Procedures for Transcribing Prescribed Medications on to a Medication Administration Record (MAR) or Medication Instruction Sheet (MIS) (Version 3)
<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>2.0</td>
<td>What does transcription mean?</td>
<td>3/4</td>
</tr>
<tr>
<td>3.0</td>
<td>Purpose of Transcribing Procedure</td>
<td>4</td>
</tr>
<tr>
<td>4.0</td>
<td>Procedure for transcribing details of a prescribed medication on to a Medicines Administration Record (MAR)</td>
<td>5 - 16</td>
</tr>
<tr>
<td>5.0</td>
<td>Procedure for transcribing details of a prescribed medication on to a Medicines Instruction Sheet (MIS)</td>
<td>17 - 24</td>
</tr>
</tbody>
</table>

**Appendices**

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Competency Framework for Transcribing Prescribed Medications on to a Medication Administration Record/Medication Instruction Sheet</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Example Medication Instruction Sheet</td>
</tr>
</tbody>
</table>
1.0 BACKGROUND

The Southern HSC Trust provides community based care to a large number of people in a variety of different settings including; Supported Living Schemes, Statutory Residential Homes, Trust Respite Facilities for Adults with a Learning Disability (registered as Nursing Homes), Day Care facilities and a person’s own home. Where prescribed medications are part of treatment or care, they are prescribed by a registered prescriber, most often the General Practitioner (GP). Some people may require support with taking this prescribed medication or with performing a specific medicines procedure; for example applying eye drops or medicated patches.

For the purposes of this procedure the term ‘service user’ will be used to refer to Patients (Trust Respite Facilities for Adults with a Learning Disability, registered as Nursing Homes), Residents (Statutory Residential Homes), Tenants (Supported Living Schemes), Children (Children’s Statutory Residential Homes and Children’s Community Nursing team), Day Care Attenders (Day Care) and people being cared for at home.

In order to adhere to Departmental requirements and ensure staff who assist service users with their prescribed medications are adequately supported, a ‘Personal Medication Record’ providing authorised directions for staff must be in place. This record must include:

- Which medicines are prescribed;
- When each medicine must be given;
- What the dose is;
- Any special information, such as giving the medicines before food.

In the Southern Trust this personal medication record is in the form of a:

- **Medication Administration Record (MAR)** to direct staff working in Supported Living Schemes, Statutory Residential Homes, Trust Respite Facilities for Adults with a Learning Disability (registered as Nursing Homes), Day care facilities and Health Care Assistants in the Community Children’s Nursing Team.

- **Medication Instruction Sheet (MIS)** to direct Domiciliary Care Workers (DCWs) or Reablement Workers assisting service users with their prescribed medication in their own home. Most medications administered by DCWs are in a Medication Aid (also called Monitored Dosage System or blister pack) and the MIS gives directions regarding the aid.

The Southern Trust has developed the following procedures to support staff undertaking to transcribe prescribed medications on to a MAR or MIS for the purposes of administering medications to service users in their care. These procedures will remain in place until regional processes are developed and agreed.

2.0 WHAT DOES ‘TRANSCRIPTION’ MEAN?

Transcribing should not be confused with prescribing. Whilst a MAR and MIS provide authorised directions for Trust staff to administer the prescribed medication in a safe and effective manner, a MAR or MIS is not an original prescription. The original prescription will have been provided by the prescriber and the medication dispensed and labelled by the pharmacist according to the prescriber’s instructions.

**Transcription is the action of copying details of prescribed medication on to a MAR or MIS.**
In most instances the pharmacy label is the primary source used to transcribe, however to ensure safety and reduce risk, the details on the label must be checked against a second source from the following list:

- Prescription originally written by an ‘authorised prescriber’* (HS21);
- Printed record obtained from the service user’s GP detailing current prescribed medication including dosage and directions;
- Written record obtained from the service user’s GP detailing current prescribed medication including dosage and directions and signed by the GP;
- List of medication obtained from the ‘Northern Ireland Electronic Care Record’** (NIECR); or
- Discharge prescription written in the hospital where the service user has been discharged directly from.

*An ‘authorised prescriber’ may be: -
  - A registered Doctor or Dentist;
  - An Independent/Supplementary Prescriber (ISP) approved by the Trust’s Non-Medical Prescribing Sub-committee of the Drugs and Therapeutics Committee; or
  - A Community Practitioner Nurse Prescriber (CPNP) when prescribing from the Nurse Prescribers’ Formulary.

**Registered nurses and social workers can get full access to the Northern Ireland Care Record. Other band 5 transcribers can get a pharmacy Technician’s view of the prescribed medicines to assist with the transcribing process. To obtain access contact the Transformational lead.

3.0 PURPOSE OF THE TRANSCRIBING PROCEDURE

The purpose of this procedure is twofold:

1. To provide an agreed framework, with specified parameters, which allows the process of transcribing to take place within a safe and supported environment; and

2. To ensure that service users receive their prescribed medication at the time identified by the prescriber and without unnecessary delay.

Please note: while the principles of transcribing medicines onto a MAR and MIS are the same, the format is different. To avoid confusion please be careful to ensure you follow the directions under the correct section.

- Section 4 outlines the process for transcribing on to a Medication Administration Record (MAR)

- Section 5 outlines the process for transcribing on to a Medication Instruction Sheet (MIS)
4.0 PROCEDURE FOR TRANSCRIBING DETAILS OF A PRESCRIBED MEDICATION ON TO A MEDICINES ADMINISTRATION RECORD (MAR)

MARs are ordered through Trimprint using the following codes:

- **Normal version** - NSV Code WOD059N
- **Shortened version** - NSV Code WOD060N (When ordering request to be ‘head to tail’)
- **Recording sheet** - NSV Code WOD061N
- **Day care MAR** and recording sheet - NSV057N

4.1 When is transcribing on to a MAR permitted?

Transcribing on to a Medication Administration Record (MAR) in the absence of one being completed and signed by an authorised prescriber for service users receiving assistance with medications in:

- Day Care facilities
- Supported Living Schemes
- Statutory Residential Homes
- Trust Respite Facilities for Adults with a Learning Disability (registered as Nursing Homes)
- Community Children’s Nursing Team (where assistance with medication is provided by Health Care Assistants)

Or

Where the MAR has been completed by the prescriber; however there are concerns regarding its clarity or details are incomplete. This should be a last resort; the prescriber should always be asked to amend this in the first instance.

In addition, transcription to a replacement MAR is permitted when:

- The existing MAR becomes illegible due to, for example, multiple changes to medication, length of time in use or damage to the existing MAR.

Transcribing is not permitted

- Where a second source to check the prescriber’s instruction cannot be obtained except in exceptional specified circumstance as outlined in 4.13;

- Where there is *any ambiguity/discrepancy* regarding the details to be transcribed from the sources listed in 4.4;

- Where the two sources used for transcribing do not match; for example the details on the label of the prescribed medication do not match the details in the second source;

- Where the patient's/client’s *allergy status has not already been and cannot be confirmed* through either the authorised prescriber as listed in 2.0 above or his/her family members or carer.

NB: Where there is any ambiguity/discrepancy, or where a change has been made, to previously prescribed medication the transcriber MUST receive *written confirmation* in the form of an email from the prescriber before transcribing can take place. The written confirmation must be signed and dated and retained in the service user’s record.
4.2 who may transcribe on to a MAR?

Transcription may only be carried out by:

- A registered nurse working in: Day Care, Supported Living, Trust Respite Facilities for Adults with a Learning Disability (registered as Nursing Homes), Statutory Residential Homes, Community Children’s Nursing Team, Community Learning Disability Team, Community Psychiatric Team or;
- A senior support worker (Band 5 and above) working in Day Care, Supported Living or Statutory Residential Home.

Before being permitted to transcribe onto a MAR, the registered nurse or senior support staff must have:

1. Undertaken appropriate training in transcribing and been deemed competent to undertake this activity. Competency should be reviewed 2 yearly or earlier should circumstances indicate otherwise. Competency should be reviewed yearly where the Transcriber has not transcribed since previous competency assessment.

2. Been approved to transcribe by the manager who will sign the ‘Authorisation to Transcribe’ form confirming that the Transcriber has received the training and has undertaken the competency assessment associated with this procedure.

3. A register of all Transcribers is to be maintained by the manager and updated yearly – click on links to documents below

[Authorisation to Transcribe Medication Form.docx]
[Register of Transcribers.docx]

4.3 The Transcriber must undertake the following steps to ensure safe and accurate transcribing:

Check the details on the label of the prescribed medication including:

- Name of the service user
- Name and strength and form of the medication
- Dosage instructions
- Route of administration
- Specific instructions for administration e.g. ‘take one hour before food’
- Frequency of administration
- Times due if printed
  - Actual times of administration may not be included on a prescription, only frequency, for example, ‘twice a day’ rather than ‘morning and lunchtime’ or ‘morning and nighttime’. Wherever possible, confirmation should be sought from the service user or family/carer on the usual times of administration. If there is any concern, contact a prescriber or pharmacist for advice.

- Any details which specify the duration of treatment
- Any details regarding the interval between doses of ‘as and when required’ medication and maximum number that can be administered
- Date of dispensing
Where a date of dispensing for a medicine taken regularly is more than 3 months ago, confirmation should be sought from the service user or their family/carer (if appropriate) that the medication is still being taken.

4.4 Ensure the details on the label of the prescribed medication match those from a second source, e.g., as in 2.0 this may be from:

- Prescription originally written by an ‘authorised prescriber’* (HS21);
- Printed record obtained from the service user’s GP detailing current prescribed medication including dosage and directions;
- Written record obtained from the service user’s GP detailing current prescribed medication including dosage and directions and signed by the GP;
- List of medication obtained from ‘The Northern Ireland Electronic Care Record; or
- Discharge prescription written in the hospital where the service user has been discharged directly from.

Please note a previously prescribed transcribed MAR cannot be used as a second source. **WHEN REWRITING THE MAR A NEW SECOND SOURCE MUST BE OBTAINED**

STAFF MUST NOT TRANSCRIBE MEDICATION ONTO A MAR AND REQUEST THE GP TO SIGN THE MAR

STAFF MUST NOT ASK ADMIN STAFF TO COMPLETE THE MAR FOR TRANSCRIBERS TO SIGN

The following abbreviations to indicate frequency may be used by the prescriber (on the second source). They are included in this procedure for reference only and must never be used to indicate frequency by the staff member transcribing onto the MAR.

- Once daily = od
- Twice daily = bd
- Three times daily = tds or tid
- Four times daily = qds or qid
- Every morning = mane
- Every night = nocte

Frequency must be written in full

**Referencing the SECOND source**

- The DATE on which the transcriber referred to the SECOND source in order to confirm that the details on the label of the prescribed medication were correct **MUST** be recorded on that second source and the second source signed by both transcribers.
- The SECOND source of information **MUST** be retained in the service user’s record.
- Where there is a discrepancy in the two sources or where details of the prescription are incomplete, the prescriber must be contacted and written clarification in the form of an email obtained **BEFORE** transcription takes place. This written clarification **MUST** be retained in the service user’s record and signed by both transcribers.
4.5 Transcribing process

- Record on the MAR using black ink.
- Writing must be clear and legible.
- Record the service user’s full name, date of birth, HCN and allergy status – stating where you obtained the allergy status information for example ‘GP printout’. Both transcribers should sign.
- The MAR can be completed electronically - click on link to open the correct MAR which can then be saved..
- If completing electronically the MAR should be printed colour. Where this is not possible the allergy box must be highlighted with a red pen. If a change is made electronically, it will be the same as rewriting the MAR, as all the medicines will have to be rechecked and signed by two transcribers and a new second source for all medicines obtained. It may be preferable to record new medicines in black ink and redo the MAR electronically when it needs to be rewritten.
- Record the date each medicine was commenced (if known); this information may be on the medication list. However if the date of commencement is not known, write the date the MAR was prepared. DO NOT TAKE THE ISSUE DATE ON THE MEDICATION LABEL AS BEING AN ACCURATE DATE THE MEDICINE WAS COMMENCED.
- Write the name of the medication in full in CAPITALS.
- Where a medication label states take ‘one or two’ tablets the prescriber must be contacted to confirm the dose to given and the medication correctly labelled (by the pharmacist), unless the service user can make a decision as to whether he/ she is to have one or two or a management plan is in place.
- Write the dose in the dose column in the same format as stated on the medication label. For example where the label states ‘2mg tablets - take two tablets’ record as ‘2mg x 2’.
- Strengths of medicines must be written in full with exception of the following:
  - G = Gram          MG = Milligram          ML = Millilitre
- Micrograms and nanograms and international units must never be abbreviated
- If small volumes are prescribed (less than 1ml) write as 0.5ml not ·5ml
- Do not use trailing zeros, i.e., 5.0mg can be read as 50mg
• Indicate the route of administration clearly. Accepted abbreviations are:

<table>
<thead>
<tr>
<th>Route</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>PO</td>
</tr>
<tr>
<td>Sublingual</td>
<td>SL</td>
</tr>
<tr>
<td>Nasogastric</td>
<td>NG</td>
</tr>
<tr>
<td>Intravenous</td>
<td>IV</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td>SC</td>
</tr>
<tr>
<td>Intramuscular</td>
<td>IM</td>
</tr>
<tr>
<td>Per gastrostomy</td>
<td>PEG</td>
</tr>
<tr>
<td>Inhalations</td>
<td>INH</td>
</tr>
<tr>
<td>Nebulised</td>
<td>NEB</td>
</tr>
<tr>
<td>Per vagina</td>
<td>PV</td>
</tr>
<tr>
<td>Per rectum</td>
<td>PR</td>
</tr>
<tr>
<td>Buccal</td>
<td>BUCC</td>
</tr>
<tr>
<td>Topical</td>
<td>TOP</td>
</tr>
</tbody>
</table>

(TOP includes eye drops and ear drops)

![Fig 1: showing how to record medication name, dose and route](image)

- Record the times of administration in the ‘time’ column of the MAR.
- On the Day Care MAR one administration time is already printed i.e. 12.30. If the medication is to be administered before 12.30, record the time in the column before 12.30. If the medication is to be administered after 12.30 record the time in the column after 12.30. See fig 2 with examples of 11:30 and 14:00.
- Clearly indicate times medication is to be given using a tick in correct box as per figs 2 and 3.

![Fig 2: Day care MAR showing how to record times and tick to indicate when medicines are to be administered](image)

- No actual times are recorded on the Residential/ Supported Living/ Respite facilities MAR - Breakfast/ Lunch/ Tea and Supper is indicated allowing transcribers to individualise the MAR to suit the needs of the facility. Actual times MUST be added.
• Corresponding administration times must also be added to the Drug Recording Sheet and where a medication is administered at a later/earlier time the actual time must be recorded with a comment to explain the reason.

Fig 3: Residential/Supported Living/Respite facilities MAR showing how to record times and tick to indicate when medicines are to be administered

• Where medication is only to be taken on specific days e.g. once weekly this must be clearly indicated – this can be achieved using a highlighter with the day of the week clearly indicated as per fig 4.

• Ensure any details which specify the duration of treatment are included e.g. if an antibiotic for 5 or 7 days. The date the medication is to be stopped should be indicated however this will require working out and will depend on the time of day it was commenced - see example in fig 4.

• Ensure any additional directions are included in the special instructions section of the MAR e.g. ‘take with food’.

• Where there is too much information to record in this space write ‘See Label’ as per fig 4.

Fig 4: Residential/Supported Living/Respite facilities MAR showing how to record weekly medicines and a medicine that is for a short duration

4.5.1 ‘As required medicines’

• Record ‘as required medicines’ in the ‘as and when required medicines’ section of the MAR

• ‘As required’ medicines **must include** the **minimum interval** between doses and **maximum frequency or dose within 24 hours**. This information may not always be on the pharmacy label; however it may be on the packaging or detailed in the Patient Information Leaflet (PIL). **Where this information is not available the prescriber must be contacted for verification.** See fig 5 example of how to record this.
Fig 5: Showing how to record ‘As required’ medicines

- Where a management plan is in place for ‘as required’ medication this should be referred to in the special instructions section of the MAR i.e. ‘as per management plan’.

4.5.2 Transcribing Buccal Midazolam products (emergency medication) on to the ‘as required’ section of the MAR:

- In the column entitled ‘Medicine’ record the name of the product (in capitals) plus the strength
  - state if the product is in a prefilled syringe
- In the column entitled ‘Dose’:
  - if the medication is to be measured, record dose in mg and amount in ml
  - if the medication is in a prefilled syringe record dose in mg 1 syringe

In the special instructions column refer to the Epilepsy Management Plan.

See example below:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPISITAL MEXAMOL</td>
<td>5mg in 24 hours</td>
</tr>
<tr>
<td>OROMUCOSAL SOLUTION</td>
<td>As per epilepsy management plan</td>
</tr>
<tr>
<td>10mg/1ml</td>
<td>Buclal</td>
</tr>
<tr>
<td>0.5ml</td>
<td></td>
</tr>
</tbody>
</table>

Fig 6: Showing how to record Buccal Midazolam products

4.6 Where a service user requires more than one MAR:

Mark 1 of 2, 2 of 2.

4.7 Discontinued/changes to prescribed medication:

Where a service user’s medication has been discontinued or changed and the prescriber is not available, or is unwilling, to record the changes on the MAR, written confirmation of the change should be obtained from the prescriber. The written confirmation may be in the form of an email and, following receipt, the MAR can be updated but must be signed by two members of staff who have been authorised to transcribe. The written confirmation must be signed and dated and retained in the service user’s record.

Every effort should be made to obtain written confirmation of discontinued medicines, however where this is not possible and is only available verbally e.g. via phone, a written record must be made of the conversation including:

- The name of the person who relayed the information that the medicine was to discontinue
- The name of the GP
- The service user’s name and HCN
- The name of the medication
- Date the medicine is to discontinue
• The date

Details should be read back to the person relaying the information recorded on the ‘Record of verbal confirmation of discontinued medicines form’ and placed in the service user’s notes. Click on link to form below and save.

Where a medication is prescribed for a short duration for example antihistamines for the summer months, the transcriber should seek written clarification as to when the medication is to be stopped before it is transcribed. This will allow for discontinuation at the agreed time without the need to go back to the prescriber for verification.

Respite - where a service user is returning for a period of respite to a Trust Respite Facility for Adults with a Learning Disability, registered as Nursing Home or Statutory Residential Home and a ‘short course’ medicine is still on the MAR that has been completed there is no need to obtain verification that the medicine is discontinued.

4.7.1 To record the discontinuation of a prescribed medication

A line must be drawn through the discontinued prescribed medication and the MAR dated and signed (by 2 staff) and the medication returned to family or community pharmacy.

4.7.2 To record changes to a prescribed medication

Where a change has been made to the dose of a previously prescribed medication the MAR should be updated in accordance with the new directions of the prescriber.

- The new directions should be written in full, according to the label and a SECOND source as listed in 4.4 ensuring that the previous directions are cancelled.

- Where the previously dispensed medication can be used to administer the new dose, for example, one tablet to be taken instead of two the container must have a coloured sticker/or marked with a red marker attached highlighting that the dose has been changed until a new supply is obtained.

- Where a medication is dispensed in a different strength from what was previously supplied; for example where a service user is prescribed Nicorandil 20 mg which was previously dispensed as 20 mg tablets and was transcribed on the MAR as 20mg x 1, but is now dispensed as Nicorandil 10mg.’ The MAR must be rewritten as 10mg x 2, however a new second source is not required as it only the strength that has changed and not the dose.

4.8 Community Children’s Nursing Team only

Where a child is to attend a hospital appointment the parent/ carer should be encouraged to take the MAR and where any changes to medication are made, request the medical staff to record the changes. Where written confirmation of a new dose has not been obtained the parent/ carer will be requested to administer the new dose until written verification is obtained and the MAR updated.

4.9 Re-writing the MAR

Transcribers should note the following when re-writing a MAR:
• Obtain a new second source for current medications
• Record in the top right hand corner of the MAR ‘Rewritten on…’ and the date it was rewritten.
• Transcribe as per steps set out in 4.5 to ensure safe and accurate transcribing;
• Ensure the date each medication was prescribed is stated and NOT the date on which the new MAR is being re-written;
• Transcribe all current medicines from the existing MAR onto the new MAR.
• Cancel the old MAR by drawing a line diagonally across the page and writing ‘rewritten’, and two Transcribers sign and date and file in service user’s record.

4.10 Checking the transcription

Whether transcribing a service user’s MAR for the first time or re-writing an existing MAR the transcription must be checked by a second person who has been deemed competent to transcribe. The MAR MUST be signed by both the transcriber and the second person providing the check.

Attempt should always be made to seek a second transcriber to check the transcription straight away. However where a second person competent to transcribe is not available to check the transcription before administration of the medication is due, the medication may be administered, however, the transcription must be checked at the earliest opportunity, and at the latest, at the next shift handover. Any delay in checking the transcription should be minimised.

Record transcription on monthly Summary Form
Click on link to form below and save

A picture should be taken of the prescribed medications and attached to the second source. It is recognised that this may not be possible in all facilities for example residential homes for elderly where there is a high volume of medicines being transcribed.

4.11 Epilepsy nurses transcribing on to Emergency Medication Seizure Management Plans

• For new referrals the consultant will be requested to sign the Emergency Medication Seizure Management Plan. However it may be necessary for the Epilepsy Nurse to sign EMPs for existing service users following this process:
• The Epilepsy Nurse/Community Nurse will provide the GP with all the relevant information.
• The prescription MUST detail all the information including the name, dose and strength of the emergency medication and at what specific point it is to be administered.
• The prescription, a GP printout or Emergency Care Summary records will be used as a second source to allow the Epilepsy Nurse/Community Nurse to sign the Emergency Medication Seizure Management Plan.
• The Epilepsy Nurse/Community Nurse will attach a copy of the prescription, printout or Emergency Care Summary records to the back of the Emergency Medication Seizure Management Plan.
• The Emergency Medication Seizure Management Plan must be second checked and signed by another Nurse
• All Epilepsy Nurses/Community Nurses to attend transcribing training

4.12 Training to transcribe
Staff who are required to transcribe must undertake appropriate training and be deemed competent in this activity. This training will be provided by the Trust’s Medicines Management Specialist Nurse i.e.
• Core training before allowed to transcribe
• Assessment of competency before being allowed to transcribe
• Refresher transcribing training yearly

Assessment of competency to transcribe
The assessment of competency will be carried out by the staff member's line manager or an appropriate nominated person (Band 5 or above) as per the ‘Competency Framework for Transcribing Prescribed Medications on to a Medication Administration Record/Medication Instruction Sheet’ (Appendix 1) using the competency assessment tool. Assessment of competency will involve:

1. Transcribing medication onto a MAR.
2. Second checking a transcription made by another member of staff to ensure accuracy and signing off the checked transcription.

Competency should be reviewed 2 yearly unless the Transcriber has not transcribed since previous competency assessment when it should be reviewed yearly. Competency will be reviewed by the manager or appropriate person using the agreed competency tool. The monthly Transcribing Summary Form can be used to check transcribing activity and enable the manager or appropriate person to check when staff are due reassessment of competency.

Where any concerns arise regarding a staff member's ability to transcribe, this must be reviewed immediately and the staff member must not be permitted to transcribe until all competency issues have been resolved. Click on link to on Assessment Tool below and save.

Revised COMPETENCY ASSES:

4.13 Instances where transcribing with one source is allowed
A number of scenarios have been identified where it is not possible to obtain a second source to enable transcribing to take place as per the process outlined in this Procedure. Transcribing with one source is permitted in the following circumstances:

• Where a service user is dispensed prescribed medications at Emergency Department (ED); before leaving, the label should be checked to ensure it contains all the information to enable transcribing to take place. Staff should not be writing on medication labels.
Please note the directions may be on a pre-printed label that is attached to the container or may be printed on the actual container as below examples.

Fig 7 Example of labelling for medicine dispensed by Emergency Department

- Where a service user is dispensed prescribed medications at ‘Out of hours GP Service’. Before leaving, the label should be checked to ensure it contains all the information to enable transcribing to take place. **Staff should not be writing on medication labels.**

- Where a service user is dispensed prescribed medications at a Family Planning Clinic. Before leaving, the label should be checked to ensure it contains all the information to enable transcribing to take place. **Staff should not be writing on medication labels.** The GP can be contacted for verification of medication dispensed at a Family Planning Clinic.

- Where the medication dose is variable for example Insulin, the Transcriber should check if the service user or family has kept a diary. Where a diary is not kept the transcriber should request the family to write the dose down.

- Where the medication dose is dependent on a blood result for example Warfarin. In this instance the **dose must always be obtained in writing** from the GP. This can be a printout or a copy of the yellow book.

- Where a GP has provided written approval that the service user can take herbal or homely remedies. The dosing directions will be on the medication pack. The transcriber should confirm the actual dosing with the service user/carer and that this is within dosing directions on pack. The Transcriber should always check with GP or Medicines Information Service CAH (Ext 2976) regarding possible interactions with prescribed medication. **If it is not possible to get information regarding possible interactions or if there is any doubt the herbal remedy should not be administered.** The facility should put an addressograph label on the pack with the service user’s details.
• Where a service user is prescribed oxygen, there will not be a label on the oxygen cylinder. Where a printout from BOC can be obtained this can be used as a second source.
• Where a service user is prescribed enteral feeds, the enteral feeding regime can be used as a second source. The dose should be recorded ‘as per enteral feeding regime’.
• Where a service user is prescribed medicated toothpaste, the transcriber should check the pharmacy label on the box. Where medicated toothpaste is recommended, written approval must be obtained from the GP. The transcriber must check the manufacturer’s instructions on the box to ensure the maximum dose is not exceeded before recording on the MAR.

4.14 Monitoring arrangements for transcribing on to a MAR

• Transcriptions MUST be monitored on an ongoing basis. The monthly Transcribing Summary Form should be used by staff to record transcribing activity. The purpose of monitoring is to ensure that transcribing takes place within the specified parameters and in accordance with the Trust’s Transcribing Procedure.
• In facilities where less than two transcriptions are carried out monthly; all transcriptions should be monitored. In facilities where more than two transcriptions are carried out monthly; a minimum of two transcribed MARs should be reviewed each month.
• Monitoring is carried out using the ‘Transcribing medications monthly monitoring Tool’.
• Transcriptions can be randomly selected from the summary of transcriptions on the ‘Transcribing Summary Sheet’ by the monitor unless specific issues were encountered by the Transcriber which would prioritise selecting for monitoring.
• Monitoring should be carried out by a staff member at Band 5 or above who has been trained to transcribe and has been deemed competent. Monitoring should be carried out by someone other than the person who has completed the transcribing. Where this is problematic, monitoring can be carried out by a Transcriber from a different facility.
• Having a picture of the medicines will assist with the monitoring process, however it is recognised that this may not be possible in all facilities, see section 4.10
• Transcribing audits will be carried out by the Medicines Management Specialist Nurse on a rolling three year programme. Learning points from monitoring should be shared across other transcribers and across other facilities as appropriate. Click on link to Monitoring Tool below and save

Revised MONTHLY MONITORING TOOL:

4.17 Transcribing incidents

Where a service user receives an incorrect medication or where a medication was omitted as a result of a transcribing error, this should be reported to a line manager immediately and advice sought from a prescriber on the care of the patient/client.
• Medication incidents involving transcribing must be reported on the Trust’s adverse incident form (IR1) using Datix.
• The line manager should investigate the events leading to the error or omission and
• The competency of staff involved in the incident reviewed and where appropriate the staff member/s may not be permitted to transcribe until all competency issues have been resolved.
5.0 PROCEDURE FOR TRANSCRIBING DETAILS OF A PRESCRIBED MEDICATION ON TO A MEDICINES INSTRUCTION SHEET (MIS)

In order to reduce the risk of error the different times of day on the Medication Instruction Sheets are colour coded. The MIS must never be printed in black and white. MISs are ordered through Peninsula Print: - Ref 22866 HM02

5.1 When is transcribing on to a MIS permitted?
Transcribing on to a Medication Instruction Sheet (MIS) where an assessment has determined level 3** assistance is required for service users receiving assistance with medications in:-

- Their own home (assistance provided by Domiciliary Care Workers, Reablement Workers or Intermediate Care Workers)

** As per Operational Guidelines when service users require assistance with medications from Domiciliary Care Workers (V 3 2018)

Transcribing is not permitted

- Where a second source to check the prescriber’s instruction cannot be obtained except in exceptional specified circumstance as outlined in 5.7;

- Where there is any ambiguity/discrepancy regarding the details to be transcribed from the sources listed in 5.3.1;

- Where the two sources used for transcribing do not match; for example the details on the label of the prescribed medication do not match the details in the second source;

- Where the patient's/client’s allergy status has not already been and cannot be confirmed through either the authorised prescriber as listed in 2.0 or his/her family members or carer.

NB: Where there is any ambiguity/discrepancy, or where a change has been made, to previously prescribed medication the transcriber MUST receive written confirmation in the form of an email from the prescriber before transcribing can take place. The written confirmation must be signed and dated and retained in the service user’s record.

5.2 Who may transcribe on to a MIS?

Transcription may only be carried out by:
- A registered Community Nurse

Where the term Community Nurse is used, this refers to a Learning Disability Nurse/ Mental Health Nurse/ District Nurse/ Specialist Nurse working in the community across all directorates in the Southern Trust.

Before transcribing on to a MIS the nurse and must have completed the transcribing training module via E-Learning or face to face training provided by the Medicines Management Specialist Nurse. Yearly refresher training must be carried out.

5.3 The nurse MUST undertake the following steps to ensure safe and accurate transcribing: -

Check the details on the label of the prescribed medication including: -

- Name of service user
- Name, strength and form of the medication
- Dosage instructions
- Route of administration
- Specific instructions for administration e.g. ‘take with food’
- Frequency of administration
- Times due if printed

Actual times of administration may not be included on a prescription, only frequency, for example, ‘twice a day’ rather than ‘morning and lunchtime’ or ‘morning and nighttime’. Wherever possible, confirmation should be sought from the service user or family/carer on the usual times of administration. If there is any concern, contact a prescriber or pharmacist for advice.

THE NURSE MUST CHECK THE INTERVALS BETWEEN DOMICILIARY CARE VISITS TO ENSURE DOSES ARE NOT ADMINISTERED TOO CLOSE TOGETHER.

- Any details which specify the duration of treatment
- Any details re intervals between doses of ‘as and when required’ medication and maximum number that can be administered
- Date of dispensing
- Where the date of dispensing for a medicine taken regularly is more than 3 months ago, confirmation should be sought from the service user or their family/carer (if appropriate) that the medication is still being taken.

Community nurses must complete the MIS in the service user’s home where they can check the details on the label of the medication.

Where a service user is prescribed a new medication that is urgent (oral medication, eye drops or creams) out of normal working hours, the Domiciliary Care Supervisor can give permission in the interim until the MIS can be prepared by the community nurse as detailed in ‘Operational Guidelines when service users require assistance with medications from Domiciliary Care Workers’ (V3 2018). However the medication must be recorded on the MIS by the end of the next working day.

5.3.1 Ensure the details on the label of the prescribed medication MATCH THOSE FROM A SECOND SOURCE, e.g., as above in 2.0 this may be from: -

- Prescription originally written by an ‘authorised prescriber’* (HS21);
- Printed record obtained from the service user’s GP detailing current prescribed medication including dosage and directions;
- A written record obtained from the service user’s GP detailing current prescribed medication including dosage and directions and signed by the GP;
- Print out of medication list obtained from the Northern Ireland Electronic Care record; or
- Discharge prescription written in the hospital where the service user has been discharged directly from and signed by the prescriber.

The following abbreviations to indicate frequency may be used by the prescriber (on the second source). They are included in this procedure for reference only and must never be used to indicate frequency on the MIS.

- Once daily = od
- Twice daily = bd
- Three times daily = tds or tid
- Four times daily = qds or qid
- Every morning = mane
Every night = nocte

Referencing the SECOND source

- The **DATE** on which the nurse referred to the SECOND source in order to confirm that the details on the label of the prescribed medication were correct MUST be recorded on that second source.
- The SECOND source of information MUST be signed and retained in the service user’s record.
- **Where there is a discrepancy in the two sources** or where details of the prescription are incomplete, the prescriber must be contacted and **written clarification in the form of an email obtained BEFORE transcription takes place**. This written clarification MUST be signed and dated and retained in the service user’s record.

5.3.2 Transcribing process

- Record the service user’s full name, address, date of birth and HCN in the details section of the MIS

5.3.3 Medication Aid (also called Monitored Dosage System)

Where the medications are in a Medication Aid, the aid must be filled by a pharmacist and sealed for example a blister pack or PillPacPlus.

Check the medicines in the Medication Aid against the second source to ensure there are no discrepancies.

To authorise the DCW to administer the medicines out of the medication aid the nurse must:

- Circle **YES** in column 1 of the MIS for each time of day the DCW is to administer medication from the Medication Aid.
- Sign and print their name
- Record the date.

Where medications have to be administered from 2 Blister packs – column 1 should indicate this at the appropriate time/s of day as shown.

![Fig 8: showing section 1 of MIS authorising permission for Domiciliary Care Workers to administer from a medication aid](image)

5.3.4 Medication from original containers

Where medication is to be administered out of the original container the nurse must:

- Record the medication instructions with clear legible handwriting using black ink in the appropriate sections of the MIS corresponding to the times of the day they have to be
given e.g. breakfast, lunch, tea and bedtime.

Where a medication is to be given several times of day, it may be very important to ensure the medicines are evenly spaced out. This will mean checking the timings of the domiciliary care visits to ensure there is a sufficient gap.

Record medicines to be given orally e.g. tablets/capsules/liquid/sachets in section 2, as follows

- Name of medication in capitals
- Strength
- Amount to be administered
- Include any special instructions e.g. to be taken with food, to be dissolved in water, dissolve under the tongue
- Where the medication is for a limited period state the date it is to be stopped e.g. AMPICILLIN 250mg one tablet until 10/07/2050.
- Where a medication label states take ‘one or two’ tablets the prescriber must be contacted to confirm the dose to given and the medication correctly labelled (by the pharmacist),
- Write the dose in the same format as stated on the medication label. For example where the label states ‘2mg tablets - take two tablets’ record as ‘2mg give 2 tablets’.
- If ‘as and when required’ medication to be administered, state what it is for, how often it can be given and maximum amount allowed in 24 hours. This information may not always be on the pharmacy label; however it may be on the packaging or detailed in the Patient Information Leaflet (PIL). Where this information is not available the prescriber must be contacted for verification.

![Table](image)

**Fig :9 Showing how to transcribe oral medications from original container**

- Where liquid medication has to be measured in an oral syringe, Domiciliary Care Workers are only allowed to give one liquid medicine (ensure syringe is ‘purple oral syringe’ and is correct size to reduce risk of error. There must be an adequate supply of oral syringes as the markings will wash off.
- Sign and also print name in section 2. Record the date.

Where the medication to be administered is a controlled drug – two Domiciliary Care Workers should be involved and a balance kept as as detailed in ‘Operational Guidelines when service users require assistance with medications from Domiciliary Care Workers’ (V3 2018). In most incidences it will only be possible to have one nurse signing the MIS. Where 2 nurses are available or the transcription is complex a second nurse should be asked to second check and sign the transcription.
5.3.5 Record medicines to be administered by specific technique e.g. creams/ointment/lotions, eye drop, ear drop, inhaler, nebuliser or patch in section 3, as follows

DCWs are allowed to administer medication via the following specific techniques:
- Instillation of eye or ear drops, application of creams/ointments/lotions, nose drops, nasal spray or medicated patch, assisting with a nebuliser, inhaler or oxygen.

**DCWs are not permitted to assist with insulin or medication where the dose changes frequently e.g. Warfarin unless it is a steady dose and is in medication aid**

Application of creams, instillation of eye drops and application of a medicated patch are taught and assessed via the Medicines Management Skills Assessments. All other specific techniques to be taught and assessed by the community nurse or appropriate health care professional e.g. COPD team.

For specific procedures always refer to the appropriate Procedure/Care Plan which should be individualised and inserted into the care plan. Procedures and competency tools are available on the Trust Intranet > go to Home Page > Clinical Guidelines and click on www.southernguidelines.hscni.net. Type in a key word to access relevant Procedure/Care Plan. They can also be obtained by going to Share Point and clicking on the following links.

- Record the name of the medication and route of administration e.g. Versatis Patch, Salbutamol Inhaler, Chloromycetin Eye Drops.
- When transcribing creams/ ointments/ lotions record the name of the cream/ ointment/ lotion and where it is to be applied.
- When transcribing medicated patches record the name of the patch and how often the patch has to be changed. The body map in the Procedure/ Care Plan should clearly show where on the body this is to be applied. Where appropriate specify how often the patch has to be rotated as some patches should not be applied to the same area within a specified period (this information will be on the Patient Information Leaflet). The nurse must meet up with the Domiciliary Care Workers involved if it is a controlled drug patch to go through the checklist for controlled drug patches (also available on the Trust Intranet).
- When transcribing medication to be administered via a nebuliser; record the name and strength of the medication to be added to the nebuliser and route of administration.
- When transcribing an inhaler, record the name of the inhaler and the number of puffs to be given; where more than one inhaler record the order they are to be administered.
- When transcribing eye drops, record the name of the eye drop, how many drops to be applied and which eye. Where more than one eye drop record the order they are to be instilled.
- When transcribing ear drops, record the name of the ear drop, how many drops to be applied and which ear.
- Where the medication is via a specific technique is for a limited period state the date it is to be stopped e.g. Fucibet cream to rash on left arm for 5 days until 10/7/50.
- Sign and print name in section 3.
- Record the date.

In most incidences it will only be possible to have one nurse signing the MIS. Where 2 nurses are available or the transcription is complex a second nurse should be asked to second check and sign the transcription.
See example:

![Image](image-url)

**Fig 10: Showing how to transcribe medicines via specific technique**

See Appendix 2 for example of a fully completed MIS.

### 5.3.6 Discontinuing medicines on MIS

To discontinue a medication, written confirmation of the change should be obtained from the prescriber. The written confirmation may be in the form of an email and following receipt the nurse can draw a line through the medicine and record signature and date in the ‘Date discontinued and name column’.

See example:

![Image](image-url)

**Fig 11: Showing how to discontinue a medicine**

### 5.4 Re-writing the MIS

The MIS should be rewritten if it becomes untidy or full or difficult to follow.

*There should never be more than one MIS (per service user) in use in a service user’s home. When a new medication is commenced or a medication is discontinued the changes/additions should be made on the current MIS in the home.*

Nurses should note the following when re-writing a MIS: -

- Transcribe as per steps in 5.3 to ensure safe and accurate transcribing;
- Transcribe all current details from the existing MIS onto the new MIS checking against a second source to see they are still correct.
- Cancel the old MIS by drawing a line diagonally across the page and writing ‘rewritten’, sign and date and file in service user’s record;

**Checking the Transcription**

In most incidences it will only be possible to have one nurse signing the MIS. Where 2 nurses are available or the transcription is complex a second nurse should be asked to second check and sign the transcription.
5.5 Complex medicine regimes

2.17 Complex Medicines Regimes

The Trust definition of a complex medicine regime is:

- Medication from a Monitored Dosage System plus more than three* medicines from the original container at any administration time.

  or

- More than three* medicines from the original container at any administration time.

*The following items must be recorded on the MIS in order for DCWS to administer them; however they do not have to be included in the total number of medicines out of the original container at any administration time:

- Nutritional supplements e.g. Procal, Fortisip etc
- Thickeners e.g. Nutilis
- Medicated body washes e.g Balneum bath oil
- Barrier creams e.g Conotrane
- Emollients e.g. E45

Where the medicines regime is complex, the community nurse will liaise with the community pharmacist/ practice based pharmacist/ Managing Your Medicines Scheme/ Medicines Use Review/ the family / the GP/ domiciliary care/ community nursing with regard to seeking possible solutions to reduce complexity

5.6 Training to transcribe

Registered nurses must undertake training in transcribing via E Learning or face to face if available.

Training MUST be refreshed annually.

Assessment of competency to transcribe

Competency will be assessed via the E Learning package as per ‘Competency Framework for Transcribing Prescribed Medications on to a Medication Administration Record/Medication Instruction Sheet’ (Appendix 2).

5.7 Instances where transcribing with one source is allowed

A number of scenarios have been identified where it is not possible to obtain a second source to enable transcribing to take place as per the process outlined in this Procedure.

Transcribing with one source is permitted in the following circumstances:

- Where a service user is dispensed prescribed medications at Emergency Department (ED); before leaving, the label should be checked to ensure it contains all the information to enable transcribing to take place. Staff should not be writing on medication labels.

Please note the directions may be on a pre-printed label that is attached to the container or may be printed on the actual container as below examples
Fig 12 Example of labelling for medicine dispensed by Emergency Department

- Where a service user is dispensed prescribed medications at ‘Out of hours GP Service’. Before leaving, the label should be checked to ensure it contains all the information to enable transcribing to take place. **Staff should not be writing on medication labels.**

- Where a service user is dispensed prescribed medications at a Family Planning Clinic. The label should be checked to ensure it contains all the information to enable transcribing to take place. **The community nurse should not be writing on the medication label.** The GP can be contacted for verification of medication dispensed at a Family Planning Clinic.
Appendix 1

MEDICINES MANAGEMENT

Competency Framework for Transcribing Prescribed Medications on to a Medication Administration Record/Medication Instruction Sheet
<table>
<thead>
<tr>
<th>Section</th>
<th>Contents</th>
<th>Page number</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Introduction</td>
<td>27</td>
</tr>
<tr>
<td>2.0</td>
<td>Training to Transcribe</td>
<td>27</td>
</tr>
<tr>
<td>3.0</td>
<td>Assessment of Competency to Transcribe</td>
<td>28/29</td>
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<tr>
<td>4.0</td>
<td>Further Advice for Managers</td>
<td>30</td>
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</table>
1.0 INTRODUCTION

This competency framework sets out the Southern Trusts expectations for safe and effective care in relation to transcribing medication on to a Medication Administration Record (MAR) or Medication Instruction Sheet (MIS).

It applies to:

- Registered nurses working in; Day Care, Supported Living, Trust Respite Facilities for Adults with a Learning Disability (registered as Nursing Homes), Statutory Residential Home, Statutory Community Children’s Nursing Team, Community Learning Disability Team or;
- Senior support workers (Band 5 and above) working in Day Care, Supported Living or Statutory Residential Home or;
- Community nurses who: transcribe whether routinely as part of their current role or occasionally to ensure that service users receive their medication at the time identified by the prescriber and without unnecessary delay.

This framework is to be used in conjunction with the following policies, procedures and guidelines:


‘Southern Trust Education and Training Competency Framework for non-nursing staff working in Domiciliary Care and Day Care, Residential and Supported Living settings’ (2014)


‘Southern Trust Medicines management Procedures for Residential Homes for Children and Young People with a learning Disability’ (2018)


‘Southern Trust Supported Living Services Medicines Management Operational Guidelines’ (2018)


‘Southern Trust Operational Guidelines: when Service Users require assistance with medications from Domiciliary Care Workers (2018)

2.0 TRAINING TO TRANSCRIBE:

2.1 Transcribing on to a Medication Administration Record (MAR)

Before being authorised by the manager to transcribe onto a MAR, staff will require training. This training will be provided by the Medicines Management Specialist Nurse and will include a theoretical and practical element. Refresher training is required annually.

2.2 Transcribing on to a Medication Instruction Sheet (MIS)

Before transcribing the community nurse must undertake training in transcribing via E Learning or face to face if available. Training MUST be refreshed annually.
3.0 ASSESSMENT OF COMPETENCY TO TRANSCRIBE:

3.1. Assessment of competency to transcribe on to a Medication Administration Record (MAR)

An assessment of competency will be carried out by staff member’s line manager or appropriate nominated person (band 5 or above) using the competency assessment tool (Appendix 3). Assessment of competency will involve:

1. Transcribing medication details on to a MAR.
2. Second checking a transcription made by another member of staff to ensure accuracy and signing off the checked transcription.

Competency should be reviewed 2 yearly unless the Transcriber has not transcribed since previous competency assessment when it should be reviewed yearly. Competency will be reviewed by the manager or appropriate person using the agreed competency tool. Where any concerns arise regarding a staff member’s ability to transcribe, this must be reviewed immediately and the staff member must not be permitted to transcribe until all competency issues have been resolved. The monthly Transcribing Summary Form can be used to check transcribing activity and enable the manager or appropriate person to check when staff are due reassessment of competency.

3.1.1 Support for Assessors

- A competency tool has been devised to assist assessors to assess competency of staff transcribing onto a MAR (simulated scenario)
- A competency Tool Kit will be provided by Medicines Management Specialist Nurse.
- The Medicines Management Specialist Nurse will assess the nominated assessors.
- The Medicines Management Specialist Nurse will carry out training to enable assessors to use the competency assessment tool appropriately and guide them regarding the processes.

3.1.2 Preparation of staff member for assessment of competency

The aim should be to enable the staff member to achieve competence where ever possible whilst not compromising the safety of the service user, the staff member or another member of staff

- The staff member should have sufficient instruction and training as per section 2.0 to prepare them for their role in transcribing medications on to a MAR.
- The staff member should have appropriate notice of the assessment and time to prepare.
- The staff member should know the level of achievement expected of them.
- The assessor should be aware of any underlying issues which may be affecting the staff member’s performance.

3.1.3 Non achievement of competencies

In the event of non-achievement of competency an action plan must be agreed with the staff member and their manager and documented.

- The staff member must be given feedback on where they have failed.
- The staff member should be given a chance to repeat the assessment within a reasonable time frame.
- Training/supervision and information should be provided as appropriate.
- The staff member will not be allowed to transcribe until this reassessment is carried out and the staff member has reached the desired level of competency.

3.1.4 Records of training and competency

It is the responsibility of the line manager to keep records of staff training and competency assessments.
A register of staff that have been trained and deemed competent to transcribe must be held by the manager.

3.2. Assessment of competency to transcribe on to a Medication Instruction Sheet (MIS)

- Assessment will be via the E Learning package.

3.2.1 Records of training and competency

It is the responsibility of the line manager to keep records of staff training and competency assessments.

4.0 FURTHER ADVICE FOR LINE MANAGERS

Further advice on this education and training competency framework can be accessed through Elizabeth Smyth, Medicines Management Specialist Nurse elizabeth.smith@southerntrust.hscni.net.
### TEA TIME

Ensure all medication in sections 1, 2 and 3 are given as directed and recording sheet signed

1. **Give medicines from Medication Aid**  
   **YES**  
   **NO**  
   Circle as appropriate  
   Nurses signature  
   Print name  
   Date

2. Give tablets/capsules/liquids/sachets out of original container as listed below

<table>
<thead>
<tr>
<th>Nurse's signature</th>
<th>Date</th>
<th>Date discontinued</th>
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<tbody>
<tr>
<td>J Brown</td>
<td>2/6/00</td>
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3. Creams/ointments/lotions, eye drop/ear drop, Inhaler, Nebuliser, Patch

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### BED TIME

Ensure all medication in sections 1, 2 and 3 are given as directed and recording sheet signed

1. **Give medicines from Medication Aid**  
   **YES**  
   **NO**  
   Circle as appropriate  
   Nurses signature  
   Print name  
   Date

2. Give tablets/capsules/liquids/sachets out of original container as listed below

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   **Paraacetamol 500mg/5ml Oral Suspension**

   **Give 10ml every 4-6 hours as requested by Hannah for pain**

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   **Tears Naturale**

   1 drop to left eye as per procedure for eye drops

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   **Voltarol 5EL patch**

   1 patch to left elbow twice daily for 14 days until 15/5/00, as per procedure for patches

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