Policy on Nurse Transcribing	
Developed by: Drogheda Services for Older People.	**Date Developed: April 2013, Sept 2023**
Developed By: Nursing Department.	**Date Approved: April 2013, February 2016, February 2021, Sept 2023**
Implementation Date: April 2013	**Review Date: September 2026**
Policy Reference Number: DSOP	**No. of Pages: 9**
Status of the Policy: Final	

MEDICATION TRANSCRIBING POLICY by Registered Nurses

1. Background

The Irish Nursing and Midwifery Board Standard Best practice would indicate that the responsibility for documenting the prescription/medication order is with the medical practitioner and/or the registered nurse prescriber to prevent the possibility of error by another individual. The decision to transcribe a prescription should only be made in the best interests of the patient/service user.

A nurse who transcribes is professionally accountable for her/his decision to transcribe and the accuracy of the transcription.

Transcribing is the act of transferring a medication order from the original prescription to the current medication administration record/prescription sheet. This activity should be directed by local health service provider policy which must stipulate required systems (i.e. a second person checking the prescription transcribed) in order to minimise the risk of error.

Transcribed orders should be signed and dated by the transcribing nurse and co-signed by the prescribing doctor or registered nurse prescriber within a designated timeframe. If a nurse is unclear about a transcribed prescription/order she or he should verify or confirm the prescription with the prescriber or pharmacist before administering the medication to the patient/service user. The practice of transcribing should be the subject of audit.

2. Scope

This policy is to be followed by registered nurses who are working for or within Drogheda Services for Older People in Saint Mary's Hospital, whose manager has agreed the activity and who undertake the following activities:

- Writing medication administration charts in Saint Mary's Hospital
- Transcribing faxed messages and prescriptions on to inpatient charts (limited activity);

3. Sources of information for transcribing

Prescription generated by an independent prescriber outside of these services but must be a medical doctor

A written record obtained from the GP e.g. repeat prescription request

A current discharge prescription from a hospital

A faxed prescription or direction from a doctor

4. Who may transcribe

Registered nurses, who have undergone a competency assessment in transcribing by their Clinical Nurse Manager. The competency assessment also requires that the registered professional should have attended an up to date medication management online course completed and have and have at least two years experience of administering medications to older people

Only those registered nurses, whose manager has agreed the person, may transcribe medications.

5. Process for Transcribing

Transcribing the information is copying from the sources above without any alterations or additions. Interpretations should only be as described in the following paragraphs. If the information in the sources is unclear this should be clarified with, and countersigned by the prescriber. **Changes may not be made based on information provided by the patient, family member or carer.** Transcribing should take into account the abilities of the staff who will be following the instructions.

5.1 Write in black ink and use **CAPITALS** for drug name and directions wherever there is sufficient room and include all prescribed /dispensed medications including externally applied medicines. Write out the dose as per International Abbreviation listing accurately. Ensure that the

frequency and maximum dosage in a 24 hour period for PRN medications is clear and concisely written.

The nurse must ensure that in line with crushing medications, that the doctor agrees with crushing and that this is charted on the prescription.

5.2 Medication transcribing should include the following information as it appears on the dispensed item label / the prescription / the repeat prescription request form, the patient held record / the fax from the doctor or the discharge prescription:

- The medication name
- The form as it appears e.g. tablet, capsule, solution
- The strength e.g. 100mg
- The dose, usually as the number of tablets or capsules
- The frequency e.g. twice a day
- The date of the transcribing
- Any additional directions or information in the special instructions box e.g. with food

5.3 Do not abbreviate medication names or directions. TABS and CAPS may not be used.

5.4 Care should be taken when transcribing drug strengths. **Prescribers** are advised to write as below and transcribers will need to follow this where there is room:

- g/G for grams
- mg for milligram
- ml for millilitre
- microgram should be written in full.

If the prescriber has not followed this advice then if there is any doubt please check with the prescriber and write the dose strength as above.

5.5 Care should be taken when reading and transcribing decimal points. The advice to **prescribers** is to write a zero in front of a decimal point for clarification e.g. 0.25mg NOT .25mg;

0.5ml NOT .5ml. If the prescriber has not followed this advice then please check with the prescriber before transcribing and add the zero if appropriate.

5.6 Prescribers may write frequencies in Latin abbreviations which should be interpreted by transcribers as follows:

- OD / od = once a day
- ON / on = once at night
- BD / bd = twice a day
- QDS / qds = four times a day
- TDS / tds = three times a day
- PRN / prn = when required

A full list is in the back of the British National Formulary.
Twice a day should be approximately twelve hourly and three times a day every eight hours.

5.7 Prescribers may use abbreviations for routes of administration but which should be fully written up by transcribers as follows:

- PR/ pr = rectally . Transcribers should only write rectally
- PV / pv = vaginally . Write vaginally
- INH / inh = by inhalation. Write by inhalation
- PO / po = orally . This can be written as po
- TOP / top = topically . Write as topically
- SL / sib ling = sublingually . Write as sublingual
- RE / re = right eye . Write as right eye or left eye.

Abbreviations may not be used for these

5.8 Transcribe any special administration instructions such as one hour before food and adjust the medication timings to reflect this if appropriate.

5.9 If there are so many prescription items that more than one medication administration record sheet is necessary then the sheets should be annotated with e.g. 1 of 3; 2 of 3, 3 of 3.

5.10 Medication Administration Records, patient compliance sheets etc will also need to have the following information;

- Patient's name and address
- Date of birth
- Name of prescribing doctor
- Any known medication allergies

5.11 If different doses are to be given at different times of the day the medication instructions should be written on two separate boxes but adjacent to each other

5.12. A Nurse must always countersign WITH ANOTHER Nurse with the medical doctor that they have transcribed the drug.

The nurse is responsible for ensuring that he/she checks down through each individual drug transcribed with another nurse and the doctor and checks same against the original prescription.

NB.If IT IS KNOWN THAT THERE IS A NEED TO CRUSH MEDICATIONS, AND THEN THIS SHOULD BE WRITTEN BY THE TRANSCRIBER AND/OR FULLY DISCUSSED WITH THE PRESCRIBER AND PHARMACIST. NURSES MUST BE FAMILIAR WITH WHAT DRUGS ARE BEING CRUSHED. THE BRITISH Formulary on crushing of medicines must be available to nurses for them to check. It is not legally acceptable for nurses to rely on the prescriber in relation to crushing of medicines. It is the responsibility of the nurse as well to know what drugs should and should not be crushed.

6. Audit

A six monthly audit of Medication Administration Sheets will be conducted.

Aspect	Percentage	Exceptions
The drug name and directions must be written in black ink and CAPITAL letters	100%	None
Medication transcribing should include: • The medication name; • The form as it appears, eg tablet, capsule, solution; • The strength; • The dose; • The frequency; • The date of transcribing and • Any additional directions.	100%	None
Abbreviations must not be used, Latin abbreviations should be interpreted and written in full.	100%	None
A nought must be put in front of decimal points.	100%	None
If the Medicines Administration Record (MAR) runs over two or more pages, each page should be numbered eg 1 of 3, 2 of 3 etc	100%	None
MAR and Patient Compliance sheets must have recorded: • Patient Name and address; •• Date of Birth; • Name and address of	100%	None

prescribing doctor and • Any known allergies.		
If different doses are required at different times of the day, the medication instructions should be written on two separate boxes but adjacent to each other.	100%	

Competency Framework. Nurse Transcribing.

1. The Nurse has read the Policy on Transcribing.

2. The Nurse can outline the responsibility for the transcribing of medications.

3. The nurse can verify the source of this information

4. The nurse verifies who should sign the administration chart

5. The Nurse can outline the Scope of this Policy as to who can transcribe

6. The nurse is clear on who they can use as information sources and who they must not use

7. The nurse can outline the transcribed information which must be written on the administration sheet

8. The nurse can outline the rules on transcribing in relation to decimal points, e.g. .5 should be written as 0.5

9. The nurse outlines the rules in relation to route of administration

10. The nurse outlines the rules in relation to various strengths e.g mgs, mls, etc

11. The nurse outlines how special instructions are written, e.g. one hour before meals.

12. The nurse outlines what happens if there is more than one medication administration sheet

13. The nurse outlines how an administration sheet is verified by a Medical Doctor and the procedure to follow

14. The nurse outlines what to do if there are different doses of the same drug to be given on the same day

A competency assessment in relation to Drug transcribing has been undertake with S/N _____, ON DATE _____. I can verify that I have deemed that this nurse is competent in nurse transcribing, or

I can verify that at this time S/N _____ REQUIRES FURTHER INSTRUCTION IN RELATION TO Nurse Transcribing.

Signed Clinical Nurse Manager _____

Staff Nurse _____

Date._____