

### 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., Sebutox, 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 lidex 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:


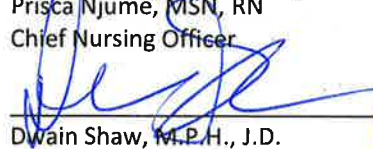
1. All MARs and TARs will be rewritten by the 11-7 nursing staff.
2. Orders are to be rewritten on the last day of the current month, **using the current**

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**

	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