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Commentary

Post-Surgery Intensive Care: A Short Note

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COMMENTARY

A patient may be moved to the intensive care unit (ICU) for more intensive monitoring. Patients on artificial ventilation, patients recovering from heart attacks or severe surgery, patients in shock, and patients with acute renal failure all require intensive care. Clinical professionals in intensive care keep a careful eye on the patient minute by minute. You'll be taken to the recovery room once the surgery is over. This unit is also known as the post-anaesthesia care unit (PACU). Clinical staff in the recovery room will keep a careful eye on you as you recover from anaesthesia. The amount of time spent recovering is determined by the type of surgery performed and the patient's condition. The clinical staff may undertake the following when a patient is recovering (Figure 1);



Figure 1: Role of clinical staff in ICU

In the recovery room, a patient can help speed up his or her recovery by practicing some breathing and movement exercises. The clinical team will assist few things like; take few deep breaths as the fluids can build up in the lungs if lie flat for a lengthy amount of time. Pneumonia can be avoided by taking deep breaths that use the entire diaphragm and belly. Coughing is another practice which aids in the removal of chest secretions which is another strategy to avoid pneumonia is to do so. Turning is another phenomenon which helps as changing positions in the recovery bed stimulates circulation and deeper breathing, as well as relieving pressure points. Even leg and foot exercises Circulation is improved by moving the legs and feet. One of the issues is poor triage of high-risk patients who require immediate admission to the ICU after surgery. According to a prior study conducted in the United Kingdom, only about 15% of patients undergoing high-risk surgery were admitted to the ICU afterward. Only 53% of these admissions were scheduled, yet they accounted for 83.8 percent of the postoperative death rate. Appropriate triage of patients for immediate admission to the ICU, on the other hand, is difficult. While various triage scoring systems have been created, and many ICUs throughout the world use written criteria or triage algorithms for patient admission, these criteria are still subject to individual physician interpretation.

The emergence of unanticipated perioperative occurrences is another factor to consider. Several studies have found a link between unexpected intraoperative or early postoperative problems and an unplanned ICU hospitalisation. Following this, there is an increase in long-term mortality. Surprisingly, between 17 percent and 76.5 percent of the problems in these trials were shown to be iatrogenic and avoidable. This indicates that there are substantial areas for improvement in order to reduce unnecessary admissions. This also explains why a "unplanned admission to the ICU" can be used as a reliable clinical indicator of patient safety. Later in the postoperative phase, adverse occurrences can develop. Delayed admission to the ICU has also been linked to an increased risk of unforeseen complications following surgery and mortality. These issues are included in the "failure to rescue" definition, which is another clinical indicator that can be used to assess care quality. It is defined as the "chance of mortality as a result of a complication." However, unlike intraoperative and early postoperative difficulties, which are captured by the "unplanned admission to the ICU" indicator, the percentage of these issues that can be avoided is unknown.

Received:	03-January-2022	Manuscript No:	IPJICC-22-12732
Editor assigned:	05-January-2022	PreQC No:	IPJICC-22-12732 (PQ)
Reviewed:	19-January-2022	QC No:	IPJICC-22-12732
Revised:	24-January-2022	Manuscript No:	IPJICC-22-12732 (R)
Published:	31-January-2022	DOI:	10.35248/ipjicc-8.1.62

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Citation Premnath G (2022) Post-Surgery Intensive Care: A Short Note. J Intensive Crit Care. 8(1):62.

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ACKNOWLEDGEMENT

None

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CONFLICT OF INTEREST

The author has nothing to disclose and also state no conflict of interest in the submission of this manuscript.