

Drug Diversion Tabletop Exercise

for Hospitals

Facilitator Guide with Scenarios

Reviewed July 6, 2026

Overview

The New Jersey Department of Health (NJDOH) created a tabletop exercise for acute care hospitals to stimulate discussion of drug diversion and review existing policies on the topic. This facilitator guide includes a discussion of the pilot drug diversion exercises and a summary of the findings and recommendations. It provides acute care facilities with tools, including scenarios and slides, to conduct their own exercises.

Summary of Pilot and Findings

The pilot exercise, conducted at four diverse New Jersey hospitals, identified several consistent themes in facility preparedness for healthcare personnel drug diversion involving injectable medications. While all facilities had processes for responding to diversion, these were often based on informal practices rather than written policies. Strong collaboration between pharmacy, nursing, and human resources was common; however, reporting requirements to regulatory agencies varied, and many facilities lacked a clear understanding of mandatory reporting to NJDOH Health Facilities Survey and Field Operations.

The exercise also highlighted limited awareness of the public health implications of injectable drug diversion, particularly the potential for bloodborne pathogen transmission. Infection Prevention staff were not consistently involved in diversion investigations despite their expertise in disease surveillance and public health reporting. Additionally, most facilities had little experience with or formal planning for large-scale patient notification following potential exposure to infectious disease.

Other findings included variation in employee drug testing policies, internal reporting mechanisms, communication with contracted healthcare personnel, staff education, and post-incident communication. Security's role also differed among facilities, particularly regarding coordination with law enforcement and evidence preservation. Although participants reported that oral medication diversion is more common than injectable diversion, the exercise reinforced the need for standardized policies, multidisciplinary collaboration, and preparedness for the unique patient safety and public health risks associated with injectable medication tampering.

Recommendations

Based on the pilot's findings, the following recommendations are intended to strengthen healthcare facility preparedness for preventing, detecting, and responding to drug diversion involving injectable medications:

1. **Establish a multidisciplinary drug diversion committee** with representation from pharmacy, nursing, infection prevention, human resources, quality, risk management, patient safety, and administration to oversee prevention, response, and policy development.
2. **Include Infection Prevention in diversion investigations**, particularly those involving injectable medications, to assess potential infectious disease transmission and coordinate with public health authorities.
3. **Develop and maintain relationships with local public health agencies** to facilitate timely communication and response during diversion events with potential public

health implications.

4. **Implement comprehensive written drug diversion policies** that address prevention, surveillance, detection, investigation, reporting, and response, including public health considerations.
5. **Standardize notification procedures** by identifying internal and external stakeholders, defining reporting requirements, and maintaining current contact information.
6. **Provide ongoing staff education** by incorporating drug diversion into new employee orientation and annual role-appropriate training for clinical and non-clinical staff.
7. **Maintain a confidential reporting mechanism** (e.g., hotline or secure reporting system) that is available 24/7 to encourage prompt reporting of suspected diversion.
8. **Address contracted providers in diversion policies and contracts** by establishing clear expectations for notification and information sharing when diversion is suspected or confirmed.
9. **Develop patient notification and response plans**, including procedures for risk assessment, patient identification, communication, testing, clinical follow-up, and coordination of resources should a diversion event result in potential patient exposure.

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 is the longest of the three and involves the transmission of a disease from an employee to patients at an acute care facility. Patient notification is covered in this scenario. Scenario #2 involves an unlocked/stocked anesthesia cart and various employees. This scenario touches on reporting and contracted employees. Scenario #3 is a pharmacy and drug tampering scenario.

Scenario #1

A nurse working in the Post-Anesthesia Care Unit (PACU) expresses concern to her supervisor that the morphine she has been administering for pain does not seem to be as effective as usual.

The PACU Nurse Manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director has run an activity report for the removal of morphine from the PACU automated dispensing cabinet for the past few months. They notice that one PACU nurse often removes larger quantities of morphine for patients, including individuals that they are not assigned to provide care to. The Pharmacy Director shares the identified pattern with the PACU Nurse Manager.

The Nurse Manager observes the PACU and notices the implicated nurse retrieving medication from the automated dispensing cabinet and then leaving the PACU.

The nurse who took the medication from the automated dispensing cabinet is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest, but hands over two syringes. Both are filled, but one has a broken seal.

The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and that this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she had left her personal cell phone in her locker, was expecting an important call, and needed to get it. Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.

An investigation of various staff reveals that co-workers have seen the implicated PACU nurse at the facility on her days off, at times when she wasn't scheduled to work, and in areas of the facility where she does not normally work.

In addition, the local health department has called the Infection Preventionist (IP) about a cluster of acute hepatitis C virus (HCV) infections in individuals who were patients at the hospital. Two of the patients share a healthcare provider and have no traditional risk factors for HCV. The treating provider ordered testing after they complained of symptoms. Both patients tested positive for HCV. They were both previously in your hospital within three weeks of each other. Both patients were in the PACU.

The nurse admits to self-administering morphine and other controlled drugs in the PACU (e.g., replacing the syringes that were intended for patients, replacing them with saline and returning the filled syringes to the automated dispensing cabinet). The nurse claims she started diverting morphine about two months ago. However, nursing attendance records

dating back 12 months indicate that the implicated nurse was working in the PACU on days when each HCV-infected patient received morphine injections.

The hospital has documentation of the nurse's completed hepatitis B vaccination series and post-vaccination serology. The nurse denied a history of hepatitis C or other bloodborne pathogens (BBP). She voluntarily agrees to BBP testing.

The results return, and the implicated nurse tests positive for hepatitis C. The hospital promptly notifies the local health department of this development as part of the ongoing investigation. Following a review of the epidemiologic information, the health department determines that the findings warrant patient notification and a recommendation for BBP testing.

The nurse has worked at the hospital for 18 months. Based on the available information, the identified infections occurred approximately six months ago, predating the nurse's reported onset of drug diversion (approximately two months ago). This discrepancy suggests that potential exposure in the PACU may have occurred over a longer period than disclosed and supports expanding the patient notification timeframe.

It is determined that all patients who received care in the PACU during the nurse's 18-month period of employment should be notified of their potential exposure and advised to undergo testing for hepatitis C and HIV. Since the nurse was observed in multiple areas beyond her assigned PACU role, the local health department is unsure of the full extent of potential exposure and whether additional patient populations may need to be included in the notification scope.

At this point, the hospital estimates that more than 1200 patients were in the PACU during the last 12 months.

Scenario #2

During her rounds, the Infection Preventionist (IP) notices that the anesthesia cart was left unlocked in one of the operating suites. She notices that there is a partially used vial of fentanyl and two syringes on top of the cart, one empty and the other filled. An anesthesiologist arrives a few minutes after the IP sees the cart. He tells the IP that he had to run to the bathroom and the rest of the team left for the day. He returns the cart to the lock-up area and leaves for the day.

The following week, an anesthesia tech sees a stocked anesthesia cart prepped for morning surgeries just inside the locked door of an operating suite. On the cart, he notices pre-filled syringes for the entire day's surgeries. There is also an empty syringe among the filled syringes. The tech begins wheeling the cart into the locked-up area when one of the anesthesiologists enters the operating suite. The doctor explains that he was in the bathroom and that the cart should be wheeled over to operating suite #3.

While cleaning the room between cases, the tech notices the anesthesiologist take one of the syringes, put it in his scrubs pocket, and walk into the bathroom. The tech waits a while and follows him into the bathroom. As the tech opens the restroom door, he sees the anesthesiologist at the sink filling a syringe with tap water.

The anesthesiologist tells him that it is not what it looks like and brushes past the tech to the operating suite. The tech tells his co-worker buddy what he saw and asks for advice. The tech is unsure whether to tell his supervisor because he doesn't want to get the doctor in trouble.

Scenario #3

During an audit of BD Pyxis™ CII Safe™ system activity at your pharmacy, the Pharmacy Director notices that a staff pharmacist has accessed the CII safe numerous times in the past 2 months without documenting a valid reason. The pharmacist entered "***" as the reason. No medications are recorded as removed from the safe at the time of these entries. Upon counting, no medication vials are missing from any of the medication drawers.

The Pharmacy Director decides to carefully examine all the medications in the BD Pyxis™ CII Safe™. Evidence of drug tampering is identified in certain opioids. They notice tiny holes at the centers of some dust cover caps.

The Pharmacy Director schedules a meeting with the staff pharmacist, who admits to tampering with the medication vials for "personal use". The staff pharmacist claims that vials were refilled with sterile saline to replace the medication removed.

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

A nurse working in the Post-Anesthesia Care Unit (PACU) expresses concern to her supervisor that the morphine she has been administering for pain does not seem to be as effective as usual.

Does the facility have policies addressing what should be done when a nurse expresses a concern about controlled drugs they are administering?

Would an adverse drug event report be made?

The PACU Nurse Manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director has run an activity report for the removal of morphine from the PACU automated dispensing cabinet for the past few months. They notice that one PACU nurse often removes larger quantities of morphine for patients, including individuals that they are not assigned to provide care to. The Pharmacy Director shares the identified pattern with the PACU Nurse Manager.

Is there someone else besides the Pharmacy Director that the Nursing Manager should have notified?

Should the Pharmacy Director have shared their findings with the Nurse Manager? To whom should they have shared the findings regarding the PACU nurse?

Is drug diversion suspected at this point?

Are there policies that specify whom the Pharmacy Director should notify when abnormalities are associated with controlled drugs?

What are the next steps?

The Nurse Manager observes the PACU and notices the implicated nurse retrieving medication from the automated dispensing cabinet and then leaving the PACU.

What does the nurse manager do? Is there a written policy to address suspected diversion and an employee not at the workstation?

Who should be notified/contacted at this moment? Is back-up necessary/required? What is the facility policy?

At what point is the PACU nurse brought in to discuss the findings from the pharmacy audit?

Who is responsible for interviewing the implicated nurse?

What actions might be taken at this point as part of the investigation?

The nurse who took the medication from the automated dispensing cabinet is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest,

but hands over two syringes. Both are filled, but one has a broken seal.

What are the next steps?

Who is involved in intercepting the implicated nurse?

Is testing performed on the contents of the syringe?

What is the policy for mandatory drug testing of employees/staff (randomly or upon suspicion)?

The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and that this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she had left her personal cell phone in her locker, was expecting an important call, and needed to get it. Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.

What actions are taken as part of the investigation?

Which internal departments/partners are involved in the investigation?

Does the diversion event prompt any policy changes or education efforts in your facility?

An investigation of various staff reveals that co-workers have seen the implicated PACU nurse at the facility on her days off, at times when she wasn't scheduled to work, and in areas of the facility where she does not normally work.

In addition, the local health department has called the Infection Preventionist (IP) about a cluster of acute hepatitis C virus (HCV) infections in individuals who were patients at the hospital. Two of the patients share a healthcare provider and have no traditional risk factors for HCV. The treating provider ordered testing after they complained of symptoms. Both patients tested positive for HCV. They were both previously in your hospital within three weeks of each other. Both patients were in the PACU.

The nurse admits to self-administering morphine and other controlled drugs in the PACU (e.g., replacing the syringes that were intended for patients, replacing them with saline and returning the filled syringes to the automated dispensing cabinet). The nurse claims she started diverting morphine about two months ago. However, nursing attendance records dating back 12 months indicate that the implicated nurse was working in the PACU on days when each HCV-infected patient received morphine injections.

The hospital has documentation of the nurse's completed hepatitis B vaccination series and post-vaccination serology. The nurse denied a history of hepatitis C or other bloodborne pathogens (BBP). She voluntarily agrees to BBP testing.

According to your facility's policy, how is the admission of addiction handled? Is this a written procedure? Who is responsible for enforcing this policy? Who is responsible for educating employees about this policy?

Would your hospital require this nurse to get BBP testing?

Is there a written policy about BBP testing when there is a suspected injectable drug diversion?

In addition to the local health department, does the facility contact the NJDOH? Which NJDOH division(s) is/are contacted? What information is provided?

Which department in the hospital is designated to work with public health during an active investigation?

What law enforcement agency(s) are contacted?

Are there any other calls made to professional boards/organizations? If so, which ones?

The results return, and the implicated nurse tests positive for hepatitis C. The hospital promptly notifies the local health department of this development as part of the ongoing investigation. Following a review of the epidemiologic information, the health department determines that the findings warrant patient notification and a recommendation for BBP testing.

The nurse has worked at the hospital for 18 months. Based on the available information, the identified infections occurred approximately six months ago, predating the nurse's reported onset of drug diversion (approximately two months ago). This discrepancy suggests that potential exposure in the PACU may have occurred over a longer period than disclosed and supports expanding the patient notification timeframe.

It is determined that all patients who received care in the PACU during the nurse's 18-month period of employment should be notified of their potential exposure and advised to undergo testing for hepatitis C and HIV. Since the nurse was observed in multiple areas beyond her assigned PACU role, the local health department is unsure of the full extent of potential exposure and whether additional patient populations may need to be included in the notification scope.

At this point, the hospital estimates that more than 1200 patients were in the PACU during the last 12 months.

Does the facility have policies/procedures in place to alert patients and other staff about an event with possible disease transmission?

Is the hospital going to pay for testing the potentially exposed patients? Who writes the testing orders?

Where will the testing be done? At the hospital or refer to private providers or an independent phlebotomy/testing company (e.g., LabCorp, Quest)?

Who writes/signs the patient notification letter?

How is patient information retrieved for notification?

Who is responsible for tracking positive cases?

How does the hospital explain what happened: To employees? To the public?

How does the hospital handle taking a large volume of calls from the public and former/current patients?

Scenario #2

During her rounds, the Infection Preventionist (IP) notices that the anesthesia cart was left unlocked in one of the operating suites. She notices that there is a partially used vial of fentanyl and two syringes on top of the cart, one empty and the other filled. An anesthesiologist arrives a few minutes after the IP sees the cart. He tells the IP that he had to run to the bathroom and the rest of the team left for the day. He returns the cart to the lock-up area and leaves for the day.

Is there a policy for filing a report at this point?

Would the IP be required to report/say anything to anyone about an unsupervised anesthesia cart with controlled drugs?

The following week, an anesthesia tech sees a stocked anesthesia cart prepped for morning surgeries just inside the locked door of an operating suite. On the cart, he notices pre-filled syringes for the entire day's surgeries. There is also an empty syringe among the filled syringes. The tech begins wheeling the cart into the locked-up area when one of the anesthesiologists enters the operating suite. The doctor explains that he was in the bathroom and that the cart should be wheeled over to operating suite #3.

What is the facility's policy about leaving anesthesia materials unsupervised?

What is the facility's policy about pre-filling syringes for the day's surgeries?

While cleaning the room between cases, the tech notices the anesthesiologist take one of the syringes, put it in his scrubs pocket, and walk into the bathroom. The tech waits a while and follows him into the bathroom. As the tech opens the restroom door, he sees the anesthesiologist at the sink filling a syringe with tap water.

The anesthesiologist tells him that it is not what it looks like and brushes past the tech to the operating suite. The tech tells his co-worker buddy what he saw and asks for advice. The tech is unsure whether to tell his supervisor because he doesn't want to get the doctor in trouble.

What is the hospital's policy for employees who suspect drug diversion? How is this policy communicated to all staff?

What is the internal process for reporting suspected drug diversion?

What type of training is provided to employees about drug diversion and reporting suspected incidents?

Is your reporting process for suspected drug diversion anonymous?

How would you evaluate the risk to patients from the tap water?

How would you identify cases of disease linked to the injection of tap water?

How would your facility respond when/if the information is less certain (e.g., how does your facility assess for patient harm in the absence of definitive evidence of tampering/substitution)?

Scenario #3

During an audit of BD Pyxis™ CII Safe™ system activity at your pharmacy, the Pharmacy Director notices that a staff pharmacist has accessed the CII safe numerous times in the past 2 months without documenting a valid reason. The pharmacist entered "*" as the reason. No medications are recorded as removed from the safe at the time of these entries. Upon counting, no medication vials are missing from any of the medication drawers.**

What is your next step?

Is drug diversion a consideration, or is it incomplete drug activity documentation?

Does the facility have a written policy on what to do when drug diversion is suspected?

Does the facility have a written policy addressing actions to take when the Pharmacy Director identifies this type of variance, or is it "just something that is done"?

The Pharmacy Director decides to carefully examine all the medications in the BD Pyxis™ CII Safe™. Evidence of drug tampering is identified in certain opioids. They notice tiny holes at the centers of some dust cover caps.

Who is notified immediately after this discovery is made?

At what point would law enforcement be notified? Now or later?

What employees would be interviewed? By whom?

Are there policies and procedures in place to guide the internal investigative process?

The Pharmacy Director schedules a meeting with the staff pharmacist, who admits to tampering with the medication vials for "personal use". The staff pharmacist claims that vials were refilled with sterile saline to replace the medication removed.

At what point is law enforcement contacted? Which agencies are contacted?

Are there any other calls made to professional boards or organizations? Which ones?

What sort of internal records might you examine as part of the investigation?

At this point, would your pharmacy send the tampered vials for testing of medication concentration and contents?

At what point would you review the employee's personnel file for the status of bloodborne pathogens (hepatitis B/C and HIV), or require testing for these viruses?

Is the local health department notified? By whom?

Would you look for any infections in patients receiving this medication since the substance used to refill the vials might not be sterile?

Is conducting a patient notification a consideration?

Who would decide whether patients should be notified?

What sort of employee or patient messaging might you send out (if any)?

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!