Purpose

To provide guidelines for the transcription of all orders written by a LIP - medication and non-medication.

Scope

This policy applies to all inpatient units.

Policy

A. All medication (except topical) orders will be transcribed by licensed nursing staff from the Medication Order Sheet (MOS) to the Medication Administration Record (MAR).

B. All non-medication orders (to include treatments, labs - urinary and serologic, and x-ray) will be transcribed by licensed nursing staff from the Non-Medication Order Sheet to the Treatment Administration Record (TAR).

Procedure

A. Admission and Other New Orders

1. The nurse will verify that the order written is complete and contains the following, as applicable:
   - Date
   - Time
   - Medication/ treatment name
   - Dosage of medication/ treatment instructions
   - Route of administration
   - Frequency of administration (i.e. b.i.d, t.i.d., q.i.d., etc.)
   - Maximum daily dose for PRNs
   - Indication for Use
2. If a component of the order is missing, nursing staff will request a revision or clarification of the order from the prescriber BEFORE transcribing.
3. If the clarification is received by telephone or verbal, a telephone or verbal order will be written by the nurse. The nurse will write his/her initial in the (RB) box of the Medication and Non-Medication Order Sheet, for read back verbal and telephone order. (For additional information please see the policy on Verbal/Telephone Orders.)

On the MAR:

4. The nurse transcribing the order will enter his/her initials in the margin by the "order date" block for every order transcribed.
5. The nurse will write the order date on the "order date" block of the form.
6. The nurse will transcribe the complete order as written by the prescriber in the "Medication, Dosage, Frequency, Route" box of the MAR, or the "Prescribed Treatment" box of the TAR.
7. The nurse will enter in pencil the date and time of the last dose/treatment to be given underneath the transcribed order on the form. The last dose may be abbreviated as **"L/D".**
   (For example: **Last dose** or **L/D**-5/25/92 @ 6 AM)
8. The nurse will enter the scheduled times of medication/treatment administration in the "Hour" block on the form.
9. The nurse will specify the times in **chronological** order, beginning with the earliest AM dose/treatment to be administered.
10. The nurse will transcribe only one medication into each box on the MAR.
11. If the medication/treatment is scheduled more than four times during a twenty-four-hour period, the nurse will use two separate blocks (of four) to record all doses/treatments individually in chronological order.
12. If two separate blocks are used, the nurse will draw a diagonal line through the second box using black ink.
13. A single line arrow will be drawn through all the unused date and time blocks until the start date and time is reached.
14. **ANY change in an order necessitates the need for the whole order to be rewritten in a new section on the form.**
15. Any order written for less than thirty days must have the ending dates/last doses indicated in the date/time blocks by **arrows entered in pencil, encompassing all blocks not to be used.**
16. The nurse transcribing the orders will legibly write his/her initials,

name/signature, and nursing classification on the bottom of the reverse side of the

B. The following Physician orders will be transcribed to the Treatment Administration Record:

1. Nutritional therapy - diet type and supplements (i.e. Ensure, Ensure Plus, special snacks, etc.)
2. Medicated shampoos (e.g., Sebutone, Selsun, etc.)
3. Topical ointments/solutions (e.g., Valisone, Hydrocortisone, Betadine, Vaseline, Bacitracin, etc.)
4. Wound dressings (e.g., sterile dry, wet-to dry, Chloropactin, etc.)
5. Non-medication treatments (e.g., turn q 2 hours, neurochecks, circulatory checks, etc.)
6. Foot/hand soaks, wraps, slings (e.g., cover Iidex with plastic wrap, etc.)
7. Admission, routine, and special blood/urine tests (e.g., STS, RPR, CBC, U/A, etc.)
8. Admission, routine, and special laboratory tests (e.g., CXR, Audiologic Screening, EKG, etc.)
9. Preparations for Off-Grounds Clinical Studies (e.g., Soap Suds Enema x 3, Barium Enema, Clear Liquid Diet x 72 hours, etc.)

NOTE:

All items not specifically listed above will be transcribed onto the Medication Administration Record.

C. Discontinued Orders - Med and Non-med On the MAR:

1. Orders to be discontinued will be shown on the appropriate form by **entering the date and the initials** of the nurse discontinuing the order in the "Date D/C'd" block in **BLACK** ink.
2. **"D/C"** will be entered in the first date/time block after discontinuance.
3. All unused date and time blocks are to be highlighted to prevent use of these areas.

D. Monthly MAR/TAR Rewrite:

1. All MARs and TARs will be rewritten by the 11-7 nursing staff.
2. Orders are to be rewritten on the last day of the current month, **using the current** form upon completion of the transcription process.
   Medication Order Sheets (MOS) and Non-Medication Order Sheets (NMOS).
3. The nurse rewriting each order is to enter her/his initials in the margin beside the "order date" blocks for each order brought forward to the new MAR/TAR.
4. **The old MAR/TAR is not to be used as the source for rewriting orders at the end of the month.** These documents are not to be used to minimize the likelihood of bringing forward erroneous information or discontinued medications/treatments.
5. Rewrites will bring forward the **original** order date of the medication/treatment.
6. **All** allergies will be written in the appropriate section of the MAR/TAR in **red** ink.

Approved by

PRNjume,RN 6/11/20
Prisca Njume, MSN, RN — Date
Chief Nursing Officer

6/11/20
Dwain Shaw, M.P.H., J.D. — Date
Chief Executive Officer

WE:car

Reviewed: 8/94, 11/04, 4/18

Revised: 1/97, 6/98, 11/00, 11/02, 2/08, 5/08, 8/09
Revised: 9/11, 8/14, 4/15, 6/10/20

Attachment: Medication Administration Record
Treatment Administration Record

Cross Reference:
Verbal/Telephone Orders