STANDARD OPERATING PROCEDURE

Medication Administration SOP

Document no.	SOP-HLC-005
Revision	1.0
Owner	Nurse Manager
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Review cycle	Every 12 months

1. Purpose

To make sure every medication is given to the right patient, in the right way, at the right time, and accurately documented, while catching errors before they reach the patient.

2. Scope

Applies to oral, topical and injectable medication administration by licensed nursing staff on inpatient units. Compounding, IV admixture and controlled substance storage are covered by separate SOPs.

Definitions

MAR	Medication administration record, the document or EHR module used to order, schedule and record each dose given.
Rights of administration	The checks performed before giving a medication: right patient, right medication, right dose, right route, right time and right documentation.
Independent double-check	A second qualified staff member verifying a high-alert medication and its dose calculation before it is given, separately from the person administering it.

3. Responsibilities

Registered Nurse (RN)	Verifies orders, prepares and administers medications, and documents administration in the MAR.
Charge Nurse	Performs independent double-checks for high-alert medications and supports staff with unclear orders.
Pharmacist	Reviews and verifies orders, checks for interactions, and dispenses medications to the unit.
Physician / Provider	Writes and clarifies medication orders and is notified of adverse reactions or errors.

RACI matrix

Activity	Registered Nurse (RN)	Charge Nurse	Pharmacist	Physician / Provider
Write and verify the medication order	I	-	R/A	R
Prepare and administer the medication	R/A	C	I	I
Perform independent double-	R	R/A	C	-

Activity	Registered Nurse (RN)	Charge Nurse	Pharmacist	Physician / Provider
check on high-alert medications				
Report and manage a medication error or reaction	R	A	C	R

R = Responsible, A = Accountable, C = Consulted, I = Informed

4. Materials and PPE

Materials, tools and systems

- Medication administration record (MAR) in the EHR
- Barcode medication administration scanner
- Patient identification wristband
- Medication cart or automated dispensing cabinet
- High-alert medication list
- Adverse reaction and medication error report forms

Personal protective equipment

- Disposable gloves for topical or injectable medications

5. Procedure

Step	Task	Owner	Done
5.1	**Review the medication order** Before the scheduled administration time, review the order in the MAR for the medication, dose, route, frequency and any special instructions, and clarify with the provider if anything is unclear or incomplete. **Warning:** Never administer a medication from an order that is unclear, incomplete or looks like it may be a duplicate. Clarify with the prescriber first.	Registered Nurse (RN)	☐
5.2	**Check for allergies and interactions** Confirm the patient's allergy status in the EHR and check the pharmacist's interaction alerts before preparing the medication.	Registered Nurse (RN)	☐
5.3	**Perform the pharmacist verification** Confirm the order has been reviewed and verified by pharmacy, including dose range and interaction checks, before it is available in the medication cart or dispensing cabinet.	Pharmacist	☐
5.4	**Prepare the medication** Retrieve the correct medication from the cart or dispensing cabinet, check the label against the MAR three times, and prepare the dose according to the order and manufacturer instructions.	Registered Nurse (RN)	☐
5.5	**Perform an independent double-check for high-alert medications** For medications on the facility's high-alert list, have a second qualified nurse independently verify the patient, medication, dose calculation and pump settings before administration. **Checkpoint:** Every high-alert medication has a documented independent double-check before it is given.	Charge Nurse	☐

Step	Task	Owner	Done
5.6	**Verify patient identity at the bedside** Scan the patient's wristband or confirm two identifiers verbally, matching them against the MAR before giving the medication. **Checkpoint:** Patient identity is confirmed with two identifiers immediately before administration, not earlier in the shift.	Registered Nurse (RN)	☐
5.7	**Explain the medication to the patient** Tell the patient the name and purpose of the medication, ask about any new symptoms or concerns, and answer questions within your scope of practice.	Registered Nurse (RN)	☐
5.8	**Administer the medication** Give the medication by the ordered route and technique, following the manufacturer's instructions and facility policy for the specific medication form.	Registered Nurse (RN)	☐
5.9	**Document administration immediately** Record the time given, dose, route and your initials in the MAR right after administering, not in advance and not from memory later in the shift.	Registered Nurse (RN)	☐
5.10	**Monitor for response and reactions** Observe the patient for expected effects and any signs of an adverse reaction within the timeframe appropriate to the medication and route.	Registered Nurse (RN)	☐
5.11	**Respond to an adverse reaction** If the patient shows signs of an adverse reaction, stop any further doses as appropriate, notify the provider immediately, and follow the facility's emergency response procedure. **Warning:** Do not wait until end of shift to report a suspected adverse reaction. Notify the provider right away.	Registered Nurse (RN)	☐
5.12	**Report and review medication errors** If an error occurs or is discovered, notify the provider and charge nurse immediately, complete the medication error report, and monitor the patient as directed.	Charge Nurse	☐

6. Quality checks

- Every high-alert medication has a documented independent double-check.
- Barcode scanning compliance meets the facility's target rate.
- MAR documentation is completed within the required time of administration.
- Medication error reports are reviewed at the unit level within the required timeframe.

7. Records

- Medication administration record (MAR)
- Independent double-check log for high-alert medications
- Adverse reaction and medication error reports
- Pharmacist order verification log

8. KPIs

- Medication error rate per patient days
- Barcode scanning compliance rate
- Percentage of high-alert medications with a documented double-check
- Time from adverse reaction identified to provider notified

9. Common mistakes

- Documenting a dose as given before it is actually administered.
- Skipping the independent double-check for a high-alert medication when busy.
- Verifying patient identity from the room whiteboard instead of the wristband.
- Giving a medication from an unclear order instead of calling the prescriber.

10. Revision history

Revision	Date	Description	Reviewed by
1.0	September 15, 2026	Initial release	Ilia Pirozhenko

Approval

Prepared by	Approved by	Date

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