



Saskatchewan Chapter of the Canadian Association of Critical Care Nurses

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Special Points of Interest in this Issue

*How to win free
tuition to attend
Dynamics 2007*

*Get to know
your CACCN
Executive*

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President's Message— Frankie Verville RN, BSN CNCC(C)

I am very pleased to have assumed the Saskatchewan Chapter presidency of the Canadian Association of Critical Care Nurses for what is undoubtedly going to be an exciting year.

This year the annual CACCN conference 'Dynamics' is being held in Regina, Saskatchewan and I am very hopeful that this will encourage Saskatchewan Critical Care Nurses to join our organization. We all face numerous challenges within our workplaces and conferences of this calibre allow us to network, teach and learn with like-minded colleagues from across Canada. The knowledge acquired at these events ensures the provision of expert critical care nursing to all members of this country.

My goals for this coming year are to: firstly, improve the linkages between all of the Critical Care Units within Saskatchewan, secondly, to identify and support the educational needs of critical care nurses in the province and thirdly, increase the chapter's membership. I look forward to hearing and working with all of you in the upcoming year.

Vice-President's Message-Sarah Sidebottom RN

Once again, it is my privilege to represent the CACCN Saskatchewan chapter for another year. I look forward to this year for a number of reasons. The first one, of course, is that we get host the national conference, Dynamics. This is a fabulous conference that touches on a wide variety of topics pertaining to critical care nurses. Along with this conference I expect our membership numbers increasing due to the conference being so close to home. With Dynamics being so close to home, it will be a privilege to sponsor a large number of our chapter to go. Keep your eyes open on sponsorship opportunities.

The second excitement of this coming year is working with our fabulous executive. We've added a few new people who have great new ideas. But along with these fabulous people, we need you. We need you to be involved - whether it's coming to our monthly meetings and giving input, or coming to our education days, or volunteering in our fundraisers – WE NEED YOU!!!! I would love to hear from you – any questions or comments or ideas.

Obesity and Ethics: Bariatrics, the Big Patient Problem in Critical Care

Reviewed by Marian Hutchinson RN

Bariatrics is a subspecialty of medicine that addresses the challenges and unique care issues often presented by obese and morbidly obese individuals.

Obesity is a growing health problem that contributes to numerous life-threatening or disabling disorders, including coronary artery disease, hypertension, type 2 diabetes mellitus, hyperlipidemia, degenerative joint disease, and obstructive sleep apnea. Significant weight reduction in the morbidly obese improves or reverses associated illness and benefits well-being.

Obesity is a significant problem in Canada as well as most of the Western world. Newfoundland and Labrador has the highest overall provincial rate of adult obesity at 38%, compared to the national average of 29%. Correlating with the prevalence of overweight and obesity, NL has the highest provincial rate of type 2 diabetes and the highest mortality rate in the country due to cardiovascular disease, including heart disease and stroke.

Childhood obesity is becoming epidemic because there is less emphasis today on physical activity. Children not only burn less calories, they eat more processed foods, which have more calories and fat.

Healthcare professionals are increasingly encountering obesity in all clinical settings. Obesity adversely affects the patient's functional status and quality of life. From the onset of care, obese patients are more challenging because diagnosis is difficult and treatment and procedures are more complicated and time-consuming.

Obesity, and especially morbid obesity, is a unique health condition that requires unique planning. There are unique challenges in each specialty area - Critical care, Emergency, Medicine, Surgery, Diagnostic imaging, Facilities, Medical/Surgical supplies, and Rehabilitation.

US Center for Disease Control has estimated that obese patients cost 37% more than people of normal weight (CDC 2004). This percentage increases as we focus specifically on bariatric patients separate from mild and moderately obese.

Bariatric Surgery is an option for some obese patients. It can be seen as a life saving, medically necessary intervention that potentially reverses the inevitable trend to fatal medical conditions. At the other extreme it can be seen as a technical fix for choices with regard to eating and exercise. The surgery has risks and represents a significant cost. *(Continued on page 3).*

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Obesity and Ethics: Bariatrics, the Big Patient Problem in Critical Care

(Continued from Page 2)

Ethical issues involved in the safe care of bariatric patients include:

Safety - Many bariatric patients require assistance with mobility and ambulation. This contributes to both patient and staff safety concerns. Non-manual methods are required for patient movement and repositioning. Prevention of workplace injury among Health Care professionals is a primary concern.

Equipment – There is a limited amount of equipment available and the cost can be a factor in availability. There are weight limits associated with some diagnostic and treatment equipment.

Stigma – is a concern and needs to be managed. Obesity has come to be an undesirable attribute.

Limited resources must be allocated in a way that balances the needs and priorities, treats everyone fairly, and can justify decisions to limit services based on adequate clinical and ethical considerations.

Staff members have a right to work in a safe environment where equipment, education and monitoring eliminate avoidable injuries.

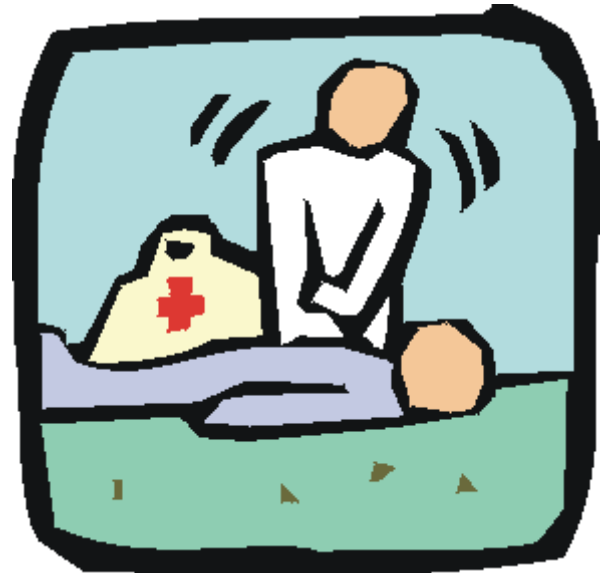
Presentation @ Dynamics 2006 by Dr. Rick Singleton, Elaine Warren

Family Presence During Resuscitation: Perceptions of Family Members and Health Care Providers – A Study In Progress

Reviewed by: Janis Fernandez

In the past, it has been standard procedure to have family members leave the room when their loved one is being resuscitated. This situation has been equated to expectant fathers not allowed to be present in the delivery room with the mother and child. It was thought at the time that the father's presence would be disruptive, another source of infection, another body taking up space in small quarters, possible lawsuit, and the father might require attention (i.e. fainting). We now routinely have fathers present in delivery rooms, and their presence is now almost expected. Similarly, there is now a push in current practice for family members to be present during resuscitative efforts of their loved one.

One of the reasons family presence is controversial is because it was believed that the psychological impact would be too difficult on the family member to watch their loved one being resuscitated. Now, we are realizing that family members are usually the ones who are with their loved one when they first require resuscitation, and many of them are initiating CPR at home before help arrives on the scene. They then usually travel with EMS to the hospital where they are then left in the waiting room, while resuscitative efforts continue behind closed doors. Downey (2005), reports that family members left in the waiting room experience high levels of stress and anxiety.



Family members have expressed the desire to be present during resuscitation efforts. This gives them a sense of peace, knowing that everything possible was being done for their loved one, and allowed them to be present during those final moments of life. Many family members find it very distressing and unnerving to leave their loved one to die with only strangers present. Family presence also helps the family to better understand the seriousness of the condition and helps to give closure. Other benefits may include: being able to say goodbye, aid bereavement, allows family members to see that their loved one is treated with respect and dignity.

Exclusion of family members is also being questioned since survival to discharge after in-hospital cardiac arrest is seldom greater than 15 % (American Heart Association, 2000), and contrasts with principles of family centered care. Myers et al (1998) surveyed 25 family members and found that 80 % would have wanted to be present and 96% believed that the choice should be left up to the family members. (Continued page 5).

Family Presence During Resuscitation

Research shows that it is the attitudes and beliefs of the doctors and nurses involved that are the major obstacles to family presence during resuscitation

(Continued from page 4). A facilitator is someone whose only role during the resuscitation effort is to provide support to the family members. The facilitator may be a nurse or a social worker who is familiar with the resuscitation process. They decide which family members should witness the resuscitation and prepare the family before entering the scene. They provide support as they stay with the family members at all times.

Currently, research shows that it is the attitudes and beliefs of the doctors and nurses involved that are the major obstacles to family presence during resuscitation. Fear has been noted as the primary reason. Fear of legalities, emotions evoked, interruption of staff performance, and fearful of the lack of control (Belanager & Reed, 1997). There is also a fear that the experience may be too traumatic for those related to the patient (Robinson et al., 1998). Hanson and Strawser (1992) performed a nine year study at Foote Hospital (MI). This was a retrospective survey of 47 bereaved families. Of those present during the resuscitation, 76% felt their adjustment to death of loved one made easier by this experience. It is important to note that there were no legal ramifications as a result of families being present during resuscitation.

Canadian research is currently underway, but the American statistics are showing that the benefits of family presence during resuscitation far outweigh the disadvantages. Family presence during resuscitation is starting to make new waves across Canadian hospitals.

Support/ position statements regarding this issue have been issued by:

- Emergency Nurses Association (1995)
- American Heart Association (2000)
- American Association of Critical Care Nurses (2004)
- Canadian Association of Critical Care Nurses (2005)
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Based on presentation by Sheila Bowles, Dr. Wendy Fallis, Asha Pereira @ Dynamics 2006 St. John's, NL

Get Involved with the Saskatchewan Chapter

Your local chapter is interested in providing services that meet your needs. Are there educational topics that you would like us to include at our next conference? Email us or better yet join us at one of our monthly executive meetings. Monthly meeting date, location and time will be sent to chapter members.

Dynamics

The Saskatchewan Chapter will be providing sponsorship to chapter members towards the cost of attending Dynamics 2007 in Regina, Saskatchewan – October 21 – 23, 2007. Applicants are invited to submit a letter of application indicating why they are interested in attending Dynamics 2007, their past participation in CACCN activities and how they will contribute to CACCN over the next year.
Executive committee members are not eligible.

Requirements of award winners:

1. Attend the annual general meeting of CACCN at Dynamics.
2. Attend all four days of dynamics workshops
3. By December 1, 2007, provide a review of at least one of the sessions attended. This review will be published in the chapter newsletter
4. DEADLINE IS AUGUST 31, 2007

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Frankie Verville

[Email Frankie Verville](#)

Vice President

Sarah Sidebottom

[Email Sarah Sidebottom](#)

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[Email Marian Hutchinson](#)

Secretary

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Education

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Publications

Patricia Henneberg

[Email Patricia Henneberg](#)

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