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Detecting and Responding to **Drug Diversion**

This is the second in a series of two articles on institutional drug diversion. The first article appeared in the June, 2015 issue of *PP&P*.

Detecting drug diversion within an institution is a challenging task that requires creativity and collaboration between multiple departments, particularly pharmacy and nursing. Diverters are invested in concealing their activity. Aware that the institution is attempting to discover and thwart their actions, their focus is on outwitting surveillance in order to feed their increasing need for the diverted drugs. Detection should rely on the use of analytics and should include recognition of patterns in the transaction history beyond what is included in statistical outlier reports. Ultimately, when confronting a suspected diverter, the investigator should possess information the diverter is confident will go undiscovered, and the response to diversion should be swift, consistent, and ever-focused on the safety of patients, the diverter, and the community at large.

Collaboration Between Departments

While staff may be trained to recognize behavioral signs of diversion, it is important to remember that these outward indicators are late signs. Earlier detection is facilitated by the use of analytics to pinpoint patterns in the transaction history beyond what is included in statistical outlier reports. Because pharmacy oversees automated dispensing cabinet (ADC) transactions and analytic reports and forwards reports to nursing leadership for review, detection and handling of diversion most heavily falls within pharmacy's and nursing's purviews.

If doses are damaged or the patient is documented to have vomited medications immediately after taking them, does the suspected staff member repeat doses of all medications or just a particular one?

Although nurses strive to deliver safe, high-quality patient care, it is not uncommon for nursing leadership to be unfamiliar with the risks of diversion; thus, they may perceive the requirement to review analytics reports as just another time-consuming task. When nursing leadership understands that diversion presents a serious patient safety risk that directly affects the quality of care patients receive, leadership is more likely to actively participate and motivate staff nurses to follow suit. In its 2015 Patient Safety Systems Chapter, The Joint Commission observed, "Patient safety emerges as a central aim of quality."[1] The Commission further states, "Leadership engagement in patient safety and quality initiatives is imperative because 75% to 80% of all initiatives that require people to change their behaviors fail in the absence of leadership managing the change."[2]

When reviewing transaction and analytics reports, input from nursing is vital because nurse managers are ideally suited to determine what is considered acceptable versus suspicious practice in their department, based on the needs of their specific patient population. Conversely, pharmacy should be cognizant that the intimate knowledge nurse managers have about their units can hamper an investigation; closeness to staff may blind nursing managers to signs of diversion and spur natural tendencies to trust and protect employees. Being aware of this potential investigator bias is necessary to gain an accurate understanding of diversion activities.

Methods of Diversion

Diversion may occur wherever controlled substances are found. Obvious locations are in the pharmacy and from ADCs, but the list also includes transportation carts, patient rooms during administration, in the hands of nursing staff before and after administration, and waste and sharps containers. Controlled substances also are found in receiving areas and mailrooms and in affiliated medical practices.

The Interview

Limit the number of people present at the interview to four: the suspect, the diversion specialist, a representative from human resources, and the manager of the unit where diversion is suspected to have occurred.

Diverters typically begin with diversion of small quantities of a particular drug using methods they consider harmless to patients. Theft of waste is one of the most common initial methods. Diversion from waste can take the form of:

- Failure to waste
- Wasting entire doses
- Delayed wasting to facilitate substitution
- Deliberate removal of a larger dose than necessary
- Premature replacement of PCAs and drips
- Theft from sharps containers

Failure to waste usually is flagged through manual or automated dose reconciliation. Wasting entire doses, delayed wasting, and removal of large doses will appear in the transaction records, but may not be flagged in anomalous usage reports until the diversion has escalated to large quantities. Therefore, investigators should examine not only each transaction, but also each user's data to identify patterns of misuse.

Because most commonly diverted substances produce dependence, and the diverter's need escalates as greater quantities are required to produce the desired effect, the majority of diverters will progress to methods involving more than waste. These include:

- Accessing medication when it is not needed
- Removing medication for a patient who was already discharged
- Removing a duplicate dose
- Reusing a fentanyl patch
- Falsifying a verbal or electronic order
- Using a colleague's login to access the ADC
- Tampering or substitution

Substitution is the most pernicious diversion method because it results in denial of needed medication to a patient and may entail a risk of transmission of blood-borne pathogens from the diverter to the patient. Diversion via substitution may occur at the ADC, at the bedside, or anywhere a drug is in transit to the bedside. Diverters may access cabinets through null transactions or purported cycle counts and then substitute the contents of vials or syringes. In several cases, particularly within procedural areas, substitution has occurred when medications were laid out in preparation for administration.

Diversion Detection

The task of the diversion investigator is to detect diversion as soon as possible after it begins. Most institutions use a monthly statistical comparison to flag potential misuse. Although useful, remember that such reports can produce both false-positive and false-negative results. Other information that may trigger suspicion includes:

- Observation of unusual behavior by colleagues
- Reports of items, such as sharps containers, being out of place
- Large numbers of rejected verbal orders
- Complaints of unrelieved pain by patients

Most diverters have a preferred drug, so an anomalous number of one-time orders for a particular drug recorded by a single user should provoke further investigation. While a daily review of transactions by user may not be feasible due to time constraints, occasional review of a full transaction report often identifies diversion that would not otherwise be revealed. Ideally, an audit of controlled substance transactions for each staff member should occur at least annually.

When diversion is suspected, review a transaction report by user, as well as by patient. A staff member who consistently fails to waste, regularly wastes entire doses, wastes frequently with a particular witness, or often withdraws a larger dose than is needed, should be suspected of diverting. In addition, examine the

time of withdrawal and waste and compare both to the time of administration. Red flags include:

- Withdrawal long before administration
- A long delay between withdrawal and wasting
- Withdrawal after the documented time of administration
- Withdrawal after the patient has been discharged from the care area

Compare the suspected diverter's usage patterns with those of other providers caring for the same patient. Does a patient require hydromorphone only when cared for by a particular nurse? For providers without a large peer group for comparison, such as anesthetists, compare the provider's current usage patterns to those of earlier months, before diversion is suspected to have begun.

It is useful to examine a suspected diverter's handling of a particular drug versus other drugs. If doses are damaged or the patient is documented to have vomited medications immediately after taking them, does the suspected staff member repeat doses of all medications or just a particular one? Is documentation of wasting sloppy with regard to all drugs or just one? If the provider is generous with analgesia in postoperative care, are non-controlled analgesics administered as generously as opiates? Are all opiates used with equal generosity or is one used more liberally than others? In most cases of legitimate use, preference for a single drug is not evident.

The Interview

When sufficient evidence exists to suspect diversion has occurred, the suspected diverter should be confronted at the earliest opportunity. Simultaneously, their access to medications and patient care activities should cease until the matter is resolved.

To respect the individual's right to privacy, the interview should take place at a location removed from the suspected diverter's work area. Limit the number of people present at the interview to four: the suspect, the diversion specialist, a representative from human resources, and the manager of the unit where diversion is suspected to have occurred. If the team anticipates that the interviewee may become belligerent, a member of security may be present as well. Ideally, the manager is someone the suspect regards as a supporter, allowing the suspected diverter to feel there is an ally in the room. The person leading the interview should have a solid command of the gathered data and be experienced in questioning a suspect. Conduct the interview in the least confrontational manner possible, but have available all relevant information detailing the reasons for suspicion. The conversation should begin with a presentation of the data. Interviewees often respond with statements such as, *I medicate my patients when they are in pain,* and *I'm just not good at documentation.* The diversion specialist should be prepared to respond with more specific information to rebut the suspected diverter's claim.

It may be difficult for some members of the interview team to maintain their resolve, especially if they know the suspected diverter personally. However, team members must understand that diversion will not stop until the opportunity is removed; it will escalate and result in severe harm to the diverter, and likely to others. It is helpful if the team has some consistent membership over time so that members can learn from each confrontation and refine the process as warranted.

Unless the interviewee provides truly satisfactory explanations for the accusations, drug testing is warranted. Because diverters often anticipate unannounced drug screenings and are prepared to adulterate specimens, personnel trained in obtaining drug specimens should oversee the collection. Typically, this training is offered to occupational health professionals, while some institutions have nursing supervisors undergo training for after-hour specimen collection.

Although employers cannot compel drug testing, most institutions have policies that allow for termination of any employee who refuses a for-cause drug screen. If a staff member is suspected of diversion and refuses a drug

screen, a report should still be made to the appropriate professional board documenting the suspected diversion.

Diversion Response

The institution's response to diversion is too important a matter to be determined by a single individual. Institutions must have policies in place that detail the appropriate response and must adhere to those policies when diversion occurs.

Once diversion is confirmed, decisions about the employment disposition of the staff member should take into account the nature of the offense and should be consistent, regardless of the staff member's role within the organization. Some institutions support a staff member through the recovery process, while others are quick to terminate employment. Regardless, the institution should make the health and safety of the staff member one of its first priorities, as personnel caught diverting are at risk for suicide or unintentional overdose. Do not allow a person suspected of being under the influence of a sedative or opioid to drive home. Details about the employee assistance program and other mental health resources should be available any time an employee is confronted. A plan should exist for evaluating staff members who appear to be a danger to themselves.

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Although most health care workers accused of diversion avoid criminal prosecution, diversion of controlled substances is a felony and should be reported to law enforcement. Multiple reporting requirements exist, including reports to the DEA (form 106), the state pharmacy board, professional licensing boards, and in some states, the Attorney General. It is key that suspected diversion be reported to the respective licensing board so that the board can undertake its own independent investigation.

Patient harm is a primary consideration in any investigation, and, if confirmed, must be reported to appropriate state and federal agencies as quickly as possible. In addition, policies should be in place for notifying patient populations of potential exposure and the need to contact the institution to undergo screening. If news media become involved, apprise them that the institution is aware of the event, and, furthermore, because the organization maintains a zero-tolerance position, an aggressive diversion prevention, detection, and response program is in place through which the situation will be addressed.

Ideally, organizations should provide information about suspected or confirmed diversion in objective terms to subsequent employers, but concerns about litigation often prompt institutions to confirm dates of employment only or offer limited information about the former employee's eligibility for rehire. A few states, such as Maryland, have an immunity provision that offers protection for good faith disclosures to subsequent employers to encourage institutions to report activity, such as suspected diversion, without the fear of legal reprisal. But even in those states, facilities are reluctant to report an employee suspected of diversion. Consequently, reports to the professional board and law enforcement are essential, as an adverse licensure action or a criminal conviction may be the only evidence subsequent employers can access.

Every diversion event should undergo a formal root-cause analysis. Subsequently, the team should institute and document performance improvement measures. If drug tampering is suspected, the response must include an assessment of the risk of transmission of blood-borne pathogens to patients. Involve infection prevention personnel in the investigation, and consider testing the diverter for infection with blood-borne viruses. It is important to use knowledge gained from each diversion event to bolster detection and prevention efforts.

Moreover, every confirmed diversion event must be quantified and reported to the finance department for rebilling. Although reimbursement may not be greatly affected, it is essential to correct itemized bills.

Conclusion

Diversion is a problem that every health care institution will encounter. Detection and investigation of diversion require expertise from a variety of fields and a considerable amount of ingenuity. When diversion is confirmed, the first goal is to ensure patient safety, followed closely by the safety of the diverter and of the community. Reporting to outside agencies is necessary for regulatory compliance and essential to prevent the diverter from doing further harm at other institutions. ■

References

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