SNiG STAFF NURSE INTEREST GROUP

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Fall Newsletter

Reflections on Nursing & Current Events!

Change of a different kind happened to us this fall and perhaps we have lost some of our innocence in Ontario.

We have had the senseless murders of two members of our armed forces, an attack on parliament, and the Ebola virus remains a menace in West Africa and a concern here in Canada.

It is hard to go to work sometimes with all these unsettling events. Yet as nurses, we are needed at point of care 24/7 .

P.R.N. we do go into harm's way, as an Ottawa nurse did at the National Cenotaph. In spite of the danger surrounding her she rushed to the fallen soldier to try and save his life. Although futile in the end, it is comforting to know that the last words the soldier heard were compassionate and kind.

Our colleagues in Africa have been facing potential harm, even death everyday as they fight the Ebola virus, and they need to be thanked for their efforts.

Nurses **do** and **can** make a difference in these difficult times!!

Also please pause on November 11th to remember and honour those who sacrificed their lives for our Canadian freedoms and democracy.

Inside this issue:

Ebola update: Your Safety Concerns have been heard

From RNAO Update

First, a big thanks to those of you who have emailed or called us this week with concerns about the levels of preparedness in your workplaces should a patient be diagnosed with the Ebola virus, and the related safety concerns for you and your health-care colleagues. RNAO heard you and acted swiftly by contacting Deputy Minister Bob Bell and Minister Eric Hoskins and they listened. We drew attention to nurses' concerns on Wednesday, urged action, and got an immediate response. See more at: RNAO Ebola update

When Medicine is Futile by Barron H. Lerner MD Retrieved from NY Times October 24, 2014

My father would have been thrilled to read "Dying in America," a new report by the Institute of Medicine that argues that we subject dying patients to too many treatments, denying them a peaceful death. But he would have asked what took us so long. A physician from the late 1950s to the late 1990s, my dad grew increasingly angry at how patients died in this country, too often in hospitals and connected to machines and tubes he knew would not help them.

He placed some of the blame for the situation at the feet of bioethics and patients' rights, two movements that I, as a young physician, had fiercely advocated. Doctors, he believed, had abrogated their duties in preventing — and, if necessary, thwarting — patients from pursuing inappropriate end-of-life interventions. We should heed my father's advice. Physicians need to reclaim some of the turf they have ceded to patients and families.

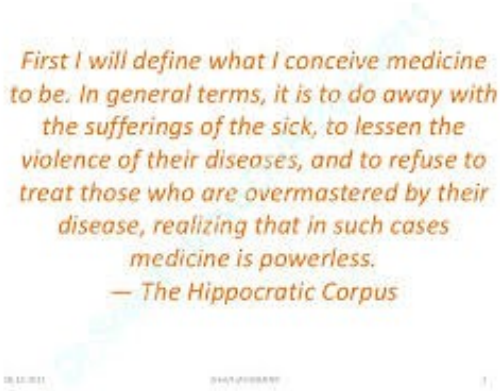
My father was an unlikely proponent of what came to be known as the "medical futility" movement in the 1990s. He was an infectious disease specialist, trained to diagnose and cure complicated infections. For much of his early career, he did just that. It was a heady time. Thanks to penicillin and other antibiotics, my dad was able to cure once-fatal infections like tuberculosis.

But as his career progressed, he found himself increasingly consulted on different types of patients. Elderly, frequently from nursing homes and suffering from dementia or cancer, these patients would be admitted to his hospital with an infection, like pneumonia.

Treating these infections, and the hospital-acquired ones that sometimes followed, did not make these people better. At best, the antibiotics preserved their poor quality of life. More often, they returned home without an infection but even sicker than when they had arrived. Even worse, many died on respirators in intensive care units, having been offered interventions that had no chance of working.

Because my father kept journals, I was able to learn about specific cases that raised these issues. One of his patients was an elderly man who, following the repair of a broken hip had experienced months of complications and infections. My dad's role, he wrote, "was to juggle his antibiotics, risk severe toxicities from the multitude of drugs employed and constantly readjust and re-dose according to the circumstances."

Another patient, despite having severe dementia, was connected to a feeding tube and a respirator, through a hole in his windpipe. The patient was "never going to get better," my father wrote, and yet "his family will not accept that reality and continues to pray for a miracle, which will not be forthcoming."
My dad concluded that he and his colleagues were ignoring the medical realities. Infections were the way that such frail individuals were supposed to die, the "final straw in the deterioration of so many of the body's vital organs and functions." Yet somehow they had become things that needed to be treated.



The medical futility movement, which argued that doctors should be able to withhold interventions that they believed would merely prolong the dying process, did not experience great success. Physicians declaring things to be "futile" sounded too much like the old system of medical paternalism, in which doctors had made life-and-death decisions for patients by themselves. It was this mind-set that bioethics, appropriately, had sought to correct. Patients (or their families) were supposed to be in charge.

Institute of Medicine new report
Dying in America

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Futility cont'd

The problem was that the new system did not account for one thing: Patients often demanded interventions that had little or no chance of succeeding. And physicians, with ethicists and lawyers looking over their shoulders, and, at times, with substantial money to be made, provided them.

This week's report builds on the futility movement and earlier efforts to improve death and dying. For example, it advocates that Medicare and other insurers pay physicians to talk to their patients about end-of-life care. It seeks to improve funding for home health services that would keep extremely ill patients out of the hospital. And it strongly promotes better training of young physicians in palliative care.

My dad would have favored all of these initiatives. But he would have wanted something else as well: for doctors to be bolder and more courageous, to see their duty not simply as providing options but as making sure patients got the most appropriate care, even if that meant saying no to specific demands.

My father carried his near-obsession with medical futility to questionable extremes. Once, he even covered a newly dead patient — who had been hospitalized for months and was in constant agony — with his own body, to stop his colleagues from trying to revive her.

Although I remain very uncomfortable with what my dad did that day, I have to admire what he wrote down afterward. He had acted "in the name of common, ordinary humanity," in line with his career-long duty to relieve "the pain of my patients who can't be cured."

Check This Out: *From the archives of the Canadian Nurses Association Ethics in Practice:* *Futility Presents Many Challenges For Nurses*
Helpful strategies when End of Life Care Considered

SNIG Reads! Have a Little Faith by Mitch Albom

Have a Little Faith is a book about a life's purpose; about losing belief and finding it again; about the divine spark inside us all. It is one man's journey, but it is everyone's story. Albom's first nonfiction book since *Tuesdays with Morrie, Have A Little Faith* begins with an unusual request: an 82-year-old rabbi from Albom's old hometown asks him to deliver his eulogy. In the end, as the rabbi nears death and a harsh winter threatens the pastor's wobbly church, Albom sadly fulfills the last request and writes the eulogy. And he finally understands what both men had been teaching all along: the profound comfort of believing in something bigger than yourself.

Nursing – Shift Work – Diabetes – Control!!

By Sandra Dennison BScN RN CDE Diabetic Nurses Interest Group

Shift work can put a strain on your health whether you are a person living with diabetes or not. The mental and physical stress that results from shift work influences the body's "circadian rhythm" which disrupts the internal clock and the regulation of daily processes such as hunger, fatigue and blood glucose control .

Some shifts are worse than others. The night shift, or the rotation of the shifts, and the speed at which they change can really increase the stress levels experienced by workers.

Which shift is the best to work?

Shifts that rotate every 2 to 3 days and move "forward" (from morning, to afternoons to nights) and not the other way around are the healthiest.

A few things to remember when working shifts include the following:

A: Diabetes is unique to each individual and so the person with diabetes should work with their diabetes care team (very important step) to have their own unique and regularly reviewed plan for their workplace.

B: Communication, cooperation and accurate information will encourage a knowledgeable, healthier and more productive environment.

C: Diabetes is a private matter and human rights legislation specifies that an employer must accommodate an individual with diabetes up to the point of "undo hardship". The employer is not psychic and in order to alter an employee's work schedule to include breaks, glucose monitoring and medication administration people who work shifts should consult with their diabetes educator team and employer.

With the new medications, new insulin types and new infusion devices there is a routine that will work for you no matter what shift you work. As well if there is a risk of hypoglycemia co-workers should be included in recognition and treatment of hypoglycemia in order to avoid an emergency, embarrassment or discrimination in the workplace.

Millions of people living with diabetes manage their disease very well both off and on-the-job and many are employed in most occupations.

For more information consult with the local office of the provincial human right commission (www.chrc-ccdp.ca) or Diabetes in the Workplace: A Guide for Employers and Employees (/diabetes-and-you/know-your rights/employment-discrimination-your rights/diabetes-in-the-workplace-guide-for-employers).

Your State of Mind "Feeling Happy" Key to Life-Long Fitness

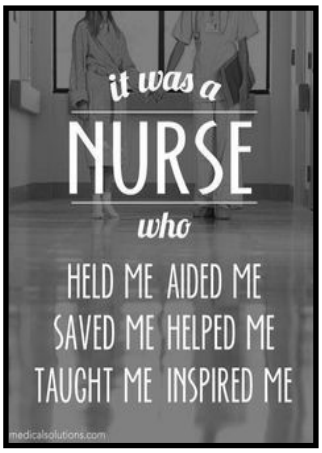
New research published in the *Canadian Medical Association Journal* reveals a link between people who try to enjoy life to the fullest and better overall health. In fact, researchers suggest fretting less may protect us from the harmful effect of stress hormones.

- Feeling down in the dumps on a regular basis places you at a three times greater risk for developing physical problems later in life.
- Feeling happy may be the secret to lifelong fitness, and reduced risks of depression

Chatelaine April 2014

A Guide to a Happy Life

In life you find that one of the most desirable qualities you can find in a person is flexibility. The ability to change with changing times, to face adversity with the same attitude one would have in facing victory.



Ban Medical Tourism!

As Canadians, we value our publicly funded, not-for-profit health system, where everyone is given equal access to care.

To protect this system, RNAO stands at the forefront of a movement to ban a profit-driven practice that threatens the foundation of Medicare. A number of Toronto-area hospitals have been engaging in medical tourism – raising millions of dollars by actively seeking and treating international patients on a pay-for-care basis.

RNAO worries this represents a shift to for-profit health care, creating a system where those who pay access care ahead of others. - See more at: RNAO Ban Medical Tourism

Influenza!

Seasonal influenza, commonly known as the flu, is an infection in the airways caused by the influenza virus. It's called 'seasonal' influenza because the virus circulates annually in the winter season in Canada. In addition to seasonal influenza, you have probably heard about avian influenza and pandemic influenza.

Seasonal influenza is a contagious respiratory illness caused by the influenza virus. It is easily caught and easily spread. Influenza typically starts with a headache, chills and cough, followed rapidly by fever, loss of appetite, muscle aches and fatigue, running nose, sneezing, watery eyes and throat irritation. Nausea, vomiting and diarrhea may also occur, especially in children.

Influenza also lowers the body's ability to fight off other infections which can lead to pneumonia, bronchitis or other complications. In addition, influenza can worsen a current medical condition such as diabetes, lung disease, heart disease, kidney disease or cancer. Between 4000 and 8000 Canadians can die of influenza and its complications annually, depending on the severity of the season.

Reference

Canadian Immunization Guide. Evergreen edition. http://www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php (external link)

How to Avoid Getting the Flu!

The seasonal influenza vaccine is safe and effective and remains the best protection against influenza viruses. Everyone over the age of six months is encouraged to get the vaccine.

It is especially important for those who are more likely to get seriously ill or suffer complications if they catch the flu. Getting the flu shot every year is important because the vaccine is reformulated annually to protect against the most current strains of the virus expected to be circulating during flu season.

This year's flu vaccines protect against specific influenza viruses and strains that are expected to make people sick this winter. Fightflu.ca

Have you had your flu shot?

Vanessa Burkoski President RNAO and SNIG member getting her flu shot!

Protect your family and friends!

In addition to getting the flu shot, you can protect yourself and your family from infection during the flu season by taking the following steps :

1:Clean hands frequently.

2:Cough and sneeze into your arm, not your hand. If you use a tissue, dispose of it as soon as possible and wash your hands.

3:If you get sick, stay home.

4:Keep your hands away from your face.

5:Keep common surface areas – for example, doorknobs, light switches, telephones and keyboards – clean and disinfected..

6:Eat healthy foods and stay physically active to keep your immune system strong.

Fightflu.ca

National Advisory Committee on Immunization Statement on Seasonal Influenza Vaccine for 2014-2015

Contact us at
frontlinenurse@yahoo.ca

You can find us on the web!

http://snig.rnao.ca

http://www.lifeofanurse.com

Leadership Caring Advocacy

The Staff Nurse Interest Group (SNIG) representing all regions in Ontario believes that staff nurses provide a leadership role during these constant times of transition when there is an acute need for renewal and reinvesting in ourselves and in our profession .

Our mandate

- To strengthen communication with our members and ensure we care for ourselves and for others.
- To value continuing education and professional growth and development.
- To use technology to provide knowledge, inspiration and to celebrate our staff nurse role.

Do you know that RNAO webinars are archived?

SNIG STAFF NURSE INTEREST GROUP

SNIG Cooks!

Pumpkin muffins a la Ros

These spice-laden treats will get you in the fall spirit!

Any leftover pumpkin puree freezes well, just scrape out of the can and into a zip top bag with air removed.

(bonus points if you measure and write the amount on the bag!), it keeps well for several months.

Ingredients:

3 cups all purpose flour
2 cups granulated sugar
2 tsp baking soda
1/2 tsp baking powder
2 tsp ground cloves
2 tsp ground cinnamon
2 tsp ground nutmeg
1 tsp ground allspice
1 tsp salt 2 cups pumpkin puree (*not pie filling) 2/3 cup vegetable oil 3 eggs

Preheat oven to 350 degrees. Line 24 muffin cups with paper liners.
In a large bowl, mix together dry ingredients. Mix wet ingredients in a medium bowl, then add to dry and stir until just combined. Fill muffin cups 2/3 full. Bake for 20-25 minutes or until a toothpick comes out clean.