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Research paper

The challenges in caring for morbidly obese patients in Intensive Care: A focused ethnographic study

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ABSTRACT

Background: Critically ill morbidly obese patients pose considerable healthcare delivery and resource utilisation challenges. However little is known about the care of these patients in intensive care.

Objective: To explore medical and nursing practices and attitudes in intensive care when caring for critically ill morbidly obese patients.

Methods: A focused ethnographic approach was adopted. Participant observation of care practices and interviews with intensive care doctors and nurses were undertaken over a four month period. Qualitative analysis was conducted using constant comparison.

Setting: An 18 bedded tertiary intensive care unit in New Zealand.

Participants: Sixty-seven intensive care nurses and 13 intensive care doctors involved with the care and management of seven critically ill patients with a body mass index ≥ 40 kg/m².

Findings: Morbidly obese patients present significant physical and language challenges for intensive care practice. The physical shape of morbidly obese patients did not appropriately fit the different equipment used. Staff used specific knowledge of the patient's body size and shape to adapt care practices and keep patients safe and comfortable. There were also specific language challenges where staff expressed concern about what words were most appropriate to use to describe body mass when in the presence of morbidly obese patients.

Conclusions: Bariatric care pathways need to be developed that use more suitable body measurements to inform the use of bariatric equipment. Intensive care staff need to engage in debate about what is acceptable, respectful, and appropriate language in the delivery of bariatric patient care.

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1. Introduction

Obesity has become a common condition in many countries, and a global focus for public health.^{1,2} Obesity is of particular concern in New Zealand with 31% of adults identified as obese with significantly higher prevalence of 46% and 67% in Māori and Pacific adult populations, respectively.³ Morbid obesity is the fastest growing category of obesity in developed countries.^{4,5} This is significant given the particular health care needs of this population.

Morbid obesity is classified as a body mass index (BMI) of greater or equal to 40 kg/m². BMI, a measure of weight adjusted for height, is the most commonly used indirect method to assess body fat.^{2,6}

BMI categorises obesity into different levels and identifies the risks of co-morbidities associated with each category.⁷ As an indirect measure of obesity, BMI has been highly criticised for: its inability to differentiate between fat and lean mass; provide information on the distribution of body fat; and incorporate the variations in the ratio of fat to lean mass in different ethnicities.^{6,8} Waist circumference, and waist:hip ratios are used to complement clinical data regarding fat distribution and health risk.^{6,7}

The critically ill morbidly obese patient places specific demands on intensive care services as a result of: prolonged mechanical ventilation needs and tracheostomy tube placement;^{9,10} increased length of intensive care stay^{11,12}; and increased respiratory and wound complications.^{9,13} This requires increased staffing support and specialist bariatric equipment.¹⁴

Despite these frequently cited challenges, the current intensive care literature provides little, if any, detail on how the size and

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shape of the morbidly obese patient challenges everyday intensive care practice. Furthermore, whilst there is evidence of the presence of weight bias in healthcare and the negative attitudes held towards obese and morbidly patients,^{15,16} no studies explore this area in the intensive care setting.

This is the second paper reporting findings from a study that explored how doctors and nurses in intensive care perceive and manage critically ill morbidly obese patients. Our first paper focused on the findings of how socially awkward moments, caused by social stigma, between staff and morbidly obese patients during care were managed.¹⁷ In this paper we report findings on the physical challenges of caring for morbidly obese patients and language challenges that pre-empted social awkwardness observed when caring for this patient population.

2. Methods

Using focused ethnographic methods, this study adopted a social constructivist paradigm that acknowledges social reality is constructed by and between individuals, who generate their knowledge and meaning from their experiences and ideas.^{18,19} Focused ethnography enables a distinct issue or shared experience within a culture or specific setting to be explored.^{20,21} Attention is focused on the specific activities and shared features of individuals in the subgroup when engaged in practices related to the distinct issue.^{20,21} This approach enabled the study's aim of understanding the 'situated' experiences of intensive care staff providing care to a subgroup of patients who were morbidly obese, to be met. Ethnographic data collection methods of participant-observation and single face-to-face interviews were conducted.

An insider perspective was adopted for this study as the primary researcher (CH) worked in the study site, and had done so for the previous seven years. The insider position is often the approach used by nurse researchers when researching not only their own specialty practice area but also their own workplace.^{22–25} The knowledge and pre-existing relationships of this insider position were used to inform fieldwork. The first author has been closely involved in the challenges of risks and other care issues for critically ill patients, particularly those people who are morbidly obese, and is a specialist educator in the fields of critical care and bariatric nursing. The second and third authors were her research supervisors.

The study setting was an 18 bedded tertiary intensive care unit (ICU) in New Zealand. Participants were ICU doctors and nurses who cared for obese patients in this unit. All ICU staff were invited to participate. Staff caring for morbidly obese patients, who were not undergoing weight loss surgery and expected to remain in the unit for more than 12 h, were observed. Informed written consent was obtained from all participants. Staff were consented prior to the data collection period whilst patients were consented to be observed at the time of data collection. For patients who were unconscious and ventilated, a family assent form was signed and retrospective consent sought from the patient. All patients were deemed to be mentally competent by the intensivist on duty and were cognitive of their surroundings at the time of consent. Eight patients were identified as eligible for the study, of which seven consented. The other eligible patient was unconscious on admission, and the severity of his head injury and the potential for him to never be in a position to formally consent was of concern. Therefore, the enrolment process was not pursued. No participants withdrew consent during the study.

Over a period of four months, ethnographic fieldwork techniques of participant observation and ethnographic interviews were conducted. The 'observer as participant' role,²⁶ was adopted during the fieldwork, where observation was favoured over

Table 1
Data sources.

Participants	n = 80
Nursing staff	
• Nurses observed in practice and interviewed	25
• Nurses observed only	28
• Nurses interviewed only	14
Medical staff	
• Doctors observed in practice only	8
• Doctors observed in practice and interviewed	5

participation.²⁷ Observations of staff occurred in all clinically designated areas of the unit and the staff room. The primary focus of the observations included: handovers and ward rounds, personal cares, and conversations between staff, and staff and patients. Interviews were conducted by the primary author and focused on four key areas: nurses' and doctors' experiences of caring for morbidly obese patients; personal thoughts and beliefs about obesity; resources and education opportunities about care and management of morbidly obese patients; and specific questions regarding interactions observed in the field. Interviews were audio-taped and transcribed verbatim.

Analysis of the data was conducted in three stages using the constant comparison technique²⁸: 'deconstruction' where data was systematically broken down into concepts²⁹; 'construction', where the concepts were reassembled into a new 'second order'³⁰; and 'confirmation' where the conceptualisation was constructed into a descriptive narrative.³¹ Analysis of the data was conducted by the primary author and verified by the second and third authors. Findings were discussed with a sample of the study participants to enable further verification.

Due to the dual identity of the primary author as a senior nurse and researcher at the study site, the role and expectations of the researcher with regards to safeguarding patients from harm were agreed by the nursing and medical leads at the hospital. How and when the researcher would intervene if a patient's welfare and safety was compromised, were agreed and communicated to all participants. Direct patient care was not undertaken by the researcher. Ethical approval was given by Health and Disability Ethics Committee of New Zealand (Approval CEN09/06/033).

3. Findings

Sixty-seven registered nurses, 13 doctors and seven patients participated in the study (Table 1). One hundred and sixty seven hours of patient observation was undertaken over 21 days with an average of 12–16 h per day. Interviews lasted between 20–80 min. Pseudonyms are used in all data excerpts.

Two themes were developed from the data. These identified that morbidly obese patients presented significant physical, and language challenges for ICU practice.

3.1. Physical challenges

The physical body of morbidly obese patients presented specific care challenges in ICU. This was because weight and not physical shape of the patient was used to assess the equipment required to nurse the patient. With the exception of the standard ICU bed (safe carrying capacity 267 kg), the weight limit of standard nursing care in ICU at the time of the study was 150 kg. Beyond this weight, specialised equipment, such as the commode and shower trolley, had to be resourced from a central equipment store or hired from an equipment company or the fully equipped bariatric ICU isolation room (weight capacity of 500 kg) utilised. The weight range of patients in this study was 122–167 kg, with a BMI range

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