SOP: Post-surgery Documentation and Recovery Care Instructions

This SOP details the **post-surgery documentation and recovery care instructions**, covering accurate recording of surgical procedures, patient monitoring protocols, pain management guidelines, wound care instructions, activity restrictions, medication administration, and follow-up appointment scheduling. The purpose is to ensure comprehensive patient recovery, minimize complications, and provide clear guidance for healthcare providers and patients during the post-operative period.

1. Purpose

To provide standardized procedures for post-surgery documentation and care, ensuring patient safety, continuity of care, and optimal recovery outcomes.

2. Scope

This SOP applies to all healthcare staff involved in post-operative care and documentation in the surgical unit.

3. Responsibilities

- Surgeons: Document surgical details and prescribe initial post-op care instructions.
- Nurses: Monitor patient recovery, administer medications, provide wound care, and document progress.
- Pharmacists: Verify medication orders and counsel on administration.
- Administrative Staff: Schedule follow-up appointments and manage patient records.

4. Procedure

1. Post-Surgery Documentation

- o Complete surgical record immediately after the procedure, including:
 - Date and time of surgery
 - Type and details of procedure performed
 - Surgeon and assisting staff names
 - Intraoperative findings
 - Immediate post-op status
- Update patient's medical record with operative notes and post-op orders.

2. Patient Monitoring

- Record vital signs as per protocol (e.g., every 15 mins for 1 hour, then hourly for 4 hours, then per shift)
- Assess pain, wound status, consciousness, and mobility regularly
- o Document all findings and escalate abnormal results promptly

3. Pain Management

- Follow prescribing physician's orders for pain medication
- o Assess pain scores at regular intervals
- o Document medication administered, response, and any side effects

4. Wound Care Instructions

- Follow sterile technique during dressing changes
- Inspect incision for signs of infection or dehiscence
- Document wound status and patient tolerance

5. Activity Restrictions

- Communicate mobilization instructions as per surgical protocol
- Assist with ambulation as indicated
- Document patient's ability to perform activities of daily living (ADLs)

6. Medication Administration

- Administer medications as ordered (including antibiotics, anticoagulants, etc.)
- Document time, dose, and route of administration

7. Patient/Family Education

- Provide verbal and written discharge instructions covering wound care, activity restrictions, warning signs, and medication schedule
- Ensure patient/family understands instructions; document education provided

8. Follow-up Appointment Scheduling

- o Arrange follow-up appointments per surgeon's instructions
- Provide written appointment details to patient/family
- Document scheduled follow-up in the medical record

5. Documentation Checklist

Task	Responsible	Completed (Yes/No)	Date/Time	Notes
Post-surgical notes completed	Surgeon			
Vital signs monitored	Nurse			
Pain assessed & managed	Nurse			
Wound status documented	Nurse			
Activity restrictions implemented	Nurse			
Medications administered	Nurse			
Patient education provided	Nurse			
Follow-up appointment scheduled	Admin			

6. References

- Hospital Post-Operative Care Policy
- National Surgical Patient Safety Guidelines
- Current Clinical Practice Standards