DEPARTMENT OF CORRECTIONS

Policy Number:	**500.202**
Title:	**Medication/Treatment/Transcription Variances**
Effective Date:	**6/5/18**

PURPOSE: To provide procedures to identify and report variances and identify when proper procedure has not been followed so corrective action can be instituted.

APPLICABILITY: Licensed and trained staff at all facilities

DEFINITIONS:

Medication variance - any medication that has been omitted, not delivered with the correct dosage, by the correct route, at the correct time/date, to the correct person, or any medication that does not have a valid order or is incorrectly documented.

Treatment variance - any treatment that is not delivered correctly.

Transcription variance - the failure to properly process a medication or treatment order as written by the prescribing authority.

PROCEDURES:

A. When a medication/treatment/transcription variance is discovered, all staff involved and aware of the variance must:
   1. Notify a nurse, if on duty, who:
      a) Observes the offender for potential side effects and adverse reactions;
      b) Documents the findings in the medical record;
      c) Notifies the facility or on-call practitioner of the variance, if clinically indicated, and follows orders as prescribed;
      d) Notifies the register nurse (RN) supervisor/designee of the variance and the action taken; and
      e) Takes appropriate action if the offender needs to be sent to an outside health care facility.

   2. Notify the watch commander, if there is no nurse on duty, who must contact the on-call practitioner.

B. The nursing staff discovering or notified of the variance must initiate the Medication/Treatment Variance form (attached).

C. The practitioner must:
   1. Respond in a timely manner to variance reports submitted by the nursing staff;
   2. Clinically assess the offender, if indicated;
   3. Order the appropriate interventions; and
   4. Document the findings and actions in the medical record, if indicated.

D. When the medication variance is pharmacy related, the contract pharmacy must:
   1. Respond in a timely manner on the appropriate pharmacy form submitted by the nursing staff; and
   2. Take corrective action to prevent the medication/treatment variance from occurring again.

E. The RN supervisor must:
   1. Review the Medication/Treatment Variance form for completeness;
   2. Ensure the proper documentation is in the medical record;
   3. Meet with the involved staff and develop an action plan to prevent future occurrences; and
   4. Forward all completed variance forms to the health services administrator.

F. The facility health services administrator must:
   1. Maintain all variance reports on file;
   2. Take corrective actions as indicated; and
   3. Forward a copy of report to central office health services for distribution.

G. The director of nursing must:
   1. Review reports by facilities; and
   2. Share reports, if indicated, with the department health services director and facility health services administrators.

INTERNAL CONTROL:

A. Documentation of medication variances is maintained by the registered nurse supervisor for six months.

ACA STANDARDS: 1-ABC-4E-16

REFERENCES: None

REPLACES: Division Directive 500.202, "Medication/Treatment/Transcription Errors," 11/19/13. All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: Medication/Treatment Variance form (500.202A)

APPROVALS:
Deputy Commissioner, Community Services
Deputy Commissioner, Facility Services
Assistant Commissioner, Facility Services
Assistant Commissioner, Operations Support