DRUG DIVERSION IN LONG TERM CARE FACILITIES
Tackling the WHO, WHAT, WHERE, WHEN, WHY, & HOW

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“Diversion” Defined

* “Diversion” means the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use.
  - Uniform Controlled Substances Act (1994)

* “Diversion” means “Any criminal act involving a prescription drug.”
  - National Association of Drug Diversion Investigators
Diversion: The Questions

* WHO is diverting medications in our industry?
* WHAT medications are most likely to be diverted?
* WHERE is diversion taking place?
* WHEN is diversion most likely to occur?
* WHY does diversion occur?
* HOW does diversion occur?
* PREVENTING DIVERSION!

WHO?

* NURSING STAFF
* CNAs (Nursing Assistants)
* QMAs (Medication Aides)
* PHYSICIANS
* PHARMACISTS
* UNLICENSED STAFF
* RESIDENTS
* VISITORS/GENERAL PUBLIC
* By nature, diversion is a clandestine activity, and many times cases are left undiscovered and unreported.

* Universal among institutions in the United States.

* Not restricted to any particular socio-economic class, culture, or geographic location.

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**WHO?**

**Why healthcare professionals:**

- **HIGH STRESS!**
  - Present when residents are in pain
  - Present when residents die
  - Demand for perfection
  - Understaffing/Overworking

- **EASY ACCESSIBILITY**
  - Many of the healthcare workers involved in diversion are those administering medications
  - Witness benefit of medications daily
PROFILE OF NURSING STAFF:
* Best nurse on the unit
* Sometimes agency staff
* Never would have suspected him/her
* Willing to work extra shifts
* Stays late after shift ends
* Comes in early for shift
* Prefers night shift
* Prefers high narcotic areas
* Prefers areas of facility with cognitively impaired residents

PROFILE OF NURSING STAFF:
* Signs out more narcotics than peers
* Recent health problems
* Recent illness/death in family
* Frequently documenting waste or borrowing doses.
* Nursing notes do not coincide with drugs given
* Frequent restroom breaks
2010 National Drug Threat Assessment Report:

* #1: OPIOIDS
  - Opioid deaths increased 98% between 2001-2009

* Other Common Drug Classes:
  - CNS depressants: benzodiazepines
  - Stimulants: amphetamines, methylphenidate
  - Anabolic steroids
  - OTC medications: dextromethorphan

WHAT?

Controlled Substances

* The federal Controlled Substances Act created 5 schedules or lists of drugs/other substances based on the following criteria:
  - Potential for abuse
  - Accepted medical use
  - Potential for dependence
WHAT?
Controlled Substances

Schedule I:
- High potential for abuse
- No accepted medical use in US
- Lack of accepted safety for use of drug under medical supervision
- Examples: Heroin, Marijuana, LSD, Ecstasy

Schedule II:
- High potential for abuse
- Currently accepted medical use in treatment in the US or currently accepted medical use with severe restrictions
- Abuse of drug may lead to severe psychological or physical dependence
- Examples: hydromorphone, methadone, oxycodone, fentanyl, morphine, codeine, hydrocodone (Hydrocodone-containing products used to be Schedule III until October 2014)
**WHAT? Controlled Substances**

**Schedule III:**
- Potential for abuse less than the drugs in I and II
- Currently accepted medical use in treatment in US
- Abuse of drug may lead to moderate or low physical dependence or high psychological dependence
- Examples: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine), buprenorphine (Suboxone)
- Hydrocodone-containing products used to be Schedule III until October 2014, now Schedule II

**Schedule IV:**
- Low potential for abuse relative to schedule III
- Currently accepted medical use in US
- Abuse may lead to limited physical dependence or psychological dependence relative to schedule III
- Examples: benzodiazepines (alprazolam, clonazepam, diazepam, temazepam, triazolam), carisoprodol
WHAT?
Controlled Substances

Schedule V:
- Low potential for abuse relative to Schedule IV
- Consist primarily of preparations containing limited quantities of certain narcotics
- Examples: cough preparations containing not more than 200mg codeine per 100mL or per 100g (Robitussin AC, Phenergan w/Codeine)

WHERE?

- Medication Room
- Restroom
- Resident Room
- Empty Room
When?

Nightshift  Shift change
During Med Pass  Breaks

WHERE/WHEN?

ANYTIME

ANYWHERE
• PERSONAL ABUSE:
  • Drug of choice
  • Trade for drug of choice

• INADEQUATE PAIN CONTROL FOR SELF OR OTHERS

• $$$ FROM DRUG TRAFFICKING

**streetrx.com**: allows buyers and sellers to anonymously report prices of prescription pills on the street in communities around the country. The information helps officials understand market forces.

**Some current prices:**
* Norco 7.5/325mg – California - $1.50/pill
* Lortab 10/325mg – Kentucky - $5.00/pill
* Adderall 30mg – Maryland - $5.00/pill
* Oxycontin 30mg – Pennsylvania - $50.00/pill
• **Drug Substitution at time of administration:**
  - gives one non-accounted for medication in place of narcotic
    (ie: gives Tylenol instead of Norco)

• **Does not administer certain medication:**
  - gives cupful of medications but leaves out tablet intended for diversion
  - pockets medication for cognitively impaired residents

• **Dilution:**
  - removes liquid medication and dilutes with water or other liquid

• **Receiving of medications:**
  - pockets full medication card as well as the proof of use sheet
  - does not document as received

• **Destruction:**
  - diverts medication but documents as destroyed

• **Removal of topical dosage forms and replacing with old/used drug:**
  - Fentanyl patches
“RED FLAGS”

- Excessive absenteeism (especially last minute or no shows)
- Frequent disappearances from work site
- Insistence on caring for specific residents, especially those with cognitive impairment
- A history of theft, shoplifting, disorderly conduct or driving infractions
- Poor interpersonal relations with co-workers, supervisors, and resident's family members*
- Sloppy record keeping
- Failure to complete tasks on time
- Volunteering to work nights or in settings with minimal staff
- Personality changes or mood swings, depression, lack of impulse control
- Visits by friends or relatives (especially when few staff on duty)

This is Real Life...

https://www.youtube.com/watch?v=7tLjWJ-qPA8&feature=player_detailpage
Personal Experience

REAL LIFE EXAMPLES

An Ounce of Prevention

Observing rules and regulations

State Operations Manual

Indiana Controlled Substance Act
http://www.in.gov/legislative/iac/To8560/A00020.PDF
**Prevention**

* Institution of Policies/Procedures
* Training on Policies/Procedures
* Auditing Policies/Procedures
* Consequences if Policies/Procedures not followed
* Re-training on Policies/Procedures

**Documentation/Accountability**

* Shift to Shift Controlled Substance Documentation
* Controlled Drug Use Records (perpetual inventory)
* Drug Destruction Records
* Emergency Drug Kit Records/Inventory
SHIFT TO SHIFT CONTROLLED DRUG RECONCILIATION SHEET

<table>
<thead>
<tr>
<th>TIME</th>
<th>SHIFT</th>
<th>INCOMING NURSE</th>
<th>Meds</th>
<th>Sheets</th>
<th>EMPLOYEE/phermeceutical/return</th>
<th>OUTGOING NURSE</th>
<th>REMARKS</th>
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1. COUNT ALL MEDICATION CONTAINERS. Container may mean a card, Ziploc bag (multiple vials or ampules), box, bottle or individual vials or ampules. For a Ziploc bag with multiple vials or ampules, count as one container. COUNT SHEETS FOR CONTROLLABLE SUBSTANCES, both for individual residents and contingency supplies.

2. DOCUMENT ANY MISMATCHES UNDER REMARKS column. Report to supervisor.

CONTROLLED DRUG USE RECORD
Chart each dose administered

<table>
<thead>
<tr>
<th>RESIDENT:</th>
<th>AMOUNT RECEIVED:</th>
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<tbody>
<tr>
<td>MEDICATION</td>
<td>RECEIVED BY:</td>
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<td>DATE:</td>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Amount Given</th>
<th>Amount Received</th>
<th>Amount Remaining</th>
<th>Nurses Signature</th>
<th>Comments/Counter Signature</th>
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Amount Removed for Destruction: Date:

Nurses Signature:

Counter/Signature:
We all have a professional responsibility to ensure the safety and well-being of our residents. This may also include reporting suspicions of drug diversion to managers. Suspicions should be investigated quickly and aggressively.

Professional Responsibility

- Maintain awareness
- Audit
- Encourage reporting
- Education
Best Practices

* Institute a drug testing policy (FEAR is a good thing)
* Contact law enforcement when drug diversion is suspected
* Incorporate medication diversion awareness training into educational program
* Zero – tolerance (again - FEAR is a good thing)
* Take immediate action
* Develop resources for intervention and treatment
* Surveillance
* Be present

If Diversion Does Occur...

* Investigate Immediately
  - Drug testing
  - Documentation auditing
  - Interview staff
  - Review any surveillance
* Contact Supervisor
* Follow Company Policies/Procedures for Reporting
Contacts

* Indiana State Department of Health (ISDH): 1-317-233-1325
* Indiana State Police Drug Tip Line: 1-800-453-4756
* Indiana State Board of Nursing: 1-317-234-2043
* DEA (northern Indiana): 1-219-681-7000
* DEA (central/southern Indiana): 1-317-226-7977

References

* www.cms.gov
* www.deadiversion.usdoj.gov
* Preventing Medication Diversion: www.uwosh.edu/ccdet/caregiver
* Diversion of Drugs within Healthcare Facilities, a Multiple Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention: http://dx.doi.org/10.1016/j.mayocp.2012.03.013
* www.drugfree.org
Thank you!

Guilty of Diversion of Mother’s Gummi Bears!