Standard Operating Procedure (SOP)

Medication Administration and Documentation Processes

This SOP details the **medication administration and documentation processes**, including accurate medication preparation, proper dosage calculation, patient identification verification, safe administration techniques, monitoring for adverse reactions, and timely, precise documentation. The purpose is to ensure safe and effective medication delivery, prevent errors, and maintain comprehensive records for patient safety and regulatory compliance.

SOP Number	[To be assigned]
Effective Date	[DD/MM/YYYY]
Review Date	[DD/MM/YYYY]
Department	[Department Name]
Prepared by	[Preparer's Name]
Approved by	[Approving Authority]

1. Purpose

To establish a standardized process for safe and effective medication administration, documentation, and prevention of medication errors, ensuring compliance with regulatory standards and safeguarding patient safety.

2. Scope

This SOP applies to all healthcare professionals authorized to administer medications within [facility name/organization].

3. Responsibilities

- All healthcare staff involved in medication administration must adhere to this SOP.
- Supervisors are responsible for monitoring compliance and providing relevant training.

4. Procedure

1. **Medication Preparation**
    - Verify prescriber's order for accuracy and completeness.
    - Check patient's allergies and contraindications.
    - Retrieve medication from designated storage.
    - Check medication label against the order (three checks: when taking from storage, before preparation, before administration).
    - Inspect medication for expiration date and integrity.
2. **Dosage Calculation**
    - Calculate dosage based on prescription and patient factors (age, weight, renal/hepatic function).
    - Double-check calculations as per policy, especially for high-alert medications (recommend independent verification).
3. **Patient Identification**
    - Use at least two patient identifiers (e.g., name and date of birth or MRN).
    - Verify identification with wristband and patient/family confirmation when possible.
4. **Safe Administration**
    - Use the "Five Rights": right patient, right medication, right dose, right route, right time.
    - Follow aseptic technique and proper route of administration.
    - Observe for correct swallowing or injection technique as appropriate.
5. **Monitoring for Adverse Reactions**
    - Monitor patient for immediate reactions post-administration.
    - Document and report adverse effects promptly following institutional policy.
6. **Documentation**
    - Document medication given (drug, dose, route, time) in the patient's health record immediately after administration.
    - Include any refusals, omissions, adverse reactions, and patient responses where relevant.
    - Sign and date each entry legibly.

5. References

- Institutional Medication Administration Policies
- Local and national regulatory requirements
- Relevant pharmacology and clinical guidelines

6. Appendices

- Sample Medication Administration Record (MAR) form
- Dosage calculation formulas
- High-alert medication list