The Mission of the Louisiana State Board of Nursing is to safeguard the life and health of the citizens of Louisiana by assuring persons practicing as Registered Nurses and Advanced Practice Registered Nurses are competent and safe.

Drug Testing 101 for Healthcare Employers

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While I am not a Medical Review Officer (MRO), I did consult with two MROs, one of whom was instrumental in developing the MRO course, before embarking on this article. I wanted to share some things I have learned over the last 22 years about looking at drug screens for healthcare professionals. Why do we have drug screens in the workplace? Studies suggest that substance abuse—which includes drugs and alcohol—costs the United States an estimated $276 billion a year, with much of the cost resulting from lost productivity and increased healthcare spending.[1] Employees who use drugs are 2.5 times more likely than other non-abusing co-workers to be absent for eight or more days. Drug abusers are 3.6 times more likely to be involved in an accident at work and five times more likely to file a workers' compensation claim.[2] Forty-four percent of abusers have sold drugs to other employees. Eighteen percent have stolen from co-workers to support their habit.[3]

The term *drug testing* can be confusing because it implies that the test will detect the presence of all drugs. However, drug tests target only specific drugs or drug classes and can detect substances only when they are present above predetermined thresholds (cutoff levels). The term *drug screening* can also be deceptive because it is often used to describe all types of drug testing. However, *drug screening* is usually used in forensic drug testing to refer to the use of immunoassay tests to distinguish specimens that test negative for a drug and/or metabolite from positive specimens.[4]

First and foremost, we need to determine what substance is being tested for? If your hospital is using the National Institute of Drug Abuse (NIDA) 5, you are testing only for amphetamines (meth, speed, crank, ecstasy), tetrahydrocannabinol (THC) (cannabinoids, marijuana, hash), cocaine (coke, crack), opiates (heroin, opium, codeine, morphine), and Phencyclidine (PCP), angel dust).[4] The NIDA 5 does not test for synthetic opiates. Synthetic opiates include demerol, dilaudid, norco, lortab and others. Synthetic opiates are the most commonly abused drugs among the participants in the Louisiana State Board of Nursing Recovering Nurse Program (RNP). Approximately 47% identify opiates/synthetic opiates as their drug of choice. The RNP has received reports from hospitals indicating that they investigated a nurse for multiple narcotics errors involving dilaudid (number 1 drug of choice among nurses in the RNP). The hospital required a drug screen but it came back negative. The specimen was not tested for synthetic opiates. Even some collection sites have argued that the synthetic opiates are tested for, if the test says opiates, but that is not the case unless it says extended opiates or lists the opiates tested for. Fentanyl and propofol require special testing. It also would be appropriate for hospitals to use a medical professionals testing panel to include all the opiates and at lower cut-off levels than may be used in less "safety sensitive positions." Physicians, nurses, and other healthcare providers may cause patient harm if they are impaired. It is important to remember that persons can be impaired even if they have a legitimate prescription. The NIDA 5 also generally uses a detection level of 2000 ng/ml for opiates, well above the 300 ng/ml normally used in testing healthcare professionals.

Another thing to consider in drug testing is how the results get reported. LSBN recommends that organizations that employee nurses require the actual results of the test, not just the MRO determination. If the person being tested provides a prescription which covers a positive test, the MRO may report the screen as being negative. However, the Louisiana State Board of Nursing Advisory Statement Regarding Practicing While Taking Prescribed Narcotic Medication (September, 2010) sets forth guidelines for Registered Nurses who are taking prescribed controlled substances. The Advisory Statement encourages employers to develop drug free workplace policies which address the use of prescription medications. It includes that nurses should inform their employers if they are taking controlled substances. Employers may require certification from the prescriber that the prescription substance does not adversely impact fitness to do the job. Impairment at work due to prescribed medications is grounds for disciplinary action. If your hospital does not have a drug free workplace program, please consult the following website http://webapps.dol.gov/elaws/asp/drugfree/menu.htm for recommendations.[5]

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Marijuana is still the most popular abused drug for non-healthcare workers. However, marijuana continues to be seen in pre-employment, random and post-accident drug screens in the healthcare workplace. The research that has been done on marijuana indicates that the metabolites are detected longer than most other drugs. Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that for single use of marijuana, the detection time in urine is 3 to 5 days. For moderate use (4 times per week), the metabolite is only detected for up to five days after the last use. For daily users, the metabolite is detected up to 10 days after the last use and for daily users using more than once per day, detection time may be up to 30 days or more.[4] Detection levels are generally set at 50 ng/ml. This level is used to avoid detection of passive inhalation. There are many synthetic marijuanas available today. If you are using a national laboratory, they can test for approximately 75 different types of synthetic marijuanas but the compounds change so frequently that the laboratories have a difficult time keeping up with new compounds.

Finally, I will close with just a few words about kratom, (Mitragyna speciosa korth). Kratom is a tropical tree indigenous to Thailand, Malaysia, Myanmar and other areas of Southeast Asia. Kratom has been used by natives of Thailand and other regions of Southeast Asia as an herbal drug for decades. Traditionally, kratom was mostly used as a stimulant by Thai and Malaysian laborers and farmers to overcome the burdens of hard work. They chewed the leaves to make them work harder and provide energy and relief from muscle strains. Kratom was also used in Southeast Asia and by Thai natives to substitute for opium when opium is not available. It has also been used to manage opioid withdrawal symptoms by chronic opioid users.[7] Kratom is sometimes used by healthcare workers and is gaining in popularity. There are urine drug screens available at some of the national labs. It currently is not a scheduled drug, but it is mood/mind-altering and addictive.

Nurses, physicians and other healthcare providers are entrusted with taking care of patients and if they are working while impaired, they could cause patient harm. The Louisiana State Board of Nursing and the Physicians Health Program have programs for nurses and doctors who develop the disease of addiction and in many cases these professionals can get help, be monitored and practice safely without disciplinary action against their license.

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