

Drug Diversion Tabletop Exercise for Ambulatory Surgery Centers

Facilitator Guide with Scenarios

Reviewed June 26, 2026

Overview

The New Jersey Department of Health (NJDOH) created a tabletop exercise for Ambulatory Surgery Centers (ASCs) to stimulate discussion of drug diversion and review existing policies on the topic.

The exercise features three scenarios where injectable opioid medication was diverted by healthcare staff. The exercise should be guided by a facilitator familiar with drug diversion and the issues surrounding the topic in health care settings. The discussion takes participants through the three scenarios and poses various questions about existing policies, handling of potential/suspected diversion, and responding to an employee who diverted injectable medications. The scenarios used during the exercises were developed by the NJDOH Communicable Disease Service, in collaboration with the staff from NJDOH Health Facilities Survey and Field Operations.

Tools for conducting drug diversion exercises

You will need a facilitator who will be the point of contact and help organize the exercise. The facilitator should be familiar with drug diversion and the materials in this guide. The facilitator should be able to reserve meeting space conducive to group discussion and invite the appropriate participants for the exercise. You will need a screen (or a blank wall), an LCD projector, a laptop, a slide advancer for presenting the PowerPoint, a sign-in sheet, and copies of existing policies to refer to during the exercise. For larger groups, it is recommended to provide name cards/tags for all.

Reserve the room for at least two hours (NOTE: It is recommended to add an additional 15 minutes before and after to allow time for setting up and questions at the end).

It should also be made clear that anyone participating in the exercise should plan to stay for the entire two-hour activity. If two hours is an unreasonable timeframe for participants, or if the exercise is being conducted during the lunch hour, consider scheduling multiple meetings to discuss different scenarios individually. The drug diversion exercises are well-suited for use during committee and staff meetings. The PowerPoint slides are designed to include scenarios and discussion questions. The facilitator should make copies of the scenarios and distribute them to each participant at the beginning of the exercise.

A participant evaluation (included) was created for the drug diversion exercise. No names are required on the evaluation. The purpose of the evaluation is to give participants an anonymous mechanism to provide feedback. The topic is sensitive, and the evaluation asks participants to highlight good practices and areas that need improvement in their facilities.

Who should I invite to participate in the exercise?

A diverse group of staff representing various departments across the facility will have the most robust discussion. While titles may vary from facility to facility, the roles and

tasks are consistent. It is recommended that a note-taker be identified.

Facility leadership should be able to assist with identifying the recommended participants at the site to invite. They should also be tasked with confirming attendance one to two days prior to the exercise.

NOTE: If scheduling certain individuals is difficult, consider using a standing meeting or committee time to hold the exercise. This way, certain individuals are already slated to attend. If the standing meeting/committee is not two hours in length, you may not be able to use all three scenarios and may wish to make a return trip to the facility.

Recommended participants include:

- Administration (Chief Medical Officer, Chief Medical Information Officer, Chief Operating Officer, Vice President for Clinical Affairs)
- Nursing administration (Chief Nursing Officer, Director of Nursing, Assistant Director of Nursing, Nursing Supervisor)
- Pharmacy (Director of Pharmacy Services, Assistant Pharmacy Director)
- Infection Prevention
- Security
- Risk Management/Quality Improvement
- Human Resources

Other participants may include:

- Patient Safety/Patient Services
- Anesthesia
- Employee & Occupational Health
- Legal
- Office of Communications/Public Information Officer

Anyone who is tasked with writing drug diversion prevention policies, enforcing policies and procedures, training staff about drug diversion, monitoring/ordering controlled drug supplies, investigating drug diversion incidents, or has any contact with controlled substances should be included.

Scenarios

The scenarios do not include roles for external partners, such as local law enforcement and public health. These scenarios promote discussion among participants and aim to create an exercise for internal staff to determine the best course of action. Depending on your state and its rules/regulations, you may need to make changes to ensure the scenario is applicable.

Scenario #1

This ASC is affiliated with a large health system. However, the ASC uses a contracted pharmacy provider and not the hospital pharmacy.

In preparation for Monday morning's procedures at the facility, the nurse begins drawing up medications for all cases that day. As she is drawing up medications from a new single-dose vial of Fentanyl, she notices that the dust cap seems loose. She thinks this is odd but uses aseptic technique to clean the top of the septum and fill syringes for the procedures.

The following week, the nurse notices that there are again loose dust caps on the Fentanyl. It also looks like one of the vials is not completely filled. She thinks this is odd, but continues to draw up medications and does not tell anyone about the suspicious vials of Fentanyl.

In the break room, the recovery nurse mentions that the patients have been complaining about pain. She said that there have been quite a few complaints in the last few weeks. In passing, the recovery nurse tells a co-worker that she has had more patients complaining of pain, despite being treated, especially those who are receiving Fentanyl.

After the conversations about patients and pain management concerns, the nurse checks the newest order of Fentanyl and sees that the caps are loose. She relays her concerns to the nurse manager, who contacts the contract pharmacy. She tells them that over the last few weeks, their ASC has received at least one vial that was not completely filled. The pharmacy director calls the manufacturer to see if there was an overlooked recall. The manufacturer says there was no recall. The contract pharmacy instructs the ASC to package the remaining vials of Fentanyl and return them to the contract pharmacy. Upon receipt, the pharmacy director examines the vials and notices very fine holes in the septum of some vials.

The pharmacy director sends the vials out for testing. Test results show that the vials are 40% Fentanyl and 60% saline. The pharmacy director reviews the pharmacy's videos and is surprised to see a new pharmacy technician tampering with vials of medication that were shipped to the ASC.

Scenario #2

The nurse enters the pre-op area to measure vital signs before the patient is taken to the operating room suite. After recording information, the nurse tells the patient to wait while he draws up the medication for the procedure. He enters the medication prep room and draws up the medications that he needs for his case. Among other pre-op meds, he draws up two syringes of Fentanyl, one for his patient and the other for himself, which he puts in his shirt pocket. He returns to the pre-op area to administer the medications to the patient.

The nurse wheels the patient into the operating room and assists the OR tech with set-up. After the case is over, he is near the door when the syringe falls out of his pocket. Both the OR tech and the doc see the syringe on the floor. The anesthesiologist picks up the syringe, places it on the table, and asks the nurse where it came from. The nurse shrugs and says that he was in a hurry and it must be a leftover from yesterday's cases. The nurse grabs the syringe from the table and walks out of the OR suite. The OR tech begins to say something to the anesthesiologist about the nurse's weird behavior but decides not to. Last week, the tech noticed that the nurse had come in when he wasn't scheduled and was hanging out near the medication prep room. The tech decides it is none of his business; he needs this job and is not getting involved. He wheels the patient to the recovery room after the procedure.

The next day, the nurse is not scheduled to work but arrives at the facility. He says he left something in his locker. As he makes his way back towards the locker room, he makes a quick move to the med prep room. He enters the Pyxis using a co-worker's code, takes a vial of Fentanyl, slips it into his pocket, and leaves the building.

On his next scheduled workday, he goes to the med prep room and fills a syringe with Fentanyl. He goes into the bathroom, injects himself with the Fentanyl, and fills the syringe with tap water before returning to the patient area. He puts the water-filled syringe on the cart where other medications for the procedure are kept. During the case, the anesthesiologist notices an unmarked syringe on the cart and asks the OR tech and nurse where it came from, since it is unlabeled. The nurse says he does not know but will dispose of it once the case is over. The unlabeled/water-filled syringe is kept off to the side of the cart.

The OR tech takes the patient to recovery, and the nurse tells the anesthesiologist he is going to the med room to get meds for the next case. The nurse empties the water-filled syringe, goes to the med prep room, fills a syringe with Fentanyl, walks to his locker, and puts the syringe in his locker. The tech approaches the nurse and tells him he saw what he did and will report it to the director of nursing.

The nurse is upset and goes into the bathroom, injects the medication, and passes out. The nurse is found by another staff member with the needle still in his arm.

Scenario #3

An endoscopy center has many procedures scheduled for the day. They have veteran staff who are used to getting through procedures quickly. Most staff have been at the center for three years or more.

A nurse anesthetist is talking with the first patient (Case #1) of the day before the start of the procedure. She has a new 50mL single-dose vial of Propofol for the case. She draws up the entire vial into a single syringe and administers half of it to the patient, along with other medications. Before the case starts, while no one else is in the room, she administers a small amount of the Propofol to herself. When the surgeon arrives, she administers the remaining Propofol to the patient. At the end of the case, she discards the needle and syringe. The nurse anesthetist starts Case #2 with a new 50mL single-use vial of Propofol. For this case, she draws up 20mL and administers it to the patient. During the case, an additional 10mL of Propofol is drawn up and administered using the same syringe as the first dose but with a new needle. At the end of the case, the needle and syringe are discarded in the sharps container; however, 20mL of Propofol remains in the vial. The nurse puts the vial in her pocket to use on the third case of the morning. Case #3 is a very large man. During the case, the nurse anesthetist finishes the first bottle of Propofol that she used on Case #2. She then opens a new vial of Propofol and administers an additional dose to Case #3 using the same syringe and new needle.

The nurse anesthetist continues to open new vials of Propofol as needed for her cases throughout the day. At the end of the day, she used five bottles of Propofol on 15 patients. She leaves the center with a half-filled bottle of Propofol in her coat pocket.

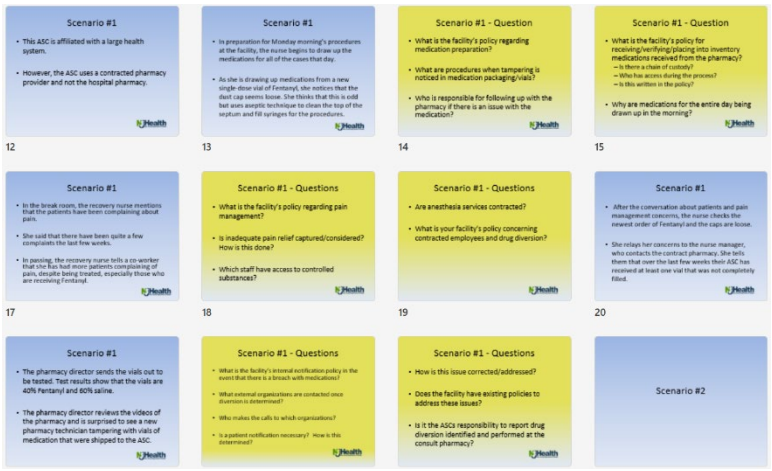
Five and a half months later, the local health department receives a call from a local gastrointestinal physician. He tells the center that he has two patients who both had procedures a few months ago at the ASC and are now positive for hepatitis C. They have no traditional risk factors for the disease and were negative for the virus a year ago. The surgery at the ASC is the only health procedure they have undergone in the last 12 months. The local health department, along with the state health department, began a public health investigation to determine if the individuals were infected with the virus during their procedures at the ASC. After reviewing patient records and infection prevention and control practices at the ASC, it is determined that patients who received injectable medication from a single nurse anesthetist within the last 3 years should be tested for bloodborne pathogens. She has been employed at the center for three years.

Sample of Slides

As noted earlier, PowerPoint slides are provided to outline the scenario and prompt discussion among participants. The slides are divided into three sections: the introduction and objectives of the exercise, the scenario (blue slides), and discussion questions (yellow slides).

The slides use color to separate the scenarios from the questions. This makes it easier for participants to follow along. It also assists the facilitator as they ask discussion questions.

Below are shown samples of the slides. The entire slide set is available as a separate attachment.



Scenarios with Questions

Also included are the three scenarios, along with discussion questions for use by the facilitator. It is not provided to participants; however, it may be a helpful reference for the note taker. This document includes the entire scenario and all the questions from the PowerPoint slides. It includes everything participants see on the slides and helps the facilitator identify which questions are included at specific points in the scenario. The scenario is bold, but the questions are not.

Depending on the type of discussion during the exercise, the facilitator may choose to skip some questions. The facilitator may find that some questions are redundant or that the issue has already been addressed. It is up to the facilitator to ask the prompting questions.

The facilitator may wish to introduce additional questions, depending on their familiarity with the facility, the issues, and the time allotted. The included questions help keep the exercise on track. Be wary of adding questions if the exercise timeframe is reduced.

Facilitator Exercise Scenarios with Discussion Questions

Scenario #1

This ASC is affiliated with a large health system. However, the ASC uses a contracted pharmacy provider and not the hospital pharmacy.

In preparation for Monday morning's procedures at the facility, the nurse begins drawing up medications for all cases that day. As she is drawing up medications from a new single-dose vial of Fentanyl, she notices that the dust cap seems loose. She thinks this is odd but uses aseptic technique to clean the top of the septum and fill syringes for the procedures.

What is the facility's policy regarding medication preparation?

What are the procedures when tampering is noticed in medication packaging/vials?

Who is responsible for following up with the pharmacy if there is an issue with the medication?

What is the facility's policy for receiving/verifying/placing into inventory medications received from the pharmacy?

Is there a chain of custody?

Who has access during the process?

Is this written in the policy?

Why are medications for the entire day being drawn up in the morning?

The following week, the nurse notices that there are again loose dust caps on the Fentanyl. It also looks like one of the vials is not completely filled. She thinks this is odd but continues to draw up medications and does not tell anyone about the suspicious vials of Fentanyl.

In the break room, the recovery nurse mentions that the patients have been complaining about pain. She said that there have been quite a few complaints in the last few weeks. In passing, the recovery nurse tells a co-worker that she has had more patients complaining of pain, despite being treated, especially those who are receiving Fentanyl.

What is the facility's policy regarding pain management?

Is inadequate pain relief captured/considered? How is this done?

Which staff have access to controlled substances?

Are anesthesia services contracted?

What is your facility's policy concerning contracted employees and drug diversion?

After the conversations about patients and pain management concerns, the nurse checks the newest order of Fentanyl and sees that the caps are loose. She relays her concerns to the nurse manager, who contacts the contract pharmacy. She tells them that over the last few weeks, their ASC has received at least one vial that was not completely filled. The pharmacy director calls the manufacturer to see if there was an overlooked recall. The manufacturer says there was no recall. The contract pharmacy instructs the ASC to package the remaining vials of Fentanyl and return them to the contract pharmacy. Upon receipt, the pharmacy director examines the vials and notices very fine holes in the septum of some vials.

The pharmacy director sends the vials out for testing. Test results show that the vials are 40% Fentanyl and 60% saline. The pharmacy director reviews the pharmacy's videos and is surprised to see a new pharmacy technician tampering with vials of medication that were shipped to the ASC.

What is the facility's internal notification policy in the event that there is a breach involving medications?

What external organizations are contacted once diversion is determined? Who makes the calls to which organizations?

Is patient notification necessary? How is this determined?

How is this issue corrected/addressed?

Does the facility have existing policies to address these issues?

Is it the ASCs responsibility to report drug diversion identified and performed at the consult pharmacy?

<u>Scenario #2</u>

The nurse enters the pre-op area to measure vital signs before the patient is taken to the operating room suite. After recording information, the nurse tells the patient to wait while he draws up the medication for the procedure. He enters the medication prep room and draws up the medications that he needs for his case. Among other pre-op meds, he draws up two syringes of Fentanyl, one for his patient and the other for himself, which he puts in his shirt pocket. He returns to the pre-op area to administer the medications to the patient.

The nurse wheels the patient into the operating room and assists the OR tech with set-up. After the case is over, he is near the door when the syringe falls out of his pocket. Both the OR tech and the doc see the syringe on the floor. The anesthesiologist picks up the syringe, places it on the table, and asks the nurse where it came from. The nurse shrugs and says that he was in a hurry and it must be a leftover from yesterday's cases. The nurse grabs the syringe from the table and walks out of the OR suite. The OR tech begins to say something to the anesthesiologist about the nurse's weird behavior but decides not to. Last week, the tech noticed that the nurse had come in when he wasn't scheduled and was hanging out near the

medication prep room. The tech decides it is none of his business; he needs this job and is not getting involved. He wheels the patient to the recovery room after the procedure.

Does the facility have an internal mechanism to report unusual behavior/potential diversion?

What is the facility's policy for drawing medication for each procedure?

The next day, the nurse is not scheduled to work but arrives at the facility. He says he left something in his locker. As he makes his way back towards the locker room, he makes a quick move to the medication prep room. He enters the Pyxis using a co-worker's code, takes a vial of Fentanyl, slips it into his pocket, and leaves the building.

On his next scheduled workday, he goes to the med prep room and fills a syringe with Fentanyl. He goes into the bathroom, injects himself with the Fentanyl, and fills the syringe with tap water before returning to the patient area. He puts the water-filled syringe on the cart where other medications for the procedure are kept.

How is the monitoring of the automated dispensing cabinet (e.g., Pyxis) conducted? By whom?

Where are medication records/automated dispensing cabinet reports kept?

Who monitors these records/reports?

When unusual behavior is suspected, how is it handled?

During the case, the anesthesiologist notices an unmarked syringe on the cart and asks the OR tech and nurse where it came from, since it is unlabeled. The nurse says he does not know but will dispose of it once the case is over. The unlabeled/water-filled syringe is kept off to the side of the cart.

The OR tech takes the patient to recovery, and the nurse tells the anesthesiologist he is going to the med room to get meds for the next case. The nurse empties the water-filled syringe, goes to the med prep room, fills a syringe with Fentanyl, walks to his locker, and puts the syringe in his locker. The tech approaches the nurse and tells him he saw what he did and will report it to the Director of Nursing.

The nurse is upset and goes into the bathroom, injects the medication, and passes out. The nurse is found by another staff member with the needle still in his arm.

Does the facility have a policy that addresses drug use in employees? Is local law enforcement contacted?

What other agencies are contacted? And by whom?

After an incident, is there an internal group that meets to discuss policies/procedures?

Is education/in-service provided to staff about the facility's diversion policies?

Is there a phone number for employees to call to alert the facility about drug diversion/employee drug use?

Scenario #3

An endoscopy center has many procedures scheduled for the day. They have veteran staff who are used to getting through procedures quickly. Most staff have been at the center for three years or more.

A nurse anesthetist is talking with the first patient (Case #1) of the day before the start of the procedure. She has a new 50mL single-dose vial of Propofol for the case. She draws up the entire vial into a single syringe and administers half of it to the patient, along with other medications. Before the case starts, while no one else is in the room, she administers a small amount of the Propofol to herself. When the surgeon arrives, she administers the remaining Propofol to the patient. At the end of the case, she discards the needle and syringe. The nurse anesthetist starts Case #2 with a new 50mL single-use vial of Propofol. For this case, she draws up 20mL and administers it to the patient. During the case, an additional 10mL of Propofol is drawn up and administered using the same syringe as the first dose but with a new needle. At the end of the case, the needle and syringe are discarded in the sharps container; however, 20mL of Propofol remains in the vial. The nurse puts the vial in her pocket to use on the third case of the morning. Case #3 is a very large man. During the case, the nurse anesthetist finishes the first bottle of Propofol that she used on Case #2. She then opens a new vial of Propofol and administers an additional dose to Case #3 using the same syringe and new needle.

What, if any, are issues that you see with the nurse anesthetist's practice?

What is the facility's policy about using single-dose vials for more than one patient?

What is the procedure for preparing medication?

Where is the medication prep usually done: in a separate room, in the surgery suite, or elsewhere?

Is anesthesia a contracted service for the center?

What are the facility's policies about anesthesia providers and medication handling?

How is medication use and waste recorded?

The nurse anesthetist continues to open new vials of Propofol as needed for her cases throughout the day. At the end of the day, she used five bottles of Propofol on 15 patients. She leaves the center with a half-filled bottle of Propofol in her coat pocket.

How are staff (center/contracted) trained on infection prevention and control/injection safety practices? How often?

Who monitors infection prevention and control at the facility? How are medications

within the facility accounted for?

Does the facility keep logs to ensure that medication vials accessed in the patient treatment area are used for a single patient? This applies to both single and multiple-dose vials.

Five and a half months later, the local health department receives a call from a local gastrointestinal physician. He tells the center that he has two patients who both had procedures a few months ago at the ASC and are now positive for hepatitis C. They have no traditional risk factors for the disease and were negative for the virus a year ago. The surgery at the ASC is the only health procedure they have undergone in the last 12 months. The local health department, along with the state health department, began a public health investigation to determine if the individuals were infected with the virus during their procedures at the ASC. After reviewing patient records and infection prevention and control practices at the ASC, it is determined that patients who received injectable medication from a single nurse anesthetist within the last three years should be tested for bloodborne pathogens. She has been employed at the center for three years.

Does the facility have a policy about the process of patient notification when disease transmission has been identified?

Does the policy include testing for bloodborne pathogens (employee/patient)?

Does the facility maintain a log of healthcare personnel's vaccination/immunization status?

What is the relationship between the local health department and the facility?

Are you aware of which local health department holds jurisdiction over the facility?

Is there an established relationship with a representative from the local health department?

Evaluation

The provided evaluation is an easy-to-use, one-page, two-sided tool with Likert-scale ratings, checkboxes, and space for open-ended responses, which may be printed and distributed to participants at the end of the exercise. The purpose is to determine whether participants found the exercise worthwhile, whether it accomplished its goal, and to gather feedback.

If you are planning to host a drug diversion exercise, you may wish to use an evaluation to assess your audience. It is up to you to decide whether to use the evaluation and how to use the information collected from participants.

Drug Diversion Exercise Evaluation

Thank you for attending today's program. Please take a few moments to complete the evaluation. We are interested in your comments, as they help us ensure that the event's learning objectives have been met and identify ways to improve future offerings. ***Place an "X" in the box that best represents your opinion***.

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
1. The facilitators encouraged participation/discussion during the **Drug Diversion Exercise**	☐	☐	☐	☐	☐
2. The exercise/discussion addressed the stated learning objectives: • Discuss existing facility policies related to drug diversion • Highlight the strengths of existing drug diversion policies at the facility • Identify gaps in existing drug diversion policies at the facility • Identify ways to train/communicate with staff about the facility's drug diversion policies • Explore the process of responding to a drug diversion incident (internally/externally)	☐	☐	☐	☐	☐
3. I felt that the exercise scenarios were realistic	☐	☐	☐	☐	☐
4. After participating in the exercise, I am clear about my role during a suspected/actual drug diversion at my facility	☐	☐	☐	☐	☐
5. As a result of participating in the exercise, I learned <u>at least one</u> new piece of information about issues surrounding drug diversion	☐	☐	☐	☐	☐

OVER

What is your position at the healthcare facility?

- ○ Administration
- ○ Medicine
- ○ Nursing
- ○ Pharmacy
- ○ Other:

How long ago was the last healthcare-related drug diversion incident in which you were involved in any way (e.g., identification, investigation, discipline, policy enforcement, etc.)?

- ○ Less than three months ago
- ○ 3-6 months ago
- ○ 7-12 months ago
- ○ More than 1 year ago
- ○ I have never been involved in a drug diversion incident
- ○ Other:

What was the most useful part of today's exercise?

What was the least useful part of today's exercise?

Do you have any recommendations for improving the effectiveness of this exercise?

Other comments:

THANK YOU FOR YOUR TIME AND PARTICIPATION!