OUD patients, a qualitative approach was used.

Specifically, symbolic interactionism (SI) was the qualitative perspective that focused on nurses' experiences caring for this patient population. In SI, theory and methodology are closely linked (Fontana, 2001). SI is a label that describes a methodological approach to the study of group life and human conduct. The emphasis of SI is the nature of social interaction and the shared meaning in the form of symbols that occurs through interaction among individuals. The purpose of SI is the interpretation of symbolic meanings and how these meanings are created within the social context (Blumer, 1969). SI serves as both the conceptual framework and the qualitative methodological approach. It also serves as a lens by which to analyze the findings.

Methodology and Data Analysis

SI as a qualitative methodology was operationalized in this study through semi-structured interviews of medical-surgical nurses. Interviews served as the primary data source from which experiences were gleaned. Registered nurses with a minimum of six months of experience who acknowledged that they have cared for suspected OUD patients were recruited as voluntary participants in this study from one or more hospitals in the southeastern United States. After assuring protection of study participant rights, demographic data were collected prior to formal interview questions. Initial questions aimed at contextual information such as describing the unit, common patient conditions treated and the typical workday. Participants were asked about what constitutes a satisfying work experience including a satisfying nurse-patient relationship. Next, nurses were asked to describe experiences caring for suspected OUD patients followed by a series of open-ended questions. In a couple of cases, a scenario reflecting a nurse caring for a suspected OUD was read to participants. The scenario and questions served as a stimulus to access the thoughts, perceptions and experiences of the nurses. Responses were recorded. Field notes were documented by the investigator to capture participant body language, as well as

contextual factors such as setting. The investigator also documented initial impressions and reflective commentary. Interviews were transcribed verbatim. To uncover multiple possible meanings, analytic techniques included raising questions of the data, comparing incidents within interviews and across interviews and coding the data for a thematic analysis. The trustworthiness of the study was enabled by using strategies that supported credibility, transferability, dependability and confirmability. The completed analysis addressed research questions that were woven into a thick, descriptive account of medical-surgical nurses' experiences caring for suspected OUD patients.

Summary

Sometimes nurses are caught between the moral and ethical imperative to provide pain relief and patient behaviors that suggest an addiction to opiates. Compounding the issue is the backdrop of the U.S. opioid epidemic, stigma, and negative attitudes towards SUD persons and the limited SUD educational preparation of healthcare professionals in general. Studies indicate that nurses, who have more contact with hospitalized SUD patients than other healthcare professionals, also have negative attitudes and limited educational preparation. There are limited studies that specifically examine the experiences of nurses working on medical-surgical units where undeclared OUD patients are often encountered. The objective of this qualitative study was to examine, thoughts, feelings, and perspectives that made up the experiences and related meanings of medical-surgical nurses caring for patients with suspected OUD. Symbolic interactionism was the qualitative approach that guided the investigation and served as a lens through which to illuminate the findings. Data were collected through interviews and coded to identify themes that captured the meaning of nursing experiences. Identified themes were woven into an account that addressed research questions and subsequent experiences.

The following chapter will explore the literature that laid the foundation for this study. It will describe a variety of factors that may contribute to the experiences and perception of nurses towards patients who abuse substances. It will also illuminate gaps that will justify the need and provide credence for the study.

Definitions

Opiate(s) refer to a group of drugs derived from the opium poppy widely grown in Afghanistan. Medically, they are used for pain and are associated with addiction related to euphoric effects (Calbeck, 2011).

Opioid Use Disorder (OUD) is a disorder characterized by using opiates with the same generic signs and symptoms of substance use disorders. It integrates a wide range of illegal and prescribed opioids (Hartney, 2018).

Substance Use Disorder (SUD):

The DSM-V recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including amphetamine-type substances, cocaine, and other stimulants); tobacco; and other or unknown substances” (Hartney, 2017, para. 3)

Eleven criteria are used to diagnose SUDs and the number of criteria present determines the severity of the disease. Criteria include (a) consuming the substance in greater quantities for longer than intended; (b) desire to reduce or stop using and inability to do so; (c) spending a lot of time obtaining, using or recovering from substance use; (d) impulses or urges to use the substance; (e) repeated inability to carry out major work, school or home obligations due to use; (f) continued use despite recurring social or interpersonal problems caused by its use; (g) eliminating or reducing social, work and recreational activities due to use; (h) recurrent use of substances in hazardous situations; (i) continued use despite awareness of physical and

psychological difficulties caused by the substance; (j) using increased amounts to get desired effect; and (k) developing withdrawal symptoms that are relieved by taking the substance (Hartney, 2017).

CHAPTER II: REVIEW OF THE LITERATURE

The purpose of this chapter is to review the current perspective of medical-surgical nurses' experiences caring for SUD patients. A review of the literature in the field consistently identified issues related to negative attitudes/perceptions towards SUD patients and inadequate knowledge to care for them. Although there were many studies that examine these issues related to all healthcare providers in general, there were limited studies that address these issues within the context of medical-surgical environments where most SUD patients, and especially OUD patients, are routinely encountered. No studies could be located specific to care of patients with suspected OUD although their care was generally referenced within the context of all SUD patients.

Within the phenomenon of nursing care of the SUD patient are factors that potentially influence the development of therapeutic relationships and therefore the quality of care. Factors include education and knowledge and nursing attitudes and perspectives. These factors are examined within the review. The chapter will conclude with a discussion of the common threads of the studies that support the need for this study.

Search Procedure

The term substance use disorder was adopted for this paper for the sake of internal consistency, but the literature, including the studies in this review used a variety of similar terms including addiction, substance abuse, illicit drug use, and substance misuse. Overall, the general

search period combining all key search terms was from 2000-2017. However, the review also included some seminal studies pre-dating that time frame to provide a baseline for comparison.

The University of Alabama's library website was used to access multiple databases. Databases primarily included CINHL PLUS, OVID, and Academic OneFile. Search terms included substance use disorder, opiate abuse, illicit drugs, substance abuse, and addiction in combination with one or more terms such as nurses' knowledge, nursing curricula, attitudes or perceptions of medical, and/or surgical nurses. Seminal studies were not limited to nurses in specific settings nor were studies related to knowledge of practicing nurses. Related to nurses' attitudes and perceptions, inclusion criteria included nurses in general hospital settings on units for medical and/or surgical conditions. Studies that involved other health care professionals were not included. Some studies in the review were found in the reference lists of other studies. Within the search, the following themes were identified: SUD content in nursing curricula, SUD knowledge and attitudes of practicing nurses, influence of SUD education on practicing nurses' attitudes, and factors affecting medical-surgical nurses' attitudes towards SUD patients. Factors affecting medical-surgical nurses' attitudes were subdivided and included positive attitudes with associated factors, neutral attitudes with associated factors, and negative attitudes with associated factors. Studies revealing negative attitudes were associated with stereotypical views, patient and nursing behaviors contributing to complex relationships and lack of knowledge/education.

Following this study's data collection and analysis, the investigator believed it necessary to search nurse-patient relationships (NPRs) as a basis for comparing study findings. The search was limited to studies conducted from 2007-2017. A goal in the search was to select studies primarily conducted from inpatient medical and/or surgical type units. Key search terms included nurse-patient relationship and nurse patient relations. Perspectives of registered nurses

and registered nurses combined with patients were included. Excluded from the review were studies including only the patient's perspective, and studies including the perspectives of physicians and non-professional or para-professional staff. Two themes emerged: influences of communication, interpersonal skills, and workplace conditions on the nurse-patient relationship and elements of trust, humor, and connectedness in the nurse-patient relationship.

SUD Content in Nursing Curricula

Nursing knowledge related to care of the patient with a SUD is important because nurses typically have initial contact with patients and opportunities for recognition, screening, and initial intervention (Fornili & Haack, 2005; Owens, Gilmore, & Pirmohamed, 2000; Rassool, 2000; Tran, Stone, Fernandez, Griffiths, & Johnson, 2009; Vadlamundi, Adams, Hogan, Wu, & Wahid, 2008). Furthermore, nursing knowledge of SUDs has been associated with their attitudes related to caring for this patient population (Chang & Yang, 2013; Ford, Bammer, & Becker, 2008, 2009; Gerace, Hughes, & Spunt, 1995; Happell et al., 2002). The following review was prefaced by seminal reviews that served as a baseline from which to compare current studies.

Seminal Studies

Howard, Walker, Walker, and Suchinsky (1997) reviewed the literature for surveys of alcohol and/or drug education in nursing programs from 1970-1995. Findings included only 11 studies examining drug and alcohol content in nursing programs. Although fraught with methodological shortcomings, findings suggested that the concentration of SUD education is limited with few course hours devoted to content in general. Content addressing legal issues, public education, and psychotherapeutic issues were scant. Other findings suggested less focus on drug education as compared to alcohol education and clinical experiences related to addictions were especially limited. The review concluded with the need to examine the

differences in chemical dependency offerings and didactic approaches and the need to identify the most cost-efficient and effective methods of providing SUD education.

Hoffman and Heinemann (1987), the most cited research of SUD content in nursing curricula (Mollica, Hyman, & Mann, 2011), used a survey approach to assess alcohol and drug related classes in nursing programs in 1987. In this U.S. study, questionnaires were mailed to greater than 1,000 nursing schools including baccalaureate, associate, and diploma. Survey questions related to required hours of instruction, content, and skills. Teaching approaches of SUD content were also examined as well as clinical areas used for instruction and the availability of SUD as elective courses.

With a 36% response rate, Hoffman and Heinemann found that all respondents reportedly taught SUD content with the required number of hours ranging from one to five hours in the majority of the programs. Additionally, there was no significant difference in the time dedicated to SUD content between baccalaureate, associate, and diploma programs. Slightly more content was provided related to alcohol abuse than drug abuse. Content areas given the greatest attention related to definition, description, psychological complications, treatment and rehabilitation, pathology, and social complications. Clinical skills (e.g., interviewing) used in the care of SUD patients were taught less frequently than content areas. The majority of nursing programs taught SUDs as part of psychiatric-mental health courses. A very small percentage of programs offered elective courses on alcoholism and/or drug abuse. Limitations included low response rate and the inability to validate whether the person completing the survey was one that could accurately attest to the content provided across the curriculum. While a high percentage of schools reported teaching all the listed content and skills, Hoffman and Heinemann questioned the adequacy of the reported 1-5 hours for gaining knowledge and skills.

Contemporary Studies

A Brazilian exploratory study surveyed 25 nursing programs strategically selected due to the high consumption of drugs and trafficking in their areas. The sample included 425 undergraduate nurses, most in their fourth year of school. Questions focused on matters such as the quantity of SUD education, placement of the content in the curriculum, theoretical content and teaching strategies, clinical practice/experiences, and management and treatment of SUD patients. Key findings included 4-8 hours of SUD instruction throughout their training. About 63% of respondents received drug and alcohol content within the context of psychiatric nursing courses. The educational activities were based on theory (37%), clinical practice (26%), discussion (26%), and research (3%). Most students viewed SUD as a psychiatric disorder and had come into contact with SUD patients to varying degrees. Eighty-seven percent believed that the addition of alcohol and drug content in nursing curricula was an urgent need (Pillon, Ramos, Villar-Luis, & Rassoul, 2004).

Mollica et al. (2011) developed a survey related to alcohol education based on the earlier work of others including Hoffman and Heinemann. In addition to questions asked in the Hoffman and Heinemann survey, they investigated the influences of health promotion initiatives and continuing education for faculty related to teaching alcohol misuse. The survey was distributed to 117 baccalaureate nursing programs in the northeastern United States.

Similar to the Hoffman and Heinemann (1987), Mollica et al., with a response rate of 23%, reported that 56% of schools required one to five hours of didactic instruction with only 30% requiring one to five clinical hours. Eighty-five percent reported having alcohol content within the context of psychiatric nursing as compared to 54% in the Hoffman study. Only one school reported six to ten hours of alcohol content in didactic and clinical experiences in all areas

of nursing (e.g., maternal child, medical-surgical). The vast majority of topics taught focused on definition, description, treatment and rehab, medical, and psychological complications and pharmacology. Sixty-three percent of schools included some patient education for those with alcohol abuse. Less attention was given to public health and legal regulations. Regarding the influence of health promotion and disease prevention, 67% reported that their education was somewhat or significantly influenced.

In another study using a modified version of the Short Alcohol Attitudes Problem Perception Questionnaire (SAAPPQ) and three case studies, Cund (2013) sought to evaluate knowledge, attitudes, and experiences of nursing students working with alcoholics. The survey was disseminated to a convenience sample of nursing students across five cohorts from one Scottish University yielding a 38% response rate. The investigator found 1-6 hours with a mean of 2.5 hours of alcohol education in three cohorts; two of the five cohorts did not receive any alcohol education in their program. Educational activities included content delivered through lecture, seminars, problem-based learning, and guest speakers for Alcoholics Anonymous. Other key findings indicated that while most students inquired about their patient's alcohol consumption, they were less knowledgeable of how to manage a patient in withdrawal. More than 50% of students reported they did not receive sufficient training to care for this patient population. Additionally, students believed that the lack of exposure to this group and limited workplace support hindered their ability to care. Student's beliefs and attitudes toward working with alcoholic patients were positive. They acknowledged a responsibility for their care, a reflection of role legitimacy, and agreed that involvement with this group in practice was important, a reflection of role adequacy.

Savage, Dyehouse, and Marcus (2014) used a cross-sectional electronic survey to assess the global shift from alcohol treatment to prevention and early identification of at-risk drinking as recommended by the World Health Organization and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NIAAA developed a curriculum aimed at baccalaureate nursing education that was released in 2010. It includes nine content areas that address alcohol abuse across the life span; examples of content areas include genetics; effects of alcohol on the brain and behavior; screening and assessment; treatment of abuse and withdrawal; and prevention. The investigators surveyed the average number of hours of alcohol content provided in adult health, maternal child, behavioral, and community health courses and the inclusion of content specific to the NIAAA curriculum. The survey was distributed to members of the American Association of Colleges of Nursing; 66 schools from 25 states responded. A response rate could not be calculated because the total pool of baccalaureate schools was not known.

Hours dedicated to alcohol education spread across the lifespan ranged from 3-38 hours with a mean of 11.3 hours. As in other studies, most content was taught within mental health courses. Regarding the nine different areas of content recommended by the NIAAA, withdrawal (87%) and treatment (88%) were included in most mental health courses and in 50% of medical-surgical courses. Prevention received less attention than other topics and was included in 63% of mental health courses. Almost half of respondents reported they taught screening and brief intervention using the NIAAA guidelines and again this was primarily taught in mental health courses. Only 9.4% of these schools who used the guidelines required student competency in this area. Finally, more than half the respondents indicated that more content on alcohol and health would benefit the students in their programs.

These studies were difficult to compare because they generally examined various aspects of SUD in nursing curricula including whether the content existed in curricula, how much, what kind, teaching methodologies, and others. However, a common finding was that most content focused on alcohol as opposed to other addictive drugs and was taught within mental health courses in generally under five hours.

SUD Knowledge and Attitudes of General Practicing Nurses

There were four studies that evaluated nurses' knowledge and/or attitudes related to caring for SUD patients. Three quantitative studies used a survey/questionnaire approach while one study was qualitative in nature. Although some surveys included other elements, only information related to knowledge, attitudes, and skills were reflected in the review. In addition, two seminal reviews were reported to serve as a baseline for reviewing other studies.

Seminal Studies

Howard and Chung (2000a) identified 14 studies in a literature review of nurses' attitudes toward substance misusing patients from 1966-1996. All but two of the studies related to alcohol abuse. Although the investigators concluded there were more positive attitudes in recent studies, there was a significant contingent of nurses with negative stereotypes of substance misusing patients. A follow-up study by Howard and Chung (2000b) examined 18 studies from 1964-1992 evaluating nurses' attitudes in experimental situations as compared to other healthcare workers. As in their first study, most studies pertained to care of alcoholic patients. In the experimental studies, nurses' attitudes toward hypothetical patients with a specific health condition plus a label of alcohol abuse were compared to similar patients without the alcoholic labels. The investigators consistently found negative attitudes directed toward patients with an alcoholic label. In comparing nurses' attitudes to other health care professionals Howard and

Chung found that nurses held more negative, punitive, and controlling positions, and were more supportive of mandatory treatment for substance misusers. They were also less tolerant of personal and social drug use. However, younger and more educated nurses had more positive attitudes than their counterparts.

Contemporary Studies

In a study using a convenience sample of 392 perinatal nurses from multiple hospitals in west Florida, participants responded to an adapted version of the Attitudes about Drug Abuse and Pregnancy questionnaire. The 34-item survey assessed knowledge and attitudes toward perinatal substance abuse. Nurses responded to knowledge questions with true, false, or not sure. An example of a true/false knowledge question was “drug abusers often have family members or significant others who abuse substances.” An example of an attitude question ranked on a Likert type scale was “women who abuse drugs and alcohol during pregnancy are more concerned with themselves than their babies.” The investigators found that knowledge scores out of a possible of 20 ranged from 6-18 (M=12.14) indicating that nurses had limited knowledge about substance use, dependence and effects. Attitude scores ranged from 16-56 (M=35.81) out of a possible 70 indicating that perinatal nurses had more negative and punitive attitudes than positive and supportive. Nurses with higher levels of nursing education had higher knowledge scores; knowledge and attitude scores were higher when nurses had substance abuse content in their nursing curriculums and when substance abuse was part of personal or family histories. However, multiple regression analyses revealed substance abuse education was the primary predictor of knowledge and attitudes (Selleck & Redding, 1999).

In another study, general practice nurses in Liverpool were surveyed related to knowledge and opinions regarding: sensible levels of alcohol consumption, current practices

managing patients who abuse alcohol, and attitudes regarding more involvement in their care in the community setting. With a response rate of 76.6%, the investigators found that 94% of respondents perceived alcohol misuse was a community problem. Whether respondents perceived their knowledge regarding sensible alcohol limits was adequate or not, 96% responded they routinely advised on sensible limits. However, when questioned about what the sensible limits were for men and women, 66% overestimated the sensible limit for men and 40% overestimated the limit for women. Forty-four percent indicated an awareness of alcohol services within the community. Regarding the current role of practice nurses, 98% routinely took alcohol histories while only 34% made referrals to any alcohol services for problematic drinkers. Regarding attitudes of respondents, 62.8% indicated they would be happy to be involved in the community care of those who misuse alcohol only if further education were provided; 24.7% were not happy to increase their role in the community. Many (47.5%) felt withdrawal should be managed in a specialist unit only (Owens et al., 2000).

For the purpose of developing a comprehensive training program on alcohol and substance abuse for nurses and other health professionals in Victoria Australia, Happel et al. (2002) surveyed nurses using the Substance Abuse Attitude Scale. It was designed to elicit knowledge (e.g., signs of intoxication, withdrawal), attitudes and beliefs (e.g., role responsibility), and skills (e.g., assessment, history, referrals) regarding substance use. With a 43% response rate, the investigators found the knowledge of practicing nurses was modest although adequate. Most respondents reported frequent encounters with this population ranging from daily to 1-2 times weekly. Referrals for alcohol or drug abuse services occurred 1-2 days weekly as reported by 35.8% of respondents and 1-2 days monthly by 39.4% of respondents. Regarding perceived knowledge and confidence, the most nurses believed they had moderate

knowledge and competence related to recognizing and managing alcohol and substance abuse patients. With regard to actual knowledge, only 12.7% identified the correct number of grams in a standard alcohol beverage; 41.8% identified the correct number of alcohol-free days per week; 84% correctly identified thiamine as a prophylaxis against memory loss. Correct responses ranging from 56-88% were given for a series of questions related to diagnosis of substance dependence, recognition of various signs substance intoxication, overdose, withdrawal, and management. Only 17% reported a lack of training and expertise related to alcohol and drugs. Regarding specific skills, the majority reported routinely assessing alcohol and drug histories. Additionally, the majority of nurses considered assessment, referral, management, and education as a part of their responsibilities.

Influence of SUD Education on General Nurses' Attitudes

It is easily argued that adequate knowledge of SUDs is essential to providing quality care to patients with SUDs. Supportive, nonjudgmental attitudes are crucial factors in the provision of quality care in that it supports establishing therapeutic relationships with SUD patients. However, is adequate knowledge of SUDs influential in developing positive, supportive, and nonjudgmental attitudes in nurses? Four studies reviewed the impact of continuing SUD education on nurses' knowledge and attitudes toward SUD patients.

A quantitative study by Vadlamudi et al. (2008) examined the outcome of education on nurses' attitudes, beliefs, and confidence levels on screening and intervention for alcohol problems. A sample of 181 of practitioner students from one school in the southeast United States who had direct contact with the alcohol abuse population participated in the study. They received a four-hour brief negotiated intervention (BNI) educational intervention prior to clinical placements. The educational intervention consisted of interactive lecture followed by faculty

demonstration of the BNI technique. The BNI is a systematic approach used to screen individuals with abuse issues and negotiate goals linked to reduce alcohol intake or referral for treatment. A pre- and post-questionnaire was completed assessing knowledge, attitudes and confidence in screening and intervention for alcohol abuse. A paired t-test was used to determine effects of the educational intervention on outcome variables.

Among the findings was a statistically significant positive effect of educational intervention on the attitudes, beliefs, and confidence levels of nurses about alcohol abuse and treatment. Effects of modifying factors (e.g., age, educational degree, past experience with alcoholic patients) were analyzed using one-way ANOVA. There was a significant modifying effect only related to experience with alcohol abuse patients; those with little experience showed significant improvement in confidence levels post intervention as compared to nurses with more experience. However, those with vast experience had greater confidence levels even prior to the intervention. The investigators concluded that as an intervention, education is an effective strategy in changing the attitudes, beliefs and confidences levels of primary care nurses.

In another study, Gerace et al. (1995) reported on a three-year program designed to improve practicing nurses' ability to recognize and respond to patients with substance related issues. The primary intervention in this quasi-experimental study was the provision of a two-day workshop annually for a period of three years to advanced practiced nurses in an urban university hospital in the U.S. The study incorporated a pre- and posttest design using Substance Abuse Knowledge Survey (SAKS), Substance Abuse Experience Survey (SAES), and Substance Abuse Attitude Scale (SAAS). The education intervention not only included the science of addiction and management but also featured content to address specific attitudes toward substance using persons. Examples included self-awareness exercises, personal values and

perceptions, and discussion with recovering patients. Education aimed at increasing nursing confidence in the care of substance misuse patients included use of interactive videotapes, expert demonstration, role-play, case studies, assessment, brief intervention, referral, responding to difficult patients, dealing with enabling behaviors and pain management issues.

SAKS measures general knowledge related to substance abuse. Post-intervention, knowledge, and confidence scores increased significantly as compared to pretest values. Continuing education was associated with greater levels of confidence in clinical skills for both alcohol and drug related skills. High confidence levels were associated with willingness to discuss substance abuse with patients.

The SAAS scale measured five areas: permissiveness, stereotyping, treatment intervention, treatment optimism, and moralism. Posttests indicated knowledge and confidence levels increased significantly; however, only one subscale of the attitude scale, treatment optimism, indicated improvement from pre to posttest. There were no significant differences in the other attitude subscales. The investigators acknowledged that attitude change and the impact on behavior is challenging to achieve and measure, but behavior changes are often possible without changes in attitudes.

Ford et al. (2008, 2009) argued that adequate substance abuse knowledge is not enough to influence nurses' attitudes. In the 2008 study, the investigators explored determinants of nurses' therapeutic attitudes to illicit drug-using patients as a basis for workplace education; 1605 Australian nurses participated. Therapeutic attitude was measured using a scale that evaluated nursing engagement such as commitment to the role (motivation, satisfaction, self-esteem) and nurses view of themselves in the role (role adequacy, role legitimacy). The Disapproval Drug Use Scale measured nurses' attitudes toward illicit drugs. Personal characteristics (e.g., age, sex,

level of education, and experience with substances), professional role requirements (e.g., role support, substance related education and experience with SUD patients) and workplace factors (e.g., years as RN, public or private sector practice) were also evaluated. Their findings included an inverse relationship between nurses' attitudes toward illicit drugs and therapeutic attitude; as disapproval toward illicit drugs increased, therapeutic attitude toward SUD patients decreased. However, as compared to the effect of professional practice factors, attitude elements were unimportant. Multi-variable regression analysis of therapeutic attitude revealed role support had the greatest impact on therapeutic attitude followed by the interaction of role support and workplace education and experience working with this patient population. Personal characteristics and workplace education by itself had no association with therapeutic attitude.

In a follow-up study a year later, the investigators sought to detail the impact of workplace education on therapeutic attitude. Thirty-four percent of nurses reported no continuing education on SUDs while the 32% who did have workplace training had less than five hours. Forty-four percent reported no or very little role support. Using multi-variable regression analysis, Ford et al. (2009) noted three findings: workplace education is not effective in the absence of role support; an increase in knowledge only affects therapeutic attitude in the presence of moderate role support; greater levels of education (>20 hrs.) and role support continued to have an impact on therapeutic attitude. Therefore, a key finding of this study was that workplace education was enhanced in the presence of role support.

Factors Affecting Medical-Surgical Nurses' Attitudes towards SUD Patients

The aforementioned review focused on education, knowledge, attitudes, and the impact of education on attitudes of nurses in general toward SUD patients. The focus of this study was to examine the experiences of medical-surgical nurses in the care of SUD patients. Many factors

can influence the meaning medical-surgical nurses' make of patient care experiences, attitudes being one of them. Specific themes identified related to attitudes included: ranking of attitudes as positive, neutral and negative with associated factors. The factors associated with negative attitudes were subdivided as stereotypical views; patient and nurse behaviors contributing to complex relationships and lack of education/knowledge. Seven studies met inclusion criteria; three were quantitative and four were qualitative in design.

Positively Ranked Attitudes and Associated Factors

Using a cross-sectional design, 489 nurses' attitudes toward substance use problems in two medical centers in Taiwan were examined by Chang and Yang (2013). An attitude scale measured nurses' attitudes related to treatment necessity, treatment optimism, and general acceptance of substance use problems, stereotypes and moralism. In addition to demographic information measured (e.g., years of experience), other variables included experience working with substance abusing patients, substance use education pre and post licensure. Key findings revealed that nurses had moderately positive attitudes as correlated with age, total nursing experience, and pre- and post-licensure education. The t-test indicated that nurses with psychiatric experiences, pre- and post-licensure SUD education, a college degree, leadership experience, and experience working with substance abusing patients had more positive attitudes than their counterparts. Hierarchical regression revealed that continuing education was a significant predictor of nurses' attitudes. However, three educational modules related to pre- and post-licensure education explained a low variance in overall attitudes. Most nurses did not have substance use education in the workplace and the low percentage of nurses who participated in the modules may have contributed to the low variance. Another interesting attitudinal finding was that nurses scored low on the moralistic subscale.

Neutrally Ranked Attitudes and Associated Factors

One study ranked nurses' attitudes overall as neutral (Chu & Galang, 2013). This prospective cross-sectional design study evaluated nurses' attitudes toward patients with illicit drug use. The study took place on a medical unit in a Canadian hospital. It also attempted to identify nurse-specific and environmental factors affecting the attitudes. The Drug and Drug Problems Perceptions Questionnaire (DDPPQ) was used to assess nurses' therapeutic attitudes towards SUD patients. Therapeutic attitude is influenced by factors that include demographic variables, role commitment (motivation, professional self-esteem), satisfaction in the role (role adequacy and legitimacy) and external variables such as role support (Cartwright, 1980). There was a 72% response rate with the mean DDPPQ score of 62.6 out of a possible score of 140. Essentially attitudes toward drug users were neutral with no significant correlation between demographic or other variables on the DDPPQ score. Low motivation (one item of the role-specific self-esteem subscale) and the role support subscale implicated attitude factors had a negative effect on the overall DDPPQ score.

Negatively Ranked Attitudes and Associated Factors

Four studies identified negative attitudes of medical-surgical nurses toward SUD patients (Natan, Beyil, & Neta, 2009; McCreddie et al., 2010; Monks, Topping, & Newell, 2012; Neville & Roan, 2014). Factors associated with the negative rankings included stereotypical views, behaviors contributing to a complicated nurse-patient relationship, and a lack of education/knowledge.

Stereotypical views. In the four studies that identified negative attitudes of medical-surgical nurses toward SUD patients, nurses' behaviors seemed to suggest the potential of stereotypical views related to substance abuse and users. These views were noted in quantitative

reports and in qualitative findings as reported by nurses and SUD patients using various descriptors that articulated the concepts of negativity and stereotyping.

Using a correlational design, Natan et al. (2009) explored nurses' attitudes and subjective norms as exhibited in intended and actual care of SUD patients based on the theory of reasoned action (TRA). In essence, a person's intent to behave in a certain way is influenced by their attitude towards the behavior and what others expect. The subjective norm is the person's belief of positive or negative social pressure to perform or avoid certain behaviors. It facilitates performance or avoidance of the behavior regardless of the person's attitude toward the behavior. The intent to behave in a certain way or behavioral intention is the determinant of an individual's behavior according to the TRA.

The investigators developed a Likert scale type questionnaire to measure responses to questions related to actual or intended care of SUD patients and attitudes including stereotypical traits and subjective norms. Of note, the investigators used stereotypical traits often attributed to SUD patients such as dangerous, scary, low cognitive level, weak character, and unhygienic. The sample included 135 internal medicine nurses from three Israeli hospitals with a response rate of 86%. Key findings included moderately negative attitudes such as negative stereotypes of SUD patients. Most nurses considered this patient population difficult. A negative correlation was found in nurses' level of stereotypes for SUD patients and care suggesting that nurses with more stereotypical views thought the quality of care provided was lower than other patients. Another negative correlation was reflected in nurses' assertions of the difficulty of caring for SUD patients and their actual care. Nurses who categorized SUD patients as difficult perceived the quality of care provided as lower. In contrast, investigation of actual care of SUD patients (as reported by the nurses) indicated that they provided a high (20%) to very high (41.5%)

quality of care with only 6.6% reporting giving a lower quality of care. Related to the intention to provide quality care, nurses who had no experience caring for SUD patients reported high (38.5%) to very high (38.5%) intentions to provide quality care; 3.8% reported they would provide a lower level of care. Nurses' discernment of subjective norms indicated they agreed with supervisors, colleagues, patients and families that they should provide adequate treatment to SUD patients; more significance was credited to opinions of supervisors and medical staff than other groups. Correlation coefficients and multiple regressions identified that attitudes, subjective norms, and behavior were significant predictors of behavioral intention, but not actual behavior. This implies that positive attitudes toward SUD patients and perceived expectations of others had an impact on nurses' intention to provide high quality care to SUD patients.

Aside from the Natan et al. study, potential stereotypical views were also noted in qualitative studies. Although not labeled as such, verbal and emotional descriptors reflecting these views toward SUD patients were reported by nurses as judgmental and a waste of space (Monks et al., 2012) and needy, manipulative, and aggressive, (Neville & Roan, 2014). Descriptors by SUD patients reflecting nurses' behaviors and stereotypical views were reflected in interactions that felt: 'condescending,' like a 'piece of shit' (McCreadie et al., 2010). These studies will be discussed in detail related to their more significant references to patient and nursing behaviors and relationships.

Patient and nurse behaviors and complex relationships. Consistent with the literature, patient behaviors contributing to negative attitudes of medical-surgical nurses included aggressiveness, violence, intimidation, manipulation, and deceit. Nurses who experienced these behaviors sometimes responded in counterproductive manners resulting in ineffective

relationships and care. This was apparent in a cascade of events descriptive of poor communication, lack of trust, and ineffective withdrawal and/or pain management.

Neville and Roan (2014) used a qualitative inductive approach using a convenience sample of 24 nurses from an acute care hospital in the northwestern U.S. Participants responded to questions about their perceptions of working with SUD patients: “What are your thoughts and feelings about working with patients with substance abuse and/or dependence issues in the hospital setting” and “How does caring for a patient with substance abuse/dependence influence your nursing care provided to hospitalized patients?” (p. 340). Comparative analysis using coding categories was used to produce common themes that included ethical duty to care, negative perceptions of caring for SUD patients, need for education, and sympathetic concern toward SUD patients. Negative perceptions were noted in responses to the first question and were based on patient behaviors such as manipulation, drug seeking, time consuming (i.e., taking time away from other patients), and fear for safety such as threatening behaviors, sudden outbursts, and violence. Other negative perceptions were noted from responses to the second question having to do with quality of care given SUD patients. Here nurses felt frustration related to recidivism and distrust toward patients, particularly regarding pain assessment. Some nurses expressed suspicion of frequent requests for pain medication, from not only SUD patients, but anyone who frequently requested pain medication. The patients’ report of pain was inconsistent with the nurses’ professional judgement of the patient’s pain. Additionally, some nurses felt like they were contributing to the problem of substance abuse by conceding to demands for pain medication. Both situations created moral conflict within the nurses. Despite negative perceptions, nurses still felt sympathy for the SUD patients’ plight, concern for their families, and an ethical duty to care.

In a grounded theory study by Monks et al. (2012), the investigators explored how nurses managed the care of SUD patients on medical wards and assessment units and the experiences of the patients receiving that care. Forty-one semi-structured interviews were collected and analyzed from multiple medical wards in England. The sample included 29 registered nurses and 12 medical patients. “Dissonant care” formed the core category supported by two sub-categories: “lack of knowledge to care” and “distrust and detachment.” Contributing to the sub-category of distrust and detachment were negative attitudes of nurses who felt intimidation, anxiety, and powerlessness related to the unpredictable behavior of SUD patients, especially where conflict, unit disruption, and violence was concerned. As a result, nurses limited interactions with patients including sometimes limiting the focus of the initial assessment process to physical complications only. The patients also distrusted nurses and recognized their distrust and detachment. The patients felt that the significance of information they provided was unacknowledged and ignored. The consequences of the mutual distrust and nursing detachment was an escalation in negative patient behaviors including verbal lashing out, physical abuse and discharge from the wards. Another previously mentioned study also identified nursing fears related to patient behaviors and violence (Natan et al., 2009).

In contrast, a small number of nurses in the study ($n = 3$) reported positive attitudes in working with SUD patients, viewing them as people and not drug users; consequently, a positive, mutually satisfying relationship was formed.

Using a constructivist grounded theory approach, McCreddie et al. (2010) investigated the strategies of SUD patients and nurses regarding pain management in acute care settings. Participants were recruited from three general hospitals in the same region of the United Kingdom. Data consisted of 11 interviews with SUD patients and five focus groups of nurses

and recovering drug users. After transcribing and coding interviews, the concept of “moral relativism” emerged with respect to individual routines and rituals in pain management within the acute care setting. With moral relativism, there are no correct codes; morality is determined within situated contexts based on knowledge, values, and experiences. People have various morals that are congruent with their situation at the time. Moralities may conflict with others in the same setting with different moralities as in the case of nurses and SUD patients.

Findings included contrasting expectations between SUD patients and nurses related to the therapeutic relationship. SUD patients expected compassion, having their pain managed, and a nonjudgmental attitude from nurses; instead, they felt the opposite including perceptions of waiting too long for pain medication. By comparison, nurses reported perceptions of a restriction in caring, a potential for reduced tolerance (related to aberrant patient behaviors) and decreased therapeutic effectiveness. The investigators suggested that successful therapeutic nurse-patient relationships enhance nurses’ satisfaction and self-esteem. The non-compliant and sometimes aggressive nature of SUD patients along with frequent readmission offers little to make the nurse feel successful in their role.

“Routines and rituals”, a core category of moral relativism, reflected pain and withdrawal management for SUD patients. From the nursing perspective, routines referred to the organized, efficient management of nursing units associated with authority and control necessitated by limited time and resources. The chaotic rituals of SUD patients to prevent withdrawal were an interruption to nurses’ routines. Nurses’ routines and SUD patients’ rituals were relative to each group to maintain their respective truths and needs; perceived threats challenged each groups’ values and self-respect.

Lack of knowledge and education. Findings from three of the studies included inadequate knowledge base as a potential contributor to negative nurses' attitudes. Consistent with the literature, nurses cited not having adequate training. None of the studies measured actual knowledge but reported knowledge and confidence based on self-reports.

In the Neville and Roan (2014) study a less prominent theme of "need for education" emerged. "Lack of knowledge to care" emerged as another sub-category in the grounded theory study by Monks et al. (2012). None of the RNs in the study had received pre- and post-licensure SUD education. Although the nurses felt competent in caring for drug-related complications, they were less confident in monitoring and managing withdrawal. Interestingly, the patients in the study also recognized nurses' inadequate knowledge, which was also reportedly well known among community drug users. Consequently, some delayed admission to the hospital for fear of unsupported withdrawal; once in the hospital they found it necessary to discuss higher methadone doses to avoid withdrawal side effects. Furthermore, inadequate management of withdrawal symptoms led to self-discharge. This as well as the McCreddie et al. (2010) study suggested that nurses lacked the understanding that drug-seeking behaviors could have been patient strategies to manage pain and withdrawal symptoms.

The Nurse-Patient Relationship—Theoretical Contributions

The NPR is central to nursing practice (Miner-Williams; 2009; Peplau, 1992) and the vehicle through which the nurse assesses and manages the care of the patient (Bridges, Nicholson, Maben, Pope, Flatley, Wilkinson, Meyer, & Tzigli, 2012). Though there are multiple NPR definitions, central elements, and contributions of select nurse theorists are described.

In 1952, Hildegard Peplau posited the nature of the NPR. A significant contribution of her work was the belief that the NPR influenced the outcome of the patient. She believed it was a therapeutic and educative alliance when the nurse and patient came to know and respect the other as persons with similarities and differences and who problem solve together. She described the relationship as developing through a series of phases that culminates in a final phase where the patient moves toward independence and healing (Forchuck, 1991). Jean Watson described the therapeutic relationship as one that is helpful, founded on mutual respect and trust, and supportive of faith and hope. It involves sensitivity to self and others and attending to the patient's physical, emotional, and spiritual needs through nursing knowledge and skills (Pullen, 2010). The essence of the NPR appears in a variety of nursing caring theories. Jean Watson's theory of transpersonal caring-healing speaks to the interconnectedness of caring and healing in the relationship (1997). Kristen Swanson's five caring processes speak to caring relationships as knowing/understanding the event of illness through the lives of patients and families, being emotionally present, enabling/informing, doing for and maintaining belief (1993). Madeline Leininger addressed caring relationships from the perspectives of people from many cultures. Her theoretical assumptions include that therapeutic care only occurs when cultural values and practices are known and utilized (Felgen, 2004).

The seminal study and contemporary studies reviewed below reflect many of the relational theoretical concepts previously described. They primarily focus on the formation of relationships, specific elements of the NPR including facilitators and barriers to relationship formation.

Seminal Study

In addition to theoretical contributions, and to gain a general perspective of NPRs, findings from a meta-ethnographic study by Bridges et al. (2013) were reviewed. Studies included in the meta-ethnography were from the published literature from Australia, Europe and North America. Inclusion criteria included those from acute care inpatient hospitals, relating to critical care and medical-surgical wards and those whose evidence was highly rated. Sixteen unique studies of high quality were included in the synthesis. Time frame of studies ranged from January 1999-October of 2009; however, twelve of these studies were published prior to 2007.

The synthesis culminated in a line of reasoning that indicated the nurses' ability to build and maintain therapeutic patient relationships was significantly influenced by organizational conditions at a unit level. Conditions in critical care units supported nurses' ability to form relationships while those on general wards appeared to inhibit relationship formation. This reasoning is described through a single third order construct: influence of setting on capacity for caring and adds to three-second order constructs: nurses' characterizations of relationships, relationship-building strategies and emotional impact on nurses.

Nurses consistently characterized NPRs as therapeutic or potentially therapeutic and a means through which to provide high quality care. The therapeutic relationship involved supporting patients in decision-making, assessing treatment responses, providing comfort and support, advocacy and more. To construct the therapeutic relationship, nurses used a variety of strategies.

Connecting with the patient, the first strategy was contingent on nurses' ability to be fully engaged in the relationship and develop emotional intimacy. It involved sharing experiences, being forthcoming, truthful, and devoted to the patient's welfare. Knowledge of the patient and

significant others, another strategy, included having information of the patient's psychosocial, environmental, and spiritual characteristics that could be used by the nurse to support patient decision making, and assess treatment response. Involving the patient in their care, the third strategy, also supported decision-making, particularly when there were conflicting opinions between patient, family, and physician.

In addition to nurse-patient characterizations and strategies to support relationship formation, was the emotional impact of the relationship on the nurse. If nurses were able to provide what they perceived was high quality care that met the patient's needs, there were feelings of gratification and fulfilment. However, if they were not able to do so, they experienced disappointment and regret. The care of some patient populations provoked more emotional or moral distress than others, such as caring for the dying, the inability to relieve suffering, implementing a care plan felt to be futile and adding to a patient's suffering, and caring for the complex needs of the elderly in the face of inadequate organizational support.

Influence of the clinical setting on the capacity to care is the third order construct that builds upon the previously described second order constructs. Various factors appeared to affect nurses' abilities to form therapeutic relationships including nurses' personal characteristics (i.e., experience, beliefs), patient's personal characteristics (aggression, dementia); but, organizational factors beyond the nurses' control were most the most influential. Nurses in critical care settings formed close relationships and advocated for their patients in treatment decisions. The primary issue to successful nurse advocacy related to the physician's elevated role in the team hierarchy and differences in patient goals from a nursing and medical perspective.

By contrast, general ward nurses often considered the inability to form therapeutic relationships with patients as related to time constraints, lack of organizational importance

ascribed to the NPR, inadequate staffing, and high patient acuity. This was especially problematic in caring for patients with time consuming, complex needs such as the elderly. On the wards, organizational importance was placed on fixed routines rather than attending complex needs of patients. As a direct result, ward nurses chose not to use strategies needed to build therapeutic relationships and chose instead strategies to disengage from the NPR to protect themselves.

Findings contrasting nurses' experiences in critical care versus general ward settings emphasize the importance of unit level conditions that influence nursing care and relationship development. Implications of this study included the need for acute care organizations and healthcare systems to value and support professional-patient relationships throughout the organizations and at the unit level.

Contemporary Studies

Six studies were reviewed, five qualitative and one quantitative. Emergent themes included influences of communication, interpersonal skills, and workplace conditions on the nurse-patient relationship, and the elements of trust, humor and connectedness in nurse-patient relationship. There was much overlap among the studies with regard to elements, contributors, and barriers in the NPR. The studies were summarized according the most prominent elemental theme in each study.

Influences of Communication, Interpersonal Skills, and Workplace Conditions on the Nurse-Patient Relationship

Ali, Mahvash, and Reza (2016) explored nurses' communicative role in the NPR. This qualitative study was based on data derived from semi-structured interviews and observations of 11 nurses and 12 patients and their families on medical surgical units in an Iranian hospital. Analysis revealed that communication in NPR was centered on the patient's need as reflected the

conceptual category entitled “the patient's need-based communication.” Two categories supported this concept: “identifying the patient’s needs” and “communicative behaviors in the face of patient’s needs.” Categories were divided into multiple subthemes.

Three subthemes emerged from “identifying the patient’s needs.” The first subtheme theme, “type of patient’s needs,” generally referred to physical and emotional needs. “Patients inquiring about their health status” originated from typical patient questions pertaining their diagnosis, treatment, prognosis and so forth. Another theme, “monitoring the patient’s health status” was another way nurses identified patient’s needs and included patient observations, asking patients about symptoms and referring to physician and nursing reports for other needs, and information obtained in the shift change report.

The category of “communicative behavior in the face of the patient’s needs” referred to nurses’ responses to needs and the use of interpersonal skills as identified in four subthemes. The first one, “caring attention,” denoted prompt nursing responsiveness to patients’ needs and requests. “Informal education,” a second subtheme referred to patient related education about conditions, medications, treatments, and more. “Inducing calmness,” another subtheme referred to nursing behaviors that promoted a sense of calm in patients such as respectfulness, politeness, patience, active listening, and expressing sympathy. “Obtaining trust of the patient,” the final subtheme was created by nursing competence and accepting their individually with unique needs. Ultimately patient trust influenced compliance with care and treatment and nursing satisfaction. The investigators concluded that upon identifying patient needs, nurses used communicative behaviors directed at meeting those needs and enhancing the quality of care. They suggested the findings of this study can be used to inform nursing policy related to improving patient care and communication strategies.

Arungwa (2014) conducted a quantitative study to determine the effect of communication on the NPR in a national orthopedic hospital in Nigeria. Primary objectives included determining nurses' communication on the quality of care and the nurses' attitudes towards patients. The effect of communication on the NPR was assessed using a cross-sectional survey of self-administered structured questionnaires to nurses and patients. A stratified random technique determined selection of participants. Eighty nurses and eighty patients participated in the study. Data were analyzed using a statistical software package for social sciences (SPSS-9th ed). Data indicated that time and culture affected nurses' interactions with patients with language and culture as barriers for nurse-patient communication. Primary factors that enhanced nursing communication included adequate staffing and nurse compensation. Findings also indicated nurses spent most their time in the planning and implementation phases within the nursing process.

For patients, interaction with nurses was affected by nurses' attitudes and organizational factors (e.g., staffing and equipment shortage, delayed medical services, costliness of care). Patients perceived nursing attitudes to be nonchalant which translated into a lack of friendly interpersonal skills between nurses and patients. The findings also indicated that although nurses consistently initiated patient communication and usually listened to their patients, they did not see the patient's perspective on situations. Additionally, nurses did not give patients feedback that ultimately hindered patient evaluation and the nursing process.

Adequate communication is essential for the development of the NPR and the promotion of quality care. The investigator concluded with several recommendations, among them a need for continuing education for nurses on therapeutic nurse-patient communication and support from health agencies for the NPR.

In a grounded theory study framed by symbolic interactionism, Segaric and Hall (2015) explained how nurses, patients, and family members formed relationships in acute care settings including dealing with the impacts of the work milieu. The investigators recruited participants from multiple acute care units from four Canadian hospitals. Their efforts enlisted 17 nurses, 13 patients, and 10 family members from whom data were gathered in the form of interviews and observations. Because of the unpredictable nature of family visits and the complexity of acute care units, participant data were collected independent of each other.

Constant comparative analysis resulted in findings that included a progressively engaging social-psychological process by which nurses, patients and their families built relationships in acute care settings. “Progressively engaging” was the conceptual category that reflected a trajectory with three different stages of engagement including “focusing on tasks,” “getting acquainted” and “establishing rapport.” The quality of interpersonal dynamics and workplace conditions were key in relationship formation. As participants moved forward, there was increased satisfaction with relationships and nursing care; trust and respect were developed, and all parties responded in reciprocal ways. Patients and families experienced well-being while nurses were intrinsically rewarded by the sense of a job well done.

Negative interpersonal dynamics were barriers to the relationship and resulted when there were limited interactions with nurses. Patients and families felt as if they had “fallen through the cracks.” Busy nurses assumed patients/families were reluctant to engage when they did not ask questions. Other reasons for limited engagement occurred with patient/family language barriers. Subsequently, nurses spent more time with others while patients and families felt overlooked and considered nurses incompetent. Adding to interpersonal barriers were organizational priorities that focused on physical care as the expense of the NPR.

Relationship stages had different outcomes. “Focusing on tasks” or “doing the job” was a stage where interactions were limited and cautious as nurses, patients and families were evaluating each other. Positive verbal and nonverbal communication (e.g., smiling, friendliness, humor, expressing gratitude) potentiated deeper connections and mutual exchange of personal information about their lives. Impersonal dynamics led to more focusing on tasks and negative interactions led to a lack of trust and respect.

Focusing on tasks or negative workplace conditions and/or personal factors such as low motivation or competence increased the potential that patients and families would begin to withdraw from relationship formation. Furthermore, they were less likely to be cooperative with nurses’ suggestions. Nurses regarded frequent questions from patients and family members annoying resulting in their stepping back.

In “getting acquainted”, also known as “doing the job with solicitude”, participants could move forward if workplace conditions and personal factors permitted. Nurses were more likely to be attentive, protective and interested in the lives of patients and families while patients and families were more cooperative and understanding of nurses’ other duties. At this stage, increasing demands of the workplace could undermine relationship building where all parties stepped back.

The final stage of “establishing rapport” was also known as “doing the job with heart.” Nurses moved toward establishing rapport when patients and families were accepting of other nursing responsibilities, were willing to help themselves, and respectful and cooperative with nurses and hospital policies. When nurses trusted patients and families, they were willing to go the “extra mile” with care. Likewise, patients and families were more accepting of nurses’

absences and minimized demands. When they trusted nurses, they were more likely to attribute their absences to caring for sicker patients.

The investigators believed their theory suggested nurses can facilitate positive interpersonal dynamics with patients and family members by being cheerful, friendly, and providing information despite demands on their time. They concluded that the theory emphasized the importance of workplace conditions undermining trust and reciprocity among nurse, patients and families and therefore relationship formation.

Elements of Trust, Humor, and Connectedness in the Nurse-Patient Relationship

The following studies focus on the elements of trust, humor, and connectedness in the NPR. These elements are mentioned in previous studies in varying degrees and descriptions with a concentrated theoretical focus here.

Belcher and Jones (2009) conducted a qualitative exploratory descriptive study to capture and describe graduate nurses' experiences establishing trust in the NPR. A purposeful sample of seven nurses with a baccalaureate degree and in their first year of practice within a transition to nursing program was selected for the study. Data were collected through semi-structured interviews and analyzed.

In general, the data revealed that nurses believed that personalities of both the nurse and patient influenced developing a trusting relationship. Personality traits associated with trust were friendliness, willingness to care, willing to help, and showing interest in others. Another factor influencing trust development was rapport. Rapport was defined as a mutual comfort level between the nurse and the patient that was influenced by honesty, confidence, and the ability to form a relationship. Developing rapport was the precursor to building trust and was supported by communication, being professional and confidence.

Communication skills were important, especially taking the time to listen to the patient. Specific purposes of communication included sharing information and explanations and having conversations around the social context to get to know the other. Language and cultural issues emerged as barriers in communication as well as the use of medical jargon.

Being professional took into account personalities, good bedside manner, personal issues and how the nurse feels on the day. A holistic approach to nursing care was how participants interpreted a good bedside manner. With limited experience, new graduate participants perceived a holistic approach as involving the patient in the plan of care and decision-making. Personal issues influencing professionalism and rapport included preoccupation with personal, issues, how the nurse felt on the day, and being busy and tired.

Being confident was supported by life and nursing experiences, job satisfaction and clinical educational support. When participants felt their knowledge and experiences were inadequate to care for a patient, it diminished their confidence and ability to form a trusting relationship. Clinical educational support was an important confidence builder when new nurses knew they could count on experienced nurses to guide them. Experiences and clinical support helped build their confidence levels and subsequent trust with patients and job satisfaction. Nurses equated establishing patient trust with simplifying their jobs because patients were more cooperative.

The investigators concluded that prerequisite to building a trusting relationship, a graduate nurse must first develop rapport. They asserted more emphasis must be placed on teaching communication skills in undergraduate and graduate nursing programs. Additionally, other factors that support developing rapport and trust such as professionalism should be included in these programs.

Tanay, Wiseman, Roberts, and Ream (2014) studied the effects of humor in the NPR in an adult cancer setting using a modified ethnographic methodology by means of observation and interviews. Using a convenience sampling strategy, 9 nurses and 12 patients participated in participant observation. Five nurses and five patients were interviewed. Nurses had one year of experience and all worked on the same ward. Data analysis revealed four key themes: “the benefit of humor in the NPR,” “humor and professionalism,” and “humor requires constant assessment and reflection.”

Among the benefits of humor was the feeling among patients and nurses that they were creating a connection. It promoted a mutual sense of comfort. Nurses perceived humor as a way of developing trust and showing they enjoyed their work. Patients felt humor was essential in the relationship, a way of spreading positive energy and that nurses were more likely to like them if they had a sense of humor. Observations indicated that when patients used humor, nurses were more likely to respond cheerfully despite being busy. Additionally, it appeared that nurses preferred caring for humorous patients. Recognizing the challenges and stress healthcare professionals experience, patients sometimes intentionally used humor to help staff cope. Likewise, nurses acknowledged humor helped them get through their day.

Nurses expressed concern about professionalism with the use of humor, specifically how their colleagues viewed them. Inexperienced nurses relied on senior nurses for the appropriateness of humor. Nurses also recognized the need to assess and reflect on the appropriate use of humor. The timing of expressing humor was important and study participants acknowledged that inappropriate use of humor could result in negative consequences.

The investigators concluded that appropriate humor benefitted both nurses and patients and was one of many communication strategies to facilitate development of the NPR. It was repeatedly associated with the development of comfort and trust between the nurse and patient.

In a grounded theory study, Miner-Williams (2007) explored the meaning of “connectedness” within the context of the NPR. The investigator ascertained an initial understanding of connectedness and found that within the context of nursing connectedness was “a caring, meaningful nurse-patient relationship in which exists an offering of self and acceptance of the other” (p. 1216). Assumptions in this study included that connectedness is a commonly experienced phenomenon, but the achievement of it is inconsistent. A second assumption was that spirituality is the lens through which connectedness in the relationship is examined. For this study, spirituality is “the core of a person’s being, the essence of being human, the channeling of fire that burns within us, and is therefore present in every human being” (p. 1218). The relational expression of spirituality is through connectedness with one self and the other.

Data were collected through semi-structured interviews from 15 nurses and 10 patients. Nursing participants included those from a variety of practice settings, primarily acute care, and with varying levels of experience. Through analysis, two core categories emerged “meeting the need” and “interpreting meaningfulness.”

“Meeting the need” centered on biopsychosocial needs and recognizing and meeting the needs of the spirit. Some needs were easily recognized and others not, such as the need to be recognized as an individual. “Interpreting meaningfulness” referred to connections within the relationship experienced as meaningful. Those who experienced meaningfulness felt a need to

share the experience with others but found it difficult to put into words. Meaningfulness sometimes involved describing a difficult experience as ultimately having a positive impact.

The process of connectedness in the NPR unfolds in phases, including setting the milieu, unfolding, and outgrowth. A spiritually competent nurse who is able and willing to identify and address the needs of the spirit establishes the milieu. Spiritual competence involves an awareness of one's impact on another person, interpersonal skills, and characteristics such as caring, thoughtfulness, and being fully engaged.

In the unfolding phase, where spiritual needs are identified and met, there is a reciprocal exchange between the nurse and patient and occasionally the blending of roles or an energy exchange. The nurse exchanges with the patient self and energy that may be in the form of actions or self-disclosure. Outgrowth, the final phase denotes the outcome of connectedness where there is comfort, healing, and growth for both the patient and the nurse.

The investigator summarizes with emphasis that the special, unique relationship of connectedness can occur in any clinical setting involving spiritually competence nurses. The importance of the study related to the outgrowth that had profound and positive consequences for patients and nurses. Finally, a desire for the nurse-patient relationship-connectedness calls for reflection and evaluation of how one approaches the patient.

In summary, the NPR is central to nursing practice and the medium through which transformation of patient/family health and the gratification and satisfaction of nursing is realized. Many overlapping characteristics or elements to the NPR contribute to its formation including good communication, interpersonal skills, and the formation of a special bond that is facilitated by trust, rapport, humor and many more. A lack of these elements, especially communication and interpersonal skills, is a barrier to relational development. Further barriers

to NPR development include language and culture, and workplace conditions, such as inadequate staffing and lack of organizational support for NPR development.

Summary

The need to prepare healthcare professionals for care of patients with SUDs has been repeatedly stated in these studies as well as recommended by international and national entities (World Health Organization, 1993; Fornili & Alemi, 2007). Further, a position statement by the American Association of Colleges of Nursing (AACN) established policies related to prevention and management of substance abuse in the nursing education community including the provision of education to nursing faculty and students (1998). To support educational initiatives, there are several substance screening programs recommended as a training tool for students as well as workforce training; one such program is the Screening, Brief Intervention, Referral and Treatment (SBIRT) provided by grantees of SAMSHA.

Despite these recommendations, there was little evidence supporting the integration of adequate SUD content in undergraduate and graduate nursing curriculums in the United States and in other parts of the world. In addition, there was no appreciable change in current studies related to hours devoted to SUD curricular content as compared to the seminal works of Howard et al. (2001) and Hoffman and Heinemann (1987). Few studies addressed topics covered and most content had to do with definition, identification and management of patients with substance abuse; there was no evidence to suggest content for managing negative attitudes or challenging patient behaviors. Similar to Hoffman and Heinemann's findings, SUD content was usually imbedded in the context of mental health courses with very little time given to clinical practice. Hoffman and Heinemann suggested the training context was linked historically to alcohol and addictions being treated in state mental hospitals that gradually shifted to inpatient psychiatric

units. The continued coupling of SUD content with mental health nursing courses may suggest that SUD is a mental health issue rather than a disease.

Three studies focused on both SUD knowledge and nursing attitudes of practicing nurses. Based on these studies a conclusion cannot be drawn related to the adequacy of knowledge, but at a minimum, they suggested that overall knowledge is limited. Only one study offered a more detailed assessment of knowledge that the investigators concluded was modest but adequate (Happel et al., 2002). The other two studies appeared limited related to actual knowledge assessed. For example, Owens et al. (2000) focused on nurses' knowledge of sensible limits of alcohol consumption; the other study was vague related to knowledge questions (Selleck & Redding, 1999). Lack of knowledge and/or need for education was also noted in three studies involving medical-surgical nurses (McCreddie et al., 2010; Monks et al., 2012; Neville & Roan, 2014).

Attitudes of nurses were also evaluated using a variety of methodologies. The concept of attitude appeared in some cases to be linked to a single attribute with findings providing a very limited picture of nursing attitudes. For example, Owens et al. (2000) assessed nurses' attitudes by their willingness to be involved in the care of patients who abuse alcohol. Other studies examined attitudes more comprehensively using instruments that measured concepts such as moralism, stereotypes, treatment optimism, role adequacy, or qualitative interviews where nurses acknowledged negative attitudes as well as their SUD patients (Chang & Yang, 2013; McCreddie et al., 2010; Monks et al., 2012; Neville & Roan, 2014). Much like the Howard and Chung's reviews (2000a, 2000b), nursing attitudes continues to be predominantly negative.

Two studies evaluated the impact of education on the knowledge and attitudes of practicing nurses using a pre and post educational design (Gerace et al. 2009; Vadamudi et al.

2008). In both studies knowledge improved, but Vadlamudi et al. also reported an improvement in attitude that was vaguely defined. Interestingly, Gerace et al. (2009) included content in their educational intervention and teaching strategies that challenged negative attitudes and provided information on managing challenging patient behaviors such as manipulation. Despite these interventions, attitudes improved in treatment optimism only. Similarly, Ford et al. (2008, 2009) examined attitude toward SUD patients in depth in terms of motivation, role adequacy, self-esteem and the impact of variables such as SUD education on attitudes. They concluded workplace education had no impact on attitude in the absence of role support.

The NPR was explored within acute care settings such medical-surgical units where the location of this study takes place. Its connection to patients with SUDs, is important because quality patient care and job satisfaction in nursing is facilitated by a positive NPR. As evidenced by studies reflecting negative attitudes of nurses toward SUD patients, the NPR appeared dysfunctional. Therefore, seven studies from acute care settings were reviewed to explicate the nature and elements of the NPR. Overall, studies focused on the influences of communication, interpersonal skills and workplace conditions on the NPR and the elements of trust, humor and connectedness in the NPR.

Communication is fundamental in the NPR (Ali et al., 2016; Arungwa, 2014; Belcher & Jones, 2009; Segaric & Hall, 2015), and essential to quality care (Arungwa, 2014). Communication is enhanced with positive interpersonal skills. Interpersonal skills were associated with non-verbal skills such as smiling and personality traits such as friendliness, politeness, respectfulness, truthfulness, patience, humor, willingness to care, showing interest in others, and expressing sympathy (Ali et al., 2016; Belcher & Jones, 2007; Bridges et al., 2013; Segaric & Hall, 2015; Tanay et al., 2014). In addition, both communication and relationships are

influenced by workplace conditions such as inadequate staffing and organizational emphasis on routines and other conditions (Arungwa, 2014; Bridges et al., 2013; Segaric & Hall, 2015).

Tanay et al. (2014) elaborated on other benefits of humor including promoting comfort between the nurse and the patient, injecting energy into the relationship, and a stress reducer given the tense nature of healthcare situations. Other actions associated with the NPR included involving patients in decision-making and the plan of care (Belcher & Jones, 2009; Bridges et al., 2013).

Outcomes of effective communication and interpersonal skills included the establishment of trust and a sense of connection or a bond (Ali et al., 2016; Behcher & Jones, 2009; Bridges et al., 2013; Miner-Williams, 2007; Segaric & Hall, 2015; Tanay et al., 2014). Other contributors to trust included nursing competence and the nurses' willingness to see the patient as an individual (Ali et al., 2016). Connecting with the patient also involved meeting the patient's spiritual needs and establishing emotional intimacy through shared experiences (Bridges et al., 2013; Miner-Williams; 2007). The combination of all the factors and more is the foundation of a good NPR.

Benefits to a positive NPR included mutual nurse-patient/family support and nurses' willingness to go the extra mile. Patients/families were accepting of nurse responsibilities, did more for themselves and minimized demands (Segaric & Hall, 2015). Other benefits of a positive NPR include comfort, health and growth for both the patient and nurse (Miner-Williams, 2007), increased patient compliance (Belcher & Jones, 2009) and increased nursing confidence and job satisfaction (Belcher & Jones, 2009; Bridges et al., 2013).

Poor communication and interpersonal skills were relational barriers. (Arungwa, 2014; Segaric & Hall, 2015), including language and/or culture (Arungwa, 2014; Belcher & Jones,

2009). Other barriers to NPR formation included poor workplace conditions and organizational priorities on throughput (Arungwa, 2014; Bridges et al., 2013; Segaric & Hall, 2015). Nursing attitudes such as being nonchalant (Arungwa, 2014) and being tired or pre-occupied with personal issues were barriers to forming relationships (Belcher & Jones, 2009). Bridges et al. (2013) also pointed out that patient characteristics such as dementia and aggression were barriers to relationship formation.

Conclusion

There is a paucity of research examining attitudes and perspectives of medical-surgical nurses caring for SUD patients, in this review, only three quantitative and three qualitative studies. Of these, only three gave insight into the overall experiences of medical-surgical nurses caring for this patient population (McCredie et al. 2010; Monks et al. 2012; Neville & Roan, 2014). None of the studies focused solely on the care of suspected OUD patients and only one study took place in the United States where addiction to opiates is epidemic. The qualitative research design, analysis and the questions asked in the Neville and Roan study served in part as the basis for the research questions in this study. However, in this study, the questions were expanded upon to explore the NPR in more depth and ascertain what interventions would improve patient care and the nurses' satisfaction in caring for them. Therefore, the intent of this study was to investigate in more detail the experiences of medical-surgical nurses caring for patients with suspected OUD. Suspected OUD patients were chosen because this population does not routinely acknowledge their problem when hospitalized for other conditions.

CHAPTER III: METHODOLOGY

The purpose of this chapter is to describe the research methodology for the study, the rationale for its selection, and how it was used. A qualitative approach, more specifically, symbolic interactionism (SI) will be defined including contributors to the SI tradition, central concepts, SI as methodology, data collection, analysis and other procedural elements of the study.

The investigator was interested in the experiences of medical-surgical nurses who have cared for patients suspected of having an OUD. Quantitative studies previously discussed were limited in explaining nurses' knowledge and attitudes. As opposed to quantitative investigations that focus on independent and dependent variables, parts of something reduced from the whole, a qualitative design emphasizes holism and humans are a holistic system. Qualitative research gives voice to people by using their intimate stories and their language (Munhall, 2012); and it will elicit more information such as thoughts and feelings related to experiences of the study population. Symbolic interactionism was the specific qualitative approach and the lens by which nurses' experiences were examined and interpreted.

Symbolic Interactionism

Symbolic interactionism (SI) describes a unique methodology to the study of human group life and human behavior. It is based on three suppositions; first, individuals behave toward things based on the meanings they have given them. Things include everything in the individual's environment such as physical objects, other human beings, categories of humans,

institutions, ideals, activities of others- everything. Secondly, the meaning of these things comes through interaction with others. Thirdly, the meanings of things are understood through an interpretive process by the individual engaged with the things (Blumer, 1969).

Contributors to Symbolic Interactionism

Although SI was influenced by evolution and behavioral theories, the most significant influence was early 20th century pragmatists, among them James, Dewey, Cooley, Thomas and Mead (Meltzer, Petras & Reynolds, 1975; Charon, 2011). Of all those who have contributed to SI, George H. Mead (1863-1931) is the perspectives' leading figure (Meltzer et al., 1975). He was a philosophy professor at the University of Chicago, from whence sprang several other major contributors of SI. Although he wrote many articles, his influence on SI came through the publishing of his lectures and notes by his students, most notably Herbert Blumer. Mead's basic philosophy was that of pragmatism, the foundation of SI. A basic assumption of pragmatism is that knowledge has to be practiced and that individuals should be examined within the context of their environment (Benzies & Allen, 2001).

Goffman, a sociology theorist, and a graduate student of the University of Chicago in the 1940s also contributed to SI. His method of studying SI was referred to as dramaturgical, the view of social life as a staged drama. From drama and ritual come the collaborative manufacture of selves; these themes are the foundation of Goffman's perspective (Charon, 2011).

Central Concepts of Symbolic Interactionism

There are a number of concepts central to SI, these include symbols, self, the mind, action, role taking, social interaction, and society. Symbols are the creation of humans and used for interaction. They represent a class of social objects and can be anything such as physical objects, animals, other people, self, emotions, past, and future. The use of symbols in

various situations represents or communicates something; users and others understand them. Symbols are often of three types: words, objects, and acts (Charon, 2011).

‘Self’ is another concept of SI; humans own a self. By this Mead meant that individuals perceive and have conceptions of themselves and communicate and act toward themselves; these behaviors refer to self-interaction (Blumer, 1969). Specifically, Mead viewed the ‘self’ as a blend of two aspects of individuals; the ‘I’, represents the impulsive nature of individuals while the ‘me’ denotes the expectations of others. The interaction between the ‘I’ and ‘me’ represents the self (Benzies & Allen, 2001).

The human mind, another concept, is described as continuous mind action or thinking in all situations. It involves self-talk about environmental situations, decisions, and actions to take. Mind action or thinking enables individuals to control their overt actions, problem solve and it accompanies all social interaction. Role taking is yet another concept of SI. Individuals consider those around them and routinely try to understand the other’s perspective on the situation. In doing so, individuals alter their actions in relation to others. It is one of the most important of all mind actions and is responsible for successful relationships, teaching, leading, competing, self-control, and much more (Charon, 2011).

Human action occurs when the individual identifies wants and determines a way to achieve the wants (Blumer, 1969). Humans engage in a continuous flow of overt and covert actions based on decisions influenced by how the situation was defined, social interaction and self-interaction. Humans continually define the situation and make decisions as they move forward. Social interaction is the source of human society; humans interact with each other and are mutually influenced by that interaction (Charon, 2011).

Symbolic Interactionism as a Methodology

The methodological position of SI consists of a direct examination of the empirical social world; it can be readily tested and confirmed by mere observation (Blumer, 1969). There are multiple variations of SI methodology. Some of the most common ones include analytic induction, grounded theory, and approaches influenced by phenomenology, ethnography, and postmodernism (Smelser & Baltes, 2001). However, this study was influenced by an early methodological version of SI by Blumer who used a naturalistic approach; it involved both exploration and inspection. Exploration is very flexible and uses any ethical process that illuminates what is occurring in the area of investigation. Initial ideas, concepts, preconceptions are subject to change through continued data collection. Inspection involves analysis, identifying significant elements within the situation, and describing the situation in relation to the elements (Blumer, 1969; Charon, 2011). These analytical elements are organizing categorical items. Inspection is flexible, creative, and not limited to one direction or bound by specific process or procedures (Blumer, 1969). Exploration and inspection is not unique to SI or unlike other qualitative exploratory approaches.

The methodological approach must honor the central concepts of SI. As in other qualitative approaches, the investigator must understand the situation from the perspective of the participants. Individuals behave toward objects based on the meaning of their objects, so the investigator must see the objects as the individual sees the object. It involves taking on the role of the individual, identifying objects of primary concern, understanding vocabulary and how participants define the situation and problem solve.

Although accessing information may involve multiple techniques (e.g., observation, life histories, interviews) all activities yield a rich descriptive account of the phenomenon as

illuminated by the participants (Blumer, 1969). This study accessed the experiences of participants through in-depth semi-structured interviewing.

Research Questions

The purpose of this study was to broadly explore and make meaning of medical-surgical nurses' experiences of caring for suspected OUD patients. The first two research questions were based on the two questions in the Neville and Roan (2014) study. They were expanded to explore the nurse-patient relationship, implications for the nurse-patient relationship and care, and implications for nursing education. The study addressed the following questions:

1. What are the thoughts, feelings or perceptions of medical-surgical nurses caring for patients with suspected OUDs;
2. How do the thoughts, feelings or perceptions of medical-surgical nurses influence relationships with and the care given to patients; and
3. What are the implications for the nurse-patient relationship and nursing education?

Population and Sample Size

RNs working on medical-surgical units comprised the study population; therefore, the sample was nonrandom and purposive. To assure adequate exposure to the OUD population, nurses had to have a minimum of six months experience. To assure this period was adequate for exposure, the investigator, employed as nursing educator at an acute care facility, informally queried five RNs on different medical-surgical units about caring for patients with suspected OUD. Nurses were asked if they had taken care of a patient suspected of OUD and whether six months experience as an RN was adequate time to encounter such a patient. Nurses responded "yes" to both questions.

Sample size for qualitative studies is generally much smaller than quantitative studies and based on saturation or redundancy of common elements that form themes. Based on study findings, Guest, Bunce and Johnson (2006) found that saturation from interviews generally occurred within the first 12 interviews but basic elemental themes emerged within the first six interviews. The investigator planned on an initial recruitment of 12 medical-surgical nurses, however; only ten volunteered for the study. Redundancy of data occurred after the first seven interviews. The investigator continued to interview the remaining participants to assure no emergence of new data.

Recruitment

After Institutional Review Board approval, recruitment procedures were initiated. Recruitment initially began at the largest hospital of a three-hospital health system in the southeastern United States. With manager approval, the investigator presented a five- minute study overview during monthly unit meetings and placed informational flyers in employee breakrooms. A recruitment flyer (see Appendix A) included the purpose of the study, investigator contact information, voluntary nature of the study, and other details. Those who needed more information and/or chose to participate in the study received additional information (see Appendix B). The investigator presented the same information to nurse residents at another hospital in the health system and gave them flyers with contact information. During meeting situations, some nurses volunteered immediately and were contacted later by investigator to schedule an interview. Eight of the ten nurses were from one hospital location while two others, who learned of the study through word of mouth, came from a large metropolitan hospital in an adjacent county.

Data Collection and Procedures

The investigator initially contacted participants by phone or email, verified whether the study participant met criteria, and arranged a date, time and meeting place. All interviews occurred in person and ranged from 45 minutes to an hour. With the exception of one participant, all interviews occurred at the participant's place of employment in a private meeting space either after their shift or on an off day. One interview occurred in the participant's apartment meeting room at the participant's request. After informed consent was obtained, participants had an opportunity to ask questions and a \$50 gift card was given in appreciation immediately prior to the interview.

For purposes of describing the sample, demographic data were collected initially during the interview such as age range, nursing degree, and years of experience. Since participation was voluntary, there was no control for the degree of diversity in the study population. Although they were all female, there was diversity in race, ages, years of experience and education. There were six Caucasian nurses and four African-American nurses. Other demographic data collected included age ranges, years of experience and nursing degree. The nurses fell into the following age ranges: 21-25 years (two), 26-30 years (one); 31-35 years (two); 36-40 years (one); 41-45 years (one); 46-50 years (two); none fell in ages ranging from 51-60 years; 61-65 years (one). The number of nurses and type of nursing degrees included: associate degree (eight); baccalaureate (one) and master's in nursing with doctorate in nursing education (one). Nurses fell into the following years of experience ranges: two years or less (three nurses); three years (four nurses). One nurse had nearly 15 years of experience and the other two had a little more than 25 years of experience.

All nurse participants cared for 5-6 patients and worked twelve-hour shifts. They cared for a wide variety of patients with medical or surgical conditions including those with cardiac, endocrine, orthopedic, neurological, urological, renal, pulmonary, and trauma related issues. Patient acuity varied with some reporting high patient acuity on their units.

Data from this study came from semi-structured interviews regarding experiences and perspectives of medical-surgical nurses' who have cared for patients with suspected OUD. Interviews provided detailed descriptions, integrated multiple perspectives, revealed participant interpretation of events, and promoted investigator connection to the experience as described by Weiss (1994). Connecting the investigator to the experience enabled role taking, a central concept of SI. The investigator also created a case scenario involving the care of a suspected OUD patient with the intent of connecting the nurse to the experience if the nurse could not recall a specific example. This scenario and interview questions were piloted with five RN colleagues who had all experienced caring for patients with suspected OUD in their careers. As noted by Weiss (1994), pilot interviews served as a field test for the interview guide and suggested where the guide needed amendments. After the pilot, the investigator eliminated redundant questions, rephrased questions for clarity, and added others. Participant responses guided which questions were asked or whether others should be added or modified with each interview. The field test also gave the investigator practice in techniques such as probing for more information, allowing for periods of silence, noticing body language, and making field/descriptive notes.

Initial interview questions (see Appendix D) were open-ended and aimed at gathering contextual data such as a description of the nursing unit, typical patient diagnoses managed on the unit, a description of a typical workday, the meaning of a therapeutic or positive nurse-

patient relationship. As the interview progressed, further questions examined experiences of caring for suspected OUD patients and perceptions about the quality of care. In only two cases were participants not able to recall a specific experience but rather an impression of experiences over the years. In these cases, the scenario was read to the participants who acknowledged that the scenario was very realistic and similar to their experiences. During the interview, the investigator asked for clarification of comments, and asked probing questions related to information that was unclear. The investigator also verified some initial impressions as a form of member checking. Redundancy was apparent after seven interviews, but the investigator continued with three more to assure no emergence of new information. A second, brief interview for the purposes of member checking occurred over the phone within 24 hours to one-month post interview depending on the availability of the investigator and participants for follow-up. Most member checking occurred within five to seven days post interview. The investigator was unable to reach two participants, however, as their interview data was in line with other participants, the data continued to be a part of the study.

Interviews were electronically recorded for accuracy. Additionally, the investigator documented brief descriptive notes during the interview that included a description of the setting, participant appearance, mannerisms and body language. Transcription of interviews occurred as soon after each interview as possible ranging from four to 36 hours post interview. Descriptive notes from each interview were typed into each transcript. Prompt review and initial analysis identified perceptions and raised additional questions that were used in a few subsequent interviews to develop a more complete picture of experiences.

The investigator also documented a few reflective notes focused on “speculation, feelings, problems, ideas, hunches, impressions, and prejudices” (Bogdan & Biklen, 1998, p.

123). Most reflective notes were hand written in the margins of transcribed interviews. Memos are a more in-depth documentation of thoughts about the data (Corbin & Strauss, 2008) and may include ideas about concepts or emerging themes as the data are analyzed. In this study, memos became a collection of codes that were reduced to form subthemes and themes. Descriptive and reflective notes and memos represent a component of data and analysis.

Analysis

From a naturalistic perspective, Blumer asserted the inspection or analysis of the data is not a fixed process or procedure; data elements are approached from different angles, queried, compared with other elements to sift out their nature (1969). To this end, several analytical strategies of qualitative research were used such as asking questions of the data and making comparisons. Asking questions stimulated thinking about the data and subsequently led to consideration of possible answers or interpretations. This allowed the investigator to take the role of the other and consider the situation from the participant's perspective. Questions can range from meanings of terms or expressions and they allow the investigator to understand how much they do not know about a concept and how much more they need to know (Corbin & Strauss, 2008).

Comparisons may be constant or theoretical. Developed by Glaser and Strauss, constant comparison involves comparing data incidents with other incidents for similarities and differences that are ultimately grouped together to form a larger descriptive category. This analytic tactic was used in grounded theory development (2008). Many qualitative researchers have adopted the constant comparative method, even when the research intent was not grounded theory (Roulston, 2013). The constant comparative method begins with the researcher performing open coding of transcripts that leads to differentiation of themes/categories and the

properties within those themes. Constant comparisons used in this study identified the primary themes that captured nurses' experiences.

Theoretical comparisons bring meaning to data that does not fit into a theme or cannot be literally interpreted such as symbolism used in language. It allows the investigator to compare the data to other life experiences that are understood (Corbin & Strauss, 2008). Overall, theoretical comparisons were limited to symbolic phrases used to describe characteristics of those suspected of OUD and common phrases used in American society to describe people in general or situations. Symbols are a central tenet of SI and were used in this study by the investigator to help interpret the experiences of nurse participants caring for patients with suspected OUD.

Transcripts were read at least two or three times before coding began. As the investigator read the transcripts, the data were also viewed through the lens of SI to identify tenets in ts of the study participants. For example, symbolic language such as "frequent flyer" characterized nurses' perceptions of unnecessary and frequent admissions of suspected OUD patients.

The coding process involved reading transcripts either line-by-line looking for key words or phrases or by one or more sentences that yielded meaning. Words or expressions (coding categories) that represented topics and patterns within the transcript were documented (Bogdan & Biklen, 1998). When the same or similar codes were noted in other transcripts, the investigator began comparison in all transcripts for the same or similar codes. Redundant and overlapping codes were reduced subsequently to form larger categories or themes that represented the bits of data that defined the theme. The following is an example of initial coding categories reduced to form larger themes proceeded by an explanation of the theme. A complete list of coding categories, subthemes, and themes are in Appendices E-I.

Frequent and/or bogus admissions, drug of choice, allergy list, and nothing else works were examples of coding categories that described interrelated patient behaviors that were reduced to the larger a subtheme of *self-regulation of pain/addiction* and ultimately the larger theme of *identification of the suspected OUD patient*. Frequent and/or bogus admissions emerged in multiple interviews where nurses reported suspected OUD patients had frequent admissions. Admissions were related to pain and/or patients knew exactly what to say such as “I have chest pain” to gain admission to the hospital and therefore access to opiates. Often these patients had no diagnostic findings or history to suggest they had a significant illness or condition requiring strong opiates, hence, the derivation of “bogus.” Nurses also noted that suspected OUD patients consistently requested one of the strongest opiates, Dilaudid to be given intravenously (IV) as the only way to manage their pain/addiction. To ensure Dilaudid would be included in pain orders patients reported they were allergic to all other opiates and/or that nothing else works. Therefore, Dilaudid became known as the drug of choice, another symbol associated with drug users.

These behaviors suggested suspected OUD patients were trying to gain access to pain medication as needed to maintain their OUD and/or prevent withdrawal. Therefore, self-regulation of pain/addiction became a subtheme that described a specific set of behaviors that led nurses to suspect a patient had an OUD. Collectively, the behaviors described in the coding categories and subthemes led nurses in the identification of suspected OUD, one of the major themes in the study.

The investigator continued to use a very flexible, naturalistic approach while exploring the data, asking questions of data and follow-up questions of nurses during member-checking interview to obtain clarify and verify initial perceptions. This was helpful in guiding the

investigation, however, it was later after the examining the data multiple times and asking questions about other potential meanings that some initial impressions began to evolve and become solid categorical ideas. The investigator also used the dissertation committee chairperson to examine data with fresh eyes and share perceptions of the data. This fresh perspective was instrumental in further examination of the data and making final selections of themes.

Next, it was determined how the thematic information would be organized and reported in the findings; also known as local integration (Weiss, 1994). The investigator organized the information by explaining the theme followed by the subtheme and overview of the subtheme. Examples of nurses' comments supporting each subtheme were listed. The final stage of analysis involved the integration of all pieces of the analysis into a logical flow to form a coherent story that ends with a general conclusion (Weiss, 1994). Interestingly, one of the final themes to emerge in the analysis, *nurses' preconceptions of OUD patients*, became the first theme to be discussed because it formed the basis for nurses' knowledge of OUD and how to identify those suspected of it. Other subthemes were organized in a cohesive order that best represented nurses' experiences.

Trustworthiness of Data

The standard of trustworthiness in naturalistic research serves a similar purpose as the traditional positivistic criteria of internal and external validity, reliability, and objectivity. Guba (1981) proposed criteria that serve as the counterparts to positivistic criteria noted above such as credibility, transferability, dependability and confirmability; these criteria have been accepted by many (Shenton, 2004). Credibility is similar to internal validity and is one of the most important factors in establishing trustworthiness. For this study credibility was established in the following

ways: adherence to research methods and strategies for data gathering and analysis previously described; periodic debriefing sessions with committee chair, evaluation of the project on an ongoing basis, the use of reflective notes and member checking. Member checking refers to verifying accuracy of data collected and verification of the investigator's initial impressions or themes with participants. This occurred throughout each interview and in a brief follow-up interview. A thick description of the phenomena and a comparison of findings with previous research enhanced credibility.

Establishing transferability is a bit more daunting because findings are bound by the context in which they occur. Guba (1981) suggests the collection of thick descriptive data that permits comparison of the study contexts to other contexts; in other words, if transferability depends on matching characteristics, the investigator needs to provide information that allows the reader to assess adequate fit or match. Thick descriptive data is accomplished by a thorough description of all contextual factors that impact the investigation. To this end, the investigator provided adequate contextual information related to the participants' work related contextual factors.

Dependability, comparable to reliability in positivist research, refers to the ability to duplicate research with similar results. Because of the changing nature of phenomena in qualitative research, similar results are problematic. Therefore, the investigator described the processes within the study in detail to enable another investigator to repeat the study, if not to get similar results. Confirmability contrasts with objectivity in positivistic research. A key principle for confirmability is the steps the investigator will take to assure that the findings reflect the thoughts and feelings of the participants and not the investigator (Shenton, 2004).

To this end, the investigator maintained an awareness of personal bias and judgements by disclosing experiences and feelings related to the phenomenon. Emerging impressions related to interview data were clarified and verified with participants through member checking.

Investigator's Experiences

I have worked as a registered nurse for more than 35 years; about half of my career has been as a staff nurse in an emergency department (ED). It was not uncommon to encounter patients known to emergency staff as frequent flyers or drug seekers. I did not initially view these patients by those stereotypes; I learned about those stereotypes from other nurses and physicians. However, after several experiences with manipulation and acting out episodes by SUD patients, I understood the genesis of those stereotypes and frankly adopted that way of thinking. Although I experienced frustration in dealing with these patients, my encounters with them did not seem too frequent. In recent years and in my current role as a hospital educator, I have heard many nurses express frustration in dealing with 'pain' patients inferring they believed the patient had a dependence problem rather than legitimate pain. I first heard of their feelings during a workshop I coordinated related to *Relationship Based Care* that was attended by 1,400 nursing staff over a 14-month period. One exercise challenged nurses to consider a patient type or population they found most difficult to relate to and I was surprised to find out those with OUD or suspected OUD were the most difficult. My impression was that their experiences with suspected OUD patients were far more frequent and frustrating than what I encountered. I feel empathy for these nurses; we are in a nursing shortage and that coupled with a heavy workload and caring for suspected OUD patients can be very stressful. Although I am very concerned for OUD patients, I am equally concerned for the nurses caring for them; this is the reason for my study. I am hoping to understand nursing experiences and that something will be uncovered that

will ultimately lead to improving the care of this patient population and the satisfaction of nurses caring for them.

Having acknowledged my experiences and frustrations dealing with this population, and concerns for the patient and the nurses caring for them, it is important to lay aside my experiences and perceptions and focus on the perceptions of the study participants. I will maintain an awareness of my thoughts and feelings during the interviews and make reflective notes as needed. Through member checking of initial impressions of transcripts, I will be able to ensure that the interpretation does not reflect my spin on the data but that of the participants.

Limitations

Limitations of this qualitative study included the inexperience of the investigator and the potential for bias. The investigator maintained an awareness of personal feelings and biases through a few reflective notes (previously mentioned). Additionally, the investigator maintained contact with the research committee chair as needed to assure the appropriateness of methodology and other study components. Another limitation was the self-report of participants related to recall of experiences and/or not feeling comfortable reporting complete experiences that were negative. To this end, the investigator maintained confidentiality of participant information and assured them that there were no ‘wrong’ answers to interview questions. Additionally, participants were informed verbally and through informed consent that they could withdraw from the study at any time. Other limitations were the inability to generalize findings as they represent a snapshot in time and are bound within a very specific context.

Ethical Considerations

Approval for the study was obtained from the University of Alabama and the acute care facility from which most study participants were recruited. Participants received an explanation

of the study verbally and in writing which included study risks and the ability to withdraw at any time without repercussions. They were informed of the approximate time involved, assured anonymity prior to the study and the receipt of a \$50 Visa gift card even if they chose to withdraw during the study (see Appendix B). Immediately prior to the interview, they were reminded of their rights prior to signing the consent form. They also signed a statement of receipt of the gift card. Interviews occurred in a mutually agreed upon private space that provided auditory and visual privacy. To assure anonymity the recordings and subsequent transcripts of each participant were identified with letters of the alphabet, nurse A, nurse B and so forth. To assure accurate interpretation of the data, member checking was done during the course of the interview and after the interview to clarify comments and meanings and verify initial impressions and potential themes.

The investigator maintained the names and contact information associated with transcripts in a separate secure location; recorded interviews were erased and all identifying information was destroyed at the completion of the study. Although it was not expected that participants would experience emotional distress, they were offered the opportunity to discontinue the interview should this occur.

Summary

A qualitative approach, using the lens of SI, was used to mine the unique experiences of medical-surgical nurses who care for suspected OUD patients. Adhering to ethical research standards, participants were interviewed to gather data that corresponded to the research questions. Research questions addressed nursing perceptions and experiences caring for suspected OUD patients, how their perceptions/experiences influenced the nurse-patient relationship and care, and the implications for the nurse-patient relationship and nursing

education. Transcribed interviews comprised the primary data source from which major themes emerged. Analytic strategies were ongoing with each interview and included asking questions, clarifying followed by coding, comparative analysis, and the use of descriptive and reflective notes that were also data sources. Themes were organized in a logical flow that told the story of medical-surgical nurses' experiences caring for the OUD patient. Strategies related to supporting the study's credibility, transferability, dependability and confirmability enhanced the trustworthiness of data and findings.

CHAPTER IV:

ANALYSIS

This chapter represents an analytical overview of the data that helped describe the experiences of medical-surgical nurses caring for patients suspected of having an OUD. From nurses' thoughts, feelings, or perceptions five themes emerged: (a) nurses' preconceptions of OUD, (b) identification of suspected OUD patients, (c) pain management, (d) paradox of thoughts, feelings and actions and (f) moving forward.

Nurses' Preconceptions of OUD

Understanding this theme begins with defining the terms thoughts, feelings, and perceptions, all apart of preconceptions and imbedded in the research questions. Thoughts, feelings, and perceptions are all nouns; each has more than one meaning. Following data analysis, the investigator matched the most appropriate meaning for each noun to the data from the Merriam-Webster Online dictionary. For the purposes of this study, thoughts are defined as an idea or opinion produced by thinking. Perception is very similar and defined as quick, acute and intuitive cognition, a capacity for comprehension. Feelings are defined as an emotional state or reaction (2017). This theme describes how nurses came to have their thoughts, feelings, and perceptions for suspected OUD patients.

Before a nurse can suspect someone has an OUD, a nurse has to have some pre-existing knowledge of SUDs or OUDs. Thoughts and perceptions of suspected OUD patients developed from experiential knowledge gained in caring for actual SUD or OUD persons. The origin of these thoughts and perceptions draws upon core learning and teaching principles synthesized

from research in of the learning sciences, in particular social constructivist learning theory. A basic premise of constructivist theories is that knowledge does not exist outside the learner. It is constructed by using prior knowledge, beliefs, and experiences and integrating it with new interactions with the environment and the world to generate new knowledge (Sawyer, 2006).

It is a valid assumption that most adults, in the United States, including the ones in this study, are aware of substance abuse and addictions through a variety of mechanisms including primary and secondary education, media, personal experience, work experience, and experiences through family and/or friends. The source of pre-existing knowledge formed the subthemes.

SUD Education in Nursing Curricula

To gain insight into what participants understood about OUDs, the investigator asked nurses if they remembered having substance abuse content in nursing school, and if so, what they remembered. In general, respondents either did not remember having content, or if remembered, were unable to recall specifics as noted in the following examples.

Nurse A: No, I don't remember getting any . . .there is just a lot they can't teach you.

Nurse B: I think we had a lecture or something in one of my community health classes, but it was not an abundance of teaching about it.

Nurse C: I think we briefly touched on it when we did our emergency room section – talking about patients coming in for pain medicine . . .we briefly touched on it.

Nurses' inability to remember more details suggests that SUD and/or OUD continues to be lacking in nursing curricula as noted previously in the literature. Experiential knowledge, however, was very powerful in shaping nurses' thoughts, feelings, and perceptions of OUDs.

Experiential Knowledge

The investigator did not ask participants whether they had cared for actual patients with SUD or OUDs as this was not the intent of the study; however, in relating their experiences, it

became clear they all had experiential knowledge. Nurses identified actual OUD or other SUD patients through medical histories, drug screens, the appearance of withdrawal, and patient acknowledgement.

Nurse B: We get a lot of withdrawal patients on our floor, so that is pretty common for us. We get a lot of patients who are admitted with it, but then we get a lot of patients that you find out later [that they] are in withdrawal.

Nurse E: But also, there are a lot of clients with substance abuse histories . . . so I do know that this patient has a positive drug screen for cocaine or whatever.

Nurse J: I've had a patient to tell me that 'I'm trying to get it [drug] the right way instead of getting it out on the streets.'

Positively identified SUD patients and especially OUD patients were also associated with a variety of behaviors related to obtaining opioids. Sometimes these behaviors appeared in patients with terminal illnesses or chronic pain who were dependent on opioids because of chronic use. These behaviors led nurses to suspect OUD in patients who did not have a known history of OUD. The following examples illustrate characteristic behaviors of actual SUD and/or OUD patients.

Nurse F: There was this lady who came in and she had cirrhosis, self-induced [from alcoholism]. . . You walked into the room and the very first question 'is it time for my pain medication.' . . . And there was a man with sickle cell who set his phone to vibrate and he would actually stay awake just so he could get his pain meds.

Nurse C: Uh, one [patient] . . . was getting 2 mg (milligrams) of Dilaudid every 2 hours. He called on the dot every 2 hours. If you were not in there, they were calling on the call bell, they were yelling and screaming until you came in there...he was very demanding.

Experience also taught nurses that patients with SUDs came from all every class and socioeconomic group.

Nurse C: Prior to becoming a nurse [my perception] was what you see on TV people in back allies dealing drug . . . going bankrupt . . . they lose their families and that kind of thing. But, as a nurse, that guy next to me who looks normal could be addicted to pain medicine. It could be 'all walks of life'.

Nurse G: It's not the person you see homeless on the street or one that is disheveled... every face is the face of a drug addict, especially prescription drugs . . . It's not a respecter of persons.

Personal experiences formed another facet of experiential knowledge. As a way of relating to or understanding SUD or OUD patients, some nurses referenced family members who had SUDs. One nurse related her understanding of addictions to a prior addiction to cigarettes. Nurses who considered their personal feelings and experiences had a clearer understanding of the issues of OUD persons; it affected their view and treatment of those with suspected OUDs.

Nurse F: When I smoked for 30 years . . . I understood that I was addicted . . . they controlled me and I did not control them. . . . And because of that I look at my patients and I say there has got to be something more long term here-they walked into this hospital addicted.

Nurse E: I come from a long line of addicts- my grandfather was an alcoholic, his brother was, and another family member was also, but my mother had chronic pain and I felt like she was sometimes mistreated. . . . I think this could have had an impact on my whole philosophy of pain . . . I don't want anyone treated like my Mom was treated. . . . I don't want to put a label on them, I just want to help them the best way I can even though it's hard to deal with some of the behaviors...

Nurse H: But now, I know people personally in my life who have had problems with drugs and so it gives me a little different perspective. . . . Lots of people [nurses] say 'I don't want to deal with them, they are just here to get drugs.' . . . I just see them as someone needing help.

Key findings from nurses' preconceptions of OUDs were experiential knowledge gained from the care of actual OUD patients or personal experiences had the greatest impact on nurses understanding of OUDs. Most nurses reported having minimal or no content in school. Nurses transferred their experiences of OUD patient behaviors to the identification of those behaviors in others. Nurses also recognized OUDs affect people from all "walks of life" rather than a specific demographic. Other factors influencing nurses' learning emerged throughout the study, including the impact of emotions and stress encountered in their experiences.

Identification of Suspected OUD Patients

As described, identification of suspected OUD patients was based on nurses' experiences and perceptions of several patient behaviors and other findings such as diagnostic results.

Nurses relied on a combination of behaviors and findings to fuel their suspicion of OUD; these formed the subthemes. Figure 1 summarizes key data points of patient behaviors and findings suggestive of OUD. Failure to address suspicions of OUD contributes to the cycle of addiction.

Self- Regulation of Pain/Addiction

The compulsion to seek opiates and the fear of going through withdrawal is significant for people with OUDs. OUD persons must constantly consider opiate sources and the ways and means to procure them. Respectively, the data revealed specific patient behaviors used to obtain opiates in the medical-surgical setting. Patient behaviors included identifying Dilaudid as the drug of choice, frequent and/or bogus admissions, setting alarms, ranking all pain as severe and other patient behaviors suggestive of little or no physical pain. Nurses considered combinations of these behaviors to identify suspicious patients.

Dilaudid was the opiate consistently requested by patients more than other opiates and, therefore, the drug of choice. Dilaudid is six to ten times stronger per milligram (mg) than morphine (Opiate Addiction and Treatment Resource, 2013). Nurses firmly believed that suspected OUD patients claimed to be allergic to most or all other pain medications exclusive of Dilaudid or that Dilaudid was the only effective pain reliever. Furthermore, patients preferred the intravenous (IV) route for immediate effects rather than the oral route.

Nurse A: Sometimes . . . they [the patient] will say, 'well, only that Dilauda [Dilaudid], nothing ever helped me but Dilauda'.

Nurse H: You know . . . their allergy list is a tip off. The list may have about 30 nonnarcotic pain medicines and Zofran (anti-nausea medication) and some of the milder

narcotics; the only thing left is Dilaudid, Demerol (opiate) and Phenergan (anti-nausea medication) . . . everything else they are allergic to.

Nurse D: He wanted me to call and get him some Dilaudid, 2 mg . . . [he] only wanted IV Dilaudid. He was fixed on 2 mgs.

Frequent admissions and/or admissions to the hospital related to pain were another hallmark of suspected OUD patients. Another term used for these patients was *frequent flyers*. These patients knew exactly what to say to guarantee hospital admission. Diagnostic tests were often negative for any condition or a significant condition requiring strong opiates.

Nurse H: I had one about two months ago who had already been here 18 times this year [within 6-month period] for chest pain, abdominal pain, some kind of pain every time. . . . They know exactly what to say to get in the door and get admitted, like chest pain . . . The hospitalists deal with the same people over and over, the frequent flyers . . . I'm talking about those who don't really have a reason to be hurting that I know of. I look at their history and everything and there is no reason . . . no major diagnoses.

Nurse D: If you're here for an upper respiratory infection or something, I don't see why you need something strong like that.

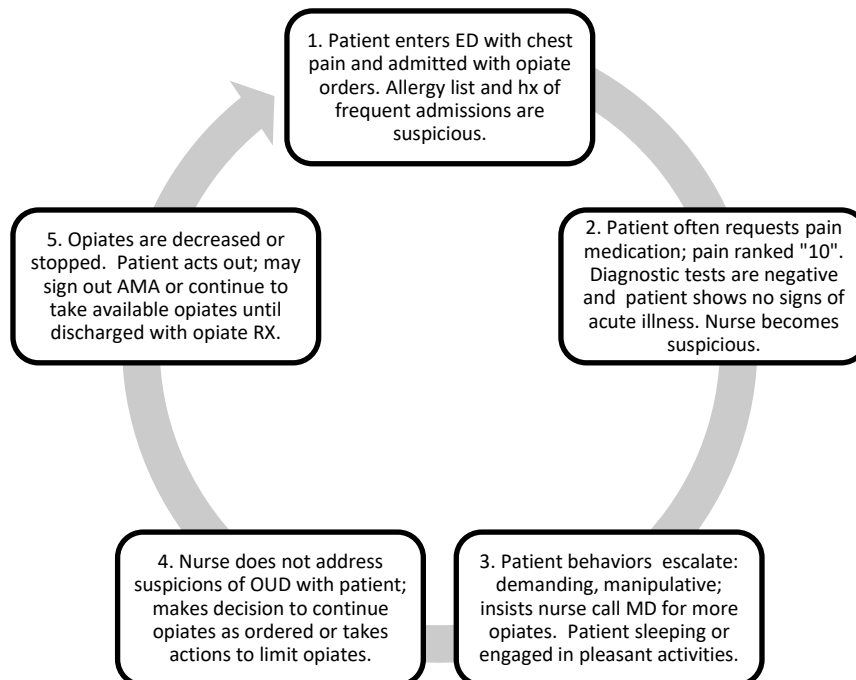


Figure 1. Summary of suspected OUD patient behaviors and nurses' responses during hospitalization contributing to cycle of addiction.

Multiple nurses identified another interesting behavior linked to suspicions of OUD; patients set cell phone alarms as reminders to call for pain medication. Most patients were knowledgeable about the ordered frequency of their medication; setting alarms ensured they would receive the maximum number of doses around the clock. If the patient did have an alarm, they would ask or expect the nurse to wake them up to give pain medication. As will be seen later in the data, it was common for patients to ask for medication more often than ordered and insist the nurse call the physician for an increase in dose or frequency. These behaviors suggested the patient may have been trying to stave off withdrawal. One nurse mentioned symptoms suggesting withdrawal.

Nurse H: I mean some of them set their alarms, like if their medicine is ordered for every 4 hours they will set their alarm for it.

Nurse I: [Nurse's response to patient who was not awakened for pain medication] 'I said, I'm sorry, I can't wake you to give you pain medicine.' [Patient] 'Well, all the other nurses do it.' [Nurse] 'The policy says PRN (as needed), the order says PRN and [that means] when necessary and you even have to have a certain level of pain before I can give it to you'. So, we had to have this conversation. She was not happy with me.

Nurse C: I've seen patients uh, get very anxious, very shaky and uh, blood pressure shoots through the roof.

Suspected OUD patients consistently rated their pain as severe according to a pain scale. For example, a universal scale referred to as the Numeric Rating Scale (NRS) rates pain from zero, meaning no pain, to a 10 meaning the worst possible pain (Krebs, Carey, & Weinberger, 2007). In the hospital from which eight nurses practiced, pain management orders used pain level ratings to determine the type of opiate, dose and the route of administration. This is a common pain management practice. For example, oral opiates are prescribed for moderate pain rated 4 to 6 on the scale; stronger opiates such as IV Morphine or Dilaudid are prescribed for

pain rated 7 to 10. Rating pain as severe usually ensured the patient would receive a strong IV opiate such as Dilaudid.

Nurse A: They will say their pain is a 10 out of 10. . . . They think they might get more [pain medicine] if they rate it more at a 7 or 8 or 9.

Nurse F: [They automatically] tell you it [pain] is a 10. Or, they have learned that if they tell you it is a 5, you don't get as much pain medication if you had said pain was an 8 or 9.

Adding to consistently rating pain as severe was either the absence of objective signs and symptoms or patient behaviors suggesting little or no physical pain. Patient behaviors included sleeping a lot, laughing, playing on Facebook, and eating while calling for pain medication. One nurse compared these behaviors to patients believed in severe pain. Literally, every nurse in the study reported and questioned these behaviors.

Nurse A: I [have seen people] with pain 10 out of 10 and almost not functional and then someone just sitting and eating just kind of makes me wonder.

Nurse J: They [the patient] are on the phone uh, or on Facebook or ordering a pizza and it kind of gives you a little bit of doubt . . . is this patient really in pain?

Nurse G: Pain 10 out of 10 . . . I did have disbelief in my heart and my mind when [the patient] is eating what I would consider the heaviest meal ever. . . The environment was not giving me those signals; her body language was not giving me those signals. [Later in reference to another patient] . . . if you ever go and stand outside her room, she's on the phone laughing and talking, she sounds great. And when you go in, it's the pain medicine thing; that's why they come to the hospital, IV pain medicine, I firmly believe.

One nurse suggested another way of identifying an OUD patient. As a former hospice nurse, she had received job training related to pain management and recognized that pain would be more difficult to control in someone with an OUD.

Nurse E: It's hard to say if you don't have any history [confirming OUD], but number one you probably wouldn't be getting really good pain control . . . they have a tolerance built up, it's hard to get their pain controlled.

While comparing the care of a suspected OUD patient with other patients, an interesting caveat emerged, the implication that OUD in itself was not a legitimate illness.

Nurse D: If there is something wrong with the patient and they are in pain, I don't mind it [giving pain medicine]. . . . So that is kind of frustrating when you know you're trying to take care of the sick patient and they [suspected OUD patient] are just calling because they want pain medicine and you know it's not time yet.

Nurse H: I get frustrated because people who are legitimately sick . . . I can't get enough pain medicine for them, but these [suspected OUD patients] are getting Dilaudid every two or three hours, enough to put down a horse and then go to smoke and they claim it is not enough.

Other nurses recognized OUD was an illness.

Nurse G: It's not that the person is a bad person, they just have a disease. They have an addiction and it is easy to lose sight of that.

Nurse I: For me . . . that patient is sick. Addiction is an illness, so the thing is how do we treat the illness? Are we medicating it or are we doing the tough thing to deal with it?

While nurses considered a variety of manipulative patient behaviors and other factors in the identification of OUD, other patient behaviors also added to their suspicions.

Range of Negative Patient Behaviors

A range of unpleasant patient behaviors around obtaining pain medication added to nurses' suspicions of OUD. They varied from demanding, consuming an inordinate amount of nursing time, manipulation, threatening to leave the hospital against medical advice (AMA), or emotional outbursts aimed at nurses such as cursing, screaming, aggressiveness, and others.

Although the previously described self-regulatory behaviors were manipulative, the more negative behaviors were likely to occur when the patient did not get what they wanted. In some cases, this meant not getting a stronger opiate or an increase in dose or frequency.

Nurse B: Uh, they generally tend to get uh, more upset when they can't get what they ask for . . . they are a lot more likely to escalate it and talk to the doctor even though we've just talked to them [doctor].

The data suggested experiences caring for actual OUD patients were instructional in identifying patient behaviors suggestive of OUD. Experiential learning is a powerful teacher. Whether or not the identified behaviors were indicative or risky OUD use or actual OUDs, nurses used this knowledge in one way or another to address pain management. On another note, as nurses described their experiences with the full range of patient behaviors, their tone and body language bespoke of the emotional distress often encountered in these situations. These stressful encounters reinforced their experiential knowledge. Moreover, with each encounter nurses faced challenging decisions regarding pain management.

Pain Management

Pain management intricately links to the life style of those with OUDs. Once nurses identified suspected OUD patients, a challenging area of care was how to manage reported pain. Nurses believed the pain was not physical in origin or at a minimal level not requiring strong opiates. Much like the orchestration used by suspected OUD patients to obtain opiates, nurses planned and devised strategies related to pain management. Most strategies limited opiates by reporting concerns to the physician or manipulating the times and means to administer opiates. In some cases, limiting opiates was out of concern for patient safety. Another strategy unrelated to limiting opiates was to go give the medication irrespective of the suspected OUD. Nurses felt that if pain was what the patient said it was, the patient was always right.

Limiting Opiates

The most common strategy reported by nurses was to communicate to the physician the need to change orders such as decreasing the dose, increasing the time between doses, and to change the route of administration. In addition, some nurses communicated suspicions of OUD. However, nurses did not necessarily call the physician every time with suspected patients.

Nurse H: I tell them ‘so and so is here for abdominal pain and their CTs and tests are negative, but they are getting Dilaudid every 2 hours; I think they are here for that. Can we back that off or can we change to something else.’ Most of the time the physicians are very receptive.

Nurse J: [Nurse talking to physician]. ‘You know I think they are here to get the pain medicine; are you sure you want to give them this much?’ . . . I had one tonight that was getting it IV every two hours and I said, ‘do you really want to keep giving it every two hours because they’re not going to be able to go home with it.’

Calling physicians normally resulted in order changes such as decreasing the amount of the drug, changing the drug, route, and other changes. In some cases, physicians stopped opiates altogether particularly if they knew the patient.

Nurse B: There are doctors among the hospitalists who are very receptive . . . they know that we know the patients a lot better than them and they really listen to us. . . . Their usual response is to just cut the medicine down [reduce dose or frequency] which really doesn’t help anybody.

Nurse H: Sometimes I’ll call the doctor and they will discontinue everything because they know the patient. If it’s a hospitalist and they deal with the same people over and over, the frequent flyers . . . they will discontinue everything other than Tylenol.

Unfortunately, when calling the physicians resulted in changing the orders or stopping the medication altogether, most patients reacted negatively causing more problems for the nurse. Some patients, however, were more accepting of the order changes.

Nurse E: But sometimes when they are drug seeking, then they are not getting anything else [per physician]. I feel frustration because I’m dealing with this [negative patient behaviors] . . . how do I deal with this?

Nurse H: They [the patient] will sign out AMA and they will go [to our other hospital]

Nurse I: [after talking with physician for an order change] Now my patient is not happy. But a lot of times I find that they stop it all together. . . . Before, when we had an option, I would say [to the patient] ‘you want to try this pain pill . . . let’s try the pain pill,’ but [the patient says] ‘no, I need the other’ [IV opiate]. But when he (the doctor) takes away the option, the pain pills are okay.

In addition to communicating concerns to physicians, several nurse-mediated strategies limited opiates given to patients. A very important one concerned nurses' professional judgement about patient safety.

Nurse F: Now the patient may be getting something every two hours and something every four hours and that's the line I have to draw, a professional judgement as to whether or not I'm going to give them that much medication.

Nurse G: On the flip side . . . when I walk in and my patient is asleep . . . literally drooling . . . and I feel their level of sedation is such that I don't think they need pain medication, I refuse [to give it] for that reason. . . . If it is not safe, I'm not going to give it. I'm just not . . . because that is my conscience and nursing license.

Other nurse-mediated strategies included limiting the frequency of opiate administration by withholding information about the ordered frequency or allowing the patient to believe they could have it every four hours as opposed to the actual frequency. One nurse would not bend the rules and give the opiate a little early as she did for other patients.

Nurse A: We kind of have this secret code on the floor [we communicate to each other] 'this patient's pain med can be given every 2 hours, but he doesn't know it, he thinks it's every 3 or every 4.' . . . Once a patient like that finds out [the truth], they are going to call you right on the two-hour mark.

Nurse F: I do not tell my patients that they can have the medication every 4 hours necessarily. I may tell them, the computer says it's too early, it won't let me in. I try to be honest with them. If it's time for them to get their pain medicine, it's time. PRN (as needed) medication is not scheduled, it's PRN. I don't volunteer it unless they ask for it.

Nurse C: Because another thing . . . some nurses will give pain medicine early. I have done that for someone who has really been hurting . . . which I know I am not supposed to do but I have. [For suspected OUD patients] I'm not giving it unless it [the time] is right on the dot.

Still another nurse-mediated strategy was to encourage less IV opiates in favor of a less potent oral opiate regardless of the pain level. Nurses also logically argued that IV opiates would not be available when the patient goes home.

Nurse J: [nurse states to patient] 'Well I gave you IV pain medicine [last time] and this round we'll give PO (oral) and this will last a little bit longer and it will take a little bit

longer to get in your system, but it will last a little longer. . . . When we discharge you, we can't send you home with IV pain medicine [Investigator: would give an oral drug that was ordered for moderate pain even if their pain is a 10?] [Nurse] They all say it is a 10 . . . I will encourage Norco (oral opiate) even if a 10.

Nurse G: [nurse states to patient] 'Let's not give the IV pain medication because when you go home you're not going to have it, let's not depend on it; let's try this Norco. . . . Because number one, we don't need to take any more of this than we need to and number two, we need to see if we can manage your pain with PO meds before you're released.'

Finally, there is much emphasis in healthcare on the use of nonpharmacological means to manage pain including positioning, application of heat or cooling methods, quiet, non-stimulating environments and others. Although a few nurses mentioned these methodologies, they were either refused by suspected OUD patients and/or ineffective.

Nurse C: [In reference to a patient who only wanted Dilaudid]. I try different things for pain such as repositioning and I offered like not IV meds, but break through medications, PO medications.

Nurse D: I had tried to put a heating pad on his back and he refused it. . . . I've tried Biofreeze and he only wanted IV Dilaudid.

Patient safety, specifically concern for over sedation, was an important reason for limiting opiates. The proper procedure for this situation is to hold the drug and notify the physician in anticipation of an order change. In fact, nurses must contact physicians for any order that seems inappropriate and/or to change the order. It was unclear whether nurses did this related to safety issues. Transitioning to an oral opiate before discharge was also a valid reason for discouraging IV Dilaudid, and yet, this action may not have been in keeping with physician's pain orders as written. The latter situation suggested nurses did not call the physician. Nurses did not seem to consider that not following physician orders precisely violated a practice standard, nor did they consider the ethical and trust violation by withholding information about the frequency of opiates. Nonpharmacological means for managing pain is a standard of care in

pain management; it is often used as an adjunct to manage pain. However, these strategies are ineffective in managing the suspected underlying problem of OUD.

The Patient is Always Right

Another strategy used by nurses was simply to give the pain medicine regardless of suspicions of OUD and their belief about the patient's pain. After all, there was a pain medication order and the patient reported pain. The legal order, the patient's report of pain, and the idea that they could not judge for sure whether the patient was hurting made the nurse feel there was no choice but to medicate. It also seemed to circumvent the moral struggle related to giving the medication when nurses did not believe the patient was in pain.

Nurse C: . . . the doctors have ordered it and they [the patient] are claiming they have pain and so we have to treat their pain-the patient is always right.

Nurse I: I have to rationalize within myself about giving this person that is eating these big, greasy hot wings and asking for pain and nausea medicine and Benadryl, all that at one time. I have to tell myself, 'well you don't know for sure [that they are not in pain]. To morally deal with it, I say, 'who am I to say they are not?'

One nurse felt it was not her responsibility to address the underlying problem of OUD and implied that she would not go against the physician's order related to pain medication.

Nurse F: I'm not going against [the physician]. You know this person has more going on than I can deal with and it's not my job to fix it. . . . If they ask enough people [for pain medicine], they are probably going to get it anyway.

The data suggested that nurses struggled to manage what they perceived was mild or fictitious pain in the guise of drug seeking behaviors. They also wanted to control or prevent the escalation of addiction by limiting opiates. In doing so, they may not have considered practice and ethical standards around communication with patients and medication administration. The data also suggested, in some cases, nurses had mixed feelings between pain orders versus patient allegations of pain versus patient behaviors, versus feelings that it was not their job to "fix the

problem.” For some nurses who questioned the existence of the patient’s pain, the availability of pain orders or believing it was not their job to address suspicions of OUD made it morally acceptable to give the pain medication.

Paradox of Thoughts, Feelings, and Actions

Intertwined with pain management was the internal conflict nurses experienced when making decisions around reported pain. Decision-making was complicated by emotions, mixed thoughts and perceptions about pain, the belief of not making a difference for suspected OUD patients and taking time away from other patients.

Although nurses discussed the possibility of an OUD among themselves and sometimes with physicians, there was no formal acknowledgement or investigation of the problem involving the patient, thus perpetuating the problem. Lack of acknowledgement promoted feelings of frustration and helplessness among nurses; these patients would return for readmission for a problem never addressed. The belief of contributing to an OUD affected the professional self-image and esteem of nurses making them feel like drug dealers rather than healers.

Paradoxically, most nurses did not find it incumbent upon themselves to address their concerns with the patient that ultimately might have disrupted the cycle addiction. Little or no relationship with the patient may have hampered the nurses’ ability to address the problem. The following emergent subthemes describe the many facets that contributed to the professional and moral distress experienced by nurses.

Conflicting Thoughts and Perceptions about Pain

As previously discussed, nurses seemed conflicted about pain management for suspected OUD patients. Another caveat adding to their conflict was the primary pain definition emphasized in nursing school and their personal experiences with pain.

All nurses in the study were familiar with McCaffery's definition of pain indicating that pain is defined by the patient. Nurses were divided in their support of the definition; some on the fence, others firmly supporting it while others did not. However, a common denominator was that most seemed to question the patient's pain or pain level regardless of their position.

These nurses illustrated being conflicted regarding the definition of pain.

Nurse B: I think the hardest problem that we've found is that . . . pain is subjective. . . . It's a hard one because you do have those patients who tolerate it better, so I'm on the fence of it. . . . I'm not the patient . . . I don't know what they're actually feeling, but at the same time you get those patients who are you know, laughing and talking and joking around and they claim [pain] is a 10 out of 10, so it is hard.

Nurse F: I would like to believe [that pain is what the patient says it is] in my heart of hearts, but I'm fairly astute, but no. [Later in the interview] I believe...they think they need the medication. Pain is what the patient says it is and it is not for me to make that value judgement-they are only going to be here three days.

Only two nurses firmly supported McCaffery's pain definition; one supported it because of personal experience with pain. The other supported it because it was indoctrinated in nursing curricula. However, both nurses still questioned the pain based on patient behaviors.

Nurse I: I do [support pain definition] simply because I have back issues . . . even though I would work . . . I hurt. So, the experience helped me to see that pain doesn't look the same on everybody. [Investigator probing deeper asks: 'Even if patient is eating greasy food and showing no objective signs of pain, do you think patient is in pain?'] [Nurse] No, I don't believe so then, but I don't know for sure.

Nurse E: I was trained that pain is subjective and that it is what you really go by. Now, when I see someone laughing and not having objective signs and symptoms of pain, it kind of makes you wonder a little bit...but people deal with pain in all kinds of ways. But you wouldn't really expect someone who is really hurting bad to be laughing . . . on the phone. . . . That's not how I'd be acting if I was in pain.

Most nurses did not agree with the subjective definition of pain primarily because of patient behaviors, their assessment of the pain, and other factors.

Nurse C: I do not [support pain definition]. I've had patients come in with chest pain a 10 out of 10 and they are talking on the phone and eating a piece of fried chicken so [their] pain is not a 10.

Nurse G: That's the quote we've been given. That is what we're told, that pain is what the patient says it is, but no, I don't believe that. I believe that we as nurses have to learn what to look for, we have to learn to look at the body language and nonverbal indicators. I go by those so much.

Overall, the data suggested patient behaviors not indicative of physical pain influenced nurses' perceptions of pain more than McCaffery's definition. However, it was clear McCaffery's definition made an indelible imprint in their minds from nursing curricula. Most nurses were at odds with the definition. Experiences such as those described added to nurses' knowledge and seemed pivotal in making many decisions regarding pain management.

Not Making a Difference

Contextual data added to the understanding and interpretation of nurses' thoughts, feelings, or perceptions related to their patient care experiences. For this study, part of the contextual data consisted of what nurses found rewarding about their jobs and the constituents of a good shift or work experience as compared to experiences caring for suspected OUD patients. Unequivocally, nurses felt making a difference and/or seeing a patient get better was rewarding. Nurses expressed feeling good about themselves with the knowledge they had helped someone such as seeing a physical change in the patient and/or the patient's expression appreciation.

Nurse D: Just feeling good about yourself, knowing you made a difference in someone's life. Even if it is only one person, that's all that counts, that one person for that night.

Nurse G: When you leave . . . [and the patient says] 'you're not coming back'; that makes you know that you made a difference.

However, in the case of OUD or suspected OUD patients, nurses expressed frustration and helplessness in not making a difference.

Nurse B: It's frustrating. It's like you go into nursing, you have to want to care about people and . . . it sucks not to be able to see somebody get better when you know they have a problem [OUD] and they don't know it.

Nurse C: I don't think I'm doing anything to help the person. I'm just feeding the addiction and I'm doing more harm than good.

Nurses identified several characteristics of a good shift or work experience including staying on top of their work, teamwork, patients, and families being okay and no negative events.

Nurse D: As far as a good night, you come in, start, stay on top of everything, you make your rounds and if they are fine, give medicines as needed; uh, no falls, just good, you don't have to call the doctor too much, uh, family members are okay.

Nurse B: It's one of those days where everybody is on top of everything . . . where you don't have things happen like we have codes (medical emergencies) . . . so days where things really go smoothly.

However, nurses felt the care of the suspected OUD patient disrupted their usual work routine and went anything but smoothly.

Nurse G: I'm spending time with them, they're out in the hallway, they are having a fit and coming to the desk, they're threatening to leave, and they might become combative. I'm calling security and I'm calling a code strong (assistance for out of control patient).

Nurses also felt that while caring for the suspected OUD patient, they spent less time with other patients, which may have had a bearing on the quality of care.

Nurse G: I'm . . . while meantime across the hall, I have a patient with lung cancer who can't breathe . . . and I can't pay attention to them because I'm dealing with this [suspected OUD patient].

Nurse D: Well, to be honest, it could decrease the quality of care [in general for other patients] because they are just taking away from another patient's assistance.

This same nurse added that the influence of opiates increased the risk for complications, as they tended to stay in bed all the time.

Nurse D: When you're [the patient] taking all that pain medicine, . . . you don't want to participate in physical therapy . . . get out of bed, sit up in a chair or walk down the hallway.

Recognition that suspected OUD patients would not improve given their treatment plan set the stage for an unrewarding patient care experience. Adding to nurses' frustrations was the shift disruption that occurred while caring for them.

Relationships: Therapeutic and Limited/Nonproductive

To establish a broad basis for comparing relationships between patients suspected of OUD versus other patients, nurses described their views of a positive or therapeutic NPR. Relationships were described in terms of characteristics, how to initiate, and evidence that the relationship existed. Elements of a NPR were communication, trust, compassion, and advocacy. Nurses perceived patients felt comfortable with them and had confidence in their abilities.

Nurse C: If you have a good relationship with your patient, you are able to talk to them on a personal level; they feel comfortable with you in the room. Trust is a big one, compassion and empathy.

Nurse J: You have to build a good trusting relationship. . . . If the patient trusts you . . . they feel confident with you as their nurse. . . . And, as their nurse, we are their advocate.

Some nurses described their approach to the relationship such as the use of interpersonal skills including positive body language, making the patient feel comfortable by sitting down to converse and getting to know the patient as a person. It also included exchanging personal information that may have been a way of establishing common ground.

Nurse H: First impressions are a big thing. When you go in, and you're smiling, and you sit down and talk to them, and not over them . . . involve them in the conversation. . . . When they know you are there for the right reasons and you're on your game . . . trust is immediately established. . . . And, we talk to them on a personal level, [do they] have kids and that type of stuff.

Nurse D: First, you have to introduce yourself . . . talk to them and get to know them, where they are from, what they like to do. . . . A lot of them ask questions [of us such as] do you have any kids. . . . They feel closer to you, they can tell you things that they won't maybe tell the doctor.

Paradoxically, while nurses were frustrated about suspected OUD patients not getting better, the data suggested there was a very limited NPR in these contexts. A therapeutic NPR might have served as a first step in making a difference in the lives of suspected OUD patients. Furthermore, nurses did not address their suspicions of OUD with the patient or discuss with the physician to evaluate and develop a plan of care.

Reasons for not establishing therapeutic relationships included difficulty connecting with and having compassion for patients with unpleasant, demanding behaviors. Distrust from the nurses diminished the potential for a meaningful NPR.

Nurse C: It's hard to imagine what they are going through when they are being so rude and so very demanding . . . it's hard to have compassion and really listen to people . . . do your job and critically think as a nurse because in your mind you are thinking, they are just wanting pain medicine and they are not really hurting. But, then maybe you think, well maybe there really is something going on, I can't really tell because they have this behavior going on all the time.

Nurse B: I think it's harder [to relate to suspected OUD patients] because they are generally more needy than some of our other patients and so it can be harder. It's a busy day and you've got five patients and they [suspected OUD patient] are constantly calling out for the pain medicine that they know they can't have right now. It tends to make it harder to relate to them than our other patients, especially for me.

One nurse believed other nurses resisted relationships with OUD and suspected OUD patients because they negatively judged them.

Nurse F: I don't think they want to have a quality relationship because the judgement has already been made; this is an addict. These folks have moved over to the other side of society as to the unwanted maybe.

Two nurses acknowledged their desire to treat all patients the same but seemed unsure whether they were able to achieve this.

Nurse G: I hope and pray . . . that I'm the same nurse for that patient that I am for other patients who are not addicted because I try to check it at the door. But, I do try my very best to show them the same compassion and the same care. I give them the same quality of care and I feel I'm giving them a higher quality of care when I don't give them the pain medicine when I don't feel they need it or it's not safe.

Nurse D: I try to be. I really can't say it is, but I try to treat all my patients the same. But, I can't say for sure.

Nurses also said this patient population resisted connecting with them because they wanted to hide their underlying problem and were only interested in meeting their opiate need. Both patient and nursing behaviors suggested mutual distrust.

Nurse H: Oh, it's [the relationship] broken. . . . They have a wall up [referring to not letting the nurse get close to form a relationship]. I already know they are going to try to manipulate the system, and try to trick you, the doctors and everybody else into getting more medicine.

Nurse G: It's a lot harder to connect, because they shut down. They will only let you in so much because they are just in the habit of covering up whatever the real problem is. . . . They're not dealing with their real feelings . . . they're not going to let me in. All you can do is go in on a personal level . . . show some interest in them as a person and sometimes they will let you in a little bit but generally all they want is their pain medication and their Phenergan and they want to be left alone.

On the contrary, several nurses illustrated being able to connect and/or at least lay the foundation for a relationship. They used various strategies including maintaining a positive, nonjudgmental, and caring attitude and putting themselves in the place of the patient suspected of OUD.

Nurse E: I try not to judge unless there are some facts to back up a drug problem; I don't like to put a label on them. Even if the patient has a bad attitude, I try to go in without an attitude and maybe be objective. I listen to what they tell me but then I assess it [pain] myself. . . . Even if they do have a drug problem, then that means we are going to have to be more aggressive with the pain management.

Nurse I: . . . these patients are individuals . . . they are humans . . . we are in the caring business . . . even if they get ugly with you . . . they are just stressed. I'm not going to take this personal, I'm just going to listen to her.

Nurse J: Um, I can relate to them simply because it's not them, it's the addiction that has taken over who they are. . . . I try to put myself in that person's shoes or think about a family member . . . I would want someone to reach out and try to help them. . . . But, at the same time you have to understand that this patient is in dire need and screaming for something and you could very well be that person who can reach out to them.

Further complicating the NPR was that nurses admitted not spending as much time with suspected OUD patients, literally avoided them, in an attempt to dodge requests for pain medication. They usually qualified this by stating they rounded on these patients the required number of times but no more. Nurses also believed less time with the patient meant less quality care. The following examples illustrate avoiding the suspected OUD patient and its impact on care.

Nurse J: [referring to other nurses]. I think the overall quality is less. The nurse feels like the patient is just drug seeking so they don't spend as much time trying to get to know the patient . . . they just give them the pain medicine and they're out.

Nurse H: It's probably worse [the quality] because you don't go in their room and assess them as much; I mean just laying eyes on the patient. I go in there the required amounts of time, but I'm not going in there as often as other patients and they are not getting assessed as frequently. . . . Some of my patients . . . I'll go in their rooms extra times just to chit chat with them and to connect with them, but I'm not doing it with those people [suspected OUD patients].

One nurse indicated she spent more time with the suspected OUD patient, but not quality of time, which was of no benefit to any of her patients.

Nurse G: I spend more [time]; it's not quality time with them. I spend more time running back and forth to their room to deal with confrontation, complaints and 'call my doctor . . . I'm not making a difference. . . . I'm certainly not benefitting my [suspected OUD] patient and I'm certainly not benefitting my other five.

A couple of nurses noted negative patient consequences to a strained NPR.

Nurse F: I think that sometimes they [other nurses] minimize that something is wrong with them [patient]. You cry wolf so many times that . . .

Nurse I: A lot of times I think that those patients have to try so hard and something major may be going on, but they have to try so hard to get the help. They have cried wolf so many times. . . . I come in and he was screaming in pain and they [other nurses] had made the decision that they were not going to call the doctor and he was hurting and he was a frequent flyer. . . . So, I call the doctor and the doctor gives me a little push back, and I'm seeing the patient and he is not. So, he said give him this [pain medicine] and send him for an x-ray. Oh, look, he [the patient] has a problem. . . . I feel like we're just missing the point . . . we can't ever, ever, ever get in our minds that we know what's going on. When we do that, we put that patient at risk.

The findings suggested most nurses seemed to struggle connecting to suspected OUD patients. Nurses were less empathetic and did not want to place themselves in a position for patient manipulation. Paradoxically, they recognized spending less time with the patient decreased the quality of care and minimizing or ignoring complaints put the patient at risk.

Addressing Suspicions of OUD

Nurses generally did not bring up the possibility of an OUD with their patients. Interview questions included whether they had ever discussed with the patient concerns for a possible OUD. The intent of this question was to see if nurses were actively trying to assess the potential problem and initiate a plan of care/action. Most nurses seemed surprised by the question and a few even a little defensive. The reasons for not addressing the issue included avoiding conflict, fear of reprisal, not being comfortable with confrontation, concern that it would not do any good, not having the time to do so, and a belief that the patient is really in pain and not drug seeking. The following examples illustrated these reasons.

Nurse A: I guess to avoid conflict, to avoid them getting the supervisor. . . . I guess my personal opinion with any addiction . . . you can tell them that its bad for them, they need to try to ween off, but until the patient wants to, they are not going to do it.

Nurse B: I did not feel comfortable with that because I've only been a nurse for a year and a half-who. . . who am I to do that? . . . I have issues with that kind of thing. . . . It's just a personal weakness of mine.

Nurse E: I guess because it goes back to a philosophy . . . ingrained in nursing school that pain is what the client says it is.

Nurse F: Right now, when I have six patients, I don't have time for things like this If I were working on a psych unit where I would be working with these patients every day, I could see. Until people reach a point of realizing they have a problem, then they don't have a problem.

Some nurses felt they were addressing suspected OUD indirectly by encouraging oral opiates instead of IV opiates and warning of dependency; however, the most common indirect

approach was asking patients how they managed pain at home. Because suspected OUD patients received IV opiates in the hospital presumably for the same level of pain experienced at home, nurses wanted to know why the patient suddenly needed and insisted on IV opiates. Many patients indicated they were taking nothing at home or only oral opiates.

Nurse I: I'll say, 'why don't we try this pill cause you're not going to have IV pain medicine at home.' I will tell them that there is a chance of dependency and that sometimes offends people. I touch on it indirectly. I don't want to offend the patient.

Nurse F: [speaking to patient]. You've been on this road a long time-how do you manage your pain at home when you don't have IV pain medications?

One nurse addressed the potential for the problem directly, initially questioning the legitimacy of the patient's pain and progressing to asking the patient about the need for help. However, she admitted that she usually did not approach a patient directly.

Nurse J: Once I started asking her about it, she started saying 'ya'll don't know what I'm going through, my life is so horrible.' . . . And I asked her did she want to get some help.

Bringing the comparison of pain management between home and hospital to the patient's attention suggested nurses were letting the patient know indirectly that they were suspicious of OUD and/or hoped the patient might acknowledge having a problem. Unfortunately, this action did not bring about the desired response. Failure to investigate the potential for OUD collaboratively with patients and physicians unwittingly fed the cycle of addiction.

Feel Like a Drug Dealer

Nurses struggled with the idea of contributing to the OUD problem when giving opioids for patients not believed to be in physical pain. They also felt powerless because they were bound to do so according to physician orders. Instead of feeling the reward of helping their patient get better, they felt they were doing the opposite.

Nurse C: I don't feel good about it. I don't think I'm doing anything to help the person. I'm just feeding the addiction and I'm doing more harm than good.

Nurse I: I don't have the tools to go against what the doctors do [order] and the patients. And, if they come through the door and they know every time they hit the door, [they are to] get this drug . . . and ordered for me [to give] every so many hours . . . it makes the nurse feel a certain way; so you do feel like the little drug pusher . . .

Later in the interview, after answering questions about addressing the potential for OUD with patients, some nurses began to consider they needed to do more. Others realized that the issue would require more support from physicians.

Nurse J: It makes me feel like I haven't stepped out and done what I was supposed to do even if it is going to be hurtful to the patient. . . . But, if I don't say anything about it, am I a solution to the problem? Am I helping the problem or am I making it worse?

Nurse D: It makes me wonder what else I could have done. What if they go home and do something bad such as kill themselves? It's just not knowing the outcome of the patient, because they're probably not going to have a good outcome.

Nurse I: I sometimes feel helpless as a nurse because when they are going to be discharged and repeatedly admitted and this stuff ordered; surely, I'm not the only one who feels this way. When they hit the door in the ED . . . they go to the floor with those orders [opiates], am I supposed to take the responsibility and say 'no you can't have it'. The physician ordered it. When can we work collectively to say no.

Overall, the data suggested nurses did not feel empowered to address and investigate suspicions of OUD with the patient. Although they reported suspicions of OUD to physicians in an attempt to limit opiates, they did not invite or suggest a collaborative effort to discuss the issue with the patient. Even if the suspected patient was not receptive to discussion or further screening for OUD at the time, it may have decreased the burden nurses felt for contributing to the problem. If in fact, nurses continue to ignore the potential OUD for whatever reason, they are in effect contributing the problem. Given those circumstances, the cycle of addiction will continue, and nurses will continue to feel frustrated and unrewarded.

Moving Forward

This final theme depicts what nurses believed would improve the care of suspected OUD patients moving forward. It includes recommended education and support from physicians and the organization.

Education

To begin at the beginning, nurses remembered little or no education on SUDs or OUDs from nursing curricula; most knowledge was personal or experiential. To identify potential knowledge gaps, the investigator gathered this information in several ways, first, by asking open-ended questions about potential beneficial topics. Secondly, the investigator evaluated concerns expressed by participants as potential topics such as how to approach the patient about OUD and verified these topics with the nurses. Lastly, the investigator examined statements made by nurses that might reveal inaccuracies or other knowledge gaps. Through these mechanisms, the following educational topics emerged: how to approach a patient about suspected OUD, pathophysiology of the disease and long-term effects, identifying OUD as a disease and signs and symptoms, and having compassion for this patient population. Additional topics identified by the investigator included ethical and practice standards related to physician orders, managing physical pain of OUD patients, recognition and management of withdrawal, resources for managing OUD patients, and communication and relational skills.

By far, the number one educational topic identified by nurses either from open-ended questions and/or verified by the investigator as a concern was how to address suspicions of OUD. Nurses believed they needed training or even a script on how to have a difficult, but sensitive conversation with the patient suspected of OUD. For some, this need may have occurred when they acknowledged they did not attempt to approach or verify suspicions with the

patient. As a new learning or a “ah-ha” moment, perhaps nurses realized care of the suspected OUD patient was incomplete when the problem was not openly addressed.

Nurse C: I think it would help to have some kind of script or education for nurses to learn how to talk to patients about this. Sometimes in the moment, it’s hard and it can come out wrong or you’re frustrated with them and you might say something you shouldn’t say.

Nurse B: [identified confronting patients as personal weakness]. I think now I would be a little more comfortable with it after having worked on the floor for a little while. I think now, yes, if there were a class. [Later in the interview, the nurse brought it up again] I think I would like to know how to approach those patients because it has to start with somebody. . . somebody has to bring it up.

Most patient behaviors were probably related to preventing withdrawal and at least one nurse described symptoms of early withdrawal. Therefore, nurses need to be thoroughly familiar with withdrawal symptoms and how to manage it. In the course of discussions, some nurses implied OUD was not a legitimate disease while another suggested nurses needed reminding. Nurses recognized a need to emphasize compassion and to view the patient holistically.

Nurse G: When it is 2 o’clock in the morning and they [OUD/suspected OUD patient] are throwing things across the room, threatening to call the doctor . . . because you won’t give them more pain medicine than what is prescribed, we tend to forget it’s an addiction. It looks like a temper tantrum . . . it is a sickness just like cancer, it just affects a different part of the body.

Nurse C: It would be nice to have like a physiology on what it actually does to the body and why it is so hard to kick.

Nurse I: I think everyone needs education to remember that these patients are individuals, that they humans, that we are in the caring business, not just the medical business but that we care about people.

Nurse J: Educate the nurses on looking at the patient as a whole, being more involved and knowing signs and symptoms; this is what we’re looking for- how we might detect if a patient has an opioid issue.

Overall, there were no outstanding inaccuracies in nurses’ statements about OUD. Some topics emerged over concerns for nurses’ statements alluding to violation of ethical and practice

standards and ineffective NPRs as previously discussed. More aggressive pain management for those with known OUDs was another topic brought to light by an experienced nurse, also previously mentioned. Another nurse, with a year's experience, did not know what resources were available in caring for OUD patients. Nurse F stated, "I don't know where my resources are or who to go to other than the chaplain." Not knowing available resources within the hospital or the community may not have stood out as a learning need because nurses did not formally address their suspicions of OUD. However, as nurses begin to evaluate the potential for OUD, knowledge of all available resources to support management will be especially important.

Finally, one nurse suggested the importance of including information on OUDs in nursing orientation while another made suggestions on teaching strategies.

Nurse E: I think it would really be good to have some special education in the orientation process or any unit really.

Nurse G: So, I think if we maybe could have some more education, videos, maybe classes that we could go to, interactive classes, [we] could learn how to deal with these people.

This data suggested that overall general education about OUDs including pain management, withdrawal and resources is a need. Nurses also need more sophisticated communication skills to address sensitive subjects in a non-threatening manner and to establish relational inroads that will help them see the human behind the disease and provide compassionate care. There is also a need to explore ethical and practice standards related to the overall management of these patients.

Improving Overall Care

Most ideas about improving the overall care of this population involved collaboration with and support from the physicians and the organization. Nurses' ideas included physicians' willingness to collaborate with them to address the potential OUD and limiting opiates. Nurses

felt very strongly that physicians should limit opiates and try more medications that are nonnarcotic. Organizational support was primarily related to having a screening process.

Nurse G: We need the doctors to be onboard with us. We need the doctors to be willing to address this. They [the patient] usually have complete faith in their physician. . . . If the doctor would sit down with them, maybe with the nurse present when they make rounds. . . so they [the patient] knows we're all on the same team together.

Nurse H: I wish doctors would not give it out like they do. . . . I think we are doing some of these people an injustice by pacifying and giving them more medicine because when they leave they are still going to need that opiate or whatever.

Nurse C: I feel like IV pain medicine should not be the first thing that is ordered. We should use more Tylenol, Motrin . . . I feel like we are just making it worse by giving them IV medicine around the clock.

One nurse identified an added benefit of limiting opioids in the hospital.

Nurse J: [By] not giving . . . so much IV pain medication to the ones we believe, or suspect are opiate addicted . . . if we start there, the word will spread [in the community].

This same nurse suggested an opiate protocol written by physicians that would allow the nurse to decrease the opioids if certain conditions were met.

Nurse J: The patient has had this amount of Dilaudid for this amount of days, the nurse can decrease the medicine to this [whatever is ordered by physician] if certain conditions were met. . . . [such as] if workup [and] all tests negative . . . vitals stable, eating and tolerating food.

There were not a lot of suggestions for organizational support; however, some nurses believed the organization could be supportive by having formal screening processes that assist in identifying these patients particularly as it related to identifying patients with multiple admissions for pain related complaints.

Nurse H: [We need] more screening. How many times can a patient be admitted for chest pain and abdominal pain in a year?

Nurse C: . . . it would be nice to know before they come to us, whether they catch it in the ER [that the patient] has been here 18 times in the past month for the same thing.

Two nurses suggested the screening process begin when patients come in the hospital ED complaining of chest pain. Nurse C, after the recording stopped, added that she knew of an ED in a neighboring town that had an observation unit to assess and observe patients with chest pain. If the pain was not diagnosed as cardiac in origin, patients would not be admitted.

Nurse J: If we had an outpatient or area where we watch them, do a cardiac workup . . . and we watch them a few hours and continue with the cardiac workup. . . . If everything comes back negative . . . they should not be admitted to the floor and continue to get morphine. [This same nurse suggested as electronic mechanism for identifying potential OUD patients]. Like we have a Sepsis board, when we have things like that in place, we automatically know when there is a red flag.

A couple of nurses recognized a need for role support.

Nurse C: Maybe a counselor or someone who come around and talk and educate patients.

Nurse D: [in response to investigators suggestion of consultant availability] Yes, and to get behind what is going on. Sometimes they drink or take medicine to ease and numb the pain from back in the days from something that happened to them when they were younger.

Overall findings from the theme moving forward suggested that little was being done to address the problem of OUD from physicians and organizations. Suggestions made by nurses included education and more collaboration between physician and organizational resources to limit opiates and have a formal screening process to identify OUD patients.

Summary

This chapter provided an overview of study findings regarding medical-surgical nurses' experiences caring for suspected OUD patients. Personal and experiential knowledge led to the identification and management of this population. Interwoven with the management of these patients was a myriad of emotions, thoughts and perceptions about pain and OUD. To manage suspected OUD patients most nurses used strategies that ran counter to traditional ways of caring and relating to patients. As a result, nurse-patient relationships were limited and nonproductive

including limiting time with patients. Perceptions around pain management were strongly influenced by patient behaviors suggesting no physical pain combined with other factors and conflicting feelings about the pain definition. Pain management strategies included limiting opiates to manage and/or prevent addiction escalation. These strategies may not have consistently adhered to ethical and practice standards regarding medication administration.

Nurses felt powerless to do anything about the underlying problem of OUD. They had a negative self-image viewing themselves as ineffective and contributors to the problem. Paradoxically, nurses were not taking steps to address their suspicions of OUD that might have disrupted the cycle of addiction and consequently enhanced their self-esteem. In reality, nurses were unwittingly contributing to the cycle of addiction by not working with the patient and physician to initiate a plan for further investigation and recovery.

The chapter concluded with suggested topics for improving the knowledge of nurses and communication strategies to address the problem. Other suggestions included collaboration between the physician and organization to limit opiates and identify actual and potential OUD patients through a formal screening process.

These findings beget a number of questions. Given opiate addiction is epidemic in the United States, why is there not a multi-pronged approach to address this life-threatening condition in all acute care settings? When can nurses and physicians begin the conversation around working collaboratively to address a harmful patient problem that also disrupts their practices daily? What can nurse pedagogy do to add or strengthen SUD content in their programs? What can nurse pedagogy offer to enhance the communication and relational skills of nurses working with challenging and sometimes unpleasant patients such as those with OUDs?

CHAPTER V:
INTERPRETATION, IMPLICATIONS AND RECOMMENDATIONS

Study Summary

Given the opiate epidemic in the United States, the current emphasis on pain management and hospitalized patient behaviors alluding to OUD, the purpose of this study was to examine medical-surgical nurses' experiences caring for suspected OUD patients. There is scant research in the United States on the experiences of medical-surgical nurses caring for SUD patients and none identified by the investigator on nurses' experiences caring for suspected OUD patients.

Therefore, the intent of this study was to address the following research questions:

1. What are the thoughts, feelings or perceptions of medical-surgical nurses for patients with suspected OUDs;
2. How do the thoughts, feelings or perceptions of medical-surgical nurses influence relationships with and the care given to patients; and
3. What are the implications for the nurse-patient relationship and nursing education?

Methodology/Data Analysis

As the investigator was interested in understanding experiences of medical-surgical nurses caring for suspected OUD patients, symbolic interactionism (SI) was the qualitative approach used in this study. SI describes the study of group life and human conduct; it emphasizes the nature of social interaction and the shared meaning in the form of symbols that occurs through the interaction with others (Blumer, 1969). SI served as the conceptual

framework, the qualitative methodological approach, and a lens by which to interpret the findings.

After obtaining IRB approval, informed consent and applying other ethical considerations, a purposive sample of nurses was recruited. Ten nurses volunteered to participate in the study. The nurses fell into the following age ranges: 21-25 years (two), 26-30 years (one); 31-35 years (two); 36-40 years (one); 41-45 years (one); 46-50 years (two); none fell in ages ranging from 51-60 years; 61-65 years (one). The number of nurses and type of nursing degrees included associate degree (eight), baccalaureate (one), and master's in nursing with doctorate in nursing education (one). Years of nursing experience included two years or less (three nurses) and three years (four nurses). One nurse had nearly 15 years of experience and the other two had a little more than 25 years' experience. All nurses worked twelve-hour shifts and took care of five to six patients.

Data came through semi-structured interviews electronically recorded for accuracy. Member checking for clarification of responses and initial impressions occurred during the interview as needed and later in a separate brief phone interview. After transcribing the interviews, the investigator looked for key words, phrases, and patterns that became coding categories. When the same or similar codes developed in another couple of transcripts, the investigator began constant comparative analysis of all transcripts. While coding and using other analytic tactics, the investigator evaluated data through the lens of SI to identify tenets as represented in the experiences of the nurses. Saturation of data occurred at approximately seven interviews; the investigator continued with three more interviews with no new thematic information emerging. Ultimately, codes became redundant and overlapping and reduced to form larger categories or themes that represented the bits of data that defined each theme.

Major Themes and Findings

From the thoughts, feelings or perceptions of medical-surgical nurses caring for suspected OUD patients, five major themes emerged supported by smaller subthemes. The themes were (a) nurses' preconceptions of OUD, (b) identification of suspected OUD patients, (c) pain management, (d) paradox of thoughts, feelings, actions and, (e) moving forward.

Nurses' preconceptions of OUD patients related to pre-existing knowledge of SUDs and OUDs that prompted suspicions of OUD. Thoughts and perceptions of suspected OUDs arose from experiential knowledge gained in caring for actual SUD or OUD persons or personal experiences. A significant finding was that nurses could not link their knowledge of SUDs/OUDs to nursing curricula.

Identification of suspected OUD patients was the second major theme supported by subthemes that described a collection of patient behaviors or other findings that fueled nurses' suspicions of OUD. Self-regulation referred to actions used by patients to access pain medication and maintain addiction and/or prevent withdrawal. Patient actions included identifying Dilaudid as the drug of choice and a preference for the IV route of administration. Frequent and/or bogus admissions for some kind of pain was another hallmark sign. Patients were referred to as frequent flyers. Chest pain was the most frequent claim that usually guaranteed admission to the hospital and therefore access to opiates. Most pain, including chest pain, was negative for significant diagnostic findings. Setting phone alarms as reminders to call for the drug and rating all pain as severe were other behaviors that usually ensured around the clock administration of the strongest opiates. Perhaps the most confounding, were behaviors suggestive of no physical pain; patients were engaged with media, eating and other pleasant activities while asking for pain medication. Additionally, there were a range of negative

behaviors used when suspected OUD patients were not able to get their drug of choice and/or the desired dose. These behaviors included signing out AMA, yelling, cursing, and aggressiveness.

Pain management was the third major theme identified in the study and intricately linked to the life style of those with OUDs. Upon identifying suspected OUD patients, nurses had decisions to make regarding pain management. Most pain strategies included limiting opiates. Nurses were able to limit opiates by reporting concerns to the physician to alter medication orders and by manipulating the times and means in which the opiates were administered. In some cases, opiates were limited due to patient safety. Another strategy unrelated to limiting opiates was to always give the pain medication regardless of suspicions. Nurses concluded that if pain was indeed what the patient said it was, the patient was always right.

The most complex of all themes was paradox of thoughts, feelings, and actions. It described the many facets that contributed to the professional and moral distress experienced by nurses. These facets included various thoughts of pain, a feeling of not making a difference for the suspected OUD patient, ineffective/nonproductive relationships, feeling like a drug dealer, and not approaching the patient about their suspicions.

Decision-making around pain management previously described, was fraught with emotional conflict based on what nurses were taught about pain in nursing school versus the absence of objective signs and symptoms of pain versus patient behaviors and nurses' personal experiences with pain. Feelings of not making a difference for suspected OUD patients became apparent as nurses contrasted their feelings about the rewards of nursing and the constituents of a good shift. Instead of the reward from making a difference, nurses experienced frustration, futility and chaotic shifts when caring for those suspected of OUD.

Because patients, nurses, and physicians did not formally acknowledge the potential for OUD in those suspected of it, the problem was self-perpetuating. This reality further prompted feelings of frustration and helplessness among nurses, knowing suspected OUD patients would be readmitted to the hospital. The belief of contributing to OUD affected the professional self-image of nurses causing them to feel like drug dealers rather than healers. Paradoxically, most nurses did not find it incumbent upon them to form a more therapeutic relationship and directly address their concerns with the patient or collaborate with the physician. Doing so may have resulted in a plan that might have disrupted the cycle of addiction. Reasons for not approaching the patient were fear of reprisal, not knowing how to initiate the difficult conversation, not feeling empowered and other reasons.

Relationships with suspected OUD patients were limited and non-productive as compared to relationships with other patients. Nurses did not take the usual steps to get to know the patient and tended to avoid the patient due to unpleasant behaviors and constant requests for pain medication. Patients resisted connecting to the nurses and seemed only interested in the relationship as far as getting pain medicine. Mutual distrust was very apparent.

Moving forward was about improving the care of this population. Nurses suggested education and collaboration between physicians and organizations to limit opiate prescriptions and the establishment of formal screening processes for OUDs. Nurses were especially interested in learning how to approach and discuss OUDs in those patients suspected.

Interpretation

Further interpretation of data occurred through alignment of research questions to relevant aspects of the literature and viewing it through the lens of SI. Although woven throughout the data, various tenets of SI are illustrated under different headings. Not all data

from this study aligns with the literature review as some questions and responses took the study in different directions.

Research Question One

What are the thoughts, feelings, or perceptions of medical-surgical for patients with suspected OUDs? Findings from this study suggest that medical-surgical nurses' thoughts, feelings, or perceptions for patients with suspected OUDs were largely negative. Their negative position related to adverse patient behaviors and other findings and based on experiences working with actual OUD patients. Seminal and contemporary studies by which this study was compared revealed negative attitudes among nurses. Nurses associated stereotypical traits with SUD patients such as scary, dangerous, low intelligence, weak character, unhygienic, and difficult (Natan et al., 2009). In contrast, and despite negative perceptions of suspected OUD patients, nurses in this study recognized that the face of addiction could belong to anyone and that OUD persons came from all walks of life. In other studies, nurses noted SUD patients as needy, manipulative, aggressive, drug seeking, time consuming, and deceitful (Monks et al., 2012; Neville & Roan, 2014). Likewise, nurses in this study used many of the same terms found in the literature to describe negative feelings and behaviors of patients with actual and suspected OUD.

In the study by Neville and Roan (2014), nurses were suspicious when patients frequently requested pain medication and their assessment of the patient's pain was incongruent with the patient's complaint of pain. Giving pain medication under these conditions created a moral dilemma for nurses as they felt they were contributing to the patient's addiction problem. The same held true for nurses in this study. In addition, they were especially suspicious of pain medication requests when patients were laughing, eating, playing on their cell phones, or

engaged in other pleasant activities. It also affected their self-image; nurses felt more like drug dealers than healers.

Other thoughts and feelings for OUD patients illustrated in the literature and this study included nurses' feelings about disruption in their routines. Routines and rituals was a sub-category of the grounded theory *moral relativism*. Routines of hospital units are organized for efficiency to coordinate patient management and resources in a timely manner. Chaotic rituals referred to actions/behaviors used by drug users to obtain drugs to prevent withdrawal, ultimately disrupting unit routines. Nurses' routines and drug users' rituals are relative to each group's respective realities, moralities, and needs. Perceived threats to routines and rituals test the individual values and self-esteem (McCredie et al., 2010). Frustration regarding unit disruption caused by SUD patients was also noted by Monks et al. (2012).

Nurses in the current study described constituents of a good shift. They included having a manageable workload and nothing out of the ordinary happening that challenged their routines. In contrast, and similar to McCredie et al., nurses often experienced routine disruption when dealing with patient behaviors to regulate pain/addiction and other adverse behaviors. Situations were described as stressful and time consuming. Nurses especially resented the time taken away from the care of other patients, also noted by Neville and Roan (2014).

Through the lens of SI, the negative position toward suspected OUD patients was further explained by the use of symbolic language tied to the behaviors of suspected OUD patients. Symbols, a central concept of SI are used in various situations to communicate something that is understood by others. *All walks of life*, for example, is a common symbolic phrase used to refer to people of all professions and positions in society; it is neither positive nor negative. Nurses recognized that SUDs are no respecter of persons. Nurses also used symbolic phrases that are

commonly associated with addiction and therefore have negative connotations such as *frequent flyers* and *drug seeking*. Although not necessarily associated with OUD patients specifically, nurses referred to patients *crying wolf* signifying a false alarm related to symptoms. Crying wolf is typically associated with negative perceptions and led nurses to minimize patient complaints.

Manipulative actions around pain management described in the literature and in this study are good examples of human action, another concept of SI. Human action results when individuals identify wants and determine ways of achieving those wants (Blumer, 1969). Overt and covert actions are influenced by how the situation is defined, social interaction and self-interaction (Charon, 2011). According to the data, patients and nurses were constantly evaluating, defining, and redefining their situations. Nurses defined the situation of drug seeking behaviors based on their experiences. They noted that patients' needs for strong opiates and the specifics in pain orders directed manipulative patient actions such as rating pain as a '10.' In recognizing these behaviors, some nurses countered by attempting to limit opiates. Unsatisfied wants or needs resulted in a change in action based on how the patient defined the situation. Patients intentionally escalated their behaviors (i.e., cursing, screaming) to force the nurse to call the doctor again and sometimes signed out AMA if the doctor refused to alter the orders.

In summary, nurses' thoughts and feelings for suspected OUD patients were predominantly negative related to patient behaviors, pain management, and disrupted unit routines. Viewing the data through the lens of SI further explicates the negative views of suspected OUD patients based on symbolic language that connotes negativity such as frequent flyer or drug seeking. Through SI, the actions of patients and nurses revealed that they constantly assessed and defined their situations related to pain management and directed their respective behaviors accordingly.

Research Question Two

How do the thoughts, feelings, or perceptions of medical-surgical nurses influence relationships with and the care given to patients? The findings in this study suggested that the first casualty of nurses' negative views of OUD and suspected OUD patients was a therapeutic NPR. Most NPRs were limited and non-productive at best. Nurses were keenly aware that the relationship was stifled because they identified constituents of a positive NPR during the interview. Their views of a therapeutic NPR mirrored that found in the literature including the importance of good communication and interpersonal skills (Ali et al., 2016; Behcher & Jones, 2009; Bridges et al., 2012; Miner-Williams, 2007; Segaric & Hall, 2015; Tanay et al., 2013). In this study, nurses referenced the importance of establishing trust and believed it occurred through demonstrating their competence (Ali et al., 2016), having confidence, and by forming rapport (Belcher & Jones, 2009). Ways of forming a bond included getting to know the patient as a person and mutual sharing bits of personal information and experiences to establish a sense of common ground (Bridges et al., 2012; Miner-Williams, 2007). Nurses' ways of knowing the bond existed included a sense of mutual comfort between the nurse and the patient (Belcher & Jones, 2009) and trust when the patient confided in the nurse.

However, negative feelings for suspected OUD had a major impact on some nurses' ability to establish a therapeutic relationship as sited in other studies (Natan et al., 2009; Bridges et al., 2012; McCreddie et al., 2010; Monks et al., 2012; Neville & Roan, 2014). Nurses reported difficulty in connecting and relating to suspected OUD patients either because of their behaviors and/or because of relational barriers erected by the patient. Upon experiencing negative patient behaviors associated with an OUD, most nurses tended to spend less time and avoided them to dodge pain medication requests and the whole range of negative behaviors. Nurses either

admitted this was their practice and/or referenced other nurses as not spending adequate time or avoiding the patient. Similarly, nurses detached themselves from SUD patients in the study by Monks et al. (2012). Patients recognized their detachment and responded with more acting out behaviors. Although the nurses in this study did not link limiting their contact with suspected OUD patients with escalation of their behaviors, it could have been a contributing factor. In contrast, a small number of nurses in this study and the study of Monks et al. reported positive attitudes in working with SUD patients, viewing them as people and not drug users; consequently, a positive NPR was formed.

Another finding of the McCreddie et al. (2010) study was nurses' reports of feeling a restriction in caring and decreased therapeutic effectiveness. In essence, nurses did not have a therapeutic relationship with SUD patients. The investigators suggested that the usual non-compliant and the aggressive nature of SUD patients along with frequent readmissions offered little to make nurses feel successful in their role. Through therapeutic NPRs, nurses can experience enhanced satisfaction and self-esteem. Similarly, nurses in this study described actions such as limiting opiates and avoiding patients that illustrated a restriction in caring and decreased therapeutic effectiveness. Some found it difficult to relate to and have compassion for suspected OUD patients due to rude and demanding behaviors, thereby inhibiting relationship formation. Failure to address suspicions with patients was more evidence of decreased therapeutic effectiveness. If the nurses had addressed their suspicions of OUD with the patient and/or collaborated with the physician to address the problem, there was the potential to help the patient, reduce readmissions and feel better about themselves.

Adding to the concept of decreased therapeutic effectiveness is the resultant decreased quality of care. All nurses in the study perceived suspected OUD patients had decreased quality

of care and primarily related it to restricting time with the patient. Less time or fewer rounds resulted in fewer assessments. Even brief encounters with patients allow the nurse to identify a variety of signs and symptoms that are detected visually or in conversation. Furthermore, adequate time allows patients to communicate concerns and problems. There was also an indication that nurses tended to minimize complaints reported by suspected OUD patients because they ‘cry wolf’ so many times nurses essentially ignore them. Nursing actions that put the patient at risk are not representative of quality care.

Natan et al. (2009) identified that nurses who categorized SUD patients as difficult perceived the quality of care provided as lower. In contrast, examination of actual care of SUD patients (as reported by the nurses) indicated that they provided a high quality of care with low percentage reporting a low quality of care. Likewise, nurses in this study perceived suspected OUD patients as difficult and all believed they received less quality of care. However, all of the nurses did not necessarily think or acknowledge that they provided less quality care.

Another factor noted in the literature as influencing the NPR was workplace conditions (e.g., short staffing, patient acuity, increased nurse-patient ratios) and organizational priorities (e.g., fixed routines) (Arungwa, 2014; Bridges et al., 2012; Segaric & Hall, 2015). Inadequate staffing created a need to focus on nursing tasks and unit routines at the expense of the NPR. Although staffing issues were not addressed in this investigation, eight nurses routinely cared for six patients during a twelve-hour shift. That coupled with a national nursing shortage makes it logical to assume that the ability to form a NPR with suspected OUD patients is even more difficult.

Examination of the NPR and care through the lens of SI calls primarily upon the concepts of role taking and ‘the self.’ With role taking, individuals consider those around them and

routinely try to understand the other's perspective on the situation. By doing so, individuals alter their actions in relation to others. Role taking is responsible for successful relationships (Charon, 2011).

The findings of this study suggested that most nurses did not take on the role of the patient as a person; rather they focused on negative, drug-seeking behaviors. Focusing on these behaviors inhibited relationship formation. Instead of trying to connect with the patient as a person, most nurses with the spent less time with them and focused on limiting opiates. Some of these strategies, believed to be for the patient's good, were manipulative and unethical such as not being forthcoming about the frequency opiates could be administered. Actions by both nurses and patients contributed to mutual distrust (Monks et al., 2012).

On the other hand, a few nurses took on the role of the person affected by the OUD, choosing to see them as human beings crying out for help and in need of compassion. They were non-judgmental and able to relate to the patient because they could see themselves or a loved one in the patient's place. Although unclear, it did not appear they spent less time with the patient although they referenced other nurses doing so. They were also more likely to approach the patient directly and indirectly about their suspicions of OUD.

'The self,' another concept of SI is a blend of two aspects of individuals; the 'I,' representing the impulsive nature of individuals while the 'me' denotes the expectations of others. The interaction between the 'I' and 'me' represents the self (Benzies & Allen, 2011).

As previously identified, nurses' self-conceptions dealing with suspected OUD patients were generally negative. They saw themselves as ineffective in making a difference in the patients' lives and felt they were contributing to the problem. Nurses also strayed from traditional ways of caring and establishing a relationship by limiting interactions, an example of

the impulsive ‘I.’ At the same time, they were careful to indicate they made the required number of nursing rounds, an example of what others expected and the ‘me.’

In summary, the thoughts, feelings, and perceptions of medical-surgical nurses negatively influenced relationships with and care of patients suspected of OUDs. Despite their knowledge of NPRs and associated benefits, and their reported ability to establish one, most nurses had limited and non-productive NPRs. Reacting to negative patient behaviors, nurses limited their contact. Limiting contact with suspected OUD patients decreased opportunities to establish relational connections, therapeutic effectiveness and quality care.

As perceived by the participants, suspected OUD patients experienced a decreased quality of care. Nurses tended to minimize their complaints putting them at higher risk for complications. Limiting contact also increased the patient’s risk because brief encounters with patients have the potential to yield important health data.

Therapeutic effectiveness was diminished when nurses were not able to take the role of the patient, thereby seeing the patient as a person in need of compassion and help. Therapeutic effectiveness may have resulted if nurses had consistently evaluated the potential for an OUD with the patient and physician. In not doing so, nurses experienced a decreased self-esteem and hopelessness in that the OUD was not addressed and could result in readmissions or more dire outcomes.

Research Question Three

What are the implications for the nurse-patient relationship and nursing education? The NPR seems to be at risk in general. Findings from several studies indicated that workplace conditions such as (e.g., short staffing, increased patient acuity and nurse-patient ratios) and organizational priorities (e.g., fixed routines) have a deleterious effect on the NPR and therefore

the quality of care (Arungwa, 2014; Bridges et al., 2012; Segaric & Hall, 2015). Given the nurse-patient ratio of study participants, coupled with a national nursing shortage it is logical to assume that relationship formation was challenging. That assumption and the difficulty in forming relationships with OUD patients and SUD patients in general implies that the quality of care for this population will be further diminished.

Seminal and contemporary studies of SUD in nursing curricula examined various aspects of SUD content including specific topics, teaching methodologies, and the quantity of time devoted to the content. The common denominator in these studies was that most content focused on alcohol rather than other drugs and the time devoted to the content generally ranged from 1-5 hours. Essentially, there was no appreciable change in the most current studies (Cund, 2013; Mollica et al., 2011; Pillon et al., 2004; Savage et al., 2014) as compared to seminal studies of Howard et al. (1997) and Hoffman and Heinemann (1987). In this study, nurses with 1-26 years of experience reported either not having SUD content in school and if so, it was minimal. Few nurses were able to recall little if any specifics; this suggested that SUD content in nursing curricula continues to be inadequate.

The literature review examined both knowledge of practicing nurses and their attitudes. While these studies evaluated different topics and aspects of nurses' knowledge, findings suggested that nurses' knowledge was limited (Owens et al., 2000; Selleck & Redding, 1999) and in one case modest but adequate (Happel et al., 2002). Lack of knowledge and/or need for education was also noted in three studies involving medical-surgical nurses (McCredie et al., 2010; Monks et al., 2012; Neville & Roan, 2014).

In this study, knowledge was assessed indirectly through responses to interview questions rather than a formal testing process; therefore, the investigator cannot speak to the overall

knowledge level of nurses regarding OUD. However, nurses and the investigator identified OUD educational needs. In general, nurses needed education on the science of OUD as a whole in addition to content on communication and relationship skills to meet the needs of this patient population. Nurses were especially interested knowing how to approach patients suspicious of OUDs with sensitivity and respect.

In review, study findings suggest the NPR may be at risk in general due to workplace and organizational factors, and more so when trying to form connections to patients with actual or suspected OUDs. Diminished NPRs have been associated with decreased quality of care. The limited education on SUDs in nursing curricula has been an ongoing issue for decades and was noted in this study. Furthermore, experienced nurses in this study felt a need for more education also. Therefore, study findings implicate the need to provide education on communication and relational skills and the need to add more in-depth content in nursing curricula related to all SUDs, as well as provide workplace training for experienced staff. These implications are expanded below along with other study implications and recommendations.

Implications and Recommendations

The final research question concerned the implications of this study's findings for the nurse-patient relationship and nursing education. Addressing these issues may improve the overall care of suspected OUD patients by positively identifying the condition. Although all SUDs are associated with a high rate of recidivism, there is no hope for recovery without actions. For suspected OUD patients, the initiation of recovery may be through assessment and relational skills of the nurse. The hope is that these actions along with other healthcare initiatives may in time significantly reduce or eliminate the opioid epidemic.

Education

Education can and must play a vital role in helping nurses identify and manage patients who have risky drug behaviors and serious OUDs. Although the focus of this study is on OUDs, nurses need the gamut of SUD education. Nursing programs and healthcare entities for workforce development can take advantage of numerous current resources available for education. There is a wealth of current information on SUDs in a variety of publications and online resources. For example, the website of the National Institute on Drug Abuse (NIDA) has alcohol and drugs of addiction information that includes: the science of addiction and how it changes the brain, preventing addiction, treatment, and recovery. In addition to publications, NIDA does research dedicated to advancing prevention and treatment of addictions. Further, the Substance Abuse and Mental Health Services Administration (SAMHSA) has numerous publications on all substances of abuse that are free and can be digitally downloaded from their website including many specifically related to OUDs. Their resources also include managing pain in those with OUDs, another need for both physicians and nurses. SAMHSA created the Addiction Technology Transfer Center (ATTC) Program in 1993 whose purpose is to enhance the preparation of addiction treatment professionals (Fornili & Haack, 2005). Among the many services and education, they provide are a collection of online courses on SUDs that are free or for a reasonable fee add continuing education credits (www.nattc.org). A simple internet search for free online courses created by credible entities are available, some created by schools of nursing funded by SAMHSA grants. In brief, there is no shortage of information and education available for the public and healthcare professionals.

Another need specific to nursing curricula is to examine the balance and presentation of pain definitions with objective signs and symptoms and assessments. The reigning pain

definition was indelibly imprinted in the minds of study participants. This emphasis was likely driven by national healthcare priorities and trends that influence nursing pedagogy. Furthermore, because healthcare reimbursement has been linked to pain management, inpatient workforce training has emphasized the need to manage pain without question. Although nurses were aware of signs and symptoms of physical pain and generally confident in their assessments, the emphasis on McCaffery's pain definition seemed to compete with and diminish their assessment findings causing nurses to second guess themselves. For some, it added to the position that pain should be treated regardless. In short, nurses should be able to make pain management decisions with less uncertainty.

The importance of NPRs and their establishment may also need to be emphasized in nursing pedagogy. If the NPR paves the way for quality care, the importance of it cannot be overemphasized. Relationships involve a give and take between nurses and patients, but the responsibility of establishing and maintaining the relationship falls upon the nurse. In this study, nurses were comfortable establishing relationships with most other patients, but less connected to actual or suspected OUD patients. More attention may be needed on how to establish relationships with patients who are challenging for any reason and frankly unpleasant. In this study, nurses also indicated that patients resisted or erected barriers to relationship formation. Motivational interviewing is non-confrontational and scripts how to establish rapport and gently ease into conversations that are more difficult. Communication strategies express empathy and include reflective listening, affirmation and ways of increasing patient self-efficacy and motivation to improve their health. This communication technique is especially relevant for all patients with chronic conditions (e.g., diabetes, heart failure, renal failure) where compliance for to treatment plans is often low.

Adding to educational needs as identified by nurses and the investigator is a screening process for patients suspected with OUDs. Several screening and brief intervention programs fit this need. These programs teach screening and a respectful approach to patients, a significant need identified by nurses in this study. Again, SAMHSA and NIDA are excellent resources for such programs. They have many resources available for training including an evidence-based practice incited by an Institute of Medicine recommendation, the Screening Brief Intervention Referral for Treatment (SBIRT) Program (SAMHSA, 2017). SBIRT is used to identify, reduce and prevent risky use and dependence on alcohol and drugs. It has three major components. The first step is screening for a SUD using standardized tools. The second step is a brief intervention, which involves engaging the patient in a conversation about problematic substance use behaviors and providing feedback and advice. This particular conversation uses motivational interviewing techniques. One such interview, the brief negotiated interview (BNI), provides a script or algorithm developed by the Boston University School of Public Health, The Art of BNI Institute (n.d.). The steps in the interview include how to establish rapport with the patient by asking the patient to describe a typical day in their life and how the use of the drug or alcohol fits into the day. It follows by asking the patient to describe the pros and cons of using the drug from the patient's perspective. Results of the screening are shared with the patient and the healthcare professional asks the patient's permission to share other information on problems associated with continued use. Ultimately, the conversation leads to readiness to change and an action plan. The third step of SBIRT involves the provision of additional resources, referral for brief therapy or additional treatment for patients who need comprehensive services.

The SBIRT program is an entire curriculum that can be used for nursing students and all health professionals with multiple resources including screening tools, recommended teaching

strategies, videos illustrating BNI, role-playing, and even competency validation tools in the use of BNI. Numerous organizations offer training, materials and online training for a fee while others are free. For example, SAMHA provides grants available for schools and other organizations wishing to implement the program. Furthermore, when conducted under Medicare and state Medicaid guidelines, physicians and some other healthcare professionals and outpatient settings maybe reimbursed for providing SBIRT (CMS Medicare Learning Network, 2017). ATTC also offers a free online 3.5-hour training program on SBIRT for healthcare professionals. YouTube provides some excellent examples of motivational interviewing that will bolster nurses' communication skills.

Workplace education for nurses and physicians is important. Nurses in this study believed physicians were overprescribing opiates and did not routinely alter dosages in preparation for patient discharge. This suggests that physicians are in need of education also. Interprofessional education (IPE) involving nurses, physicians, and other healthcare professionals who come in contact with this population may enhance the care of this patient population as well as forge more collaborative relationships.

The investigator noted a need to remediate and emphasize ethical decision-making and practice standards with regard to care of the OUD population in workplace training. This may also be a need in nursing pedagogy. Some nurses withheld information from patients about the frequency opiates were prescribed and some manipulated physician orders to give a less potent oral opiate. The latter issue carries the most significant consequences. Although their actions posed no risk or harm to the patient, nurses are bound by practice standards to follow physician orders as written and to notify and question the physician for orders that seem inappropriate for whatever reason.

Study findings clearly illustrated that experience working with OUD patients and those suspected of it was a powerful teacher. However, nurses in the study were at a loss for how to approach and communicate their concerns. Workplace training will need to include teaching strategies that mimic realistic nurse-patient situations to develop these important interpersonal skills. Morrison, Ross, Kalman, and Kemp (2011) suggested designing instruction based on Banddura's social learning theory, which involves four steps. The first step consists of presenting a model of interpersonal behavior to the learner that could be a video or role-play. Through observation, the learner is instructed to identify key elements of the behavior and interaction. Learners will then discuss their observations. Secondly, the learner is directed to develop a verbal and imaginal model of the behavior that may include paraphrasing the behavior or drawing an image of the behavior. The third step includes a mental rehearsal of the behavior. The last step is overt practice such in role-playing using realistic scenarios. Likewise, nursing students need to be acquainted with behaviors associated with substance abuse didactically and experientially. Because actual clinical experiences do not provide adequate opportunities, they too need simulated experiences using role-playing as previously described. Repetitive practice helps instill "go to" and automatic responses in stressful situations. However, role-playing, regardless of the realism, does not evoke the same kind of emotional responses and angst nurses experience in the real world. It also cannot duplicate the other situations nurses grapple with simultaneously such as the care of five or six other patients.

Physician and Organizational Support

Most nurses in the study felt strongly that physicians in hospital and other settings should limit opiate prescriptions. A number of entities including the CDC have made that recommendation. In March of 2016, the CDC recommended opioid prescribing guidelines for

primary care clinicians apart from those prescribed for cancer, palliative, and end-of-life care. While only voluntary, it recommends appropriate initiation and continuation for chronic pain, opioid selection, dosage, duration, follow-up, and discontinuation. It also includes assessing risk and addressing harms of opioid use (Dowell, Haegerich, & Chou, 2016). Likewise, many state lawmakers have responded by introducing bills to limit prescribing while the Food and Drug Administration is pressuring drug companies to create more tamper-resistant products. (Silverman, 2016).

Regarding limiting opiates, hospitals should collaborate with physicians to accomplish this task. One of the largest private hospital chains in the U.S. is doing just that. In a recent article published in *Kaiser Health News*, doctors are beginning to assume some responsibility for the opioid epidemic. Admitting they have prescribed opioids excessively to make their patients as “pain-free as possible,” they now want to help solve the problem. Along these lines, HCA, America’s largest private hospital chain has initiated a new protocol. Part of that protocol includes surgeons discussing with their patients what to expect regarding post-operative pain using the following script.

We will treat the pain, but you should expect that you're going to have some pain. And you should also understand that taking a narcotic [dose so high] that you have no pain, really puts you at risk of becoming addicted to that narcotic (Farmer, 2018, para. 3).

Similar discussions should also occur for patients with non-surgical pain; especially when the patient is insisting on large and/or frequent doses of opiates.

Other measures taken to reduce clinician pressure to overprescribe opioids were made by The Department of Health & Human Services (HHS). They proposed removing HCAHPS patient satisfaction survey questions related to pain management from the hospital payment scoring calculation (2016). Effective January of 2018, calculations associated with pain

management responses were removed from the HCAHPS survey. Although patients will continue to be surveyed for purposes of assessing their pain experiences, questions will focus on staff communication about pain (Lehrman, 2016).

Other organizational support as identified by study participants was the need to implement a screening program in hospitals to identify risky drug use and disorders. Educating nurses and other healthcare providers, already discussed, is one part of the process. The other part is adopting and implementing a program. Such an ambitious undertaking may need to be implemented in phases for practical purposes. For example, the ED may be a starting place where many patients present intoxicated from alcohol or other drugs and as victims of various accidents. This could also include patients who frequent the ED for pain related reasons.

Although some types of pain, especially chest pain need evaluating each time, screening for opiates during this time or in a special observational area would be ideal. SBIRT or BNI are simple tools to initiate in the ED by trained physicians and nurses.

Another significant consideration with SBIRT and other screening programs is that the results are only valid if the patient is honest about their drug use. Already hospitals initiate a minimal screening on patients for substance use on admission. In fact, this screening occurs in physician offices and other healthcare entities. When patients acknowledge they drink or smoke for example, other questions are usually asked to determine the quantity. In this study, nurses believed they cared for patients who did not disclose their risky opioid use or disorder. For this reason, when screening results suggest there is no problem and patient behaviors suggest otherwise, nurses need a protocol or action plan that involves other healthcare professionals to delve deeper into the potential problem. It may involve additional diagnostics to rule out painful

conditions. It can never be assumed that patients who exhibit some drug seeking behaviors do not have a medical or surgical condition.

Ultimately, if physicians and nurses are not able to identify positively that the patient has an OUD and the patient continues to complain of pain and need of opiates, they should be referred to pain specialists to evaluate treatments that will ultimately reduce the need for opiates.

Role support would be a valuable adjunct for busy hospital nurses dealing with actual and suspected OUD patients. Ford et al. (2008, 2009) examined nurses' attitudes toward SUD patients and the impact of education on attitudes. They concluded workplace education had no impact on nurses' attitudes in the absence of role support. Role support can come in many forms, including having a reduced workload and/or additional nursing staff who can spend the time needed to care for OUD patients. However, this is not a practical solution in the face of a widespread nursing shortage. SUD specialists or other trained professionals such as social workers, chaplains and others may be able to intervene and communicate with SUD patients and suggest practical actions to deal with negative behaviors.

In review, findings of this study support the need for education on OUDs and the entire gamut of SUDs in nursing curricula and in healthcare settings. SUD education appears to be minimal or absent from nursing curricula. Although addictions have always existed, the current opioid epidemic makes this finding more significant and yet the issue persists. There are many current education resources on SUDs including evidence-based screening and brief intervention programs that are available for training health care professionals. In addition to education on OUDs, nurses need education on communication, relational skills and ethical decision-making. This is especially important for any population perceived to be difficult and challenging.

Another recommendation suggested by nurses and recommended by national healthcare agencies is the need to reduce opiate prescriptions. In the hospital settings from which these nurses practice, there was little evidence to suggest physicians were on board with that recommendation. However, at a minimum, nurses can still champion the cause by routinely communicating with physicians about their concerns for OUD and the need to reduce opiates in a timely manner.

Limitations

Study limitations included a small sample size primarily taken from one acute care hospital in the southeast making findings less generalizable. Additionally, eight of ten participants were from associate degree programs. Associate prepared nurses may have had less academic preparation related to SUDs and professional communication/relational skills as compared to those with more advanced degrees.

Although the investigator identified personal thoughts, feelings, and experiences around OUDs to avoid potential bias, there can be no guarantee of the elimination of all bias. There was also no way to verify the accuracy of respondents' statements about their experiences. Some may have been reluctant to express complete thoughts and feelings about care of OUD patients. In addition, this study did not consider patient characteristics such as race and/or class that may have potentially influenced suspicions of OUD.

Recommendations for Future Research

The investigator was unable to find studies addressing nurses' experiences caring for suspected OUD patients, therefore, studies are needed to validate similarities in patient behaviors and nurses' responses to those behaviors. Additionally, the sample population should include a balance of baccalaureate and associate prepared nurses to assess for variations in thoughts and

perceptions. Another consideration for investigation should include the influence of racial and class elements on nurses' perceptions of suspected OUD patients. Are nurses more likely to assume patients of difference races or classes have a drug problem? As pain management was a focus in this study, other areas of investigation may include whether pain management strategies for suspected OUD patients differ for those of other races or classes.

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APPENDIX A:

VOLUNTARY PARTICIPATION NEEDED IN RESEARCH ANNOUNCEMENT

Purpose: To explore medical-surgical nurses' experiences caring for patients with suspected dependence/addiction to opiates

Qualifications: Must be registered nurse working on a medical or surgical unit with at least 6 months experience and have worked with a patient or patients suspected of having dependence/addiction to opiates. This will not include the care of patients with painful terminal conditions/diseases where addiction is a consequence of long term pain management.

How You Can Contribute: Agree to be interviewed (at your convenience) about your experiences working with patients you suspected were addicted to opiates.

Time Commitment: Varies; approximately one hour. Your interview will be transcribed and at a later time, you will be asked to review the investigator's interpretation of the interview and make corrections if needed which may take about 15 minutes.

Confidentiality and privacy will be maintained and you may withdraw from the study at any time.

In appreciation, volunteers will receive a \$50 gift card!

Interested persons or those seeking more information should contact Angela Bridges, MSN at: abbridges@crimson.ua.edu or call 205-826-9051

APPENDIX B:

ADDITIONAL INFORMATION TO STUDY PARTICIPANTS

Purpose: To explore medical-surgical nurses' experiences caring for patients with suspected dependence/addiction to opiates

Significance: There are few studies in the United States, where opiate addiction is epidemic, that explore the experiences of medical-surgical nurses caring for patients with suspected dependence/addiction to opiates. The findings of this study may be used to support education in nursing programs, workforce training and to improve the quality of care of this patient population and the experiences of nurses caring for them.

Criteria: Participant Volunteers must have a minimum of 6 months *current* experience working on med-surg and have cared for a patient or patients suspected of opiate dependence/addiction. Patients suspected of opioid use disorder do not include those with terminal illnesses or chronic painful conditions such as sickle cell disease where dependence is often a consequence of the illness.

Expectations: Volunteers will sign a consent be interviewed about their experiences caring for patients with suspected opiate dependence/addiction. Interviews will be recorded for analysis and will be kept confidential. Volunteers may withdraw consent and stop participation at any time before, during or after the interview. Privacy and anonymity will be assured.

Time: The time to complete the interview may vary but may take about 45 minutes to an hour and will be done at the convenience of the participant. Participants will be called for a brief second interview to validate accurate interpretation of the interview. Total time anticipated for both interviews will be approximately 1.5 hours.

Place: Interviews will occur in a private mutually agreed upon space.

Thank you: In appreciation a \$50 gift card will be given to those who meet study qualifications and agree to be interviewed. Participants may still withdraw after the interview and keep the gift card.

Contact: Angela Bridges through email or cell phone
abbridges@crimson.ua.edu
(205) 826-9051

APPENDIX C:

CASE SCENARIO

Susan is a registered nurse who works on a busy medical-surgical unit. She has only been at work for 90 minutes and has already completed a new patient admission, check blood sugars, given insulin and called a physician for orders. As she begins to round on her six patients, she pauses to respond to a call light. As she enters the room of Ms. Levins, a 38 year old female admitted for lower back pain, Susan notices that she is talking and laughing on her cell phone. Ms. Levins glances at Susan, places her hand over the receiver and whispers “bring me something for pain.” Susan begins to elicit a more detailed assessment of Ms. Levin’s pain. Exasperated with the questions, Ms. Levins places her caller on hold and snaps “My pain is a 10; it is hurting in the same place it always hurts. It has been three and a half hours since my last OxyContin and by the time you bring it back, it will have been four hours. Please hurry, the last time I had to wait nearly 45 minutes”. Before Susan could leave the room, Ms. Levin’s was back on the phone while munching on a cookie. Susan recalls comments by the off going nurse at shift change, “she’s been here many times you know; she is demanding and will run you ragged; you better get her pain med pronto or she will flip out”.

APPENDIX D:

INTERVIEW QUESTION GUIDE

1. Describe your unit in terms of size, shifts, number and mix of staff and patients.
2. What patient diagnoses are typically cared for on this unit?
3. Describe a typical work day—such as what you normally do when you arrive at work.
4. What factors contribute to good or satisfying workday?
5. What makes for a satisfying nurse-patient relationship?
6. What did you experience when I read the nurse-patient scenario? Thoughts? Feelings?
7. Why do you think the nurse in the scenario left the room in dread?
8. Tell me of a specific time that you cared for a patient suspected of opiate addiction. What was that like?
9. What signs, symptoms or behaviors lead you to suspect a patient admitted for medical or surgical problem has a dependence/addiction to opiates?
10. What words or expressions would you use to characterize someone with opiate addiction?
11. Prior to becoming an RN, how did you view people who abused or were addicted to substances?
12. Do you think you relate differently to patients you suspect have opiate addiction? If so, how and why?
13. What do you remember about substance abuse education as taught in nursing school or on the job training?

14. Have you ever confronted a patient with suspected opiate addiction about their addiction?
Why or why not?
15. If you were going to confront a patient addiction, tell me how you would approach it, what you would say?
16. Have you ever confronted a physician regarding a patient suspected of opiate addiction?
Why or why not. If yes, how often?
17. Overall, how would you rate the quality of the nurse-patient relationship in suspected patient addiction? Explain your rating.
18. Overall, how would you rate the overall quality of care that a patient with suspected opiate addiction receives? Explain your rating.
19. As a member of the nursing profession, how do you feel about yourself when you care for a patient with suspected opiate addiction as you describe?
20. How can the care of this population be improved?
21. What resources or interventions would enhance the satisfaction level of nurses caring for this patient population?
22. If education was mentioned an intervention ask participant to describe what topics should be included in the education.

APPENDIX E:

THEME: NURSES PRECONCEPTIONS OF OUD

Sub-theme: SUD in Nursing Curricula	Subtheme: Experiential Knowledge
<p style="text-align: center;">Coding Examples Related to Education</p> <p>Nurse A: No, I don't remember getting any...there is just a lot they can't teach you.</p> <p>Nurse B: I think we had a lecture or something in one of my community health classes, but it was not an abundance of teaching about it.</p> <p>Nurse E: Nothing, I mean that was 26 years ago, I remember that pain was a subjective, but I don't remember anything about addiction</p> <p>Nurse F: Yes, but most of it was geared toward addicted nurses and now I can understand why [laughs]</p>	<p style="text-align: center;">Coding Examples</p> <p>Nurse F: There was this lady who came in and she had cirrhosis, self-induced [from alcoholism]. You walked into the room and the very first question 'is it time for my pain medication?' And there was a man with sickle cell who set his phone to vibrate and he would actually stay awake just so he could get his pain meds.</p> <p>Nurse B: We get a lot of withdrawal patients on our floor...they send a bunch to us because they are not so medically unstable that they need to be monitored like our stepdown unit</p> <p>Nurse C: [in reference to actual OUD patient]... he was getting 2 mg of Dilaudid every 2 hours. He called on the dot every 2 hours. . . .If you were not in there, they were calling on the call bell...yelling and screaming until you came in there...he was very demanding.</p>

APPENDIX F:

THEME: IDENTIFICATION OF SUSPECTED OUD PATIENTS

Subtheme: Self-Regulation Pain/Addiction

Code: Drug of Choice

Related to Drug Allergies

Nurse J: [patient states] “I am allergic to everything but Dilaudid”...[Nurse] “Dilaudid is the drug of choice.

Nurse H:...their allergy list is a tip off. The only thing left is Dilaudid, Demerol and Phenergan... everything else they are allergic to.

Nurse C: I guess the main medicine I see with addiction is Dilaudid...allergic to everything but Dilaudid and Phenergan.

Related to Only Dilaudid works

Nurse A:...nothing ever helped me but Dilaudid.

Nurse D:....he only wanted IV Dilaudid.

Code: Pain Meds Around the clock

Related Setting Alarms and “Wake me up”

Nurse A: Some of them will go to sleep and set alarms.

Nurse B: you can hear the alarms go off

Nurse C: They know how often they can get it and they set their phone alarms

Nurse I: She was mad because I wouldn’t wake her up for her pain medicine

Code: Ranking Pain as Severe

Nurse A: they will say their pain is a 10 out of 10

Nurse F: automatically tell you it [pain] is a 10

Nurse J: And they say a 10 or 15 [later] but they always tell you it’s a 10

Nurse D: You’re sleeping and your pain is a 10?

Code: Behaviors not Suggesting Pain

Nurse J: they [the patient] are on the phone uh, or on Facebook or ordering a pizza

Nurse H: Family brings in KFC and they [the patient] are having a party in their room

Nurse B: You’ll walk in and they are laughing

Nurse G: [the patient] is eating what I would consider the heaviest meal ever

Nurse G: if you ever go and stand outside her room, she's on the phone, laughing and talking, she sounds great.

Nurse E: You wouldn't really expect someone who is really hurting bad to be laughing...on the phone . . .

Code: No Signs of Pain

Nurse D: You're showing no signs on pain

Nurse G: Her body language was not giving me those signals

Code: Frequent or Bogus Admissions

Nurse H:...here 18 times this year [within 6 month period] for chest pain

Nurse J: A lot of them are coming into hospital claiming chest pain.

Nurse C: claiming to have chest pain and they are just wanting a fix

Nurse G: she is a repeat admit as well and they never find anything wrong with her.

Nurse D: upper respiratory infection or something, I just don't see why you need Dilaudid or morphine-something strong like that.

Nurse H:...don't really have a reason to be hurting that I know of. I look at their history and everything and there is no reason...there were no major diagnoses.

Code: Can't get Pain Under Control

Interesting Caveat for recognizing addiction

Nurse E: they have a tolerance built up, it's hard to get their pain controlled.

Code: Interesting Caveat OUD Illness/Not Illness-(Not in Context with Theme)

Related to Not Thinking OUD an Illness

Nurse D: If there is something wrong with the patient . . .you're trying to take care of the sick patient and they [suspected OUD patient]

Nurse H: I get frustrated because people who are legitimately sick

Recognizing OUD as Illness

Nurse G: they just have a disease

Nurse I: For me...that patient is sick. Addiction is an illness.

Subtheme: Range of Negative Behaviors

Code: Acting Out

Usually Related to OUD patients not Getting What They Wanted

Nurse G:...they are having a fit and coming to the desk,...threatening to leave, and they might become combative, I'm calling security.

Nurse D: [Patient] 'Well, I'm going to leave. He demanded that I call the doctor again.

Nurse H: . . .some way to approach them so that if they are aggressive

Nurse B:...they generally tend to get uh, more upset when they can't get what they ask for. Nurse
H: Nurse H: They [the patient] will sign out AMA.

APPENDIX G:

THEME: PAIN MANAGEMENT

Subtheme: Limiting Opiates

Code: Calling MD to Report Suspicions/Alter Orders

Related to Calling MD to Report Suspicions of OUD and MD Responses

Nurse B: The hospitalists are very receptive...usual response is to just cut the medicine down [reduce dose or frequency].

Nurse D: I have...asked if there is something else we can give because they don't seem to be in a lot of pain...some doctors say 'well okay, let's stop the IV pain meds and let's try something else'

Nurse H: their CTs and tests are negative but they are getting Dilaudid every 2 hours; I think they are here for that, can we back that off or can we change to something else? ...the physicians are very receptive.

Nurse I: I'll see them when rounding....and ask if we can extend the time between doses. And they usually do

Code: Nurse-Mediated Interventions-Limiting Opiates

Related to Moving to Oral Opiates

Nurse J: [Nurse states to patient] 'well I gave you IV pain medicine [last time] and this round we'll give PO' [Investigator: so you would give an oral drug that was ordered for moderate pain even if their pain is a 10?] [Nurse] They all say it [their pain] is a 10, yes.

Nurse G: [nurse states to patient] 'Let's not give the IV pain . . .when you go home, you're not going to have it

Related to Not Giving Opiates as Frequently as Ordered

Nurse A: We kind of have this secret code on the floor... 'the patient's pain med can be given every 2 hours but he doesn't know it, he thinks it's every 3 or every 4'

Nurse F: I do not tell my patients that they can have the medication every 4 hours necessarily....don't volunteer it unless they ask for it.

Nurse C: Some nurses will give pain medicine early....I'm not giving it unless it [the time] is right on the dot.

Related to Patient Safety

Nurse F:...that's the line I have to draw, a professional judgement as to whether or not I'm going to give them that much medication.

Nurse G:...and I feel their level of sedation...I don't think they need pain medication,...if it is not safe, I'm not going to give it

Related to Nonpharmacological pain management

Nurse C: I try different things for pain such as repositioning...

Nurse D: I had tried a heating pad on his back and he refused it....I've tried Biofreeze . . .

Code: Behaviors/ Limiting Opiates (Some listed under Range of Negative Behaviors)

Nurse E:...when they are drug seeking, then they are not getting anything else [per physician] I'm dealing with this [negative patient behaviors]...how do I deal with this?

Nurse I: [after talking with physician for an order change] Now my patient is not happy. But when he (the doctor) takes away the option, the pain pills are okay.

Subtheme-The Patient is Always Right

Nurse C:...the doctors have ordered it and they [the patient] are claiming they have pain and so we have to treat their pain-the patient is always right.

Nurse I: I have to tell myself—'well you don't know for sure [that they are not in pain]. To morally deal with it, I say, 'who am I to say they are not'?

Related to MD orders/Not my Job to Fix it

Nurse F:...I'm not the physician...I'm not going against...it's not my job to fix it.

APPENDIX H:

THEME: PARADOX OF THOUGHTS, FEELINGS, AND ACTIONS

<p>Conflicting Thoughts and Perceptions about Pain</p>
<p>Code: Conflicted about Pain Definition</p>
<p>Nurse B: I think the hardest problem that we've found is that...pain is subjective. . . so I'm on the fence of it.</p> <p>Nurse F: I would like to believe [that pain is what the patient says it is]but no. [Later in the interview] Pain is what the patient says it is and it is not for me to make that value judgement.</p>
<p>Code: Non-Supportive of Pain Definition</p>
<p>Nurse C: I do not [support pain definition]...talking on the phone and eating a piece of fried chicken</p> <p>Nurse G: That's the quote we've been given...but no, I don't believe that</p>
<p>Code: Supportive of Pain Definition</p>
<p>Nurse I: I do [support pain definition] simply because I have back issues</p> <p>Nurse E: I was trained that pain is subjective and that it is what you really go by</p>
<p>Subtheme: Feel Like a Drug Dealer</p>
<p>Code: Contributing to the Problem</p>
<p>Nurse C: I'm just feeding the addiction and I'm doing more harm than good.</p> <p>Nurse I: I don't have the tools to go against what the doctors do (order) and ordered for me [to give] every so many hours...so you do feel like the little drug pusher</p> <p>Nurse H: [I] feel like a drug dealer.</p>
<p>Subtheme: Not Making a Difference</p>
<p>Code: Making a Difference</p>
<p><i>Related to being able to feel it or know it</i></p> <p>Nurse D: Just feeling good about yourself, knowing you made a difference in someone's life.</p> <p>Nurse G: When you leave...[and the patient says] 'you're not coming back'; that makes you know that you made a difference.</p> <p>Nurse A: When I saw that man go from being unresponsive to eating steak</p>
<p>Code: Not Getting Better</p>
<p>Nurse B: It's frustrating...it sucks not to be able to see somebody get better when you know they</p>

have a problem [OUD] and they don't know it.

Nurse C: I don't think I'm doing anything to help the person. I'm just feeding the addiction and I'm doing more harm than good.

Code: Good Shift/Work Experience

Nurse D: Stay on top of everything, they [patients] are fine, no falls, just good, you don't have to call the doctor too much...family members are okay.

Nurse B:...everybody is on top of everything . . .you don't have things happen like we have codes...things really go smoothly.

Code: Bad Shift/ Work Experience

Nurse G:...they're out in the hallway, they are having a fit and coming to the desk...threatening to leave and they might become combative. I'm calling security and I'm calling a code strong.

Nurse C: He [OUD patient] called on the dot every 2 hours. . . they were yelling and screaming until you came in there.

Subtheme: Relationships, Limited and Nonproductive

Code: Therapeutic Nurse-Patient Relationship

Contextual: Related to what nurse does and patient feels & elements

Nurse C:...you are able to talk to them on a personal level; they feel comfortable with you in the room. Trust is a big one, compassion and empathy.

Nurse J: You have to build a good trusting relationship. . . . they feel confident with you as their nurse. . . .we are their advocate.

Nurse E:...the nurse does...the nursing process using objective and subjective findings....They [the patient] feel they can trust you...they feel comfortable with you, they feel their needs are met . . .you demonstrate that you have that caring attitude

F: Being professional...instilling confidence in my patient...advocate...letting them know I care...be approachable...[feel] trust and I feel confident that they can say what they want to say, need to say.

Related to initiating the relationship

Nurse D: Introduce yourself, talk to them and get to know them, where they are from, what they like to do. feel closer to you, they can tell you things that they won't maybe tell the doctor

H: First impressions are a big...you're smiling, and you sit down, talk to them...involve them in the conversation...talk to them on a personal level, [do they] have kids.

Code: Limited/Nonproductive

Nurse B: I think it's harder [to relate to suspected OUD patients] because they are generally more needy

Nurse C: It's hard to imagine what they are going through when they are being so rude...it's hard to have compassion and really listen to people...

Related to less compassion

Nurse D: When they are drug seekers around the clock...it's kind of hard to feel sorry for them

Related to view of other nurses' relationships

Nurse F: I don't think they want to have a quality relationship because the judgement has already been made; this is an addict

Related to patient barriers

G: It's a lot harder to connect, because they shut down..... they are just in the habit of covering up . . they're not going to let me in.

Nurse C: if you are...trying to take a different route with the pain medicine or trying to do other things for their pain, they're not as open to talking to you, or as receptive to you or the relationship.

Nurse H: Oh, it's [the relationship] broken....They have a wall

Code: Limiting Patient Contact/Avoiding

Related to behaviors

Nurse J:...the patient is just drug seeking so they don't spend as much time trying to get to know the patient...they just give them the pain medicine and they're out.

Related to quality

Nurse H: It's probably worse [the quality] because you don't go in their room and assess them as much.

Caveat: More time but not quality

Nurse G: I spend more [time]; it's not quality time with them. . . . I'm not making a difference....

Code: Consequences of Limited/Nonproductive Relationship

Risk to patient

Nurse F: I think that sometimes they [other nurses] minimize that something is wrong with them [patient]...you cry wolf so many times that...

Nurse I:...those patients have to try so hard and something major may be going on...They have cried wolf so many timesOh, look, he [the patient] has a problem.

Code: Unclear About Care/Relationship

Related to-is the relationship the same? Treated the same"

Nurse D: I try to... I really can't say it is, but I try to treat all my patients the same.

Nurse G: I hope and pray...that I'm the same nurse for that patient that I am for other patients

Code: Positive Nurse-Patient Relationship

Related to being nonjudgmental

Nurse E: I try not to judge...I don't like to put a label on them....I try to go in without an attitude and maybe be objective. I listen to what they tell me but then I assess

Related to connecting-humanness, listening

Nurse I:...these patients are individuals...they are humans...we are in the caring business...even if they get ugly with you...I'm just going to listen to her.

Related to empathy

Nurse J: Um, I can relate to them...because it's not them it's the addiction. . I try to put myself in that person's shoes.

Subtheme: Addressing Suspicions of OUD

Code: Reasons for Not Addressing

Nurse A: I guess to avoid conflict, to avoid them getting the supervisor....you can tell them that its bad for them...but until the patient wants to, they are not going to do it.

Nurse B: I did not feel comfortable with that because I've only been a nurse for a year.... I have issues with that kind of thing. . .personal weakness

Nurse E: I guess because it goes back to a philosophy...pain is what the client says it is.

Nurse F: I don't have time for things like this Until people [realize] they have a problem, then they don't have a problem.

Nurse H: I feel like I can get in trouble for that

Nurse I: I don't want to offend the patient

Code: Indirect Approach

Related to asking about how pain managed at home

Nurse F:...how do you manage your pain at home when you don't have IV pain medications”?

Nurse G: “[I have] not point blank...but in a roundabout way” [speaking to the patient] ‘If you're taking Norco...how do you manage your patient at home-you don't have IV pain medicine at home?

Nurse I: I touch on it indirectly.....but I have had conversations about...why don't we try this pill cause you're not going to have IV pain medicine at home.

Code: Feelings about Not Approaching

Nurse J: It makes me feel like I haven't stepped out and done what I was supposed to do

Nurse D: It makes me wonder what else I could have done. What if they go home and do something bad such as kill themselves.

Nurse I: I sometimes feel helpless as a nurse because when they are going to be discharged and repeatedly admitted

Code: Direct Approach

Related to only one nurse

Nurse J: Once I started asking her about it, she started saying.... And I asked her did she want to get some help

APPENDIX I:

THEME: MOVING FORWARD

Subtheme: Education

Code: Education Identified by Nurses

Communication in general

Related to approaching patient about OUD with sensitivity

Nurse B: ...how to approach those patients because it has to start with somebody

Nurse C:...would help to have some kind of script or education for nurses to learn how to talk to patients about this

Nurse G: some ways to approach the patient so we wouldn't be accusatory...in such a way that they would be receptive and not become defensive"

Nurse H: some way to approach them so that if they are aggressive, you approach them this way...like a script".

Nurse A:...like to know more about how to confront them (the patient)

Related to other communication needs

Nurse J: to talk to the doctors about the amount of pain medicine they (the patients) are getting and how often they are getting it".

Related to Generalized OUD Knowledge

Nurse C:...nice to have like a physiology on what it actually does to the body and why it is so hard to kick.

Nurse A: What does someone's brain look like that is addicted to anything

Nurse D: [wanted to know what caused individuals to become addicted]. Were they prescribed medicine and became addicted or was it something they were taking on the street?

Nurse J:...and knowing signs and symptoms, things in place that would raise a red flag like a screening process.

Nurse I: I would love to know the harmful effects of patients being addicted to the drugs

Related to Humanity and Caring

Nurse I: I think everyone needs education to remember that these patients are individuals-that they humans, that we are in the caring business..... I would love to know the harmful effects of patients being addicted to the drugs—what does that do to the patient long term. What harm are we causing"?"

Nurse J: Educate nurses on looking at the patient as a whole, being more involved.

Code: Education Needs Identified by Investigator

See elements under various themes related to need for education such as participants not remembering what they received on SUD in nursing, addiction makes pain hard to control

Related to other education

Nurse G:...it is a sickness just like cancer, it just affects a different part of the body

Nurse F: I don't know what my resources are or who to go to other than the chaplain

Related to how and when it should be taught in healthcare settings

Nurse E:...would really be good to have some special education in the orientation process or any unit really . . .

Nurse G:...videos, maybe classes that we could go to, interactive classes, could learn how to deal with these people.

Subtheme: Improving Overall Care

Code: Nurse/MD Collaboration

Nurse G: We need the doctors to be onboard with us. . . doctors need to be willing to address this . . .

Code: MD Limit Opiates

Nurse H: I wish doctors would not give it out like they do.

Nurse C: I feel like IV pain medicine should not be the first thing that is ordered. We should use more Tylenol, Motrin.

Nurse A: They [doctors] sometimes feed those addictions like when they schedule meds every two hours.

Nurse C: A lot needs to start with the doctors...instead of prescribing the medications, maybe talking to them (patient) more about it

Nurse D: you can't just prescribe everyone opiates. . . you need to try something else first.

Related to benefits of decreasing opiates in hospital

Nurse J: [by] not giving...so much IV pain medication...if we start there, the word will spread [in the community].

Related to having a protocol to limit opiates

Nurse J:...the patient has had this amount of Dilaudid for this amount of days, the nurse can decrease the medicine to this [whatever is ordered by physician] if certain conditions were met.

Code: Organizational Support

Related to screening

Nurse H: [We need] more screening. How many times can a patient be admitted for chest pain

and abdominal pain in a year?

Nurse C:...it would be nice to know before they come to us, that the patient] has been here 18 times in the past month

Related to where to screen

When recording stopped, Nurse C mentioned familiarity with ED (in another county) having observation place to evaluate chest pain.

Nurse J: If we had an outpatient or area where we watch them, do a cardiac...like we have a Sepsis board we automatically know when there is a red flag (electronic process).

Code: Role Support

Nurse C: Maybe a counselor or someone who come around and talk and educate patients.
. . . specially trained to talk with them about it.

Nurse D: [in response to investigators suggestion of consultant availability] Yes, to get behind what is going on

APPENDIX J:
IRB APPROVAL

THE UNIVERSITY OF ALABAMA® | Office of the Vice President for
Research & Economic Development
Office for Research Compliance

February 13, 2018

Angela Bridges, MSN, RN
DNP Program
Capstone College of Nursing
The University of Alabama
Box 870358

Re: IRB # 17-OR-110-R1 "Medical-Surgical Nurses' Experiences Caring for Patients with Suspected Opioid Use Disorder"

Dear Ms. Bridges:

The University of Alabama Institutional Review Board has granted approval for your renewal application. Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on February 12, 2019. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,



Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer
Office of Research Compliance

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

March 23, 2017

Angela Bridges, MSN, RN
DNP Program
Capstone College of Nursing
The University of Alabama
Box 870358

Re: IRB # 17-OR-110: "Medical-Surgical Nurses' Experiences Caring for Patients with Suspected Opioid Use Disorder"

Dear Ms. Bridges,

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your approval will expire on March 22, 2018. If the study continues beyond that date, you must complete and submit the Renewal Form within e-Protocol. If you modify the application, please submit the Revision Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Final Report Form.

Please use the IRB-stamped flyer consent form.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB approval number. Good luck with your research.

Sincerely,



Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer
Office for Research Compliance

cc: Dr. Nirmala Erevelles

Attention Medical-Surgical Nurses: Voluntary Participation Needed in Research

Purpose: To explore medical-surgical nurses' experiences caring for patients with suspected dependence/addiction to opiates, also known as opioid use disorder

Qualifications: Must be a registered nurse working on an inpatient medical and/or surgical unit with at least 6 months experience; experience must include working with a patient or patients suspected of having a dependence/addiction to opiates. This will not include experiences caring for patients with painful terminal conditions/diseases such as cancer or sickle cell disease where addiction is a consequence of pain management.

How You Can Contribute: Agree to be interviewed (at your convenience) about your experiences working with patients you suspected were addicted to opiates. You will be audio recorded to accurately transcribe your interview for Analysis.

Time Commitment: Varies; up to a maximum of two hours. The initial interview time may range from 30-90 minutes. After the interview is transcribed and analyzed, the investigator (Angela Bridges) will meet in person or on the phone to share impressions/interpretation of the interview data. You will be asked to verify accuracy of the interpretation and make corrections as needed.

Confidentiality and privacy will be maintained and you may withdraw from the study at any time.

In appreciation, volunteers will receive a \$50 gift card!

Interested persons or those seeking more information should contact Angela Bridges, MSN at: abbridges@crimson.ua.edu or call cell 205-826-9051

UA IRB Approved Document
Approval date: 3/23/2017
Expiration date: 3/22/2018

CONSENT FORM: NONMEDICAL HUMAN SUBJECTS STUDY

FOR QUESTIONS ABOUT THE STUDY YOU MAY CONTACT: Angela Bridges, 5004 Malachite Court, Northport AL, 35473; (205) 826-9051; abbridges@crimson.ua.edu or Angela's faculty supervisor, Dr. Nirmala Erevelles, University of Alabama, Tuscaloosa AL 35401; 205-348-1179 (office) or nerevell@bamaed.ua.edu

DESCRIPTION: You are invited to participate in a research study about and entitled *Medical-Surgical Nurses' Experiences Caring for Patients with Suspected Opioid Use Disorder*. Opioid or opiate use disorder (OUD) is a contemporary term referring to individuals addicted to opiate pain killers. For purposes of this study, experiences involving patients with terminal illnesses such as cancer and sickle cell disease will not be included as opiate addiction is an expected consequence of long term pain management. Approximately twelve nurses will be recruited for this study. The purpose of this study is to learn of nurses' experiences caring for this population that may identify gaps in knowledge that can ultimately lead to education and interventions that will improve care of this population as well as the satisfaction of nurses caring for them. Overall research questions to be addressed in the study include:

1. What are the thoughts, feelings or perceptions of medical-surgical nurses for patients with suspected OUDs?
2. How do the thoughts, feelings or perceptions of medical-surgical nurses influence relationships with and the care given to patients?
3. What are the implications for the nurse-patient relationship and nursing education?

Your participation will include providing demographic data about yourself (for example, years of experience, nursing degree) and an in-depth interview in which you will be asked to describe experiences caring for suspected opioid use disorder patients. Examples of questions will include:

1. Tell me of a time that you cared for a patient suspected of opiate addiction. What was that like?
2. What signs, symptoms or behaviors lead you to suspect a patient admitted for a medical or surgical problem has a dependence/addiction to opiates?
3. What words or expressions would you use to characterize someone with opiate addiction?
4. Have you ever confronted a patient with suspected opiate addiction about your suspicions? Why or why not?
5. Overall, how would you rate the quality of the nurse-patient relationship in suspected opiate addiction? Explain your rating.

Immediately prior to the interview and obtaining informed consent, the investigator will explain and provide in writing brief details of the study and your rights. Upon consent, the interview will begin and your responses audio recorded to accurately transcribe information for analysis. While recording, the investigator will jot down additional thoughts or notes about your responses that will be identified with your recording. Audio recordings will not be labeled directly with

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 3/23/2017
EXPIRATION DATE: 3/22/2018

your identity. To protect your privacy, you will be identified as “nurse” followed by a letter in the alphabet (for example, nurse A). Your coded identity will correspond to a document with your actual identifying information secured separately (from recordings, transcripts, notes) in a locked file in the investigator’s home. The document will be accessed to contact you for follow-up questions if needed and to verify the accuracy of your interview as interpreted/analyzed by the investigator. The recording will be destroyed following transcription as well as all identifying data at the conclusion of analysis.

RISKS AND BENEFITS: The risks associated with participation in this study are considered minimal. A couple of potential risks and procedures to minimize risks are described below but there may be risks that are unforeseeable. There is a potential risk to your psychological well-being upon recall and discussion of unpleasant experiences. If at any time you feel stress beyond what you encounter in daily living, please advise the investigator who will stop the interview and withdraw you from the study. For significant distress, the investigator will recommend additional counseling support through the employee assistance program that is both confidential and available at no cost to you. You may keep the gift card in appreciation for your willingness to participate in the study. There is a potential minimal risk to your economic well-being if your privacy or confidentiality were inadvertently breached and sensitive information available to your manager. Depending on the nature of the information breached (for example, potentially discrediting information about the manager or DCH), disciplinary action could result that ultimately could impact your economic well-being. To minimize the potential threat to economic well being, privacy and confidentiality during the interviews will be provided with all interview data secured in locked file in the investigator’s home. Only the investigator will have direct access to the data. During the course of the investigation, the investigator’s co-investigator (University of Alabama research faculty member) may have access to de-identified interview data for the purpose of guiding the investigator in further data collection and analysis. At the completion of data analysis, all identifying information linking you to the study will be destroyed.

There are no direct benefits related to study participation. Potentially, you may find it gratifying knowing that you are contributing to research that may ultimately lead to improved care of opiate use disorder patients and the satisfaction of nurses caring for them. The investigator cannot guarantee or promise that you will receive additional benefits.

TIME INVOLVEMENT: Your participation in this study may take up to a maximum of two hours. In general the initial interview is estimated to range from 30-90 minutes. Within a month after the initial interview, a brief follow-up interview in person or by phone is estimated to range from 15-30 minutes. The intent of the follow-up interview is to verify the investigator’s impressions or interpretation of data; this process is referred to as member checking. At this time, you can correct inaccuracies or misconceptions.

PAYMENTS: You will receive a \$50 Visa gift card in appreciation for your participation. If you at any time during the course of the study you withdraw further participation or use of data, you may keep the gift card.

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CONSENT FORM APPROVED: 3/23/2017
EXPIRATION DATE: 3/22/2018

SUBJECTS' RIGHTS: If you have read this form and have decided to participate in this project, please understand that your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty. You have the right to refuse to answer particular questions. Your individual privacy will be maintained in all published and written data resulting from this study.

If you have questions, concerns, or complaints about your rights as a participant in this research study, you may contact Ms. Tanta Myles, the Research Compliance Officer at The University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html or send an email to participantoutreach@bama.ua.edu. After you participate, you are also encouraged to complete the online survey for research participants at http://osp.ua.edu/site/PRCO_ParticipantSurvey.html.

I give consent to be interviewed which includes being audio-taped for the purpose of accurately transcribing information for analysis.
Please initial: _____

I give consent to be re-contacted after the initial interview for member checking (previously described).
Please initial: _____

The extra copy of this consent form is for you to keep.

SIGNATURE _____ DATE _____

Protocol Approval Date: _____

Protocol Expiration Date: _____

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 3/23/2017
EXPIRATION DATE: 3/23/2018

APPENDIX K:
SITE APPROVAL



March 9, 2017

Angela Bridges
5004 Malachite Court
Northport, AL 35473

RE: "Medical-Surgical Nurses' Experiences Caring for Patients with Suspected Opioid Use Disorder"

Dear Ms. Bridges:

The Application for Review and materials you submitted to the Institutional Review Board (IRB) for the above named study were reviewed and granted approval via expedited review. This approval applies to DCH Regional Medical Center only as requested. In addition, the request to waive the IRB application fee was approved.

It is expected that you and the study staff will work closely with other DCH staff to ensure the safety and welfare of nurses who enroll in this study. As principal investigator, you are expected to keep appropriate records concerning the study and your subjects. Furthermore as a condition of this approval, the Institutional Review Board must be notified of any complications or unanticipated circumstances encountered. Study amendments are not to be implemented without prior IRB approval except when necessary to eliminate apparent immediate hazards to human subjects.

Your application will expire on March 9, 2018. If the study continues beyond that date, you must complete a Continuing Review Status Report. The IRB should be notified upon completion of the study and a copy of the final results provided.

We look forward to working with you and good luck with your research.

Sincerely,

A black rectangular box redacting the signature of Chris Jones, J.D.

Chris Jones, J.D.
General Counsel
IRB Signatory Designee

: dw



February 19, 2018

Institutional Review Board
FWA #00006291
NOTICE OF CONTINUING REVIEW OUTCOME

Name of Study: "Medical-Surgical Nurses Experiences Caring for Patients with Suspected Opioid Use Disorder"

Principal Investigator: Angela Bridges, EDD (ABD) MSN

Items for Review: Data Collection Completed, Summary Pending

Date Reviewed: February 19, 2018

Review Outcome: Approved for an additional one (1) year period

Approval Expiration: February 19, 2019



Chris Jones, J.D.
General Counsel
IRB Signatory Designee

dw