Standard Operating Procedure
Transcription of Medication by District Nursing Services

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.
Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Adapted from All Wales District Nursing Forum Standard Operating Procedure Transcribing of Medication by District Nursing Services 14/02/2025.	12/08/25

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Adapted from All District Nursing Forum Standard Operating Procedure
District Nurse Leads
Head of Community Services Medicines Management

Circulated to the following for Consultation

Date	Role / Designation
28/6/25	District Nurse Team Leader Community Service Managers Head of Nursing Head of Community Services Medicines Management

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? NMC (2018a) The Code Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates Future Nurse: Standards of Proficiency for Registered Nurses (NMC, 2018b). The Welsh National Standards for medication reviews can be accessed: awttc.nhs.wales/files/guidelines-and-pils/welsh-national-standards-for-medication-review-pdf/

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differentia**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impacts that may arise from the implementation of this policy*** Improved timely access to medication for patients requiring medicines administered by a district/community nurse. Removes delays in waiting for a prescriber to complete a medicines administration chart.
Age				X	
Disability				X	
Gender reassignment	X				
Pregnancy and Maternity	X				
Race	X				
Religion or Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and Civil Partnership	X				
Welsh Language	x				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?

no risks identified

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?
None identified

Have you identified any training and / or resource implications as a result of implementing this?

Please record any training or resource issues /requirements associated with the implementation of your document

The following had been provided as part of the All-Wales work:

- Part 1:e learning module 'Transcribing of Medication' via Y Ty Dysgu. The training provides a comprehensive outline of transcribing, legality, requirements and best practice with a range of transcribing examples and scenarios.
- Part 2: Online Competency assessment – mock case scenarios involving transcription of medicines information and a quiz.

1 Introduction

The legal and ethical framework for transcribing of medicines is provided by the Nursing and Midwifery Council (NMC) for registered nurses, within NMC (2018a) The Code Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates. The NMC (2018a) emphasise that registrants are accountable for their own practice. The NMC withdrew previous guidance relating to Standards for Medicines Management following the publication of the Future nurse: Standards of Proficiency for Registered Nurses (NMC, 2018b). These latest standards produced by the NMC (2018b) require the registrant to demonstrate the knowledge and skills which would allow them to:

> "Undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product" (Annex B: Section 11.5)

Transcribing can be defined as the act of making an exact copy, usually in writing. In the context of this guidance, transcribing is the copying of previously prescribed medicines details to enable their administration in line with legislation i.e. in accordance with the instructions of a prescriber" (RPS, 2019).

Prescribing can be defined as the advising and authorising the use of a medicine and often involves issuing a written prescription such as a WP10, which is dispensed by a pharmacy in order to provide the required medication. It is stipulated within law as to who can and cannot prescribe medicines and medical devices.

Transcriber refers to a registered nurse working within the District Nursing Service, who is required to transcribe medication as part of a person's care.

There is no requirement for an Independent Prescribing qualification to undertake the practice of transcribing.

Medication Administration Record (MAR) chart in PTHB refers to **a long stay inpatient medication record (code: AWMR05.16).** It should be noted that the MAR chart in a community setting is not an authorisation to administer or a prescription, but a record of administration. As such, therefore the signature of the prescriber of the medicine is not required on the MAR chart. The healthcare professional responsible for administration should therefore always refer to the dispensed medication label and retains the responsibility for following the instructions on the dispensed medication label.

In a hospital setting the medication chart is both an authorisation to administer and an administration record. (This is why a hospital nurse is able to administer medication from the stock cupboard that is not labelled with the patient's name, as the chart provides the authority). In the hospital setting the medication

administration chart will cover all of the individual's regular medication, and also any prescribed prn/stat medication.

In the community setting specifically district nursing services, the medication administration record (MAR) is used as a record of administration, as the legal authority to administer medication, has already been provided via the GP. District Nursing services only administer those drugs which the individual cannot safely do themselves. These tend to be specific medications such as insulin, hydroxocobalamin (B12), Low Molecular Weight Heparins (LMWH) and palliative care medication for people at the end of their life. The process of transcribing for any of these drugs is the same regardless of what the specific drug is. If the medication label, which is on the medication dispensed by a pharmacist or GP practice dispensary, contains sufficient information for the nurse to administer from, then that information can be accurately transcribed onto the MAR chart for the nurse to sign off on administration.

Medicines reconciliation – the process of creating an accurate list of a person's current medication that has been prescribed. The All Wales medicines reconciliation policy can be access here: Multidisciplinary medicines reconciliation policy - All Wales Therapeutics and Toxicology Centre

2 Objective

District Nursing teams provide care to patients within their own home / care setting. Transcribing may occur in any of these settings, and therefore this SOP applies to:

- all registered nursing staff working within the District Nursing Service,
- all prescribed medication (including Controlled Drugs and Insulin)
- all care settings.

Registered nurses within District Nursing (excluding future Registered Nursing Associate's (RNAs)) are directed to this SOP, to ensure that staff are supported to deliver best practice and minimise the risk of error. Any staff member who is asked to transcribe must have undertaken the associated training, have been assessed as competent and that it is within their scope of practice. Transcribing is used only to ensure safe and continuous care: ensuring the medication is administered accurately, without undue delay. When transcribing, particular attention should be given to the medication name, dose, form and route of administration.

Those undertaking transcribing must be appropriately trained and assessed as competent to do so at Health Board Level.

3 Definitions

- **DN** – District Nursing
- **PTHB** – Powys Teaching Health Board
- **NMC** Nursing and Midwifery Council
- **RPS** Royal Pharmaceutical Society
- **MAR** Medication Administration Record
- **LMWH** Low Molecular Weight Heparins
- **PRN medications** "pro re nata" meaning when required in the event of specific symptoms
- **STAT medications –** "statim" given as per routine at specific times
- **RNA** Registered Nursing Associate's
- **SOP** standard operating procedure
- **CHC** Continuing Health Care
- **EPMA** electronic prescribing and medicines administration system
- **TTH "**To Take Home"
- **TTO "**To Take Out"

4. Scope

This SOP applies to any registered nurse (excluding future Registered Nursing Associates) working within a District Nursing team, who is required to transcribe medication as part of a person's care within their own home or a care setting, provided they have undergone the necessary training. The person/patient must be on the District Nurse's caseload, for a District Nurse or registered community nurse to carry out transcribing.

District Nurses will only transcribe for their own service and are not responsible for transcription on behalf of external services, including CHC-commissioned carers.

5 Responsibilities

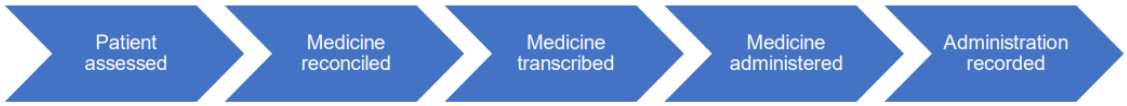
In current community practice, the prescriber issues a direction for a medicine/device to be administered to a patient in their own home via a WP10, or as part of discharge medication from a hospital setting. This direction grants the legal authority for the medication administration. There is no contractual requirement for a GP to additionally authorise MAR charts.

5.1 Responsibilities of Prescriber:

- Ensure that the direction to administer medication is unambiguous, legible and explicit.
- Conduct a thorough evaluation of ongoing medication for long-term conditions through a multi- disciplinary review on an annual basis, or as deemed clinically appropriate. The Welsh National Standards for medication reviews can be accessed here:

	awttc.nhs.wales/files/guidelines-and-pils/welsh-national-standards-for-medication-review-pdf/ • Assess the appropriateness of the medication prescribed.
	5.2 Responsibility of Transcriber: • Confirm there is sufficient information available for accurate transcription. • Complete the training detailed in this SOP and any updates required to be able to safely transcribe. • Adhere to the NMC (2018a) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, at all times. • Communicate with the prescribing clinician and inform the GP who holds ongoing medical responsibility for the patient, of any concerns
	5.3 Responsibility of Team Leader: • Ensure all registered staff have completed required training detailed in this SOP and are deemed competent prior to transcribing medication.

6. Specific Procedure



Patient assessed by community nurse and admitted onto caseload.	• Patients reviewed to assess if able to self-administer.
	
	• If a patient is unable to self-administer, the following steps are taken:
	  ○ First, consider if a family member/friend can assist the patient in self-administration.
	  ○ If no family member is available, proceed with the SOP
	
	Risk Assessment and Mitigation Measures:
	
	In order to ensure safe medication administration, it is essential to consider potential risks associated with transcribing for each individual. The following are specific risks and corresponding mitigation measures:
	Setting (e.g., own home or multiple residence, access to medicines):
	• Mitigation measures:

	➢ All drugs are individually labelled. ➢ **No stock drugs are available within the setting** **Personnel** (e.g., staff consider transcribing an administrative task, limited access to patient records): • Mitigation measures: o Implement the Transcribing Standard SOP. o Only registered nursing staff who have completed training and been assessed as competent are authorised to transcribe. **Medicines Label Updates** (ensuring it's up-to-date with any recent changes): • Mitigation measure o Utilise additional sources of information to confirm medicine labels. **High-Risk Medicines:** • All of the above mitigation measures apply to ensure safe administration.
Medicine reconciled	The dispensed medicine is checked by the nurse to verify the following; • Patient's name is clearly stated on the pharmacy/dispensary label. • Name and strength of the medication • Dose to be administered. • Route of administration • Frequency of administration. • Expiry date of the medication. • Any special instructions concerning administration. If there are no clear directions to follow, e.g. the pharmacy label states; 'as required' or 'as directed,' or any of the above details are missing or unclear, then a prescriber MUST be contacted. The prescriber MUST issue a direction clearly stating the dose and frequency of administration. This direction must be in a written format such as an email or letter and must be reviewed by the nurse before proceeding with transcribing. This must be printed out and attached to the MAR chart as soon as possible. The Registered Nurse carries out the reconciliation process using the pharmacy label on the medicine container/box.

	This information is cross referenced against ONE of the sources below ensuring reasonable steps have been taken to identify that it is the most recent copy available: • A written direction by a GP • A written direction by an independent prescriber if within their scope of practice • A MAR if prescription remains unchanged. • A relevant hospital prescription chart. • A letter from a hospital /prescriber directly involved with patients care. • A relevant discharge summary / TTH /TTO, • A GP summary available via Welsh Clinical Portal • An electronic prescribing and medicines administration system (ePMA). If the information on the medicine container/box corresponds to the source used above, then the Registered Nurse can start to transcribe the medication. Where a change in medication is advised by a prescriber e.g. email or letter, a prescription must be issued or prescribed on the MAR chart by the prescriber for administration and subsequent transcription. Any verifying information must be supported by a valid prescription/dispensed item. For specific scenarios, for instance, involving palliative care, please refer to 'Handling Acute Medication Changes section below'.
Medicine transcribed	The Registered Nurse completes the MAR and includes the following details as a minimum: • Patient's name, NHS number, date of birth and allergies • Medication name as stated on the pharmacy label • Dose of medication • Frequency of medication • Route of medication • Any additional directions (e.g. one hour before food) After transcribing the medication, the registered nurse must: • Provide their full name and identify themselves as the transcriber e.g., Florence Knight (Transcriber). • Sign the entry. • Indicate their designation. • Document the date and time of transcription The nurse MUST: • Use block capitals to write all details • Use a black biro pen rather than gel to avoid smudges and ensure writing is clear.

	• Complete the date the chart started in the 'chart details section' • Indicate on the front of the chart, if patient requires more than one MAR chart (e.g., 1 of 3.) A registered nurse who is not an independent prescriber **MUST NOT**: • Initiate a new medication • Amend a current prescription without a written instruction from a prescriber. There is no requirement for an Independent Prescribing qualification to undertake the practice of transcribing. **Handling Acute Medication Changes** In cases where a prescriber makes an acute change to a medication (e.g., adjustments to palliative care medication or insulin) that requires timely implementation and results in the existing label on the medication not reflecting the new dose, a registered nurse may transcribe the amendment, provided there is a written direction in place and the nurse is clear about the new instructions. This written direction must be dated and either printed and kept with the MAR chart, ready for reference when the next dose is administered, or an explanation should be provided within the MAR chart indicating where the written direction can be digitally accessed. The amendment should be recorded as a new entry on the MAR chart, with the previous entry crossed through and clearly marked as superseded. <u>It is important to note that only the MAR chart is to be amended in this way, not the pharmacy/dispensary label.</u> There should be a clear audit trail to explain any discrepancy between the MAR chart and the pharmacy/dispensary label, ensuring that those administering the medication have no doubt about the correct dose to administer. In scenarios where a medication change is advised by a non-prescriber (e.g., a palliative care nurse updates the WCP advising an increase in dose), the prescriber must be contacted to ensure that their records (e.g., GP medication records) are updated.

	For example, Insulin regime changes made by a Diabetes Specialist Nurse who is not an Independent Prescriber cannot be transcribed and a written authorisation for the regimen change would need to be supplied by a prescriber. Note Independent Non-medical Prescribers can only prescribe if they have independently assessed the patient, agree the therapeutic option and the medication to be prescribed is within their scope of practice. This updated record should evidence that the prescriber formally acknowledges and authorises the change in dosage based on the non prescriber's advice. Once the prescriber has reviewed and approved the change, their updated records will serve as the authority for transcription. The transcriber can then proceed with updating the MAR chart based on the prescriber's new instructions. While there may be a temporary period where the MAR chart and the pharmacy label do not match, this is acceptable in these circumstances when it is in the best interest of the individual. However, there must be clear documentation justifying the discrepancy. This constitutes an exception to the usual policy, with the primary focus on ensuring the timely administration of the correct dose during the interim period. Following any acute medication change, the GP should be informed within 72 hours, and a request for an updated, ongoing prescription should be made to ensure consistency in future medication administration.
Medicine administered	It is each registered nurses' responsibility to check prior to administration that the information copied onto the MAR chart corresponds to the pharmacy/dispensary label that has been dispensed within the last 6 months. The 6 'R's must be adhered to. 1. Right patient 2. Right drug 3. Right route 4. Right time 5. Right dose 6. Right to refuse (check with patient at time of administration). 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. The registered nurse must ensure that the medication is the patient's current therapy and remains accountable for the decision to transcribe. Where there is any doubt about the medicine to be administered, the registered nurse should withhold and contact the relevant prescriber for further clarification in writing. This must be documented in the patient's records. The ongoing medication for long-term conditions should be reviewed by the prescriber as part of a multi- disciplinary review on an annual basis or, as deemed clinically appropriate. It is the prescriber's responsibility to review the appropriateness of the medication prescribed. If the MAR chart is lost / misplaced please refer to Health Board incident reporting process and; • Before the next dose is due, re-write the MAR chart using the valid authorisation to administer as above. • Establish administration history. • Document in clinical record, that chart has been lost and rewritten in accordance with Transcribing SOP • Report loss of the MAR chart via Datix If unable to rewrite the MAR chart as confirmation of medication/doses are not available, do not administer medication and contact the prescriber to re issue confirmation of medication/doses. If the lost MAR chart is later found: mark as discontinued by crossing through medication. Sign and date MAR chart and record in clinical record.
Administration recorded	Any medicine administered or not administered must be recorded on the MAR chart, including the date, time, dose (if applicable) and signature/initials of nurse responsible for the administration.

Outcome	Following transcribing of the MAR chart by the registered nurse, the patient will receive the required medication at the right time, by the right route and at the right dose.

7.0 Registered Nurses Accountability

7.1. Any registered nurse working in the DN service who transcribes a medication 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.

7.2. The registered nurse must ensure that they have fulfilled all training requirements to attain transcribing competency, prior to transcribing any medication onto MAR charts.

7.3. Any registered nurse in the DN service administering against a transcription is personally and professionally accountable for doing so. They must ensure that they are able to verify its accuracy as per above procedure.
If they have any concerns regarding the transcribed information, then they should not administer the medication and contact the authorised prescriber and appropriate line manager.

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

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

8. Reporting Transcribing Errors

8.1. 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.

8.2 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 in line with best practice and/or duty of candour if it applies:

the patient and or relatives/carers where appropriate; the patient's doctor; the transcribing nurse's DN team leader, and clinical lead.

8.3. The patient's physical condition should be observed, monitored and recorded in the patient's clinical record.

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

8.5 All details of the incident must be documented in the patient's clinical records and an electronic incident form completed (currently using DATIX software). The incident form should include the level of harm evident at the time of reporting and any immediate actions taken. Any harm and adverse outcomes can subsequently be updated on the electronic incident form.

8.6 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.

Completing a DATIX is encouraged to promote learning from near-miss incidents.

9.0 Training and Assessment of Competency

9.1 Transcribing training comprises of:

Part 1: Theory – e learning module 'Transcribing of Medication' via Y Ty Dysgu. The training provides a comprehensive outline of transcribing, legality, requirements and best practice with a range of transcribing examples and scenarios.
Part 2: Online Competency assessment – mock case scenarios involving transcription of medicines information and a quiz. Transcriptions must be completed accurately and in accordance with the transcribing policy.

9.2 Following completion of the online training, the registered nurse will need to be assessed as competent against the competency framework in Appendix 1, prior to transcribing medication.
Assessment of competency can be carried out by the DN team leader, Clinical lead or a practice development nurse, as long as they have demonstrable expertise and recent practical experience in transcribing medication. The completed and signed competency framework must be kept securely by the DN team lead or Clinical Lead and can be added onto the Electronic Staff Record (ESR) as additional training.

9.3 All elements of the transcribing training outlined above and sign off of the competency framework, must be completed successfully for a registered nurse to be deemed as competent to transcribe.

9.4 If the registered nurse is not deemed as competent by the DN team lead or Clinical Lead, they will be required to complete all elements of the training and assessment of competency again as per 8.1-8.3

9.5 Competence is valid for 1 year from the date final competency is deemed. Training must be repeated successfully each year, otherwise the competency will lapse and the individual must not transcribe.

10.0 Monitoring Compliance, Audit & Review

10.1 Transcribing MUST be monitored on an ongoing basis by Clinical and DN team leads, to ensure that it is used appropriately and is not resulting in additional high levels of work for registered nurses working in DN services.

10.2 This process will include alerting the team leader when transcribing has occurred and completion of a short survey, particularly during implementation of transcribing. This will allow for assessment of situation when transcribing was required, any concerns and benefits.

10.3. The DN Team leader or Clinical Lead will undertake a random sample of transcribed medications, which will be assessed against the standards within this SOP on a 6 monthly basis. The results of this, including any learning and or recommended amendments to the SOP will be shared with the DN team, Clinical lead, Community Services Manager, Medicine Management Team/Medicines Safety Group and All Wales Professional DN forum.

10.4. Transcribing Incidents recorded electronically on the DATIX software currently in use should be used to identify trends in errors in line with the NHS Wales National Policy on Patient Safety Incident Reporting & Management, as well as shaping current and future training needs by DN team leaders and clinical leads.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

11. References / Bibliography

- NMC (2018a) The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates https://www.nmc.org.uk/globalassets/sitedocuments/nmcpublications/nmc-code.pdf
- NMC (2018b) Future nurse: Standards of proficiency for registered nurses https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurseproficiencies.pdf
- Royal Pharmaceutical Society / Royal College of Nursing (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings Admin of Meds prof guidance.pdf (rpharms.com)

Additional Sources

- East London NHS Foundation Trust (2022) Policy for Transcribing Medication Administration Records in ELFT Community Health Services. Available at: Policy for Transcribing of Medication Administration Records 3.docx (live.com). Accessed 13/02/24
- hcrg Care Group (2021) Production of Medicine Administration Records: Community Nursing

Appendix A

Producing a MAR chart – Competency Framework

Performance criteria; you need to:	**Date & signature of person achieving the competency**	**Date and signature of person assessing that the competency has been achieved**
Show evidence you have read, understood and are able to follow the SOP for Producing a MAR chart in your service		
Reconcile the medicines between the pharmacy/dispensary labels and the original direction to administer, or up to date reference source, before transcribing		
Refer any queries or ambiguities to an appropriate person and ensure they are resolved prior to completing the medicines administration record		
Accurately document the medicines onto the administration record relevant to your service area using the patient's reconciled list of medicines and the original direction to administer		
Ensure patient details, allergy status, name of medicine, strength, dose, frequency, route, timing and any special instructions are documented clearly and unambiguously.		
Demonstrate how and when a medicine can be cancelled from the medicines administration record		

Demonstrate how and when a medicine can be altered on the medicines administration record		
Knowledge and understanding; you need to be able to:		
Know what a legal direction to administer could be in your service.		
Know what could be used as an up to date reference source in your service, if the pharmacy/dispensary labels are used as the legal direction to administer the medicine.		
Know why it is essential to reconcile the medicines before creating a MAR chart		
Know your responsibility that applies to creating a MAR chart		
Know why it is essential to ensure the MAR chart is checked before it is put into use (this could be a self-check)		
Know what your actions would be if you were unable to create the MAR chart because: • Of incomplete directions (as directed), • the medicines label and the direction to administer is different		
All relevant criteria achieved		

Adapted from: hcrg Care Group 'Producing a MAR chart Competency'