Drug Diversion:
The 2018 Crisis Update & Our Future

September 20, 2018
Webinar Month 118

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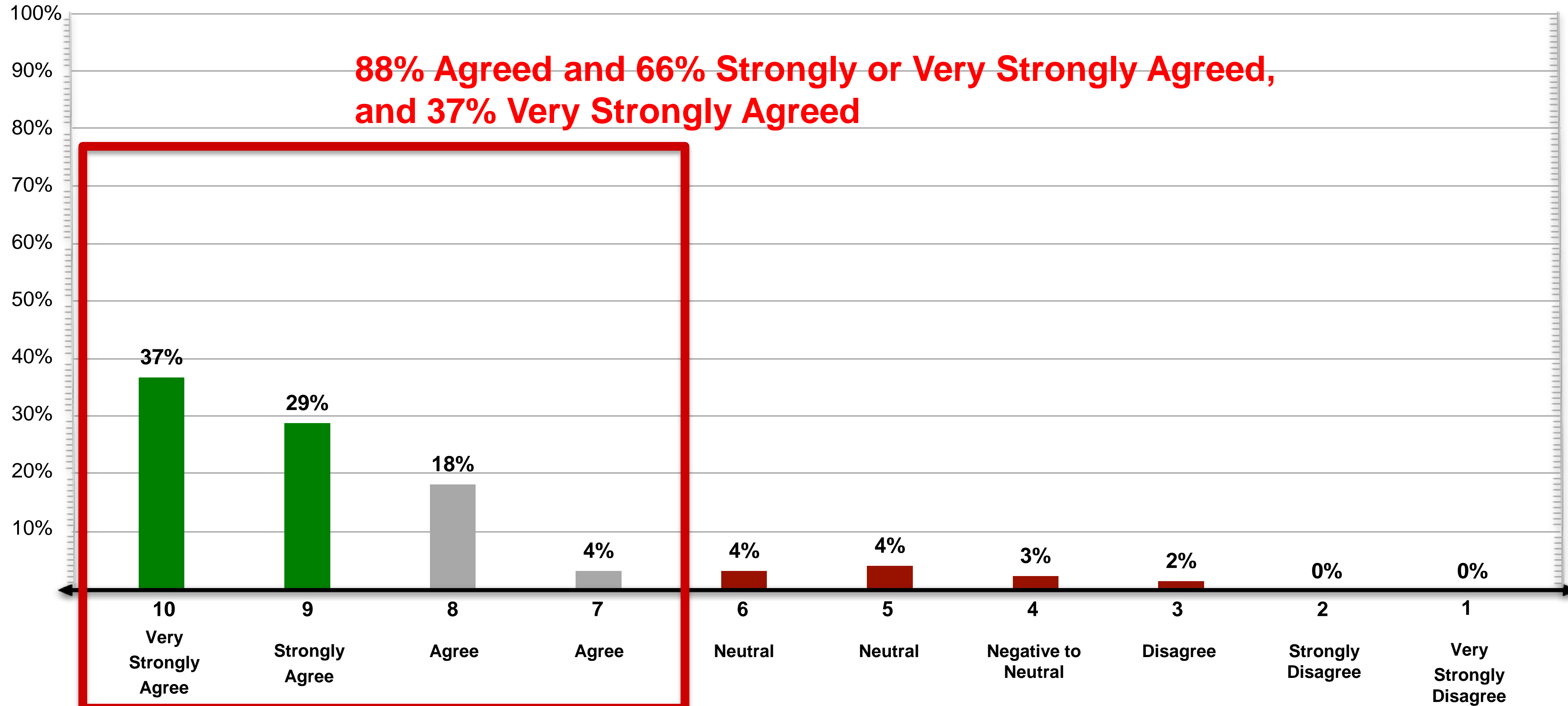
Anonymous Survey Questions

I am interested in ADDITIONAL INFORMATION on:
Drug Diversion Including Speakers from Hospital Programs



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Specific Drug Diversion Issues I would like covered include:

- Anesthesia provider monitoring
- Any and all of it
- Auditing of records
- Best practice in data reporting to oversight committee
- Best practices in using tools like RX auditor, auditing tools for non-pain associated controlled substances (like stimulants)
- Better methods to educate staff for awareness
- Characteristics to look for with drug diversion
- Commonly missed diversion tactics
- Conducting the interview- see NJ drug diversion meeting from June sponsored by NJDOH
- Conflict of interest
- Data on how often this actually happens by state, etc.
- Detecting diversion
- Diversion in the pharmacy department
- Diversion program details who, what when how.
- Drug screen panels
- Effective auditing resources, processes
- Falsifying patient administration to divert.
- Gold standard for a drug diversion hospital program
- Handling improper drug wasting
- Helping staff feel empowered to report suspicions
- How do we catch the culprits using the EHR
- How FFS Medicare folks are applicable to this topic
- How to convince administration to invest in diversion program
- How to identify a drug diverter
- How to influence anesthesia into this process? What should be the practice for Propofol?
- How to start a program from scratch
- I would like to hear testimonial from a healthcare worker who has successfully completed a BRN diversion program
- Identifying bad practice vs diversion
- IV medication safety storage for narcotics on inpatient units - how do you mitigate risk for diversion.

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- Is there a federal or interstate communication available for offenders. Of drug diversions? We have seen the professional boards who give slow reaction to providing discipline on licenses and in the meantime, the diverter is jumping state lines.
- Law review
- Monitoring practices
- MRO negative due to RX for same drug they diverted
- My situation is that I cover all system entities that are not acute care, LTC, homecare/ hospice, physician practices and a social service agency which can all easily have this as an issue.
- New methods of diversion discovered. What to look for to catch them.
- Nurse manager daily and weekly responsibility and the amount of time that it takes
- Opioids
- Opioids
- OR setting - anesthesia (fentanyl)
- Out patient environment
- Patient sources of diversion
- Possible techniques used by staff to divert medications.
- Programs for nursing homes
- Proper response to detection
- Setting up a planned program
- Should policy state extract time to waste.
- Staff signing for discarding without actually seeing disposal.
- State health department role
- Streamlining auditing processes, artificial intelligence software
- The way of diversion that others have encountered
- Types of audits used in long term care
- Ways diversion happens; stories
- Ways to audit anesthesia providers
- What are indicators of drug diversions
- What is the best process for auditing controls in automated dispensing machines?
- What prompts an investigation? Does the hospital have to initiate an investigation?

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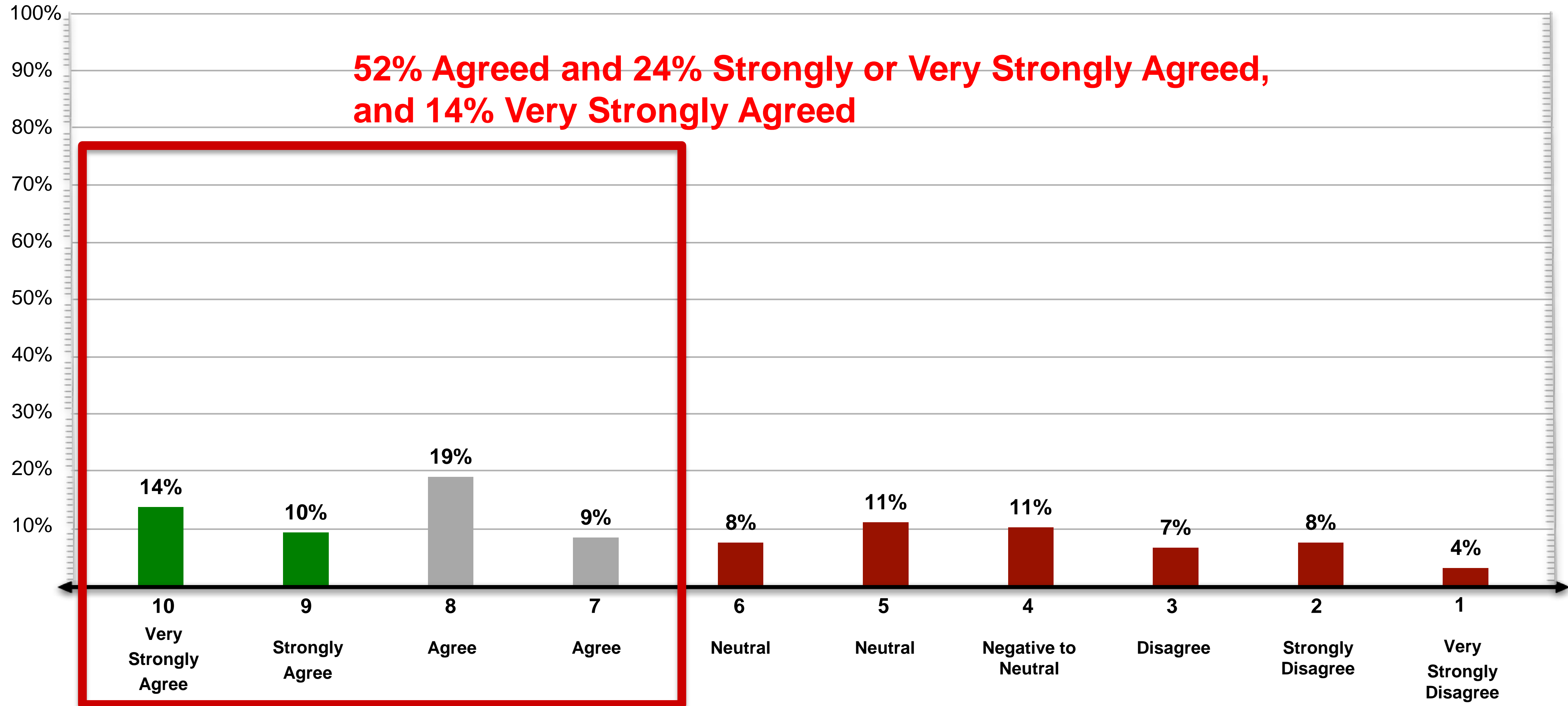
Anonymous Survey Questions

I am interested in ADDITIONAL INFORMATION on:
CONFLICT OF INTEREST ISSUES RELATED TO SAFETY



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Specific Conflict of Interest Issues I would like covered include:

- Any related to diversion
- Anything
- Bullying
- Chief compliance officer and other VPs
- Conflicts with entrepreneurial type ventures within a physicians office
- Disclaimers should be automatic
- Industry sponsored education
- Outpatient surgical centers
- Pharmacy and investigation
- Primer on conflict of interest for risk manage
- Receiving food etc., from schools of nursing at a hospital?
- Research
- Self insured facilities
- Staff report of safety issue and need for action to be taken
- Strong declaration
- Unknown
- What constitutes a conflict of interest?
- Workplace violence and prepping colleagues for a simulation event to minimize real fear

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Specific Topics regarding ELECTRONIC RECORD and PATIENT SAFETY I would like covered include:

- A roadmap to conducting a drug audit
- Anything
- Care received by patient's from nurses potentially diverting
- Chance of identity theft
- Closing gaps in the timeline of patient care
- Communicating shift to shift hand off
- Communication of work place violence concerns and patient handling issues.
- Copy & paste
- Copy and paste functionality
- Diversion, security, violence in healthcare
- Drop down menus and errors
- Ed violence
- Fall prevention
- Governance of EHR - it's role in clinical decisions
- Highest risk areas
- How do we put tracking systems in our EHRS to find safety problems. What are the most common missed diagnosis issues.
- How to make the record as accurate as possible instead of just automatically answering the questions in the same way.
- Leveraging the medical record to enhance patient safety
- Medication reconciliation how it is best done using an electronic health record
- Patients accessing their records
- Preventing overlays
- Software integration
- Types of errors seen with EHR
- Unapproved abbreviations typed into free text fields and if this has resulted in any patient harms/errors. Our physicians want to do away with ISMP abbreviation recommendations and only use TJC as they do not believe this is an error prone area.
- Vendors do not correct their systems and so many chances for ade/drug interactions, duplications and how these electronic record vendors do not correct these findings. Health literacy of these dc summaries and medication summaries of these systems.
- What is available
- When implementing a new EMR, key items to monitor.
- Why can't they function from clinical needs instead of the ehr dictating clinical practice
- With large system-wide EMR systems, what is a healthcare provider/staff going to be held accountable for reviewing in order to care for a patient? In other words, how far back in a patients medical record history is a provider going to need to review or be accountable for reviewing when you might now have years worth of data you can access.

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