Preventing Medication Diversion

caregivers

PREVENT *abuse/neglect* PROTECT *clients* PROMOTE *dignity*

FACILITATOR GUIDE

Developed by:

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Center for Career Development (CCDET)

Wisconsin Department of Health Services
Division of Quality Assurance

www.uwosh.edu/ccdet/caregiver

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Learning Points

Let's review the main learning points.

- Increase Awareness of Medication Diversion in Long-Term Care
- Understand Controlled Substances
- Learn Best Practices for Preventing Diversion
- Report Drug Diversion by Caregivers

Introduction to Medication Diversion

It's estimated that over 6 million people in America use prescription medications for non-medical purposes. In other words, the medication is "diverted" – used for another purpose or by a different person. For the purposes of this training, the term "medication diversion" refers to theft of another person's prescription drugs.

The abuse of prescription medications, especially controlled substances, is not restricted to any particular socio-economic class, culture or geographic location. It may seem that health care professionals would be the last group to abuse prescription drugs. Unfortunately, that is not the case.

Think about the reasons why caregivers may be even more susceptible to drug diversion than others?

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[Give the group a minute or two to jot down their thoughts. Then ask for answers from the whole group.
Possible responses:

- *Access*
- *They see residents taking meds with no ill-effects*
- *Realize the euphoria, pain relief that may occur*
- *They are familiar with meds; don't see them as addictive or harmful*
- *Job stress]*

Because of the availability of prescription drugs in long-term care facilities, it's important that managers, supervisors and staff are aware of the dangers and outcomes of diverting medication.

Controlled Substances

The federal Controlled Substances Act created five schedules or lists of medications or other substances based on the substance's potential for abuse, accepted medical use, and the potential for dependence. A controlled substance is generally defined as a substance that is regulated by the government.

The lower the Schedule Number, the higher the risk for abuse and/or dependence.

Schedule I

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence. Some examples of Schedule I drugs are: **heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote**

[Note: States have the ability to create their own schedules and the federal and state schedules do not always match up. For example, medical marijuana may be legally prescribed in some states; but the federal schedules currently prohibit its sale for any use.]

Schedule II

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are: **Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin**

Schedule III

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are:
Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone

Schedule IV

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are:
Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol

Schedule V

Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are:
cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin

Source: http://www.dea.gov/druginfo/ds.shtml

Commonly Abused Prescription Medications

According to the US Drug Enforcement Agency, hydrocodone is the most frequently prescribed opioid in the United States. It is associated with more drug abuse and diversion than any other legal or illegal opioid.

There are three types of prescription drugs that are most commonly abused because of the effects they may produce. Most are classified as Schedule II drugs:

Opioids are most often prescribed to treat pain. They have a high risk for addiction and overdose. Opioids become even more dangerous when abusers override the newer time-release versions by crushing the pills and snorting or injecting the medication to increase the effect. Used or discarded Fentanyl patches are attractive to abusers because a significant level of the drug remains. Theft of liquids is often disguised by refilling the container with another non-medical liquid.

Dangers: Opioid abuse can lead to respiratory distress and even death, especially when combined with other drugs, including alcohol.

Central Nervous System (CNS) Depressants are used to treat anxiety and sleep disorders. In addition to becoming addictive, they pose the added danger of significant withdrawal symptoms if a long-term user stops taking them abruptly.

Dangers: Overdose can cause significant breathing problems or death, especially when combined with other drugs, including alcohol.

Stimulants are prescribed to treat certain sleep disorders and attention deficit hyperactivity disorder (ADHD). Stimulants are not likely to be prescribed for the average resident in long-term care.

Dangers: Abusing stimulants can lead to dangerously high body temperature, seizure and cardiovascular distress.

Take a look at the following chart. Draw a circle around any of the prescription medications that have ever been prescribed for your residents:

Some Commonly Abused Prescription Medications

Opioids	CNS Depressants	Stimulants
• Oxycodone (OxyContin, Percodan, Percocet) • Hydrocodone (Vicodin, Lortab, Lorcet) • Hydromorphone (Dilaudid) • Meperidine (Demerol) • Diphenoxylate (Lomotil) • Morphine (Kadian, Avinza, MS Contin) • Codeine • Fentanyl (Duragesic) • Methadone	<u>Barbiturates:</u> • Mephobarbital (Mebaral) • Pentobarbital sodium (Nembutal) <u>Benzodiazepines:</u> • Diazepam (Valium) • Chlordiazepoxide hydrochloride (Librium) • Alprazolam (Xanax) • Triazolam (Halcion) • Estazolam (ProSom) • Clonazepam (Klonopin) • Lorazepam (Ativan)	• Dextroamphetamine (Dexedrine and Adderall) • Methylphenidate (Ritalin and Concerta)

[Ask participants how many of the drugs they circled? More than 5? More than 10?]

This exercise emphasizes the need for vigilance in maintaining strict procedures for handling controlled substances in your facility.

The Wisconsin Division of Quality Assurance estimates that oxycodone, morphine, fentanyl and hydrocodone products are the most often diverted medications in long-term care facilities.

It's likely that diverted medications originally prescribed for residents in long-term care are most often diverted by caregivers for personal use. However, opioids in particular also have increased value on the illicit drug market ("on the street").

Preventing Medication Diversion

The old saying about an ounce of prevention being worth a pound of cure certainly holds true in this situation. Let's take a look at some of the ways both facility procedures and staff responses can help prevent diversion.

Observing the Rules and Regulations

Chapters DHS 132 and DHS 83 Wisconsin Administrative Code outline requirements for the storage and handling of controlled substances for some long-term care facilities:

Nursing Homes
http://www.legis.state.wi.us/rsb/code/dhs/dhs132.pdf

Assisted Living Medication Management Initiative
https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm

Knowing Your Responsibilities

As an employee of a long-term care facility, it is your ethical responsibility to ensure the safety and well-being of residents. That includes caregivers reporting suspicions of drug diversion to a supervisor and managers aggressively investigating allegations.

You have a professional responsibility to store, administer and dispose of controlled substances appropriately, guarding against abuse while ensuring that patients have medication available when they need it.

No one likes to face the prospect of an employee stealing a resident's much-needed medication. But keep in mind that drug dependence and addiction are powerful motivators for staff to circumvent your rules and regulations.

It may be difficult to approach this sensitive topic with employees. However, it's critical that facilities maintain an awareness of the potential for drug diversion and create a culture that not only encourages reporting but insists on it!

Increasing Awareness: Recognizing Red Flags

The following “red flags” may indicate that a person is drug-impaired and/or may be diverting a resident’s medications for personal use. It’s important to note that these signs are not absolute proof, just indicators. However, observing several signs in one person demonstrates a need for further action.

- Excessive absenteeism, especially last minute call-ins or no shows
- Frequent disappearances from the work site, e.g. unexplained or questionable absences; long trips to the bathroom or secured area where drugs are kept
- Insistence on caring for specific residents who are prescribed controlled substances, especially residents with cognitive impairments
- A history of theft, shoplifting, multiple small claims for unpaid bills, disorderly conduct or driving infractions
- Poor interpersonal relations with co-workers, supervisors, and residents’ family members. (Interestingly, residents who have been victims of medication diversion often report liking the perpetrator.)
- Sloppy record keeping, frequently “forgetting” to chart or count meds
- Failure to complete tasks on time
- Volunteering to work nights or in settings with few other staff
- A consistent decline in personal hygiene and appearance
- Personality changes or mood swings, depression, lack of impulse control, etc.
- Visits by friends or relatives of the caregiver, especially when few staff are on duty

What Employers Can Do

If you recognize any of these signs, confronting an employee suspected of using drugs or diverting controlled substances is critical. Sometimes, the threat of job loss can be a motivator for an abuser to seek help. As part of any job action, encourage your employee to seek drug treatment assistance.

There are a wide variety of programs available that vary from self-help to in-patient recovery program. Some employers offer Employee Assistance Programs (EAP). The federal Substance Abuse and Mental Health Services Administration maintains an online resource for finding local treatment options: http://www.samhsa.gov/find-help.

What Employees Can Do

If you suspect that a co-worker is using drugs or diverting controlled substances, don't help the user avoid facing the consequences. Report your suspicions to your supervisor right away. Well-meaning caregivers who cover up or protect a user are enabling that person's behavior.

It may be hard to report to a supervisor, but not reporting endangers you, your job and those in your care.

Developing Best Practices

[Asking your audience for input will likely produce unique ideas. You may still direct the discussion by offering any strategies you have identified prior to the training or use suggested responses listed below.]

Think about some best practices that facility managers and supervisors can utilize to discourage/prevent diversion of medications by employees. Here are a few ideas to get you started:

- Include appropriate medication administration and handling procedures into job duties of caregivers authorized to administer meds. E.g. follow formal charting procedures; have 2 people count meds at the end of every shift, etc.
- Make unexpected rounds yourself; stay in touch with staff and residents daily
- Aggressively safeguard medications slated for disposal; count them regularly; staff with access to locked storage units must maintain keys on his/her person

Now jot down some ideas of your own:

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[Give participants several minutes to jot down their thoughts. Ask the group for responses individually. Record responses on a flip chart. If you have a larger audience, consider breaking the group into smaller teams. Ask them to appoint a recorder and reporter. Ask each group to report out on their suggestions. Document responses on a flip chart. At the end of the exercise, give participants an opportunity to copy new ideas into their own training materials.

There are multiple responses possible. If the group does not include the following, suggest them yourself:

- *Institute a drug testing policy; although you may not be able to require the test, many times a perpetrator will agree to it*
- *Contact law enforcement when drug diversion is suspected*
- *Incorporate medication diversion awareness training into new employee orientation and/or consider using this training as continuing education for staff*
- *State zero tolerance for medication diversion to all staff*
- *Make it clear that caregivers must report suspected medication diversion immediately; ensure that each caregiver knows to whom they should report*
- *Receive reports from caregivers in a positive way; let the reporter know you will investigate further*
- *Immediately intervene when you suspect drug or alcohol impairment or medication diversion*
- *Develop resources for intervention and treatment]*

Activity: Applying Best Practices

The following examples are based on cases reported to the Wisconsin Division of Quality Assurance. Keep in mind the best practices that we just discussed when completing this activity.

[A small group may discuss each example together. Break larger groups into smaller teams and give an example to each team. Ask teams to choose a recorder and reporter for reporting back to the larger group. Keep your flip chart from the best practices discussion available. Students may wish to add to the list after completing this activity.]

Example #1:

CNA Laurie entered resident Marie's room to help her get dressed for the day. At the time, Marie was in the bathroom with the door closed. A moment later, medication aide Michael also entered Marie's room to deliver her morning meds. Michael shouted through the bathroom door to remind Marie to take her meds. He then placed the med cup on her table before leaving the room.

Laurie thought it was odd that Michael was delivering the meds. She believed that a student medication aide was supposed to be delivering meds that week. Laurie contacted RN Betty. Betty examined Marie's med cup and determined that a 20 mg dose of oxycodone was missing. Michael later stated that the student medication aide had filled the med cup and he hadn't paid any attention. However, the student stated Michael had "taken over" the medication pass that morning.

The facility administrator asked Michael to provide a urine sample, which tested positive for oxycodone and morphine.

The facility reported the incident to the state as well as local law enforcement.

What best practices did the facility and staff demonstrate in this example?

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[Suggested responses include:

- *Staff were aware of "red flags" that something didn't seem right*
- *Staff felt comfortable taking her concerns to a supervisor*
- *Supervisor included interview with the resident who was very alert*
- *Facility asked for urine sample*
- *Facility reported incident to both law enforcement and the state]*

Example #2:

Residential Care Apartment Complex (RCAC) director Judy had been receiving reports for about 6 weeks that medication counts were off or residents complained about not receiving PRN meds. The busy director wrote it off as sloppy record-keeping or forgetful residents.

After one resident's family complained loudly about their mother's claim of not receiving her pain medication, the director began to question staff. Resident Assistant (RA) Juanita admitted that she suspected her co-worker, medication aide Ashley, might be taking medications. Juanita had observed that Ashley insisted on delivering meds to certain residents and it seemed to Juanita that Ashley sometimes disappeared for long periods of time. Juanita said she didn't know what to do and never mentioned her suspicions to anyone. Shortly after the director began interviewing staff, Ashley quit her job. She is now working in a CBRF in a nearby city.

The director breathed a sigh of relief that Ashley was no longer her employee and considered the problem solved.

What best practices did the facility fail to observe in this example?

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[Suggested responses include:

- *Supervisor disregarded red flags, complaints of missing meds*
- *The caregiver Juanita did not report her suspicions to management*
- *Juanita said she didn't "know what to do." Did the facility have clear policies about observing red flags and reporting?*
- *Did facility staff receive training on recognizing signs of drug impairment and/or drug diversion?*
- *Supervisor failed to report an incident that may meet the definition of misconduct to the state*
- *Supervisor did not report as a crime to law enforcement]*

Should a facility report an incident to the state or law enforcement when a suspected caregiver quits or is fired? Why or why not?

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[Suggested responses include:

- *Substantiated finding of caregiver misconduct follow caregivers to other facilities statewide and minimize the risk of repeat behavior at a new location*
- *Even complaints that cannot be substantiated are maintained by DQA and sometimes indicate a pattern of behavior by a caregiver if repeat allegations are made by different employers*
- *Medication diversion that does not meet the administrative definition of caregiver misconduct may still be a violation of the law]*

Example #3:

Louise is a resident assistant (RA) who starts her shift at 6:30 a.m. at a small CBRF. Her first task of the day is to count medications with RA Chai, who works nights. It seems Chai is always in a hurry to leave. He sometimes tries to convince Louise not to "waste time" counting the meds. Louise usually gives in and just signs off on the medication count.

Today, Supervisor Barbara asks to see Louise in her office. Barbara says that medication counts between the a.m. and p.m. shifts are indicating missing medications, most often Vicodin and Percocet.

On one hand, Louise is pretty sure that Chai is the one stealing medications. But if she discloses her suspicions to her supervisor, Louise will have to admit that she didn't really count the meds in the first place.

Why do you think Louise agreed to Chai's request?

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[Suggested responses:

- *Louise wanted to cooperate with her co-worker*
- *She didn't realize that it could reflect on her*
- *She didn't know how to say no*

How could the CBRF have prevented this incident?

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[Suggested responses:

- *Conduct spot checks of med counts on all shifts*
- *Ensure that staff feel confident about refusing a request from a co-worker*
- *Give caregivers the power to avoid awkward situations by suggesting language they might use in such a situation. For example, Louise could then respond to Chai's request by stating: "Hey—that's a serious work rule violation. I don't want to lose my job!"]*

Reporting Drug Diversion by Caregivers

Significant and long-lasting penalties await caregivers in Wisconsin who divert medications from those in their care. Both administrative and criminal penalties may apply. For that reason, the Division of Quality Assurance strongly urges facilities to contact law enforcement in addition to reporting to the state. For some facility types, it is mandatory to report to law enforcement.

Wisconsin's Caregiver Law

Wisconsin's Caregiver Law defines caregiver misconduct as abuse or neglect of a resident or misappropriation of a resident's property. Drug diversion meets the definition of misappropriation when the following criteria are met:

MISAPPROPRIATION OF PROPERTY
The intentional taking, carrying away, using, transferring, concealing or retaining possession of a client's movable property without the client's consent and with the intent to deprive the client of possession of the property.

Therefore, facilities regulated by the Division of Quality Assurance are required to report suspected cases of drug diversion to the state when the facts may meet the definition outlined above. As always, if in doubt, report it out!

If Wisconsin's regulatory agencies (the Wisconsin Department of Health Services or the Department of Safety and Professional Services) substantiate a finding of misappropriation against a caregiver, that caregiver may be temporarily or permanently barred from working in a health care facility. In effect, the caregiver loses not only his/her current job, but any opportunity for future jobs in the field of health care.

Criminal Charges and Penalties

In some cases, medication diversion may constitute caregiver misconduct, a criminal violation or both.

When caregivers divert prescription medications belonging to a resident or a facility, local law enforcement may initiate investigations and file charges. The Wisconsin Department of Justice Medicaid Fraud Unit also prosecutes cases. There are a wide range of criminal charges that may be pursued depending on the facts of the case.

Criminal charges and convictions in Wisconsin are permanently maintained by the Department of Justice Crime Information Bureau as law enforcement records. And caregiver background checks always include a query of these records. Therefore, if a finding cannot be substantiated, there will still be a record of any criminal cases involving wrongdoing by a caregiver.

Consider the following incident:

During a routine traffic stop, a police officer observes a clear bag of unidentified pills on the passenger seat. The driver, Ashley, tells the officer that she took the pills from the healthcare facility where she works because "the residents didn't need them anymore."

An interview of staff at the facility revealed that Ashley was sometimes responsible for destroying medications no longer used by residents. A co-worker admitted that Ashley had convinced him to sign the medication destruction form without actually witnessing the disposal of the meds.

The incident may not clearly meet the definition of caregiver misappropriation since the meds were no longer in the possession of the owner. However, there is a clear violation of the law. In this case the caregiver was charged with multiple counts of Theft-Movable Property <$2500 (Class A Misdemeanor) and Possession of Illegally Obtained Prescription (Class U Misdemeanor).

Wrap-Up

Detecting and preventing medication diversion is another step in providing safe and effective care to residents in long-term care. As we also see, observing the behavioral signs of drug impairment and/or diversion also protects employers and staff.

Learning Points

Let's review the learning points from today's training:

- Increase Awareness of Medication Diversion in Long-Term Care
- Understand Controlled Substances
- Learn Best Practices for Preventing Diversion
- Report Drug Diversion by Caregivers

NOTE: This material was developed by the Wisconsin Department of Health Services-Division of Quality Assurance and the University of Wisconsin Oshkosh Center for Career Development and Employability Training (CCDET) as part of the federal Caregiver Abuse and Neglect Prevention Project.

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Training Materials Checklist

For this training, you will need:

- Laptop computer (recommended)
- MS PowerPoint (PPT Viewer can be downloaded for free at Microsoft.com)
- LCD Projector (recommended)
- Screen for viewing the PPT (recommended)
- Flip chart and markers
- Printed Participant Guides
- Pens or pencils
- Evaluation (optional)
- Certificate of completion (optional)

Note: It is strongly recommended that the PPT be viewed using an LCD projector. If that option is not available, the PPT may be downloaded and printed as a handout.