# Effective Diversion Program in Ten Steps

*Prevent and properly respond to diversion*

By Kim New, JD, BSN, RN


I was recently asked to present a series of tips for drug diversion prevention, detection and response, and to limit the list to the top ten. This was not an easy task, and every diversion investigator's top ten list would probably be slightly different. The following are my top ten list of important steps toward developing a robust drug diversion program. The details of how to implement each tip will vary from institution to institution and this list is only a broad outline.

## 1 Develop a formal program

Ideally this will include an oversight committee, a response team and a diversion program manager (the diversion specialist).[1] Having a structured program will help streamline processes and eliminate duplication of tasks, and will assist in your efforts to have a consistent approach to diversion. Maintaining a diversion program is hard work and requires a sustained effort. Without a formal program, many initiatives lose momentum and fail.

## 2 Education for all staff

Healthcare personnel are focused on patient care and outcomes—the concept that a peer might steal medication and perhaps even harm a patient is the farthest thing from their minds. At a minimum, education should focus on the scope of the problem (convey the fact that, yes, this really happens!), the potential impact on patients and colleagues, common behaviors and signs of diversion, how to report concerns, and where to go if they need help. Clinical staff that have access to controlled substances benefit from education about institutional expectations, professional implications of controlled substance handling, and how to protect themselves professionally.

## 3 Implement robust policies and procedures

Institutional policies are often vague, sometimes outdated, and staff may be unaware of them. When a staff member is involved in risky activities, such as delaying waste or carrying controlled substances in pockets, and formal discipline is necessary, leaders may be hard pressed to cite a policy that addresses the behavior in question.

## 4 Maximize automation and analytics across the institution

Monitoring or surveilling controlled substance transactions is extremely time consuming, if not impossible, when manual systems are in place. Automated dispensing technology usually improves drug security, and vastly increases accountability.

Resources are always limited, so it's essential to use automation and transaction analytics to reduce the time required to do meaningful auditing. Facilities with manual

[1] For a detailed discussion of diversion program components, see New, K. (2013) Drug Diversion: How Robust is Your Prevention and Detection Program? *New Perspectives on Healthcare Risk Management, Control and Governance. (36)*1, 10–15.

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drug dispensing processes and those without analytics programs often abandon auditing altogether.

## 5 Use surveillance data or audit findings to improve compliance

Having been responsible for ongoing surveillance of drug transactions for many years, I always find that when a surveillance program starts, a great deal of noncompliance in medication handling is identified.

Noncompliance creates noise in surveillance and analytics data, and may mask diversion, so it is essential to use the findings to improve how the staff manages controlled substances. In fact, when I am onsite at a facility and staff report that their controlled substance handling practices are perfect, I always go to transaction records to determine if this is true.

Transaction data can identify pulling medications early in anticipation of need (administration happens much later), pulling too much medication (lots of returning or wasting of complete doses), delaying waste, PCA key workarounds (pulling the keys at the beginning of the shift and no additional transactions until they are returned at the end of the shift), and even carrying medications in pockets (often identified when the first transaction of the day is to waste or return a medication that was not removed on that shift).

## 6 Include nontraditional surveillance parameters

When diversion is suspected but unproven, there are multiple sources of data that can flesh out what is really happening. Badge reader reports, bedside medication scanning data, charge capture, incident reports, patient complaints, and even transactions for secondary drugs (such as ondansetron, acetaminophen, diphenhydramine, promethazine and others) can bolster an investigation.

## 7 Perform ongoing risk assessments

Diversion risk rounds have been discussed in prior columns so there is no need to go into detail about what they involve here.[2] However, the value of these rounds cannot be stressed enough. There are many opportunities for diversion that can never be identified through transaction surveillance alone. To have a truly comprehensive program, it is essential to include areas where controlled substances are purchased, stored, prepared, administered, wasted and destroyed.

When conducting risk rounds at facilities, the discoveries can be staggering. At one facility the Director of Pharmacy and I discovered that the lids to the internal return bins on the drug cabinets had not been locked.

At another facility the storage cabinets for anesthesia used were broken and there was no way to secure the drugs temporarily (one provider had actually barricaded his cabinet with a piece of medical equipment). Rounding on a regular basis, including in outpatient settings and free-standing clinics and care settings, can provide immense value to the diversion prevention efforts of the facility.

## 8 Define internal and external reporting requirements

Checklists are the best tool to ensure important steps are not forgotten. Diversion is an emotionally charged issue and very few cases are the same. Without a defined reporting process, there is a significant risk that someone or some entity will be left out. Cases of patient harm require special considerations, and time is of the essence. Every institution should have a reporting plan so that response processes can be smooth and comprehensive.

## 9 Collaborate with external stakeholders

Many facilities are reluctant to report diversion externally. There are risks to external reporting. Unfortunately, a pattern of not reporting diversion externally poses severe risk to the institution. Fear of negative publicity, litigation and regulatory intervention are among the reasons facilities do not report diversion cases. However, most—if not all—external regulatory entities have the same goals as

[2] New, K. (2015). Diversion Risk Rounds: A Reality Check on Your Drug Handling Policies. *Digital Insights on Healthcare Risk Management, Control and Governance*. *2*(1).

the facility, namely to prevent and properly respond to diversion.

Reach out to external authorities, such as the DEA, law enforcement, professional boards and the department of health, at a time when there is not an active investigation. Doing so can result in a mutually beneficial working relationship and increased trust.

## 10 Include physicians and midlevel providers

Physicians and midlevel providers are at risk, just as employed nonphysician staffs are. This group has prescribing authority and may have access to controlled substances.

Physicians and midlevel providers should be educated about prescribing practices and how to protect themselves against being unwitting participants in a staff or patient diversion scheme. This group of providers needs education on how to handle special challenges, such as office settings. It is also important to have a parallel process for impairment/diversion in this group of providers.

## Conclusion

A robust diversion program is something that every institution needs, and is a multifaceted effort that cannot be built in a moment, or by one person. The tips above are steps that should be considered in the design of any diversion program, and should be applied in ways that fit the resources and situation of the institution. **NP**

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