Policy for Transcribing Medication Administration Records in ELFT Community Health Services

Version:	3.0
Consultation Groups	Community Nursing Team Leads/Managers
Approved By	Clinical Policies Review and Alignment Committee Nursing Development Steering Group
Ratified By:	Medicines Committee
Date ratified:	12th January 2022
Name and Job Title of authors:	Fatima Hafesji, Lead Pharmacist Tower Hamlets Community Health Service Charity Okoli, Lead Pharmacist Community Health Newham
Executive Director Lead:	Paul Gilluley
Implementation Date:	12th January 2022
Last Review Date:	November 2021
Next Review Date	November 2024

Services	**Applicable to**
Trust wide	
Mental Health and LD	
Community Health Services	√

Members of the Community Services Clinical Polices Alignment Group:

- Caroline Ogunsola QN – Professional Development Lead Nurse - Convener
- Dupe Fagbenro – Deputy Chief Pharmacist – London
- Nike Bademosi – Deputy Lead Nurse – Tower Hamlets
- Rashida Goswami – Team Lead – Tower Hamlets
- Chantal Riviera – Clinical Lead Newham
- Jacinth Morrison – Clinical Lead Newham
- Fatima Hafesji – Lead Pharmacist Tower Hamlets CHS
- Veena Shivnath – Joint Lead Pharmacists Bedfordshire CHS
- Caroline White - Deputy Lead Nurse, Bedfordshire
- Victoria Stone – Locality Manager - Bedfordshire
- Sarah O'Hare QN – Locality Manager, Bedfordshire
- Edward Phillips – Practice Development Nurse, Bedfordshire
- Georgina Amparado – Molina – Clinical Lead Tower hamlets
- Claire Porter – MacMillan Lead Nurse for Palliative Care
- Charity Okoli – Lead Pharmacist – Newham CHS
- Emma Robinson – Clinical Lead, Tower Hamlets
- Sharon Eplett – Head of Quality & Performance Beds
- Davinder Kaur – Clinical Lead - Tower Hamlets
- Vikramsingh Totaram – Diabetes Nurse Specialist

East London
NHS Foundation Trust

Version Control Summary

Version	Date	Authors	Status	Comment
1.0	July 2018	Whitney Yeboah Kikelomo Pinheiro	Final	
2.0	October 2018	Whitney Yeboah Tsana Simmonds Kikelomo Pinheiro	Final	Updated to include Appendix C: Transcribing Procedure Flowchart Minor updates in sections 5.0 and 7.0 to include “Refer to Appendix C: Transcribing Procedure Flowchart”
3.0	November 2021	Fatima Hafesji Charity Okoli	Final	Policy re-named from: Transcribing procedure for Medication Administration Recording in Community Health Services to: Policy for transcribing Medication Administration Records in Community Health Services 1.0 Executive summary, Introduction reviewed and updated Purpose changed to 2.0 Scope and purpose – updated. New section added: 3.0 Exclusions New section added: 4.0 Associated Policies Section 3 of original policy ‘Duties’ changed to section 5.0 ‘Roles and Responsibilities’ 5.0 Roles and responsibilities updated 5.1 Transcriber and 5.4 Pharmacist responsibilities updated. New responsibilities section added for 5.3 Clinical lead, 5.2 Team lead and 5.5 Practice Development/Education and Training team responsibilities.

				5.6 Nurse administering medication responsibilities updated. 6.0 Training and Competence rewritten and updated 7.0 Structure of transcribing training and competency rewritten 8.0 Transcribing procedure updated 9.0 Appropriate sources of information updated to emphasise referral letters cannot be used and which sources are considered to be appropriate 10.0 Carrying out a transcription updated New section added: 11.0 Transcribing controlled drugs New section added: 12.0 Reducing Risk New section added: 13.0 Retention of Records 14.0 Accountability updated to include that of transcriber, clinical and team leads. 15.0 Reporting of transcribing errors updated to include duty of Candour and Datix incident reporting. 16.0 Audit and monitoring updated to include clinical and team lead responsibilities in co-ordinating audit in respective teams. 17.0 All references updated to reflect this version of policy – references annotated throughout text. Appendix 1 transcriber specimen list reviewed updated to include date when nurse is deemed competent to transcribe. Appendix 2 Transcriber

				Competency Framework reviewed and rewritten to include more depth around professional accountability, transcribing high risk drugs, risk management. Appendix 3 Transcribing Procedure Flow chart reviewed and updated Appendix 4 Transcribing Accuracy Flow Chart reviewed and updated Appendix 5 – New section. Examples of good transcribing practice included. Appendix 6 – new section. Voiding transcriptions added.

Contents

Executive Summary

Transcribing onto Medicines Administration Records (MAR) Charts is a routine nursing activity within Community Health Services (CHS) which provides continuity of care however, if not properly conducted it carries significant risks to patient safety.

It is common for Community Health Services within the trust to receive medical and prescribing services from external providers; however the administration of medicines remains the responsibility of trust staff. To accommodate these situations an agreed process is required to record administration of medicines that are not prescribed by trust staff. The function of a MAR chart is to provide a permanent record of the patients' treatment with medicines whilst in the care of the trust. The MAR chart enables direction and recording of medicine administration to patients.

This policy provides a framework to support safe transcribing within Community Health Services in East London Foundation Trust. It is aimed at all Community Health Service staff involved in the transcribing and administration of medicines and defines the procedures which must be followed.

1.0. Introduction

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

1.2. Transcribing can be defined as the act of making an exact copy, usually in writing. Transcribing is the copying of previously prescribed medicine details to enable their administration in line with legislation (i.e. in accordance with the instructions of a prescriber) [1]. This means that there must always be an original copy or document from which the transcribed copy is made. The prescription issued by the prescriber is the original. The prescriber is responsible for generating the original instruction and 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].

1.3. Transcribing is the copying of medicines information for the purposes of administration, it cannot be used in place of prescribing to issue or add new medicines or alter/change original prescriptions [1]. This includes, for example from discharge letters, FP10s, transfer letters, copying illegible patient administrations charts onto new charts whether hand-written or computer-generated. The Royal Pharmaceutical Society of Great Britain Professional guidance on the administration of medicines in healthcare settings (co-produced with the Royal College of Nursing) advises that *transcribing should be used only in the patient's best interests to ensure safe and continuous care: ensuring the medication is administered accurately, without undue delay*.

1.4. The professional guidance recognises that care is being increasingly provided in more "closer to home'" settings that are often nurse led, and recommends organisations undertake a risk assessment to develop a management process to enable transcribing to be undertaken safely where necessary. Organisations must ensure that safeguards are in place to assure that transcribed information is not inadvertently used as a prescription.

1.5. The guidance goes on to state that:

- Those undertaking transcribing must be appropriately trained and assessed as competent to do so
- An audit trail must exist for all transcribed medicines
- Medicines are not transcribed where details are illegible, unclear, ambiguous or incomplete.
- Particular care is taken in transcribing details of high risk medicines such as insulin, anticoagulants, cytotoxics, or controlled drugs.
- Organisational policy defines the procedure for dealing with errors in transcribed information.

1.6. In community-based practice, medication may be transcribed from an authorisation to administer issued by a prescriber onto a 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. Scope and Purpose

2.1. This policy provides guidance and a framework to support the safe and appropriate transcribing of medicines for the purpose of recording administration within ELFT community health services. It describes the situations that constitute transcribing, who can transcribe medicines information and provides an overview of the process and requirements for transcribing.

3.0. Exclusions

3.1. This policy only applies to the ELFT Medication Prescription and Administration Record and does not apply to the PAN London End of Life Care Medicines Authorisation and Administration Record (MAAR chart) or any other MAR chart in use within Bedfordshire.

4.0. Associated Policies

To be used in conjunction with this policy

- ELFT Medicines Policy
- ELFT Procedural Guidelines for the Administration of Medicines by Staff in Community Health Services
- ELFT Medicines Reconciliation Policy
- ELFT Patients Own Drugs Policy
- ELFT Incident Policy
- ELFT policy for the use of Controlled drugs in the domiciliary setting

5.0. Roles and Responsibilities

5.1. Transcriber

- The transcriber must ensure that:

- Their ELFT transcribing competency training is up-to-date and that they have been deemed as competent to transcribe by their line manager/team lead or supervisor.
- Details of medicines are transcribed in-line with this policy, the trust medicines Policy and associated policies outlined in section 4.
- Accept responsibility for their actions and transcribe only where they have referred to a minimum of two reliable sources of information and are confident that the information that they have transcribed is accurate.
- All medicines details transcribed are legible, accurate, appropriate and safe for the patient. The transcriber must only transcribe and enable administration of medicine where they are confident that the information provided is accurate.
- Where medicines information is unclear or they believe it to be inaccurate or unsafe they must not transcribe. In such circumstances the transcriber must contact the prescriber and ensure resolution of the query. Where the prescriber cannot be contacted directly, they must ensure that another accountable prescribing clinician is consulted to rectify the matter to prevent undue delay to patient care. Where the transcriber is unable to resolve this independently they must escalate to their team lead/manager for support and action.
- Record keeping is legible and accurate ensuring that an audit trail of all communication with primary or secondary care to resolve queries is maintained.
- Where controlled drugs and high risk medicines are transcribed extra care and caution must be taken to ensure that this is accurate.

5.2. Clinical Lead

- Read and fully understand this policy, how it relates to their service and be assured that application within their service complies with all clinical governance requirements.
- To have overall oversight of transcribing practice within their teams
- To report back to directorate executive teams on areas of performance in relation to transcribing.

- Ensure that staff who will transcribe as part of their role have read and understood the policy.
- Ensure that the nurse is provided with protected time to undertake the transcribing competency training (and refresher training where applicable), in-line with this policy
- Maintain a central secure specimen signature list of all staff who have been deemed competent to transcribe and to review this list quarterly to account for staff change and movement or change in circumstance surrounding the staff competency (Appendix 1).
- To co-ordinate and conduct the trust transcribing audit as part of the medicines management audit cycle in accordance with the audit timeframe and guidance provided by the Quality Assurance team.
- If a member of staff moves from one ELFT team to another and has completed the transcribing assessment where the clinical/team lead has been provided with specific feedback for on the job training by the Practice development/Education and training team, this information must be shared and passed onto the clinical lead for the receiving team where the member of staff will be placed. This is to ensure continuity of supervision and to support completion of the final competency framework if this is yet to be completed.

5.3. Team Lead

- Must have read and familiarised themselves with this policy.
- Must be deemed as competent to transcribe and have demonstrated this through transcribing training, assessment and competency framework completion (Appendix 2) (unless the team lead is a NMP who is *regularly* prescribing)
- To co-ordinate nurse completion of the transcribing competency framework
- To support staff on the job, in conjunction with individual feedback and recommendations received from the training team to determine final competency (Appendix 2).
- Where gaps in transcribing have been identified for staff having completed competency assessment, team leaders must have day to day oversight and monitoring of those areas to ensure competency has been achieved in practice before the nurse is deemed as competent to transcribe.
- The date(s) of training and decision of deemed competency must be documented in the staff supervision records with the transcribing competence form (Appendix 2).
- If transcribing incidents are reported, action to manage the incident, investigation and feedback must be taken in a timely manner, in-line with the trust incident policy and fed back to the clinical lead with overall service oversight.

5.4. Pharmacist

- Review transcribing practice via trust audit and clinical incidents ensuring that this is in-line with the requirements of this policy.
- To provide feedback on transcribing audit data to the Leadership teams at directorate Quality Assurance Groups or equivalent.
- Pharmacy team, including Pharmacists and Technicians to work with the Practice development team to guide and provide input into the content of the transcribing training package delivered at ELFT.

- Pharmacy team to support the delivery of theory in conjunction with the Practice Development Team and where resource permits support with delivery of the competency assessment.

5.5. Practice Development/ Education and Training team

- To co-ordinate delivery of the transcribing training in ELFT CHS directorates
- To work in conjunction with directorate pharmacy leads and team to update the transcribing training package and competency assessment.
- To support in providing constructive verbal feedback to nurses who have completed transcribing training and assessment
- To support in providing verbal and written feedback to managers, team leads or supervisors to facilitate them with on the job training (if required) and final completion of the competency framework to deem staff as competent.

5.6. Staff member administering medicine

- Staff must only administer medication where they are confident that it is safe and appropriate for them to do so.
- Staff must administer medicines in-line with the associated policies (Section 4.0), personal training and competencies (Section 6.0).
- If the staff member finds a transcription that is unclear or they believe it to be inaccurate or unsafe they must not administer the medicine but contact the transcriber, prescriber or team lead for clarity, escalation and resolution of the problem. The transcribing nurse should clarify any anomalies with the prescriber asking for written confirmation and documenting any action taken in the patient records.
- Where administration of a medication may have been delayed or omitted due to a transcribing error or discrepancy, staff should complete an incident report via DATIX in line with the trust Incident Policy.

6.0. Training and Competence

6.1 Transcribing can only be carried out if the nurse has/is:

- Registered with the Nursing and Midwifery Council.
- Has at least one year's post registration experience with regular exposure to medicines administration
- In a Band 5 position or above.
- Completed the Trust transcribing training competency assessment and transcribing competency framework in line with this policy.
- Deemed competent to transcribe by their Team leader and completed a transcriber signature specimen form. (Appendix 1)
- Competency from external organisations or other NHS trusts cannot be carried over to ELFT. New members of staff must complete the in house transcribing training provided in order to be able to transcribe on MAR charts.

7.0 Structure of Transcribing Training:

7.1 Transcribing training comprises of:

Part 1: Theory – Taught element of training package co-delivered by Pharmacy and PDF/E&T teams, on-line or face-to-face. Training provides a comprehensive outline of transcribing, legality, requirements and best practice with a range of transcribing examples (Appendix 5).

Part 2a: Competency assessment – mock scenarios involving transcription of medicines information. Transcriptions must be completed accurately and in accordance with the transcribing policy. Feedback from assessment is utilised to determine further training needs and communicated to team leads/manager or supervisor.

Part 2b: Competency can only be signed off upon completion of the transcribing competency framework (Appendix 2). This is the final step to deem transcriber competency and must be completed for all staff. The framework must be completed on the job and must be coordinated and overseen by team leads with oversight and reporting to Clinical leads. This framework must be utilised for all staff who intend to transcribe and in particular for staff where feedback from the competency assessment (Part 2a) identified gaps in transcribing performance.

The competency assessment must be kept on file electronically and securely by the team lead with restricted access and shared with the Clinical Lead/Lead Pharmacist as requested.

7.2 All elements of the transcribing training outlined above must be completed successfully for an individual to be deemed as competent to transcribe. The final sign off is determined by the Team/Clinical lead upon completing the competency framework in Appendix 2.

If the nurse fails to meet criteria deemed as critical information in the competency-based assessment (Part 2a) they will be expected to take a resit assessment at the next training opportunity. The team/clinical lead are expected to support staff with necessary supervised practical training until they are able to resit the competency assessment.

7.3 Competence is valid for 3 years from the date final competency is deemed. This date must be recorded on the transcriber signature specimen form (Appendix 1). This must be held by both the team and clinical lead. Training must be repeated successfully within 3 years after the initial competency, otherwise the competency will lapse and the individual must not transcribe.

7.4 Pharmacists and non-medical prescribers do not require transcribing training or competency assessments. Their qualification deems them as competent to appropriately record medicines information, however where it has been more than six months since a non-medical prescriber may have prescribed it is recommended that they also undertake transcribing training to support their own CPD and reflective practice.

8.0 Transcribing Procedure

(Refer to Appendix 3 for the Transcribing Procedure Flowchart)

8.1. Transcribing includes:

- Completing the patients details legibly on the front of the MAR chart
- Writing out a patient's current prescribed medication from a valid authorisation to administer (see section 9) onto an ELFT Medication Administration Record (MAR) chart
- Copying transcribed medication from one medication administration record chart to another i.e. rewriting a MAR chart.

8.2. Transcribing can only take place for therapy already authorised in a prescription or an 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.

8.3. The original authorisation to administer must be filed and available within the patient's notes and uploaded to EMIS/SystmONE.

8.4. 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.

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

8.6. The Identity of the transcriber must be clearly recorded. The transcriber must sign, date and print their name against each medicine entry.

8.7. A second transcription check must be obtained for each transcription. 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.

8.8. A second check for accuracy of the transcribed information must be carried out within 24 hours of the transcription by an approved transcriber other than the original transcriber and the signature of the second checker must be appended to the chart.

8.9. In exceptional circumstances (or in an emergency) if the original authorisation to administer (Section 9.0) is not available, and it is not possible to obtain one without undue delay (where in the clinical opinion of the nurse the risk to the

patients from omitting a dose is high) a transcription can be made from the details included on the pharmacy label attached to the *most recently* dispensed medication.

8.10. The transcriber must ensure that the medication is the patient's current therapy and remains accountable for the decision to transcribe. An authorisation to administer *must* be obtained within 24 hours and the transcription checked against this for accuracy.

9.0. Appropriate Sources of Information

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

9.2. Prior to transcribing the transcribing nurse must perform a complete medication reconciliation using at minimum of TWO of the authoritative quality information sources listed below :

- A current, signed prescription i.e. FP10 from an authorised prescriber
- Recent hospital/hospice discharge summary that has been signed by the discharging doctor
- The pharmacy administration instruction label attached to medicines that have been dispensed within the last six months. ***However the registered nurse must be confident that this is the most recently dispensed medication.***
- A copy of the most recent GP repeat medication request which must be supported by the patient's electronic medical record.
- List of medication obtained from 'Summary Care Records" or patient's electronic notes e.g. EMIS, SystmONE, RiO.
- A copy of the patient's latest medication list from General Practitioner
- Official clinic letter clearly identifying the patient, medicines and regimens.

9.3. This information must either be attached to the MAR chart where the medication has been transcribed 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.

9.4. Each time the MAR chart or a medication on the MAR chart is rewritten this information must be checked against the original authorisation to administer i.e. GP record/Patients Own Drugs as changes can occur between the time medicines are initially transcribed and the new transcription. This is particularly applicable when new MAR charts are transcribed to continue administration of medication.

9.5. It is important for transcribers to be aware that the above mentioned sources of medication history from the GP are unlikely to be up to date if a service user has been discharged from hospital or other care provider as the most recent information may not have been communicated/actioned at this stage. In instances where service users have been discharged from another care

provider, the discharge summary relating to this period of care must be utilised to reconcile the medication.

9.6. If accurate information is not provided by the referrer e.g. discharge summary, the Single Point of Access (SPA) and nursing teams are within their jurisdiction to refuse referrals /seek further information to ensure this information is provided before accepting a service user onto the caseload. If this situation arises, it must be communicated urgently in writing i.e. email to the referrer.

9.7. Referral letters should not be used for transcription purposes. They are not considered as an appropriate source of information when reconciling medicines to be transcribed on the MAR chart. This is because medication changes may occur between the point of referral to the time of discharge.

9.8. 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

9.9. 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 e.g. Warfarin. The dose must be confirmed utilising the most recent authorisation source e.g. 'yellow book'.

9.10. If the registered nurse who is transcribing has any doubts or identifies any discrepancies during the process of transcribing medication they must stop and obtain written confirmation clarifying the medication specifics from the original/authorised prescriber.

10.0. Carrying Out a Transcription

Refer to Appendix 3 and 4 for Transcribing Procedure Flowchart and Appendix 5 and 6 for examples of good transcribing practice to be used in conjunction with this section of the policy.

10.1. Transcriptions must comply with the Medicines Policy. Reference should be made to the Policy for guidance on the approved manner in which to record medicines information, including permitted abbreviations, cancellation and the use of multiple charts. All transcriptions should be printed legibly in BLACK ink and capital letters on the medication administration chart

10.2. All transcribed medication must be written in the appropriate section of the medication chart i.e. regular/prn etc.

10.3. All transcriptions must include the following information:

- Patient's full name
- NHS number
- Date of birth
- Known allergies
- Date of transcription
- Generic name of drug (printed in CAPITALs)
- Drug dose
- Strength
- Formulation i.e. capsule/tablets/suspension, modified release, controlled release 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
- Source of transcription
- Transcriber signature

10.4. In the following scenarios the transcription must be voided clearly (Appendix 7) by scoring through the transcription, signed, timed and dated by the nurse and then re-written on a new MAR chart:

- Where there is a transcription error
- Where medication administration rows are full on the Mar chart.
- This also applies to old MAR charts which must be voided in their entirety on all page including the front page to prevent inadvertent administration of historic medicines.

10.5. Examples of good transcribing practice can be found in Appendix 5 and utilised as a reference source to guide good transcribing practice

11.0. Transcribing Controlled Drugs

11.1. Transcribing Controlled drugs (CD) is a high risk activity. Precautions must be taken when transcribing these to minimise error and risk. When transcribing controlled drugs, the transcriber must ensure that transcriptions are legible and that all details listed in section 10 of this policy are included in the transcription.

11.2. Only an experienced band 5 registered nurse that has been identified by the clinical lead or team leader as competent to manage controlled drugs and nurses band 6 and above can transcribe controlled drugs.

11.3. The nurse 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.

11.4. Where Controlled drugs are transcribed the registered nurse next visiting the patient for CD administration must carry out a second check of the transcription prior to administration. This must be within 24 hours of the medication being transcribed onto the MAR chart to provide assurance and safety.

11.5. Administration should not take place where a second transcription check has not taken place for a CD transcribed onto a MAR chart.

12.0. Reducing Risk

12.1. Use of concurrent MAR charts increases the risk of administration errors. Therefore nurses should limit the number of MAR charts in use.

12.2. If more than one MAR chart is in use, they should be held together and should indicate the existence of the other. Where possible, i.e. if some medicines are discontinued, multiple MAR charts should be condensed into one.

12.3. The MAR chart should be rewritten in full if it becomes unclear or ambiguous.

12.4. Where there is any doubt about the medicine to be administered the RN should withhold and contact the relevant prescriber for further clarification in writing. This must be documented in the patient's electronic records.

12.5. It is common where only one medication is being administered, that the medication is crossed off and re-transcribed on a new medication section of the same MAR chart e.g. for Insulin, however this poses risk and inadvertent administration of incorrect doses or frequency of medication and should therefore be avoided. Where medication is to be continued, it should always be re-transcribed on to a new MAR chart.

12.6. Where a medication has been indicated for once daily administration i.e. with no specific indication of the time of day to be administered, it is important for the transcribing nurse to refer to the BNF (or prescriber if not apparent in the BNF) to ensure that the medication is transcribed to be administered at the optimal time that it can be administered in accordance with scheduled visits. There is a risk that if one specified time is not adhered to there may be variability of medication administration and possibility of omission or duplicate administration in some instances e.g. Enoxaparin [12] to be administered ''once daily means it could be administered at any time of the day. Therefore it is recommended that the nurse discusses this with the patient/carer to confirm what time it had been administered in the inpatient setting in secondary care to determine if continuation of timing can be facilitated by scheduled visits or if timing must change in order to ensure administration can be supported by the district nursing team. The agreed time of day for administration should be annotated on the MAR chart and clearly documented in the clinical notes for audit trail purposes.

12.7. On occasions some medication doses may fall outside of the pre-printed timings on the ELFT MAR chart. In such instances these should be documented in the blank boxes in the time column above and below the pre-

printed timings and also annotated in the additional information section of the MAR chart so that information is clear and not omitted inadvertently.

12.8. If accurate information is not provided by referrer e.g. GP, hospital, hospice the nurse should consult with the team/clinical lead who should assess the circumstances and make a judgement whether to refuse/accept the referral. If this is the case, this must be communicated in writing e.g. email and documented in the patient electronic notes.

13.0. Retention of Records

13.1. The MAR chart remains the property of ELFT

13.2. The MAR chart must be retained in the service user's home while in use.

13.3. MAR charts no longer in use (e.g. from previous months or voided) must be removed promptly from the premises and returned to the respective ELFT CHS base [16].

13.4. As per ELFT Health Record Policy trust policy the MAR chart must be scanned and uploaded to the service user electronic record i.e. EMIS/SystmONE as a clinical document for audit trail purposes[17].

14.0. Accountability

14.1. A nurse 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.

14.2. Transcribing is not a virtue of the nursing qualification therefore a nurse must ensure that they have fulfilled all training requirements to attain transcribing competency prior to transcribing any medication onto MAR charts.

14.3. 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 9. 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.

14.4. Transcribing information should be obtained from the most authoritative place possible and should take into account any recent prescription changes.

14.5. Clinical and Team leads have accountability, responsibility and oversight for transcribing within their teams and must assure practice within teams is in accordance with this policy.

15.0. Reporting Transcribing Errors

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

15.2. 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 transcribing nurse's team leader, and clinical lead.

15.3. The patient's physical condition should be observed, monitored and recorded on the electronic records system.

15.4. The team or clinical lead should endeavour to ensure the correct health care professionals are consulted to assure medicines safety or advise on further monitoring e.g. GP, Pharmacist, NHS 111

15.5. All details of the incident must be documented in the patient's medical records and a Datix form completed.

15.6. A Duty of candour letter should be sent to the patient in accordance with the ELFT duty of Candour and being open policy.

15.7. If a transcribing error has been noticed and the medication has not been administered the error should be investigated and rectified immediately so that inadvertent administration cannot take place.

15.8. A Datix incident report should be submitted containing accurate and succinct information relating to the transcribing error. If the error resulted in a dose omission an additional Datix should be submitted to capture this with exact information on the medication i.e. name, dose, frequency and the number of delayed or missed doses.

16.0. Audit and Monitoring

16.1. Transcribing MUST be monitored on an ongoing basis by Clinical and team leads.

16.2. Clinical leads in conjunction with team leads for the service must co-ordinate and implement a systematic plan for conducting the annual transcribing audit as part of the trust audit cycle. This is to provide assurance and ensure a systematic process for assessing transcribing practice.

16.3. The audit process includes assessing a random sample of transcriptions against standards relating to accuracy and adherence to the Trust Medicines Policy and this Transcribing Policy. .

16.4. The Lead Pharmacist/ directorate CHS Pharmacy team will support in reviewing audit performance and with reporting to the Quality Assurance Groups or Leadership meetings in conjunction with the Clinical leads for each directorate.

16.5. Audit action trackers should be compiled by Clinical leads in conjunction with team leads with feedback from the Lead Pharmacist/directorate CHS Pharmacy team and submitted to the directorate Quality Assurance team.

16.6. Transcribing Incidents recorded on Datix should be used to identify trends in errors as well as shaping current and future training needs.

17.0. References

1. RPSGB Professional guidance on the administration of medicines in a healthcare setting. January 2019. Accessed November 2021.
2. Royal College of Nursing, Medicines Management: An overview of Nursing 2020. Accessed November 2021.
3. Royal College of Nursing and RPSGB, Guidance on Prescribing, Dispensing, Supplying and Administration of Medicines. March 2020. Accessed November 2021.
4. National Institute for Health and Care Excellence (2015) Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes: NICE guideline NG5. London: NICE. Accesses November 2021.
5. National Institute for Health and Care Excellence (2016) Medicines optimisation: quality standard QS120. London: NICE. Accessed November 2021.
6. ELFT Procedure for the Transcribing of Medication for the Purpose of Recording Administration in Community Health Services 2018.
7. ELFT Medicines Policy. Version 13. May 2020. Accessed November 2021.
8. ELFT Medicines Reconciliation Policy Version 10. November 2021. Accessed November 2021.
9. ELFT Procedural Guidelines for the Administration of Medicines by Staff in Community Health Services. March 2019. Accessed November 2021.
10. ELFT Patient's Own Drugs policy Version 3. September 2021. Accessed November 2021.
11. ELFT, Policy for the safe management of 'Patient's own' controlled drugs in the domiciliary setting. Version 6. May 2021. Accessed November 2021.
12. ELFT Safe Administration of Low Molecular Weight Heparins (LMWH) in Patients Transferred to Bedfordshire Community Health Services (including changing time of dose administration). Accessed November 2021.
13. ELFT Incident Policy Version 10. December 2018. Accessed November 2021.
14. ELFT Duty of Candour and being open Policy, Version 1. December 2020. Accessed December 2021.
15. 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 2020. Accessed November 2021.
16. ELFT Record Keeping Policy Version 1. October 2020. Accessed January 2022.
17. ELFT Health Records Policy, 2019. Accessed January 2022

Appendix 1: Transcribing Staff Competency and Signature Specimen and List

CHS Team and Locality: **Month:**
Year:

Clinical Lead with oversight and responsibility:

This List should be updated quarterly to account for staff movement between teams to facilitate removal of staff leavers and to document date of deemed competency upon completion of the Transcribing competency framework.

This List must be held centrally by the Clinical Lead.

Nurse Name	Position held in team	Signature	Date competency framework completed

Appendix 2: Transcriber Competency Framework (4 pages)

Nurse Name ……. Date……..

Directorate and Team……..

All nurses who meet the requirements for a transcribing role and are not non-medical prescribers must successfully undertake this competency framework below after completing the ELFT CHS Transcribing training and must be signed off as competent by senior nurses (B6 and above) who have themselves successfully completed the competency assessment and framework and are deemed as competent to transcribe. This framework is to be utlilised to deem final competency of nurses intending to transcribe. It should be used in conjunction with any feedback provided by the Practice development/Education and training teams in relation to completion of Part 1 and Part 2a of the ELFT Transcribing training.

Upon completion, a copy of this competency framework must be scanned and all pages saved on the staff file. An electronic copy (i.e. Scanned) must be held securely by the Clinical Lead.

Standard	Competency Descriptor	Date	1st Assessors Name and Signature	Date	2nd Assessors Name and Signature
Professional & Organisational					
1	Is a registered nurse with the NMC and has at least one year's post registration experience with regular exposure to medicines drug administration				
2	Has passed the mandatory Safe use of medicines training				
3	Able to demonstrate a clear understanding of the ***ELFT Community Health Services Medicines Administration Policy***				
4	Has read in completion and with understanding the ***ELFT Policy for Transcribing Medication Administration Records in Community Health Services***				
5	Has read in completion and demonstrates an understanding of the ***ELFT policy for the Policy on the Safe Management of Patients Own Controlled Drugs in Domiciliary Setting***				

Training					
6	Has attended Part 1 ELFT Transcribing Training (Theory)				
7	Has completed the ELFT Transcribing competency assessment (Part 2a)				
Transcribing					
8	Prior to transcribing, the nurse checks for additional, multiple or duplicate MAR charts in circulation and consolidates all information to ensure only one or the minimum charts are in circulation at the same time.				
9	Ensures any historic charts no linger in use are returned to base to be scanned to EMIS/SystmONE as per trust record keeping requirements.				
10	Demonstrates an understanding of the risk with multiple circulating MAR charts.				
11	Records the patient's full name, date of birth, NHS number and allergy status legibly in Black Ink.				
12	Has used a minimum of TWO reliable sources of information which are current as defined by the Trust Transcribing Policy *(Section 9)* and annotates these on the MAR chart.				
13	Transcription is printed legibly in capital letters, black indelible ink and includes all details as per the Trust Transcribing policy *(Section 10)* i.e. name of medicine, route, formulation, time & frequency.				
14	Has printed, signed and dated the transcription clearly.				
15	Adds additional medicines information in the correct section of the MAR chart where required in reference to dose timing, monitoring, frequency or duration etc.				
16	Clearly voids the transcription where it is no longer valid or discontinued, signing and dating clearly on the MAR chart.				
Transcribing Insulin					
17	Insulin is clearly transcribed ensuring the brand name, strength of Insulin and device are all stated.				
18	The Insulin dose is transcribed as UNITS (not any other abbreviations or 'as directed')				
19	The correct timing and frequency of Insulin administration is transcribed.				

20	Where specific BSL monitoring has been instructed by the prescriber this is annotated on the additional information section of the MAR chart for that transcription.				
Transcribing Controlled Drugs					
21	Where a controlled drug is transcribed extra caution is taken to ensure the validity of sources of information used to reconcile medicines is current and accurate.				
22	The generic and brand name of CDs are transcribed along with formulation, strength, frequency and timing.				
23	Where a controlled drug is transcribed, it is indicated by annotating the transcription with the following symbol: 				
Transcribing Low Molecular Weight Heparins					
24	The name, strength and injector type of the LMWH should be transcribed on the MAR chart				
25	Where a specific administration time has not been indicated, the transcriber should confirm the usual administration time with the service user/carer particularly if they have been stepped down from secondary care.				
26	The most recent documented weight of the patient should have been recorded as indicated on the discharge summary.				
27	The Indication (whether prophylaxis or treatment) and duration of therapy are transcribed on the MAR chart.				
28	Where the duration of therapy has been limited to a set number of days this is reflected on the MAR chart to prevent inadvertent administration				
Risk minimisation and Escalation					
29	Where a medication is to be administered on a specific day all other administration boxes relating to that medication are crossed through to prevent inadvertent administration on another day.				
30	Has demonstrated appropriate action that should be taken if there is a discrepancy between the sources of information				
31	Has demonstrated appropriate action and escalation where the prescription is unsafe or unclear (being aware of own limitations)				
32	Ensures Transcriptions are double checked by an experienced senior nurse within the				

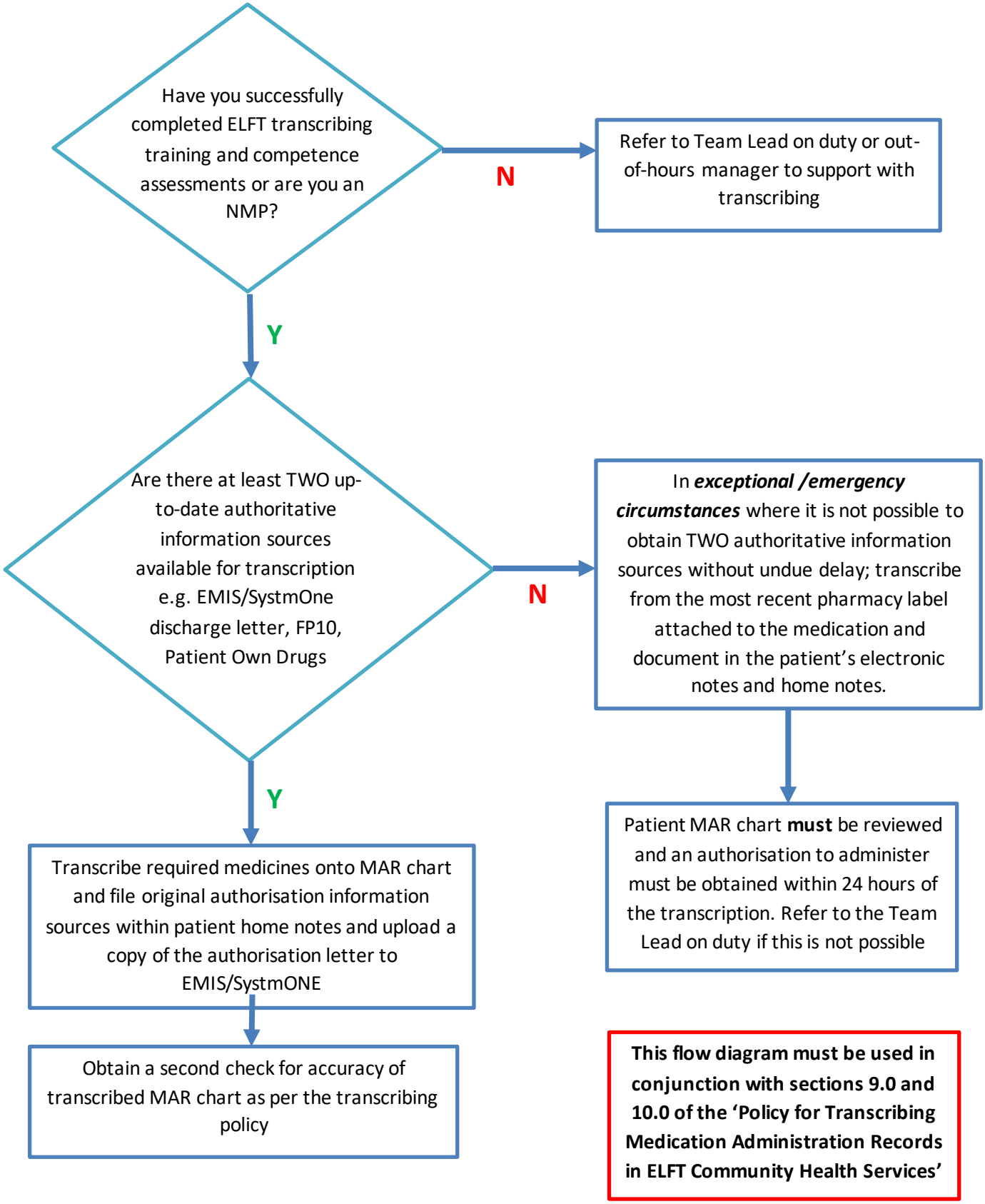
	team within 24 hours, communicating this requirement via handovers or as agreed by the team/clinical lead				
33	Has completed a minimum of five additional accurate transcriptions in practice following training with a focus on areas where additional support needs were identified				
Medication Incident reporting					
34	Understands the escalation process in the event of a transcribing or administration error as a result of poor transcribing				
35	Knows how to report a transcribing error on DATIX ensuring that the name of the medication is included in the incident report along with the dose and indication of any missed doses as a result.				
Final Competency Sign off					
Deemed competent by (B6 RN and above):			**Signature:**	**Date:**	

Upon completion of this framework, obtain nurse specimen signature and annotate date of deemed competency.

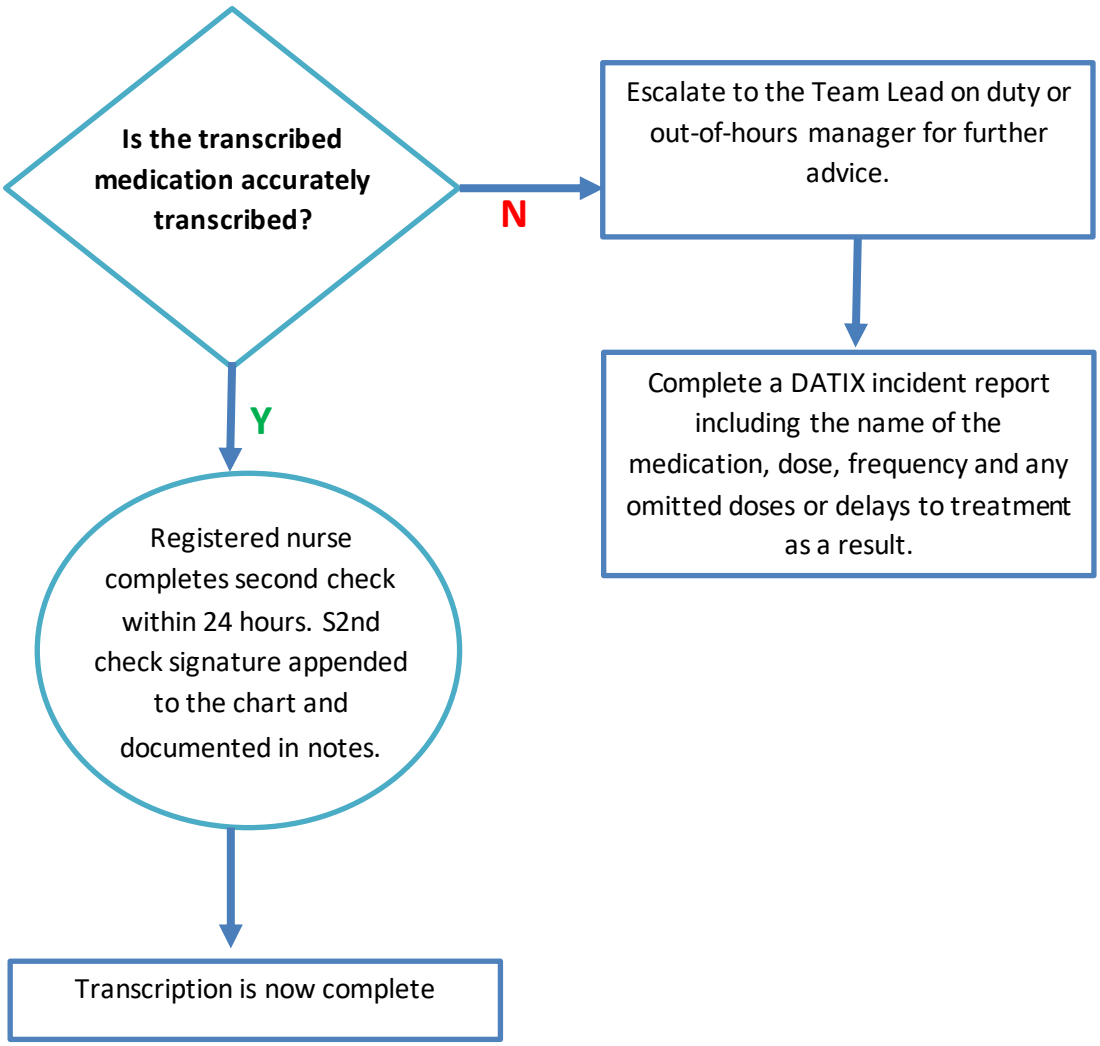
Competency is valid from 3 years of this date.

Additional information or notes:

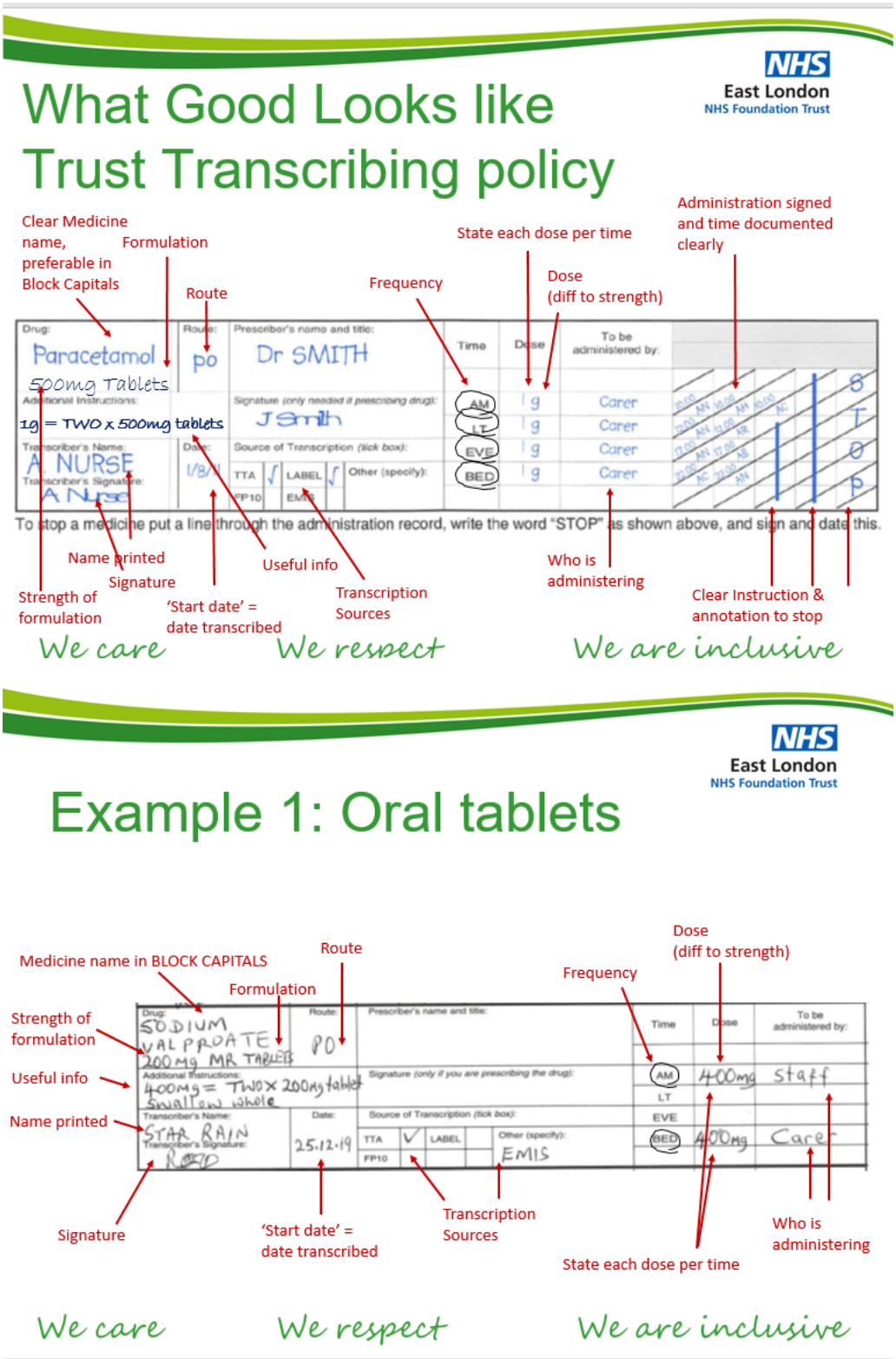
Appendix 3: Transcribing Procedure Flowchart



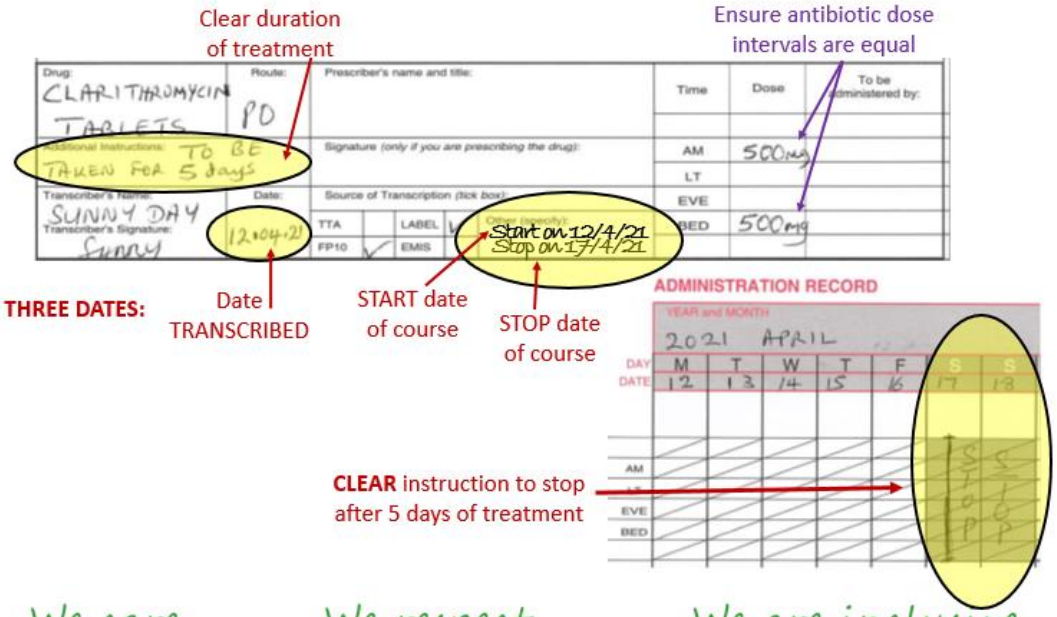
Appendix 4: Transcribing Accuracy Flow Chart



Appendix 5 – Examples of Good Transcribing Practice

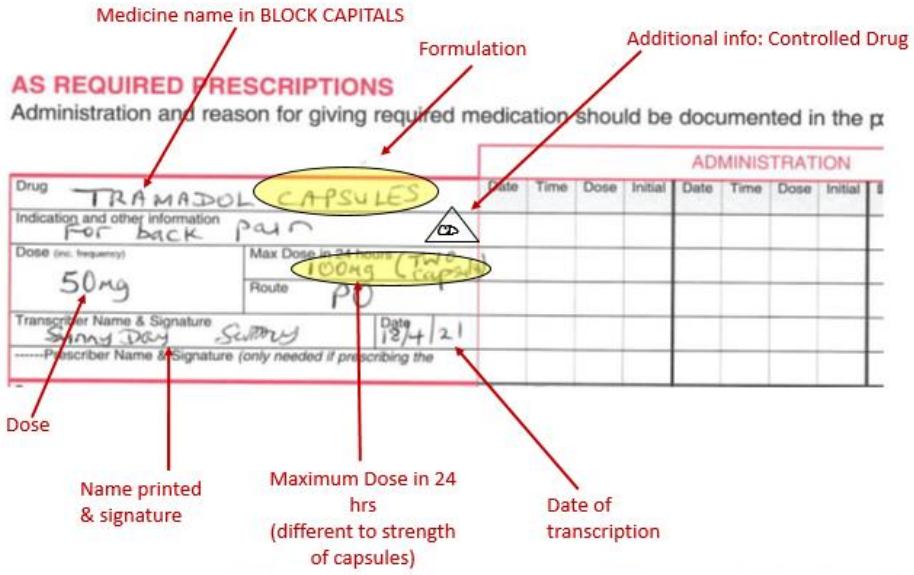


Example 2: Acute Course



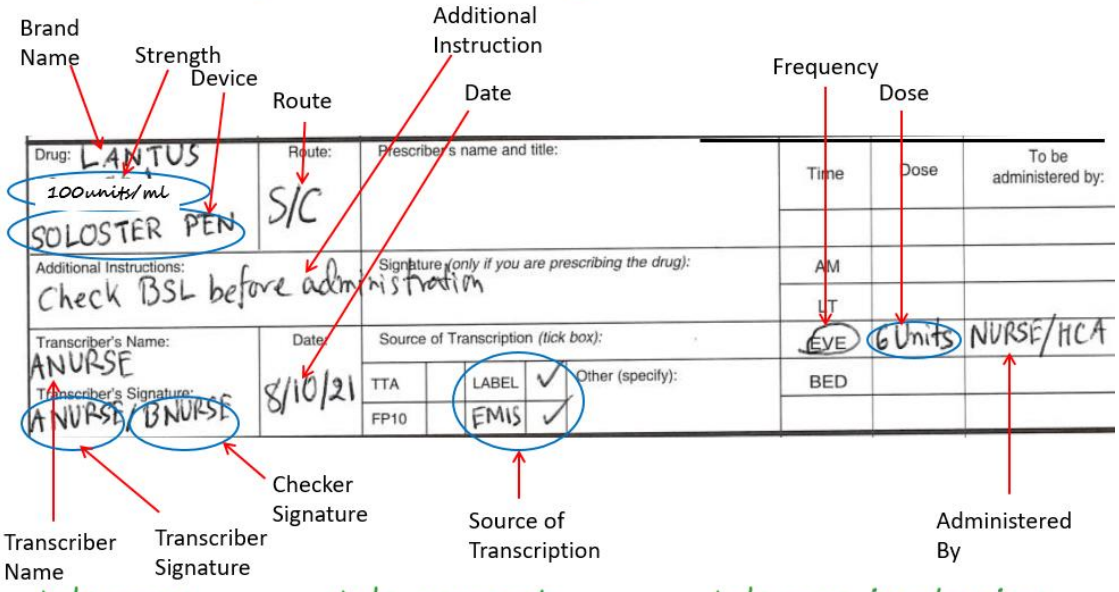
We care We respect We are inclusive

Example 3 – PRN Medication



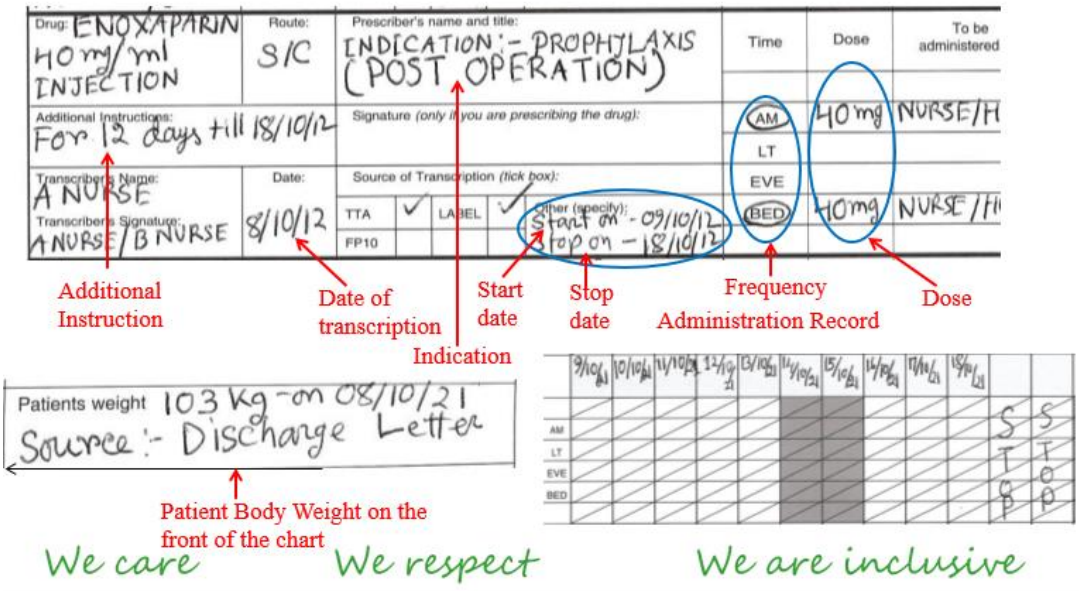
We care We respect We are inclusive

Example 4 – Regular Insulin



We care We respect We are inclusive

Example 5 – Low Molecular Heparin



We care We respect We are inclusive

Appendix 6 – Voiding a transcription

MAR chart cancellations

NHS
East London
NHS Foundation Trust

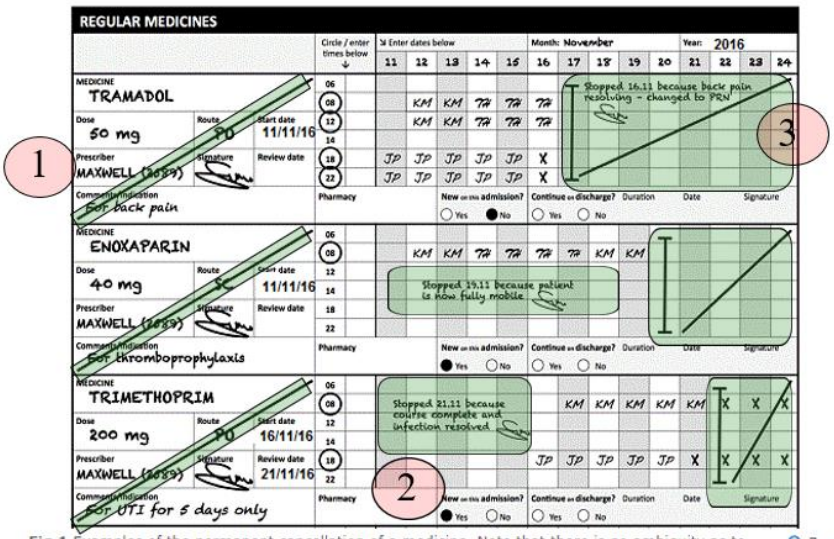


Fig 1 Examples of the permanent cancellation of a medicine. Note that there is no ambiguity as to whether any more doses should be administered or whether the medicine should be transcribed to a new chart. The reason for stopping the medicine has been clarified in each case. Note that the discontinuation of trimethoprim was anticipated at the start of the course with crosses placed in the redundant administration boxes after 21.11 but that the cancellation has subsequently been confirmed in the usual way

Zoom

1) All transcriptions crossed through clearly
2) Reason for stopping documented signed and dated
3) Future administration cancelled – prevents inadvertent administration

We care We respect We are inclusive