Outpatient Diversion Risk

Include outpatient care locations as potential diversion areas

By Kim New, JD, BSN, RN

Institutional diversion prevention, detection and response efforts frequently focus on inpatient processes. Admittedly, there is often so much risk associated with inpatient units that assessing other areas of exposure may be considered secondary.

Staffs at many facilities admit that physician offices, clinics and outpatient care areas are out of sight and consequently out of mind. If there is not a pressing issue, these settings often are not examined. From a diversion perspective, practices in these areas can result in substantial opportunities for diversion, so outpatient care areas should receive ongoing consideration within the overarching diversion program.

Risks in outpatient clinics and physician offices are similar. Prescription pads and blanks are often a source for diversion, but are not usually kept secure. Large quantities may be kept on hand, and pads can be found in multiple locations throughout the patient care area.

Because of the risk of diversion, the smallest practical number of pads should be kept on hand, and those available should be stored in a locked drawer or cabinet when not in use. Pads should be serialized and blanks should be tracked to ensure they are being used appropriately.

For instance, staff at one clinic was using prescription pads (with DEA numbers prominently displayed) as notepads to jot down information obtained during phone calls. Practitioners may use prescription blanks (containing DEA numbers) for work excuses or school notes. This practice should be avoided, and nonprescription orders and notes should instead be placed on office stationery.

In many offices, the details of the prescription are filled out by medical assistants and prescriptions are later signed by busy and distracted practitioners. This can facilitate errors and prescription forgeries, and should be prohibited.

Controls to audit

Controlled substance samples and stock should be ordered under the DEA number of the physician or practitioner whose patients will receive the medications. There should be a biennial inventory of all controlled substances, including samples. Records relating to procurement should be reconciled regularly by a manager. Records of the purchase, ordering, inventory and administration of all controlled substances for the previous two years should be kept in a readily retrievable location separate from other business records.

CII records should be separated from CIII-V records. There should be several individuals with knowledge of the controlled substance inventory and associated records who can respond to questions if the DEA or another regulatory agency visits the clinic.

Many clinics have an abundance of traffic in and out of patient care areas where medication storage is not usually well monitored. All controlled substances should be stored securely at all times. There should be limited access to controlled substances. That means staff without a legitimate need to access the controlled drugs, such as nonclinical reception staff, should not have a key or code to do so.

Two staff members should verify the count of all controlled substances stored in the office at the beginning and end of each shift or, at a minimum, once per shift. Expired items should either be sent for destruction with a reverse distributor or wasted by two staff members. Records relating

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to wasting and destruction must be kept with other readily retrievable records.

Special consideration should be given to controlled substance waste practices. Intact vials or pills of controlled substances should not be placed in trash cans or sharps containers. Some drugs are regulated as hazardous substances as well; testosterone is considered an endocrine disruptor, and both testosterone gel and diazepam are considered hazardous controlled substances.

Although EPA proposed rules have not yet been made official, that agency strongly recommends that waste of these drugs be combusted or incinerated rather than wasted into the sink.

Samples of controlled substances can also present a diversion risk. Incoming controlled substance samples are often opened without supervision and shortages may not be questioned by managers. Controlled substance samples should be opened by two staff members and placed into stock. The samples should be kept secure and, sequestered from noncontrolled samples.

Even if an office has a practice of properly securing controlled substance samples, some controlled substance samples may not be recognized as such by staff. For instance, suvorexant and eluxadoline are controlled substances that are commonly thought to be noncontrolled drugs and are present in sample cabinets in many offices.

Outpatient clinic and doctor's office checklist

1. How many prescription pads are present?
2. Are prescription pads stored in a secure location?
3. Are prescribers checking their own profile regularly to ensure prompt detection of prescription forgery?
4. Are prescribers completing all fields in prescriptions that are issued (as opposed to allowing office staff to do so)?
5. Are prescriptions awaiting patient pickup kept secure, logged, and removed in a timely fashion if not picked up?
6. Are controlled substance samples kept secure until the patient is present to receive them?
7. If controlled substance samples are provided for patient pickup, is there a log with a record of the patient's signature acknowledging receipt?
8. Are controlled substance samples and medications ordered under the DEA number of the physician or practitioner whose patients will be receiving them?
9. Are two staff members involved in opening and stocking incoming controlled substances?
10. Are all controlled substance samples stored securely in an area with limited access?
11. Are all controlled substance inventories stored securely in an area with limited access?
12. Are controlled substance counts witnessed and being done as often as expected?
13. How is staff wasting controlled substances, including hazardous medications?
14. Are records of procurement, orders, inventories, administration, waste and destruction for the prior two years readily retrievable and kept separate from other business records?
15. Is the office staff aware of the risk of diversion and how to report suspicions?
16. Are prescribers aware of diversion risks?

Some offices administer controlled substances to patients and must keep stock on hand. Testosterone is the most common controlled substance used in the office setting. Testosterone is often supplied in a multi-dose vial, so each dose should require an entry on a declining inventory sheet. Benzodiazepines and opioids may also be kept in physician offices for administration to patients.

There should be periodic auditing of patient records to ensure doses that are documented on the inventory sheet are also documented as administered in the patient record. Controlled substances should only be kept on hand if they are truly needed. If a medication has not been administered in the past six months, strong consideration should be given to eliminating it from the office inventory.

Watch patient pickups

Most offices have a practice of preparing prescriptions and packs of samples for patients to pick up outside of a regular appointment. Bags of samples are commonly left behind the reception desk until they are picked up, even when they contain controlled substances. Prescriptions are also left unsecured while awaiting pickup.

Suvorexant and eluxadoline are controlled substances that are commonly thought to be noncontrolled drugs.

It is not uncommon to find large numbers of prescriptions for controlled substances at the reception desk. Many times there are prescriptions that have been waiting to be picked up for months. To help reduce the risk of diversion, controlled substance samples should not be prepared until the patient is present to receive them and at that time the patient or his representative should sign a log acknowledging receipt.

Prescriptions awaiting pickup should be logged and kept in a locked drawer. One staff member should have responsibility for checking the drawer each day and removing any prescriptions that have been waiting longer than ten days. When patients or their representatives pick up prescriptions, they should provide some type of identification and should sign the prescription log.

Staff education

All office staff needs to be educated about the risk of diversion and how to report concerns. This should happen at least at initial hire and annually thereafter. Physician and mid-level practitioner staff should be educated about appropriate prescribing and diversion risks in the office setting.

Prescriptions may wait to be picked up for months.

The institutional diversion program manager should ensure that policies and procedures are in place to address the unique challenges of controlled substance security in the outpatient setting. Diversion risk rounds should be conducted regularly to ensure that risks are identified and addressed.

Conclusion

Diversion risk exists in clinics and physician offices as well as in hospitals. As in the inpatient setting, mitigating the risk of diversion requires robust processes to monitor controlled substances, auditing for compliance with controlled substance handling expectations, and education of all staff. **NP**

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If you don't like how things are, change it! You're not a tree.
~Jim Rohn