

Guidelines for Nutrition Support Treatment in Critically Ill Patients and Its Evaluation

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DESCRIPTION

It is impossible to overstate the value of nutrition in the hospital, particularly in the critical care unit. In addition to comorbidities including higher infectious morbidity, multiple organ failure, prolonged hospital stays, and disproportionate mortality, critical illness is frequently accompanied with a catabolic stress state in which patients display a systemic inflammatory response. Understanding the molecular and biological effects of diet in maintaining homeostasis in critically sick patients has advanced significantly over the past three decades. In the past, supplying exogenous fuels to critically sick patients in order to preserve lean body mass and assist them during the stress response has been considered of as an extra service. The feeding is believed to help lower the metabolic response to stress, minimize oxidative cellular damage, and affect immunological responses in a positive way. This approach has recently developed to represent nutrition therapy. The clinical course of a severe illness can be improved by early EN, appropriate macro- and vitamin supplementation, and strict glycemic management. Early nutrition support therapy, particularly when administered by enteral feeding, is regarded as a proactive therapeutic approach that may lessen the severity of a disease, lessen complications, minimize ICU stay, and enhance patient outcomes. We advise that all patients admitted to the ICU who is anticipated to have insufficient voluntary intake have their nutrition risk evaluated. Early EN treatment will likely be more beneficial for those who have a high risk for malnutrition.

Patients who had biliopancreatic diversion (with or without duodenal switch), gastric bypass, or sleeve gastrectomy are more likely to be vitamin deficient. These deficiency states should be assessed and treated in critically sick patients. Malabsorptive procedures are more likely to result in nutritional and metabolic

issues, such as biliopancreatic diversion and very long-limb Roux-en-Y gastric bypass. It is crucial to rule out a potential thiamine deficit before giving IV fluids that include dextrose. A daily multivitamin containing iron and vitamin B12, as well as calcium and vitamin D pills, are also recommended. The ideal vitamin supplementation plan is not yet agreed upon.

Once they have been altered, serum micronutrient levels should be monitored yearly. Dehydration and low oral intake are frequently tolerated and have no symptomatic effects in the majority of terminally ill patients, despite the fact that a drop in patient volitional intake typically causes worry for carers and families. The carer should anticipate and effectively address this anxiety in order to help debunk myths and lessen emotional pain. Rarely, cultural, ethnic, religious, or personal patient considerations could prevail over scientific findings and call for the administration of ANH. Unfortunately, there is presently inadequate information to properly describe the advantages and hazards of ANH in patients who are terminally ill.

According to scientific, moral, and legal perspectives, withholding and removing ANH are equivalent. To help healthcare practitioners make moral choices regarding whether to start, continue, or stop ANH, a number of professional organizations have released guidelines or position statements. Consistent themes include respect for patient autonomy and dignity, realistic therapeutic objectives, open communication between practitioners and patients, families, or surrogate decision makers, and engagement of an interdisciplinary ethics committee or panel consultation when problems cannot be addressed. If a dispute involving ANH cannot be addressed, maintaining care until it is; switching to equally competent, willing practitioners if it cannot; and never switching to an untrained, unwilling practitioner.

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