Introduction

The term "recovery from anesthesia" to return to the preanesthetic state. Recovery is dangerous especially for significant number of patients and it can be a life threatening process best managed by prompt intervention delivered by skilled medical and nursing personnel. For anesthesiologists, involvement in optimizing recovering from anaestheia is one component of preoperative medicine. The recovery period starts as soon as the patient leave the operating room under the direct supervision of the anesthetisit ***(Aitkenhead and Smith, 2007)***.

The PACU should be located close to the operating suit to permit anesthesiologists and surgeons to be nearly and permit rapid return of the operating room if necessary. The PACU should have good access to immediate radiographic, blood bank, blood gases, and other clinical laboratory services. Having the PACU located near the ICU is also useful, especially because nursing staff is shared between the units.

The size of the units is determined by the surgical caseload of the institution. Approximately 1.5 PACU beds per operating room utilized are usually adequate. This is roughly equivalent to two beds for every four procedures performed in a 24-hour period. An open ward is optimal for patient observation; however, at least one isolation room is a helpful addition to every PACU for the management of that patient with either contaminated wounds or server immunosuppressant. A separate Pediatric PACU is also useful when the volume of pediatric cases is high ***(Diaconescu and Grecu, 2007)***.

The PACU is an area where anesthesiologists have a primary responsibility for managing patients in the immediate post operative phase. Anesthesiologists are the physicians responsible for the patient in this critical time of emergence and recovery and will be called upon not

just for "airway" emergencies, but also for decisions on pain management, managing patients' homodynamics, managing neurological status issues, nausea/vomiting, reviewing central line placements, and evaluating possible serious postoperative complications and anesthesiologists arrange appropriate consultations are needed and must be able to communicate with those consultants in an informed manner. Anesthesiologists also set the standards and make the assessments on when and where patients are discharged from the PACU ***(Lepousec et al., 2007)***.

The patient is transferred to the PACU after the surgical procedure, anesthesia reversal, and extubation (if it was necessary). The amount of time the patient spends in the PACU depends on the length of surgery, type of surgery, status of regional anesthesia (e.g. spinal anesthesia). and the patient's level of consciousness. Rather than being sent to the PACU, some patients may be transferred directly to the critical care unit. For example, patient who have had coronary artery bypass grafting are sent directly to the critical unit ***(Edler et al., 2007)***.

The patient is dischargd from the PACU when he or she meets established criteria for discharge, as determined by a scale. One example is the Aldrete scale, which scores the patient's mobility, respiratory status, circulation, consciousness. And pulse oximetry. Depending on the type of surgery and the patient's condition, the patient may be admitted to either a general surgical floor on the intensive care unit. Since the patient may still sedated from anesthesia, safety is a primary goal. The patient's call light should be in the hand and side rails up. Patient in a day surgery setting are either discharged from the PACU to the unit, or are directly discharged home after they have urinated, gotten out of bed, and tolerated a small amount of oral intake ***(Awad and Chung, 2006)***.