Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE TRANSCRIBING AT GRANVILLE COURT RESIDENTIAL AND NURSING HOME

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*May 2022*	*New SOP. Approved at DTG (May 22)*
1.1	*20/6/2023*	*Reviewed. Section 4.2 minor amendment for clarify transcribing after reconciliation record is completed. Link to competency document added. Links to reference documents updated. Minor amendments to out of hours procedure, training requirements and change of Non-Medical Prescribing Lead. Approved at PHMD Group (9 August 2023).*
1.2	*November 2023*	*4.2 Rewording of requirements for Transcribing on MAR charts to align to the competency document.* *Approved at Drugs and Therapeutic Group (30 November 2023).*
1.3	*May 2024*	*Reviewed. Changes to frequency of training and completion of competenciesAddition of process when OTC medicines require administering* *Approved at Drug and Therapeutics Group (30 May 2024).*

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1. INTRODUCTION

Organisational policies and procedures for transcribing are underpinned by risk assessment. Such policies are clear about who can transcribe, when it can be used, and the difference between transcribing and prescribing.
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, cytotoxic drugs, or controlled drugs. (RPS/RCN 2019).

The safety of the patient is paramount, and the use of transcribing should not be used to overcome shortages of prescribers, other poor local processes or inefficiencies within systems or care pathways. Transcribing should only be used when it is in the patient's best interests to ensure safe and continuous care (Understanding transcribing for medicines administration in healthcare – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice (2022)

Granville Court is a residential and nursing home for people with severe learning disabilities who also have physical health needs. The home has permanent residents and people admitted for respite care. People who are admitted for respite care continue to have their primary care needs met where they have their permanent residence. A Medicines Administration Record (MAR) chart cannot be accessed from their GP or local pharmacy for respite care. Therefore, nurses are expected to transcribe onto a trust MAR chart the medication required for the resident's respite care. Permanent residents also sometimes require urgent medication in an out of hours situation. At these times a printed MAR is not accessible so the nurses will need to transcribe.

The risk of transcribing at Granville Court is assessed and mitigated by having robust processes in place, staff have current information about the resident and their medication, they use the label on the dispensed medications for transcribing, which in turn is dispensed from the prescription, staff have knowledge about the medication they are transcribing and have been assessed as competent to transcribe on an annual basis.

The Trust's Safe and Secure Handling of Medicine Procedures states that, for in-patients, all medicines including medicines bought over the counter (e.g. vitamins) and complementary medicines, must be prescribed on the MAR chart. If new items are purchased over the counter, a prescriber would need to assess if these are safe to be administered to the resident alongside their current medications.

Transcribing Definition - "Transcribing can be defined as the act of making an exact copy, usually in writing, of previously prescribed medicines details to enable their administration in line with legislation (i.e., in accordance with the instructions of a prescriber). Since 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. Transcribing is used only in the patient's best interests to ensure safe and continuous care: ensuring the medication is administered accurately, without undue delay" (RPS/RCN 2019)

2. SCOPE

Transcribing is to be completed by nurses working at Granville Court who have been assessed as competent.

3. DUTIES AND RESPONSIBILITIES

Chief Pharmacist:
Is responsible for ensuring that the Trust has a comprehensive standard operating procedure for Granville Court for Transcribing.

Non-medical Prescribing Lead:
Will ensure SOP is relevant to current practice and will support Medicine Optimisation Nurse with training and competency completion.

Service Managers and Modern Matron will ensure dissemination and implementation of the SOP. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Charge Nurse will disseminate and implement the agreed SOP. They will maintain an overview of associated training needs and ensure nurses maintain their competency

Transcribers:
To be responsible for ensuring medications are transcribed accurately and safely.
They must maintain their competency to transcribe by undertaking the appropriate continuous professional development

4. PROCEDURES

4.1. Medicine Reconciliation

Most of the transcribing at Granville Court is for people receiving respite care. Medication must be reconciled on admission and the information documented on the trusts medicine reconciliation tool. It is important to use the following sources for reconciling the medication; the in date dispensed medication, which has been checked against the residents "summary care record". If the summary care record is not available, the most up to date "medication history sheet"/" FP10 repeat medication slip" that accompanies the dispensed medication should be used. The relative/carer will confirm the resident's prescribed medication, dosages and route before the nurse transcribes the medication onto the Medicine Administration Record (MAR). Allergy status must also be confirmed by the carers. Any discrepancy must be resolved with a prescriber before Transcribing.

Medicine Reconciliation Definition - "Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' includes prescribed medicines, over-the-counter medicines, medicines bought from the internet or complementary medicines.
Any discrepancies in the medicine reconciliation process would need to be resolved before transcribing" (NICE 2015).

4.2. Transcribing

Respite Residence. Once the medicines have been reconciled as correct for respite residents, the nurse will transcribe the information from the reconciliation tool onto the MAR chart**.**

Permanent Residence. Transcribing for permanent residents is in exceptional circumstances such as out of hours (see section 4.2.2) when the prescriber is unable to amend the medication administration record.

Procedure For all Residents
Any discrepancy must be resolved with the prescriber before transcribing.

- Any changes to a dose of previously prescribed medication or discontinuing of medication must be under the instructions of the prescriber. The transcribing nurses and prescriber must follow the communication as described above.
- A new prescription must be written for the new medication dose and the dispensed medication used to transcribe the MAR.
- If the previous medication is to be discontinued a diagonal line must go through the medication and unused medication boxes on the MAR chart. It must be signed and dated by both nurses.
- Changes must be communicated at handover and update any care plans

Transcribed MAR charts must have recorded:

- Patient's name
- NHS number
- Date of Birth
- Allergy status must be confirmed by the nurse. Any discrepancy must be resolved with a prescriber before Transcribing. Enter details of drug or other allergies in the appropriate section when initially completing the MAR. If none are known, this must also be indicated. Information added on allergy status must be signed and dated at the time of entry or amendment.
- Medication name which must be written legibly in black ink.
- Form (tablet, capsules, solution, injection)
- Strength - The use of decimal points should be avoided where possible e.g., transcribe as 200 micrograms and not 0.2mg, or transcribe as 2mg and not 2.0mg.
- Dose. A zero must be put in front of any decimal point. Where doses are less than 1g, the dose should be written as milligrams and where less than 1mg should be written as micrograms (micrograms should not be abbreviated). If small volumes are prescribed (less than 1ml) write as 0.5ml and not .5ml

  The following units may be used for expressing strength or dosage:

  - g = grams
  - mg = milligram
  - ml = milliliters
  - micrograms – **must be written in full**
  - nanograms - **must be written in full**
  - `units' - **must be written in full**

  - Dose and frequency– timings for medications should be clear. To reduce the risk of error, any medications that have a different dose at a different time (e.g.,10mg each morning and 20mg at night) are to be written onto another line of the MAR chart.

  - Any intended for 'once weekly' requires clearly indicating on the chart and other days marked out. Write out the frequency in words and not figures e.g., THREE TIMES A DAY or THREE x DAILY and not 3 x daily or 3 times a day.

- Route – should be identified clearly. Accepted abbreviations are:
  - IV =Intravenous
  - SC = Subcutaneous
  - PR = Per Rectum
  - PV = Per Vagina
  - INH= By Inhalation
  - PO = By Mouth
  - IM= Intramuscular
  - NEB = By Nebuliser
  - Oral = By Mouth
  - Gastro/PEG = By Gastrostomy
  - Top = Topical

All other routes should be written out in full e.g., Sublingual, Buccal. Only one route should be indicated for a given administration time.

- Any additional instructions – for example, to be administered after food or 'for external use only'.
- Ensure any indications for `as required drugs` are copied. The dose interval should be specified (e.g., every 4 hours) as well as the maximum quantity that could be administered (e.g., max 30mg in 24 hours).
- Medications with 'as directed' instructions are to be queried with the prescriber if indications and frequency are not clear e.g., if this refers to a patient's care plan in place then 'as per care plan' can be added for the administering nurse to refer to. A maximum dose is 24 hours should be specified.
- **All transcriptions should include the transcribed date**
- **The identity of the transcriber must be clearly recorded including the transcriber's full name and their signature and be endorsed with a "T" in a circle at the right-hand corner of the transcriber's names in the signature box**
- Document any medication that has not been transcribed in the resident's record and inform the prescriber
- All medicines that are transcribed must be checked by another nurse competent in transcribing. The person checking the transcription must also put "**checked by**" followed by their full name in the signature box and sign and date.
- Multiple MAR charts must be condensed onto one chart whenever possible. If the patient requires more than one MAR chart, 1 of 2, or 2 of 2 etc. must be marked clearly on the front of the charts.

4.3. Out of hours Transcribing Procedure for Respite and Permanent Residents

The changes are communicated verbally to both nurses involved in the transcribing and confirmed by the prescriber by an appropriately secure electronic method such as NHS email. If there are any discrepancies between the verbal and electronic communication, the medication should not be administered until resolved by the prescriber. The patient's records should include the written account of the verbal communication and the sent email. The dispensed medication will be checked against written and verbal communication and used to do the transcription.

4.4. Purchase of over-the-counter medications for administration

There may be occasions where medications, including complementary medicines and herbal or homely remedies, are unable to be prescribed and are required to be purchased over the counter.

This may occur if the resident has visited a healthcare professional such as a dentist, and under these circumstances evidence should be obtained to support this advice provided by the healthcare profession including the suggested medication, strength, route, dose including maximum dose in 24 hours, and the reason for and duration of use.

Our Trust Safe and Secure Handling of Medicine Procedures states that 'for in-patients, all medicines including medicines bought over the counter (e.g. vitamins) and complementary medicines, must be prescribed on the MAR chart'.

If new items are purchased over the counter, a prescriber would need to assess if these are safe to be administered to the resident alongside their current medications.

The Care Quality Commission (2023) guidance states that 'All over-the-counter products purchased on behalf of the person or brought into a care setting should be:

- checked with an appropriate healthcare professional to make sure they are suitable
- in date
- stored according to the manufacturer's guidance
- recorded in care plans

Any support provided by care staff to help people use OTC products must be recorded. If care staff are responsible for administration, record this on a medicines administration record in line with policy.

The first consideration should be the patient's GP for this medication to be assessed as safe alongside their current prescribed medication and added onto the MAR chart.

If this cannot be done for any reason, the medication must not be administered until a prescriber can confirm in writing that it is safe to do so, and they have assessed this alongside their current prescribed medications.

Evidence of this written confirmation should be sent via a secure electronic method such as NHS email and be kept as an auditable trail along with the evidence obtained regarding the advice to obtain the medication for the resident.

Once there is clear written evidence that a prescriber has assessed all the medication as safe for the resident to take alongside current medication and allergy status, this new medication can be transcribed onto the MAR chart.

Any over the counter medications should be kept in their original container with the directions for use, storage and expiry date visible.

5. TRAINING AND COMPETENCY ASSESSMENT

The nurses must be trained and competent to Transcribe medication. Assessment of competency must be undertaken initially and then two yearly. Assessment must be by a prescriber. The transcribing competency template on the intranet competency website should be used to assess competence.

In addition to Transcribing training and competency, transcribers are required to ensure their Medicine Administration annual competencies are kept up to date as well as any role specific training competencies such as Insulin Safety training.

CRS20 - Transcribing Granville Court - Competency Assessment

6. REFERENCES

- Care Quality Commission (2022) Medicines administration records in adult social care - Care Quality Commission (cqc.org.uk)
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