

Waking up in intensive care: what you'll see and feel

What you will see and feel when you wake in intensive care — and why the confusion, the beeps and the tubes are all expected.

In hospital

Educational draft. Clinical review pending. Quotations retained from the original text are not verified member testimonials.

Waking up in intensive care is one of the strangest experiences of the whole journey — and knowing what you will see and feel takes most of the fright out of it.

Intensive care exists so the team can watch you closely through the first hours after surgery. Someone is always at the nurses' station, looking at screens that track your heart, breathing and blood pressure. You are the most watched person in the building.

What you will see

- Monitors above and beside you, with moving lines and numbers. The nurses read them constantly; you do not need to.
- Other beds, usually separated by curtains. The ward is busier than you expect — and busier at night than you would believe.
- Tubes and lines: an IV in your arm, sometimes a small tube in your wrist, a urinary catheter, and often a chest drain. Each one has a job and a plan for removal.
- Some people wake up still connected to a breathing tube, and cannot speak until it is removed. If that is you, the nurses will use pen and paper or yes-and-no questions. It comes out when you are ready, not on a fixed clock.

The sounds take getting used to: beeps, pumps, alarms. Most alarms are routine — the machine is asking for attention, not announcing danger — and the team answers them within seconds.

What you will feel

- Groggy and confused. Time gets blurry, and you may ask the same question ten times. That is the anaesthetic and the pain relief talking, not you.
- Thirsty, with a dry mouth. Sips of water or ice are usually allowed once the team says so.
- Cold, then hot. Blankets appear and disappear; shivering is common.
- Sore around the chest, especially when you cough or move. Say so — pain relief is part of the plan, and there is no prize for toughing it out.

Most people remember fragments — a voice, a light, a hand — rather than a continuous story. That is normal, and it means the sedation did its job.

“I kept asking what time it was, and the nurse answered the same way every time. After the fifth repetition I understood: patience is literally their job, and mine was just to rest.”

What helps

- Rest between checks. Sleep is not lazy here; it is the treatment.
- Keep early visits short. Seeing your family is medicine, but a few minutes is enough at first.
- Ask the nurses to write things down for you — what time it is, what happened — so you can stop holding it in your head.

What to ask your team

- When will the breathing tube come out, if it is still in?
- What are the alarms telling you, and which ones should I pay attention to?
- When will I move to the regular ward, and what has to happen first?

Take it to your team

The intensive care team expects confusion and questions — they see it every day. Ask them to explain what is on the screen, what each tube is for, and when it will come out. The more you understand, the less the room frightens you.

Call for help if

Once the breathing tube is out, call for help if you suddenly cannot catch your breath, if chest pain becomes sharp or worse, or if your heart suddenly races and will not settle. You are already in the safest place to be unwell — the call button is there for exactly this.

The days in intensive care blur for most people, and that is the point. The team's decisions guide every step, and the decisions about your care belong to you and your team.

Questions to take to my team

☐ When will the breathing tube come out, if it is still in?

☐ What are the alarms telling you, and which ones should I pay attention to?

☐ When will I move to the regular ward, and what has to happen first?

For discussion and personal reference. Your care team's individual instructions take priority. For an emergency, contact your local emergency service; do not wait for a community reply.