

Transcribing Medicines

1. Introduction and Purpose

Traditionally, transcribing has been the responsibility of the prescriber. However, there are situations in which transcribing by regulated health professionals who are non-prescribers may enhance access to and continuity of care. Further, as electronic prescribing becomes increasingly common, the need to transcribe may also increase, particularly in rural and remote areas.

The purpose of this document is to provide guidance for regulated nurses on the practice of transcribing information on prescriptions and outline NZNO's position on transcribing, including identifying the risks and benefits associated with transcribing, and provides some recommended approaches.

Transcribing in the broadest sense is defined by the Oxford Dictionary as 'making an exact copy of a text'. Transcribing of medications is defined as "the accurate copying of previously prescribed medicines details to enable their administration in line with legislation" (Specialist Pharmacy Service, 2022).

2. Transcribing in practice

For the purposes of this document, transcribing is defined as 'the legitimate copying of prescription information from one source to another without any alterations or additions'.

This may include any of the following activities:

- writing out a client's current medication on to a Medication Administration Record Chart used as an audit record of medicines administered
- completing a list of a client's current medication in a care plan or medication history in the client's notes
- producing a medication reminder chart to support clients or their carers in the administration of medicines
- writing instructions for health care support workers, when delegating the task of administration of medicines
- writing medicines in discharge or transfer letters
- completing patient management plans

It is important that transcribing is not confused with prescribing. Prescribing is described as the process of information gathering, clinical decision-making, communication and evaluation which results in the *initiation, continuation, adjustment, or cessation* of medicinal treatment (Nursing and Midwifery Board of Australia, 2021) and is restricted to health practitioners with recognised prescribing authority working within their defined scope of practice.

Transcribing should also not be confused with '**prescribing by proxy**', i.e. assessing a patient, deciding what medicines are needed, generating a script and then getting a prescriber to sign it. NZNO does not support prescribing by proxy due to the risks

involved for the patient, nurse and prescriber. If a nurse wishes to prescribe, then the nurse needs to undertake the education required by the Nursing Council of New Zealand (NCNZ) to include prescribing in their scope of practice.

3. NZNO position on transcribing

NZNO does not support the routine practice of transcribing. However, NZNO believes transcribing is an appropriate activity within the scope of nursing practice in certain circumstances (as outlined above). Where appropriate guidance, education, policies and procedures are in place, nurses and midwives may safely transcribe. NZNO recommends any transcribing that has taken place be signed off as soon as practicable by the prescriber currently responsible for the patient. NZNO reminds nurses they are accountable for their practice at all times, including when transcribing.

In some situations, a nurse may be asked by a patient or patient's family to provide a list of currently prescribed medicines. Copying a list of medicines from one form to another is considered a form of transcribing, even where dose, frequency and other information may not be copied. If requested to provide such a list, NZNO recommends the nurse follow the procedures outlined in this document and ensure their employer has a working policy in place to guide practice. Nurses must remain aware of their responsibilities and accountability at all times.

Photocopying or photographing a Medication Administration Record Chart is not transcribing.

4. Risks of transcribing

The primary risk of transcribing is that an error or errors occur in the transcription process, resulting in an incorrect medicine being administered to a person. This may result in serious harm or even death.

Risk factors for errors in transcribing include:

- the greater the number of medicines to transcribe (9 or more), the greater the risk of error (Ben-Yehuda et al., 2011)
- the greater the length of stay (13 days or more), the greater the risk of error (Ben-Yehuda et al., 2011).

Among studies of medication errors, transcribing errors were among the least likely, although still occurred frequently. An Auckland study of handwritten lists of medicines on discharge summaries identified 0.8 errors per surgical discharge summary and 1.42 errors per medical summary (McMillan, Allan & Black, 2006) and a similar study in Australia found 12.1 per cent of handwritten and 13.3 per cent of electronic discharge summaries contained medication errors (Callen, McIntosh & Li, 2010). Both studies further confirm error risks exist in transcribing practice.

The transcriber must ensure the medicines they are transcribing are the most current and up to date available – referring to the medicines reconciliation may be required (see Appendix 2 for further information on medicines reconciliation).

5. Benefits of transcribing

The primary benefits of transcribing are to improve timely access to care, improve patient education, and maintain continuity of care. Where a prescriber is not immediately available to transcribe medicines, such as in home care or community settings, the nurse may facilitate timely care including education, admission or discharge through transcribing. Specific examples within primary health care where transcribing can be seen as particularly helpful for nurses and clients include:

- diabetes sick day management
- aspects of INR /Warfarin management (some of this is covered under standing orders)
- where insulin initiation and titration is being managed
- within nurse clinics
- nurse outreach clinics
- rural nursing care

6. Process of transcribing

The following outlines a recommended policy and procedure for transcribing. Individual settings may wish to use this as a template and adapt it for local use.

1. Background - Why transcribing may be required.
2. Definition
3. Scope - Who is covered by the policy/procedure.
4. Sources of information permitted for transcribing
E.g., original prescription/repeat prescription/dispensed item label/patient held record/fax or electronic communication from prescriber/discharge prescription.
NB. As noted above, it is essential to ensure the medicines being transcribed are the most current and up to date available and referring to the medicines reconciliation record may be necessary.
5. Groups authorised to transcribe
E.g., registered nurses, registered midwives, enrolled nurses within certain contexts e.g. primary health care, aged and residential care.
6. Competency training and assessment for transcribing
What specific training must the practitioner complete (if any) and who assesses their competence.
7. Process for transcribing
 - a. If the information from any source is unclear, then this should be clarified with and countersigned by the prescriber currently responsible for the patient before transcription, or before any medication administration, or before any medication administration is withheld.
 - b. Changes may not be made based on unsolicited information provided by the patient, family member or carer (transcribing is not medicines reconciliation).

- c. The following information should be present on any information needing to be transcribed:
 - i. Patient's name and address
 - ii. NHI number
 - iii. Date of birth
 - iv. Name and location of prescriber
 - v. Any known medication allergies
- d. Entries should be completed in black ink and CAPITALS should be used for drug names. All prescribed/dispensed medicines should be included – including topical and any other medications (e.g. vitamins, self-purchased products, over-the-counter medications). Where a dose requires writing the number of tablets (e.g. compound preparations) write the dose in words and not figures, i.e. 'TWO' not '2'.
- e. Where the style of recording chart requires it, write out the frequency in words and not figures, e.g. THREE TIMES A DAY or THREE x DAILY, not 3 x daily or 3 times a day. See Appendix 1 for commonly used abbreviations that should be written in full when transcribing for a patient or health care support worker.
- f. Medication transcribing should include the following information as it appears on the original prescription/repeat prescription/dispensed item label/patient held record/fax or electronic communication from prescriber/discharge prescription:
 - i. The medication name
 - ii. The form it appears in, e.g. tablet, capsule, solution
 - iii. The strength, e.g. 100mg
 - iv. The dose, usually as the number of tablets or capsules
 - v. The frequency, e.g. twice a day
 - vi. The date of the prescription
 - vii. Any additional directions or information, e.g. to be taken with food
- g. Do not abbreviate medication names or directions
- h. Write a zero on front of a decimal point for clarification, e.g. 0.25mg not .25mg. Be particularly cautious with the use of decimal points.
- i. When a medication is prescribed to be taken 'as directed', clarity as to what this actually means must be sought from the prescriber.
- j. The date, time, name and designation of the person transcribing should be noted on the new document.
- k. The transcription should be independently double-checked by a second regulated health practitioner where possible and their name, designation and the date and time noted on the new document.
- l. Where possible, the transcription should be sighted and confirmed by the prescriber currently responsible for the patient.
- m. Where transcription is occurring from one Medication Administration Record Chart to another, then the original document should be cancelled by drawing a diagonal line across it and writing 'Re-written' and signing and dating the sheet.
- n. In situations such as InteRAI transcribing or transcribing from the Medication Administration Record to a patient education sheet, the following should be included: 'these drugs are transcribed from xxx,

and, as such, are not a legal prescription. When administering medications or making clinical decisions the original prescription should be used.

8. A regular audit of transcribing practice should be undertaken. NZNO recommends this be done three monthly for the first year and then annually.

Nurses must remember that they are accountable for validating the accuracy and completeness of the transcription before the administration of medications to the client if they are administering medications that have been transcribed (College of Registered Nurses Nova Scotia, 2014).

Resources

- Health Quality and Safety Commission. *Medicine Reconciliation Standards* (2012)
- Health Quality and Safety Commission. *National medication chart: User guide* (2021).

References

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Appendix 1 – useful abbreviations and information

(Health Quality & Safety Commission, 2012)

The following abbreviations can be commonly found on prescriptions. When transcribing these for a patient or a health care support worker, NZNO recommends they are written in full.

- ac = before food
- cc = with food
- pc=after food
- mane = morning
- midi = midday
- nocte = night
- q4h = every four hours
- q6h = every six hours
- q8h = every eight hours
- q12h = every twelve hours
- BD/bd = twice a day
- QID/qid = four times a day
- TDS/tds = three times a day
- PRN/prn = when required.
- Buc = buccal
- PR/pr = rectally
- PV/pv = vaginally
- INH/inh = by inhalation
- RE/LE = right/left eye
- PO/po = orally
- TOP/top = topically
- subling = sublingually
- subcut = subcutaneously
- IM = intramuscularly
- IV = intravenously
- neb = nebuliser
- nj = nasojejunal
- PEG = via percutaneous endoscopic gastrostomy
- NG = via nasogastric tube

Twice a day should be approximately 12 hourly and three times a day every eight hours.

- > g/G for grams
- > mg for milligram
- > ml for millilitre
- > microgram = write microgram in full

Appendix 2 – glossary

Medicines reconciliation – an evidence-based process involving three core steps:

- Collecting the most accurate medicines list using at least two different information sources, the primary source being the patient.
- Comparing the most accurate medicines list against the current medication chart and clinical notes for any documented changes to medicines.
- Communicating any discrepancies (ie. undocumented changes, whether intended or not) to the prescriber to reconcile and action (Health Quality and Safety Commission, 2011).

Prescribing – the process of information gathering, clinical decision-making, communication and evaluation which results in the *initiation, continuation, adjustment, or cessation* of medicinal treatment (Nursing and Midwifery Board of Australia, 2013).

Transcribing – the legitimate copying of prescription information from one source to another without any alterations or additions.

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Mission statement

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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