



# Drug Diversion Exercise Facilitator's Guide

New Jersey Department of Health  
Communicable Disease Service  
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## **Overview**

The New Jersey Department of Health (NJDOH) created a tabletop exercise for acute care facilities to stimulate a discussion of drug diversion and to review existing policies related to the topic.

The exercise featured three scenarios where injectable opioid medication was diverted by healthcare staff. A facilitator guided participants through each scenario and posed 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, in collaboration with the staff from NJDOH Health Facilities Survey and Field Operations.

This facilitator guide includes a discussion of the pilot drug diversion exercise conducted at four New Jersey acute care facilities; a summary of the findings and recommendations from our pilot; and provides acute care facilities with the tools, including the scenarios and slides, to conduct their own exercises.

## **The Pilot**

NJDOH held exercises at four New Jersey acute care facilities from January through March 2016 using three different scenarios that highlight examples of drug diversion by health care personnel. The facilities that volunteered to participate in the pilot were located in the north, central, and south New Jersey and represented a cross-section of New Jersey hospitals. Facilities were located in urban and suburban areas and included teaching and community medical centers. The NJDOH is thankful to the four facilities that participated in this pilot program.

The facilitator at the exercise had access to a presentation that included an overview of drug diversion for the participants. The facilitator was also provided color-coded slides with three scenarios and questions. Slides with the scenarios are blue; slides with questions for the participants are yellow. The participants received copies of the scenarios only. Not having the questions in advance makes for a more spontaneous, real-time discussion among participants. The facilitator was experienced with group facilitation, was well acquainted with the slides, and had a good understanding of the issues related to drug diversion. Having an experienced facilitator is important to ensure that key areas are discussed by the participants. Sometimes questions were skipped as the topic had already been discussed earlier in the exercise.

Each facility offered a dialogue of how drug tampering/diversion of injectable opioid medications are monitored and their response to a potential/suspected incident. Most of the

facilities were forthcoming with information about their experiences with drug diversion. They also shared how certain events shaped their current policies and procedures.

Commonalities were noted among the facilities. It was clear that each facility had a plan for responding to drug diversion with injectable medications. The methods and processes were different and were not always documented as official policies. A common remark from individuals during the exercise was that “This is just our practice; nothing is in writing”.

The exercise revealed many findings that were of interest because they included everything from how employees are informed about drug diversion reporting, the role of certain internal departments when a diversion is suspected/revealed to how drug tampering/diversion is reported to external agencies. The departments, roles and actions vary greatly from facility to facility.

While we conducted exercises in four facilities throughout the state, the facilities faced similar challenges with regard to drug tampering and diversion. During all four exercises discussions focused on similar topics.

## **Findings**

1. Policies vary from facility to facility
  - a. The number and scope of policies pertaining to drug tampering/diversion varied greatly from facility to facility. During the exercise, common responses about policy included “It is just what we do,” “People have worked here a long time and know what to do” or “There is nothing written down that is that specific”.
  - b. Facilities cited common practices, such as “Fitness for Duty” or basic Human Resources policies. At the conclusion of the exercise, participants appeared to see the value of having specific policies outlining processes and procedures for drug diversion. Participants noted that these policies would have an added benefit of protecting the organization from liability.
2. Existing relationships among internal departments were strong
  - a. During the exercise, there was evidence that the nursing supervisors and pharmacy department were in constant communication. This included running reports and meetings to discuss abnormalities associated with drug dispensing machines.
  - b. There was also a solid relationship with all clinical departments and the Human Resources departments. The Human Resources representatives were well versed and an integral partner in suspected/confirmed employee drug diversion.
  - c. Of the four facilities that participated in the exercise, only one had a drug diversion committee.

3. Inconsistent reporting to various regulatory/licensing entities
  - a. We found that some facilities were more apt to contact law enforcement than others. In fact, two facilities mentioned that they rarely contact local law enforcement. Depending on the circumstances and amount of drug theft, the federal Drug Enforcement Agency (DEA) may or may not be contacted. In fact, one facility mentioned that law enforcement and the DEA were low on their radar. The term “significant loss” was commonly used but the definition of this varied. The question of “How much does it take for you to contact the DEA” was posed at each exercise. Facilities did not concretely answer the questions. Most alluded to a form that they complete for wasting/drug loss. One participant from a facility mentioned that the DEA only wants to know if there are large amounts of drug missing/unaccounted for, not small amounts. The participant continued to say that they look for patterns of loss, not only amount of loss.
  - b. It was clear during the exercises that facilities readily contacted the professional boards (e.g., Board of Nursing, Board of Medical Examiners, Board of Pharmacy), as those entities are responsible for professional licensing and all have their own impaired professional programs. NOTE: New Jersey has a Clearing House which is meant to aid facilities in obtaining access to assistance for impaired licensed and certified healthcare professionals. The Health Care Professional Responsibility and Reporting Enhancement Act requires New Jersey health care entities (NJSA 26:2H-1) to report health care professionals licensed or certified by the New Jersey Division of Consumer Affairs or by the New Jersey Department of Health who are employed by, under contract to render professional services to, or have clinical privileges granted by that healthcare entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry to notify the New Jersey Division of Consumer Affairs, Health Care Professional information Clearing House Coordinator regarding the health care professional’s conduct relating to impairment, incompetence or professional misconduct which related to patient safety and the health care entity has taken action against them ([www.njconsumeraffairs.gov/Pages/hcreporting.aspx](http://www.njconsumeraffairs.gov/Pages/hcreporting.aspx)).
  - c. The Health Facilities Survey and Field Operations (HFS&FO), the division responsible for conducting inspections of State Licensed and Medicare Certified facilities, has regulations which require State Licensed facilities to report all criminal acts or potentially criminal acts that occur within a facility and pose a danger to the life and safety of patients/residents, staff, or the public to the appropriate police authorities and to the HFS&FO. These regulations are located in NJAC 8:43E 10.11. When prompted whether the facility contacts the HFS&FO division, a common response was “We contact the state when we notify the professional boards.” This is a common misnomer that “The State” is one call and that the information is disseminated to other areas within state government.

4. Facilities unaware of the public health implications (potential disease transmission) of injection medication tampering/diversion
  - a. The scope of this exercise was drug diversion of injectable medications. The scenarios include transmission of disease from a diverting employee to patients. All four facilities mentioned that they had more experience with the theft of oral medications (pills), which have no infectious disease transmission potential.
  - b. At each exercise, it was clear that while they were familiar with monitoring, reporting, and investigating suspected drug diversion, they did not consider investigating potential disease transmission due to diversion.
  
5. Infection prevention department did not play a consistent role; not always included in the communication of a drug diversion event at the facility
  - a. The Infection Preventionist (IP) was present at half of the exercises. When present during the exercise, the IP's knowledge of disease transmission/public health impact and experience with investigating and reporting communicable diseases and outbreaks was an asset. Typically, the IP has established relationships with the local and state health departments. IPs are tasked with conducting surveillance for reportable communicable diseases and detecting unusual clusters of disease among patients.
  
  - b. During the discussion at one facility it was recognized that the IP should be included in discussions pertaining to drug diversion, particularly injectable medications. In the exercises where the IP was present, the IP served as the link to public health authorities in the event of the need for patient notification or the identification of disease transmission due to drug diversion.
  
6. Most facilities had little or no experience with patient notification
  - a. Facilities mentioned that they had past experience with notifying patients about recalled products. None of the facilities that participated in the exercises had experience with notifying a large group of individuals potentially exposed to a blood borne pathogen.
  
  - b. During the one scenario which included a large patient notification due to disease transmission from an employee to a patient, participants were unsure of how they would handle the situation. There were no written protocols for mounting a large response that would include accessing medical records, obtaining contact information, writing notification letters, setting up testing logistics, writing the orders for testing, determining payment for testing, monitoring positive results, setting up a hotline for the public to call with questions, etc. One of the participants stated that the facility would "do the right thing" and take care of everything, however, nothing was written down to address the issue.

7. Policies varied on routine drug testing of employees
  - a. Each facility had different policies about testing employees for controlled substances. This included referring employees for testing after they were suspected of diverting drugs. However, participants were aware that testing should include drugs that the employee is suspected of diverting, not just street drugs and alcohol.
  - b. The Human Resources representatives were familiar with testing an employee who was enrolled in an addiction monitoring program affiliated with the New Jersey professional boards (voluntary testing required over a specified timeframe to maintain license).
  
8. No clear understanding or line of communication with contracted staff (e.g., anesthesia personnel)
  - a. In one of the scenarios, an anesthesiologist is suspected of tampering with filled syringes. Most of the facilities mentioned that anesthesia services were contracted. They explained that contracted employees are handled differently than hospital employees as the facility does not have direct oversight of the individual.
  - b. Participants in the exercise were questioned as to how much information about the contracted employee should be shared with the facility. A question was raised about what types and how much information about contracted employees that facility should have/be made aware. Participants agreed that they should be provided with information, especially if a contracted employee is in an addiction monitoring program or has had prior issues with addiction. Exactly which department within the facility should have this information varied by facility.
  
9. Facilities had a clear understanding of resources from addicted licensed health professionals (i.e., nurses, physicians, and pharmacists)
  - a. The Human Resources representatives who played at each exercise were well versed on the requirements for licensed health professionals who diverted drugs due to an addiction. Facilities varied on the type of work that these professionals were able to perform while being monitored.
  - b. Some representatives mentioned that they would likely terminate an employee who stole/committed theft. Some noted that when a nurse has completed the addiction program he/she would be reintroduced to work in an environment where there would not be access to controlled substances. Pharmacy will hire a pharmacist who completed an addiction program.

10. Communicating a drug diversion incident to facility staff varied
  - a. It was revealed that after a drug diversion occurs at a facility, there is little or no communication to other staff about the incident.
  - b. We asked whether the facilities used the incident as a learning opportunity for staff education/re-education about drug diversion. Most commented that this was not the case. The incident is handled in-house for the most part.
  - c. However, many participants who participated in the exercise thought that having an annual in-service for most employees that included drug diversion was a good idea.
  
11. Amount of information about drug diversion provided to employees/staff varied by facility
  - a. All facilities acknowledged that the new employee orientation includes minimal information about drug diversion. These orientations include non-clinical staff (e.g., housekeeping, dietary aides, clerical, administrative) for whom detailed drug diversion information would not be relevant.
  - b. Some facilities mentioned that they hold additional orientations for nurses and/or clinical staff. At this orientation the issue of drug diversion and the professional licensing board addiction programs are covered in detail, as well as other Employee Assistance Programs.
  
12. Internal reporting of suspected/possible drug diversion varied by facility
  - a. All facilities have a dedicated phone number or “hotline” for employees to report concerns about various issue. The “hotline” is available 24/7 but is not a dedicated drug diversion. Employees can use these “hotlines” to report any concern, including patient and employee safety.
  - b. The department that monitors/receives the phone messages varied by facility. However, participants reported that employees often reported concerns directly to human resources or their supervisor.
  
13. Role of security
  - a. Security was present at three of the four exercises. Their involvement in responding to discussion questions varied greatly. In one instance the security representative mentioned that they work very closely with law enforcement and contact them frequently. This was not the case with the other two facilities. The security representative from one facility would carefully consider the risk of creating panic or tarnishing the reputation of the facility when deciding to contact local law enforcement.
  - b. Security representatives saw their role as assisting with chain of custody in the event that injection equipment or vials need to be secured for testing or as evidence. They provided detailed information about how they work with



departments to install and monitor cameras in the pharmacy and in areas where controlled substances are stored/accessed.

#### 14. Injectable medications vs. Pills

- a. The scenarios created for this exercise featured injectable opioid medications such as fentanyl. We focused on injectable medication due to the potential for disease transmission.
- b. Participants reported that any drug diversion exercise should include a pill diversion scenario, as that is more common. This is a consideration for anyone conducting drug diversion exercises.

### **Recommendations**

#### 1. Multi-disciplinary Drug Diversion Committee

- a. One of the four facilities that participated in the pilot project had an internal drug diversion committee that met on a regular basis. The facility's committee is multi-disciplinary and consists of representatives from nursing, administration, pharmacy, risk management, quality improvement, patient safety, human resources, and infection control.
- b. Having a committee that is able to focus solely on this issue may be helpful to facilities to create their drug diversion policies. This is a pro-active way to address the issues and concerns and discuss strategies and policies to prevent, detect and respond to drug diversion.

#### 2. Infection Preventionists should be involved in discussions related to injectable medications and diversion/tampering

- a. During one of the exercises, it was noted that the IP was the hospital liaison with the local public health department. IPs are instrumental to surveillance efforts and monitor the healthcare facility (and satellites) for odd occurrences of disease and outbreaks.
- b. We recommend that the IP be included in a drug diversion committee (particularly when tampering or diversion involves an injectable medication) or in any instance where there is a need to collaborate with public health authorities.

#### 3. Facilities should have a close working relationship with the local public health agency

- a. Some exercise participants were unclear about the role of public health and did not understand how the facility interacts with the local health department. Key

members of facility staff should understand the role of public health agencies in disease investigations and diversion events.

- b. All acute care facilities should have the contact information of the local/county health department public health official/nursing staff readily available and should establish a working relationship with public health authorities to facilitate a response in the event of a diversion.
4. Policies specifically about drug diversion (should include prevention, surveillance/monitoring, detection, and response)
  - a. It is recommended that healthcare facilities develop written drug diversion policies that address prevention of, detection of, and response to a suspected drug diversion event. While facilities noted that “they just know what to do and how things go at their facility,” it is important to ensure that key aspects are written into policy to protect employees, the facility, and the patient.
  - b. The New Jersey Drug Diversion Coalition is working to create a drug diversion policy template to address consistent issues.
5. Standardize criteria regarding who is contacted in the a suspected/confirmed diversion, both internally and externally
  - a. Written policies addressed in #4 above should include a list with contact information for internal and external stakeholders who need to be contacted in the event of a suspected drug diversion.
  - b. Having a written list of internal and external stakeholders to be notified helps to ensure that all who need to be aware of the situation.
6. Drug diversion policies should be included in new hire orientation and should be considered as a topic for annual in-service trainings for employees (NOTE: amount of and depth of information may vary depending on the employee’s role at the facility)
  - a. While all facilities mentioned that the topic of drug diversion is covered in new employee orientation, and in some cases in a secondary orientation for clinical staff, it is recommended that drug diversion education be an annual item to include in staff in-services.
  - b. Drug diversion resources are available on the Centers for Disease Control and Prevention (CDC) website at no charge (<https://www.cdc.gov/injectionsafety>). They can be incorporated to existing staff in-service materials or included in other relevant workshops on a yearly basis.
7. Internal mechanism for 24/7 anonymous and/or confidential reporting of suspected drug diversion (e.g. hotline).

- a. While most facilities already had a dedicated phone line for employees to report any type of facility issue, not all did. Some facilities thought that the relationship between an employee and supervisor is strong enough that a face-to-face conversation was adequate.
  - b. We recommend that facilities consider having a phone line that receives incoming messages or a dedicated email inbox to receive messages. While we recognize that email messages would not be anonymous, there should be some level of confidentiality associated.
8. Facilities should determine what reporting requirements related to suspected/confirmed drug diversion are included in contracts with provider groups
  - a. Exercise participants were unsure if the facility would be notified in the event a contracted employee was suspected of drug diversion outside their facility.
  - b. We recommend that facility leadership discuss whether contracts with provider groups should include notification in the event an employee is suspected of drug diversion and the mechanism by which the facility will be notified.
9. Mechanisms for patient notification and accompanying components (i.e., logistics, writing orders, patient testing, accessing patient records, results, and follow-up, etc.) should be determined in advance of events
  - a. None of the four facilities had participated in a patient notification related to a drug diversion or outbreak event. This means that the components of a patient notification, such as risk assessment, testing, communications, and clinical follow-up, were not on the radar of those who are making policies to prevent or identify drug diversion.
  - b. We recommend that facilities have an internal conversation with department heads/administrators who will be involved in a patient notification. Discussing logistics and resources is a key component to responding to a patient notification, especially a drug diversion incident that may expose patients to a bloodborne pathogen. Patient notifications are a time and staff-intensive event that may last for months or years, depending on the scope of the breach.

### **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.

NOTE: We brought a laptop to each exercise to take notes. It was easier than writing everything out and then transcribing. The note-taker used the PowerPoint slides as an outline to take notes that lined up with the discussion questions. No other equipment is needed.

Participants were also 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. NOTE: The Human Resources, Pharmacy and Quality/Risk Management players were the more likely to have policies with them. Not all players had policies to bring, but were aware of the process.

We would recommend having name cards for all participants (can be hand-written) and a sign-in sheet. NJDOH also brought One & Only Campaign materials for all participants and left whatever participants did not take for the facility.

Reserve the room for at least two hours (NOTE: We recommend adding 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 first scenario, #1, is considerably longer and more involved. The other scenarios, #2 and #3, are shorter and may be discussed together. A follow-up meeting with participants is recommended to discuss the exercise and potential to discuss findings is also recommended.

We made copies of the scenarios and disseminated them to each participant at the beginning of the exercise. We wanted the participants to 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. The scenarios provided to the participants do not have the discussion questions, as we didn't want people to get too far ahead of the exercise.

A participant evaluation was also created for the exercise. No names were required on the evaluation. The purpose of this was to see if we covered each learning objective, but also to give participants an anonymous mechanism to provide feedback. We know that the subject is sensitive and we were asking participants to highlight good practices and areas that needed improvement at their facilities. You may wish to create an evaluation and use it as a way to illicit additional information from participants.

### **Who should I invite to participate in the exercise?**

In the four exercises held in New Jersey, we found that those with a diverse group of staff representing various departments across the facility had the most robust discussion about the

issue. We found that while a titles may vary from facility to facility, the role/tasks are consistent. We also recommend 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

## **Summary**

This facilitator guide is an overview of the four exercises that were developed as part of New Jersey Department of Health's injection safety initiative. It was developed to raise awareness among healthcare facilities about drug diversion and to identify what these facilities are doing to prevent, detect and respond to a drug diversion/drug tampering event.

The scenarios were crafted to fit the regulations and licensing requirements in New Jersey. If using these scenarios outside of the state, please check to ensure that appropriate verbiage and information about reporting and state licensing board programs are used.

The scenarios were developed to be used by acute care facilities. They do not include roles for external partners, such as local law enforcement and public health. The idea was to create an exercise for internal staff to determine the best course of action. Creating scenarios for multiple partners is a consideration for future exercises.

We hope that this guide has been helpful in highlighting our findings during the pilot project. Our recommendations are based on what we observed and responses provided by participants during the exercises.

## **Scenarios**

The scenarios on the next few pages are the three that we used for the four New Jersey exercises. Depending on your state and the rules/regulations, you may need to make changes so that the scenario is applicable.

Scenario #1 is the longest of the three and involves a disease transmission from an employee to patients at an acute care facility. Patient notification is covered in this scenario. Scenario #2 involves an unlocked/stocked anesthesia cart and various employees This is the scenario that touches on reporting and contracted employees. Scenario #3 is a pharmacy and drug tampering scenario.



## Scenario #1

1. A nurse working in the Post-Anesthesia Care Unit (PACU) expresses concern to her supervisor that the morphine she has been administering for pain does not seem to be as effective as usual.
2. The PACU Nurse Manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director runs an activity report for the removal of morphine from the PACU drug dispensing device for the past few months. He/she notices that is a particular PACU nurse who often removes larger quantities of morphine for patients, including individuals that she is not assigned to provide care. The Pharmacy Director shares the drug pattern with the Nurse Manager.
3. The nurse manager observes the PACU and notices that the implicated nurse retrieves medication from the drug dispensing device and then leaves the PACU.
4. The nurse who took the medication from the drug dispensing device is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest but hands over two syringes. Both are filled but one has a broken seal.
5. The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she left her personal cell in her locker, was expecting an important call and needed to get it. Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.
6. An investigation of various staff reveals that co-workers have seen the PACU nurse at the facility on her days off and at times when she wasn't scheduled to work and in areas of the facility where she does not normally work.

In addition, the local health department has called the Infection Preventionist (IP) about a cluster of acute hepatitis C virus (HCV) infections in individuals who were patients at the hospital. Two of the patients share a healthcare provider and have no traditional risk factors for HCV. Their healthcare provider ordered testing after they complained of symptoms. Both patients tested positive for HCV. They were both previously in your hospital within three weeks of each other. Both patients were in the PACU.

The nurse admits to self-administering morphine and other controlled drugs throughout the hospital (e.g., replacing the syringes that were intended for patients, replacing them with saline and returning the filled syringes to the PACU). The nurse claimed she started diverting morphine about two months ago.

However, nursing attendance records dating back 12 months indicate that the nurse was working in the PACU on days when each HCV-infected patient received morphine injections. The nurse has documentation of completing the hepatitis B series and has documentation of post-vaccination serology; she does not admit to being positive for HCV or any other bloodborne pathogen. The nurse tests positive for HCV. The hospital informs the local health department to alert them to this new development. The health department tells the hospital that they may need to do a patient notification of all patients who may have received medication that was administered/prepared by this employee.

The nurse has worked at your hospital for 18 months. Since both HCV+ patients were in the PACU six months ago, it is determined that a patient notification to all patients who received care in the PACU when the nurse was working within the last year to get tested for hepatitis C and HIV. Since the nurse was seen in various locations, not just her assigned work area, disease investigators from the local health department are unsure of the extent of patient notification. At this point, the hospital estimates that more than 1200 patients were in the PACU during the last 12 months.





## Scenario #2

1. During her rounds, the Infection Preventionist (IP) notices that the anesthesia cart was left unlocked in one of the operating suites. She notices that there is a partially used vial of fentanyl and two syringes on top of the cart, one empty and the other filled. An anesthesiologist arrives a few minutes after the IP sees the cart. He tells the IP that he had to run to the bathroom and the rest of the team left for the day. He returns the cart to the lock-up area and leaves for the day.

2. The following week, an anesthesia tech sees a stocked anesthesia cart prepped for morning surgeries just inside the locked door of an operating suite. On the cart he notices pre-filled syringes for the entire day's surgeries. There is also an empty syringe among the filled syringes. The tech begins to wheel the cart to the locked up area, when one of the anesthesiologists enters the operating suite. The doc explains that he was in the bathroom and that cart should be wheeled over to operating suite #3.

3. While cleaning the room in between cases, the tech notices that the anesthesiologist takes one of the syringes and puts it in his scrubs pocket and walks into the bathroom. The tech waits a while and follows him into the bathroom. As the tech opens the door to the restroom, he sees the anesthesiologist at the sink filling a syringe with tap water.

The anesthesiologist tells him that it is not what it looks like and brushes past the tech to the operating suite. The tech tells a co-worker buddy of his what he saw and asks for advice. The tech is unsure whether to tell his supervisor because he doesn't want to get the doc in trouble.



### Scenario #3

1. During an audit of Pyxis CII Safe activity in your pharmacy the Pharmacy Director notices that a staff pharmacist has entered the CII safe numerous times in the past 2 months without documenting a valid reason for accessing the safe. The pharmacist entered \*\*\* as the reason. No medications are recorded as removed from the safe at the time of these entries. And upon counting, no medication vials are missing from any of the medication drawers.
2. The Pharmacy Director decides to carefully examine of all the medications in the Pyxis CII Safe. Evidence of drug tampering is identified in certain opioids. He/she notices tiny holes in the center of some of the dust cover caps.
3. The Pharmacy Director schedules a meeting with the staff pharmacist, who admits to tampering with the medication vials for “personal use”. The staff pharmacist claims that vials were refilled with sterile saline to replace the medication amounts taken out.

## 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.

The image displays a grid of eight PowerPoint slides for 'Scenario #1'. The slides are arranged in two rows of four. The top row contains slides 14, 15, 16, and 17. The bottom row contains slides 20, 21, 22, and 23. Slides 14, 17, 20, and 23 are blue and contain the scenario text. Slides 15, 16, 21, and 22 are yellow and contain discussion questions. Each slide has an NJ Health logo in the bottom right corner.

Slide Number	Color	Content Type	Key Text
14	Blue	Scenario	The PACU nurse manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director runs an activity report for the removal of morphine from the drug dispensing device in the PACU for the past few months. He/she notices that a particular PACU nurse often removes larger quantities of morphine for patients, including individuals that she is not assigned to provide care. The Pharmacy Director shares the drug pattern with the nurse manager.
15	Yellow	Questions	Is there someone else besides that Pharmacy Director that the nurse manager should have notified? Should the Pharmacy Director have shared his/her findings with the nurse manager? To whom should he have shared his findings regarding the PACU nurse and drug pattern?
16	Yellow	Questions	Is drug diversion suspected upon finding this information? Are there policies addressing who the Pharmacy Director should notify when there are abnormalities associated with controlled drugs? What are the next steps?
17	Blue	Scenario	The nurse manager observes the PACU and notices that the implicated nurse retrieves medication from the drug dispensing device and then leaves the PACU.
20	Blue	Scenario	The nurse who took the medication from the drug dispensing device is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest but hands over two syringes. Both are filled but one has a broken seal.
21	Yellow	Questions	What are the next steps? Who is involved with intercepting the implicated nurse? Is testing performed on the contents of the syringe? What is the policy for mandatory drug testing of employees (randomly or upon suspicion)?
22	Blue	Scenario	The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she left her personal cell in her locker, was expecting an important call and needed to get it.
23	Blue	Scenario	Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.

## **Scenarios with Questions**

We have also included all of the 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.

While we have tried to include prompting questions related to the scenario, 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).



### Scenario #1

1. A nurse working in the Post-Anesthesia Care Unit (PACU) expresses concern to her supervisor that the morphine she has been administering for pain does not seem to be as effective as usual.

A. Does the facility have policies addressing what should be done when a nurse expresses a concern about controlled drugs he/she is administering?

B. Would an Adverse Drug Events report be made?

2. The PACU Nurse Manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director runs an activity report for the removal of morphine from the PACU drug dispensing device for the past few months. He/she notices that is a particular PACU nurse who often removes larger quantities of morphine for patients, including individuals that she is not assigned to provide care. The Pharmacy Director shares the drug pattern with the Nurse Manager.

A. Is there someone else besides the Pharmacy Director that the nursing manager should have notified? Should the Pharmacy Director have shared his findings with the nurse manager? To whom should he have shared his findings regarding the PACU nurse?

A. Is drug diversion suspected at this point?

B. Are there policies addressing who the Pharmacy Director should notify when there are abnormalities associated with controlled drugs?

C. What are the next steps?

3. The nurse manager observes the PACU and notices that the implicated nurse retrieves medication from the drug dispensing device and then leaves the PACU.

A. The nurse left the PACU, what does the nurse manager do?

a. Is there a written policy to address this type of situation: suspected diversion and employee not at work station?

B. Who does she call? Is back-up necessary/required? What is the facility policy?

- C. At what point is the PACU nurse brought in to discuss the findings from the pharmacy audit?
- D. Who is responsible for interviewing the employee?
- E. What actions might be taken at this point as part of the investigation?

4. The nurse who took the medication from the drug dispensing device is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest but hands over two syringes. Both are filled but one has a broken seal.

- A. What are the next steps?
- B. Who is involved with intercepting the implicated nurse?
- C. Is testing performed on the contents of the syringe?
- D. What is the policy for mandatory drug testing of employees (randomly or upon suspicion)?

4. The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she left her personal cell in her locker, was expecting an important call and needed to get it. Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.

- A. What actions are taken as part of the investigation?
- B. Who is involved in the investigation (internal)?
- C. Does the diversion prompt any policy changes or education efforts in your facility?

5. An investigation of various staff reveals that co-workers have seen the PACU nurse at the facility on her days off and at times when she wasn't scheduled to work and in areas of the facility where she does not normally work.

In addition, the local health department has called the Infection Preventionist (IP) about a cluster of acute hepatitis C virus (HCV) infections in individuals who were patients at the hospital. Two of the patients share a healthcare provider and have no traditional risk factors for HCV. Their healthcare provider ordered testing after they complained of symptoms. Both

patients tested positive for HCV. They were both previously in your hospital within three weeks of each other. Both patients were in the PACU.

The nurse admits to self-administering morphine and other controlled drugs throughout the hospital (e.g., replacing the syringes that were intended for patients, replacing them with saline and returning the filled syringes to the PACU). The nurse claimed she started diverting morphine about two months ago.

However, nursing attendance records dating back 12 months indicate that the nurse was working in the PACU on days when each HCV-infected patient received morphine injections. The nurse has documentation of completing the hepatitis B series and has documentation of post-vaccination serology; she does not admit to being positive for HCV or any other bloodborne pathogen.

- A. According to your facility's policy, how is the admission of addiction handled?
- B. Is this a written procedure? Who is responsible for enforcing this policy? Who is responsible for educating employees about this policy?
- C. Would your hospital require this nurse to get tested for bloodborne pathogens?
- D. Is there a written policy about testing for bloodborne pathogens when there is a suspect diversion?
- E. Besides the local health department, does the facility contact the NJDOH? Which NJDOH division(s) is/are contacted? What information is provided?
- F. Which department in the hospital is designated to work with the local/state health department during an active disease investigation?
- G. What law enforcement agency(s) are contacted?
- H. Are there any other calls made to professional boards/organization? Which ones?

The nurse tests positive for HCV. The hospital informs the local health department to alert them to this new development. The health department tells the hospital that they may need to do a patient notification of all patients who may have received medication that was administered/prepared by this employee.

The nurse has worked at your hospital for 18 months. Since both HCV+ patients were in the PACU six months ago, it is determined that a patient notification to all patients who received

care in the PACU when the nurse was working within the last year to get tested for hepatitis C and HIV.

Since the nurse was seen in various locations, not just her assigned work area, disease investigators from the local health department are unsure of the extent of patient notification. At this point, the hospital estimates that more than 1200 patients were in the PACU during the last 12 months.

- A. Does the facility have policies/procedures in place to alert patients and other staff about a possible disease transmission?
- B. Is the hospital going to pay for testing the potentially exposed patients?
  - a. Who writes/signs the patient notification letter?
  - b. Who writes the testing orders?
- C. Where will the testing be done? At the hospital or refer to private providers or independent phlebotomy/testing company (e.g., LabCorp, Quest)
- D. How is patient information retrieved to notify patients?
- E. Who is responsible for tracking positive cases?
- F. How does the hospital explain what happened to employees? To the public?
- G. How does the hospital handle taking a large volume of calls from the public and former/current patients?





## Scenario #2

1. During her rounds, the Infection Preventionist (IP) notices that the anesthesia cart was left unlocked in one of the operating suites. She notices that there is a partially used vial of fentanyl and two syringes on top of the cart, one empty and the other filled. An anesthesiologist arrives a few minutes after the IP sees the cart. He tells the IP that he had to run to the bathroom and the rest of the team left for the day. He returns the cart to the lock-up area and leaves for the day.

- A. Is there a policy for filing a report at this point?
- B. Would the IP be required to report/say anything to anyone about an unsupervised, anesthesia cart with controlled drugs?

2. The following week, an anesthesia tech sees a stocked anesthesia cart prepped for morning surgeries just inside the locked door of an operating suite. On the cart he notices pre-filled syringes for the entire day's surgeries. There is also an empty syringe among the filled syringes. The tech begins to wheel the cart to the locked up area, when one of the anesthesiologists enters the operating suite. The doc explains that he was in the bathroom and that cart should be wheeled over to operating suite #3.

- A. What is the facility's policy about leaving anesthesia materials unsupervised?
- B. What is the facility policy about pre-filling syringes for the day's surgeries?

3. While cleaning the room in between cases, the tech notices that the anesthesiologist takes one of the syringes and puts it in his scrubs pocket and walks into the bathroom. The tech waits a while and follows him into the bathroom. As the tech opens the door to the restroom, he sees the anesthesiologist at the sink filling a syringe with tap water.

The anesthesiologist tells him that it is not what it looks like and brushes past the tech to the operating suite. The tech tells a co-worker buddy of his what he saw and asks for advice. The tech is unsure whether to tell his supervisor because he doesn't want to get the doc in trouble.

- A. What is the hospital's policy for employees who suspect a drug diversion?
  - a. How is this policy communicated to all staff?

- B. What is the internal process for reporting a suspected drug diversion?
- C. What type of training is provided to employees about drug diversion and reporting suspected incidents?
- D. Is your reporting process for suspected diversion anonymous?
- E. How would you evaluate the risk to patients from the tap water?
- F. How would you identify cases of disease linked to the injection of tap water?
- G. How would your facility respond when/if the information is less certain (e.g., how does your facility assess for patient harm absent definitive evidence of tampering/substitution)?



### Scenario #3

1. During an audit of Pyxis CII Safe activity in your pharmacy the Pharmacy Director notices that a staff pharmacist has entered the CII safe numerous times in the past 2 months without documenting a valid reason for accessing the safe. The pharmacist entered \*\*\* as the reason. No medications are recorded as removed from the safe at the time of these entries. And upon counting, no medication vials are missing from any of the medication drawers.

- A. What is your next step?
- B. Is drug diversion a consideration or is it incomplete drug activity documentation?
- C. Does the facility have any written policy about what to do when there is a suspected drug diversion?
- D. Does the facility have a written policy addressing actions to take when the Pharmacy Director identifies this type of variance or is it “just something that is done”?

2. The Pharmacy Director decides to carefully examine of all the medications in the Pyxis CII Safe. Evidence of drug tampering is identified in certain opioids. He/she notices tiny holes in the center of some of the dust cover caps.

- A. Who is notified immediately after this discovery is made?
- B. Would law enforcement be notified now or later? At what point?
- C. What employees would be interviewed? By whom?
- D. Are there policies and procedures in place to guide the internal investigative process?

3. The Pharmacy Director schedules a meeting with the staff pharmacist, who admits to tampering with the medication vials for “personal use”. The staff pharmacist claims that vials were refilled with sterile saline to replace the medication amounts taken out.

- D. At what point is law enforcement contacted? Which law enforcement agencies are contacted?

- a. As per NJLPS, drug diversion is required to be reported to the Drug Control Unit (via a DDC-52 form) in addition to the DEA immediately upon discovery. Of course, law enforcement should also be advised and a police report obtained. The reporting requirements are included for practitioners and non-practitioners (i.e. wholesalers, pharmacies, distributors, etc.). Basically anyone who holds a CDS permit. Failure to do so is considered a breach of professional responsibility and may subject the licensee to disciplinary action.
- b. According to Controlled Dangerous Substances regulations N.J.A.C. 13:45H-2.4(c) and 2.5(d), the registrant shall notify the Drug Control Unit of any theft or loss of any controlled substances upon discovery. The supplier shall be responsible for reporting in-transit losses of controlled substances by the common or contract carrier selected pursuant to discovery. The registrant shall also complete a DDC-52 form regarding any theft or loss. Thefts must be reported whether or not the controlled substances are subsequently recovered and/or the responsible parties are identified and action is taken against them.

<http://www.njconsumeraffairs.gov/dcu/Pages/default.aspx>

- B. Are there any other calls made to professional boards or organizations? Which ones?
- C. What sort of internal records might you examine as part of the investigation?
- D. At this point, would your pharmacy send the tampered vials to be tested for medication concentration and contents?
- E. At what point would you look at the employee's personnel file for status of bloodborne pathogens (hepatitis B/C and HIV) or require testing for these viruses?
  - a. Is the local health department notified?
  - b. Who would contact the local health department?
- F. Would you look for any infections in patients receiving this medication since the substance used to refill the vials might not be sterile?
  - a. Is conducting a patient notification a consideration?
  - b. Who would decide whether patients should be notified?
- G. What sort of employee or patient messaging might you send out (if any)?

## **Evaluation**

We created an evaluation for participants. We wanted to know whether the exercise covered the objectives and what participants learned as a result of the exercise. We wanted participant's opinions about what they thought were the strengths and weaknesses of the exercise. We included open-ended questions for participants to provide feedback.

We distributed this evaluation at the end of the exercise and asked participants to complete the evaluation before leaving. Evaluations were collected. We used comments on the evaluations to shape responses and create this document.

We tried to make the evaluation 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.



### 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 <b>Drug Diversion Exercise</b>					
2. The exercise/discussion addressed the stated learning objectives: <ul style="list-style-type: none"> <li>• Discuss existing facility policies related to drug diversion</li> <li>• Highlight the strengths of existing drug diversion policies at the facility</li> <li>• Identify gaps in existing drug diversion policies at the facility</li> <li>• Identify ways to train/communicate with staff about the facility's drug diversion policies</li> <li>• Explore the process of responding to a drug diversion incident (internally/externally)</li> </ul>					
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 <u>at least one</u> new piece of information about issues surrounding drug diversion					

OVER

What is your position at the healthcare facility?

- Administration
- Nursing
- Pharmacy
- Risk Management/Quality Improvement
- Human Resources
- 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? \_\_\_\_\_

This Drug Diversion Exercise is a Pilot Project. Do you have any recommendations about how to make the exercise better?

\_\_\_\_\_

\_\_\_\_\_

Other comments? \_\_\_\_\_

\_\_\_\_\_

Thank you for your time and participation!