T. Diversion of Controlled Substance in Health Care Setting

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The Painkiller Addiction Epidemic

- **Deaths:**
  - 50 Americans die from painkiller overdoses each day
  - 16,000 deaths and 475,000 emergency department visits a year.

- For every 1 overdose death from painkillers there are:
  - 10 treatment admissions for abuse
  - 32 emergency department visits for misuse or abuse
  - 130 people who abuse or are dependent
  - 825 people who take prescription painkillers for nonmedical use
WHAT THIS MEANS IN A HEALTHCARE SETTING:

- Easy to get
- Hospital liability
- Physician group liability
- Criminal and civil consequences
- Patient care
- Patient safety

What we will discuss today

- One example
- How to detect and address diversion:
  - By healthcare workers
  - By patients
  - By physicians
- Theft versus Tampering (why tampering is worse)
- How and when to report
- Private law suits from diversion
  - against hospitals and MDs
- The need for legislative and regulatory support: state and federal law, department of health regs
  - One state's approach to the epidemic: Florida
Diversion in Facilities/Practices

- Nurses /medical professionals who divert controlled substances pose significant threats to patient safety and become a liability to the healthcare organizations.
- Nurses /medical professionals who divert use the patients illness as a means to obtain the medications.
- By doing this the patient is put at risk.

What to look for in charts/OmniCell reports

- Removing controlled substances with no “Doctor’s orders”
- Removing controlled substances for patients “not assigned” to them
- Removing controlled substances for patients that have been discharged from their care
- Removing controlled substances and not documenting them on the “MAR” (Medication Administration Record)
What to look for in charts/OmniCell reports

- Patient charting reveals excessive pulls for “PRN” medication compared to other nurses assigned to that patient.
- Discrepancies from the OmniCell machines on a regular basis.
- Pulling out controlled substances, tablets, in lower dosages in order to obtain more pills, when the exact dosage is available.
- Pulling out larger dosages of injectables to obtain more waste.

What to look for in charts/OmniCell reports

- Patient continuing to complain about pain, even though the nurse has documented the administration of pain medications.
- Falsifying records
- Removing PRN medications to frequently (ex. Order q 4 hrs, pulls q 2 hrs).
- Not documenting waste
TAMPERING

- The most dangerous part of diversion
- The nurse/medical professional diverts the medication and replaces it with another substance. The patient receives this unknown substance instead of the correct medication. (saline is commonly used).
- The nurse/medical professional uses patient’s syringe/needle to inject themselves

In the April edition of the *Annals of Internal Medicine*, researchers from the Florida Department of Health and the Mayo Clinic in Jacksonville described another case in which five patients were infected with hepatitis C there by a radiology technician, who eventually acknowledged diverting fentanyl intended for patients in the interventional radiology area. (2)

"The technician reported rare self-administration of fentanyl from a syringe that had been filled with fentanyl in preparation for patient care. The technician would replace the removable needle of the prefilled syringe with a smaller-gauge needle with the original needle, replace the administered fentanyl with saline, and return the filled syringe to patient care." (2)
Radiology Technologist
Steven Larry Beumel

- Employee at Mayo Clinic Jacksonville.
- Addicted to Fentanyl since 2006.
- 3000 patients tested
- 5 Hep C infections
- 1 death

Radiology Technologist
Steven Larry Beumel

- Plead guilty to one count of tampering with a consumer product resulting in death, four counts of tampering with a consumer product resulting in serious bodily injury and five counts of stealing a synthetic narcotic by deception.

- Sentenced 30 years Federal Prison
Exeter Hospital - New Hampshire

Traveling Hospital Technician

- David Kwiatkowski, 32,
- Worked in the Cardiac Catheterization Lab at Exeter Hospital

Diverting Fentanyl for personal use
Traveling Hospital Technician

- Grabbed the loaded syringes when he brought lead aprons into the procedure room.
- They suspect Kwiatkowski then replaced the Fentanyl syringes with saline syringes that were tainted with his strain of Hepatitis C.
  - Erratic behavior, excessive sweating, bathroom trips
  - "fresh track marks"
  - "a red face, red eyes and white foam around his mouth"
  - Tendency to lie, employees told investigators.
  - Bloodshot eyes, claimed crying all night about a dead aunt who never existed.
- When his roommate inquired about the needles in his laundry, Kwiatkowski told her he had cancer and was being treated at Portsmouth Regional hospital, according to the affidavit. Investigators found no documentation to prove this.

TAMPERING

- 30 people were infected with Hep C.

- "What we’re talking about here is drug diversion. That's healthcare workers doing drugs and getting so hooked on them that they are even stealing them at their worksite," New Hampshire Public Health Director Jose Montero, MD, said in an interview this week with HealthLeaders Media.

- Montero said clearly this is a problem healthcare leaders need to find ways to solve.
Sentencing of David Kwiatkowski

- December 2, 2013, Kwiatkowski pleaded guilty to seven counts of tampering with a consumer product and seven counts of obtaining controlled substances by fraud
- According to the plea agreement, Kwiatkowski told an investigator, “I'm going to kill a lot of people out of this.”
- 30 people were infected with Hepatitis C
- The U.S. District Court in New Hampshire sentenced him to 39 years in prison

Widespread Panic

- Testing was recommended for about 4,700 people in New Hampshire alone, and officials are still determining who should be tested elsewhere. In addition to Arizona, hospitals and state health agencies have confirmed that Kwiatkowski also worked in Georgia, Kansas, Maryland, Michigan, New York and Pennsylvania before being hired in New Hampshire in April 2011.
- Kwiatkowski was fired from an Arizona hospital in 2010 after a fellow employee found him passed out in the men's room with a syringe floating in the toilet, according to documents obtained by CNN. A spokeswoman for the Arizona Heart Hospital said Kwiatkowski was immediately fired, and he relinquished his license as a radiologic technologist
TAMPERING

• In Colorado three years ago, a hospital surgical technician was let go after she was found to have replaced fentanyl taken through syringes with saline, sometimes in syringes that had been previously used. She was only caught after a syringe in the tech’s pocket pricked a co-worker. The hospital had to track down 5,700 potential exposures. Before the case was closed, she had re-infected 36 individuals with hepatitis C.

Private causes of action

• From the Colorado case:
  • Suits against the hospital and the anesthesiologists
    • Medical negligence (anesthesiologists; duty to lock meds)
    • Negligent hiring by hospital
    • Negligent retention, training and supervision
    • Respondeat Superior –responsible for the actions taken by one of its employees within the scope of that person’s employment
    • Reckless and intentional infliction of emotional distress
    • Violations of Consumer Protection Act
It’s not always nurses taking pills: What to look for with support staff

- These are individuals that cannot access the OmniCell Machine.
- Radiologic Technologist
- Surgical Technicians
- Certified Nursing Assistants

What to look for with support staff

- Employees that always want to help with disposing of the waste.
- Employees that hang around after their services are complete.
- Employees that volunteer to help everyone.
- Employees unnecessarily touching syringes for procedures.
- Employees in areas they should not be in.
Possible Signs of Impairment

- Unfortunately there may be no signs at all if the nurse is able to divert what he/she needs to feed their addiction or dependency
- Excessive sick leave
- Extended breaks or lunches
- Personality changes
- Continued patient complaints
- Unable to perform certain routine tasks
- Pattern of multiple errors
- Sleepiness

Possible Signs of Impairment

- Changes in appearance
- Nurse coming in on days off
- Nurse taking extra shifts (this affords them the opportunity to divert additional medications)
- Pulling controlled medications at the beginning and end of their shifts

- This could be your most stellar employee
Health Care Professions

- Health Care Professionals have an ethical duty to protect patients, colleagues, the profession and the community
- Part of this duty is to report impaired professionals and ensure that they receive the proper help
- Drug diversion affects everyone in a nursing department

Goal

- The goal as a nurse, nurse manager or other hospital employee is to make sure that the professionals that you work with everyday are not in distress. Distress can come from a variety of reasons, not only drug abuse. As an organization we want to stop diversion before it happens. One way to do this is paying attention to the people around us. We all know when changes start to show in our co-workers. To help our fellow employees to get the help they need to assist them to overcome their issues.
Reporting Requirements

• Must report to DEA immediately
  The registrant shall notify the Field Division Office of the Administration in his area, in writing, of the theft or significant loss of any controlled substances within one business day of discovery of such loss or theft. The registrant shall also complete, and submit to the Field Division Office in his area, DEA Form 106 regarding the loss or theft.

Reporting Requirements

• Must report to Local Law Enforcement – Example Florida:
  Florida State Statute: 893.07(5)(b)
  In the event of the discovery of the theft or significant loss of controlled substances, report such theft or significant loss to the sheriff of that county within 24 hours after discovery. A person who fails to report a theft or significant loss of a substance listed in s. 893.03(3), (4), or (5) within 24 hours after discovery as required in this paragraph commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.
  A person who fails to report a theft or significant loss of a substance listed in s. 893.03(2) within 24 hours after discovery as required in this paragraph commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.
• Concerns of attorneys: HIPAA and State Privacy
What do we report....

• If we think there’s a problem but we can’t prove drugs are missing?
  • Example: we think the nurse is taking from the waste or from the PRN ordered drugs

Important!

• Good relationships with local law enforcement
• Know who to call
  • Cell phone numbers
• Similarly: physician groups having good relationships with pharmacies
• Train staff on how to detect and to whom they should report
Reporting Requirements

- State Licensure Board – Florida example
  Florida State Statute 464.018(k) Disciplinary actions.
  Failing to report to the department any person who the
  licensee knows is in violation of this part or of the rules of
  the department or the board; however, if the licensee
  verifies that such person is actively participating in a
  board-approved program for the treatment of a physical or
  mental condition, the licensee is required to report such
  person only to an impaired professionals consultant.(the
  second part of this paragraph only applies if the nurse is
  already in a program when diversion is found)

Facility Controlled Substance Diversion Prevention Program

- Review and audit controlled substance data
- Create controls and identify potential concerns for
  controlled substance diversion
- Training program to educate staff on controlled
  substance diversion
- Camera surveillance in high risk areas
- Minimize the risk of diversion by having standards for
  ordering and prescribing controlled substances
- Maintain chain of custody and use witnesses when
  wasting controlled substances
Prevention

• Place processes in place to resolve controlled substance discrepancies upon discovery, no later than end of shift
• Create a standard process to investigate potential diversion cases
• Test controlled substance waste that is returned to pharmacy
• Drug testing policy

Diversion by patients

• Physician groups
• Prescription pads – stolen and “skimmed”
  • Script: $100+ & skim 10/week = $1000
  • Pills: 60 for $20 & sell $5 each pill = $300
• Nurses calling in prescriptions for self
• Routine monitoring:
  • Check data base
  • Secure script pads: locked w/ one person with key
  • Behavior
  • Cameras
  • Ask for ID
Pill Mills - Florida

- Declared a public health emergency
- No more MD dispensing of Schedule 2&3
- Pain Management Physicians register/ownership
- Prescriptions:
  - quantity in both textual and numerical formats;
  - dated with the abbreviated month written
  - written on counterfeit-proof prescription pads purchased from a DOH-approved vendor or must be electronically prescribed.

Diversion by Physicians

- What’s a group to do when they find their partner is diverting for himself?
  - Employment agreements
  - Shareholder agreements
  - Leaves of absence
  - PRN/recovery
  - Reports to the Board of Medicine