Opiates in the Workplace
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Jill Bode Medication Safety Coordinator/Pharmacist MGMC.
• No financial relationships to disclose relevant to presentation
Objectives

- General awareness of data showing the national impact of abuse of medications
- Basic physiology of opiate receptor sensitivity
- MGMC staff accountability for recognizing potential controlled drug diversion including tools used for monitoring
• More people die from drug overdoses each year than automobile accidents

• 2014: 47,000 people died from drug overdoses....more than the number of people who died from AIDS in the peak if the AIDS epidemic in 1995

• Most heroin users first exposure to opiates was with prescription drugs

• Number of people trying heroin for the first time
  • 2006: 90,000
  • 2012: 156,000
Statistics

• From 2000 to 2015 more than half a million people died from drug overdoses
  • Deaths from prescription opioids have more than quadrupled since 1999
• 1991: 76 million prescriptions for opioids
  • 2011: 219 million
91 Americans die every day from an opioid overdose (that includes prescription opioids and heroin).
Some states have more opioid prescriptions per person than others.

Source: IMS, National Prescription Audit (NPA™), 2012.
Sources of Prescription Opioids Among Past-Year Non-Medical Users

- Given by a friend or relative for free
- Prescribed by ≥1 physicians
- Stolen from a friend or relative
- Bought from a friend or relative
- Bought from a drug dealer or other stranger
- Other

Number of Days of Past-Year Non-Medical Use

- Any
- 1-29
- 30-99
- 100-199
- 200-365

Percent of Users

 Obtain from the US National Survey on Drug Use and Health, 2008 through 2011. Estimate is statistically significantly different from that for highest-frequency users (200-365 days) (P<.05). Includes written fake prescriptions and those opioids stolen from a physician’s office, clinic, hospital, or pharmacy; purchases on the internet; and obtained some other way.

How do people get the opiates to abuse?

The 2009 National Survey on Drug Use and Health revealed that when painkillers are used for nonmedical reasons, they are usually obtained from a friend or family member.

- 0.4% Internet vendor
- 5% Drug dealer or stranger
- 18% Prescribing doctor
- 70% Family and friends

Obtained through one of the following:
- 5% Stolen
- 10% Purchased
- 55% Obtained for free

Source: Substance Abuse and Mental Health Services Administration
Medication Diversion

• Educate
  • Understand the epidemic
  • Understand the ease that people become addicted
  • Understand the role of MGMC to educate and protect employees from the situation
  • Understand the role of all MGMC employees to understand the issue and to be involved in being aware of behaviors suggesting potential problems with co-workers
  • Understand the issue isn’t always addiction but also the ability to divert and sell drugs illegally for profit.
Medication Diversion

• Healthcare workers:
  • High stress
  • Long Hours
  • Tough scheduling affecting family life
  • Little time to decompress after stressful situations
  • Access
Opiate Abuse By Healthcare Workers

• *National Institute on Drug Abuse* estimates that 10% of US adults abuse drugs during their lifetime

• American Nurses Association (ANA)
  - Estimates 10% nurses are dependent on some type of drug
    - Typically more dependent on prescription drugs more than the general public
      • Amphetamines, opiates, sedatives, tranquilizers, and inhalants
  - 2009 “Drug Addiction among nurses: Confronting a Quiet Epidemic” Modern Medicine
Medication Diversion

• Typical diversion starts with these techniques:
  • Taking waste for personal use
  • Stealing Controlled substances from patients
  • Tampering with the patients controlled substance medications
    • Replacing the medication w saline etc.
  • Remove excessive amounts of controlled substances from automated dispensing machines
    • Using prn medications
Which Professions are at the greatest risk

- **Access** is the greatest indicator of risk
  - Anesthesia providers
  - Operating Room staff
  - Emergency room employees
  - Pharmacy employees
  - Office settings
    - Physicians and dentists and their staff
    - Typically less stringent storage and accountability practices
Opiates

• Seven slides of opiate history – Some irony in these.
Opiates

• Excluding distilled spirits, the first addictive ingredient isolated from a natural product was morphine, which was extracted from crude opium by F.W.A. Sertturner, a German pharmacist, in 1806. Increasingly widespread use of morphine, which constitutes roughly 10 percent of crude opium, revolutionized pain control.

Pathways of Addiction; Musto
Opiates

• One of the first careful studies of morphine addiction was made in 1875 by Levinstein, who identified key elements in opiate addiction that would interest researchers:

• Around the turn of the century, several new medical research issues attracted investigators: communicable diseases, bacteria, and viruses; the immune system, with its antibodies and antigens; autointoxication, or the body poisoning itself; the endocrine glands and their production of hormones; and the rapidly developing fields of biochemistry and pharmacology. A number of researchers in the United States and abroad attempted to apply those contemporary approaches to the study of illicit drug abuse, addiction (specifically, opiate addiction), and its treatment.
Opiates

• Late 1800’s Bayer introduces Heroin to the market to treat pain
  • Quickly pulled from market due to addiction issues
Morphine vs Codeine vs Heroin

**Morphine** - replacing the -OH group shown in red with -OCH₃ produces **codeine**. Replacing the both the red and blue -OH groups with OOCOCH₃ produces heroin.

**Codeine** - the methoxy addition is shown in red.

**Heroin** - the -OOCOCH₃ groups that replaced the -OH groups in morphine are shown in red.
Opiates

• Application of the concept of "autointoxication" to research on narcotic dependence emerged from the theories of Elie Metchnikoff, who won a **Nobel Prize in medicine in 1908 for his work on toxins** thought to be the product of fermentation in the large intestine (Metchnikoff, 1901). Other theories applied to drug addiction in the early 1900s included the blockage of endocrine gland passages (Sollier, 1898), changes in cell protoplasm (Cloetta, 1903), **degenerative changes in brain cells** (Wilcox, 1923), or **changes in cell permeability** (Fauser and Ottenstein, 1924). One other approach, exemplified by the New York physician Dr. Ernest S. Bishop, led to the claim that as long as the **toxin or antibodies were balanced by a dose of morphine**, the person would feel and function normally—a theory similar to that proposed for methadone treatment today (Bishop, 1920).
Opiates

• Around the **time of World War I**, extensive drug use in the United States—a combination of morphine, heroin, opium, and cocaine—created a growing fear of drug abuse. The association of opium with Chinese immigrants, cocaine with African Americans, and morphine addiction with **careless physicians** prompted more and more restrictive **legislation** and an antagonism to easy access to those drugs. A six-year federal effort to control the distribution of opiates and cocaine led to the **Harrison Anti-Narcotics Act of 1914**.
Opiates

• Regulations associated with the Harrison Act and promulgated by the U.S. Treasury Department in 1915 indicated that the maintenance of nonmedical addicts on narcotics to avoid withdrawal would not be considered legitimate medical practice. The federal government then began to use the act to prosecute doctors who issued prescriptions for that purpose.

• In 1919, the Supreme Court ratified the federal government's interpretation of the laws. The position against maintenance was controversial, however, not only because it seemed to represent an intrusion into medical practice, but also because the Gioffredi and Valenti hypotheses—that opiate use causes permanent physiological changes through creation of antibodies or a toxin—seemed to give support to those who considered addiction a medical disease.
Opiates

• 100 years later......
5th Vital Sign

• Joint Commission
  • Early 2000’s begins a campaign to treat patients pain
  • PAIN is the 5th vital sign
Opiates

• Since 1999, sales of prescription opioids in the US have quadrupled.
Opiates

• High profiled cases of celebrity deaths
  • Whitney Houston
  • Anna Nicole Smith
  • Prince
  • Michael Jackson and Joan Rivers
    • Propofol mis mgmt by providers
      • Still perceive as same issue by public.
Opiates

• Today...2017

• Physicians under pressure: CDC Guideline for prescribing opiates for Chronic pain 2016

• Increased regulatory pressure on prescribers related to prescribing habits of opiates.

• Physicians losing license to practice and charged with malpractice related to opiate prescribing and pain treatment
Opiates

- Headlines in the Des Moines Register Thursday, January 26, 2017 page 8A:
  
  “Narcotics Abuse Issue Needs Legislators’ Focus, Democrats Say.”
Opiates

- Georgia Senate Committee Passes Measure Making it A Crime For Physicians To Deliberately Ignore Information That A Patient Is Getting Too Many Opioid Prescriptions.
- The *Atlanta Journal-Constitution* (2/10, Hart) reported a Georgia Senate committee passed a bill by the “narrowest of votes” that would make it a crime for physicians “to deliberately ignore information on whether his patient was getting too many opiate prescriptions.” The measure will now be considered by the full Georgia Senate, before proceeding to the House if approved. Some physicians have criticized the bill saying that such cases “should be handled first by the medical board, not police.”
Opiates

• The DEA has been under growing political pressure to reduce the supply of opioids. A group of U.S. Senators sent a letter to the agency this summer demanding that opioid quotas be reduced.
It’s going to get even harder for chronic pain patients in the United States to get prescriptions refilled for hydrocodone, oxycodone, morphine and other opioids classified as Schedule II controlled substances.

The Drug Enforcement Administration has announced plans to reduce the amount of almost every Schedule II opioid pain medication manufactured in the U.S. by 25 percent or more. The 2017 quota for hydrocodone, which is sold under brand names like Vicodin, Lortab and Lorcet, is being reduced by a third.
Opiates - 2017

• The DEA’s order, which is being published in the Federal Register, comes just seven months after the Centers for Disease Control and Prevention released guidelines that discourage primary care physicians from prescribing opioids from chronic pain. The guidelines have had a chilling effect on many patients and their doctors, who have reduced opioid doses or stopped prescribing them altogether.
Opiates - 2017

• “The purpose of quotas are to provide for the adequate and uninterrupted supply for legitimate medical need of the types of schedule I and II controlled substances that have a potential for abuse, while limiting the amounts available to prevent diversion,” the DEA said in a press release.
Opiates

• “Once the aggregate quota is set, DEA allocates individual manufacturing and procurement quotas to those companies that apply for it. **DEA may revise a company’s quota at any time during the year if change is warranted** due to increased sales or exports; new manufacturers entering the market; new product development; or product recalls.”
Opiates

- Most drug overdoses are actually caused by illegal opioids such as heroin and bootleg fentanyl.
- Pain patients unable to get opioids legally are turning to pain medication sold on the streets.
- Efforts to restrict the supply of opioids may only be making things worse.
  - Illegal supply becomes the only supply.
Opiates

• Deaths
  • Street supply of heroin and fentanyl come with risks of purity and consistency of strengths
Opiates

• What actually causes death with Opiates?
  • Respiratory depression

• Too much risk taking to get the pleasure and the fine line of too much respiratory depression – therapeutic index of risk vs benefit is small and underappreciated by abusers
Pleasure

Surprise! Humans enjoy pleasure.
Endorphins

- **Endorphins** ("endogenous morphine") are **endogenous opioid neuropeptides**. They are produced by the **central nervous system** and the **pituitary gland**.

- It consists of two parts: **endo**- and **orphin**; these are short forms of the words **endogenous** and **morphine**, intended to mean "a morphine-like substance originating from within the body".
  - The principal function of endorphins is to inhibit the transmission of **pain** signals; they may also produce a feeling of **euphoria** very similar to that produced by other **opioids**.
Endorphin Receptor filled by Opiates

Like an evil twin, the morphine molecule locks onto the endorphin-receptor sites on nerve endings in the brain and begins the succession of events that leads to euphoria or analgesia.
Endorphins vs Opiates: Hyper stimulation of receptors.

• When **endorphins** lock into the opioid receptors, they are **almost immediately broken down by enzymes**, allowing them to be recycled and reused down the road.

• However, when similarly shaped but **chemically different opiates** lock into these same receptors, they are **resistant to the enzymes and continue reactivating the receptors over and over**, extending the "high" and increasing euphoric feelings, as well as the likelihood of dependence.
Opiate potency

- Morphine the standard potency for comparison
- Heroin – 2-3 times potency of morphine
- Fentanyl – 80 times potency of morphine
- Dilaudid - 4 times potency of morphine
- Codeine – 1/20\(^{th}\) potency of morphine
- Hydrocodone – ½ the potency of morphine
- Naloxone – higher affinity for the receptor than opiates and has NO euphoric OR pain relieving effects
- Carfentinil – 10,000 times more potent than morphine
  - Veterinary; horses, elephants
Naloxone

• Iowa legislature passed law effective July 1, 2016
  • Firefighters, paramedics and police officers are now allowed to administer Narcan to someone suffering from a heroin overdose.
  • Narcan is an opiate antagonist. Binds to the receptor but do not activate the receptors. Has a higher affinity for the receptor than other opiates.
Opiate Dependency

• Tolerance vs Dependence vs Addiction

  • **Tolerance**
    • When the dose required to produce effect requires an increase
    • Many Oncology patients use extremely high doses of opiates due to tolerance
  
  • **Physical Dependence**
    • When negative consequences (withdrawal symptoms) occur physiologically if a substance is stopped.

  • **Addiction**
    • The *psychological and behavioral response* that develops when a person cannot cope without the substance causing the addiction.

Common to see tolerance and physical dependence together

*Main difference is the psychological state*
Consequences

• DEA is a legal body
  • Formed in 1970”s under President Nixon
    • Jails are filled with drug related crime prisoners.
  • Using controlled substances in an illegal way is a crime.
  • People ruin their lives with bad decisions around controlled substances.
  • This is a flame people shouldn’t play with
  • It takes the village to protect each other
  • Reputations are on the line
    • Not just individual but also institutional
Opiates – Mary Greeley Role - Employees

• **Access**
  • Healthcare workers have ACCESS
  • We need to all be aware of the impact of access....
  • Combining access with normal human desire for pleasure and the curious nature of humans brings about temptations. These temptations put us all in a heightened state of risk.
  • Humans make mistakes humans are simply that...**human**.
  • Access and temptation can’t be ignored.
Mary Greeley’s Role – institutionally and as a population

• Educate
• Use systems that help prevent employees from taking risks
• Help each other out
  • Have tough conversations with each other
  • Use the systems that are in place to help each other
  • Continue to evaluate processes that help prevent temptation and increase accountability.
Techniques

• A variety of techniques exist and are used by different healthcare professionals to help reduce issues with diversion
Diversion and techniques to monitor diversion possibilities – MGMC

• Tracking movement of controlled substances throughout the house
  • Omnicells track movement from receipt into the facility to dispenses for patients
    • Most risk points exist AFTER controlled meds are dispensed from Omnicells to the pt.
      • Provider trusted to document and waste appropriately
        • Second witnesses required for waste.
          • Industry wide - many second witnesses are poorly attempted and offer many opportunities for diversion.
    • Exception is anesthesia – manual tracking process of individually signed out fanny packs and record keeping double checked by pharmacy upon return of the fanny pack

• Omnicell in the pharmacy dept.
  • Two pharmacy dept personnel participate in hand offs of the controlled substances.
Diversion and techniques to monitor diversion possibilities

• Techniques used at MGMC to monitor diversion
  • **Daily** controlled substance discrepancy follow up and resolution.
    • Nurse mgr reports of activity, Null transaction report review, Discrepancy report review, Override report review
  • **Monthly** review of user pairs in Omnicells with controlled substance transactions
  • **Monthly** review of controlled substance access by users in Omnicells
  • **Starting soon:** Pandora
    • Omnicell purchase of a vendor who tracks Omnicell usage by users and uses data to signal high risk activity. Basis is measuring activity of individual users vs others use and vs standard deviations.
ED

• Lots of drug seekers come to EDs.
  • Monthly meeting of ED providers, ED physician, Pharmacy Director, Behavioral Health Director, Case Managers to discuss patients who come to ED frequently drug seeking to discuss possible solutions.
  • Some of these patients have plans set up to address some needs and commonly have the pt made aware they are of concern.
  • What community resources are available?
Contracts

• Some physicians have patients sign contracts of compliance.
  • No other providers
  • No early refills
  • Checking PMP etc.
  • Full compliance and participation in the plan of use of opiates
  • Feeling need to document this activity to protect themselves vs scrutiny of regulators
Increased Regulatory Oversight

• Joint Commission, CDC
  • Introducing plans for participation to include educational plans for discharging patients on opiates.
    • Education
    • Monitoring data on naloxone use and ADR’s associated with opiates
    • Developing safe metrics to monitor opiate use – asking for institutions to develop standard practices for monitoring and educating patients on opiate use and risk, assessing patients clinically and developing more patient discharge education if patients are going home on opiate therapy.
      • Consistent use of pain scores, availability of O2 sat monitoring, CO2 monitoring, standard practice for monitoring respirations while patients are in house and on opiate therapy.
    • Using pain management data to implement process improvements.
Increased Regulatory Oversight

• Secure and Responsible Drug Disposal Act of 2010
  • DEA authority over drug disposal regulations
  • CS rendered non-retrievable
• Hydrocodone Schedule II (2014)
• Tramadol Schedule IV (2014)
• CDC Guideline on Prescribing Opioids for Chronic Pain (2016)
Iowa Board of Pharmacy – PMP (Prescription Monitoring Program)

• **PMP Information for Practitioners**

  Authorized health care practitioners (prescribers and pharmacists) are able to access PMP information regarding their patients' use of controlled substances to assist them in determining appropriate treatment options and to improve the quality of patient care. The [Practitioner's Use Policy](https://pmp.iowa.gov/IAPMPWebCenter/) defines the terms and requirements for using the PMP. The PMP website's address is [https://pmp.iowa.gov/IAPMPWebCenter/](https://pmp.iowa.gov/IAPMPWebCenter/).

• The PMP is a health care tool for practitioners to assist in identifying potential diversion, misuse, or abuse of controlled substances by their patients while facilitating the most appropriate and effective medical use of those substances.
• Pharmacy Reporting
  • All Iowa licensed pharmacies, whether the pharmacy is located within or outside the state of Iowa, are required to report to the Iowa PMP. Reports are to be submitted weekly.
PMP Data 2015

CII-CIV CONTROLLED SUBSTANCES DOSES DISPENSED
JANUARY - DECEMBER 2015

- Oxycodeone 8%
- Methylphenidates 5%
- Tramadol 15%
- Hydrocodone 20%
- Vyvanse 2%
- Zolpidem 4%
- Diazepam 2%
- Clonazepam 6%
- Lorazepam 6%
- All Other Substances 23%
- Alprazolam 9%
PMP Data – Oct 6, 2014 hydrocodone becomes C-II

*beginning 2013, includes nonresident pharmacies; required to report effective 1/1/2013

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<td>297,424</td>
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<td>332,908</td>
<td>425,604</td>
<td>769,937</td>
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<td>217</td>
<td>249</td>
<td>186</td>
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<td>3</td>
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<td>1</td>
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<td>1</td>
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<td>825,693</td>
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<td>1</td>
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<td>8</td>
<td>2</td>
<td>-</td>
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<td>-</td>
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<td># Individual patients filling CII, III, IV Rx</td>
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<td>1,447,418</td>
<td>1,142,768</td>
<td>1,498,700</td>
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<td>1,769</td>
<td>1,576</td>
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<td>72</td>
<td>49</td>
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<td>3</td>
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<td>9</td>
<td>2</td>
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<td>Total # Rx dispensed for period:</td>
<td>4,442,017</td>
<td>4,531,643</td>
<td>4,668,502</td>
<td>4,679,271</td>
<td>4,800,912</td>
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<td>242,691,025</td>
<td>253,631,999</td>
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<td>260,092,453</td>
<td>269,466,402</td>
<td>303,030,950</td>
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PMP Data

• 2010 – 2015
  • # pts filling C-II increased – hydrocodone changed to C-II 2014
  • # patients filling C-II and C-III: increased 17%
  • # patients filling C-II, C-III and C-IV: increased 28%
  • # of doses of controlled substances prescribed: increased 25%

• # patients with multiple pharmacies and/or prescribers decreased exponentially. PMP access
ASHP – CSDPP (Controlled Substance Diversion Prevention Program)

• ASHP (American Society of Health Systems Pharmacists) Guidelines on Preventing Diversion of Controlled Substances 2

• Purpose

• Controlled substances (CS) diversion in health systems can lead to serious patient safety issues, harm to the diverter, and significant liability risk to the organization.
ASHP-CSDPP (Controlled Substance Diversion Prevention Program)

- Key elements of the organization oversight and accountability
  
  - The organization establishes an interdisciplinary CS management program with systems *that discourage diversion and enhance accountability.*
  - HCWs authorized to access or handle CS are trained and competent
  - The organization establishes an interdisciplinary CSDPP committee to **provide** leadership and direction for developing policies and procedures and for overseeing the CSDPP.
  - **Suggested committee membership** includes staff from the following departments: Medicine, Anesthesia, Pharmacy, Nursing, Security, Human Resources, Compliance, Risk Management, Administration, Legal, Media/Communications, Information Technology, and Employee Health. Pharmacy should have a leadership role on the CSDPP committee.
Drug Diversion Implications

• Patient safety – Public safety issue
• Employee health issue
• Clinical quality and readmissions issue
• Legal and compliance issue
U.S. Outbreaks Associated with Drug Diversion by Healthcare Providers, 1983-2013

Drug thefts at U-M hospital: A nurse's death, a doctor's overdose and 16,000 missing pills

Department of Justice
U.S. Attorney's Office
District of Massachusetts

Monday, September 28, 2015

MGH to Pay $2.3 Million to Resolve Drug Diversion Allegations

(CBS/AP) A Minnesota nurse who was supposed to sedate a patient before surgery instead took most of the painkillers for herself and told the patient to "man up" - giving him such a small dose of medication that he was writhing in pain on the operating table, according to criminal charges.
• On a single day in December last year a nurse and doctor both overdosed on stolen pain medication in different areas.
• ICU RN was found dead in a locked bathroom with syringe on floor.
• Anesthesia resident was found in a locked bathroom in cardiac arrest with a syringe and his doctor's kit of pain medications.

Ann Arbor News
In the largest settlement of its kind to date related to drug diversion at a hospital, a Massachusetts institution had to pay $2.3 million to the government to resolve allegations of allowing employees to divert controlled substances for personal use. The hospital also agreed to incorporate a corrective action plan to prevent and address future diversions.

Major nurse diversion, failure to report in timeframe, no biennial inventory, not using DEA 222 form properly, unable to provide 2 years worth of readily-retrievable ADC records.
Behaviors/Signs of Diversion

- Removal under someone else
- Issuing without an order
- Dropping/breaking containers
- Issuing for patient not needing pain med
- Drop on discharged patient
- Volunteers for overtime often, willing to float or stay late often
- Comes into work when not assigned of scheduled
- Readily volunteers to medicate other patients
- Volunteers to waste medication that was not administered by him/her
- Giving less than what was ordered
- Cancelled transactions
- Volunteers to waste medication that was not administered by him/her
- Giving less than what was ordered
- Cancelled transactions
- Duplicative doses
- Asks coworker to witness a waste that has already been wasted
- Volunteers to waste medication that was not administered by him/her
- Asks coworker to witness a waste that has already been wasted
- Frequent trips to bathroom, long trips off unit
- Discrepancies between patient reports of pain relief and charted meds
- Consistently signing out max amount of narcotics
- Consistently uses more drugs for cases than colleagues
- Heavy wastage of drugs
- Drugs and syringes in pockets
- Anesthesia record does not reconcile with drug dispensed/administered to patient
- Patient has unusually significant or uncontrolled pain after anesthesia
- Higher pain score as compared to other anesthesia providers
- Inappropriate drug choices and doses for patients

Addressing Substance Use Disorder for Anesthesia Professionals-AANA
http://www.aana.com/resources2/professionalpractice/Pages/Addressing-Substance-Use-Disorder-for-Anesthesia-Professionals-.aspx#SAB
Examples of common risk points and methods of diversion

• **Procurement**
  • Purchase order and packing slip removed from records
  • Unauthorized individual orders CS on stolen DEA 222 form
  • Product container is compromised

• **Preparation and Dispensing**
  • CS are replaced by product of similar appearance when prepackaging
  • Removing volume from pre-mixed infusion
  • Multi-dose vial overfill diverted
  • Prepared syringe contents is replaced with saline solution

• **Prescribing**
  • Prescription pads are diverted and forged to obtain CS
  • Prescriber self-prescribes controlled substances
  • Verbal orders for CS created, but not verified by prescriber
  • Written prescriptions altered by patients

• **Administration**
  • CS are withdrawn from an ADD on discharged or transferred patient
  • Medication documented as given, but not administered to patient
  • Waste is not adequately witnessed and subsequently diverted
  • Substitute drug is removed and administered while CS is diverted

• **Waste and Removal**
  • CS waste is removed from unsecure waste container
  • CS waste in syringe is replaced with saline
  • Expired CS are diverted from holding area Waste and Removal

ASHP – CSDPP
Diversion impact

• Summary
  • Addiction is a general population epidemic and healthcare workers have same approx. population risk as the general population
  • Increased access makes hospitals and clinics susceptible to diversion
    • Many case of healthcare worker diversion have shown healthcare workers who bypass the processes put in place.
  • Diversion within the healthcare institution may be a symptom of addiction either by the healthcare worker or their friends or family, or selling of the drugs for profit.
  • Institutions are responsible for creating diversion deterrent processes
  • Co-worker behavior surveillance is a critical part of the diversion deterrent process
  • Risk of diversion is an issue of patient safety, public health, healthcare worker safety, and the risk of facility and worker reputation is at stake.
  • The responsibility of keeping MGMC free of these risks lies with each and every one of us.
Questions?