# Investigating Institutional Drug Diversion

*Kimberly New BSN RN JD*

**Keywords:** Drug diversion, drug tampering, investigation

*Drug diversion is ubiquitous in healthcare institutions using drugs. Due to its clandestine nature, it is not easy to identify and statistics are hard to come by. This article outlines the problem, recommends possible interventions for facilities, and offers the legal nurse consultant some specific techniques to use when investigating a case involving allegations of diversion.*

Liability due to diversion is an evolving issue in health law. Law enforcement and facilities increasingly acknowledge institutional drug diversion, theft of drugs from facilities or patients by healthcare personnel, as a problem in the United States and abroad. Since diversion is clandestine by nature, reliable data about prevalence of institutional diversion are not available, but diversion occurs at most or all institutions using controlled substances. Many diversion incidents go undiscovered, and probably most that are discovered are never reported outside the institution. Estimates of the number of nurses that divert vary, and are generally not based on scientific data. In perhaps the only published study, 6.6% of nurses reported illicit use of prescription-type drugs within the past year[i]. The author's own experience as a diversion investigator suggests that 6.6% is a substantial underestimate.

Diversion is a multi-victim crime posing a significant risk to patient safety, co-workers, institutions, third-party payors, the community at large, and the diverter. Patients may be harmed by an impaired provider when they are denied pain relief or by blood-borne pathogens introduced through tampering and

*The liability of the diverter lies in actual harm done to others. Institutional liability usually lies in insufficient diligence to prevent the diversion.*

substitution. The institution can be exposed to civil and regulatory liability, negative publicity, and may even face potential closure[ii]. Payors may be billed for drugs that were never administered, and may incur additional costs for the care of patients who have been infected or otherwise harmed. Hazards to the community may take the form of diverters driving while impaired. The diverter himself imperils his own health by using escalating doses of controlled substances, often in combination with large amounts of acetaminophen, risking criminal and civil liability, loss of license, exclusion from health care by the federal government[iii], and injury or death.

## LEGAL CONSEQUENCES OF DIVERSION

The liability of the diverter lies in actual harm done to others. Institutional liability usually lies in insufficient diligence to prevent the diversion. In several well-publicized cases, the diverter was held criminally liable and the facility settled for civil liability.

- In a case concluded in Texas in 2009, Jon Dale Jones, an Army hospital CRNA and retired Army captain who diverted fentanyl by substitution resulted in 15 patients becoming infected with hepatitis C. Jones pled guilty to assault and to stealing drugs and was sentenced to 41 months in federal prison[iv].
- In a 2010 case in Colorado, Kristen Parker, a scrub tech who worked at an ambulatory surgery center diverted fentanyl by substitution. Parker was sentenced to 30 years in prison for tampering with a consumer product and obtaining controlled substances by deceit[v]; patients sued the hospital and anesthesia staff for unrelieved pain endured during procedures[vi].
- In another Colorado case only 2 months later, Ashton Daigle, a surgical nurse, substituted saline and tap water for fentanyl and returned the vials to stock. Daigle was sentenced to 54 months in prison for tampering with a consumer product and creating a counterfeit controlled substance; patients sued the hospital for unrelieved pain endured during procedures[vii].
- In a case that came to light in New Hampshire in 2013, David Kwiatkowski, a traveling radiology tech, substituted stolen syringes filled with saline (without changing needles) for new syringes of fentanyl. Kwiatkowski was sentenced to 39 years in prison for obtaining controlled substances by fraud and tampering with a consumer product; several facilities and agencies where he had worked were sued by patients who became infected with hepatitis C through his tampering[viii].
- In another 2013 case in Minnesota, Blake Zenner, an OR nurse, diverted hydromorphone by refilling syringes with contaminated saline. Zenner was sentenced to 24 months in federal prison for obtaining a controlled substance by fraud. The hospital and the diverter were sued by patients who claimed unrelieved pain, and several patients acquired Gram-negative sepsis through contamination (including one that died)[ix].

Facilities in which diversion occurs can be penalized for failing to comply with the *Medicare Conditions of Participation Regarding Pharmaceutical Services*, which require that drug security measures comply with the Controlled Substances Act of 1970[x]. The Conditions require that only authorized personnel have access to locked areas, and that abuses and losses of controlled substances be reported in accordance with federal and state law to the Director of Pharmacy and the CEO, as appropriate. The Controlled Substances Act also requires strict medication security, accurate record keeping, and prompt reporting of theft or loss to Drug Enforcement Administration (DEA)[xi].

DEA investigations into inpatient processes have become increasingly common. In 2014, the DEA fined one of the nation's largest health systems $1.55 million to settle claims of deficiencies in the management of controlled medications at its hospitals and clinics. In addition to the fine, the government required the health system to undertake a rigorous action plan to remediate perceived laxities in their drug security and record-keeping[xii].

## INVESTIGATING A SUSPECTED DIVERSION EVENT

Drug diversion in a healthcare facility can take many forms, and typically follows an inexorable pattern of escalation. Many diverters begin by diverting from waste, which may be difficult or impossible to detect. Failing to waste is a common method, and is usually identified quickly by a review of the suspect's drug transactions. Many facilities have a culture of complacency about waste procedure, which facilitates diversion by this method. Other diverters may be more savvy, and hide their failure to waste by a combination of methods: substituting a neutral substance for an opioid in order to deceive a waste wit-

ness, pretending to waste an entire dose by claiming that the patient refused the medication, maximizing the amount of waste available by removing larger-than-needed dosage units, and even removing previously discarded opioids from waste containers.

Eventually, the quantity of drug needed exceeds the amount available from waste, and other methods come into play. One common method consists of removing pain medication from stock when the patient doesn't have pain, and documenting administration as if it had been done. A similar method is removing medication under the name of a patient that has been discharged from the clinical area or from the facility. Removal of duplicate doses is another tactic; the diverter often removes doses from different drug cabinets, thinking that that will mask the duplication. The diverter may remove medication without a provider prescription; the diverter may or may not falsify a verbal prescription.

Diverters often try to escape detection by removing drugs under the sign-on of a colleague who has stepped away from the cabinet without signing out, or may hover behind a colleague to acquire her password. Both hospital staff and impostors have been found to pilfer medications that patients or families have brought from home. Diversion of fentanyl from patches is an often-overlooked risk; nurses may perceive the patches to be at lower risk of diversion than oral or IV forms, but they are a preferred target for some diverters. Used patches can be diverted, but some diverters will place used patches on patients and keep the fresh patches for their own use. In one case last year, a nurse removed patches from patients, put them in his mouth to extract the drug, then replaced them on the patient an hour or so later[xiii].

The most egregious method of diversion is substitution or tampering. In these cases, the diverter removes the controlled drug from a vial, syringe, or administration device and replaces it with another substance. Because substitution is usually done in haste, the diverter may use the same needle throughout the process, resulting in contamination with the diverter's own blood. The substituted material is then administered to a patient immediately or returned to stock. Diverters may collect used vials or syringes and fill them with saline or tap water, and repeatedly exchange them for unused vials in the cabinet. They frequently gain access to the cabinet by means of a cancelled transaction or under the pretense of checking inventory; in either case, they have entered without appearing to have removed any drug. Tampering and substitution entail a risk of introducing blood-borne pathogens to containers that are supposed to be sterile, in addition to denial of analgesics to patients that need them.

Most diverters take one or occasionally two drugs far more often than any other. The preferred drug is usually an opioid. As the diversion scheme progresses, other drugs may be added to help the diverter cope with symptoms of opioid abuse, and sometimes to mask substitution. For instance, a diverter may begin to divert benzodiazepines to alleviate anxiety. He may divert promethazine or ketorolac to substitute for a diverted opioid, so the patient experiences some sedation or analgesia when the substitute is administered. Promethazine, diphenhydramine, and ondansetron are frequently stolen to alleviate nausea or pruritus resulting from opioid abuse. Sometimes hospital staff will casually or regularly divert sleep aids to help them cope with irregular work schedules.

Investigation of a suspected diversion event usually involves reviewing drug cabinet data and analytic reports. Often the initial suspicion arises when a user is a statistical outlier compared to his peers. Analytic reports may be available to highlight suspicious behavior, such as frequent medication overrides or regularly choosing the same witness to waste. In all cases, the transaction record must be compared to the documentation in the medical record. Key items in the record include:

- documentation of administration
- pain scales
- vital signs
- prior analgesic requirement
- timing of administration as compared to removal; regular documentation of administration before the drug has been obtained from the cabinet is a strong indicator of diversion.

## BEHAVIORAL SIGNS

Behavioral signs of diversion typically occur late in the development of a diversion habit. Ideally, diversion would be detected by other methods before such signs occur. Diverters are typically high performers at the start of their diversion activity, and do not often fit preconceived ideas of how a drug abuser should appear. They may be new orientees or experienced leaders. They are often award winners and have advanced academic achievements.

There are, however, some common behaviors that can be recognized as indicating diversion. Diverters frequently come to work earlier than their scheduled shift, and stay late. They volunteer for overtime and may appear for work when not scheduled. They choose their preferred medication when other options are available, and often request supplemental orders for breakthrough pain. They make increasingly frequent trips to the bathroom, where the vast majority of diverters choose to self-administer. They often volunteer to administer medications for their colleagues' patients, and may considered unusually helpful. Outward signs of impairment, such as deteriorating work performance and passing out, occur later.

## ESSENTIAL ELEMENTS OF A DIVERSION PROGRAM

Every healthcare facility must have a robust program to prevent, detect, and respond to diversion. Liability for the institution typically arises from the failure to have such a program or to use it effectively.

The diversion program should include policies that specifically outline measures to prevent, detect, and properly report diversion. The policies should spell out a mechanism for responding promptly to diversion, including clear delineation of who is responsible for each component of the response. The policies should mandate reporting to DEA and law enforcement. There should be a regular program of auditing for diversion, and the person entrusted with undertaking the audits should have sufficient time allotted to do so. There should also be a systematic process of ongoing risk assessment (i.e., Diversion Risk Rounds)[xiv].

Collaboration between departments such as nursing and pharmacy is essential. A collaborative relationship with external agencies, including regulatory bodies and law enforcement, established in advance of a crisis, can make the involvement of law enforcement during a crisis more constructive, and can reduce adverse publicity associated with diversion.

Regular education on diversion for all clinical, medical, and nonclinical staff is indispensable. Staff must understand that diversion creates an unsafe environment for patients, that diversion occurs at all institutions where controlled substances are handled, and that all staff have a role in preventing and reporting diversion. Diversion education should be a part of orientation for new employees, and should occur annually after hire.

## PREVENTION

The best response to drug diversion is prevention. Diversion cannot be prevented entirely; it occurs in every healthcare facility, and requires vigilance on the part of the facility to prevent harm to patients and others. The facility's first step is appropriate pre-employment screening of potential hires. The facility must require compliance with medication-handling policies, and establish a culture of compliance and vigilance. Finally, the facility must make resources available to staff to manage stress and reduce the risk of turning to diversion as a substitute for stress management, and be certain that employees are aware of those resources.

## REFERENCES:


[i] Trinkoff AM, Storr CL. Substance use among nurses: differences between specialties. Am J Public Health. April 1998;88(4):581-585.

[ii] State Operations Manual: Appendix Q - Guidelines for Determining Immediate Jeopardy. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf. Issued Feb 14, 2014. Accessed August 15, 2015.

[iii] 42 U.S.C. §1320a-7 et seq. Medicare Conditions of Participation for Hospitals.

[iv] Former Army nurse pleads guilty in hep-C case. www.timesfreepress.com/news/local/story/2009/apr/07/ex-army-nurse-pleads-guilty-hepatitis-c-case/214869/. Published April 7, 2009. Accessed August 15, 2015.

[v] Statement by US Attorney David Gaouette regarding today's Kristen Parker hearing. www.justice.gov/archive/usao/co/news/2010/January10/1_20_10.html. Published January 20, 2010. Accessed August 15, 2015.

[vi] Lawsuit Names Anesthesiologist In Kristen Parker Case. denver.cbslocal.com/2011/03/07/lawsuit-names-doctors-in-kristen-parker-case/. Published March 7, 2011. Accessed August 15, 2015.

[vii] Boulder nurse sentenced to federal prison for tampering with a consumer product and creating a counterfeit controlled substance. www.justice.gov/archive/usao/co/news/2010/March10/3_5_10.html. Published March 5, 2010. Accessed August 15, 2015.

[iix] Former hospital employee sentenced in connection with widespread hepatitis C outbreak. www.justice.gov/usao-ks/pr/former-hospital-employee-sentenced-connection-widespread-hepatitis-c-outbreak. Published December 2, 2013. Accessed August 15, 2015.

[ix] Kimball nurse sentenced for fraudulently obtaining a controlled substance. www.justice.gov/usao-mn/pr/kimball-nurse-sentenced-fraudulently-obtaining-controlled-substance. Published March 20, 2013. Accessed August 15, 2015.

[x] 42 C.F.R. § 482.25 et seq. Conditions of Participation: Pharmaceutical Services.

[xi] 21 U.S.C. 13 § 801 et seq. Comprehensive Drug Abuse Prevention and Control Act.

[xii] Dignity Health agrees to pay $1.55 million in civil penalties to resolve Controlled Substances Act claims. www.justice.gov/usao-edca/pr/dignity-health-agrees-pay-155-million-civil-penalties-resolve-controlled-substances-act. Published July 16, 2014. Accessed August 15, 2015.

[xiii] State: Nurse peeled pain patches off clients, put them in his mouth, put them back. www.startribune.com/state-nurse-peeled-pain-patches-off-clients-put-them-in-his-mouth-put-them-back/284154821/. Published November 29, 2014. Accessed August 15, 2015.

[xiv] New K. Diversion risk rounds: a reality check on your drug handling policies. AHIA Digital Insights. Summer 2015; 2(1): 9-12.



**Ms. New**, a nurse attorney, is a specialist in controlled substance security and DEA regulatory compliance and is a consultant to healthcare facilities. She helps facilities establish and expand their drug diversion programs with goal of improving patient safety. She is a frequent author and national speaker on the subject of health facility diversion. You may contact her at Kim_New@zoho.com or (865) 456-1813.