Institutional Diversion Prevention, Detection and Response

Kimberly S. New JD BSN RN
Discussion Points

- Scope of the problem
- External authorities
- Impact on the patient and institution
- Diversion prevention, detection and response program
- Methods of drug diversion
- Diversion investigation walk through
How Big a Deal Is It?

• Reliable statistics on the prevalence of drug diversion by nurses are not available

• By its nature, diversion is a clandestine activity, and methods in place in many institutions leave cases undiscovered or unreported

• Drug diversion by health care providers is universal among institutions in the United States
Involvement of External Authorities

- Must report to DEA immediately (Form 106)
- State Licensure Board and/or Professional Assistance
- Department of Health (patient harm issues)
- Law Enforcement - crimes, issues of abuse/neglect/reckless endangerment, fraud
- Pharmacy Board
- FDA/OCI (tampering cases)
Why Don’t We Hear More?

- Fear of negative publicity
- Fear of State and Federal agency involvement
- Uncertainty about reporting requirements and avenues
- Justification that terminating the employee is enough
Who and Why?

The major factors impacting the incidence of drug misuse by healthcare professionals are access and availability of controlled substances.

Generally, healthcare workers divert for personal use and are extremely secretive about it.

Frequency

Approximately 1 nurse per month

- Award winners
- New Grads
- Team Leaders
- Pediatric and neonatal nurses
- Pregnant nurses
- Clusters of nurses
Impact on Institution

- Liability-civil, regulatory
- Negative publicity
- License and participation in Medicare/Medicaid in jeopardy

Hospitals are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment.

State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
DEA on Pre-Employment Screening

21 CFR 1301.90 Employee screening procedures. (Non-practitioners)

• Obtaining certain information by non-practitioners is vital to assess the likelihood of an employee committing a drug security breach

• Need to know is a matter of business necessity, essential to overall controlled substances security

• Conviction of crimes and unauthorized use of controlled substances are activities that are proper subjects for inquiry
Pre-Employment Screening

- Criminal background check
- Primary source verification of licensure
- Drug screen
- Question:

Have you ever been disciplined, terminated, allowed to resign or denied employment because of mishandling of a controlled substance or a drug diversion issue?
DEA on Corrective Action

21 CFR 1301.92  Illicit activities by employees
• Employees who possess, sell, use or divert controlled substances will subject themselves not only to State or Federal prosecution
• Employer will immediately determine status of continued employment by assessing the seriousness of the violation, the position of responsibility held by the employee, past record of employment, etc.
Conditions of Participation

• §482.25(a)(3) - Current and accurate records must be kept of the receipt and disposition of all scheduled drugs

• §482.25(b)(2)(i-ii) - All drugs and biologicals must be kept in a secure area, and locked when appropriate

• §482.25(b)(7) - Abuses and losses of controlled substances must be reported, in accordance with applicable Federal and State laws, to the individual responsible for the pharmaceutical service, and to the chief executive officer, as appropriate
Joint Commission Medication Management (MM) Standards:

- Procurement
- Storage and Security
- Dispensing and Administration
Impact on Patients

- Impairment and addiction put patients at risk
- Strong likelihood of denying patients appropriate pain relief
- Potential to expose patients to bloodborne pathogens
- Falsification of records (fraud)
- Theft
Tampering

Exeter Hospital –

- 8 states
- 3,798 tested from Exeter alone
- 44 cases of hepatitis C
- Multiple class action lawsuits including suits against institutions that allegedly failed to properly report
- Clear behavioral signs went unreported

David Kwiatkowski
Recognition of Patient Harm

Diversion doesn’t always result in patient harm, but beware of these situations:

- Diversion of scheduled (non prn) doses
- Documentation of pain at the time medication is diverted
- Evidence of substitution and tampering, including transmission of infection
- Impairment resulting in patient harm or reckless endangerment
Essential Components of Diversion Prevention and Detection Program

- Policies to prevent, detect and properly report diversion
- Collaborative relationship between nursing, pharmacy and other key departments
- Method of surveillance/auditing including concurrent review of medical records
- Prompt attention to surveillance data received
- Collaborative relationship with law enforcement and regulatory agencies
- Education, education and education
Recognition of Diversion

• Hospitals may have automated drug cabinets that produce data about controlled substance transactions, but many diversion schemes can’t be detected this way.

• Personal observation is vital! It may be the only clue.
Education

Most essential component of any diversion program!

- All-inclusive
- At hire and at least annually
- Emphasize recognition and reporting

Goal – Develop a culture in which employees recognize the risks and feel individual responsibility for reporting
Why Many Don’t Report

- Uncertainty or disbelief
- Turning a blind eye to signs and symptoms (surely I was mistaken)
- Hoping the problem will go away—this is an isolated event
- Concern about what getting involved will mean for them
Enabling

Some well intended staff may enable by:

• Ignoring what is going on
• Trying to protect their colleague by taking responsibility for his/her actions (it’s my fault—I didn’t train him properly)
• Covering up and making excuses or minimizing what is happening
• Doing their colleague’s work for them
Reporting Suspicion

• Once an employee suspects impairment or diversion, patient safety concerns require that it be reported immediately
• Certainty is not required-just a good faith concern
• Employees should know that concerns will be taken seriously and confidentially
Core Program Components

• Diversion Specialist aka “go to person”
• Diversion Response Team
• Diversion Committee - multidisciplinary
• Diversion Risk Rounds (unannounced and at least quarterly)
Diversion Specialist Collects Data

Event Details

* Describe the event in your own words:

Oxycontin 20 mg was found lying on the counter in the front 3W med room. No discrepancy in either omnicell on the floor. Charge nurse indicated it was not there at 8:30am when she went through. Pharmacist found it at ~11am lying on the counter.

Event Details

* Describe the event in your own words:

MORPHINE 2MG CARPUJECT RETRIEVED FROM OMNICELL ALONG WITH LABETALOL FOR ADMINISTRATION TO PATIENT AND WENT TO NSG STATION 2. MEDS WERE ON CHART. I WAS CALLED TO OMNICELL TO WITNESS A WASTE. WHEN I RETURNED, THE MORPHINE WHICH WAS UNOPENED, WAS GONE. AN EXTENSIVE SEARCH WAS DONE BUT UNSUCCESSFUL. SUBSEQUENTLY, PHARMACIST, WAS INFORMED OF THIS EVENT.
Diversion Response Team

- Often includes Diversion Specialist, pharmacy and the supervisor of the employee suspected of diversion
- Structured according to organizational culture and preferences
- Must be able to meet on very short notice and at odd hours
- Must have the authority to require a drug screen and to suspend an employee
Diversion Committee

RCA

TJC MM.08.01.01

The hospital evaluates the effectiveness of its medication management system:

• Analyze data
• Keep up with best practices
• Identify and implement improvement measures
• Re-evaluate system
Diversion Risk Rounds
Surveillance Technology

• Many hospitals have surveillance technology
• Not as common in long term care facilities
• Provides flags and reveals issues to focus on
• Many selective reports can be run when doing an investigation
Drug Cabinet Dispensing System

• RN signs on with unique username and password
• RN selects the patient, drug desired and quantity
• Single bin is unlocked and nurse required to key in the quantity present before removal

• 2 users required for “waste” or return
Automated Dispensing-Single Access Bin
Wasting Injectable CS
Returning CS
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Drugs of Choice

Injectables:
• Hydromorphone
• Fentanyl
• Propofol

Pills and liquids:
Hydrocodone
Oxycodone
Methods of Diversion

Removal of/diversion from fentanyl patches

Removal too frequently
• Gets an extra dose in

Giving less than ordered more frequently

Use from inconspicuous vessel
Removal When Not Needed

Pain Assessment

* Final Report *

Pain Assessment Entered On: 04/13/10 20:38
Performed On: 04/13/10 18:00 by O , M

Pain Scale 0 - 10 Required
Pain Scale Patient Communication Status: Patient can communicate
Primary Pain Intensity: 0 None

O'Donnell, M. - 04/13/10 20:37

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Withdrawal for Discharged Patient

No order for Dilaudid

Discharged @ 0200
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False Verbal Order

Ambulatory to checkout in care of responsible driver. Vicodin ii po per vo Dr. Oros

PAIN SCALE: 0 - No Pain
Methods of Diversion

Substitution in administration and wasting
• Substitution of look-alike pills

Frequent null transactions and discrepancies (attempt to confuse and discourage further investigation)

Removal of larger doses than necessary
## Failure to Waste

**Versed 2 mg: 0.25 mg IV q 3 hr prn pain**

**Morphine 2 mg inj: 0.25 mg IV q 3 hr prn**

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Frequent Wasting of Entire Dose

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Witness Name: H, Ri

Patient: 1

(Confidential)
Methods of Diversion

Withdrawal from PCA and drip lines

Removal under sign-on of colleague

Removal of unspent syringes from sharps boxes

Pilfering patient medications brought from home
When Diversion Suspected

- Diversion team put on alert
- Verification of data and analysis of situation
- Nurse immediately removed from patient contact or intercepted; drug cabinet access discontinued
- Initial interview of nurse including review of medical record and drug cabinet records
- Urine drug screen
- Suspension pending conclusion of investigation
Testing the Explanation

Removed Nexium, Tylenol, Vitamins D and C with Methadone, but only removed a duplicate dose of Methadone.
Diversion confirmed

- Determine employment disposition
- Report to law enforcement and all relevant state and federal agencies
- Consider billing implications and rebill if necessary
- Notify patients if applicable
How a Diversion Investigation Develops
You forwarded this message on 8/10/2012 10:40 AM.

From: New, Kimberly S
To: Snyder, Solon M
Cc: Barton, Delre A; Flett, Amy B
Subject: Delayed wasting

Sent: Fri 8/10/2012 10:01 AM

Hi Solon:

I know that things get busy and sometimes it’s not easy to waste immediately after a dose, but I have noticed that she has a longstanding pattern that I believe ought to be addressed. I look at transactions by other nurses on your unit on a daily basis, and others seem to be able to waste in a more timely fashion. It often holds waste throughout a shift and then wastes everything at once, or only wastes a couple of times in a shift despite giving multiple doses. This approach is risky from a diversion standpoint on many levels. As you can see below, she began administering Dilaudid at 07:01 and didn’t waste until over 12 hours later. Clearly she went to the bathroom at least once during this time, and waste should NEVER UNDER ANY CIRCUMSTANCES accompany anyone when they go to the bathroom! I would be grateful if you would speak with her about this and encourage her to follow proper procedure (i.e., waste as quickly after a dose as possible).

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Thanks-

Kim

Kimberly S. New
Compliance Specialist
University of Tennessee Medical Center
2121 Medical Center Way, Suite 310
Knoxville, TN 37920

(865) 305-9116 - direct
(865) 456-1813 - mobile
### Diversion Investigation

**8/9/12-PD placed on “watch list” for “bulk wasting”**

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Diversion Investigation

February 2013—received alert that PD flagged on Pandora “Anomalous Usage” report for hydromorphone

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For the Dates
2/1/2013 to 2/12/2013

University of Tennessee Medical Center
Diversion Investigation

Review of recent transactions-Patient comatose and on hydromorphone drip. No one else administering hydromorphone except PD.
Diversion Investigation

Run report comparing her to her peers on

### Dispensing Practices Report

**2/12/2013 13:10:21**

**Date Range:** 1/1/2013 00:00:00 - 2/12/2013 23:59:59.99

**Site:** * - (All)

**Area:** 10E

**Item:** 0705780 - HYDROmorphine 2mg INJ

**Item Control Levels:** * - (0,1,2,3,4,5,6)

**Average dose/transaction day:** 0.88

**Standard Deviation:** 0.92

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Diversion Investigation

Nurse manager questions staff re: comatose patient

Call PD in to meet with her:

– Huge delay
– Allow PD to explain- “I medicate my patients”
– UDS-dilute
– Suspension
* CONFIDENTIAL *

1924 Alcoa Hwy Box 36
Knoxville, TN 37920

EMPLOYEE NAME: [REDACTED]
SOCIAL SECURITY #: [REDACTED]
CASE NUMBER: 32613

The Specimen was tested for the following drugs:
- Amphetamines
- Cannabinoids
- Opiates
- Propoxyphene
- Alcohol
- Barbiturates
- Cocaine
- Oxycodone/Oxymorphone
- Meperidine

TEST RESULTS:
- RESULTS: Invalid per MRO
- DILUTE?: Yes

COLLECTION:
- COLLECTION DATE: 02/21/2013
- TEST TYPE: Reasonable Cause
- TEST PROFILE: 11-Panel

LABORATORY:
- LABORATORY: LabCorp
- COLLECTION SITE: UTMCK

SPECIMEN:
- SPECIMEN RECEIVED: 02/13/2013
- MRO RECEIVED: 02/21/2013
- RESULTS RECEIVED: 02/18/2013
Diversion Investigation

Expanded review of her transactions

• 10.95 mg of Dilaudid identified as missing via failure to waste

• One Percocet 10/325 also missing

Test her story

• Not statistically significant and way below peers on all other CS on her transaction report

Occurrence report check-no issues
Diversion Investigation

- Removing Dilaudid doses when there isn’t any pain documented
- Removing Dilaudid doses when there isn’t an order (in anticipation of getting one)
- *Wasting* entire syringes of Dilaudid but *returning* other CS not used
- Dividing one time Dilaudid doses so that more than one syringe can be obtained
- Failing to waste Dilaudid
- Requesting orders for Dilaudid when other medications patient was already on not tried
- Bulk wasting Dilaudid
- Delayed wasting of Dilaudid
- Wasting more Dilaudid than she withdrew and documenting administration of medication when none was obtained (wasting is obviously lax if someone is witnessing this or she is substituting syringes)
- Documenting pain scores inconsistent with colleagues (i.e., two Percocet per day for several days, and then on her 2 consecutive shifts patient gets 5 doses of Percocet and 5 doses of Dilaudid)
- Giving implausible excuses for pulling Dilaudid and not administering (“may be discharged today”)
- Documenting administration of IV Dilaudid at time of discharge
- Administering Dilaudid to patients for whom it is not appropriate
Dividing “one time” Dilaudid doses so that more than one syringe can be obtained

- MD orders 0.2 mg Dilaudid in a one time dose
- 2 mg Dilaudid in a syringe, so waste is 1.8 mg

0.1 mg from 2 mg Dilaudid syringe so 1.9 mg waste

0.1 mg from another 2 mg Dilaudid syringe with 1.9 mg waste

= 3.8 mg “waste”
Diversion Investigation

• Report missing medication to DEA
• Report to TBI and KPD
• Report to Professional Assistance and Board of Nursing
• Report to Pharmacy Board
• Spreadsheet to billing to rebill those with missing medication
Thank you!

Kimberly New, JD BSN RN
NADDI Tennessee Chapter President
(865) 456-1813
Knew@naddi.org