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Drug Diversion Prevention in Healthcare

Second Edition

Kimberly New, BSN, JD

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Contents

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About the Author

Kimberly New, BSN, JD, RN

Kimberly New, BSN, JD, RN, is a consultant to healthcare institutions on the subject of drug security and diversion. She is the founder and principal consultant of Diversion Specialists, a firm that specializes in the prevention, detection, and response to drug diversion by healthcare personnel. New advises institutions on issues of controlled substance security and Drug Enforcement Administration regulatory compliance and helps healthcare facilities set up and expand their drug diversion programs with the goal of protecting patients, staff, and facilities from the harm frequently associated with diversion. She is a nurse and an attorney, with extensive clinical experience as a nurse as well as many years of experience as a healthcare lawyer. She has also worked as a compliance officer at both a large long-term care company and an academic medical center.

New is a frequent author and national speaker on the subject of health facility diversion. She is the executive director of the International Health Facility Diversion Association. New has been featured in *USA Today* and *The Wall Street Journal* and has served as a guest author for the Centers for Disease Control and Prevention Safe Healthcare and Department of Health and Human Services aids.gov blogs.

Preface

Drug diversion by healthcare personnel is a pervasive problem. All healthcare facilities, clinics, and offices that use controlled substances face this issue at one time or another. Unfortunately, there are few resources available to assist facilities in addressing diversion. This book is a guide for healthcare institutions seeking to build or improve their diversion programs or those dealing with discoveries related to diversion.

Every institution is vulnerable to diversion and must have a robust program to address it. While isolated practices to prevent and detect diversion, such as end-of-shift counts, have been used for many years, attention has focused recently on the need to have more elaborate programs involving a multidisciplinary effort to address more subtle tactics used by diverters. Regulatory agencies have increasingly stringent requirements for the structure and content of programs; settlements between the Drug Enforcement Administration and institutions investigated for diversion generally include a requirement that the institution's diversion program be altered to conform to a defined set of criteria.

Although many institutions undertake isolated efforts to develop a diversion program, my experience suggests that a comprehensive and adequate program is present at a minority of facilities. Obstacles to the implementation of an adequate program include a lack of support from executives, a lack of resources, a lack of understanding of the risks, a lack of necessary expertise, and a fear of negative publicity or regulatory scrutiny that might result from the discovery of diversion.

Insufficient attention to diversion is not confined to one type of institution. Facilities ranging from critical access hospitals and long-term care facilities to large and prestigious academic medical centers have been penalized for inadequate diversion controls within the past decade.

Chapter 1

Introduction to Drug Diversion

Drug diversion is the theft of drugs. Because most healthcare facilities' focus on diversion is of controlled drugs, the term is often assumed to refer to those in particular, but not all diverted or abused drugs fall into that category. Therefore, many of the principles explored in this book apply to theft of other drugs as well, even though it deals chiefly with diversion of controlled drugs.

Healthcare facilities must comply with numerous diversion-related requirements. Most states have detailed Board of Pharmacy regulations, which may impose more restrictive controls than those required by federal law for some medications. Federal laws and regulations, such as the Controlled Substances Act, dictate numerous drug security and accountability measures. The Secure and Responsible Drug Disposal Act of 2010 and, in many cases, municipal waste handling regulations set requirements for disposing of some types of pharmaceutical waste. The Medicare *Conditions of Participation* and various survey agencies have established standards to which facilities must adhere relating to patient safety, nursing practice, pharmacy operations, and medical staff processes.

Drug diversion almost certainly occurs in every facility where controlled substances are handled and stored. The perpetrators of such diversion may be nurses, pharmacists, anesthesiologists, other physicians, midlevel providers, nonclinical staff, patients, impostors, and even visitors and patients' family members. Although a diverter is not necessarily a person with legitimate access to medications, our focus is on diversion by institutional staff, including high-risk groups such as nurses, pharmacists, and anesthesia staff.

Institutional diversion is diversion that occurs in healthcare institutions, including hospitals, nursing homes, ambulatory surgery centers, medical and dental offices, veterinary facilities, research centers, and other care facilities. This type of diversion differs from diversion in the community in several ways. First, in institutions, the diverters are chiefly healthcare personnel, although anyone within an institution may divert if there is access and availability. Therefore, addressing diversion within institutions requires a thorough understanding of the methods used to access medications legitimately as well as the methods used to conceal their theft. Most diversion within institutions is for personal use, particularly at the hands of direct care providers. Diversion for resale is slightly more common among pharmacists and pharmacy staff, largely because pharmacy diversion can be more difficult to detect and because the quantities of controlled drugs available to a savvy diverter can be substantial.

Figure 2.1: Recommended membership of the diversion oversight committee	
Nursing	Compliance
Pharmacy	Infection prevention
Anesthesia	Human resources
Security	Employee health
Risk management	Finance
Quality	Research
Chief medical officer	Internal audit
Accreditation	Ad hoc members

Stakeholders

Depending on the responsibilities of various departments within an organization, the stakeholder group may vary. The roles of the stakeholders in the diversion program are as follows:

Nursing and pharmacy

In most circumstances, nursing has more regular access to controlled substances as part of its job functions than does any other profession within an institution; therefore, nursing staff members are caught diverting more often than other staff. Pharmacy staff also have regular access, and the pharmacy department is ultimately responsible and accountable for security of controlled substances.

Nursing and pharmacy, as a partnership, should lead the diversion program. These two departments often don't fully understand each other's workflows; there is often some level of disconnect between them. However, in order to lead effectively, they must collaborate. Such collaboration can be accomplished in several ways: for example, pharmacy can present a diversion-related topic quarterly at nursing leadership meetings, the institution can form a pharmacy/nursing workgroup that meets regularly to discuss controlled substance handling and diversion-related issues.

Anesthesia

Anesthesia is an extremely high-diversion-risk provider group due to unique workflows and the extremely powerful and addictive drugs they regularly use in their practice. Fear of not having the medications they need when they need them can lead anesthesia providers to develop workarounds and unsafe handling practices. Having anesthesia representation on the oversight committee will help ensure that program directives take into account the special processes that are part of anesthesia practice and will help garner anesthesia buy-in. When controlled substance security is presented in the context of patient and staff safety, anesthesia providers are often more inclined to work toward solutions than they are when requirements are simply imposed without explanation.

Chapter 3

Regulatory Requirements and Best Practices

Drug diversion in healthcare facilities has been the subject of increasing focus by regulatory authorities in the past several years. In many cases, the expectations of these authorities are not explicit in regulations but come to light in the settlements reached between the Department of Justice/Drug Enforcement Administration (DEA) and facilities where violations or poor practices are identified. In general, DEA and other authorities expect facilities to adhere to the best available practices for patient safety and drug security, regardless of whether those practices are spelled out in published regulations. Consequently, in terms of expectations by regular authorities, there is no real distinction between what is required and what is considered to be best practice. The technology and understanding of how to deal with drug diversion is evolving more quickly than regulations can be rewritten, and facilities are expected to keep abreast of the best practices available.

Most facilities have a core group of stakeholders that recognize the scope of the problem and risks associated with diversion. Unfortunately, regulation does not explicitly mandate that facilities have a diversion program, so it may be difficult for even committed people to gain support for some of the essential processes. When I visit facilities where administrators are resistant to my recommendations, an argument I hear often is, "Just show me the regulations that require it." They are not usually content with best-practice guidelines.

Therefore, to support the diversion program effort, refer to the controlled substance- and diversion-related requirements with which facilities must comply. Sources of such requirements include the Centers for Medicare and Medicaid Services (CMS), DEA, the Food and Drug Administration (FDA), the Environmental Protection Agency (EPA), survey agencies, state regulations, and professional boards. There are numerous best practices and guidelines available to provide direction and support. Sources for guidelines include ASHP, Centers for Disease Control and Prevention (CDC), and the Institute for Safe Medication Practices (ISMP), to name a few.

Several states have developed toolkits and roadmaps to help facilities perform their own gap analyses; many are freely available online, including the Minnesota Hospital Association roadmap, the California Hospital Association roadmap, and the Missouri Bureau of Narcotics and Dangerous Drugs

for me to find unsecured medications, discrepancies at the cabinet, sharps containers full of unspent syringes, and staff who offer forthright answers. In contrast, when a prearranged schedule for rounding has been shared with managers, I often find that everything is perfect on the units I visit. No discrepancies are present, medication rooms are clean and organized, and staff offer similar scripted answers to my questions. Although I understand that managers naturally don't want a consultant to find problems in their areas of responsibility, risk rounds are an opportunity to identify practices that need improvement via a nonpunitive process, unlike instances in which a surveyor or regulatory agent happens upon the same findings. This is true whether I am rounding or whether the institution's own team is doing so.

The rounding team must be small, consisting of only two or three individuals, since the rounds must not disrupt patient care. The team typically consists of a pharmacy staff member and the diversion specialist or someone else with a clinical background. Having pharmacy representation allows the team to access the drug cabinets and explore inventory and discrepancy status. For example, I often inquire about the storage methods for propofol, and I verify the count of propofol in the ADC or storage area. I also like to know whether any controlled substances are stored in the refrigerator and, if so, how they are stored. For instance, is lorazepam in an open bin in the refrigerator next to respiratory therapy medications, or is it in a lockbox within the refrigerator? Having a team member with a good understanding of clinical processes ensures that unique workflows involving potential risk are identified and evaluated. As a nurse, I am aware that some units require customized review. In the labor and delivery departments, I am intent on knowing whether nurses pre-pull opioids for anesthesia in preparation for epidural placement. I find that in the post-anesthesia care unit, nurses may be required to transport patients, and this may complicate the timing of wasting unused opioids.

Notes from the field

The diversion rounds team needs to be sensitive to situations in which clinical responsibilities dictate that rounds be abandoned and rescheduled. For example, rounding in the emergency room during a mass trauma, or when a unit is extremely short-staffed, is ill advised. Likewise, if a unit has recently had a diversion case that has left staff demoralized, rounding should be deferred for some time to allow staff to start to heal.

The risk rounding process should be explained to clinical managers before risk rounds ever begin. Managers should understand that these are conducted by an objective team and that results are handled in a nonpunitive manner. A team leader, nurse educator, or charge nurse on the unit will be asked to assist the rounding team by accompanying them or providing them with direction. I often find these staff to be extremely forthcoming with information about risky practices, and they often point out areas of risk that the rounding team may not have otherwise seen.

At the time of rounds, the supervisor of the unit should be notified when the rounding team arrives but should not accompany the team during rounds; frank conversations with staff are essential to the function of risk rounds, and the presence of the supervisor might inhibit such openness. I often spend five or ten minutes with the clinical manager to discuss their perceptions regarding diversion

risk on the unit. If managers have any role in diversion auditing, I ask them to describe their approach to it and to assess its effectiveness. The manager should be apprised of the findings when rounds are complete, and a report should be made to the diversion oversight committee or a quality improvement committee. Performance improvement measures should be proposed where needed, and reevaluation should occur the next time rounds are made in the unit. As previously noted, findings should not be presented in a punitive manner; the purpose of the process is to encourage staff to be invested in improvement and receptive to change.

A checklist is a useful tool to guide and document rounds; an example of such a checklist is shown in Appendix F.

Risk Rounds in the Pharmacy

The rounding team should be mindful that although the focus is often directed toward clinical units, when considering diversion risk, the pharmacy is an area that must be reviewed as well. In fact, the pharmacy can be an excellent starting point for a new rounding team, since it helps the team gain an understanding of the following:

- How drugs enter the facility
- How they are prepared
- How they are transported to areas outside of the pharmacy
- How they are removed from remote locations when they expire
- Ultimately, how unusable drugs leave the facility

The initial review of the pharmacy may require more depth than review of other areas but may not need to be undertaken as frequently. A comprehensive review of the pharmacy can usually be done twice annually. Some of the key areas to look for in the pharmacy are discussed later in this section.

The rounds team should start by verifying that the entry points to the pharmacy are secure and that traffic into the pharmacy is minimized and can be tracked. This is best accomplished with badge readers and surveillance cameras. When they enter, team members should be asked to sign in to a visitor log, as opposed to being "buzzed in" and allowed to enter without an escort.

When looking at how drugs are obtained, the team should speak with pharmacy staff who are responsible for purchasing and receiving, and they should assess for separation of duties. Ordering, receiving, and stocking of controlled medications must be completely separate and done by different individuals whenever possible. If there are limited staff and complete separation of duties isn't possible, I recommend that receipt and reconciliation of incoming controlled substance inventory be done with a witness. That said, I have worked with some retail pharmacies where there was one

Chapter 7

Patterns of Drug Diversion

Through most of the 20th century, diverters found little challenge in avoiding discovery. Drug security, when it was used, consisted of locking narcotics up so that only authorized providers could access them; it was assumed that the providers themselves would not take drugs inappropriately. The advent of end-of-shift counts created communal accountability for all of the clinical staff on a shift but did not create a direct way to find the individual responsible for missing drugs. Automated dispensing cabinets (ADC) came into widespread use in the 1980s, giving facilities the ability to track doses of medication based on the individual provider and patient by whom they are used.

Although ADCs and analytics programs designed to scrutinize drug transactions have greatly improved the detection of diversion, there are still ways that a clever diverter can steal drugs and avoid detection, unless the facility's surveillance is even more clever than they are. The "arms race" between methods of diversion and methods of detection makes a robust and flexible program necessary. In reality, diversion can't be prevented entirely, and there are many methods of diversion that aren't captured by ADC data.

Diversion may occur wherever controlled substances are found. Although facilities often consider the locations most at risk by facilities are the pharmacy, operative and procedural settings, and ADCs, diversion can also occur from transportation carts, from patient rooms, by clinical staff before and after administration, and from waste containers, to name a few sources. Theft of controlled substances also occurs from receiving areas and mailrooms and in medical offices affiliated with institutions. In short, diversion is a risk anywhere controlled substances are present and anywhere there are tools, such as prescription pads, available to allow it to occur.

Commonly Diverted Drugs

The most commonly diverted controlled substances have changed over time as certain drugs have become less routinely used in clinical settings and other drugs have gained popularity. For example, although meperidine is still used in various settings, it is much less frequently ordered today than it was in the past. This drug has consequently lost favor among diverters, owing most likely to the risk of raising a red flag with even a few transactions. Facilities and the clinical areas within them often

differ as to which opioids are most commonly prescribed. Diverters tend to gravitate toward a drug that is used frequently where they work so that they can blend in with other staff members. I have even known of cases in which a diverting staff member transferred to another clinical unit so that he could have increased access to his drug of choice without risk of detection.

Many healthcare workers believe that diverters start with pills and eventually progress to injectables; my experience indicates that such a progression is not the rule. In the cases I have investigated, most diverters started diverting injectable opioids and never used pills at all. The same has been true at most hospitals and healthcare institutions with which I work. See Figure 7.1 for a list of commonly diverted drugs in healthcare facilities.

Facilities should be aware that many factors can influence the list of drugs that are most commonly diverted. For instance, over the past few years, drug shortages have resulted in a decrease in use of the limited drugs and a substantial increase in oxycodone diversion cases. Some facilities have strictly limited or eliminated hydromorphone usage in certain units, so diverters have turned to morphine and fentanyl instead.

Figure 7.1: Commonly diverted drugs

Injectables	Pills and liquids	Other forms	Potentiating drugs	Drugs used to treat adverse effects
Hydromorphone	Hydrocodone	Fentanyl patches	Ondansetron	Ondansetron
Morphine	Oxycodone	Anesthesia gases	Promethazine	Benzodiazepines
Fentanyl	Cyclobenzaprine		Diphenhydramine	Zolpidem
Propofol	Gabapentin			Other sedatives
Midazolam	Ketorolac			
	Benzodiazepines			

The following discussion of the most commonly diverted drugs is based on situations in which the diverter is personally using the drugs. Most direct care providers, such as nurses, anesthesiologists, and patient care technicians, divert for personal use and are extremely secretive about it. If an individual is diverting drugs to sell on the street, however, she is likely to choose her drugs by balancing the risk of being discovered against the drug's potential street value. There is a greater likelihood that diversion from the pharmacy (rather than that from a clinic) will be motivated by a desire to sell the drugs rather than use them personally. The main reason for the difference between clinical and pharmacy personnel is the sheer volume of drugs present in the pharmacy environment; additionally, diversion from the pharmacy can be difficult to detect. A clever diversion scheme in the pharmacy can result in the theft of very large quantities of drugs over long periods of time (Murphy, 2015).

For purposes of personal use, generally speaking, most diverters have an opioid of choice, which I will refer to as the primary drug. The most diverted injectable opioids include hydromorphone, morphine, and fentanyl. The more frequently diverted noninjectable opioids include oral hydrocodone

clean a bathroom and discovered that a ceiling tile was ajar. Further inspection revealed that someone had stashed drug-related paraphernalia in the ceiling.

Some diverters find reasons to waste medications frequently with their peers. In one case I investigated, the nurse had found an over-the-counter lookalike pill that he substituted for hydrocodone while wasting. He regularly pulled hydrocodone, ostensibly for patients who needed it, and then approached his colleagues to waste the tablets, stating that the patient had refused the dose. Further investigation revealed that he was wasting the over-the-counter pill and keeping the hydrocodone. In a recent case, a similar diversion scheme was confirmed when the charge nurse took photos through the opening of the sharps container. The pictures showed multiple acetaminophen tablets and none of the opioid tablets that were supposedly wasted.

Across the country I find that wasting responsibilities aren't taken seriously, so diversion during the wasting process isn't difficult. To maximize their opportunities to divert, many diverting staff have admitted that they choose submissive or new staff members to waste with, as these individuals are more likely to consent to wasting without visually witnessing the destruction. For the same reason, diverters will sometimes hold waste until the next shift comes in and then claim that they already physically wasted the medication but forgot to document the waste in the automated drug cabinet. When the diverter asks oncoming staff to witness the waste so he can go home, they often relent and do so.

In my experience, most diverters have a prescription for the drug they are diverting. Diverters have admitted to me that they make annual trips to urgent care centers to ensure that they always have a prescription that will account for a finding on a urine drug screen. When they are asked to submit to a drug screen, these staff members are often cooperative and nonchalant because they know that the prescription will explain away a positive result.

Figure 9.1 shows some characteristics that many diverters share.

Figure 9.1: Common characteristics of drug diverters
Are hard workers
Are award winners
Are friendly with peers and the medical staff
Commonly serve as preceptors to new staff
Have frequent disappearances, such as being in the bathroom or dirty utility room for an extended time
Volunteer for overtime and come to work when not scheduled
Enter rooms of patients not under their care who are on PCA pumps or have controlled substance drips
Come to work before their shift starts and stay late
Help colleagues medicate their patients and review medication orders of patients not under their care
Waste lots and waste complete doses, or in some situations rarely waste at all
Frequent events that require wasting doses that don't reach the patient, such as dropping doses or having a patient refuse a dose
Repeatedly choose the same people to witness their waste
Frequently hold waste until the oncoming shift

Appendixes

Appendix A

Basic Auditing Components

Date of Transaction:

Time of Transaction:

Patient ID:

Patient Name:

Drug/Form:

Transaction Type (removal, return, waste):

Quantity (of removal) or Amount of Waste:

Drug Cabinet:

User Name:

Witness Name (if applicable):

Waste Reason (if applicable):

1. **Was there a valid order for the transaction?**
    - Was this a one-time order?
    - Were the dosage size and form of administration appropriate?
    - Did the staff member who removed the medication administer it?
    - Was administration documented?
    - Wast this a canceled transaction?
2. **Was the medication administered immediately after removal?**
    - Barcode scanned?

Appendix E

Diversion Program Structure

Diversion Operating/Oversight Committee

Composition guidelines

- Pharmacy
- Nursing
- Anesthesia
- Security
- Risk Management or General Counsel
- Accreditation or Magnet
- Chief Medical Officer
- Compliance
- Human Resources
- Employee Health
- Infection Prevention
- Internal Audit
- Quality and Safety
- Finance
- Research Department (if applicable)
- Ad hoc members (such as environmental services or laboratory, when needed)

Functions

- Oversees diversion prevention, detection, and response activities of the institution
- Facilitates the development of policies, procedures, and standard operating procedures or work guidelines, and ensures these are kept current
- Ensures a uniform diversion prevention, detection, and response effort across the facility and health system as relevant
- Analyzes and tracks data regarding diversion events
- Directs and ensures implementation of diversion and impairment educational programs for all staff
- Reviews each diversion event and directs changes that are warranted
- Develops workgroups for addressing barriers and difficult issues

Diversion Specialist

Recommended qualifications

- Clinical experience
- Solid understanding of EHR and other relevant patient records, drug cabinet reports, analytics reports and drug-handling expectations
- Familiarity with relevant standards and regulatory requirements, including those promulgated by DEA, Board of Pharmacy, FDA, EPA, CMS, ISMP, accreditation organizations, and other relevant regulations and best practices
- Experience auditing/investigating

Suggested functions

- Oversees and directs the daily activities of the diversion program
- Collects data that is suspicious for or indicative of diversion from across the institution
- Serves as a controlled substance and diversion resource to staff
- Provides or oversees training to new and existing staff
- Convenes the Diversion Response Team when a diversion incident is suspected
- Serves as a liaison to regulatory agencies, law enforcement, labor unions, and other relevant external entities

Appendix F

Diversion Risk Rounds Checklist

The group doing rounds should be very small. Ideally the rounding team will consist of two people, one person from pharmacy who can access the drug cabinets and the diversion specialist or another member of the diversion response team.

Rounds consist primarily of observation. In order to assess processes accurately, rounds should be unannounced. The charge nurse is often the best staff member to accompany the rounding team. The manager of the unit should not accompany the rounding team, because staff are less likely to have candid discussions when a manager is present. If the unit being observed is too busy to accommodate rounds, the rounds should be deferred. Units should not be allowed to defer rounds repeatedly, however.

Staff should be asked all of the questions below periodically in each area, but each question does not need to be posed on each visit.

Determine where controlled substances are stored, transported, and used in each area and assess for security and handling practices:

<u>General clinical units with automated controlled substance storage:</u>

- How are controlled substances delivered to the location for regular stock replenishment?
    - Are there problems with discrepancies after stocking?
- Are controlled substances stored in a locked medication room?
    - Is the door kept closed?
    - How do staff gain access to the medication room (badge, keypad)?
    - If a keypad is used to access the medication room, how often is the code changed?
    - Which staff have access to the medication room?
- Access medication refrigerator and confirm that any controlled substances are stored in a separate locked compartment.

Appendix H

Diversion Response Protocol

Suspicion of diversion may arise from many different sources, including but not limited to:

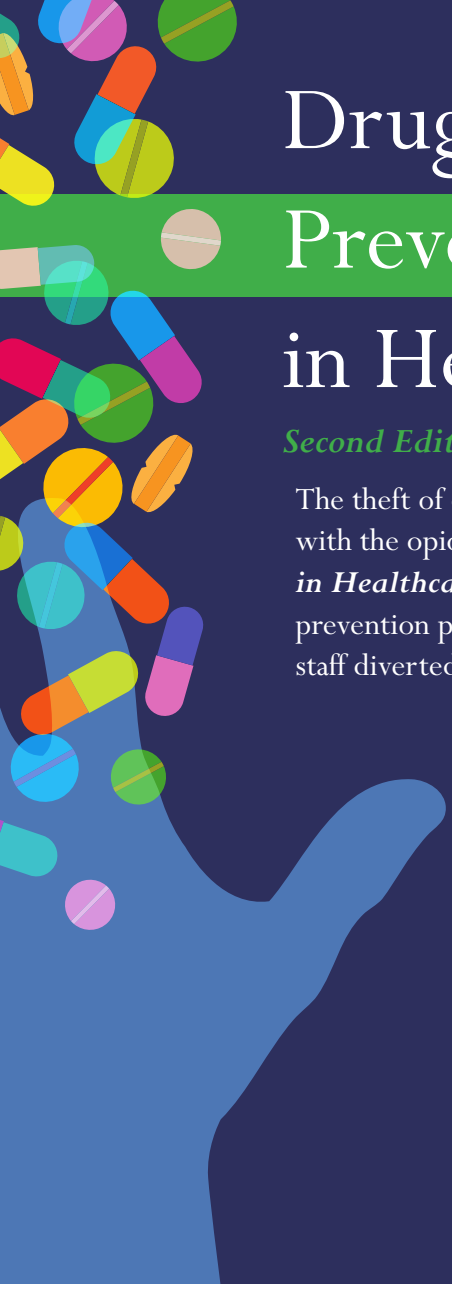
- Physical evidence (such as a syringe in a staff bathroom or a discrepancy at the Pyxis)
- Patient complaint of refractory pain
- Audit or report relating to high risk/controlled medication handling
- Report of a concern from an associate or other individual
- Behavioral manifestations such as signs of impairment or a pattern of deteriorating work performance

HOSPITAL will have a Diversion Response Team led by the _____ that will respond to all suspected or known diversion and diversion related events. The Diversion Response Team will be composed of members that are capable of round-the-clock availability, and shall include _____, _____, and _____ (fill in).

When suspicion of potential diversion arises from a source other than signs of impairment, the Response Team will convene, review all available information and initiate an investigation if warranted. With the guidance of the _____ will decide what steps to take, including whether to monitor the situation or intervene, as relevant. In the interest of protecting patients and staff, the Response Team will be authorized to commence a thorough diversion investigation including, but not limited to reviewing analytics report and ADC data, verifying medication transactions in HOSPITAL medical records, interviewing witnesses, reviewing video surveillance data, and obtaining work schedules and badge reader data. If after its initial review, the Response Team determines that there is reasonable suspicion that drug diversion has occurred, it will refer the case to _____ for further handling, to include interviewing the suspected associate. If there is a suspicion that diversion may be involved in cases where an associate is investigated for impairment, the Diversion Response Team will be notified after the associate has been evaluated/treated for impairment.

Upon notification of suspicion of diversion, the Diversion Response Team will take the following steps, as appropriate:

1. **Convene in person, via phone or email to determine the appropriate course of action including steps such as:**
    - Conducting a review or further audit of high risk/controlled substance transactions and/or analytics reports
    - Sequestering and processing physical evidence (such as in cases of potential tampering)
    - Interviewing witnesses and staff with knowledge of the issue
    - Discontinuing ADC and medication access
    - Making an initial determination regarding whether there is a possibility of patient or associate harm associated with the situation
    - Making a decision to monitor the situation
2. **The _____, or Diversion Response Team leader will assign tasks and due dates for tasks to Response Team members in conjunction with the decided upon course of action.**
3. **Medical staff, midlevel providers, residents, fellows, students, and other non-standard associate staff will be referred to the appropriate entity for investigation and diversion response. In these situations, the Diversion Response Team will coordinate with that entity as appropriate.**
4. **Every Diversion Response Team action, including interviews, transaction review, etc. will be documented according to HOSPITAL Diversion Program standard work processes.**
5. **Appropriate external reporting will be undertaken, as appropriate, but not limited to the following:**
    - DEA (report of diversion is required within one business day of discovery to the DEA via Form 106 and to the DEA Field Office in writing)
    - Law enforcement (on the advice of counsel)
    - Professional licensing board and/or department of health
    - FDA Office of Criminal Investigations (in tampering cases on the advice of counsel)
6. **Following each case, the Diversion Response Team will undertake a post-case review and recommend process changes as appropriate.**
7. **The details of each investigation, regardless of whether Diversion is confirmed, will be reported to the Diversion Oversight Committee.**



Drug Diversion Prevention in Healthcare

Second Edition

The theft of drugs and medicines by staff has vexed the healthcare industry for centuries —and with the opioid epidemic diversion the stakes are higher than ever. ***Drug Diversion Prevention in Healthcare, Second Edition*** is loaded with tools and info showing you how to make a solid prevention plan. This new edition also contains case studies and real-life examples of how healthcare staff diverted drugs, how they were caught, and the steps taken afterwards.

Written by diversion prevention expert **Kim New**, this book is designed to help nursing, patient safety, and hospital security officials foster awareness of drug diversion, fight the "it can't happen here" mentality, keep staff accountable, and monitor and audit the drugs moving through your facility to ensure they reach the right patient.

This book will help you:

- Learn the tell-tale signs of potential diversion
- Fight the "It can't happen here" mentality
- Create awareness among staff using tools and checklists
- Establish an effective and proactive drug diversion prevention plan
- Learn to recognize suspected diverters and mitigate problem areas in your hospital
- Effectively confront and deal with diverters in your facility
- Create audits that monitor drug distribution, from delivery to patient administration

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Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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