Superior Healthcare Group

Medication Transcribing Policy

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Contents

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Important Notice

This is a controlled document which is uncontrolled when printed. Please always access the latest copies of policies and procedures from The Superior Healthcare Group's Policies and Procedures Library stored on Microsoft Teams. If you do not have access to The Superior Healthcare Group's Policies and Procedures Library, please contact the author of this policy to confirm that it is the latest version using the contact details shown above.

Accessible Formats

In accordance with the Accessible Information Standard, this policy is available in alternative formats upon request, including large print or easy read. Employees and clients who require information in a specific format should speak to their Nurse Manager, Coordinator or the Registered Manager.

1. Background

Safe medicines management is fundamental to delivering high-quality care and protecting the people we support from avoidable harm. Medication information is often transferred between prescriptions, dispensing labels, Medication Administration Records (MARs), care plans, PRN protocols and electronic medication systems. Errors during transcription or amendments can increase the risk of medication incidents and compromise individual safety.

This policy sets out the requirements for the accurate transcription of medication information, the safe management of medication changes, and the effective escalation and resolution of medication discrepancies.

2. Purpose

The purpose of this policy is to ensure that all medication transcribing activities within Superior Healthcare are completed accurately, safely and in accordance with current legislation, professional guidance and best practice.

This policy aims to:

- Promote safe medicines management.
- Reduce the risk of medication errors.
- Ensure medication changes are authorised prior to implementation.
- Establish a clear escalation pathway for medication discrepancies.
- Support accurate documentation and communication.
- Ensure compliance with regulatory requirements.

2.1. Relevant Key Lines of Enquiry

This policy supports The Superior Healthcare Group to evidence compliance with the following Key Lines of Enquiry:

Key Question	Key Line of Enquiry
SAFE	Medicines are managed safely, and risks associated with medication errors are reduced.
CARING	Individuals receive safe, person-centred support in relation to their medicines.
RESPONSIVE	Medication changes are communicated and implemented promptly.
EFFECTIVE	Employees are competent and follow robust medicines management procedures.
WELL LED	Effective governance systems support safe medicines management practices.

2.2. Legal References

This policy supports The Superior Healthcare Group to evidence compliance with the following legal requirements:

- Legislation 1 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Legislation 2 Care Quality Commission Fundamental Standards
- Legislation 3 Mental Capacity Act 2005
- Legislation 4 NICE Guideline SC1: Managing Medicines in Care Homes

- Legislation 5 Royal Pharmaceutical Society Professional Guidance
- Legislation 6 Human Medicines Regulations 2012
- Legislation 7 Misuse of Drugs Regulations 2001 (where applicable)

3. Scope

a. This policy applies to all Superior Healthcare employees involved in medicines management, including:
- Registered Nurses
- Healthcare Assistants
- Support Workers
- Clinical Leads
- Nurse Managers
- Operations and Management Teams

b. The Director of Clinical Operations has overall responsibility for implementation and oversight of this policy.

4. Objectives

- Ensure medication information is transcribed accurate
- Ensure medication changes are only implemented following confirmation from an authorised source.
- Maintain accurate and up-to-date MAR charts and care records.
- Ensure medication discrepancies are identified and escalated promptly.
- Promote clear communication between members of the care team.
- Ensure all actions are appropriately documented and auditable.
- Support safe and effective medicines administration.

5. Policy

5.1. Responsibilities

a. All employees involved in medicines management are responsible for:
- Following this policy at all times.
- Ensuring all transcriptions are accurate and complete.
- Using authorised sources when transcribing information.
- Escalating concerns and discrepancies immediately.
- Maintaining clear and contemporaneous records.
- Communicating medication changes appropriately.

b. The Nurse Manager is responsible for reviewing discrepancies, implementing corrective actions, and ensuring outcomes are communicated effectively to the care team.

c. Where the Nurse Manager is unavailable, the Clinical On-Call Practitioner will provide advice and authorise actions required to resolve discrepancies safely.

5.2. Authorised Sources for Transcribing

a. Medication information may only be transcribed from recognised and authorised sources, including:
   - Prescriptions issued by authorised prescribers.
   - Pharmacy dispensing labels.
   - Hospital discharge documentation.
   - Written instructions from a prescriber, pharmacist, specialist nurse or authorised healthcare professionals
   - Electronic prescribing systems.

b. Medication information must never be transcribed from verbal reports that have not been confirmed by an authorised healthcare professional.

5.3. Changes to Medicines

a. MAR instructions **must not** be altered unless the medication change has been confirmed by a prescriber or another authorised healthcare professional. This includes:

   - Starting new medicines.
   - Stopping medicines.
   - Altering doses.
   - Changing administration times.
   - Changing routes of administration.
   - Suspending medicines.

b. Where a medication change is communicated verbally during an urgent situation, written confirmation must be obtained as soon as possible.
c. Where available, medication amendments must be authorised by a Nurse Manager, checked and countersigned by a second trained and competent member of the team. This is the case in double up care packages.

5.4. Medication Discrepancies

a. Any discrepancy identified between:
   - MAR charts
   - Prescriptions
   - Dispensing labels
   - PRN protocols
   - Care plans
   - Electronic medication systems
   - Medication stock held in the home

must be escalated immediately to the Nurse Manager or Clinical On-Call Practitioner.

b. Medication administration must not proceed where safe administration cannot be assured.

5.5. Communication of Medication Changes

The care team must be informed of all medicines that have been:

- Started
- Stopped
- Amended
- Suspended

This communication must occur:

- At the earliest opportunity.
- During handover.
- Through approved communication systems.
- Through updates to care plans and medication documentation.

6. Procedure

6.1. Transcribing Medication Information

When transcribing medication information, employees must:

1. Verify the authorised source document.
2. Check the medication name.
3. Check the strength and formulation.
4. Check the prescribed dose.
5. Check the route of administration.
6. Check the frequency of administration.
7. Record any additional administration instructions.
8. Ensure all information is transferred accurately.
9. Get authorisation from Nurse Manager or Clinical On-Call.
10. Sign, print name and date the transcription on the MAR.
11. Write detail of the transcribing activity in the client's log book.

Note: employees must seek clarification from our clinical teams immediately (either Nurse Manager or Clinical On-Call) to transcribe directly onto a paper MAR chart. Photos needs to be taken of the transcribed medication/MAR as well as new prescription/advice/medication (if different) and sent to the clinician for discussion and approval.

6.2. Updating Records Following Medication Changes

Following confirmation of a medication change:

- The MAR chart must be updated promptly.
- Care plans must be reviewed and amended.
- PRN protocols must be updated where required.
- Risk assessments must be amended where appropriate.
- Electronic medication systems must be updated where applicable.
- Medication stock records should be reviewed and reconciled.
- Assigned Nurse Manager needs to be informed – via email, to add onto notes and update MAR chart electronically. All amendments must include:

- Date and time.
- Source of the instruction.
- Name of the individual making the amendment.
- Independent checker details where required.

6.3. Escalation of Medication Discrepancies

When a medication discrepancy is identified:

1. Stop and verify all available information.
2. Determine whether administration can safely proceed.
3. Do not administer the medication if safety cannot be confirmed.
4. Escalate immediately to the Nurse Manager or Clinical On-Call.
5. Review all authorised source documentation.
6. Obtain clarification from the prescriber, pharmacist or authorised healthcare professional.
7. Implement the agreed authorised outcome.
8. Update all relevant records.
9. Inform the care team.
10. Complete all required documentation.

6.4. Documentation Requirements

All medication discrepancies and outcomes must be documented fully, including:

- What was identified.
- Who raised the concern.
- Date and time raised.
- Action taken.
- Individuals consulted.
- Authorisation obtained.
- Date and time authorisation was received.
- Outcome agreed.
- Date and method of team communication.
- Confirmation that records were updated.

Documentation must be:

- Accurate
- Legible
- Timely
- Factual
- Auditable

Where a medication error or near miss occurs, an incident report must be completed in accordance with the Incident Reporting Policy.

6.5. Training and Competency

Only employees assessed as competent in medicines management may undertake medication transcribing activities.

Employees must:

- Complete medicines management training.
- Successfully complete competency assessments.
- Participate in refresher training.
- Demonstrate understanding of escalation processes and documentation standards.

Compliance will be monitored through:

- Medication audits.
- MAR audits.
- Clinical governance reviews.
- Incident investigations.
- Competency assessments.
- Supervision and appraisal processes.

7. References

- We have used the following resources to ensure that the policy is relevant and current:
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission Fundamental Standards
- NICE Guideline SC1: Managing Medicines in Care Homes
- Mental Capacity Act 2005
- Human Medicines Regulations 2012
- Royal Pharmaceutical Society Professional Guidance
- Superior Healthcare Medicines Management Policy
- Superior Healthcare Medication Administration Policy
- Superior Healthcare Incident Reporting Policy
- Superior Healthcare Record Keeping Policy
- Superior Healthcare PRN Medicines Policy