# Standard Operating Procedure (SOP): Medication Administration and Reconciliation Processes

This SOP details the **medication administration and reconciliation processes**, covering accurate medication dispensing, verification protocols, patient identification, documentation requirements, monitoring for adverse effects, and reconciliation procedures during transitions of care. The goal is to ensure safe, effective, and consistent medication management to prevent errors and enhance patient safety across all healthcare settings.

## 1. Purpose

To provide a standardized approach for medication administration and reconciliation, minimizing the risk of medication errors, and ensuring continuity and safety of patient care.

## 2. Scope

This SOP applies to all healthcare staff involved in the prescribing, dispensing, administration, and documentation of medications in all patient care areas.

## 3. Responsibilities

- **Prescribers:** Ensure accurate and complete medication orders.
- **Nurses/Pharmacists:** Verify, administer, and document medications as per protocol.
- **Healthcare Staff:** Monitor and report adverse effects, participate in medication reconciliation during transitions of care.

## 4. Definitions

- **Medication Reconciliation:** The process of creating the most accurate list possible of all medications a patient is taking and comparing that list against the physician's orders.
- **Medication Administration:** The act of giving a medication to a patient as prescribed and documenting it appropriately.

## 5. Procedure

### 5.1 Accurate Medication Dispensing

- Dispense medications as per the prescriber's order, checking for clarity, dose, and frequency.
- Check medication label and expiration date.
- Double-check high-alert medications with a second qualified professional.

### 5.2 Verification Protocols

- Verify **right patient, right medication, right dose, right route, right time**, and right documentation prior to administration.
- Cross-check patient's allergies and previous adverse drug reactions.

### 5.3 Patient Identification

- Use at least two patient identifiers (e.g., full name and date of birth).
- Confirm identity verbally with the patient and with the medical record/wristband.

### 5.4 Administration and Documentation

- Administer medications as prescribed, ensuring patient understanding and consent.
- Document administration in the patient's medication record immediately after administration.

### 5.5 Monitoring and Adverse Effect Management

- Observe and monitor the patient for expected and adverse effects post-administration.
- Report and document any adverse drug reactions per institutional policy.

### 5.6 Medication Reconciliation

- Conduct medication reconciliation at every transition of care (admission, transfer, discharge).
- Compare the patient's medication list with new physician orders and resolve discrepancies.
- Involve the patient and/or caregiver in the reconciliation process.
- Document the reconciled list and communicate updates to all care team members.

## 6. Documentation

- Maintain clear, accurate, and timely records of all administered medications.
- Document all medication reconciliations, including changes, omissions, and rationale.
- Use approved forms or electronic systems adhering to confidentiality and regulatory standards.

## 7. Training and Competency

- All relevant staff must receive initial and ongoing competency-based training in medication administration and reconciliation procedures.

## 8. Quality Assurance and Audit

- Regular audits of medication errors, administration documentation, and reconciliation records to ensure compliance and identify areas for improvement.
- Immediate investigation and reporting of any adverse events or near-misses as per policy.

## 9. References

- Institutional Medication Policy
- National Patient Safety Goals
- Relevant regulatory agency guidance