Procedure for the Transcribing of Medication for the Purpose of Recording Administration in Community Health Services
<table>
<thead>
<tr>
<th><strong>Version:</strong></th>
<th>1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultation Groups</strong></td>
<td>Community Nursing Team Leads/Managers</td>
</tr>
</tbody>
</table>
| **Approved By** | Clinical Policies Review and Alignment Committee  
Nursing Development Steering Group |
| **Ratified By:** | Medicines Committee |
| **Date ratified:** | 18 July 2018 |
| **Name and Job Title of authors:** | Clinical Pharmacist  
Lead Pharmacist Bedfordshire |
| **Executive Director Lead:** | Medical Director |
| **Implementation Date:** | July 2018 |
| **Last Review Date:** | July 2018 |
| **Next Review Date** | July 2021 |

<table>
<thead>
<tr>
<th>Services</th>
<th><strong>Applicable to</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide</td>
<td></td>
</tr>
<tr>
<td>Mental Health and LD</td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td>✓</td>
</tr>
<tr>
<td>Version</td>
<td>Date</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>1.0</td>
<td>July 2018</td>
</tr>
<tr>
<td>2.0</td>
<td>October 2018</td>
</tr>
</tbody>
</table>
Executive Summary

1. Introduction
2. Purpose
3. Duties
4. Training and Competence
5. Transcribing Procedure
6. Appropriate Sources of Information
7. Carrying out a Transcription
8. Accountability
9. Reporting Errors
10. Audit and Monitoring
11. References

Appendix A: Register of Transcribing Competent Staff
Appendix B: Transcribing Competence Form
Appendix C: Transcribing Procedure Flowchart
Transcribing onto Medicines Administration Record Charts is a routine activity within Community Health Services and carries risks to patient safety if not properly conducted. This procedure provides a framework to support safe transcribing within Community Health Services in the Trust. It is aimed at all community Health Services staff involved in the administration of medicines and defines procedures which must be followed.

1.0. Introduction

1.1. Transcribing is not covered by the Medicines Act, or Human Medicines Regulations 2012 and it is not prescribing.

1.2. The dictionary defines transcribing as the act of making an exact copy usually in writing. This means that there must always be an original copy or document from which the transcribed copy is made. The prescription issued by an appropriate prescriber is the original. The prescriber responsible for generating the original instruction carries the legal liability for the content of that instruction. If this is then transcribed accurately and without any alteration the person making the transcribed copy does not assume that liability. If inaccuracies appear as a result of transcribing, the transcriber bears legal responsibility for the inaccuracies.

1.3. The NMC states that “Any act by which medicinal products are written from one form of direction to administer to another is transcribing. This includes, for example, discharge letters, transfer letters, copying illegible patient administrations charts onto new charts, whether hand-written or computer-generated.” It advises that transcribing should only be undertaken in exceptional circumstances and should not be routine practice. However, the NMC recognises that care is being increasingly provided in more “closer to home” settings that are often nurse led, and recommends managers/employers undertake a risk assessment to develop a management process to enable transcribing to be undertaken where necessary.

1.4. In community-based practice, medication may be transcribed from an authorisation to administer issued by a prescriber onto a Medicines Administration Record (MAR) Chart for the purposes of recording administration. It should be noted that the MAR chart is not an authorisation to administer or a prescription, but a record of administration, therefore the signature of the prescriber of the medicine is not required on the MAR chart. The healthcare professional carrying out the administration should therefore always refer to the original prescription and retains the responsibility for following the instructions on the original prescription.

2.0. Purpose

2.1. This procedure provides the framework to support the safe and appropriate transcribing of medicines information for the purpose of recording administration of medicines. It describes the situations that constitute transcribing, who can transcribe medicines information and gives an overview of the process and requirements for transcribing.

3.0. Duties
3.1. **Transcriber**
- Ensure that all medicines details are accurate, appropriate and safe for the patient. The transcriber must only transcribe and enable administration of medicine where they are confident that this is the case.
- If the transcriber finds medicines information that is unclear or they believe to be inaccurate or unsafe they must not transcribe. They must contact an appropriate prescriber and ensure resolution of the problem.
- Transcribe medicines details in-line with this procedure, the Medicines Policy and other associated policies.
- Ensure that their training is up-to-date.

3.2. **Manager**
- Read and fully understand the procedure, how it relates to their service and be assured that application within their service complies with all clinical governance requirements.
- Ensure that staff have read and understood the procedure.
- Ensure that the transcriber undertakes necessary training (and refresher training), in-line with this policy, and that this is documented.
- Ensure time is made available for the individual to train.
- Take action, in-line with the appropriate policies, in response to errors relating to transcribing.

3.3. **Pharmacist**
- Review transcribing practice via audits and clinical incidents ensuring that it is in-line with the requirements of this procedure.
- Transcribe, where appropriate, in-line with this policy.
- Provide transcribing training, in-line with this policy.

3.4. **Staff member administering medicine**
- Accept responsibility for their actions and must only administer when they are confident that it is safe and appropriate for them to do so.
- If the staff member finds a transcription that is unclear or they believe to be inaccurate or unsafe they must not administer the medicine but contact the appropriate clinician, including the transcriber, prescriber or manager for resolution of the problem.
- Administer medicines in-line with relevant policies and personal training and competencies.

4.0. **Training and Competence**

4.1 Transcribing can only be carried out if the registered healthcare professional has/is:
- At least one year’s post registration experience with exposure to drug administration
- In a Band 5 position or above.
- Registered with an appropriate professional body
- Successfully completed Trust training and competence assessments for transcribing
- Deemed competent to transcribe by their Team Leader and completed a transcriber signature form. A register containing signatures (Appendix A) of all staff deemed competent to transcribe in each team will be held by the Team leads. This register must be updated annually.

4.2 Transcribing Training comprises:
- i. Theory – taught element of training, via on-line learning or face-to-face training.
ii. Competency based test – mock scenarios involving transcription of medicines information. Transcriptions must be completed accurately and in accordance with the procedure.

4.3 Both elements must be completed successfully for an individual to be approved to transcribe. If the individual fails the competency-based training there may be an opportunity to take a resit test, depending on the nature of reasons for failure and on agreement of the manager/service lead.

4.4 Competence is valid for 3 years. Training must be repeated successfully within 3 years after the initial competency, otherwise the competency will lapse and the individual must not transcribe.

4.5 Pharmacists and non-medical prescribers do not require transcribing training or competence assessments. Their qualification shows they are competent to appropriately record medicines information.

5.0. Transcribing Procedure
(Please Refer to Appendix C for Transcribing Procedure Flowchart)

5.1. Transcribing includes:
- Writing out a patient’s current dispensed medication from a valid authorisation to administer (see section 6.0) onto a Medication Administration Record (MAR) chart
- Copying transcribed medication from one medication administration record chart to another i.e. rewriting a MAR chart.
- Producing a medication reminder chart to support patients and their Carers in the administration of medication.

5.2. Transcribing can only take place for therapy already authorised in a prescription or other authorisation to administer generated by a qualified prescriber. Transcribing cannot be used to initiate a new medicine, even on the direction of a prescriber. A prescription or direction to administer must already be in place for the transcriber to transcribe.

5.3. The original authorisation to administer must be available, and filed within patient’s notes folder.

5.4. In exceptional circumstances where the original authorisation to administer is not available and it is not possible to obtain one without undue delay; and in the clinical opinion of the healthcare professional the risk to the patients from omitting a dose is high, transcription can be from the details included on the pharmacy label attached to the medication. The transcriber must ensure that the medication is the patient’s current therapy and remains accountable for the decision to transcribe. An appropriate authorisation to administer must be obtained as soon as is practicable and the transcription checked against it for accuracy.

5.5. The transcriber must not make any changes to therapy, must not transcribe anything they believe to be incorrect or unsafe and must not guess. If the source of information that the transcriber is using is unclear in any way then transcribing must not occur.

5.6. If the transcriber finds something that they believe to be wrong or unsafe or unclear they must refer to an appropriate prescriber.

5.7. The Identity of Transcriber must be clearly recorded. The transcriber must sign and print their name against each medicines entry.

5.8. It is best practice to obtain a second check, although it is recognised that there are circumstances when this may not be possible at the point of transcribing e.g. in
patients’ homes. In this instance, it is advisable to have a short mental break between transcribing the chart and the final check for accuracy. A second check for accuracy of the transcribed information must be carried out within 24 hours of the transcription by an approved transcriber and the signature of the second checker appended to the chart.

6.0. **Appropriate Sources of Information**

6.1. Reference should be made to the Medicines Reconciliation Policy for guidance on how to collect and confirm details of current therapy.

6.2. The registered healthcare professional must only use authoritative quality information when transcribing medication. This information must either be attached to the transcription or stored in the patient’s home notes so the registered healthcare professionals administering the medication can check that the transcription and the authoritative information correspond. Prior to transcribing the registered healthcare professional must perform a complete medication reconciliation using at least TWO of the authoritative quality information methods listed:

- A signed prescription from an authorised prescriber*
- Recent hospital/hospice discharge letters that have been signed by the discharging doctor
- The pharmacy administration instruction label attached to medication that has been dispensed within the last six months. However the registered nurse healthcare professional must be confident that this is the most recently dispensed medication.
- A signed authorisation document from the prescriber which identifies the patient and documents the name of medication, dose, frequency route of administration and duration of therapy if appropriate
- A copy of the most recent repeat medication request which must be supported by a verbal medication history from the patient/carer/responsible other or confirmation from the dispensing chemist or GP. This should also be fully documented in the patient’s notes.
- List of medication obtained from “Care Summary records” or patient’s electronic notes.
- A copy of the patient’s latest medication list from General Practitioner
- Clinic letter clearly identifying the patient and medicines and regimens.

6.3. An ‘authorised prescriber’ may be:-

- A registered Doctor or Dentist
- An independent/supplementary prescriber (Non-medical prescriber)
- Community Practitioner Nurse Prescriber (CPNP) when prescribing from the Nurse Prescribers’ Formulary

6.4. Transcribing is not permitted where a second source to check prescriber’s instruction cannot be obtained except in exceptional specified circumstance as outlined below:

- Patient is dispensed prescribed medications at an Emergency Department
- Patient is dispensed prescribed medications at ‘Out of hours GP Service’
- Patient is dispensed prescribed medications at a Family Planning Clinic
- Medication dose is variable for example Insulin or Warfarin. The dose must always be obtained in writing also.

6.5. If the registered nurse healthcare professional who is transcribing has any doubts or identifies any discrepancies during the process of transcribing medication they must stop and gain written confirmation from the original/authorised prescriber*.
7.0.  **Carrying Out a Transcription**  
(Please Refer to Appendix C for Transcribing Procedure Flowchart)

7.1.  Reference should be made to the Medicines Policy for guidance on the approved way to record medicines information, including permitted abbreviations, cancellation and the use of multiple charts, where necessary. Transcriptions must comply with the Medicines Policy.

7.2.  All transcriptions should be printed legibly in BLACK ink and capital letters on the medication administration chart.

7.3.  All transcribed medication must be written in the appropriate section of the medication chart i.e. regular/pm/once only etc.

7.4.  All transcriptions must include the following:
- Date of transcription
- Patient’s full name
- NHS number
- Date of birth
- Known allergies
- Generic name of drug (printed in CAPITALs)
- Drug dose
- Strength
- Formulation i.e. capsule/tablets/suspension etc.
- Timing
- Frequency
- Duration (if appropriate e.g. antibiotics or time limited eye drops)
- Route of administration
- Additional instructions e.g. with or after food, store in the fridge

7.5.  Any errors must be scored through, signed, timed and dated by the registered healthcare professional and re-written.

7.6.  When transcribing controlled drugs (CD), the transcriber must ensure all details listed above are included in the transcription and must pay particular attention to details such as the form, formulation and strengths of the CD being transcribed e.g. morphine sulphate 10mg tablets (Sevredol® 10mg tablets) and morphine sulphate 10mg m/r tablets (MST® CONTINUS® 10 mg prolonged release tablets) are not the same thing.

8.0.  **Accountability**

8.1.  A registered healthcare professional who transcribes a medication list is professionally accountable for the accuracy of their work and must make all reasonable efforts to ensure that the transcribed list is an accurate reflection of the patient’s current therapy.

8.2.  Any healthcare professional choosing to administer against a transcription is personally and professionally accountable for doing so. They must ensure that they are able to verify its accuracy as directed by section 6. If they have any concerns regarding the transcribed information or competence of any individual undertaking transcribing then they should not administer the medication and contact the authorised prescriber and appropriate line manager.

8.3.  Transcribing information should be obtained from the most authoritative place possible and should take into account any recent prescription changes.
9.0. Reporting Errors in Transcriptions

9.1. If a transcribing error is discovered, the transcription must be cancelled and it must not be used to administer medicines or to provide information to others.

9.2. If it is found that the medicines have been incorrectly transcribed and the medication has been administered, the following people need to be notified immediately: the patient and or relatives/carers where appropriate; the patient’s doctor; the transcriber’s line manager or supervisor, and the Clinical lead.

9.3. The details of the incident must be documented in the patient’s records and a Datix form completed, and a Duty of candour letter sent to the patient appropriately.

9.4. The patient’s physical condition should be observed appropriately and recorded on the electronic records system.

9.5. If a transcribing error has been noticed and the medication has not been administered the error should be investigated and rectified.

9.6. The patient should be notified of the error and it should be documented in the patient’s notes, a Datix form completed and the line manager notified.

10.0. Audit and Monitoring

10.1. Transcribing MUST be monitored on an ongoing basis. Each ward/unit/service must develop a process for systematic assessment of transcribing practice that includes assessing a random sample of transcriptions for accuracy and adherence to Medicines Policy and Trust Transcribing Procedure, not less than annually.

10.2. Incidents recorded on Datix should be used to identify trends in challenges with Transcribing as well as training needs.

11.0. References

- Barts Health NHS Trust, Standard operating procedure for transcribing and prescribing onto the Medication Administration Record (MAR) chart (October 2012)
- East London Foundation NHS Trust, Policy for the reconciliation of Medicines (December 2016)
- East London Foundation NHS Trust, Policy for the safe management of ‘Patient’s own’ controlled drugs in the domiciliary setting (July 2015)
- Greenwich Teaching Primary Care NHS Trust, Guidelines for the transcribing of medication by registered nurses (June 2009)
- Lincolnshire Community Health Services NHS Trust, Policy to support the transcription of medicines in exceptional circumstances incorporating medicines reconciliation within a community hospital or hospice setting (October 2016)
- Southern Health and Social Care Trust, Procedures for Transcribing Prescribed Medications on to a Medication Administration Record (MAR) or Medication Instruction Sheet (MIS) (October 2015)
- East & South East England Specialist Pharmacy Services, Medicines Use Safety Division – Community Health Services. Transcribing: Guidance to support the safe and appropriate use
of transcribing of medicines information for the purpose of recording administration of medicines in various health and social care environments.

- Worcester Health and Care NHS Trust Medication Transcribing Policy November 2016

Appendix A: Register of Transcribing Competent Staff
<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date Competency Assessment Framework Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Transcribing Competence Form

Name........................................................................................................................................................................ Date.................................................................

Team........................................................................................................................................................................

All registered healthcare professionals who meet the requirements for a transcribing role and are not non-medical prescribers must successfully undertake the competency assessment framework below and be signed as competent by senior nurses (B6 and above) who have themselves successfully completed the competency assessments.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Date</th>
<th>1st Assessors Name and Signature</th>
<th>Date</th>
<th>2nd Assessors Name and Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has read the Trust Transcribing medicines procedure and is able to demonstrate an understanding of the procedure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has attended East London Foundation Trust Transcribing Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has passed the transcribing assessments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recorded the patient’s full name, date of birth, NHS number and allergy status?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has used TWO sources of information which are current and reliable as defined by the organisational procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transcription is printed as per Trust Transcription procedure (capital letters, black indelible ink and includes all relevant details)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has demonstrated appropriate action that should be taken if there is a discrepancy between the sources of information?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has demonstrated appropriate action where the prescription is unsafe or unclear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures Transcription is checked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to demonstrate a clear understanding of the Trust Community Health Services Medicines Administration Policy (2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a registered nurse, able to demonstrate a clear understanding of delegation as per the Nursing and Midwifery Council advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has completed five additional accurate transcription in practice following training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Transcribing Procedure Flowchart

Have you successfully completed ELFT transcribing training and competence assessments or are you an NMP?

Y

Are there at least TWO up-to-date authoritative information sources available for transcription e.g. SCR, discharge letters, and Patient Own Drugs (see section 6.0)

N

Refer to Team Lead on duty or out-of-hours manager for advice

N

In exceptional circumstances where it is not possible to obtain TWO authoritative information sources without undue delay; transcribe from the pharmacy label attached to the medication and document in the patient’s electronic notes and home notes.

Y

Transcribe required medicines onto MAR chart (see section 7.0) and file original authorisation information sources within patient home notes

Obtain a second check for accuracy of transcribed MAR chart as per local procedure

Patient must be reviewed and an appropriate authorisation to administer must be obtained within 24 hours or referred to the Lead Nurse on duty if not possible
Appendix C: Transcribing Procedure Flowchart (Continued)

Is the transcription of the MAR chart accurate?

If it is within the NMP’s scope of practice then the MAR chart can be amended. All changes must be documented in the patients electronic notes and home notes.

If you are not an NMP then escalate this to the Team Lead on duty or out-of-hours manager for further advice.

Second check signature appended to the chart or second check documented in notes. Transcription is now completed.