Another major advantage of providing short-term intensive care in a developed recovery facility (OIR) is to alleviate that demand on the ICU service and therefore increase total critical care provision within an individual hospital trust. The continuum of critical care in our trust, for example, includes the elements of the ICU, HDUs and the OIR.

I agree with Jones and Harper (and Ziser and his colleagues) who are quite correct to point out the disadvantages and dangers in the inappropriate use of an ordinary recovery ward as either an ICU overflow unit or an ill-equipped area pressured into providing postoperative ventilation. The formal development of beds and staffing within recovery to OIR or POCCU standards is essential to achieve safe critical care for the surgical patient.

We prefer the term Overnight Intensive Recovery as it is descriptive of the duration, function and geography of the facility. It is crucial to persuade others that this is for postoperative surgical patients only, and that it occurs in a theatre recovery ward staffed by (trained and supervised) recovery nurses and supported by anaesthetic medical staff. Although in this context critical care is probably a better term than intensive care, it has to be accepted that this OIR activity will require a 1:1 nurse:patient ratio in order to manage ventilated patients, invasive monitoring and pharmacological support.

I do take gentle issue with Jones and Harper in their assertion that the development of the OIR at St Thomas' (and more recently at Guy's) Hospital, London was only for cardiac surgical patients. It should be emphasized that cardiac surgery is not a necessary ingredient in the development of OIR beds. However, whilst it is absolutely true that the original development of cardiac fast-tracking at St Thomas', and the use of the recovery ward for their postoperative management in the early 1980s, led to the development of the OIR, its function then, and now, also includes a significant non-cardiac workload. Currently, the annual throughput of both OIRs is around 300 non-cardiac patients, elective and emergency, from a wide number of specialties in addition to the cardiac surgical workload. Finally, our OIRs were created within rather than ‘adjacent to’ the recovery wards, which emphasizes the efficiencies in staffing and supervision that are achieved when both general recovery and OIR areas are integral to one another.

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Postoperative critical care: overnight intensive recovery

Editor—I read with interest the editorial by Jones and Harper describing the rationale for developing the Post Operative Critical Care Unit (POCCU) in the operating theatres at the Royal Liverpool University Hospitals. This elegant solution to the problems of providing short-term critical care for the surgical patient is, as they acknowledge, similar in many respects to the Overnight Intensive Recovery (OIR) concept which we have been actively promoting for a number of years.

The demands on the ICU are highly competitive and the elective, or even the emergency surgical, patient prioritizes poorly against other urgent or medical admissions. In our experience, the development of another existing resource, namely the recovery ward/postoperative care unit, together with the extended role of the recovery nurses, has made a significant impact on reducing operative cancellation rates and waiting times for surgical procedures requiring critical care.