National Association of Drug Diversion Investigators

NADDI Institutional Drug Diversion Toolkit

The following checklist is a compilation of recommendations to consider during an Institutional Drug Diversion Investigation. While each case may present with a wide range of variables, the below guide has been useful to many investigators identifying various areas to review.

Commonly Diverted Controlled Substances: (Listed are suggestions of commonly diverted drugs/types)

- ☐ Opioids/Narcotics (Most commonly diverted drug class)
  - ☐ Codeine
  - ☐ Fentanyl
  - ☐ Hydrocodone
  - ☐ Hydromorphone
  - ☐ Ketamine
  - ☐ Morphine
  - ☐ Meperidine
  - ☐ Oxycodone
  - ☐ Propoxyphene
  - ☐ Tramadol
- ☐ Benzodiazepines
  - ☐ Alprazolam
  - ☐ Diazepam
  - ☐ Lorazepam
  - ☐ others
- ☐ Barbiturates
- ☐ Amphetamines

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Automated Dispensing Machine (ADM) reports to run and analyze:

☐ Nurse specific report(s) for both controlled and non-controlled substances; all transactions including removals, wastes, returns, inventory, overrides etc.

☐ Run all discrepancy/override reports available daily. Review and focus on:

- The discrepancy resolution reasons (Look for any inappropriate resolutions).
- Any specific staff member, or two, that are reconciling a larger number of discrepancies (A diverter may partner with someone, or use unsuspecting staff, to reconcile discrepancies).

☐ Review any floor stock removals (if applicable to the institution). Floor stock removals are used for emergency withdraws, prior to the patient being entered into the medical record. A procedure commonly used by Emergency Room staff.

☐ Patient specific report(s) for all medications and all transaction types for both controlled and non-controlled substances. (Sometimes another user will return or waste a medication that was removed by a different user.)

- ☐ Was there a valid order for the transaction(s).
- ☐ Was the order outside of the patient treatment protocols. (Normal Frequency, Dosage and Form of administration)
- ☐ Was the order, administration and waste properly documented.
- ☐ Was the time frame between the removal & administration, and administration & wasting appropriate.

☐ Anomalous usage report (Compare: Was the user an outlier compared to peers?).

☐ ADM machine access (Does the subject have access to multiple machines? Is the subject working and assigned to the area of the machine at the time of access?).

☐ ADM access level (What types of medications can be removed by each job class. Did the ADM user remove medications outside their job function?).

☐ Run count adjustment reports for non-controlled substances.

☐ **Non-control medications of concern** (Listed are suggestions of commonly diverted drugs/types)

- ☐ Acetaminophen/ibuprofen (fever/pain)
- ☐ Clonidine (tachycardia may be used to self-medicate withdrawal symptoms)

- ☐ Colace/Bisacodyl (laxatives and stool softeners)
- ☐ Diphenhydramine (antihistamine/opioid enhancer/also stop drug itch caused by opioids)
- ☐ Famotidine/Metoclopramide (GI medications may be used to self-medicate withdrawal symptoms)
- ☐ Gabapentin (opioid enhancer)
- ☐ Hydroxyzine (antihistamine/opioid enhancer)
- ☐ Lomotil/atropine/diphenoxylate (antidiarrheal medication may be used to self-medicate withdrawal symptoms)
- ☐ Loperamide (antidiarrheal medication may be used to self-medicate withdrawal symptoms)
- ☐ Naloxone (opioid rescue)
- ☐ Ondansetron/promethazine (anti-emetics may be used to self-medicate withdrawal symptoms)
- ☐ Propofol (anesthesia)
- ☐ Other drugs to consider based on potential profitability (*high priced cancer meds; diabetes meds, COVID related meds, and insulin. Many are diverted based on price and/or abuse as steroid substitutes).*

☐ **Removal/patterns that should raise red flags.**

- ☐ Cancelled Transactions.
- ☐ Documentation: changes/lacking/errors (no doctor's orders for patient).
- ☐ Failure to document administration or waste.
- ☐ Holding onto medications prior to administration.
- ☐ Removals right before end of shift.
- ☐ Removals after patient has been discharged or after patient has expired.
- ☐ Removals for patient not assigned to employee.
- ☐ Removal of larger dosages of injectables (creating more waste).
- ☐ Removal: Frequent removal of prn medications; outlier compared to other nurses.

- ☐ Removals when patient is undergoing testing/x-rays or treatment in other area.
- ☐ Returns (Medication dispensed but not administered. Check for substitutions.)
- ☐ Substitution: removing lower dosage forms to obtain more dosage units.
- ☐ Substitution: Be alert to common dosage units swapped - shape/size/color/markings.
  - ☐ Acetaminophen for oxycodone/acetaminophen "APAP" (Percocet)
  - ☐ Ibuprofen for hydrocodone/APAP (Norco)
- ☐ Substitution: Be alert to vial tampering. Check seals; vial integrity; packaging tampering.
- ☐ Waste: Full Vials.
- ☐ Waste: Large Amounts (routinely).
- ☐ Waste: Late (several hours between dispense and waste).

Electronic Medical Record (EMR) review tips to correlate with other reports:

- ☐ Was the electronic medication administration record (aka eMAR) appropriately documented (using bar code scanning or was the eMar documented after the medication was supposed to be administered "Action vs Recorded Time").
- ☐ Was the medication administered per the medication order? Was the patient receiving medications day of, prior and post (did other staff treat pain). Did the employee administer the medication outside the scope of their practice?
- ☐ Documented and appropriate pain scale? (pre- and post-administration).
- ☐ Review medical chart notes to determine if the patient needed the medication and if the employee documented why the patient needed the medication (e.g., radiology, physical therapy, etc.).
- ☐ Patient staff assignments (which staff member is assigned to which patient; did the employee pull medications for a patient not assigned to them?)
- ☐ Richmond Agitation and Sedation Score (RASS score). Similar, to a pain score but measures agitation and possibly why a sedative may be used.
- ☐ Vitals (blood pressure, respiration rate). Did the respiration rate go down after an opioid was administered?

☐ Patient room assignment & discharge time (was the patient in another unit when the medications were removed for them or were medications removed after patient was discharged).

☐ ED Patient Care Timeline (minute by minute patient care activity, helps understand what is happening with the patient).

☐ Discharge navigator (will document which staff member is discharging the patient)

☐ Medication Administration Record (Mar) alert history (report that identifies if medication is administered to late/early, outside pain scale, duplication, etc.).

☐ ADT (admission, discharge, and transfer) events.

☐ Clarity report (EMR backend report) to identify if subject is accessing electronic medical records they are not supposed to. Surfing for patients prescribed opioids.

☐ Anesthesia record (electronic/paper)

☐ Verbal order documentation (In most institutions an RN can place a verbal order for the physician. The physician is then supposed to go back and put the order in to validate it).

☐ How close was a medication removed or administered prior to discharge? If less than 30 minutes this may be a red flag. Providers like to monitor patients for up to 30 minutes after an opioid is administered to ensure there is no adverse reaction. If you see a removal and/or administration 5 minutes before discharge this may be a red flag.

Employee Patterns that should Raise Red Flags:

☐ Frequent or unexplained callouts or tardiness.

- Is there a pattern.
- Did the callouts just start.

☐ Disappears from work regularly.

- Stays gone for an extended period of time.
- Does not use the bathroom on the unit.
- Observed in storage rooms, empty patient rooms or solitary locations frequently.

☐ Excessive drowsiness and/or found sleeping on the job.

☐ Frequent accidents (on/off the job)

☐ Extremely helpful.

- Volunteers to work extra shifts regularly.
- Arriving early, staying later than normal shift, or showing up on day off for a visit.
- Volunteers to assist with medication administration/disposal.

☐ Appearance or Observable changes in Demeanor

- Deterioration
- Poor Hygiene
- Significant weight loss or gain
- Starts wearing long sleeves (out of the norm)
- Extremely sleepy, fidgety, or hyper conduct

☐ Decline of work product/poor judgement.

- Makes more or consistent mistakes.
- Ordinary tasks require greater effort.
- Poor documentation, inconsistencies, and unexplained errors.
- Makes repetitive excuses for the same poor performance/mistakes.
- Request's co-workers to sign off on waste that was not actually witnessed.

☐ Easily distracted/confused.

- Cognitive lapses in understanding or judgement.
- Unable to concentrate.
- Memory Loss.

☐ Mood swings.

- Highs to low.
- Low to highs.
- Outbursts of anger.
- Easily brought to tears.

☐ Personality changes.

- Difficulty getting along with coworkers.
- Start resenting authority.
- Isolation from other staff.
- Defensiveness.
- Secretive.

☐ Change in friendships/associations.

☐ Personal problems.

- Financial
- Marital (Separation/Divorce)

Security Patterns that should Raise Red Flags:

☐ Expired medications are unaccounted for in holding area.

☐ Product containers are compromised (potential adulteration).

☐ Prescription pads are missing (Potential Rx Fraud).

☐ Avoidance of or blocking of Security Camera's. Especially during the wasting process.

☐ Syringes, Needles, or drug paraphernalia is found in locker room, bathroom, or regular trash.

☐ Waste containers are compromised or molested.

Subject Matter Expert Team:

☐ Anesthesia Personnel

☐ Compliance Director/Officer

☐ Finance/Internal Audit Review

☐ Human Resource

☐ Investigator/Security

☐ Legal Department

☐ Nursing Manager and Nurse Executive

☐ Pharmacy Inpatient Director

☐ Quality and Risk Manager

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Investigation Tips:

☐ Employee human resource file (time employed, prior incidents, etc.).

☐ Facility access (Badge card used for hospital, medication room, elevator, parking garage, etc.).

☐ Time sheets (Did the suspect enter the facility when they were not working?).

☐ Peer comparison for outlier signals (Manual report created to compare users of similar practice in the same unit).

☐ Camera access (work with security and download video segments of subject possibly entering the facility after hours or entering medication rooms).

☐ Regulatory board search for past accusations and national website (state & national "nursys.com")

☐ Background check (Accurint)

☐ Social media (Facebook, Instagram, and internet)

☐ Traveling nurse must not be alerted to investigator interview ahead of time and should be interviewed within 24 hours of case identification. No suspected diverter should be alerted ahead of time unless they must be removed from their duties (patient safety), pending a full investigation.

☐ Complete & full audit of any suspected diverter (extend the purview to close personal employees/friends for possible involvement)

Interview Tips:

☐ Document interview event. (Date, time, participants, breaks, statements, etc.)

☐ Who is included in the interview process? (Investigator, Human Resources, Union Representative)

☐ Should subjects manager be in the interview? Differing Opinions/Personal Style

- *Some Interviewers have had tremendous success when including a unit director or equivalent to the interview process, as they are often helpful in pointing out inaccuracies in the information given or to provide clarity regarding unit specific practices.*
- *If it can be articulated that the relationship between supervisor and suspect compromises the integrity of the investigative process, then the supervisor should be left out of the interview. Some investigators find it easier to build a rapport with the suspect, and find it intimidating for the interviewee to have a supervisor in the room. Thus, they are less likely to speak freely and admit to improper procedures or illegal activity.*

- *But if the manager is not included in the interview, they should be immediately close or available to answer any questions that might arise. Also meeting with the manager ahead of time can usually get many questions answered prior to the interview. Giving basic knowledge of the unit's workflow, internal processes, policies, and procedures.*

☐ If a subject admits diversion, or if the investigator believes the accusations are substantiated, the subject's badge and facility property should be surrendered. Search of the employee and the employee locker should be considered (following policy and procedures).

Post Interview Actions/Notifications:

☐ Written resignation or termination letter.

☐ Complete all time sheets.

☐ Obtain correct address for forwarding last check/W2 forms & correspondence.

☐ Process vacation time.

☐ Obtain/reset voicemail password and outgoing message.

☐ Obtain keys, access badge(s), computer, pager, cell phone, uniforms, other property or equipment.

☐ Obtain/reset computer login.

☐ Conduct exit interview & instruct on:

- Trespass warning.
- Employee Assistance Program (EAP).
- State Intervention Program (self-reporting).
- Insurance (COBRA).
- 401K Options (if necessary).

☐ Remove employee from all distribution lists, mailing lists, and directories.

☐ Alert Security personnel and immediately inactivate subjects password/key/card access to ADM, EMR, and secure areas (badge access) of the facility.

☐ Alert unit staff to employee suspension/termination/removal and to be aware of who is scheduled and should be in unit. (A restricted or removed employee that has been caught diverting may come in after hours dressed in scrubs attempting to get medications. Subjects have been known to claim they forgot their badge (to access medication room), so they inquire if somebody can open for them, or will attempt to piggyback when somebody enters the medication room.)

☐ Notify appropriate agencies:

- ☐ Law enforcement
- ☐ Drug Enforcement Administration (DEA)
- ☐ Regulatory Board notification of loss, diversion, administrative violations of employee (pharmacy, nursing, and medical)
- ☐ Food and Drug Administration (cases where tampering occurs)
- ☐ Centers for Disease Control and Prevention (cases where infection outbreak may have occurred)

Notes: