Acacium Group Transcription

Procedure Reference | SOP MEDS 23

Version | V2.2

Procedure Name	Transcription
Purpose of Document	To ensure that Acacium Group workers have the knowledge to transcribe medication for administration effectively and safely in the community setting.
Target Audience	All healthcare workers
Version	V2.2
Author	Anna Meakin
Date of Approval	April 2023
Published Date	April 2023
Lead Director	Karen Matthews-Shard
Review Frequency	Every 2 years, or when clinical or operation processes change.
Last Reviewed	March 2024
Next Review Date	March 2026
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
DRAFT V1	July 2022	New SOP	AM
V1	Apr 2023	Review	Clinical Advisory Group
V2	Jan 2024	Rebrand	Clinical Advisory Group
V2.1	Mar 2024	Reviewed and rebranded	Clinical Advisory Group
V2.2	Apr 2024	eMARS Transcription section added	Clinical Advisory Group

Table of Contents

1. Introduction

The Royal Pharmaceutical Society (RPS) and the Royal College of Nursing (RCN) define transcribing as the accurate copying of previously prescribed medicine details to enable their administration in line with legislation (i.e. in accordance with the instructions of a prescriber. (Professional Guidance on the Administration of Medicines in Healthcare Settings January 2019)

There is no direct legislation on transcribing. However, legislation does cover administration under the direction of a prescriber and the Medicines and Healthcare products Regulatory Agency (MHRA) has advised that a direction to administer needs to be in writing for a Prescription Only Medicine (POM). (Medicines Use & Safety, Medicines Use and Safety Team February 2022)

2. Aim

The aim of this standard operating procedure is to ensure that Acacium Group workers are aware of the requirements relating to transcription of medication and to ensure the safety of clients in the community at all times.

Transcribing is used only in the patient's best interests to ensure safe and continuous care: ensuring the medication is administered safely, accurately, without undue delay.

3. Who needs to be aware of this procedure

All Acacium Group workers who are trained and competent to undertake the transcription of medication for administration.

4. Duties

Responsibilities of the Chief Executive and Board
While ultimate responsibility is vested in the Board, executive responsibility is delegated to Group Clinical Director for clinical policies and processes. Compliance with this process will be achieved by:

- Training and competency assessment
- Implementation of effective control measures.
- Accurate assessment and care planning

Responsibilities of Directors / Chief Nurses / Clinical Leads

- Provide staff to implement correct medication management for clients/Service Users in the community with clinical assessment and care planning
- Ensure training and competency assessment is completed for relevant staff
- Complete audits and quality assurance controls on transcribed documents

Responsibilities of Employees

- To work within their scope of practice
- To follow policy and guidelines relating to medication management and administration in line with Acacium Group Medication Management Policy
- To attend training as required
- To report any concerns around medication administration or transcription to their line manager

5. Transcription in Medication Management

Transcribing is the exact copying of medicines details for the purposes of administration only.

The medication administration record (MAR) is used to record the medication administered to the client in the community setting and transcription of medication is made onto the MAR by a trained and competent member of staff.

Transcribing cannot be used:

- in place of prescribing
- to supply or dispense medicines
- to add new medicines
- to alter or change original prescriptions.

For example, if information is transcribed on to a chart it cannot be used as a prescription to supply medicines to a patient or to a healthcare setting,

6. Equipment

- MAR Chart (handwritten or hard copy)
- Source Prescription (this may be in the form of a discharge letter or other – see Appendix)
- Electronic means of preparing and sharing the MAR chart for printing, if applicable

7. Procedure for Digital Medication Transcription

This procedure is for community divisions that use remote digital transcription of MAR charts for their Service Users/Clients.

	Action	Rationale
1.	Before transcription occurs, the transcriber must check the following: • The client's full name • The client's date of birth • Any intended treatment stop date. Information regarding any allergies the client may have	To check the identity of the client
2.	Prescription is gained from Primary or Secondary provider (must be no older than 3 months) and sent by email to clinical lead The prescription can be in the form of: - FP10 prescription - FP10 repeat prescription - Discharge Letter - Hospital consultant communication in written, verified format See Appendix B for examples	The prescription is needed to provide the information of medication for administration, A new source of prescription is sourced every 8 weeks to ensure that the medication transcribed is current.
3.	Medication is transcribed onto digital MAR chart electronically by the Clinical Lead for the client, converted to a PDF document, locked and saved.	Second clinical leads provide a check to prevent error.

	A second clinical lead checks the transcription. Both clinical leads sign the MAR chart digitally as transcriber 1 and transcriber 2.	Prevents alterations and changes being made. Example MAR chart Appendix C
4.	If the client has Over the Counter (OTC) medication – this will be transcribed on the MAR chart, marked as OTC, and given if deemed suitable and recommended for the client. This will feature on the Medication Risk Assessment with authorising evidence of need.	To provide safe medication administration.
5.	MAR chart is sent electronically to the central administration team for printing and distribution to the client	
6.	If medication is prescribed during the life of the current MAR chart, this is handwritten on the document by a member of the staff taking care of the client, if they are competent and confident to do so. The Clinical lead for the client will be made aware, approve the transcription, and ask for the prescription to be forwarded to place on the client's file	To enable to prompt administration of prescribed medication.
7.	Client's medication in their home setting is reviewed monthly by the clinical lead to ensure dosage/stock correct as per the MAR chart. Any discrepancy will be addressed and corrected.	To ensure accuracy and availability of current medication.

8. Procedure for Handwritten Transcription

In some community divisions, the transcription of medication is completed by hand in the home of the client

	Action	Rationale
1.	Before transcription occurs, the transcriber must check the following: • The client's full name • The client's date of birth • Any intended treatment stop date. Information regarding any allergies the client may have	To check the identity of the client
2.	Prescription is gained from Primary or Secondary provider (must be no older than 3 months) and sent by email to clinical lead The prescription can be in the form of: - FP10 prescription - FP10 repeat prescription - Discharge Letter - Hospital consultant communication in written, verified format See Appendix B for examples	The prescription is needed to provide the information of medication for administration, A new source of prescription is sourced every 8 weeks to ensure that the medication transcribed is current.

3.	Medication is transcribed onto MAR by hand by a trained healthcare practitioner, this must be completed legibly and in black ink. Drug, route, dose & max dose (for PRN medication) & frequency must all be completed A second trained healthcare practitioner checks the transcription, and both sign the MAR as transcriber 1 and transcriber 2.	Second clinical leads provide a check to prevent error.
4.	If the client has Over the Counter (OTC) medication – this will be transcribed on the MAR chart, marked as OTC, and given if deemed suitable and recommended for the client.	To provide safe medication administration.
5.	If medication is prescribed during the life of the current MAR chart, this is handwritten on the document by a member of the staff taking care of the client, if they are competent and confident to do so. The Clinical lead for the client will be made aware, approve the transcription and ask for the prescription to be forwarded to place on the client's file	To enable to prompt administration of prescribed medication.

Medicines should not be transcribed where details are illegible, unclear, ambiguous, or incomplete.

Particular care should be taken in transcribing details of high-risk medicines such as insulin, anticoagulants, or controlled drugs.

9. Procedure for digital eMARS Transcription

This procedure is for community divisions that use eMAR transcription of MAR charts for their Service Users/Clients

	Action	Rationale
1.	Before transcription occurs, the transcriber must check the following: • The client's full name • The client's date of birth • Any intended treatment stop date. Information regarding any allergies and the client may have and the client's weight must be recorded in carelink under "referral details" then "medication requirements"	To check the identity of the client and ensure that the weight and allergies pull through to the eMAR chart in the home
2.	Prescription is gained from Primary or Secondary provider (must be no older than 3 months) and sent by email to clinical lead The prescription can be in the form of: - FP10 prescription - FP10 repeat prescription - Discharge Letter	The prescription is needed to provide the information of medication for administration, A new source of prescription is sourced every 8 weeks to ensure that the medication transcribed is current.

	- Hospital consultant communication in written, verified format See Appendix B for examples	
3.	Medication is transcribed onto EMAR chart electronically by the Clinical Lead for the client. See Appendix for full details on how this happens. 25th of the month is put as the "end date" to ensure it is reviewing periodically. A second clinical lead checks and signs the transcription.	Second clinical leads provide a check to prevent error. Prevents alterations and changes being made.
4.	If the client has Over the Counter (OTC) medication – this will be transcribed on the MAR chart, marked as OTC, and given if deemed suitable and recommended for the client. This will feature on the Medication Risk Assessment with authorising evidence of need.	To provide safe medication administration.
6.	If medication is prescribed during the life of the current MAR chart, a member of staff must contact the clinical lead or clinical lead on call and advise a new medication has been prescribed. The clinical lead or clinical lead on call will then give permission for the worker to transcribe it using "medication setup" functionality. The Clinical lead who gave permission for this will receive the evidence from the worker and then will be the 2nd transcriber.	To enable to prompt administration of prescribed medication.
7.	Client's medication in their home setting is reviewed monthly by the clinical lead to ensure dosage/stock correct as per the MAR chart. Any discrepancy will be addressed and corrected.	To ensure accuracy and availability of current medication.
8.	The Clinical lead or allocated person will review the eMars monthly and change the end date	To ensure regular review of the medications is occurring.

10. Abbreviations and Terminology on Medication Administration Records

In accordance with NICE Guidelines, internationally recognised units and symbols can be used when transcribing as listed below:

https://bnf.nice.org.uk/about/abbreviations-and-symbols/

Abbreviation	Explanation
P.O.	(Latin and means Per Os): by the mouth
SL	sublingual (under the tongue)
BUCC	Buccal (in between the cheek and gum)
PR	rectally or per rectum
PV	vaginally or per vagina
i/m	intramuscular
i/v	Intravenous

SC	subc, subcut, subq: subcutaneous
INH	inhaled
TD	Transdermal
Topical	should be written in full , not abbreviated
Eye	write it out and designate right or left eye or both eyes
Ear	write it out and designate right or left ear or both ears
Nose	nasally…designate which nostril or both nostrils
NGT	nasogastric tube
PEG	percutaneous endoscopic gastrostomy
RIG	Radiologically Inserted Gastrostomy
max.	maximum
prn	pro re nata (when required)

The following should be noted: (NICE Guidelines 2022)

- The strength or quantity to be contained in capsules, lozenges, tablets etc. should be stated. In particular, the strength of liquid preparations should be clearly stated (e.g. 125 mg/5 mL).
- Quantities of 1 gram or more should be written as 1 g, 1.5 g etc.
- Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g.
- Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg.
- When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g. 0.5 mL, not .5 ml.
- 'Micrograms' and 'nanograms' should not be abbreviated. Similarly, 'units' should not be abbreviated.
- Dose and dose frequency should be stated
- in the case of preparations to be taken 'as required' a minimum dose interval should be specified.
- The names of drugs and preparations should be written clearly and not abbreviated, using approved titles only

Acacium Group will not use Latin abbreviations for the frequency medication should be given e.g. Four times daily is the correct way to state how often the medication should be administered, not QDS.

11. Audit Requirements

Acacium Group have internal auditors to provide quality assurance and accuracy of all documentation produced by the Clinical Leads.
This includes audit of the MAR charts for accuracy and completion against the client's prescription.

12. Errors in Transcription

When an error occurs, this is reported in line with Acacium Group Incident Reporting Policy.

Any training need identified addressed and any trend identified is acted upon to resolve.

13. Associated Policies / SOPs

Policies
CLIN 03 Medicines Management Policy
CLIN 13 Record Keeping Policy
ORG 04 Incident Reporting Policy

14. References

- Professional Guidance on the Administration of Medicines in Healthcare Settings January 2019 The Royal Pharmaceutical Society (RPS) and Royal College of Nursing (RCN)
- National Institute for Health and Care Excellence. (2015). Guidance. NG5. Medicines optimisation: The safe and effective use of medicines to enable the best possible outcomes
- National Institute for Health and Care Excellence. (2017). Guidance. NG67: Managing medicines for adults receiving social care in the community.

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

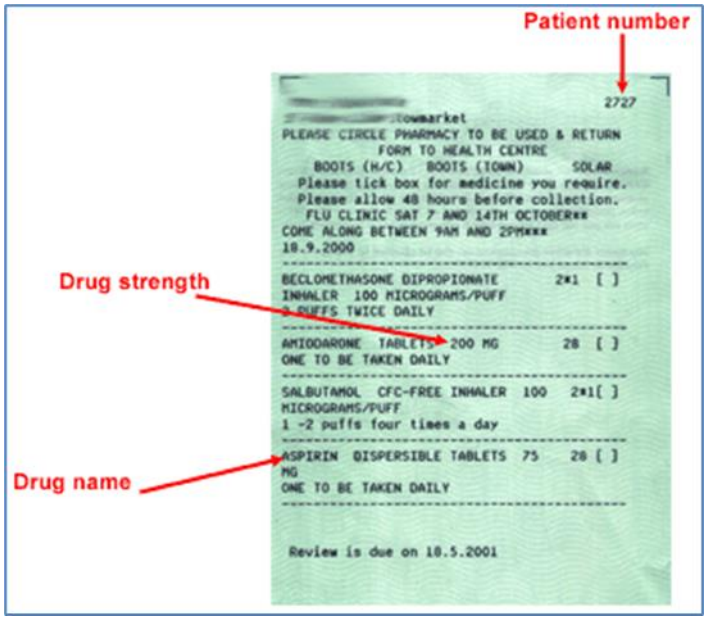
pulse Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group

Appendix B: Example Prescriptions

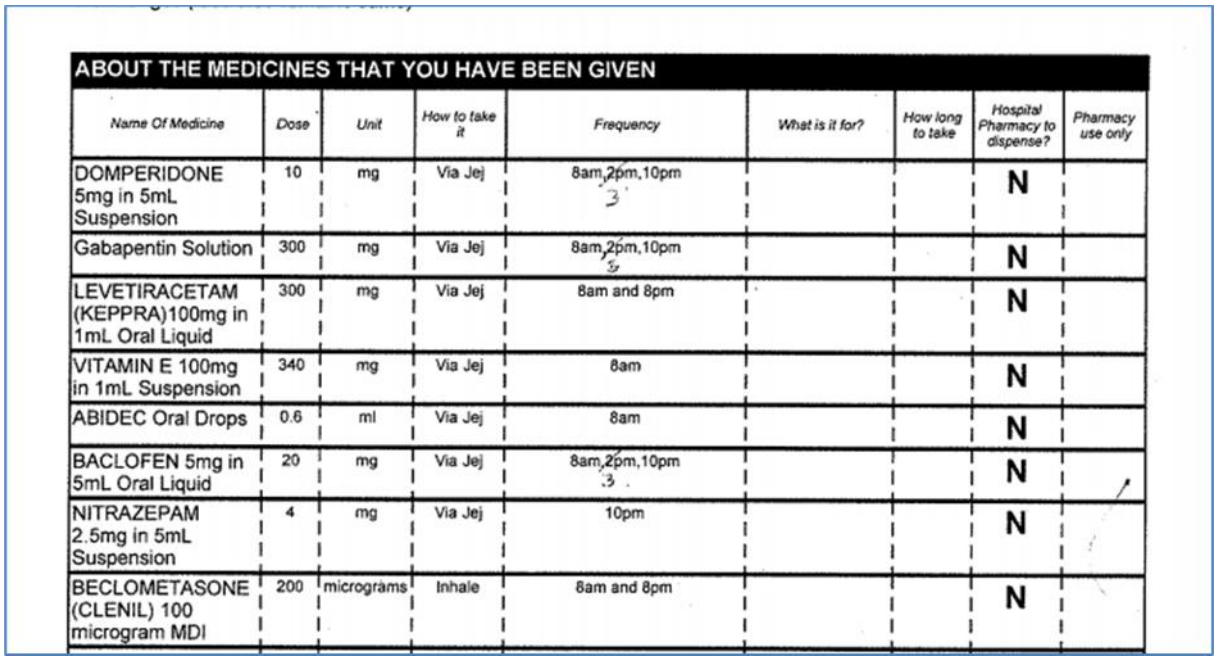
Examples of source prescriptions used for the transcription of medication onto a MAR chart.

FP10 Example

Repeat Prescription Example



Discharge Letter Example



ABOUT THE MEDICINES THAT YOU HAVE BEEN GIVEN

Name Of Medicine	Dose	Unit	How to take it	Frequency	What is it for?	How long to take	Hospital Pharmacy to dispense?	Pharmacy use only
DOMPERIDONE 5mg in 5mL Suspension	10	mg	Via Jej	8am,2pm,10pm 3			N	
Gabapentin Solution	300	mg	Via Jej	8am,2pm,10pm 3			N	
LEVETIRACETAM (KEPPRA)100mg in 1mL Oral Liquid	300	mg	Via Jej	8am and 8pm			N	
VITAMIN E 100mg in 1mL Suspension	340	mg	Via Jej	8am			N	
ABIDEC Oral Drops	0.6	ml	Via Jej	8am			N	
BACLOFEN 5mg in 5mL Oral Liquid	20	mg	Via Jej	8am,2pm,10pm 3			N	
NITRAZEPAM 2.5mg in 5mL Suspension	4	mg	Via Jej	10pm			N	
BECLOMETASONE (CLENIL) 100 microgram MDI	200	micrograms	Inhale	8am and 8pm			N	

Appendix C: Example MAR Chart

Medication Administration Chart

Client Name: **Address:** **DOB:** **Weight:**	**Allergies:**

Medication statement:

Consent:
Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. You must ensure the client has given consent for you to administer medication prior to doing so. You must ensure the client has received sufficient information and fully understands the nature, purpose and risks of the procedure.

Checks:
Prior to any administration of medicines support workers and nurses must check:
• The identity of the client to whom the medicine is to be administered.
• You must check that the client is not allergic to the medicine before administering it.
• You must check that the prescription or the label on medicine dispensed is clearly written and unambiguous.
• You must check the expiry date (where it exists) of the medicine to be administered.
• The right drug, dose and route is also clear.
• You must contact the prescriber or the GP or ambulance without delay where the patient develops a reaction to the medicine.

Documentation:
You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld (W) or refused (R) by the patient or omitted (O) using the agreed abbreviations. You must ensure your signature is clear, legible and that the entry is dated and for PRN medication the amount administered is also documented.

Reporting incidents:
If a support worker or nurse realises that an error has been made, e.g. a drug has been omitted, given incorrectly or the procedure has failed, then the following principles should be followed:
• Check the client's well being and tell them what has happened obtain advice if necessary e.g. from line manager, clinical lead, clinical director or prescriber.
• Arrange any necessary immediate treatment or follow up for the patient.
• Inform the prescriber, line manager and clinical director at the first available opportunity.
• If a serious error occurs resulting in the patient requiring admission to hospital then the manager or director on call must be notified immediately.
Any errors involving controlled drugs must be reported to the clinical director who is the accountable officer.

Transcribing:
Wherever possible transcribing (re-writing of a prescription onto a MAR chart) should only be done as a last resort, the transcribing should be in clear handwriting using black ink and capitals and checked by yourself and a second competent Pulse Community Healthcare worker. In situations where this is not possible the transcribing should be checked by an adult with full capacity, this may be the client, a family member or friend. Both persons checking the transcription must sign the MAR chart.

REGULAR MEDICATIONS

Code	R Refused	O - Omitted	D - Destroyed	A - Absent	N – No Stock	T – Given by third party	V- Vomited

Month & Year		Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG:																																	
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Start date		Additional Instructions																															

Reason For Medication Not Administered

(R) Refused (O) Omitted (D) Destroyed (A) Absent (V) Vomiting (N) No Stock (T) Given by Third Party

Date	Drug/ Dose	Reason	Print & sign	Comments

Signature Log

Name Printed	Name Signed	Initial	Date

PRN (WHEN REQUIRED) MEDICATION

DRUG:		**Date**																													
DOSE:		**Time**																													
ROUTE:		**Dose**																													
FREQUENCY:		**Sign**																													
Transcriber Signature 1	Date																														
Transcriber Signature 2	Date																														
Maximum dose in 24 Hours:		Additional Instructions																													
DRUG:		**Date**																													
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Transcriber Signature 2	Date																														
Maximum dose in 24 Hours		Additional Instructions																													
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Transcriber Signature 2	Date																														
Maximum dose in 24 Hours		Additional Instructions																													

PRN (WHEN REQUIRED) MEDICATION

DRUG:		**Date**																															
DOSE:		**Time**																															
ROUTE:		**Dose**																															
FREQUENCY:		**Sign**																															
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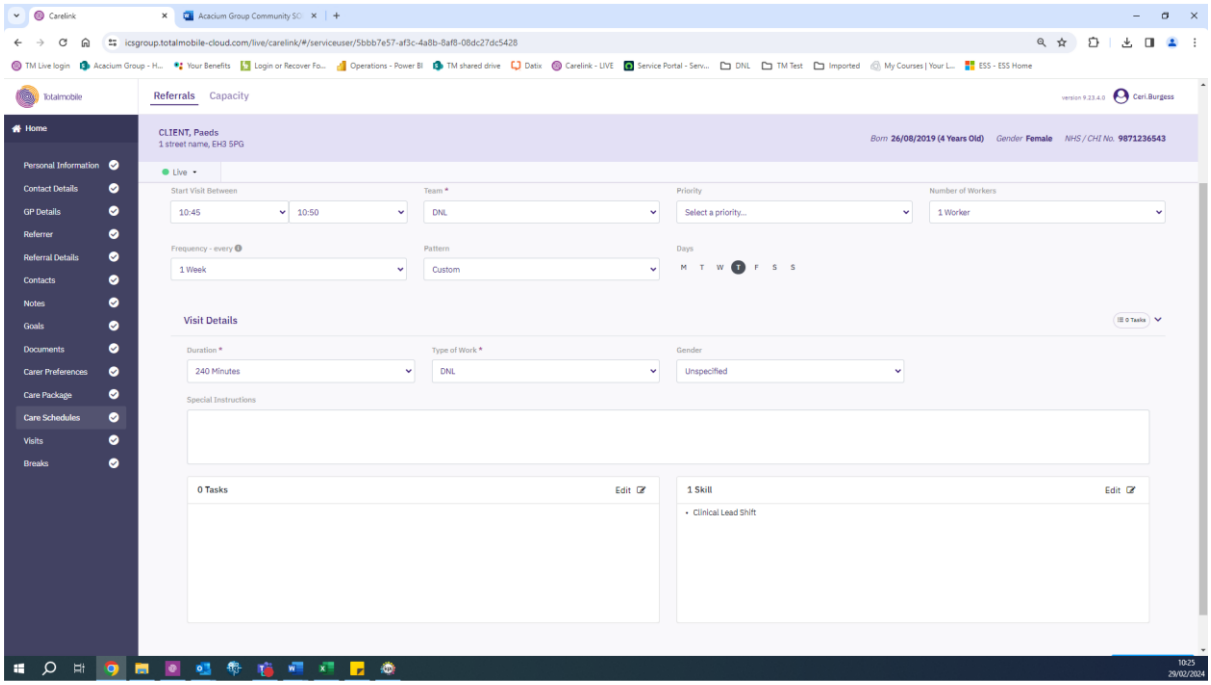
Appendix D: eMars CL Set-up

Part 1: Make yourself a “clinical lead shift on optimise”.

Click on care schedules > add series > fill in the information.

Remember the start visit between must be 15 mins on from the current time. I.e. if you are doing it at 11am then start visit will be 1115 as it can take a little while to go from CareLink to optimise.

Please remember that in “skill” in the bottom right you **MUST** select clinical lead shift. This is to prevent any GDPR issues.



Please remember that in “skill” in the bottom right you **MUST** select clinical lead shift. This is to prevent any GDPR issues.