Drug Diversion Prevention: A Pharmacy Buyer's Perspective

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Speaker-Presenters

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Learning Objectives

- **Summarize** the U.S. Drug Enforcement Administration (DEA) requirements for reporting suspected loss or diversion
- **Explain** an enhancement to either your Reverse Distributor (RD) or Automated Dispensing Cabinet (ADC) processes that would enhance diversion controls
- **Classify** 2 common characteristics of a diverter
- **Identify** 3 potential signs of diversion
- **Indicate** 2 occupational factors associated with diversion in health care professionals

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Sarasota Memorial Health Care System Pharmacy Buyer Team

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Case #1- What Would You Do?

- 2/10/21-Reverse Distributor (RD) inventoried & packaged 8 boxes of expired Controlled Substances (CS) in the presence of the buyer
- The sealed boxes were placed in the vault under video surveillance, awaiting pick-up by the carrier
- 2/24/21-Director of Pharmacy (DOP) notified that a box of CS did not make it to the RD processing center

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Case #1-Talking Points

- Do you have a RD procedure?
- Is your pharmacy under video surveillance?
- Who is responsible for the missing CS?
- What changes would you implement?

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ASHP (2017) Guidelines On Preventing Diversion Of CS-Returns, Wastes & Disposal

- Storage of expired/unusable CS
- RD documentation verified & reconciled before CS leave pharmacy
- Pharmacy team member assists with all phases of transfer to RD

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Video Surveillance

- Are there cameras in your pharmacy?
- Are your expired/unusable CS under camera?
- Do you have cameras in the medication rooms/over the ADCs?
- Are they well-received? HIPAA concerns?
- Who monitors/reviews camera footage?
- How long is the retention time?

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DEA Reporting

- SUPPLIERS are responsible for reporting ***ALL*** in-transit losses of CS
- Any theft or significant loss should be reported IN WRITING to the local DEA field office within ONE business day of discovery
- Use DEA Form 106 to report when a CS is lost in transit
- Complete Form 106 after the circumstances surrounding the loss of CS are clear

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Lessons Learned- Changes Implemented (part 1)

- Reverse Distributor
  - Use of Sturdier boxes
  - Seals boxes with tamper-evident tape
  - Takes photo image of packages awaiting pick-up from carrier

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Lessons Learned- Changes Implemented (part 2)

- Pharmacy
  - Pharmacy buyer or technician assists with all aspects of RD process
  - Boxes are labeled after they're sealed (1 of X, 2 of X, etc.)
  - Pharmacy team member retrieving boxes for carrier verifies that each box is present

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Case #2-CS Missing From ADC's Where Did They Go?

- 11/17/19-#9 oxycodone 10mg/acetaminophen 325mg tabs missing from the endoscopy device
- 11/18/19-#9 hydrocodone 5mg tabs & #8 hydrocodone 10mg tabs missing from the Cath Lab device

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Case #2–CS Missing From ADC's Where Did They Go? (continued)

- 11/26/19–#17 hydrocodone 10mg tabs missing from the Emergency Dept. device
- 3/15/20–#9 hydrocodone tabs missing from the Cath Lab device

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Case #2–Talking Points

- Does your organization require regular ADC CS inventories?
- Are ADC discrepancy reports regularly reviewed?
- What other reports would you review for this specific case?
- Where are your ADC keys stored?
- What does a diverter look like?

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What Does A Diverter Look Like?

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Common Characteristics (part 1)

- High achiever, well respected by coworkers
- Significant stress in personal life
- Night shift
- Critical care or other unit where nursing staff have increased autonomy

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Common Characteristics (part 2)

- Agency/Traveler
- Legitimate prescription for drug being diverted
- Preceptor
- Extremely helpful

Generally, healthcare workers divert for personal use

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Potential Signs Of Diversion

- Frequent disappearances (e.g. being in the bathroom or dirty utility room for an extended time)
- Volunteering for overtime (OT), coming to work when not scheduled
- Coming to work before their shift starts & staying late

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Potential Signs Of Diversion (continued)

- Helping colleagues medicate their patients and reviewing medication orders of patients not under their care
- Heavy wasting of drugs, wasting of complete doses, or no wasting
- Frequent events that require wasting doses that don't reach the patient: dropping doses, patient refusing a dose, etc.
- Repeatedly choosing the same people to witness their waste

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Diversion In Healthcare

1 in 10 healthcare professionals struggle with addiction or abuse drugs not prescribed

Occupational Factors for Healthcare Professionals:

- Easy access and availability of controlled substances
- Comfort level with use
- See the positive effects drugs have on patients
- Knowledge and sense of control-"I'm in control"

(ISMP, 2020)

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Diversion In Healthcare (continued)

Occupational Factors for Healthcare Professionals

- Injuries and chronic pain (self-medication)
- Physical demands of job
- Compassion fatigue and burnout
- Suppression of feelings and emotions

(ISMP, 2020)

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Diversion Trends At SMHCS

- Contrary to cases 4 to 5 years ago-in most diversion cases now, the CS is documented on eMAR (however, not given to the patient)
- Removing more CS than peers (even when working fewer shifts)
- Tylenol®/Look-a-Like substitutions

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Diversion Trends At SMHCS (continued)

- Conflicting pain assessments compared to peers caring for the same patient
- At times, only provider to medicate during hospitalization
- Pattern of removing more CS pain medications for cognitively impaired patients or patients with communication barriers

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Diversion Trends At SMHCS (continued)

- Full wastes/Delayed waste transactions
- Involved in discrepancies
- Not following orders (jumping to two tablets without a previous repeat dose given)
- Frequent efforts to help other nurses administer pain medication

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Case #3–Colleague Diverter
How Did I Not Notice?

- Analytical software indicated possible diversion of CS by an RN
- Diversion Specialist conducted a full audit of CS transactions
- Quick Response Team convened
- The caregiver was interviewed and questioned regarding practices with CS
- Caregiver admitted to diversion

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Monday Morning Quarterback
What Clues Did I Miss?

- Weight loss
- Calling in sick, or coming in late
- Personal illnesses, surgeries
- Wearing long sleeves
- Frequently medicating other nurse's patients

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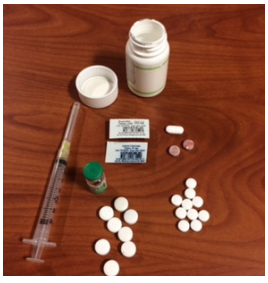

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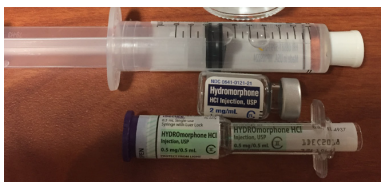

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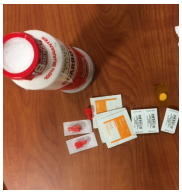
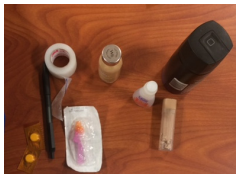

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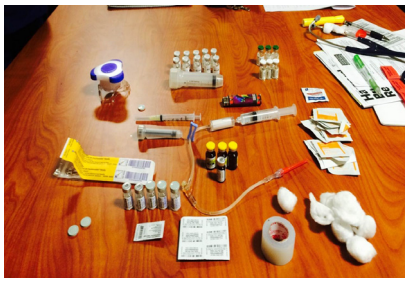

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See Something, Say Something

- The patient reports not receiving medication
- Inadequate pain management when a particular nurse administers the medication
- Frequent verbal orders entered by a particular nurse for a specific CS
- Nurse entering orders for higher-than-normal doses (2mg IV hydromorphone)

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See Something, Say Something (continued)

- Nurse entering orders under provider are not likely to order CS (i.e. Infectious Disease Physicians)
- Patterns of IV and PO CS that are administered together
- Discrepancy issues with a particular provider
- Any other concerns of diversion or impairment

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Questions?

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