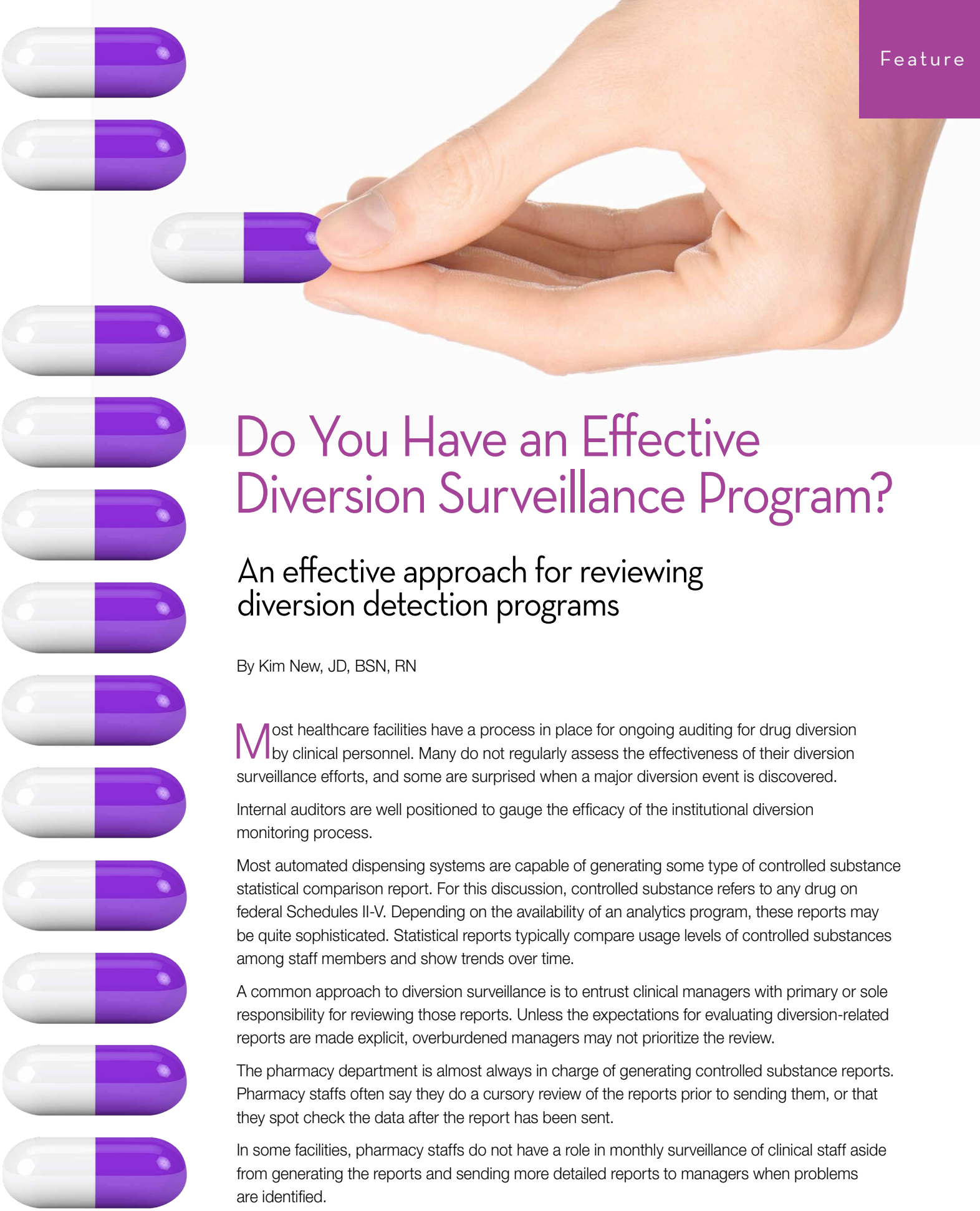


Do You Have an Effective Diversion Surveillance Program?

An effective approach for reviewing diversion detection programs

By Kim New, JD, BSN, RN

Most healthcare facilities have a process in place for ongoing auditing for drug diversion by clinical personnel. Many do not regularly assess the effectiveness of their diversion surveillance efforts, and some are surprised when a major diversion event is discovered.

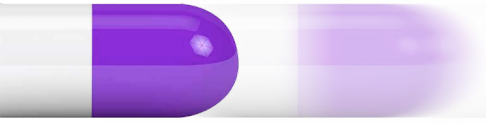
Internal auditors are well positioned to gauge the efficacy of the institutional diversion monitoring process.

Most automated dispensing systems are capable of generating some type of controlled substance statistical comparison report. For this discussion, controlled substance refers to any drug on federal Schedules II-V. Depending on the availability of an analytics program, these reports may be quite sophisticated. Statistical reports typically compare usage levels of controlled substances among staff members and show trends over time.

A common approach to diversion surveillance is to entrust clinical managers with primary or sole responsibility for reviewing those reports. Unless the expectations for evaluating diversion-related reports are made explicit, overburdened managers may not prioritize the review.

The pharmacy department is almost always in charge of generating controlled substance reports. Pharmacy staffs often say they do a cursory review of the reports prior to sending them, or that they spot check the data after the report has been sent.

In some facilities, pharmacy staffs do not have a role in monthly surveillance of clinical staff aside from generating the reports and sending more detailed reports to managers when problems are identified.



Unresolved discrepancies are often so common that they are not taken seriously.

Clinical managers should be reviewing their staffs' controlled substance transaction data on a regular basis because they are uniquely positioned to know what staff members typically do and what would be considered abnormal.

There should also be an independent review of the data each month because clinical managers usually struggle with objectivity when they review their own staff. Ideally, independent reviews should be done by a diversion specialist, or diversion program manager. But if such a role does not exist, it is most often done by a pharmacy staff member.

In order to hold clinical managers and other personnel accountable for reviewing controlled substance reports, there must be:

- A policy that clearly specifies what reports will be generated
- Who will have responsibility for reviewing the reports
- A deadline for how long the manager has to complete the review
- Guidelines for how the review should be documented

If your organization does not have such a policy, it is likely you will find the reports are only looked at sporadically, and that some managers do a better job than others.

The best way to assess the effectiveness of the diversion surveillance process is for you to:

- Interview pharmacy staff responsible for generating the reports
- Speak with clinical managers who receive the reports
- Determine how often diversion is identified and how it is identified
- Undertake an independent review of the reports for each unit

Discrepancies

Unresolved controlled substance discrepancies are common in healthcare facilities—often so common that they are not taken seriously. If they go unmonitored, staff may see outright theft of controlled substances as a viable method of diverting. Even if discrepancies are not evidence of diversion, they do reflect a lack of accountability and poor controls.

Best practice is that discrepancies are appropriately resolved before the end of each shift. Those discrepancies that are not capable of being resolved should be escalated to a supervisor, manager or pharmacist. Clinical managers should be reviewing reports of unresolved discrepancies daily or weekly.

Staffs often struggle with discrepancy resolution and may need training on how to appropriately resolve a discrepancy.

In many facilities, there is a focus on discrepancies. Some have mandated discrepancy resolution prior to the end of the shift, and have enforced this by sending discrepancy resolution performance reports to high level leadership.

Although very few discrepancies may be found at the drug cabinets, a review of transactions often reveals that staffs are simply clearing discrepancies as a "count back error," and are not actually determining what caused the discrepancy.

To assess discrepancy resolution, you should request information about discrepancies, review transaction reports reflecting discrepancies, and track the count to ensure that discrepancy resolution makes sense and that all missing controlled substances are actually accounted for.

Overrides

Most clinical units within a facility should be profiled, meaning they should require pharmacy verification of a medication order before a staff member can remove the drug. Units that may not be profiled include procedural and surgical areas, PACUs and the Emergency Department.

In profiled units, if a staff member has a need to remove a drug urgently, prior to pharmacy verification, the staff member may have an option to override the system and pull the drug. The number of nonprofiled units within the facility should be limited, and the drugs that can be removed via override should be strictly limited to only those drugs that might truly be needed in an emergency.

Because overrides for controlled substances are a popular method of diversion, managers in profiled units should review reports of overrides daily or weekly. Very few overrides should be occurring, so this review should not be overly time consuming to perform.

To assess overrides, an auditor should request and review an override report for each profiled unit to determine if overrides are appropriate.

Statistical comparison reports

Some facilities configure statistical comparison reports to include up to 90 days of transaction data. This volume of data tends to dilute the results. The best data set for a statistical comparison is typically one month.

Most facilities review statistical comparison data by unit, but in very small facilities this may not be feasible. Small facilities may need to generate these reports with data for the entire institution.

What constitutes an outlier should be defined in the institutional surveillance policy. For standard statistical comparisons, most facilities choose two to three standard deviations above the mean.

You should request the institution's standard statistical comparison report and do a detailed review of each significant outlier. This means verifying 30 days of transactions for the drug in question, and looking generally at transaction data for patterns of diversion. Some transaction patterns that are commonly associated with diversion include:

1. Delayed administration
2. Delayed waste
3. Overrides
4. Returns
5. Cancelled transactions
6. Wasting of complete doses
7. Pulling excessively large doses
8. Duplicate doses

As a part of this review, an auditor should, at a minimum, verify that:

1. There was an order for the drug removed
2. The smallest practical dose was removed
3. The patient's condition warranted administration
4. The clinical staff member who pulled the drug was the one who administered it
5. The dose was documented as administered
6. The drug was scanned (if applicable)
7. Any remaining drug was appropriately wasted

Audit results for process improvement

Even if the basic diversion surveillance audit does not identify a diversion scheme, the audit results can be used to improve institutional diversion prevention and detection processes.

In some instances, an auditor will discover that too many reports are being generated, and that report generation needs to be more streamlined and focused. The audit may reveal that not all managers are receiving the reports as

> "No man has a good enough memory to be a successful liar."
> - Abraham Lincoln

intended, that the expected review is too time-consuming, or that there is confusion amongst managers about what they need to do with the data they receive.

You may also find evidence of poor practice or a lack of controls such as inappropriate discrepancy resolution, an excessively large list of medications that can be overridden, controlled drugs being removed without an order, excessively large doses being removed, handing off controlled substances from staff member to staff member, or other issues.

Conclusion

Auditing for compliance with diversion detection measures is one of the most important patient safety processes to which internal auditors can contribute. It should be given the same priority as other processes that are critical for patient safety. DI

Evaluating your diversion detection program

- What controlled substance transaction and analytics reports are available for identifying diversion?
- Which reports are regularly generated, and how often?
- Who has responsibility for reviewing controlled substance transaction data and reports?
- Is there a policy that defines the process of diversion-related report review?
- Do the reports currently being generated meet at least minimum expectations for report review (i.e., discrepancies, overrides and statistical comparison)?
- Is there a method for documenting report reviews, and if so, is there evidence the reviews are being done?
- What do clinical managers have to say about the report reviews? Do they understand the reports? Are they able to complete their review within expected timeframes?
- How many diversion cases has the facility had in the past year and how were they identified?
- What does the auditor's independent report review reveal?

Kim New is the principal at Diversion Specialists and is a specialist in controlled substance security and DEA regulatory compliance, and is a consultant to healthcare facilities across the country. She works with facilities to set up and expand their drug diversion programs with the goal of improving patient safety. You can reach her at Kim_New@zoho.com or (865) 456-1813.