ACCP Clinical Administration PRN (CADM)

Summary of CADM Roundtable on Opioid Stewardship Part 2

Held October 8, 2018, 12 PMEST

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**Introduction/background**

Thank you to the 20 or so participants in our Roundtable discussion. This was the third such Roundtable, and the second in a series on Opioid Stewardship.

It was recently learned at one member’s institution that the Drug Enforcement Agency has begun to perform onsite surveys of hospital pharmacies. In the past, surveys were performed only for significant loss reports, theft, or confidential complaint. However, given the epidemic of opioid abuse of prescription pharmaceuticals in the community, many of which are commonly used in hospitals, the DEA has devoted resources to ensuring compliance in hospitals.

This Roundtable focused on controlled substance management policies, processes, and workflows that may be of interest to members. Below is a summary of background on the topic. The bullet points are examples of strategies that members report are in place to address the topic.

**Diversion Detection** – It is expected that each DEA registrant maintains full accountability of all doses of controlled substances in their possession. It was asked how members detect diversion.

* Vendor applications providing retrospective surveillance using automated dispensing cabinet (ADC) transactions. Algorithms in application flag high use, number of discrepancies, and wasting with the same witness frequently (buddy system = higher risk). Depending on data provided and vendor capability, may be able to tie in timecard data to detect access during non-worked hours.
* Pharmacy oversight of open discrepancy resolution and undocumented waste. Pharmacy technician alerted to unresolved issues. Investigated and reviewed with pharmacist. Then pharmacy technician brings to attention of the involved user. If not resolved, will escalate to user’s leader.
* Pharmacy monthly review of discrepancy resolution reasons. In the past, noticed a lot of reasons provided were generic and non-informative, e.g. “.”, “Resolved”, “Unknown”. During monthly review, unacceptable resolution reasons are brought to the attention of the user’s leader.
* ADC overrides generate medication order in the EHR which has to be reviewed by the pharmacist.
* Focused review of all steps in the flow of controlled substances in the pharmacy.
* Diversion committee reviews all processes.
* Anesthesia controlled substance waste sent to pharmacy and tested PRN.

**PDMP checking** - Many states require that prescribers check the Prescription Drug Monitoring Database (PDMP). Some of those require documentation of that check, by whom, and when. Health-systems report struggling with the documentation of this check and auditing to detect failure to document.

* PDMP link incorporated into EHR banner.
* Some states require notification to the state for delegates that check PDMP.
* Some PDMPs allow checking of multiple states that share data. No current functionality (?) to check other states automatically. Have to change to other states.

**Drug testing of staff** – This is an important part of a strategy to detect impaired staff. ASHP policy 1717 states that there should be defined criteria for how and when testing is done as well as testing validations. Impaired individuals should be referred to employer-sponsored recovery programs.

* Random testing for pharmacy staff. 3 per month (5% annually).
* Considering anesthesia. Not currently considering nursing.
* Impaired staff are being reported by colleagues to leadership.
* Controversy about random testing. Due to low yield and the risk of false negatives/positives, there is a case to be made for strictly for-cause testing.

**Staff education on compliance** – Most institutions are providing staff education based on Joint Commission standards related to pain management. The education typically focuses on ordering, monitoring, strategies for sparing, risks of abuse, and recovery/treatment. But are institutions emphasizing the regulatory aspects including personal liability for improper or incomplete documentation? The DEA will look at actual practice: storage, how long held in possession outside of the usual storage location, how wasted.

* Storage and access is monitored very closely.
* 30-60 min max in staff control before final disposition.

**Diversion taskforce** – Some organizations have put together oversight committees and/or ad hoc investigation task forces.

* Working on membership of the committee. So far, have included Pharmacy, Security, HR. Considering Risk, Compliance, Legal, Nursing leadership, senior leadership.
* When a medication is missing, e.g. fentaNYL infusion, sending out mass communication to all departments with the goal of finding quickly.
* Focusing diversion detection on off-shifts.
* For a significant loss, Security will close down a patient care area until the loss is resolved.
* Quarterly review of data and events by a committee.
* For-cause investigation task force. Core group of diversion committee not involved in direct patient care investigates. Interfaces with leader and HR to look at all aspects and reasons.

**Additional information**

1. American Society of Health-Systems Pharmacists. ASHP Guidelines on Preventing Diversion of Controlled Substances. *Am J Health-Syst Pharm*. 2017; 74:e10-33. <http://www.ajhp.org/content/ajhp/early/2016/12/22/ajhp160919.full.pdf>.
2. American Society of Health-Systems Pharmacists. Pharmacy Management: Human Resources–*Positions*. Drug Testing (1717). <https://www.ashp.org/-/media/assets/policy-guidelines/docs/policy-positions/policy-positions-human-resources.ashx>. Accessed Oct 9, 2018.