

Transcribing Guidance for Care Services

Includes paper medication administration records (MAR) charts and electronic medication administration record (eMAR) systems

Purpose and scope

This guidance sets out the Jersey Care Commission's expectations for transcribing medication details onto paper MAR charts or into eMAR systems. It should be used alongside the Commission's wider Standards and, where relevant, guidance on eMAR systems, both available on the Commission's website.

It describes when transcribing may be appropriate, when it must not be carried out, the required sources and checks, training and responsibilities, and the processes for both paper MAR and eMAR transcribing. The guidance applies to care services where care/support workers administer medication.

Key definitions

Transcribing - the action of accurately copying details of prescribed medication onto a MAR chart or into an eMAR system. This includes using electronic copy-and-paste functions.

Prescribing - when a prescriber issues an instruction for a specific medication to be supplied and taken, usually in the form of a prescription.

If a prescriber writes directly onto a MAR chart as part of routine practice, this is prescribing, not transcribing, and therefore is not subject to these transcribing requirements. However, any MAR/drug chart completed by a prescriber should include care receiver details; drug name, strength and formulation; quantity; dose and frequency; duration; authorisation details; and the care receiver's allergy status.

Any further transfer, rewriting or alteration of this information by anyone other than a prescriber is considered transcribing.

Please note, this applies to a small number of services that use 'hospital style drug charts' and have prescribers within their team and is not to be confused with services where the prescriber produces a prescription and adds relevant information to a separate MAR chart for use in the service.

Introduction of eMAR systems

Some services are starting to implement eMAR systems. There are important differences between entering medication information directly into an eMAR system and traditional transcribing onto a paper MAR chart. Currently, because of limited integration between pharmacies and eMAR systems in Jersey, most services manually enter medication information into eMAR systems. Once integration advances and eMAR entries are automatically populated by a pharmacy system at dispensing, transcribing into eMAR should be limited to exceptional circumstances only.

For the purposes of the Standards and this guidance, both traditional transcribing onto paper MAR charts and entering information into an eMAR system are considered transcribing. Copying and pasting from electronic resources is also transcribing, as it remains vulnerable to human error. This guidance covers steps and requirements for both paper and eMAR transcribing.

Standards relating to transcribing and MAR charts

The Standards require that medication and MAR charts be in place before care begins, wherever possible. This reduces the need for manual transcribing and allows time for details to be added to eMAR systems.

Relevant Standards include:

Care and support services with accommodation: Systems will be in place to ensure the safe management of medication when a person arrives or leaves the accommodation, i.e. a current valid prescription should be obtained in advance of admission, so that the medication is in place within the accommodation's usual system.

Home care and support in the community: Where care/support workers will be required to administer medications, arrangements should be made to ensure that a valid prescription is obtained in advance of the commencement of care so that the correct medication is in place with the relevant MAR charts.

Day care services for adults: Where care/support workers will be required to administer medications, arrangements should be made to ensure that a valid prescription is obtained in advance of the commencement of care, so that the correct medication is in place with the relevant MAR charts (a separate supply for the medication that is required whilst attending the day care service).

Where people who attend day services require a short course of medication (i.e. antibiotics, where a separate supply is not appropriate), then the registered person must ensure that:

- It is recorded in the personal plan.
 - Where it has not been possible for the prescriber/pharmacist to produce a MAR chart for the day care service, correct transcribing procedures are followed to produce a MAR chart.
 - There are processes to establish when the last dose was taken.
 - The medication is only administered from the original dispensed packaging.
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When transcribing should (and should not) be used

Transcribing should only be used:

- When it is in the care receiver's best interests and necessary to ensure safe and continuous medication administration without undue delay.
- When there is a lack of pharmacy integration with eMAR systems used.
- In exceptional circumstances (see below), where appropriate second-source verification is available.

Exceptional circumstances where limited paper MAR transcribing may be acceptable:

- **Hospital-only medication** that is supplied after an outpatient clinic or on discharge when community pharmacies do not accept responsibility for adding medication to MAR charts.

Note: MAR charts may be available from wards on request, or a discharge summary may serve as a second source for transcribing. For outpatient prescriptions, the hospital pharmacy may provide a 'dispensing list' on request to use as a second source.
- **Day services** where a pharmacist or prescriber cannot provide a MAR chart; a temporary MAR may be produced following this guidance, and every effort will be made to obtain an authorised MAR as soon as possible.
- **Supply outside pharmacy opening hours** (for example, from an on-call GP) where written authorisation from the prescriber and/or a copy of the prescription accompanies the supply, to avoid undue delay in administration.

Transcribing is not permitted:

- Where a second source to check the prescriber's instruction cannot be obtained.
 - Where there is any ambiguity or discrepancy regarding the details to be transcribed.
 - Where the two sources used for transcribing do not match (for example, the details on the dispensed label do not match the second source).
 - Where the care receiver's allergy status has not already been, and cannot be, confirmed via the authorised prescriber, the care receiver or their family/carer.
 - For non-prescribed medication (such as over-the-counter items or homely remedies) unless accompanied by an authorisation from a doctor or pharmacist and clearly marked as 'not prescribed'.
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Roles, responsibilities and training

- The Registered Manager or a designated senior member of staff should have responsibility for overseeing transcribing activity.
- Only staff who are appropriately trained and assessed as competent may undertake transcribing. Training applies to both paper MAR and eMAR transcribing. Services may develop their own training or use an external provider. Services must be able to evidence robust training for transcribers and checkers. Training records and competency checks should be maintained and reviewed at least annually or after any incidents.

Required information sources and verification

There must be two sources available for transcribing. The pharmacy supplied medication box and dispensing label are required, and one of the following as a second source:

- A copy of the prescription (community).
- A copy of the discharge summary (recent hospital discharge).
- A copy of the dispensing list from the hospital pharmacy (outpatient prescriptions).
- A GP-provided medication record.
- Written authorisation from the GP or relevant consultant.
- For eMAR transcribing: a pharmacy-produced MAR chart (paper or digital).

If the two sources do not match exactly, do not transcribe; contact the prescriber for written clarification and retain that clarification in the care record.

When checking the medication label, always confirm:

- ✓ Name of the care receiver/service user
- ✓ Name, strength, form and quantity of the medication
- ✓ Dosage instructions
- ✓ Route of administration
- ✓ Additional warnings, cautionary labels or instructions, e.g., 'take one hour before food'
- ✓ Time due (if printed)
- ✓ Date of dispensing

Record any details that specify the duration of treatment (for example, antibiotic or steroid courses). For as required (PRN) medication, record minimum intervals between doses and the maximum frequency or dose in a 24-hour period. If such details are not present on the label contact the prescriber.

Safe use of abbreviations and units

Do not use frequency abbreviations when transcribing onto MAR charts; write frequency in full. Prescriber abbreviations that may be used include:

- OD = once daily
- BD = twice daily
- TDS = three times daily
- QDS = four times daily
- mane = every morning
- nocte = every night
- PRN = when required
- STAT = immediately

When transcribing, write the frequency in full rather than using these abbreviations, for example, “THREE times a day”.

Abbreviations relating to doses should also be used with caution.

Using g (grams), mg (milligrams) and ml (millilitres) is acceptable.

The following abbreviations must not be used and should be written in full:

m^{cg}/ μg = micrograms

ng = nanograms

iu = units (international units)

Decimal points must be clear; 0.5 ml is acceptable, but .5 ml is not.

Paper MAR transcribing process (key steps)

- Check the availability and accuracy of two sources of information as outlined above.
- Use black ink. Writing must be clear and legible.
- Record the care receiver’s full name, date of birth, URN/social security number and GP practice.
- Record allergy status and state the source of that information (for example, “GP printout”); if ‘none known’, indicate this.

- Record the date each medication was commenced (if known). If the date of commencement is not known, record the date the MAR was prepared. Do not assume the dispensing date is the start date of treatment.
- Write the full name of the medication in CAPITALS, including formulation and strength.
- Specify dose clearly, including the number of tablets/capsules/drops and frequency, written out in full. Example formats: “TWO tablets THREE times daily”; “5 ml taken THREE times a day”; “ONE drop into RIGHT eye FOUR times a day.”
- If the label indicates “one or two tablets” contact the prescriber to confirm the exact dose unless the care receiver can choose or a variable dose plan is in place.
- Make the route of administration explicit.
- Record quantity received to allow stock balance on the MAR chart.
- For medication taken on specific days (for example, once weekly), indicate this clearly (for example, by highlighting the relevant day).
- Ensure any duration of treatment is recorded and, where appropriate, indicate the date the medication should stop. Calculations for stop dates must take the start time of day into account.
- Include any additional special instructions or warnings from the label on the MAR chart (for example, “take with food”). Where there is too much information to record in the space, write “See Label”.
- Do not cross out errors or use correction fluid. Use “(error)*” around the error, add a footnote explaining the correction and have both transcribers sign the note.
- The transcriber must record their name, role, and sign the MAR entry.
- A second checker must check the entry and countersign to confirm accuracy.

eMAR transcribing process (key steps)

- Note the two sources used for the entry in the eMAR audit log.
 - Ensure the full medication name, formulation, strength, dose, frequency, route and indication (if PRN) are entered.
 - Include any additional special instructions or warnings from the label.
 - If transcribing from a photograph of a label and medication box, ensure the photo includes all required details; do not rely on partial photos.
 - The transcriber must record their name, role, and sign the eMAR entry (or use the electronic equivalent). The system must preserve a timestamped audit log.
 - A second checker must check the entry and physically or electronically countersign.
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PRN medication

PRN entries must include minimum intervals between doses and the maximum dose or frequency in any 24-hour period (for example, “every 4–6 hours, maximum eight tablets per day”). If this information is not on the label, check the PIL or contact the prescriber. PRN use should be supported by an up-to-date PRN protocol included in the care record.

Checking and second checks

- All MAR charts and eMAR **MUST** be signed by both the transcriber and the second checker. Attempts should be made to obtain the second checker immediately.
- Providers should ensure that transcribers have access to a trained second checker as part of their policy.
- If a second checker is not available and the medication is due, give the medication and obtain the check as soon as possible afterwards; do not delay administration solely to wait for a checker.

- Any verbal or telephone confirmations should be heard by both the transcriber and checker and must be followed up with a written confirmation, which is retained in the service user's record.
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Transcribing incidents and reporting

- If a care receiver receives an incorrect medication or a medication is omitted because of a transcribing error, report to the line manager immediately and seek prescriber advice.
 - Medication incidents involving transcribing must be reported and recorded in line with the service's medication incident policy.
 - Significant incidents should be submitted under the notification system to the Jersey Care Commission as appropriate.
 - The line manager should investigate the events leading to the error or omission. Review the competency of staff involved and restrict transcribing duties where necessary until competency issues are resolved.
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Audit trail and records retention

- Retain all written clarifications from prescribers and copies of sources used for transcribing in the care record.
- Ensure auditing and reconciliation processes include transcribed entries and that records are available for inspection.
- Audit trails should exist for all transcribed medication to protect both the service and care receivers.
- Include transcribed entries in routine medicines reconciliation and audits; escalate any discrepancies immediately.

Quick step-by-step checklist

1. **Training** – both the transcriber and checker must be trained.
2. **Source verification** – for transcribing, there must be two sources of information as outlined above.
3. **Include full details** - medication name, formulation, strength, dose, frequency, route, indication (if PRN), and any additional instructions or warnings.
4. **Transcriber identity & sign** - transcriber records name, role and signs the entry (or electronic equivalent).
5. **Second check** - the second checker must carry out a full check of the transcribed entry and physically or electronically countersign.
6. **Audit & review** - include transcribed entries in routine medicines reconciliation and audits; escalate any discrepancies immediately.