INSTITUTE FOR EXCELLENCE

CONTROLLED SUBSTANCE MANAGEMENT

By Stephen M. Dorman, M.D.

Controlled substance management has always been a challenge for an anesthesia practice. Turnover is rapid by demand, and occasionally documentation of controlled substance use does not receive the priority that is required.

The consequences of inaccurate documentation can be devastating. The result of poor documentation can be accusations of diversion, suspension of privileges, termination of privileges, and reporting to licensing boards. These actions can result is loss of income for the provider or loss of career. One cannot overemphasize the importance of accurate and timely documentation of controlled substance administration.

Management of controlled substances takes on various forms depending on the technology of the healthcare facility. Some hospitals still use the “check out a narcotics box” to state-of-theart automated dispensing machines or dispensing carts with barcode scanning. Finally, though not yet a scheduled medication universally, propofol and ephedrine should be managed as carefully as fentanyl. All of these medications are known drugs of abuse.

“Abuse” and “diversion” are separate issues. Abuse implies that the provider is personally using the medication. Diversion implies that the medication is being diverted to other individuals or family members. It also could imply that the medication is used for sale. Either way if medications are found on a person outside of the hospital, the individual may be prosecuted for theft at a minimum.

Below are a set of principles, that, if followed, will guarantee success and hospital satisfaction. It will also keep a license intact.

Medication Removal:

1. Only remove the amount of controlled substance that you will need. To remove too much medication can give the impression of diversion. It also creates delays based on methods to return the unused, that is unopened, medication.
2. Only remove controlled medication for one patient at a time.
3. Make sure that the timing of the removal is accurate. Do not remove and record medication withdrawal at 11:00am for an 8:00am case. Removing medication too early for a case can be equally problematic.

Medication Administration:

1. All medication should be drawn up individually and labeled with drug name, concentration, and a “beyond use” parameter. Since most injectable substances do not contain preservatives, this “beyond use” is timed to be the end of the case. If the

medication has been diluted, the volume and nature of the diluent and new drug concentration must be indicated (TJC NPSG 3.0).

2. Do not draw up medication for an emergency cart. Frequently these medications go beyond the time parameter and carts may be left unsecured. It is high risk.
3. Be accurate about administration timing. Should a surveyor or other provider notice that 50 micrograms of fentanyl were recorded on the anesthesia record, but only 25 micrograms remained from a 100 microgram ampoule, this would be very problematic. Joint Commission had been known to do live count reconciliation during the middle of cases and cite providers when counts don't match.
4. One of the most problematic documentation issues occurs when a provider retrospectively records narcotics administration, such as at the end of the case.

Wasting of controlled substances:

1. DEA requires that medications be disposed of in a non-retrievable manner. The CMS COP specifically prohibits the disposing of controlled substances into a "container", meaning a container such as a sharps container.
2. EPA does not endorse disposing of controlled substances into the public sewer system, such as "down the drain."
3. Acceptable methods of disposal include the use of an absorbent material inside a container. This renders the medication non-retrievable. Another method is to return all unused, but drawn up, medication to pharmacy.
4. "Witnessed" wasting is a practice that does not result in detection of abuse or diversion. Those intending to abuse or divert will simply make a "show" for disposing a labeled syringe contained saline or water. Many hospitals still use this method of substance control, but multiple incidences have proven this method is ineffective. All that nurses can attest to is that they observed a provider wasting a "clear liquid."
5. If medication is returned to pharmacy, it can be assayed using inexpensive optical density refractometers to detect both drug and concentration. Modern machines also can detect the difference between fentanyl and sterile water.

Management of controlled substances:

1. The most problematic issue is medication security. All medication, but particularly controlled substances, must be locked at all times unless the medication is personally attended by a provider. There have been arguments about the need for rapid access, but this plea will fall on deaf ears if someone finds a controlled substance that would be accessible by any provider other than the one who is responsible for it.
2. Do not carry controlled substances in a pocket. Special clipboards are available that have a storage section in them. If it is necessary to transport medication, this is the ideal way. No one is sure how this became such a survey hot spot, but it is, nonetheless.
3. Do not keep controlled substances in a personal locker, and never in a personal item such as a backpack or briefcase.

4. If you are using any controlled substance, consult an employee assistance program immediately. It may save your license, your career or your freedom.

Issues that give the impression of abuse or diversion:

1. Habitually checking out more than necessary controlled substances.
2. No wasting at all, or constant high volume wasting.
3. High dose narcotics for short cases, or for pediatric cases. (Level of consciousness or pain levels will be compared in PACU).
4. Inaccurate documentation.
5. Lack of proper wasting according to hospital policy.
6. Finding controlled substance in a personal item: locker, backpack, briefcase, or purse.
7. For hospitals that have usage analysis software, significant variations of controlled substance use when compared to peer providers. The longer the analysis period the more accurate the data analysis. It is important to note that peers doing similar functions should be compared. It is not accurate to compare a cardiac anesthesia provider or endoscopy provider to an outpatient pediatric provider.
8. The “splitting” of doses among patients, despite the short supply of the controlled substance.