Distribution of medical equipment and medical resources in intensive care during Covid-19 in medical hospitals.

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Abstract

Medical equipment is essential in hospitals, and it also aids in the treatment of many medical disorders. In recent years, the healthcare business has seen the introduction of a wide range of innovative medical equipment. Every hospital requires medical equipment in order to deliver high-quality, cost-effective care. Medical equipment will have specific responsibilities and aims, but all medical equipment is meant to provide patients with treatment and safety. So, these are the functions of medical equipment. The progress of surgical equipment has lowered the amount of hospital stays and even allows doctors to manage complicated and serious situations. The advancement of medical equipment technology has enabled the medical profession to execute more sophisticated procedures.

Keywords: Intensive Care Unit, Covid-19, Medical equipment.

Introduction

This research investigates the short and long-term availability of medical equipment. The work is divided into two parts. The first component looks at the medical equipment inventory at the study institution. We examine the replacement, maintenance, and reinforcement of present medical equipment by evaluating local guidelines and gauging clinical personnel appreciation. As a result, the recommendation is to upgrade the current inventory of equipment as needed. The second portion examined demand in the short and medium term. We projected future demand with a horizon using Holt-Winters models. As a result of this poor performance outcome, we advised that the hospital gradually remedy the problem identified in the inventory. The findings indicate that general medicine inpatient demand tends to rise with time; for example, respiratory and genitourinary disorders have the biggest growth in general medicine inpatient demand. This increment did not include any additional upgrades to the projected inventory [1].

The electromagnetic interference of mobile phones with medical equipment is a critical concern for the medical safety of patients who use life-sustaining medical devices. This analysis focuses on the interference of mobile phones with implanted medical devices and medical equipment placed in key sections of hospitals. A detailed examination of the data indicates that mobile phones can interfere with the operation of medical equipment, with the specific effect and degree of interference depending on the technology used and the separation distance. According to the findings and suggestions of the research, in addition to reducing interference, keeping mobile phones a suitable distance away from medical devices and adopting technical standards can lead to their effective usage in hospital communication systems [2].

ICUs have become an essential feature of the health-care system since their widespread introduction more than a half-century ago. Although most ICUs are situated in high-income nations, they are becoming more common in low- and middle-income countries' health-care systems. A task group was formed by the World Federation of Societies of Intensive and Critical Care Medicine. To combine current models for ICU stratification, we conducted a scoping assessment of the peer-reviewed and grey literature. Based on these and task force member comments. An Intensive Care Unit (ICU) is a structured system for providing treatment to critically sick patients that provides extensive and specialised medical and nursing care to ensure the medical safety of patients who are utilising life-sustaining medical equipment [3].

Intensive care is a subspecialty of medicine that deals with the diagnosis, treatment, and follow-up of critically sick or wounded patients. On a variety of concerns, it requires input from other fields of medicine. A critical care specialist is trained to care for such patients around the clock. Different types of critical care units (ICUs) have been described based on his flexibility to make decisions in the ICU - open, closed, or semi-closed. Without a doubt, all critically ill patients should be assessed by an intensivist. As a result, it is believed that a closed ICU paradigm would be optimal. However, this is not always possible, and other models may be more appropriate in

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resource-constrained nations [4].

Second, doctors misinterpret the aims and methods of patient autonomy; third, the general public's great dread of rationing; and fourth, fee-for-service driven utilisation of modern medical technology and treatments that beget ICU expansion [5].

Conclusion

The abundance of high-quality information makes it impossible to address all of the issues about ICU admission, discharge, and triage. Despite these limitations, the Task Force members think that these suggestions provide a complete framework to help practitioners make educated decisions during the admission, discharge, and triage processes, as well as resolve concerns of nonbeneficial care and rationing. We must continue to develop preventative measures to lessen the burden of critical illness, educate our noncritical care colleagues about these treatments, and increase our outreach by establishing early detection and intervention systems.

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