

Preventing, Detecting, and Investigating Drug Diversion in Health Care Facilities

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Drug diversion harms patients, staff members, the community, institutions, and the diverters themselves. To maintain a safe care environment, institutions must have policies and procedures in place to prevent, detect, and respond to diversion, and the policies and procedures must be followed consistently. This article provides key considerations for developing policies and procedures to prevent and detect drug diversion, to conduct a drug diversion investigation, and to report drug diversion to the appropriate authorities.

Learning Objectives

- Identify risks of drug diversion.
- Discuss how to prevent and detect drug diversion.
- Describe investigative processes related to drug diversion.

The abuse of prescription drugs in the United States is a grave public health concern. The Centers for Disease Control and Prevention (2011) reports a 300% increase in painkiller prescriptions in the United States from 1999 to 2008. Estimates are that 20% of the population age 12 and older has used prescription drugs for nonmedical reasons at least once (National Institute on Drug Abuse, 2011). Health care providers are not immune. Although estimates of substance abuse among various disciplines of health care workers have been made, reliable statistics on the prevalence of drug diversion in health care facilities are not available, at least in part because diversion is by its nature a clandestine activity. However, drug diversion is a “real and constant threat in health care settings” and must be treated as such (State of New Hampshire, 2013). Nurses with a substance use disorder “may turn to the workplace for access or diversion” when they are otherwise unable to obtain the drugs they are using (National Council of State Boards of Nursing, 2014).

Although most health care facilities try to address drug diversion, their approaches vary greatly (McClure, O’Neal, Grauer, Couldry, & King, 2011). Some have formal programs; others manage the problem reactively. Some aggressively monitor and audit activity for drug diversion; others recognize only the most obvious cases. When diversion is detected, some facilities pursue arrest and criminal prosecution, and some do not involve any outside agency. Some facilities treat diverters differently based on their professional role. That is, an institution may have one set of practices for nurses and another for nonclinical staff. For instance, a diverting nurse may be allowed to continue employment and be supported through treatment, while a diverting central supply technician is terminated and reported to law enforcement.

Recent high-profile diversion cases involving substantial patient harm have caused public health and government officials to recognize the threat to patients, health care workers, hospitals, the community, and the diverters themselves. Several initiatives have resulted, and there is momentum behind an effort to mandate that health care facilities develop formal processes to prevent, recognize, and appropriately address drug diversion (Maryland Department of Health and Mental Hygiene, 2013; Minnesota Department of Health/Minnesota Hospital Association, 2013; State of New Hampshire, 2013). This article describes the risks of drug diversion and discusses the use of policies and procedures to prevent, detect, and investigate it.

Risks of Diversion

Several reported cases of diversion-related patient injury demonstrate the magnitude of harm that a diverting health care worker can cause. Typically, patients can be harmed by receiving care from an impaired provider, being denied pain medication, receiving an unsafe substance instead of a controlled substance, or receiving injections from tainted needles, syringes, or vials.

In a 2012 case, a nurse pleaded guilty to theft of hydromorphone in a hospital. The nurse removed hydromorphone from medication bags and replaced it with saline. Twenty-five patients were infected with *Ochrobactrum anthropi*, a blood-borne pathogen. Six required treatment in an intensive care setting; three underwent surgical intervention because of symptoms from an unidentified source; and one died. The nurse was sentenced to 2 years in prison (Hanners, 2013).

In a 2013 case, a radiology technician who had worked extensively as a traveler pleaded guilty in federal court to charges of drug theft and tampering after he was found to have stolen fentanyl at several institutions. He took syringes containing fentanyl, injected himself, replaced the fentanyl with saline, and returned the tainted syringes for patient use. More than 45 patients con-

tracted hepatitis C as a result of his diversion. The technician was sentenced to 39 years in prison (Marchock, 2013).

A 2012 case illustrates how drug diversion can put the community at risk. An anesthesia assistant was charged with multiple offenses after she was involved in a serious car accident because she was driving the wrong way on a highway. Five people in the other car were injured, some critically. An I.V. bag, a needle, and several vials of propofol were found in the anesthesia assistant's car. It is believed she had just injected herself with propofol she diverted from her workplace and was under the influence at the time of the accident (Ibata, 2012).

When diversion occurs, health care facilities face several areas of risk, including regulatory liability and penalties. Because hospitals are required to provide care in a safe setting free from abuse (42 C.F.R. § 482.13(c), 2006), a diversion case involving patient harm may result in Immediate Jeopardy (Centers for Medicare & Medicaid Services, 2004), which is a threat of termination from the Medicare and Medicaid programs due to deficiencies in care that have or are likely to cause serious injury or death. A diversion event that could result in Immediate Jeopardy, for instance, is a case in which a diverter is substituting saline for an opioid and leaving blood-tainted syringes for use on patients. Health care facilities may also face negative publicity and civil liability as a result of diversion (Miller, 2009; Sanborn, 2013).

Of course, the risks to the diverting health care worker include the loss of his or her professional license. The worker may also be excluded from health care employment by the federal government under the Office of Inspector General's (OIG) exclusionary authority. The OIG, for example, can exclude individuals from work in health care if they are guilty of a felony or misdemeanor drug-related offense. Diverting health care workers also risk incarceration (42 U.S.C. § 1320a-7(a)(4), 1996; 21 U.S.C. § 841 et seq., 1980), physical injury, and death. They may become infected with a blood-borne pathogen or die of an overdose (Berge, Dillon, Sikkink, Taylor, & Lanier, 2012). Many diverted opiates are in fixed combination with acetaminophen; as the diverter's opiate need escalates, the accompanying dose of acetaminophen can reach lethal levels.

Preventing Diversion

Although diversion cannot be prevented entirely, health care facilities must make every effort to deter it. The first line of defense is comprehensive preemployment screening. The requirements for background checks differ from state to state but, generally, persons who will have access to controlled substances should be assessed for the likelihood that they may be involved in a drug security breach (21 C.F.R. § 1301.90, 1975). References should be carefully checked and should include persons with personal knowledge of the candidate's clinical employment history. Clinical applicants who fail to provide a clinical reference should be regarded with suspicion. During one investigation of a new employee who was

diverting, the examiner found that no clinical references had been provided during the hiring process. The new nurse had worked in clinical settings at other institutions over the years, but none of his references were clinical personnel. Eventually, the examiner learned that the nurse had been caught diverting but had been allowed to resign without being reported to the appropriate authorities.

Orientation of new employees should include education about the risks of diversion and the institution's policies regarding diversion. New employees should be made aware of the resources available to them if they find themselves at risk, such as Employee and Professional Assistance programs. Self-reporting protocols should be detailed, if relevant. Any policy of immunity from corrective action, such as allowing individuals who comply with treatment and rehabilitation to keep their jobs, should be fully explained.

Drug Security

The most important feature of a diversion prevention program is drug security. Every facility must ensure that controlled substances and other high-risk drugs are stored securely from the moment they enter the facility until they are used. The Conditions of Participation (COP) for hospitals require that schedules II through V controlled substances be locked in a secure area accessible only to authorized personnel (42 C.F.R. § 482.25(b)(2)(i-iii), 1986). The Joint Commission (2013) also requires safe storage to prevent diversion.

Detailed policies and procedures should ensure the following:

- Storage areas are in locations that can be monitored to prevent unauthorized access.
- Traffic into storage areas is minimized.
- Controlled substance handling, including removal, wasting, and returning, is strictly managed.
- Staff members who administer controlled substances know the requirements that must be met.
- The amount of time drugs are out of secure storage is minimal.
- Unused doses are returned, not wasted.
- Controlled substances are withdrawn for one patient at a time.
- Controlled substances are administered immediately after they are removed from the cabinet.
- Controlled substances are not handed off from one provider to another, or such handoffs are strictly limited.

Many diverting nurses prefer to divert from waste because they believe such diversion does not harm the patient or the institution. One nurse developed a practice of hanging a new bag of hydromorphone for patient-controlled analgesia at the start of every shift, regardless of whether or not the existing bag contained sufficient hydromorphone. She later admitted that this practice allowed her to divert enough hydromorphone waste to meet her ever-increasing needs without having to resort to a more easily identifiable means of diversion.

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