Drug Diversion Tabletop Exercise for Ambulatory Surgery Centers (ASCs)

Facilitator Guide with Scenarios

March 19, 2018

Overview

The New Jersey Department of Health (NJDOH) created a tabletop exercise for Ambulatory Surgery Centers (ASCs) to stimulate a discussion of drug diversion and to review existing policies related to the topic.

The exercise features three scenarios where injectable opioid medication was diverted by healthcare staff. The exercise should be guided by a facilitator who is familiar with the topic of drug diversion and the issues surrounding diversion in health care settings. The discussion takes participants through the three scenarios and poses various questions about existing policies, handling of potential/suspected diversion and responding to an employee who diverted injectable medications. The scenarios used during the exercises were developed by the NJDOH Injection Safety Team and the Infection Control Assessment and Response (ICAR) Team, in collaboration with the staff from NJDOH Health Facilities Survey and Field Operations.

The scenarios mirror those that were developed and piloted at four acute care facilities by the NJDOH Injection Safety Team in early 2016.

Tools for conducting drug diversion exercises

You will need a champion at each facility who will be the point of contact and assist with organizing an exercise. The contact person should be able to reserve meeting space conducive to a group discussion and be able to invite the right people to the exercise. You will need a screen (or blank wall), LCD projector, laptop, and a slide advancer to present the PowerPoint.

Participants are asked to bring copies of existing policies to refer to during the exercise. This is something that the facility contact should relay to all who participants.

If there are a lot of players, it is recommended to have name cards/tags for all participants (can be hand-written) and a sign-in sheet.

Reserve the room for at least two hours (NOTE: It is recommended to add an additional 15 minutes before and after to allow time for set-up and for those who linger with questions at the end).

It should also be made clear that anyone participating in the exercise should plan to stay for the entire two-hour activity. If two hours is an unreasonable timeframe for those who will be playing, or the exercise is being conducted over a lunch hour, perhaps schedule multiple meetings where different scenarios can be discussed individually. The drug diversion exercises are good for committee meetings and staff meetings.

The facilitator should make copies of the scenarios and distribute to each participant at the beginning of the exercise. It is recommended that participants have the scenario to refer back

to in case they had a question. The PowerPoint slides are designed to that the scenarios are included, along with discussion questions.

A participant evaluation (included) was created for the drug diversion exercise. No names are required on the evaluation. The purpose of the evaluation is to give participants an anonymous mechanism to provide feedback. The topic is sensitive, and the evaluation asks participants to highlight good practices and areas that needed improvement at their facilities.

Who should I invite to participate in the exercise?

A diverse group of staff representing various departments across the facility will have the most robust discussion about the issue. While titles may vary from facility to facility, the role/tasks are consistent. It is recommended that a note taker and a facilitator should be included in the list of participants. The facilitator should be someone familiar with the topic of drug diversion and the materials included in this guide.

The facility contact should be able to assist with identifying the titles/individuals at the site to invite. They should also be tasked with confirming attendance one to two days prior to the exercise.

NOTE: if it appears to be difficult to schedule certain individuals, perhaps use a standing meeting or committee time to hold the exercise. This way, certain individuals are already slated to attend. If the standing meeting/committee is not two hours in length, you may not be able to use all three scenarios and may wish to make a return trip to the facility.

Recommended participants include:

- Administration (Chief Medical Officer, Chief Medical Information Officer, Chief Operating Officer, Vice President for Clinical Affairs)
- Nursing administration (Chief Nursing Officer, Director of Nursing, Assistant Director of Nursing, Nursing Supervisor)
- Pharmacy (Director of Pharmacy Services, Assistant Pharmacy Director)
- Infection Prevention
- Security
- Risk Management/Quality Improvement
- Human Resources

Other participants may include:

- Patient Safety/Patient Services
- Anesthesia
- Employee & Occupational Health
- Legal
- Office of Communications/Public Information Officer

ASCs my not have as many staff as the acute care facility does, however anyone who is tasked with writing drug diversion plans, enforcing policies, training staff about drug diversion, monitoring/ordering controlled drug supplies, investigating drug diversion incidents, or has any contact with controlled substances should be invited.

Scenarios

The scenarios were developed to be used by Ambulatory Surgery Centers (ASCs). They do not include roles for external partners, such as local law enforcement and public health. The idea of the exercise is to create an exercise for internal staff to determine the best course of action. The scenarios promote discussion among those who are tasked with enforcing policies and investigating internal reports of diversion. Creating scenarios for multiple partners is a consideration for future exercises

Use the scenario sheets below to give to participants.

Scenario #1

This ASC is affiliated with a large health system. However, the ASC uses a contracted pharmacy provider and not the hospital pharmacy.

In preparation for Monday morning's procedures at the facility, the nurse begins to draw up the medications for all of the cases that day. As she is drawing up medications from a new single-dose vial of Fentanyl, she notices that the dust cap seems loose. She thinks that this is odd but uses aseptic technique to clean the top of the septum and fill syringes for the procedures.

The following week, the nurse notices that there are again loose dust caps on the Fentanyl. It also looks like one of the vials is not completely filled. She thinks this is odd but continues to draw up medications and does not tell anyone about the suspicious vials of Fentanyl.

In the break room, the recovery nurse mentions that the patients have been complaining about pain. She said that there have been quite a few complaints the last few weeks. In passing, the recovery nurse tells a co-worker that she has had more patients complaining of pain, despite being treated, especially those who are receiving Fentanyl.

After the conversation about patients and pain management concerns, the nurse checks the newest order of Fentanyl and the caps are loose. She relays her concerns to the nurse manager, who contacts the contract pharmacy. She tells them that over the last few weeks their ASC has received at least one vial that was not completely filled. The pharmacy director places a call to the manufacturer to see if there was a recall that was overlooked. The manufacturer says there was no recall. The contract pharmacy directs the ASC to package the remaining vials of Fentanyl and return them to the contract pharmacy. Once received, the pharmacy director examines the vials and notices that there are very fine holes in the septum in some of the vials.

The pharmacy director sends the vials out to be tested. Test results show that the vials are 40% Fentanyl and 60% saline. The pharmacy director reviews the videos of the pharmacy and is surprised to see a new pharmacy technician tampering with vials of medication that were shipped to the ASC.

Scenario #2

The nurse enters the pre-op area to take vitals before the patient is taken to the operating room suite. After recording information, the nurse tells the patient to wait while he draws up the medication for the procedure. He enters the medication prep room and draws up the medications that he needs for his case. Among other pre-op meds, he draws up two syringes of Fentanyl, one for his patient and the other for himself and he puts it in his shirt pocket. He returns to the pre-op area to administer the medications to his patient.

The nurse wheels the patient into the operating room and assists the OR tech with set-up. After the case is over, he is near the door when the syringe falls out of his pocket. Both the OR tech and the doc see the syringe on the floor. The anesthesiologist picks up the syringe and places it on the table and asks the nurse where the syringe came from. The nurse shrugs and says that he was in a hurry and it must be a left over from yesterday's cases. The nurse grabs the syringe from the table and walks out of the OR suite. The OR tech begins to say something to the anesthesiologist about the nurse's weird behavior but decides not to. Last week the tech noticed the nurse came in when he wasn't scheduled and was hanging out near the medication preparation area/room. The tech decides it is none of his business, he needs this job and is not getting involved. He wheels the patient to the recovery room after the procedure is over.

The next day, the nurse is not scheduled to work, but arrives at the facility. He says he left something in his locker. As he makes his way back towards the locker room, he makes a quick move to the medication room. He enters the Pyxis using a co-worker's code, takes a vial of Fentanyl, slips it in his pocket and leaves the building.

On his next scheduled work day, he goes to the medication room and fills a syringe with Fentanyl. He goes into the bathroom, injects himself with the Fentanyl, and fills the syringe with tap water before returning to the patient area. He puts the water-filled syringe on the cart where other medications for the procedure are kept. During the case, the anesthesiologist sees an unmarked syringe on the cart and asks the OR tech and nurse where the syringe came from, as it is not labeled. The nurse says he does not know but that he will dispose of it once the case is over. The unlabeled/water filled syringe is kept off to the side of the cart.

The OR tech takes the patient to recovery and the nurse tells the anesthesiologist he is going to the med room to get meds for the next case. The nurse empties the water-filled syringe goes to the med room and fills a syringe with Fentanyl, walks to his locker and puts the syringe in his locker. The tech approaches the nurse and tells him that he saw what he did and is going to tell the director of nursing.

The nurse is upset and goes into the bathroom, injects the medication and passes out. The nurse is found by another staff member with the needle still in his arm.

Scenario #3

An endoscopy center has many procedures scheduled for the day. They have veteran staff who are used to getting through procedures quickly. Most staff have been at the center for three years or more.

A nurse anesthetist is talking with the first patient (Case #1) of the day before the start of the procedure. She has a new 50mL single-dose vial of Propofol for the case. She draws up the entire vial into a single syringe and administers half to the patient along with other medications. Before the case starts, while nobody else is in the room, she administers a small amount of the Propofol to herself. When the surgeon arrives, she administers the remaining Propofol to the patient. At the end of the case, she discards the needle and syringe. The nurse anesthetist starts Case #2 with a new 50mL single-use vial of Propofol. For this case, she draws up 20mL and administers it to the patient. During the case, an additional 10mL of Propofol is drawn up and administered using the same syringe as the first dose but a new needle. At the end of the case, the needle and syringe are discarded in the sharps container; however, 20mL of Propofol remain in the vial. The nurse puts the vial in her pocket to use on the third case of the morning. Case #3 is a very large man. During the case, the nurse anesthetist finishes the first bottle of Propofol that she used on Case #2. She then opens a new vial of Propofol and administers an additional dose to Case #3 using the same syringe and new needle.

The nurse anesthetist continues to open new vials of Propofol as needed for her cases throughout the day. At the end of the day, she has used five bottles of Propofol on 15 patients. She leaves the center with a half-filled bottle of Propofol in her coat pocket.

Five and a half months later, the local health department receives a call from a local gastrointestinal (GI) physician. He tells the center that he has two patients who both had procedures a few months ago at the ASC and are now positive for hepatitis C. They have no traditional risk factors for the disease and were negative for the virus a year ago. The surgery at the ASC is the only health procedure they underwent in the last 12 months. The local health department, along with the state health department, begin a public health investigation to determine if the individuals were infected with the virus during their procedures at the ASC. After reviewing patient records and infection prevention and control practices at the ASC, it is determined that patients who received injectable medication from one nurse anesthetist within the last three years, should be tested for bloodborne pathogens. She has been employed at the center for three years.

Sample of Slides

As noted earlier in the Exercise Facilitator Guide, the exercise used PowerPoint slides to lay out the scenario and prompt discussion among the participants. The slides are divided into three sections: the introduction and objectives of the exercise, the scenario (blue slides) and discussion questions (yellow slides).

The slides use color to separate the scenarios from the questions. This makes it easier for participants to follow along. It also assists the facilitator as they ask discussion questions.

Shown below are samples of the slides. The entire slide set is available as a separate attachment.

Scenarios with Questions

Also included are the three scenarios with the discussion questions. This document is typically used by the facilitator. This document includes the entire scenario and each of the questions asked on the PowerPoint. It includes everything that the participants see on the slides. This document is helpful to the facilitator so that they are aware which questions are included at certain points in the scenario.

Depending on the type of discussion during the exercise, the facilitator may decide to skip some of the questions. The facilitator may find that some of the questions may be redundant or the issue has been addressed. It is up to the facilitator to ask the prompting questions.

The facilitator may wish to introduce additional questions, depending on their familiarity with the facility, the issues and the time allotted. The questions that are included help keep the exercise on track. Be wary of adding additional questions if there is a reduced timeframe for the exercise.

The scenario with questions is not provided to participants. This document is to be used by the facilitator (and perhaps the note taker). The scenario is bolded, and questions are not bold.

Facilitator Exercise Scenarios with Discussion Questions

Scenario #1

This ASC is affiliated with a large health system. However, the ASC uses a contracted pharmacy provider and not the hospital pharmacy.

In preparation for Monday morning's procedures at the facility, the nurse begins to draw up the medications for all of the cases that day. As she is drawing up medications from a new single-dose vial of Fentanyl, she notices that the dust cap seems loose. She thinks that this is odd but uses aseptic technique to clean the top of the septum and fill syringes for the procedures.

What is the facility's policy regarding medication preparation?

What are procedures when tampering is noticed in medication packaging/vials?

Who is responsible for following up with the pharmacy if there is an issue with the medication?

What is the facility's policy for receiving/verifying/placing into inventory medications received from the pharmacy? Is there a chain of custody? Who has access during the process?

Is this written in the policy?

Why are medications for the entire day being drawn up in the morning?

The following week, the nurse notices that there are again loose dust caps on the Fentanyl. It also looks like one of the vials is not completely filled. She thinks this is odd but continues to draw up medications and does not tell anyone about the suspicious vials of Fentanyl.

In the break room, the recovery nurse mentions that the patients have been complaining about pain. She said that there have been quite a few complaints the last few weeks. In passing, the recovery nurse tells a co-worker that she has had more patients complaining of pain, despite being treated, especially those who are receiving Fentanyl.

What is the facility's policy regarding pain management?

- Is inadequate pain relief captured/considered? How is this done?

Which staff have access to controlled substances?

Are anesthesia services contracted? What is your facility's policy concerning contracted employees and drug diversion?

After the conversation about patients and pain management concerns, the nurse checks the newest order of Fentanyl and the caps are loose. She relays her concerns to the nurse manager, who contacts the contract pharmacy. She tells them that over the last few weeks their ASC has received at least one vial that was not completely filled. The pharmacy director places a call to the manufacturer to see if there was a recall that was overlooked. The manufacturer says there was no recall. The contract pharmacy directs the ASC to package the remaining vials of Fentanyl and return them to the contract pharmacy. Once received, the pharmacy director examines the vials and notices that there are very fine holes in the septum in some of the vials.

The pharmacy director sends the vials out to be tested. Test results show that the vials are 40% Fentanyl and 60% saline. The pharmacy director reviews the videos of the pharmacy and is surprised to see a new pharmacy technician tampering with vials of medication that were shipped to the ASC.

What is the facility's internal notification policy in the event that there is a breach with medications?

What external organizations are contacted once diversion is determined?

Who makes the calls to which organizations?

Is a patient notification necessary? How is this determined?

How is this issue corrected/addressed?

Does the facility have existing policies to address these issues?

Scenario #2

The nurse enters the pre-op area to take vitals before the patient is taken to the operating room suite. After recording information, the nurse tells the patient to wait while he draws up the medication for the procedure. He enters the medication prep room and draws up the medications that he needs for his case. Among other pre-op meds, he draws up two syringes

of Fentanyl, one for his patient and the other for himself and he puts it in his shirt pocket. He returns to the pre-op area to administer the medications to his patient.

The nurse wheels the patient into the operating room and assists the OR tech with set-up. After the case is over, he is near the door when the syringe falls out of his pocket. Both the OR tech and the doc see the syringe on the floor. The anesthesiologist picks up the syringe and places it on the table and asks the nurse where the syringe came from. The nurse shrugs and says that he was in a hurry and it must be a left over from yesterday's cases.

The nurse grabs the syringe from the table and walks out of the OR suite. The OR tech begins to say something to the anesthesiologist about the nurse's weird behavior but decides not to. Last week the tech noticed the nurse came in when he wasn't scheduled and was hanging out near the medication preparation area/room. The tech decides it is none of his business, he needs this job and is not getting involved. He wheels the patient to the recovery room after the procedure is over.

Does the facility have an internal mechanism to report unusual behavior/potential diversion?

What is the facility's policy for drawing medication for each procedure?

The next day, the nurse is not scheduled to work, but arrives at the facility. He says he left something in his locker. As he makes his way back towards the locker room, he makes a quick move to the medication room. He enters the Pyxis using a co-worker's code, takes a vial of Fentanyl, slips it in his pocket and leaves the building.

On his next scheduled work day, he goes to the medication room and fills a syringe with Fentanyl syringe. He goes into the bathroom, injects himself with the Fentanyl, and fills the syringe with tap water before returning to the patient area. He puts the water-filled syringe on the cart where other medications for the procedure are kept.

How is monitoring of the medication machines conducted? By whom?

Where are medication/Pyxis records kept? Who monitors these records?

When unusual behavior is suspected, how is it handled?

During the case, the anesthesiologist sees an unmarked syringe on the cart and asks the OR tech and nurse where the syringe came from, as it is not labeled. The nurse says he does not know but that he will dispose of it once the case is over. The unlabeled/water filled syringe is kept off to the side of the cart.

The OR tech takes the patient to recovery and the nurse tells the anesthesiologist he is going to the med room to get meds for the next case. The nurse empties the water-filled syringe goes to the med room and fills a syringe with Fentanyl, walks to his locker and puts the syringe in his locker. The tech approaches the nurse and tells him that he saw what he did and is going to tell the director of nursing.

The nurse is upset and goes into the bathroom, injects the medication and passes out. The nurse is found by another staff member with the needle still in his arm.

Does the facility have a policy that addresses drug use in employees?

Is local law enforcement contacted?

What other agencies are contacted? And by whom?

After a diversion incident, is there an internal group that meets to discuss policies/procedures?

Is education/in-service provided to staff about the facilities diversion policies?

Is there a phone number for employees to call to alert the facility about drug diversion/employee drug use?

Scenario #3

An endoscopy center has many procedures scheduled for the day. They have veteran staff who are used to getting through procedures quickly. Most staff have been at the center for three years or more.

A nurse anesthetist is talking with the first patient (Case #1) of the day before the start of the procedure. She has a new 50mL single-dose vial of Propofol for the case. She draws up the entire vial into a single syringe and administers half to the patient along with other medications. Before the case starts, while nobody else is in the room, she administers a small amount of the Propofol to herself. When the surgeon arrives, she administers the remaining Propofol to the patient. At the end of the case, she discards the needle and syringe. The nurse

anesthetist starts Case #2 with a new 50mL single-use vial of Propofol. For this case, she draws up 20mL and administers it to the patient. During the case, an additional 10mL of Propofol is drawn up and administered using the same syringe as the first dose but a new needle. At the end of the case, the needle and syringe are discarded in the sharps container; however, 20mL of Propofol remain in the vial. The nurse puts the vial in her pocket to use on the third case of the morning. Case #3 is a very large man. During the case, the nurse anesthetist finishes the first bottle of Propofol that she used on Case #2. She then opens a new vial of Propofol and administers an additional dose to Case #3 using the same syringe and new needle.

What, if any, are issues that you see with the nurse anesthetist's practice?

What is the facility's policy about using single-dose vials for more than one patient?

What is the procedure for preparing medication? Where is the medication preparation usually done: separate room, in surgery suite, or other?

Is anesthesia a contracted service for the center? What are the facility's policies about anesthesia providers and medication handling? How is medication use and waste recorded?

The nurse anesthetist continues to open new vials of Propofol as needed for her cases throughout the day. At the end of the day, she has used five bottles of Propofol on 15 patients. She leaves the center with a half-filled bottle of Propofol in her coat pocket.

How are staff (center/contracted) trained on infection prevention and control/injection safety practices? How often?

Who monitors infection prevention and control at the facility?

How are medications within the facility accounted for?

Does the facility keep logs to ensure that medication vials accessed in the patient treatment area are used for a single patient? This applies to both single and multiple-dose vials.

Five and a half months later, the local health department receives a call from a local gastrointestinal (GI) physician. He tells the center that he has two patients who both had procedures a few months ago at the ASC and are now positive for hepatitis C. They have no traditional risk factors for the disease and were negative for the virus a year ago.

The surgery at the ASC is the only health procedure they underwent in the last 12 months. The local health department, along with the state health department, begin a public health investigation to determine if the individuals were infected with the virus during their procedures at the ASC. After reviewing patient records and infection prevention and control practices at the ASC, it is determined that patients who received injectable medication from one nurse anesthetist within the last three years, should be tested for bloodborne pathogens. She has been employed at the center for three years.

Does the facility have a policy about the process of patient notification when a disease transmission has been identified?

Does the policy include testing for bloodborne pathogens (employee/patient)?

Does the facility maintain a log of healthcare personnel's vaccination/immunization status?

What is the relationship with the local health department and the facility?

- Are you aware of which local health department holds jurisdiction over the facility?
- Is there an established relationship with a representative from the local health department?

Evaluation

Below is a participant evaluation. The purpose is to determine whether the participants found the exercise worthwhile, if the exercise accomplished its goal and for participants to provide feedback.

The evaluation should be distributed to participants at the end of the exercise. The evaluation is an easy-to-use document. It is a one-page, two-sided tool with a rating scale (Likert), check boxes and space for open-ended responses.

If you are planning to host a drug diversion exercise, you may wish to use an evaluation to assess your audience. However, if you are adding the exercise to an existing group as a skill-building and/or group discussion, the evaluation may be skipped. It is up to you to determine if you will use the evaluation and what you will do with the information collected from participants.

If you decide that you would like to use the exercises at an in-service and offer continuing education credits, the evaluation may be helpful. Most continuing education providers require that participants complete an evaluation at the end of the program.

You may print the evaluation on the last two pages to give to exercise participants.

Drug Diversion Exercise-Acute Care Health Facility

Thank you for attending today's program. Please take a few moments to complete the evaluation. We are interested in your comments, as they assist us in ensuring that the learning objectives of the event have been met and ways to improve future offerings. ***Please place an "X" in the box that best represents your opinion***.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1. The facilitators encouraged participation/discussion during the **Drug Diversion Exercise**					
2. The exercise/discussion addressed the stated learning objectives: • Discuss existing facility policies related to drug diversion • Highlight the strengths of existing drug diversion policies at the facility • Identify gaps in existing drug diversion policies at the facility • Identify ways to train/communicate with staff about the facility's drug diversion policies • Explore the process of responding to a drug diversion incident (internally/externally)					
3. I felt that the exercise scenarios were realistic					
4. After participating in the exercise, I am clear about my role during a suspected/actual drug diversion at my facility					
5. As a result of participating in the exercise, I learned at least one new piece of information about issues surrounding drug diversion					

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What is your position at the healthcare facility?

- ❍ Administration
- ❍ Medicine
- ❍ Nursing
- ❍ Pharmacy
- ❍ Other: ____

How long ago was the last drug diversion incident at the healthcare facility in which you were involved in any way (e.g., identification, investigation, discipline, policy enforcement, etc.)?

- ❍ Less than three months ago
- ❍ 3-6 months ago
- ❍ 7-12 months ago
- ❍ More than 1 year ago
- ❍ I have never been involved with a drug diversion incident
- ❍ Other: ____

What was the most useful part of today's exercise? ____

What was the least useful part of today's exercise? ____

Do you have any recommendations about how to make the exercise better?

____

____

Other comments? ____

____

Thank you for your time and participation!