€5.75 Vol 32 No 3 April 2024

WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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Cavan nurses lead in cancer care

Nurse-led oncology unit celebrates 25 years

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1) WHO 2021, key facts document

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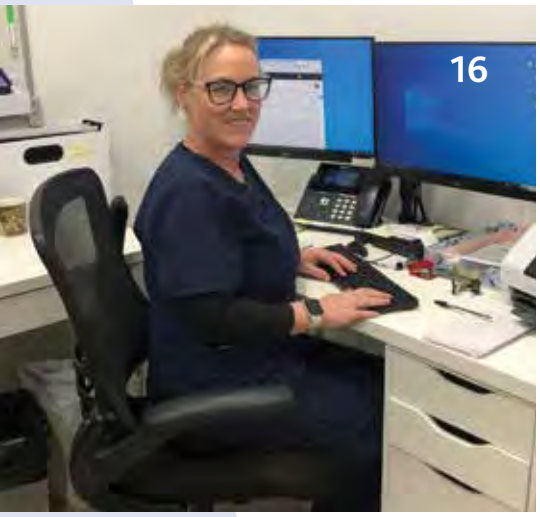

On the cover
(l-r): Deirdre Brady, senior nurse oncology; Alice Ryan, oncology liaison CNS; Dympna McPhillips, oncology CNS; Nora Donohoe, multi-task assistant; Nicola Galligan, senior nurse oncology; Margaret Gilmartin, CNM3 oncology, haematology and infusion suite; Sharon Fitzpatrick, ADON; Claire Smith, haematology CNS; Sheila O'Hagan, healthcare assistant; and Rose Mary Smyth, oncology ANP, all from Cavan General Hospital

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LIVING

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WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 39,000** members of the INMO. It is published eight times a year and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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WIN INMO Irish Nurses and Midwives Organisation
World of Irish Nursing & Midwifery

(ISSN: 2009-4264)
Volume 32 Number 2
April 2024

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WIN – World of Irish Nursing & Midwifery is published in conjunction with the Irish Nurses and Midwives Organisation by **MedMedia Group**, Specialists in Healthcare Publishing & Design.

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Pay proposals accepted by majority vote

BALLOT results on the latest public sector pay proposals concluded with INMO members voting in their favour. Nurse and midwives' pay will now be agreed for the next 30 months, unless there is a repeat of the recent extraordinary inflation rises. Members should be assured if there are any additional pressures on the cost of living that unions are able to go back to the table to negotiate with government. It was clear during the balloting period that members saw the benefit of their membership first hand by returning a strong endorsement of the trade union negotiated proposals.

During information and balloting sessions that were held in workplaces around the country, many of you expressed that issues relating to long-standing salary and allowance anomalies need to be dealt with in the local bargaining clause.

At the time of going to print, all the large public sector unions have returned a majority yes vote to the public sector pay proposals. If the overall position of all trade unions is in favour, it means that the opportunity will be there for members to have their say on the local bargaining clause. This will be a new chapter for membership participation within our democratic structures.

The Executive Council, branches and sections will have a central decision-making function to determine the approach the INMO takes. This is a very exciting time and will be the foundation on which the next generation of activists within our union is built.

Trade union membership is a choice in this country. It is a choice that I am proud to report the majority of nurses and midwives continue to make. Trade union membership generally has been in decline in recent times, however currently the statistics show that the majority of trade union members in Ireland are women workers.

Over the month of May, we are engaging in a campaign, together with our colleagues in other Irish Congress of Trade Union unions to showcase the benefits of being a member of a trade union. We believe it is important to do this and to encourage greater democracy and engagement at workplace, branch and section levels.

As part of ICTU's 'Better in a Trade Union' campaign, the INMO will be taking part in Trade Union Week. Trade Union Week will mark the culmination of the Better in a Trade Union campaign, which was launched in January to promote the values and benefits of trade union membership. Featuring public and private sector workers from across the island of Ireland, the campaign highlights benefits such as enhanced job security, advice and support, improved terms and conditions of employment, and better pay.

We are planning some events in workplaces across the country to encourage nurses and midwives who haven't already done so to join a union. These events will provide a great opportunity for you to catch up with fellow union members and your local official. Keep an eye on your emails to find out what Union Week event will be taking place in your workplace.

I want to sincerely thank all INMO nurse and midwife representatives who staffed the balloting stations over the past four weeks. I met many of you as you organised ballots in workplaces early in the morning and late in the evening to ensure your colleagues got their say and had a vote. You provided clarification where needed on questions and encouraged your colleagues to get involved.

Many people in our movement talk of solidarity and to me this is a clear example of solidarity at work, INMO representatives taking their own time to be relevant and visible to members who they work with. It is a great testimony of our strength as a union and a part of our connection to members that we must support and strengthen.

Go raibh míle maith agaibh.

Phil Ní Sheaghdha
General Secretary, INMO

Irish **Nurses** and **Midwives** Organisation
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105TH ANNUAL DELEGATE CONFERENCE

8 - 10 MAY 2024
CROKE PARK, DUBLIN

DELEGATES, WATCH OUT FOR YOUR ADC PACKS ARRIVING IN APRIL

Gobnait O'Connell Award Nominations

Nominations for our Gobnait O'Connell award are now open!

This award is presented every year at ADC to an INMO member for their exceptional contribution to the union.

The nominee may have been particularly effective and dynamic in recruiting members, highlighting the Organisation's activities to others, developing best practice and policies on behalf of their Section/special interest group, negotiating improvements in working conditions for nurses and midwives or making an exceptional contribution to INMO activities in a spirit of loyalty and dedication.

Nominating a member for this award must come from her/his branch or section and the nomination must be submitted via email to **necactivities@inmo.ie** by **12pm, Monday, April 8, 2024**.

For more details on nominating criteria, contact your branch, section or Industrial Relations Official.

A positive focus with the president

Karen McGowan, INMO president

Signing off as president

THE time has come to write my final president's page. I want to thank my family who have supported me during this time but also my close friends who kept me focused. It has been my pleasure to be the voice of nursing and midwifery.

We must focus on what has been achieved and where this progress will bring the INMO to next. It has been a great privilege for me as president to have had such a strong management team around me. I am thankful to have grown into the role of president, it has been a wonderful experience. The management team has always been available to the Executive Council and to me to give clear guidance and support during the most difficult times. I have seen the retirement of Liam Doran and Dave Hughes during my time and subsequently the renewed leadership of general secretary Phil Ní Sheaghdha and deputy general secretary Edward Mathews.

What is clear is the strength of the past and current Executives. The mandate from members at ADC each year is so important and I'm honoured to have moved members' priorities forward during my term. Areas we have made progress on include:

- Restoration of work hours to a 37.5-hour week
- The extension of Building Momentum which secured pay rises for nurses and midwives
- Enhanced practice salary scale in all public and private sector employments
- Covid-19 pandemic recognition payment
- Safe staffing framework for surgical and medical wards
- Establishment of the health division of the Health and Safety Authority.

We also continued to campaign around ongoing issues, including:

- Hospital overcrowding/trolley count
- Housing
- The ICTU Better in a Trade Union campaign
- The ICTU Stop the Stigma Campaign.

The INMO's professional, industrial relations, media, library, information office and maintenance teams are instrumental to the activities within the Organisation. I have had the pleasure with working with these teams and I cannot thank them enough for their hard work.

I have really enjoyed meeting members during the recent balloting on the new public service pay deal. It gave me a real sense of pride and purpose being so involved with the INMO. I will remain an active member at branch, section and hospital level. It was vital to be able to provide advice and promote the INMO. Union membership is vital in the workplace. Through your union you can advocate and raise concerns locally and have the strength of the union behind you to guide you.

INMO president Karen McGowan pictured with her Executive Council colleagues (2020-2022 term) and members of the INMO senior management team

Executive Council update

I AM proud of the gains we have made in nursing and midwifery. The structure of the Executive Council is a vital element in the progression of our issues in healthcare. I was part of the Executive Council prior to becoming president, experience that was imperative in the post. I took over as president from Martina Harkin-Kelly, a strong leader who I learned so much from. It was a difficult tenure as we emerged from Covid-19 but it was managed with such professionalism and with the members at the forefront of everything we do. I am so thankful to the officers in my first term in office Eilish Fitzgerald, first-vice president, and Kathryn Courtney, second-vice president. They were a pleasure to work with and brought such expertise which helped me lead the next term.

Current first-vice president Mary Tully has been a great support to me in my role and is so professional in her interactions with members. Second-vice president Caroline Gourley has also shown great commitment to the officer role and I thank her for her hard work and dedication to the INMO. They have strengthened the officer roles.

As a collective the Executive Council supported me in my role as president and ensured that nursing and midwifery were represented at the many meetings we attended. I want to place on record my sincere thanks to them.

As an Executive, we have grown together in this time and learned so much from each other. Our strength in unity has been vital. We have had many debates but have been unified in our approach overall. It has been an absolute pleasure to chair our meetings and ensure each voice is heard. We have worked hard during this term and I could not thank members enough for their dedication. I will miss the debates as this brings the true passion for the profession to the table.

I wish the very best to the incoming Executive Council who will be endorsed at ADC 2024. To the new officers who will be elected at conference, I have no doubt that you will continue to steer this wonderful organisation and continue as a strong voice for nursing and midwifery.

Slán go foil
Karen

Get in touch

You can contact me at INMO HQ at Tel: 01 6640 600 or by email to: president@inmo.ie

Irish Nurses and Midwives Organisation
Working Together

2024 Nurse and Midwife Representative Training

The INMO provides Representative Training to our members.

The aim of the Basic Representative Training Course is to provide members in the workplace with the knowledge, skills and confidence to represent and support members in the workplace. The Representative also acts as a liaison between the INMO Members, INMO Officials and INMO Head Office.

The training course takes place over two days and there are agreements within the public health service for paid released time off to attend INMO Rep Training Courses.

The INMO also provides an Advanced Representative Training Course. This training is at advanced level, the requirement for attending the Advanced Representative Training is to have completed the Basic Representative Training and have been an active INMO Representative in the workplace for at least one year.

If you are interested in attending a Representative Training Course in 2024, please make contact with your INMO Official.

Month	Date	Location
APRIL	18 & 19	Dublin
JUNE	05 & 06	Waterford
	12 & 13	Galway
	19 & 20	Dublin
JULY	16 & 17	Dublin
SEPTEMBER	10 & 11	Dublin
OCTOBER	03 & 04	Sligo
	08 & 09	Cork
	14 & 15	Dublin

**Please note that the dates and locations are subject to change*

CONTACT YOUR INMO OFFICIAL

Dublin: 01 6640600, Cork: 021 4703000, Galway: 091 581818 and Limerick: 061 308999

INMO Professional

Irish Nurses and Midwives Organisation
Working Together

NEW INMO SECTION

INMO INCLUSION HEALTH NURSES SECTION

Our aims are to develop and share excellence in nursing and midwifery in Inclusion Health.

To support practitioners in professional and practice development, education and research.

See section focus page for further details. If you wish to be aligned with this new section please email membership@inmo.ie to be included in the Inclusion Health section. Contact Section Development Officer jean.carroll@inmo.ie with any further queries.Section Development Officer jean.carroll@inmo.ie with any further queries.

Email: **membership@inmo.ie**

For more information email jean.carroll@inmo.ie

INMO calls for end to 'detrimental' recruitment freeze for frontline staff

The INMO has called on the HSE to end the moratorium on recruiting frontline patient-facing staff. This latest call came as the HSE confirmed that emergency department attendances are up 13% compared to the same period in 2023.

INMO general secretary Phil Ní Sheaghdha said: "It should come as no surprise to the HSE that attendances were going to rise based on flu and Covid projections that were provided prior to Christmas. Our members are now bearing the brunt of public disappointment and in some cases aggression for the state of the health service while working in extremely challenging environments.

"None of the problems that are currently facing the health service have come out of nowhere. It was clear that the budget allocated to the HSE by government didn't take additional demand into account. We have fewer GPs, so for many people going to their local ED is now the first port of call rather than a last resort. The additional pressures on the system by rapid population growth have been well flagged, as well as an ageing population who now have complex co-morbidities.

"The answer to these challenges should not be a moratorium on hiring frontline patient-facing staff. Staff who are leaving because of retirement or for other reasons are not being replaced. This is having an extremely damaging impact on patient safety and staff morale.

"The very high-risk scenarios now faced by our members, and in their view, the working environment under which they are now forced to work, poses real and present risks to their ability to provide timely and safe care to patients which in turn exposes them to potential regulatory inquiries and unsafe working conditions.

INMO general secretary Phil Ní Sheaghdha: *"Our members are facing very high-risk scenarios"*

"The HSE recruitment freeze is going to have detrimental outcomes on patient care in the long-term but also on the ability to retain staff into the future. The recruitment moratorium must be reversed urgently."

Staff morale at all time low in face of dangerous levels of overcrowding after 'holiday' weekends

WITH no let-up in overcrowding throughout February in the wake of the St Brigid's Day holiday weekend, the INMO called on the HSE to outline what steps it was taking in the run up to the St Patrick's Day and Easter weekends to ensure March didn't see a repeat of the dangerous scenes witnessed in overcrowded hospitals.

Almost 11,000 patients went without a hospital bed in February, according to INMO TrolleyWatch figures. A total of 10,991 admitted patients were on trolleys during the month, with the top five most overcrowded hospitals being:

- University Hospital Limerick – 2,247 patients
- Cork University Hospital – 1,070 patients
- University Hospital Galway – 987 patients
- St Vincent's University Hospital – 651 patients
- Sligo University Hospital – 649 patients.

INMO general secretary Phil Ní Sheaghdha said: "Since the end of January, I have been in the majority of hospitals that the INMO counts trolleys in and have witnessed dangerous scenes in many hospitals with patients being treated in completely inappropriate spaces. It is clear that most hospitals are operating at over 100% occupancy, meaning that patients are being cared for in all available spaces which is unsafe.

"Nurses and midwives are highly trained professionals who have a deep appreciation for the provision of safe care for their patients. It is impossible for them to provide care in a safe manner in the current conditions in our public health system. Many are reporting that the intention to leave, whether to retire early, move abroad or move to another position in the community or private sector, is worryingly high.

"The morale of our members is on the floor and many feel a sense of helplessness when it comes to being able to carry out their roles to the high levels they have been trained to. This is not helped by the HSE's baseless hiring freeze of patient-facing staff *(see above)*.

"The system of hiring was very slow to begin with but the introduction of a derogation system and a blanket ban on hiring will render very unsafe situations even worse.

"Directors of nursing and midwifery are now saying population growth has not been factored in, the increased daily activity has not been factored in, and they will not be able to stand over levels of care due to the recruitment freeze. If we are going to have any hope of turning things around for our public health service then safe staffing must be the number one priority – nothing less will do."

Post-St Patrick's Day

If the HSE took any steps ahead of St Patrick's Day weekend, it made little impact on hospital overcrowding, which remained out of control, with 651 admitted patients, including 14 children, being treated in Irish hospitals without a bed after the 'holiday'.

Ms Ní Sheaghdha said: "We are out the other side of another bank holiday where hospital overcrowding remains completely out of control. Nurses, midwives and the patients they are trying to provide safe and timely care to have all been left in a completely unfair situation."

With the Easter weekend fast approaching, the INMO was once again calling on the HSE to draw up a hospital-by-hospital plan to ensure that the system would not be completely overwhelmed by the end of that holiday weekend.

INMO director of industrial relations **Albert Murphy** updates members on recent national issues

Full outcome of cross-union ballots on pay deal due end of March

MEMBERS of the INMO throughout the country have been balloting over the past six weeks in relation to the proposals for a new Public Sector Pay Agreement.

The pay proposals contain a number of cost-of-living related salary increases for nurses and midwives. These increases, which would be applied over the duration of the agreement, are equivalent to a total increase of 9.25% from January 1, 2024 to end of June 2026.

There is also provision for a local bargaining unit of 1% which is due to be paid in mid-2025.

While the ballot of INMO members had concluded at the time of going to press (*see editorial on page 5*), balloting was ongoing among other public service unions of the Irish Congress of Trade Unions. The outcome of the aggregate ballot is expected at the end of March 2024.

In the event that the proposals are accepted by the Public Services Committee of ICTU, the INMO will be seeking the earliest implementation date of pay awards for members.

Dispute over outsourcing of Naas local injuries unit

A DISPUTE has arisen between Naas General Hospital and the INMO and other unions in relation to the outsourcing to a private provider of the hospital's local injuries unit (LIU).

Agreement had originally been reached that a pilot would run for six-weeks only, due to limited funding that was available to the project. There was also agreement that the preferred model of LIU would be owned and governed by Naas General Hospital. The unions secured protections for members in relation to this project. However, the hospital announced that it was not in a position to cease the project and this is the subject of the dispute. Hospital management is in breach of information and consultation legislation, as well as the outsourcing provisions of the Building Momentum Agreement.

The matter has been referred to the National Joint Council for its next meeting, ahead of which the unions are meeting locally to consider its response.

Long Covid claim referred back to Labour Court

A RECOMMENDATION was issued by the Labour Court in November 2023 stating that the HSE and the Department of Health should engage with unions with a view to reaching an agreement on the arrangements to be put in place for those who are suffering from Long Covid. However, due to a failure to reach an agreement in the interim, this claim has now been referred back to the Labour Court.

The INMO understands that there are approximately 150 healthcare workers who are currently on the Special Leave with Pay Scheme (SLWP), which is due to expire on the March 31, 2024.

There are a further 150 healthcare workers who are not comprehended as part of the Scheme as the Scheme was closed with effect from February 2022.

The employers' view is that the government decision states that the Scheme should cease on March 31, 2024 and that any healthcare workers who are unable to resume work due to Long Covid should be dealt with under the existing Public Service Sick Pay Schemes.

The unions have made it clear in their submissions to the Labour Court that Ireland is an outlier in respect of its treatment of healthcare workers who are suffering from Long Covid, as a number of European countries have legislated for schemes in respect of Long Covid which is recognised as an occupational illness.

At the time of writing the unions are seeking an early Labour Court hearing prior to the expiration of the scheme on March 31. The INMO will keep members informed of progress on this important matter.

HSE plans to repurpose long-awaited Nenagh CNU must be halted

THE INMO has called on the HSE to call a halt to plans to repurpose the long-awaited community nursing unit (CNU) in Nenagh, Co Tipperary.

INMO IRE Karen Liston said: "The decision by the HSE to repurpose the new community nursing unit in Nenagh into a step-down facility for University Hospital Limerick without consulting unions and patients who were anxiously waiting to move from St Conlon's Nursing Home is extremely disappointing.

"Nursing staff and the residents of St Conlon's Nursing Home deserve to work and be treated in their state-of-the art facility that was promised to them and that would meet HIQA standards.

"It has also been reported that this proposed step-down facility will be outsourced to a private provider. The INMO cannot stand over the further outsourcing of a public health service. The residents of St Conlon's and the wider Nenagh community were promised a publicly funded and run service for care of older people. It is not acceptable for the HSE to change their minds at the last minute."

INMO IRE Karen Liston: *"HSE move is extremely disappointing for nursing staff and patients in Nenagh"*

WRC awards INMO member €10,000

FOLLOWING a recent third-party adjudication hearing, the Workplace Relations Commission (WRC) recommended that an INMO member be paid €10,000 in compensation for their employer's failure to adhere to procedures in a reasonable timeframe under the HSE Dignity at Work Policy.

This case was taken under the Industrial Relations Act for a member working in the Cork region.

The adjudicator's decision was particularly critical of the employer: "The impact on the worker of having raised a complaint in good faith against her manager was devastating, both personally and professionally. The delays in this instance were excessive and hugely damaging in their effect. The adjudication officer (AO) found the worker's experience of raising a complaint against her manager (as opposed to as against a colleague) to be particularly troubling and the AO was struck by the failure of her employer to mind her through the process."

The INMO highlighted that the Dignity at Work Policy requires promptness, discretion and sensitivity and for the employer to support and encourage mediation. Once the worker raised a formal complaint and the employer submitted the complaint to the National Investigations Unit, the employer should have considered appointing an independent investigator if there was no investigator from the NIU panel available, which is common practice.

The AO accepted the INMO's submission that the onus is on management to adequately resource the investigation. There is also an onus on management to communicate throughout the process and information should not have to be pursued regarding developments.

The employer has an obligation to adhere to and apply its own policies. It was found that it failed to do so, with disastrous consequences for the worker.

The AO fully accepted the view expressed by the worker that, having been through the process, people would be discouraged by the process from making a complaint about their line manager, whatever about making a complaint about a colleague, which the AO found to be fundamentally unacceptable.

The AO said workers cannot be left without a remedy by their employer in circumstances where they raise a Dignity at Work issue against a manager. They cannot suffer detriment as a result of having raised an issue in good faith.

The AO did not accept the submission made by the employer in relation to 'cost-increasing claims'. If accepted, the net effect of such an argument would be that the WRC would have no jurisdiction to award compensation under the Industrial Relations Act in a case such as this, producing a situation where an employer could circumnavigate both a worker's right to avail of, and/or be subject to, agreed internal applicable policies, as well as the worker's right to natural justice and fair procedures, with no potential consequence for the employer. It would create a situation whereby an employer who is bound by national pay agreements would be free to breach its own policies in relation to its employees, with impunity. There is simply no legal reality to that line of argument.

The AO recommended that the employer pay the worker €10,000 in full and final settlement of this dispute.

– Liam Conway, INMO IRO

Location allowance in Manorhamilton

FOLLOWING INMO representation, nurses working in the rheumatology department at Our Lady's Hospital, Manorhamilton, Co Leitrim are now in receipt of the Location Allowance. This allowance is currently valued at €2,554 per annum. The HSE has confirmed the allowance has been applied with payment backdated to the March 1, 2019 for nursing staff working in the rheumatology department .

– Neal Donohue, INMO IRO

Additional staff for Listowel

THE INMO is in the process of engaging with and balloting members at Listowel Community Hospital in relation to a claim for additional staffing. Following a number of conciliation conferences, a Joint Review Group process and further engagement with the HSE, the INMO and SIPTU secured additional staffing resources in a proposal to be put to members. This claim resulted in gains across the hospital in nursing, healthcare assistant and cleaning staff hours.

– Liam Conway, INMO IRO

INMO deputy general secretary **Edward Mathews** rounds up global nursing

Investing in nursing makes economic sense and benefits all – ICN

TO MARK International Women's Day on March 8, the International Council of Nurses (ICN) called on governments to recognise the benefits of investing in nurses for the healthcare and wellbeing of the global population.

This year's United Nations International Women's Day campaign, 'Invest in Women: Accelerate Progress', echoes the ICN's mission to support and invest in nurses to ensure that they are recognised and valued for the unique contribution that they make to societies everywhere. The official International Women's Day campaign theme of 'Inspire Inclusion' is also in line with the ICN's ambition to maximise the effectiveness of nurses by helping them to gain access to influential positions where they can make a real difference to the everyday lives of females.

ICN President Dr Pamela Cipriano noted that nursing is a 90% female profession, and the care nurses provide is often undervalued without recognition of the substantial positive economic impact that nurses contribute to healthcare. Investing in nursing creates dividends, not just for nurses and the patients they care for, but for the safety, dignity and prospects of all women and girls.

ICN encouraged celebrating the achievements of nurses everywhere as we continue in our efforts to make the world a healthier and safer place for all humankind.

Dr Cipriano said that this occasion would be a good day for governments to recognise that investing in women, and in nursing in particular, brings health, economic and societal benefits that far outweigh their initial costs.

"We need many millions more nurses, both women and men, to meet the needs of the world's growing population, and there are millions of women who would willingly join the ranks of the nursing profession given the chance to do so. The ICN calls on governments to do just that so that we can finally reap the rewards of a far-sighted investment in the good of us all," she said.

International Nurses Day

The economic power of care, which creates healthy people and societies and drives healthy economies, will be highlighted by the ICN on International Nurses Day on May 12 under the theme: 'Our Nurses. Our Future. The economic power of care'.

Speaking about this year's theme the ICN President remarked that despite being the backbone of healthcare, nursing often faces financial constraints and societal undervaluation. Continuing ICN's overarching theme 'Our Nurses. Our Future' and the policy actions of the ICN Charter for Change, the ICN has chosen to focus IND 2024 on the economic power of care with the aim of reshaping perceptions and demonstrating how strategic investment in nursing can bring considerable economic and societal benefits.

"The ICN believes that now is the time for a shift in perspective. We have seen time and again how financial crises often lead to budgetary

restrictions in healthcare, typically at the expense of nursing services. This reductionist approach overlooks the substantial and often underemphasised economic value that nursing contributes to healthcare and society as a whole," said Dr Cipriano.

"Policymakers, healthcare administrators and even the general public are often unaware or misinformed about the return on investment that adequate funding in nursing can provide, especially in financially turbulent times such as these. Drawing from the lessons learned from the Covid-19 pandemic and recognising the increasing threat to the health of populations around the world due to conflicts, the climate crisis and financial instability, we believe the time is right to advocate for a shift in perspective and policy."

The ICN will release a special report on the economic power of care on May 12, 2024.

Global nurse leaders warn scale of critical challenges

THE INMO joined 13 national nursing association members of ICN, together representing millions of nurses worldwide, at the ICN International Workforce Forum (IWF) in Sweden in February.

Nursing organisations from Europe, North America and Australia attending the Forum, said there was a core group of critical challenges facing the nursing workforce. These profound challenges led them to reaffirm a call made by the ICN more than a year ago that we are experiencing a global health emergency.

They highlighted many concerns detrimentally affecting nurses' working environments and consequently creating major risks to public health. Such issues include international migration, recruitment and retention, workload, safe staffing levels, violence and burnout.

The ICN President spoke about the profound challenges continuing to impact nurses arising from the pandemic, where nurses are still being profoundly affected in their daily work by shortages that undermine safe staffing, lack of fair pay, poor conditions and violence in the workplace, all of which were exacerbated by the pandemic and its aftershocks. She called for a policy shift from a focus on supporting individual nurse resilience to ensuring that all healthcare systems – providers and employers – meet their duty of care to ensure that nurses are fully supported and can work in safety to provide effective care to their patients.

The ICN CEO considered the picture painted by the national

and midwifery news

ICM chooses climate theme for International Day of the Midwife

THE theme for this year's International Day of the Midwife (IDM) has been announced by the International Confederations of Midwives (ICM) as 'Midwives: A Vital Climate Solution'.

The INMO, will join the ICM and midwives across the world, in celebrating this day, which takes place annually on May 5.

Climate change is the greatest health challenge of our time. Our warming planet has more heatwaves, more floods, and more natural disasters that significantly impact the health of women and babies. Putting resources and efforts into addressing the climate crisis is a matter of extreme urgency.

The ICM recognises that midwives are a vital solution in adapting health systems to climate change, and lowering carbon emissions overall. Midwives deliver safe and environmentally sustainable health services and are among the first responders when climate disasters hit. It is for this reason that the ICM chose the theme for this year's IDM.

Midwives might not immediately see themselves as a part of the climate solution. At the same time it is obvious that the midwifery model of care is environmentally friendly. Evidence shows that continuity of midwife care leads to optimal and safe outcomes by using fewer resources, and resulting in less medical waste and a reduced ecological footprint. The care midwives provide also helps ensure that resources and the time and expertise of obstetricians are more available to women with complex care needs.

Globally, healthcare services emit around 5% of greenhouse gases. By offering continuity of care in communities, midwives reduce the need for avoidable travel to health facilities, thereby cutting the carbon footprint of healthcare while ensuring accessibility.

Continuity of midwife care also empowers mothers to meet their breastfeeding goals, meaning mothers will often breastfeed longer. Breastfeeding requires no packaging or shipping, creates no waste, and has a negligible water footprint. Helping mothers meet their breastfeeding goals is good for the short- and long-term health of babies and mothers, and it's a win for the planet.

The ICM noted that: "Beyond maternal and newborn care, midwives serve as champions of sexual and reproductive health. By providing education, contraception and comprehensive abortion care, we give women the choice about if and when they want to start a family. Promoting women's rights and economic resilience helps to reduce families' vulnerability to the impacts of climate change."

The ICM said that midwives are uniquely positioned to quickly reach and care for women, gender diverse people and babies affected by climate-related disasters. They can serve as vital links for delivering prompt reproductive and maternal health services, and can act as essential networks for disseminating evidence-based information and distributing supplies. Midwives are critical health workers who ensure that essential reproductive and maternal health services remain accessible and responsive to the needs of communities.

Midwives are indeed a vital climate solution. As we celebrate the International Day of the Midwife, the ICM, and the INMO, calls for investment, resources, autonomy and a seat at every decision-making table to include continuity of midwife care as a cornerstone of health system planning for climate resilience.

The INMO encourages all midwives to join us in this celebration and to advocate for action towards a healthier planet and healthier communities.

facing nursing is a global health emergency

nurses associations in attendance as representing a crisis in nursing which amounts to full scale global health emergency, where governments must not close their eyes to these warnings but act.

The nurses associations spoke about their very deep levels of concern about over reliance on migration. They strongly support the right of individual nurses to move across borders to improve their careers and their lives, but equally they highlighted the risks of the increasing level of large scale nurse migration.

ICN and the national nurses associations present also urged that the language in the WHO Pandemic Accord, currently being finalised, be strengthened regarding workforce, especially in relation to the WHO's voluntary code on international migration and widening inequalities. Additionally, the Pandemic Accord should also address the lack of accurate data on nurse infections and deaths during any future pandemics.

The ICN CEO said: "The lack of accurate data on nurse infections and deaths during the Covid-19 pandemic and since is unacceptable. It is vital that all countries collect such data because it will help to ensure that nursing staff are fully protected during pandemics and other health emergencies, and honour the sacrifice of nurses who lost their lives."

The CEO also said that health workers, and especially nurses, should be represented in any governance arrangements that will be established to monitor the Pandemic Accord.

Cavan nurses lead way in cancer care

As Cavan General Hospital prepares to celebrate 25 years of its nurse-led oncology service, **Freda Hughes** spoke to ANP Rose Mary Smyth, who has been there since day one

THE nurse-led oncology service at Cavan General Hospital is celebrating 25 years since its foundation this year. Started in September 1999 under the medical direction of Prof John McCaffrey, consultant oncologist at Mater Misericordiae Hospital, the department has recently gained an oncology advanced nurse practitioner (ANP) post, which is held by Rose Mary Smyth.

Ms Smyth, who has worked at the department since its inception, explained that the service was developed in response to the needs of patients who previously had to travel long distances to the Mater Hospital in Dublin, often staying overnight in B&Bs.

Today the service provides medical oncology care to the people of Cavan, Monaghan and the surrounding counties. It is a satellite service with medical oncology support from the Mater Hospital's Cancer Centre in Dublin.

In November 1999, the National Council for Professional Development of Nurses was established by the Commission on Nursing,[1] whereby the council approved clinical nurse/midwife specialist posts and domains of competency were identified, giving direction for the oncology clinical nurse specialists at the new facility in Cavan.

"The service was developed in response to patients' needs, Ms Smyth told *WIN*. "It's so important that treatments are accessible. It allows us to personalise our service and take some of the stress out of it. We provide a high-quality service and our staff are constantly updating their knowledge and seeking out new developments."

Many improvements have been made to the service since those days. In 1999 there was one visiting consultant oncologist and two clinical nurse specialists providing a select number of treatments. Today, three visiting medical oncology consultants see patients in an outpatient capacity and decide on proposed treatments and plans of care that are co-ordinated and scheduled by the oncology liaison nurse.

The day-to-day treatment and management of disease is provided on the nurse-led oncology day ward, which is run by the oncology clinical nurse manager 3, clinical nurse specialist and senior nurse, ensuring that the that patients with a treatment-related problem receive the care they need in a timely and appropriate manner.

The oncology survivorship nurse is available to patients who have finished their cancer treatment and are now considered 'cancer free'. The aim of the service is to provide support, information and advice, as well as to signpost patients to relevant services and help them to readjust to life following a cancer diagnosis.

The acute oncology service (AOS) was also developed in response to the Covid-19 pandemic and funded by the NCCP. The AOS post ensures that patients who develop a cancer treatment related problems receive the care they need quickly and in the most appropriate setting.

More recently the department has seen the development of Ms Smyth's oncology

ANP post, which supports and manages patients on oral anticancer medication.

"I could see there was a vast amount of patients going on to oral treatments and I felt there was a need for an individualised service for these patients.

"I spoke to the director of nursing and proposed to set up a service improvement initiative to look at the management of patients on all anti-cancer medications in the hospital. It's very simple to bring a patient into the day ward and infuse their chemotherapy and then send them home, but actually sending the patient home from an outpatient clinic with a prescription for medications and how to take them is far more complex.

"Most of the patients are on oral anti-cancer medications. I review them, I restage them, I order their scans, I prescribe their medications and I look after them quite autonomously."

Multidisciplinary approach

Alongside oncology, there is a haematology nurse-led service with a visiting haematology consultant once a week. The haematology CNSs manage a wide range of blood disorders, including both benign and malignant conditions on the oncology day ward, infusion suite and virtually at home. They also run nurse-led clinics to support this complex group of patients.

"The nurse-led oncology/haematology treatments and reviews that are provided in Cavan General Hospital are in line with any other systemic anti-cancer treatment (SACT) centre nationally," Ms Smyth explained.

Keeping up to date with evolving treatments and promoting nurse-led initiatives, such as providing scalp cooling, is something Ms Smyth and her colleagues do with pride. In 2023, one of the service's clinical nurse specialists received an award from the Irish Association for Nurses in Oncology for a poster on scalp cooling, which was presented at the annual conference.

All nurses in oncology are involved locally in education at study days and training events, and participate at nursing grand rounds. Constant review and audit of the service promotes best practice and positive service development.

Locally, cancer patients are also supported by the palliative care team within the hospital and community palliative care nursing services that support patients at home. More recently, allied healthcare professionals, such as an oncology social worker and a dietitian, have been appointed and are supporting patients and families through complex cancer care.

Pictured (above l-r): Mags Gilmartin, CNM3 for oncology, haematology and infusion suite, and Rose Mary Smyth, ANP in oncology, both at Cavan General Hospital

Main photo opposite page (l-r): Deirdre Brady, senior nurse oncology; Alice Ryan, oncology liaison CNS; Dympna McPhillips, oncology CNS; Nora Donohoe, multi-task assistant; Nicola Galligan, senior nurse oncology; Margaret Gilmartin, CNM3 oncology, haematology and infusion suite; Sharon Fitzpatrick, ADON; Claire Smith, haematology CNS; Sheila O'Hagan, healthcare assistant; and Rose Mary Smyth, oncology ANP

The hospital's oncology pharmacy service provides pharmacy support for patients on SACT and the recently established National Cancer Information System supports prescribing, dispensing and administration of drugs and treatments.

The nurse-led oncology service also works in conjunction with the community intervention team, which provides phlebotomy and nursing services to cancer patients in their homes. There are cancer support centres in Cavan town and Monaghan and the Friends of Cavan Oncology Service, a non-profit group provides financial support for cancer patients.

The oncology service is supported on site by medical, surgical, radiology, histology, laboratory, cardiology and many other disciplines. This, together with senior nursing and management resources, enables and supports service development on a daily basis.

The satellite service is now known as the 'hub and spoke' model,[2] with designated National Cancer Control Programme (NCCP) inpatient cancer centres, part-time consultant commitment and less complex SACT. The overall vision and principles of the NCCP SACT model of care are that patients with a cancer diagnosis will receive safe, timely, high-quality, patient-centred care that is accessible and suitable to their needs.

The NCCP, in line with Sláintecare, identifies six principles underpinning best practice. The nurse-led oncology service is guided by these principles. Each SACT protocol has specific evidence-based practices that are adhered to, and all nursing practices are evidence-based. The service is provided by well-trained staff that develop their practice and ensure all SACT-related safety measures are met.

"In September 2024 the team will celebrate 25 years of nurse-led oncology services in Cavan General Hospital. This is a monumental milestone for patients, families and the staff of the hospital and oncology service," Ms Smyth said.

"For those of us who have been around since its opening, it will remind us of the journey and changes over the years. For those who have passed, we will remember and appreciate every moment we were privileged to care for them.

"To celebrate this journey, we are holding a carol service in December to remember, celebrate and most importantly approach the next 25 years with optimism and a determination to continue to provide high-quality patient-centred care for cancer patients and their families."

"I love nursing; it's what I always wanted to do. Advanced practice has allowed me to progress in my role without having to move into management, which never interested me. The whole team here is amazing and we are extremely proud of the service we provide."

References
1. DOHC (2000) Implementation of Recommendations of the Commission on Nursing. First Annual Progress Report of Monitoring Committee.
2. HSE, NCCP (2022) Systemic Anti-Cancer Therapy Models of Care. Available at: www.hse.ie

In the community

Melissa Hammond works as an ANP in general practice, advocating for a role that offers a career path for nurses who wish to work in the primary care setting. Interview by **Freda Hughes**

"THE advanced nurse practitioner (ANP) role in general practice bridges the gap between the nurses and doctors in the practice and brings a greater sense of team spirit," according to Melissa Hammond, who works as an ANP in Bray Family Practice in Co Wicklow.

"Advanced practice roles are inspirational for nurses because they show a progression path that doesn't involve leaving the clinical setting."

Ms Hammond said she absolutely loves her job because every day is different. She sees a diverse cohort of patients of all ages, and her role differs from general nurses in general practice in that she is an autonomous practitioner.

Ms Hammond's journey started in acute care in the hospital setting after qualifying from Queens University Belfast in 2004. From there she worked in critical care and cardiothoracic care for two years before moving back to Dublin. There was a recruitment embargo in place at the time, meaning she could not apply for work in the public health service. Instead she took up a post working in cardiology and the high dependency unit in Blackrock Clinic in Dublin.

Ms Hammond later moved to St James's Hospital in Dublin where she worked in the ICU. While there, she completed postgraduate courses in cardiovascular nursing and intensive care nursing. She moved to ICU in the Beacon Hospital when she got a promotional opportunity as a clinical co-ordinator for several years, progressing to CNM1 and CNM2.

At this point she decided to study for her masters in advance practice with prescribing in UCD. It was from here in 2015, that she decided to specialise further and stick to the clinical side of nursing. She moved into a clinical nurse specialist role in St Michael's heart failure unit, under St Vincent's University Hospital, and began her masters journey with UCD in Advanced Practice Nursing and Prescribing.

There she helped to launch virtual medical consultations long before the pandemic, which provided a link between secondary care specialists and general practitioners (GPs). The virtual consultations were also used to cater for patients who were too unwell to attend the hospital or who were on long waiting lists to see a specialist.

"This was a really good eye opener for me about the sort of care that happens in the community. I realised how alone community care practitioners often are in their practice," Ms Hammond told *WIN*.

She moved to St Vincent's University Hospital and completed her advanced practice competencies 500 hours in critical care. She wanted to develop competencies in general nursing rather than just cardiology/heart failure. In that role she could complete a full episode of care to deal with the exacerbations of COPD, diabetic emergencies and other complications of chronic illness.

ANP in general practice, Melissa Hammond: "It's the beginning of a bright future for nursing and the diversity of nursing."

Chronic disease management

While working in St Vincent's, Ms Hammond read about the HSE's community chronic disease management programme. The idea that diseases such as COPD, heart failure, diabetes, asthma and transient ischaemic attacks (TIAs) could be managed through a GP in a community setting

appealed to her. The programme was designed to keep people well in the community and out of hospital. She contacted the NMBI to see what role she could play on that programme with the various competencies and qualifications she had and they told her about the ANP pathway in general practice.

"The really good thing about the ANP role is once you are trained and your supervised care has been signed off by your mentor, you can divert your roles as much as you want. I'm a believer in ANP-to-ANP pathways. We have a huge potential for healthcare and to be the link between primary and secondary care."

Having completed her training, Ms Hammond started working in a general practice in Greystones as part of the chronic disease team in 2022. In this role, she saw her patients with chronic disease at least twice a year, using evidence-based programmes that are produced through the HSE pathway and are tailored to the specific chronic disease or diseases the person is living with. She has since moved to another general practice in Bray where she has broadened her scope even further.

"Because I'm a prescriber and can carry out advanced health assessment, I could independently look after these patients. Now, if a patient rings up with a suspected urinary or respiratory tract infection I can see and treat them and keep the GP free to see other patients," she said.

"Role awareness and following the guidelines and best practice are so important for professional indemnity. If something is not within my scope of practice, I refer them on to the GP."

A new preventative chronic disease programme has recently been rolled out that also deals with opportunistic findings. For example, if a patient comes in for bloods and the ANP notices that they've got high cholesterol, high blood pressure or that they smoke, they can refer the patient to preventative programmes depending on their risk factors. The patient is then monitored every nine months or so. With multiple morbidities often seen in chronic disease, Ms Hammond believes it's important to constantly broaden one's knowledge and scope.

Strength in numbers

It was when she signed up for a course in diabetes care in St Columcille's Hospital, Loughlinstown that Ms Hammond met another general practice ANP who added her to a WhatsApp group for advanced practitioners working in this area. She said being part of a network of like-minded professionals is hugely beneficial.

Melissa Hammond (centre) with colleagues at the Irish Cardiac Society Frontiers in Cardiology meeting, June 2023

> "We have a huge potential to be the link between primary and secondary care"

"It was great to become part of a network. There were only 20 of us then (two years ago), but now there are 43 nationwide. With Sláintecare more care is being moved into the community and general practitioners are right at the forefront of everything. We realised that more awareness of our role could potentially help ease waiting lists for GPs and in acute hospitals."

The group has met with Minister for Health Stephen Donnelly and the chief nurse at the Department of Health, Rachel Kenna. The group is also part of the INMO's ANP Section and gave a presentation at the section's conference on the role of ANPs in general practice. They have formed a specific group for general practice ANPs and have elected a committee. The group's aim is to support people who are considering moving into the role and to promote recognition and awareness of general practice ANPs.

"There's a real shortage of GPs and ANPs in general practice, so we are looking for investment and recognition so that the role can be further developed and we can increase our numbers. There is so much to recommend in terms of career progression," Ms Hammond said.

Education pathways

The group also met with the NMBI to discuss the lack of a formal education pathway at undergraduate level for nurses who want to work in general practice. ANPs can mentor medical students while they are on placement, and the group believes that if students are to see nursing in general practice and are made aware of advanced practice nursing from an early stage, they would be much more likely to think about it as a career option.

"I do think it's the beginning of a bright future for nursing and the diversity of nursing. It's an exciting time for our role which prior to this has been somewhat hidden within general practice. There's so much pressure imposed on general practice and the community, and this is a way of facilitating their ability to deliver."

INMO focus on female health to mark International Women's Day

WIN reports on the Ladies Lounge event held in The Richmond

INTERNATIONAL Women's Day on March 8 saw the INMO host a special event organised by the union's president, Karen McGowan, bringing together a range of specialists in women's health.

The morning session saw a presentation from Dr Geraldine Connolly, consultant gynaecologist at the Rotunda and CHI Temple St Hospitals, who specialises in adolescent and paediatric gynaecology. Dr Connolly discussed some of the common issues that children and adolescents experience and the role of education in both preventing problems and providing reassurance about puberty and menstruation.

Attendees also heard from Jean Coffey, an advanced nurse practitioner (ANP) at the Rotunda Hospital. Ms Coffey discussed the role of nurses and midwives in reproductive and sexual health promotion and advocacy. She noted the importance of ensuring safety in cases of unintended pregnancy and, in particular, of improving access to sexual and reproductive healthcare as well as improving maternity outcomes among minority groups.

Ms Coffey highlighted the role of nurses and midwives in identifying areas for improvement, including their specified role in the government's Women's Health Action Plan, with regard to developing the quality of women's healthcare in Ireland.

Karen Pleace, nurse and assistant professor in women's Health at DCU, gave a presentation on premature ovarian insufficiency (POI), highlighting the treatments available for those experiencing premature menopause and the potential health risks for those with POI.

The morning session concluded with a presentation on mood disturbances and hormones by Dr Yvonne Hartnett, senior registrar in psychiatry at the Coombe Hospital. She described the high incidence of depression among women and the impact of hormonal fluctuations on women's mental health, particularly around menopause.

Dr Hartnett also described a study on perinatal mental health and described the effects of premenstrual dysphoric disorder and premenstrual exacerbation of psychiatric conditions.

The afternoon began with a session on genito-urinary health by Dr Shayi Dezayi, gynaecology registrar and menopause specialist at Beaumont Hospital.

This was followed by a presentation on pelvic floor health by women's health physiotherapist, Aoife Harvey. Ms Harvey described the causes and treatments of stress and urge incontinence in women and in particular the role of vaginal oestrogen in ensuring long-term pelvic health, and emphasised the range of non-surgical interventions available to treat uterine prolapse. She also noted the importance of improving postnatal care, alongside the current emphasis on menopausal care in Ireland.

Sinéad Cleary, ANP at the Women's Health Unit at Tallaght University Hospital, discussed the status of the Irish cervical screening programme and the aim to eliminate cervical cancer in Ireland. She described the rollout of the nonavalent vaccine for HPV, which, alongside screening, leads to a reduction in the incidence of cervical cancer of up to 90%. Ms Cleary also discussed the rollout of the school-based vaccine and catch-up programme, describing the switch from primary cytology screening to HPV screening as part of the improvements in the national screening programme.

Yvonne Counihan, a clinical nurse specialist (CNS) in endometriosis at Tallaght University Hospital, gave a detailed presentation on the nature, incidence and treatment of endometriosis. She stated that endometriosis affects approximately 10% of women, many of whom experience severe pain in addition to a range of other invisible symptoms.

Ms Counihan spoke about the difficulties women have experienced in obtaining a diagnosis of endometriosis and the high level of specialist training required to identify it via laparoscopy. Her presentation also outlined the clinical pathway for

Pictured at the INMO event on International Women's Day at the Richmond Education and Event Centre were: (opposite page) Speakers Jean Coffey, advanced nurse practitioner, Rotunda Hospital; Kate Pleace, nurse, PhD student and assistant professor in women's health, DCU; Dr Yvonne Hartnett, senior registrar in psychiatry, Coombe Hospital and PhD candidate, UCD; Dr Geraldine Connelly, consultant gynaecologist, Rotunda Hospital and CHI Temple St (above, left) Karen McGowan, INMO president; (above left, top) Phil Ní Sheaghdha, INMO general secretary; (above left, bottom) audience members

endometriosis patients and the role of the endometriosis CNS in providing specialist treatment.

Ms Counihan also described the development of the endometriosis service in Tallaght University Hospital and spoke about the impact of this service and the need for this specialism to continue to develop and grow.

Ms McGowan spoke on the Stop the Stigma campaign, which brings together unions within ICTU calling for workplace accommodations and the introduction of formalised workplace policies for menstruation and menopause. The aim of the campaign is to support those affected to continue their careers and ensure their safety and wellbeing through all life stages, and the campaign aims to recognise women's health as a key factor in workplace gender equality.

INMO general secretary Phil Ní Sheaghdha concluded the event by noting the significant cultural and clinical progress made in women's health in Ireland in recent decades. She emphasised the importance of conversation and education in safeguarding women's health and saving women's lives.

Ms Ní Sheaghdha congratulated the INMO president for bringing the speakers together and for her continued advocacy for excellence in women's healthcare.

Yvonne Counihan, clinical nurse specialist in endometriosis at Tallaght University Hospital, Dublin pictured addressing the meeting:

Sinéad Cleary, advanced nurse practitioner inthe Women's Health Unit at Tallaght University Hospital, Dublin

Section focus

INMO Professional

Jean Carroll, Section Development Officer

Pay commensurate with duties the priority for practice nurses

MEETINGS of the GP Practice Nurses Section will be taking place over the coming weeks, with the reinvigoration of the section a top priority.

At the most recent meeting in March, the election of officers took place and the priority issues for the section were discussed.

Under Sláintecare and the Enhanced Community Care Programme, many general practice nurses have enhanced their role and are now delivering chronic disease management clinics to patients, providing both preventative and opportunistic care.

This seamless transition has happened with little to no remuneration to nurses working within general practice.

The section aims to address this as an immediate priority. The section's next meeting is scheduled for April 25 at 5pm online.

If you would like to get in touch with the section officers, please contact jean.carroll@inmo.ie

INMO welcomes formation of inclusion health group as part of section network

NURSES and midwives working in the area of inclusion health will be happy to hear that they now have a dedicated section.

In 2019 a professional interest group was established for nurse and midwife practitioners working in contexts where access to and uptake of health services is limited as a result of marginalisation, discrimination or lack of awareness.

Since then membership has grown and the group – Nurses and Midwives for Inclusion Health – has been formally established as part of the INMO national section network.

The INMO Inclusion Health Section will allow members nationally to access additional networking, peer support, education and support services in the area of inclusion health.

Some examples of these practice areas include: homeless health, migrant or refugee health, Traveller health, mental health, disability health, forensic and prisoner health, addiction health and sexual health.

Our aims are to develop and share excellence in nursing and midwifery in inclusion health and to support practitioners in professional and practice development, education and research.

If you are interested in aligning to the INMO Inclusion Health Section, please contact membership@inmo.ie to be kept up to date with developments.

The next section meeting is scheduled for Tuesday, May 21 at 11am at the Richmond Education and Event Centre.

Please contact section development officer Jean Carroll with any questions at jean.carroll@inmo.ie

Dermatology aesthetic nurses form new section under INMO banner

THE INMO would like to welcome a new section that was established recently following a decision of the INMO Executive Council.

The Dermatology Aesthetic Nurses Section is intended for nurses and midwives who currently work in or are interested in working in dermatology and aesthetics.

Aesthetic dermatology is a growing area of professional practice and specialism, with nurses working in both the public and private sectors.

This new INMO section will provide a unique opportunity to network with other nurses who are working in dermatology and aesthetics and will offer a voice to advocate on behalf of your fellow members.

For further information on joining an this section, please contact Jean Carroll at jean.carroll@inmo.ie

In brief...

Busy schedule for COOP conference

BOOK your place for the annual conference of the Care of the Older Person (COOP) Section, which is scheduled to take place on Tuesday, May 28 in the Midland Park Hotel, Portlaoise.

The line up for the day will include national updates in gerontology, safe staffing, medico-legal issues, among many more topics.

Book your place now by emailing education@inmo.ie

Next stop West Cork for Retired Section

THE Retired Section is planning a trip to stay at the four-star Clonakilty Park Hotel in West Cork on May 6 for five days with John McGinley Travel.

Bookings can be made by calling the travel agency directly at Tel: 074 9135201.

Get in touch with Geraldine Sweeney from the social committee 087 2794701.

Retired Section members are also invited to attend *The Pull of the Stars* in the Gate Theatre at 2pm on Saturday April 13. Book directly with the Gate on 01 5720732.

Get in touch

Contact: Jean Carroll
Section Development Officer
at HQ at Tel: 01 6640 600
or email: jean.carroll@inmo.ie

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Introduction to effective library search skills

Apr 15

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information seeking skills to get the most up to date information for clinical practice, reflection, or policy development. This course will assist participants who are undertaking academic programmes.

Fee: €50 INMO members; €85 non members

Understanding and developing care plans

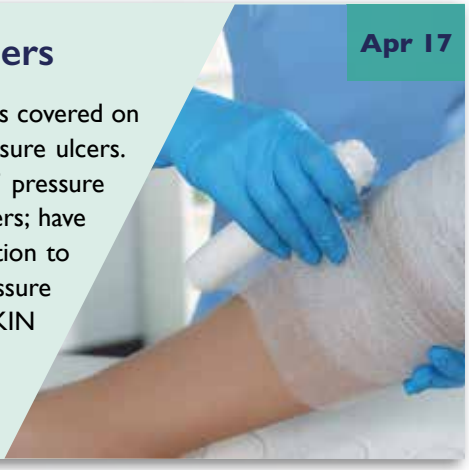
Apr 15

This programme provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

Fee: €50 INMO members; €85 non members

Introduction to treating and preventing pressure ulcers

Apr 17



This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. After completing this course, participants will be able to: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

Fee: €50 INMO members; €85 non members

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together



21	MAY	**National Care of the Older Person Section** Midlands Park Hotel, Portlaoise, Co Laois
24	SEP	**Telephone Triage Section** The Richmond Education and Event Centre, Dublin
05	OCT	**Operating Department Nurses Section** Slieve Russell Hotel, Cavan
19	OCT	**Public Health Nurses Section** Online Webinar
07	NOV	**All Ireland Midwives Conference** Fairways Hotel, Dundalk, Co Louth
16	NOV	**National Childrens Nurses Section** Online Webinar

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Apr 11 **Diabetes – a general overview**

This course will give a general overview of diabetes. It will give insight into the different diagnosis of diabetes, treatment options and management of it. Participants will learn about blood glucose testing, ketone testing, insulin pump and sensors and emergencies.

Apr 15 **Introduction to effective library search skills**

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information seeking skills to get the most up to date information for clinical practice, reflection, or policy development. This course will assist participants who are undertaking academic programmes.

Apr 15 **Understanding and developing care plans for nurses and midwives**

This programme provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

Apr 17 **Introduction to treating and preventing pressure ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. After completing this course, participants will be able to: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

Apr 18 **Adult asthma – getting the basics right**

This short online programme is aimed at nurses and midwives working in clinical practice who require basic knowledge and skills to care for people with asthma on a day-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with asthma utilising current best practice.

Apr 18 **Retirement planning seminar** *(sold out)*

INMO Professional, in partnership with Cornmarket Financial Services, have developed an in-person seminar to help support members planning for retirement. Topics covered on the day will include: superannuation explained, when a full pension is available, the calculation of the lump sum, options for increasing your retirement benefits, AVCs, Personal Retirement Savings Accounts (PRSAs), savings plans, planning your finances in retirement, what to do about any surplus income you may have in retirement and your own individual requirements. Fee: €10 INMO members; €45 non-members.

Apr 23 **Improve your academic writing skills and research skills**

This short online course is designed for nurses and midwives who are undertaking third-level academic programmes. This course will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer on to a course at a future date will be offered. For non-attendance, there is no refund or transfer. If a course is cancelled due to insufficient numbers, a full online refund will be issued.

Apr 24 **Phlebotomy** *(in person) (sold out)*

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work and hold an up to date Hand Hygiene Training certificate (within the last two years).

Apr 25 **COPD – getting the basics right**

This short online programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for people with COPD on a day-today basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with COPD utilising current best practice.

Apr 25 **Retirement planning seminar** *(in person in Galway)*

INMO Professional, in partnership with Cornmarket Financial Services, have developed an in-person seminar to help support members planning for retirement. Topics covered on the day will include: superannuation explained, when a full pension is available, the calculation of the lump sum, options for increasing your retirement benefits, AVCs, Personal Retirement Savings Accounts (PRSAs), savings plans, planning your finances in retirement, what to do about any surplus income you may have in retirement and your own individual requirements. Fee: €10 INMO members; €45 non-members.

Apr 30 **Legal and ethical aspects of nursing and midwifery practices** *(in person)*

This one-day course in legal ethics provides you with an opportunity to develop an understanding of legal issues relating to the practice of nursing and midwifery. The programme will be invaluable for those who seek to frame and update their thinking about ethical and legal issues in the practice of nursing and midwifery in the context of an ever-evolving legal landscape.

May 3 **Safe administration of medicines in residential care**

The aim of this workshop is to outline the professional, legal and best practice requirements for safe administration of medicines in a residential care setting. This course will identify the professional and legal requirements for safe administration of medicines in residential care settings, identify the 10 rights of medication administration, identify the requirements for a valid prescription and identify the requirements for record keeping when administering medicines in the centre.

May 14 **Falls reduction, assessment and review**

The purpose of this online programme is to promote a consistent approach to falls reduction for older people through assessment, individualised care planning and post-falls review. It promotes excellence among nurses who provide care to the patients at risk of falls, informed by current evidence. The main aim is to assist nurses to identify those patients or residents who are at risk of falls and to reduce that risk by providing knowledge on falls reduction techniques, ultimately improving patient safety and minimising injuries in the older population.

May 15 **Telephone assessment and advice skills for nurses and midwives**

This online programme is for nurses and midwives involved in providing telephone assessment and advice in the ED, general practice and other community settings. Such calls assess patients' needs and may provide advice for self care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller in a professional and tactful manner.

May 16 **Paediatric asthma – understanding the basics**

This short online programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for children and their families with asthma on a day-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the child with asthma utilising current best practice.

May 21 **Nursing and midwifery records under the spotlight** *(in person)*

This workshop is designed to equip registered nurses and midwives, working in a variety of healthcare settings, with the knowledge to maintain nursing records in accordance with legal and professional standards. Participants will be provided with the opportunity to review examples of records based on real case studies with a view to identifying and avoiding common legal pitfalls. The day will include both theory and practical sessions with interactive group work.

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Irish Nurses and Midwives Organisation
Working Together

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HAVE YOU BOOKED YOUR PLACE?

Below are some of our online courses scheduled in April/May 2024 for nurses and midwives.

APR 18

Adult asthma
- getting the basics right

This programme is aimed at nurses and midwives working in clinical practice who require basic knowledge and skills to care for people with asthma on a day-today basis.

APR 23

Improve your academic writing and research skills

This course will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study.

APR 25

Chronic Obstructive Pulmonary Disease (COPD)

This programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for people with COPD on a day-today basis.

MAY 03

Safe administration of medicines in residential care

The programme will outline the professional, legal and best practice requirements for safe administration of medicines in a residential care setting.

MAY 14

Falls reduction, assessment and review

This programme will promote a consistent approach to falls reduction for older people through assessment, individualised care planning and post-falls review.

MAY 15

Telephone assessment and advice skills

This programme is for nurses and midwives involved in providing telephone assessment and advice in A&E, general practice and other community settings.

Book now, call us on **01 6640618/41**

For more information go to www.inmoprofessional.ie/course

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Nursing records under the spotlight

In person course, The Richmond Education and Event Centre, Dublin

Scan the code to view the course

MAY 21

This new workshop is designed to equip registered nurses and midwives, working in a variety of healthcare settings, with the knowledge to maintain nursing records in accordance with legal and professional standards.

Participants will be provided with the opportunity to review examples of records based on real case studies with a view to identifying and avoiding common legal pitfalls. The day will include both theory and practical sessions with interactive group work.

Fee: €110 for INMO members; €185 for non members

Book now, call us on **01 6640618/41**

www.inmoprofessional.ie/course

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer on to a course at a future date will be offered. For non-attendance, there is no refund or transfer. If a course is cancelled due to insufficient numbers, a full online refund will be issued.

May 21 **Understanding epilepsy**

Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and concomitant diseases, as well as navigate how their life is affected by their diseases. The management of patients with complex medical conditions, including epilepsy, is increasingly being overseen by nurses. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education and support to their patients with epilepsy given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

May 23 **Mindfulness and meditation in holistic nursing and midwifery care**

We invite all nurses and midwives to learn mindfulness and meditation for holistic nursing and midwifery care. International research has proven that the practice of mindfulness brings measurable physiological changes in the brain called neuroplasticity. Practitioners report improved general sense of wellbeing and less stress and pain. We will explore the process of psychosomatic illnesses and how we can help our patients during difficult times.

May 29 **Complaints management for healthcare staff in acute or residential settings**

This short online programme most relevant to senior nurse managers within the acute or residential healthcare settings to provide them with the key skills of communication tools to minimise the negative impact complaints can have in their workplace. Therefore, effective management of complaints is central to improve services and prioritise an open, honest and transparent health service.

May 30 **Introduction to basal and mealtime insulin management in people with type 1 diabetes**

This new course will give nurses an insight into the management of insulin for people who have type 1 diabetes. Upon completion of this course, nurses will understand insulin, the insight into different insulin types, the management of insulin around bolus mealtime insulin and basal insulin, as well as activity and its effects on insulin.

Jun 4 **The importance of documentation for nurses and midwives**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right.

Jun 13 **Tracheostomy care study day**

This programme introduces a holistic and inter-disciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy.

Jun 14 **Management skills**

This programme outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients. The programme will explore both management and leadership functions and how these are applied in practice so as to promote quality and safety of care. Key topics covered include: management principles and competencies, team building, delegation and clinical supervision. Participants will gain effective management competencies that can be applied in the workplace to promote quality and safety in healthcare delivery.

Jun 19 **Person-centred care planning in ID services**

The aim of this programme is to outline the nurse's role in the process of person-centred assessment and care planning for service users within a legal and professional framework. This programme is relevant to management and frontline staff, who work in residential care and disability services.

Jun 25 **Risk management and incident reporting**

This programme outlines the core principles of best practice in managing risk, underpinned by the philosophy that care needs must be balanced against risk in the clinical environment. There is a clear emphasis that positive risk management is key for all stakeholders and requires comprehensive documentation to enhance an open, democratic and transparent culture and reflective practice. Identification and assessment of risk and controls to manage risk will be discussed, and a group exercise on clinical incident forms and reports will be conducted. Ultimately, this programme promotes best practice with regard to risk management and patient safety.

Lessons from a pandemic

Covid-19 and the latest CPD articles are on the agenda for the INMO Library this month

THIS month we look at the topic of Covid-19, and highlight a wide range of CPD articles that will assist nurses keep up to date. If you would like the full text of any of the following articles, please contact the library for further details.

Covid-19

- Damra JK et al. Stress and loneliness: exploring adolescents' use of social media as a coping strategy during Covid-19. Nursing Children & Young People, January 2024 vol.36 no.1
- Tracy MF et al. Emotional, mental health and physical symptom experience of patients hospitalized with Covid-19 up to 3 months post-hospitalization: A longitudinal study. Journal of Clinical Nursing February 2024 vol,33 no.2
- McGuone D et al. Covid-19 outcomes in patients with pre-existing cardiovascular disease and risk factors: perspectives from a hospital in Ireland. British Journal of Cardiac Nursing, January 2024 vol.19 No.1
- Robinson R et al. Rapid nursing redeployment from a specialist ward to a COVID-19 high-dependency setting. British Journal of Nursing, February 2024 vol.33 no.3
- Zhang Y et al. Experiences of maintaining awake prone positioning in non-intubated patients with Covid-19: A qualitative study. Nursing in Critical Care January 2024 vol.29 no.1
- Credland N et al. The impact of Covid-19 on mental health and wellbeing in critical care nurses – a longitudinal, qualitative study. Nursing in Critical Care, January 2024 vol.29 no.1
- Lucchini A, Villa M, Del Sorbo A, Pigato I et al. Determinants of increased nursing workload in the Covid era: A retrospective analysis of prospectively collected data. Nursing in Critical Care, January 2024 vol.29 no.1
- Siddique H et al. Resilience and burnout of healthcare workers during the early Covid-19 pandemic. British Journal of Nursing February 2024 vol.33 no.3

CPD articles

If you would like any of the following articles in full text, please contact the library at library@inmo.ie

- Fleming S, Burke E, Doyle C et al. Ensuring effective communication when undertaking a systematic health assessment. Learning Disability Practice, February 2024, Vol 27, Issue 1
- Butler S. History taking for advanced clinical practitioners: what should you ask? Nursing Times; 2024:120: 3
- Robinson S. Maintaining a safe environment in emergency department waiting rooms. Emergency Nurse, March 2024, Vol 32, Issue 2
- Harley J. How to design and deliver a small group teaching session. Nursing Management, February 2024, Vol 31 issue 1
- Jones-Barry S, Vennard K. Chronic obstructive pulmonary disease: reducing the risk of winter exacerbations. Primary Health Care, January 2024, Vol 34 issue 1
- Parry A. Understanding the use of oxygen delivery devices. Nursing Standard, 2024, Vol 39 issue 3
- Bayram-Weston Z et al. Vitamin B complex: B group vitamins and their role in the body. Nursing Times, 2024, 120: 3
- McNee D, Beckett H. Getting end-of-life education right for children's nursing students. Nursing Times, 2024, 120: 3
- Mills A. Improving health literacy to support better health outcomes. Nursing Times, 2024, 120: 3

Exciting changes coming to INMO Library online resources

The library is changing how members will access our online resources, including databases and journals. As part of our commitment to providing you with an enhanced online experience, the online library will be integrated into the main INMO website and access to library resources including databases and journals will be via OpenAthens. Therefore, the Nurse2Nurse website will cease to exist. This change will occur over the coming months, so to ensure uninterrupted access please register for OpenAthens by contacting the library at niamh.adams@inmo.ie or call 01 6640625

Contact the library

If you require any articles in full text, assistance with accessing the online library or would like to make an appointment to visit in person, email library@inmo.ie or phone us on 01 6640614/25

Online – Introduction to Effective Library Search Skills

Next course date: Wednesday, April 15, 2024

Fee: €30 INMO members; €65 non-members

This course is aimed at nurses and midwives who would like to develop their searching skills to effectively find the most relevant information for clinical practice, reflection and policy development. This course will also be of benefit to those who are undertaking, or about to commence, post-registration academic programmes.

INMO Professional

IRISH NURSES AND MIDWIVES ORGANISATION
The Whitworth Building, North Brunswick Street, Dublin 7
Tel: 01 664 0648 Fax: 01 661 0466
Email: jean.carroll@inmo.ie

NATIONAL SECTION AFFILIATION FORM

Please complete this form using Block Capitals

Full Name:

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- ☐ CIT Nurse Section
- ☐ Clinical Placement Co-Ordinators Section
- ☐ Clinical Nurse / Midwife Specialist
- ☐ Clinical Nurse / Midwife Manager Section
- ☐ Community RGN Section
- ☐ Dermatology Aesthetic Section
- ☐ Director of Nursing/ Midwifery/ Director of Public Health Nursing Section
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- ☐ Inclusion Health Section
- ☐ Internationally Educated Nurses Section
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- ☐ School Nurses Section
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Second Section Option, for information purposes only is: _____

Please complete the above form and return to the **INMO Membership Department**

The Whitworth Building, North Brunswick Street, Dublin 7
Tel: 01 664 0600 Fax: 01 661 0466 Email: membership@inmo.ie

INMO Professional

Midwifery library update

THIS month's current awareness bulletin looks at a wide range of midwifery topics including some Irish research articles.

Students and newly qualified midwives

- Lloyd B, Bradshaw C, McCarthy J et al. Midwifery students' experiences of their clinical internship placement during the Covid-19 pandemic in Ireland: A qualitative descriptive study. Midwifery 2023; 127:103861
- Arundell F, Sheehan A, Peters K. Strategies used by midwives to enhance knowledge and skill development in midwifery students: an appreciative inquiry study. BMC Nursing 2024, Feb 23; 23(1):1-10
- McNeill M, Kitson-Reynolds E. Student midwives' experiences of clinical placement and the decision to enter the professional register. British Journal of Midwifery 2024 Jan; 32(1):14-20

Breastfeeding

- Hamnøy IL, Kjelsvik M, Bærug AB, Dahl BM. A balancing act – midwives' and public health nurses' experiences with breastfeeding counselling. Scandinavian Journal of Caring Sciences 2024; 38(1):92-103
- Gallagher L, Brady V, Kuliukas L et al. Australian, Irish, and Swedish women's comfort levels when breastfeeding in public. BMC Public Health 23, 2535 (2023). https://doi.org/10.1186/s12889-023-17472-z
- McGuigan M, Larkin P. Laid-back breastfeeding: knowledge, attitudes and practices of midwives and student midwives in Ireland. International breastfeeding journal 2024, Feb 19; 19(1):13

Working conditions

- Carvajal B, Hancock A, Lewney K et al. A global overview of midwives' working conditions: A rapid review of literature on positive practice environment. Women and birth: journal of the Australian College of Midwives 2024 Feb; 37(1):15-50

Safe staffing

- Griffiths P, Turner L, Lown J, Sanders J. Evidence on the use of Birthrate Plus to guide safe staffing in maternity services - A systematic scoping review. Women and birth: journal of the Australian College of Midwives 2024; 37:317-24

Advanced midwifery practice

- Toll K, Sharp T, Reynolds K, Bradfield Z. Advanced midwifery practice: A scoping review. Women and birth: journal of the Australian College of Midwives 2024 Feb; 37(1):106-17

Water birth

- Mellado-García E, Díaz-Rodríguez L, Cortés-Martín J et al. Systematic reviews and synthesis without meta-analysis on hydrotherapy for pain control in labor. Healthcare (Basel) 2024, Feb 1; 12(3):373. doi: 10.3390/healthcare12030373
- McKinney JA, Vilchez G, Jowers A et al. Water-birth: a systematic review and meta-analysis of maternal and neonatal outcomes. American Journal of Obstetrics and Gynecology 2024. https://doi.org/10.1016/j.ajog.2023.08.034

Perinatal Mental Health

- Terry R, Hudson T. Increased rates of perinatal mental illness following Covid-19: the call for sufficient midwifery provision British Journal of Midwifery March 2024; 32(3)

RCM iLearn – Down syndrome course

A new 10-minute course entitled 'Down Syndrome: the importance of language' has been released this month on the RCM iLearn platform. Language is very powerful, particularly from the mouth of a healthcare professional. It can have a profound impact on the experience and emotions of people and their loved ones living with a condition, or being told their unborn baby could have a condition identified by antenatal screening. Words and terminology should be free from discrimination and prejudice, as well as being respectful, compassionate and valuing all people.

On completion of the course, you should have:

- Developed a knowledge base around the importance of language when discussing Down syndrome
- Increased your awareness of the implications of poor practice, including discriminatory or prejudicial views surrounding Down syndrome
- Challenged your current perceptions and attitudes towards Down syndrome, making recommendations for best practice when caring for families in maternity services.

Contact the library

For further information on any of the resources mentioned here, or to gain access to the INMO Library resources via OpenAthens or to RCM iLearn, please contact us at email: library@inmo.ie or Tel: 01-6640614/25.

RCM i-learn access for INMO midwife members

Free access is available to all midwife members of the INMO. If you are interested in learning more about the modules outlined or in completing a learning module, visit: **www.inmoprofessional.ie/RCMAccess** or email the INMO library at: library@inmo.ie for further information

Royal College of Midwives

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy and the staff of the Information Office

Maternity leave in premature birth

Q. I am a staff nurse working in the public health service. I had planned to start my maternity leave at week 37 of my pregnancy, two weeks before the end of the week when my baby was due. However, my baby came seven weeks before I planned to go on maternity leave. This would mean that I started my maternity leave earlier than expected. I believe that there have been some changes in the maternity legislation in relation to premature births?

If your baby was born before the date when you were due to start maternity leave, your maternity leave (which starts immediately when the baby is born) lasts for 26 weeks from the date of your baby's birth. For premature births on or since October 1, 2017 maternity leave is extended for an extra period after the end of this 26 weeks (Maternity Benefit is also payable for this extra period). Under these arrangements, in addition to the current 26 weeks paid maternity leave, nurses/midwives will be entitled to an additional period of paid maternity leave. It corresponds to the time period between your baby's actual birth date and the expected start date of your maternity leave. To make a claim for any additional period due to a premature birth, nurses/midwives need to contact the Maternity Benefits Section by contacting the Department of Social Protection, to inform that section of the premature birth before the end of the first 26 weeks of Maternity Benefit.

Injury on way to work

Q. I have a question in relation to an occupational injury. I was getting out of my car at the hospital car park and tripped. I am currently out on sick leave as a result of my injury. My employer advised me that I am not entitled to the injury allowance as it was not an injury at work. I am concerned that I will be use up my sick leave entitlement.

Your employer is correct in this instance. An injury allowance may be granted where a nurse/midwife employed in the public health service is injured:

- In the actual discharge of his or her duty
- Without his or her own default
- By some injury attributable solely to the nature of their duty.

Entitlement to the allowance arises only where all three of the conditions are met.

However, if you are paying class A1 stamp you have an entitlement to Injury Benefit from the Department of Social Protection. Accidents while on an unbroken journey to or from work are covered by this. Application for Injury Benefit should be made within 21 days of your injury/incapacity. This is important because if you do not claim in time you may lose benefit.

Promotion near retirement

Q. I am currently a senior enhanced staff nurse working in the public health service and am considering taking up a CNM1 post. I am due to retire at the end of the year. Will this affect my pension if I take up this promotional post? I currently work night duty and weekends.

If you take up a promotional post and then retire within three years of this promotion, your pension and lump sum may be affected. To determine how much of a loss you may have, you should contact your superannuation department. Your salary will be averaged out over the previous three years and your allowances held in the former grade will no longer be applicable.

Annual leave cancelled by employer

Q. I had annual leave booked and authorised by my employer, however a week before I was due to take this leave my employer advised that they were cancelling my annual leave. Can they do this?

Under Section 20 of the Organisation of Working Time Act, the employer must give one month's notice of their intention to cancel annual leave. The employer having consulted the employee or the trade union (if any) of which he or she is a member, not later than one month before the day on which the annual leave or, as the case may be, the portion thereof concerned is due to commence. Any such cancellation of leave however is most unusual and should not occur.

Know your rights and entitlements

The INMO Information Office offers same-day responses to all questions

Contact Information Officers Catherine Hopkins and Catherine O'Connor at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie, catherine.oconnor@inmo.ie
Mon to Thur 9am-5pm; Fri 8.30am-4.30pm

- Annual leave
- Sick leave
- Maternity leave
- Parental leave
- Pregnancy-related sick leave
- Pay and allowances
- Flexible working
- Public holidays
- Career breaks
- Injury at work
- Agency workers
- Incremental credit

Quality & Safety

A column by Maureen Flynn

Clinical audit tools: supporting nurses and midwives

CLINICAL audits play a pivotal role in ensuring the delivery of high-quality and evidence-based patient care. For nurses and midwives, who are integral to the healthcare system, understanding and conducting clinical audits are essential components of our practice. In this month's column we share information on the new Clinical Audit Toolkit available to assist us in undertaking clinical audits.

NCCA Clinical Audit Toolkit

Clinical audit is a process not only to pinpoint areas in need of improvement, but also to highlight positive findings worth celebrating and sharing. The HSE's National Centre for Clinical Audit (NCCA) serves as a valuable resource to support nurses and midwives in their clinical audit endeavours, providing education, tools and guidance to enhance the quality of patient care.

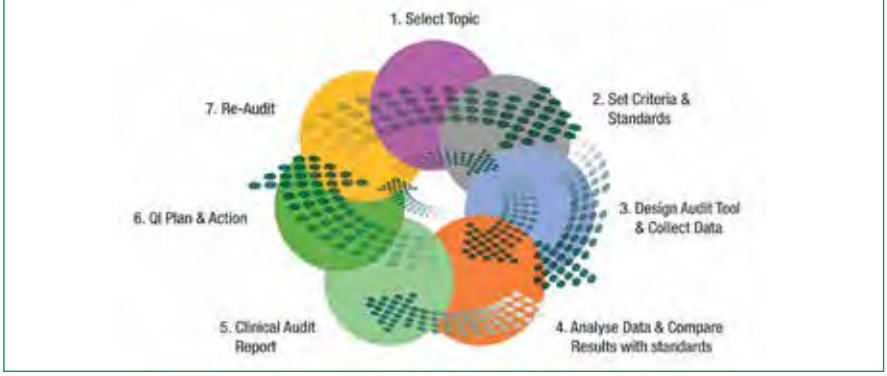
The new innovative Clinical Audit Toolkit is designed with customisable templates. It aims to streamline the clinical audit process and enhance the quality of patient care. The templates provide a structured framework for conducting clinical audits, documenting findings and implementing quality improvement initiatives. Its user-friendly interface simplifies the navigation and utilisation of the clinical audit tools, such as:

- The clinical proposal form
- Clinical audit report template
- Quality improvement action plan template
- Terms of reference template for local clinical audit committees.

Benefits

The customisable nature of the templates, allows nurses and midwives to tailor the clinical audit tools to suit the specific needs and requirements of their clinical settings. By utilising this toolkit, you can efficiently conduct clinical audits, identify areas for improvement and implement evidence-based practices to enhance patient outcomes. The toolkit also facilitates collaboration among healthcare teams, fosters a culture of continuous quality improvement, and supports the development of best practices in clinical care.

Clinical audit process



Learn more

Last year the NCCA conducted a training needs assessment to identify gaps and areas for improvement in clinical audit training. The feedback received from staff members, including nurses and midwives, highlighted the need for more practical training, using Irish examples, shorter, accessible training sessions and a need for tools for use in clinical audit. To respond to this need the NCCA devised additional training sessions in the form of:

- 'Practical training in clinical audit for healthcare professionals': this offers participants a walk through each step of the seven stages of the clinical audit cycle, giving practical examples to enhance learning. This new two-hour session details how to select a topic, choosing criteria and standards, designing a tool for clinical audit and collecting data, analysing data, writing a report, developing a quality improvement plan and re-auditing. In each stage instructors provide real examples form practice to enhance the learning experience
- A series of webinars called 'Clinical Audit Learning Hours'. These recorded webinars provide a convenient and accessible way for nurses and midwives to stay updated on key issues in clinical audit such as data analysis, quality improvement, governance, GDPR and the impact of the Patient Safety Act.

Get involved

At your next team, unit or ward meeting you might talk about clinical audit and how audits are undertaken in your area of practice. To expand your learning it's good to know that all of the education and training opportunities provided by the NCCA are available for booking through HSeLanD. By engaging in practical clinical audit exercises, you can gain confidence in your clinical audit skills and be better prepared to implement clinical audits in your own settings.

Further information

The prospectuses for 'Education and Training', 'Clinical Audit toolkit', 'Practical Guide for Clinical Audit and Nomenclature Guide' (glossary of terms used in clinical audit) are all available for staff on the NCCA webpages. Please scan the QR code to locate them.

The NCCA looks forward to working with nurses and midwives to enhance patient quality and safety. If you have any queries regarding clinical audit please email ncca@hse.ie

Dr Maureen Flynn is the director of nursing and QPS lead with the HSE Office of the Nursing and Midwifery Services Director

Acknowledgements: Special thanks to my colleagues Selene Daly and Majella Daly from NCCA for collaborating and assistance in writing this column

Student and new graduate update

With Jamie Murphy

Focus on: understanding your payslip

I'M JAMIE Murphy, the go-to person for students and new graduates at the INMO. Having completed my studies at Trinity College Dublin, I understand the ups and downs of student life. While we've made strides in valuing student nurses and midwives, there is still more to do. Feel free to connect with me about anything – whether it's good vibes or challenges. Let's team up to make your journey awesome and ensure it's a success.

New graduates, congratulations on reaching this milestone in your career. Many of you will be familiar with your pay slips already. Understanding your pay is crucial. Legally your payslip should outline your gross wages, deductions and other essential details, including things like employer details, employee number and position.

Your payslip is divided into two columns. On the left-hand side is the payments column, where you will find your gross pay. This is the total amount paid to you before any deductions are made for that pay period. Net pay is the total amount paid once all deductions are made for that period. Basic pay is the standard amount paid before any additional premiums or allowances are added. Allowances are only relevant to graduates and do not apply to students on placement.

It is important to monitor your basic pay to ensure that it increases in line with your increments. To calculate your salary point from your hourly rate you must multiply your hourly rate by 37.5 to give you your weekly rate. Then multiply your weekly rate by 52.18 to give an estimate of your yearly salary.

Premium pay, encompassing various factors like weekends and holidays, is itemised separately from your basic pay. New graduates should look into potential allowances that might be applicable to you, such as the specialist qualification allowance or location allowance. You can get more information on the INMO website at: **inmo.ie/salary_information**

Pay scale

The successful 2019 INMO strike for better conditions and pay for nurses and midwives resulted in the introduction of the enhanced practice salary scale. Graduates are now eligible to apply for the enhanced practice contract once they reach the fourth point on the old pay scale.

Reaching the fourth point on the payscale can be achieved one year and 16 weeks post internship. For example, a staff nurse who graduated in September 2023 will be eligible to apply for the enhanced nurse salary in approximately January 2025. The application for the new salary scale must be submitted before your increment date to benefit from the pay increase.

The INMO is actively engaging in order to have this term reviewed, nonetheless I advise all new graduates to put a reminder on their calendars to have their application for the new salary scale completed and signed by their line manager before their increment date.

Watch out for errors. Unfortunately, in the past I was incorrectly paid in my workplace. When I became an INMO rep I attended training and it was here that I discovered the error with my pay scale. I worked with my industrial relations officer Bernadette Stenson and we got my pay scale, and that of my colleagues, corrected.

If you have any questions or issues on your pay scale, please do not hesitate to contact me.

Deductions

Deductions include PAYE (income tax),

USC and PRSI. You should optimise tax credits applicable to your circumstances, such as the flat rate expense of €733 for nurses/midwives who are obliged to buy and launder their own uniforms, or a tax credit of €750 if you are renting from a private landlord. You can update these details via **www.revenue.ie**.

You should update Revenue promptly about changes affecting your tax credits to benefit. Nonetheless, your tax credits can be amended up to four years and backdated. It's important to understand pension deductions.

All nurses employed within the public sector on or after January 1, 2013 are part of the Single Public Service Pension Scheme. You can familiarise yourself with its rules at **singlepensionscheme.gov.ie**

Union membership

INMO membership is free for all undergraduate students but following graduation there is a fee (see: **www.inmo.ie/membership**).If you choose to pay your membership by deduction at source, it will come directly from your salary and will be listed as a deduction on your payslip.

You can contact me directly or send an email to: membership@inmo.ie if you require any assistance with your membership application.

Jamie Murphy is the INMO student and new graduate officer. You can contact her with any problems, queries, questions or ideas that you might have – relating to students and new graduates – by email to: Jamie.murphy@inmo.ie

Chickenpox vaccination

Subject to the funding being secured, varicella immunisation will be added to the Primary Childhood Immunisation Programme next year

LAST year the Health Information and Quality Authority (HIQA) published its Health Technology Assessment (HTA) of adding the chickenpox (varicella) vaccine to the routine childhood immunisation programme. This assessment was requested by the Department of Health following a policy recommendation from the National Immunisation Advisory Committee (NIAC).

As an acute infectious disease, chicken pox causes a blister-like rash, itching, tiredness and fever. In some cases complications can be severe. It also puts a significant burden on the economy as parents can need extended time off work to care for infected children.

HIQA's assessment found that there was "clear and consistent evidence from a strong evidence base" that the chickenpox vaccine was safe and effective in preventing chickenpox and its complications and that adding the chickenpox vaccine to the childhood immunisation programme was likely to be cost effective.[1]

The Department of Health told *WIN* that, based on NIAC's recommendation and the advice of the chief medical officer, "the Minister has approved the introduction of the varicella vaccine into the Primary Childhood Immunisation Programme, subject to funding being made available via the 2025 Estimates process".

Those wishing to avail of the vaccine ahead of this will have to do so privately.

Symptoms and spread

Those incubating varicella may have a temperature and feel non-specifically unwell in the one to two days before rash onset. In children, rash is often the first sign of the disease.

The rash starts off as red spots that typically develop into small fluid-filled blisters (vesicles) that then crust over before healing. The rash usually appears on the head and then the trunk, followed by the arms or legs. Successive crops appear over several days.

The clinical course is generally mild in healthy children with malaise, itching and temperature for two to three days. Adults and children with immunocompromising conditions are more likely to have severe disease and more complications.

Varicella-zoster virus is spread through the respiratory tract and direct contact or inhalation of aerosols from vesicular lesions of acute varicella or zoster with skin lesions. It is highly infectious. Virus incubation to development of the typical rash is from 14-16 days (range 10-21 days). The incubation period may be prolonged in immunocompromised individuals or those who have received immunoglobulin with antibodies to varicella zoster.

Individuals with varicella infection are most infectious for one to two days before rash onset through to the first four to five days, or until the lesions have formed crusts. Shingles is less infectious.

Complications

Of the 58,000 cases of chickenpox every year in Ireland, approximately one in 250 cases will be hospitalised with associated complications.[1] Approximately one-third of people who have had chickenpox will develop shingles at some point during their lifetime due to reactivation of the virus.

The risk of complications in varicella varies with age. Complications are infrequent among healthy children but occur much more frequently in those older than 15 years of age and infants younger than one year of age. Most commonly reported complications include:

- Secondary bacterial skin infection
- Pneumonia (viral or secondary bacterial)
- Neurological complications,meningitis, encephalitis (1.8/100,000 cases).

Death-rate varies by age group and immunologic status:

- 1/100,000 among children one to 14 years of age
- 2.7/100,000 among individuals 15 to 19 years of age
- 25.2/100,000 among adults aged 30-49.

Only hospitalised varicella cases are notifiable in Ireland.

Pregnancy

Infection with varicella in the first 20 weeks of pregnancy can cause a variety of abnormalities in the foetus, including: low birth weight, underdevelopment of limbs, skin scarring, poor development of localised muscles and brain abnormality. The mortality rate ranges from 1-2%.

Varicella (chickenpox) vesicles on a child's back

Maternal varicella infection from five days before to two days after delivery may result in overwhelming infection in the infant and a fatality rate as high as 30%.

Diagnosis

Varicella zoster infection can usually be diagnosed based on clinical presentation (typical rash). Laboratory diagnosis is sometimes sought to confirm diagnosis. The virus can be demonstrated in vesicular fluid in chickenpox and shingles lesions. Serology tests are available and can be used to demonstrate immunity.

Prevention

Varicella infection is prevented using a live attenuated vaccine or varicella zoster immunoglobulin (VZIG). Two doses of varicella vaccine are recommended in both children and adults in specific risk groups, including non-immune healthcare workers, laboratory staff at risk of exposure, household contacts of immunocompromised patients, children in residential units for severe disability and non-immune women of child-bearing age.

Under specialist hospital supervision and protocols, certain categories of immunocompromised patients may be vaccinated. Women of childbearing age without a history of varicella infection should have their immunity checked. Women with negative serology should be vaccinated prior to pregnancy, if no contraindications exist. Pregnancy should be avoided for three months following the last dose of varicella vaccine.

See the HSE's immunisation guidelines for more specific information on varicella vaccination at: **www.hse.ie**

- Alison Moore

Reference
1. www.hiqa.ie/reports-and-publications/health-technology-assessment/hta-expansion-childhood-immunisation-schedule

Focus on: Urinary incontinence

Part one of a short series on urinary incontinence looks at the different kinds of the incontinence and their diagnosis

URINARY incontinence (UI) is an extremely common complaint worldwide. It has mental, social and medical impacts on individuals and societies. It is a condition characterised by the involuntary leakage of urine, which can significantly impact one's quality of life and self-esteem.[1]

In Ireland, UI affects as many as one-third of the population. Despite a significant number of people experiencing symptoms and the presence of available treatments, only three out of five individuals with UI discuss their symptoms with a healthcare professional. Research suggests that nearly 50% of adult women in Ireland experience UI, but only 40% of those who have symptoms actively seek medical care for it.[2,3]

Risks and causes

Age: Age plays a pivotal role in the risk of developing UI due to the natural alterations that occur in bladder function and muscle tone as individuals grow older.[4]

Gender: The incidence of UI is notably higher among women compared to men, primarily attributable to various factors inherent to the female reproductive system. Women frequently encounter UI due to the physiological stresses induced by pregnancy and childbirth, which can weaken pelvic floor muscles and nerves essential for urinary control. Additionally, hormonal fluctuations throughout a woman's life, such as those experienced during menopause, can further contribute to UI development.[5]

Smoking: Smoking can contribute to chronic coughing, which can strain the pelvic floor muscles and increase the risk of stress incontinence. Quitting smoking may reduce this risk and promote better pelvic floor health.[6]

Chronic conditions: Certain medical conditions, such as diabetes, multiple sclerosis and Parkinson's disease, can affect nerve function and increase the risk of incontinence; pelvic surgeries could also cause urinary incontinence.[7]

Medications: Some medications, including diuretics, sedatives and antipsychotic drugs, may contribute to urinary incontinence as a side effect.[8]

Besides these risks, UI can develop due to other causes such as bladder outlet obstruction, eg. an enlarged prostate in men can obstruct the urethra and interfere with bladder emptying, leading to overflow incontinence. Urinary tract infections (UTIs) also can lead to irritation and inflammation, causing urinary incontinence.[9,10]

Types of urinary incontinence

There are different types of UI, including:

Stress incontinence: This is when urine leaks out when physical pressure is placed on the bladder (eg. during coughing or laughing). This can happen when the muscles that prevent urination are weakened or damaged. For example, the pelvic floor muscles and urethral sphincter

Urge incontinence: This is urinary leaking as the person feels a sudden, intense urge to pass urine, or soon afterwards. This can be caused by overactivity of the native detrusor muscles of the bladder. These muscles normally control the storage and releasing of urine from the bladder

Mixed incontinence: This type of incontinence is characterised by the presence of both stress incontinence and urge incontinence in the same individual

Overflow incontinence: This is the inability to fully empty the bladder, leading to urinary leaking. This is often caused by an obstruction to the bladder. This prevents it emptying fully, causing urine to overflow from the full bladder

Continuous incontinence: This is the inability of bladder to store any urine at all, causing continuous urinary leaking. This may be caused by a problem with the bladder or ureteric orifices from birth, spinal injury or a bladder fistula (an abnormal communication that can form between the bladder and a nearby area, such as the vagina, in women).[11]

Diagnostic evaluation

Investigations for urinary incontinence are essential to diagnose the underlying causes and determine the most appropriate treatment. Investigations include the following steps.

Medical history and physical examination: A detailed medical history and physical examination are often the first steps in evaluating UI and a patient questionnaire will be a helpful tool in measuring outcome and quality of life. The history should include details of the type, timing and severity of UI and other urinary symptoms.

The history should allow UI to be categorised into stress urinary incontinence (SUI), urge urinary incontinence (UUI) or mixed urinary incontinence (MUI). It should also identify patients who need rapid referral to an appropriate specialist. These include patients with associated pain, haematuria, a history of recurrent UTI, pelvic surgery (particularly prostate surgery) or radiotherapy, constant leakage suggesting a fistula, voiding difficulty or a suspected neurological disease.[1]

Bladder diary: A bladder diary, also known as micturition or voiding diary, involves keeping a detailed record of fluid intake, urine output, incontinence episodes and associated circumstances over a set period. It helps evaluate patterns and triggers of incontinence. The bladder diary is an important step in the evaluation and management of lower urinary tract dysfunction, including UI, and to support diagnoses, such as overactive bladder (OAB) or polyuria.[1]

Urinalysis and UTI: A urinalysis involves testing a urine sample for signs of infection, blood or other abnormalities that may contribute to urinary incontinence

and might need further assessment and management.[1]

Post-void residual volume measurement (PVR): This test measures the amount of urine left in the bladder after voiding, helping to assess bladder emptying and potential issues with incomplete emptying. Post-void residual can be measured by using catheter or ultrasound.[1]

Urodynamic testing: Urodynamic testing is a combination of non-invasive investigation such as uroflowmetry and invasive investigations such as a pressure flow study with or without urethral pressure profilometry. It involves an evaluation on how the bladder, urethra and sphincter muscles function during urine storage and release. It helps diagnose the specific type of urinary incontinence. Urodynamic tests help to differentiate the predominant type of UI in patients presenting with mixed UI as well as to assess the detrusor contractility and leak point pressures.[1]

Pad testing: This entails measurement of urine loss using an absorbent pad worn over a certain period of time or during a physical exercise to identify the presence and severity of UI.[1]

Imaging: Imaging improves the understanding of the anatomical and functional abnormalities that may cause UI. Imaging is used to understand the relationship between anatomy and function, between conditions of the central nervous system or of the urinary tract and UI. Ultrasound is preferred due to its ability to produce dynamic images at lower cost and wider availability.[1]

Other investigation could be used to evaluate any lower urinary system, such as cystoscopy, which is a camera test to visualise the inside of the bladder and urethra. A more advanced test such as video urodynamics could also be used in select cases to obtain more details about the urinary function.[12,13]

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Part two of this series will focus on disease management

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For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Name:** BETMIGA 25 mg prolonged-release tablets & BETMIGA 50 mg prolonged-release tablets. **Presentation:** Prolonged-release tablets containing 25 mg or 50 mg mirabegron. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Posology and administration:** The recommended dose is 50 mg orally once daily in adults (including elderly patients). Mirabegron should not be used in paediatrics for OAB. A reduced dose of 25 mg once daily is recommended for special populations (please see the full SPC for information on special populations). The tablet should be taken with liquids, swallowed whole and is not to be chewed, divided, or crushed. The tablet may be taken with or without food. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SPC. Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Warnings and Precautions:** Renal impairment: BETMIGA has not been studied in patients with end stage renal disease (eGFR < 15 ml/min/1.73 m^2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2); based on a pharmacokinetic study (see section 5.2 of the SPC) a dose of 25 mg once daily is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hepatic impairment: BETMIGA has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. This medicinal product is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with mirabegron, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: BETMIGA, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies (see section 5.1 of the SPC). However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinics medicinal products for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medicinal products for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with BETMIGA; however, BETMIGA should be administered with caution to patients with clinically significant BOO. BETMIGA should also be administered with caution to patients taking antimuscarinic medicinal products for the treatment of OAB. **Interactions:** Caution is advised if mirabegron is co-administered with medicinal products with a narrow therapeutic index and significantly metabolised by CYP2D6. Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. In patients with mild to moderate renal impairment or mild hepatic impairment, concomitantly receiving strong CYP3A inhibitors, the recommended dose is 25 mg once daily. For patients who are initiating a combination of mirabegron and digoxin (P-gp substrate), the lowest dose for digoxin should be prescribed initially (see the SPC for full prescribing information). The potential for inhibition of P-gp by mirabegron should be considered when BETMIGA is combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Pregnancy and lactation:** BETMIGA is not recommended in women of childbearing potential not using contraception. This medicinal product is not recommended during pregnancy. BETMIGA should not be administered during breast-feeding. **Undesirable effects:** Summary of the safety profile: The safety of BETMIGA was evaluated in 8433 adult patients with OAB, of which 5648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received BETMIGA for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with this medicinal product, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for adult patients treated with BETMIGA 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving BETMIGA 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving BETMIGA 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving BETMIGA 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving BETMIGA 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. Adverse reactions: The following list reflects the adverse reactions observed with mirabegron in adults with OAB in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000) and not known (cannot be established from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The adverse events are grouped by MedDRA system organ class. *Infections and infestations:* Common: Urinary tract infection, Uncommon: Vaginal infection, Cystitis. *Psychiatric disorders:* Not known (cannot be estimated from the available data): Insomnia*, Confusional state*. *Nervous system disorders:* Common: Headache*, Dizziness*. *Eye disorders:* Rare: Eyelid oedema. *Cardiac disorders:* Common: Tachycardia, Uncommon: Palpitation, Atrial fibrillation. *Vascular disorders:* Very rare: Hypertensive crisis*. *Gastrointestinal disorders:* Common: Nausea*, Constipation*, Diarrhoea*, Uncommon: Dyspepsia, Gastritis, Rare: Lip oedema. *Skin and subcutaneous tissue disorders:* Uncommon: Urticaria, Rash, Rash macular, Rash papular, Pruritus, Rare: Leukocytoclastic vasculitis, Purpura, Angioedema*. *Musculoskeletal and connective tissue disorders:* Uncommon: Joint swelling. *Renal and urinary disorders:* Rare: Urinary retention*. *Reproductive system and breast disorders:* Uncommon: Vulvovaginal pruritus. *Investigations:* Uncommon: Blood pressure increased, GGT increased, AST increased, ALT increased. * signifies adverse reactions observed during post-marketing experience. Prescribers should consult the SPC in relation to other adverse reactions. **Overdose:** Treatment for overdose should be symptomatic and supportive. In the event of overdose, pulse rate, blood pressure, and ECG monitoring is recommended. **Basic NHS Cost:** Great Britain (GB)/Northern Ireland(NI): BETMIGA 50 mg x 30 = £29, BETMIGA 25 mg x 30 tablets = £29. Ireland (IE): POA. **Legal classification:** POM. **Marketing Authorisation number(s):** (GB): PLGB 00166/0415-0416. NI/IE: EU/1/12/809/001-006, EU/1/12/809/008-013, EU/1/12/809/015-018. **Marketing Authorisation Holder:** GB: Astellas Pharma Ltd., 300 Dashwood Lang Road, Bourne Business Park, Addlestone, United Kingdom, KT15 2NX. NI/IE: Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Date of Preparation of Prescribing information:** January 2023. **Job bag number:** MAT-IE-BET-2023-00001. **Further information available from:** GB/NI: Astellas Pharma Ltd, Medical Information: 0800 783 5018. IE: Astellas Pharma Co. Ltd., Tel.: +353 1 467 1555. For full prescribing information, please see the Summary of Product Characteristics, which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-GB/northernireland/; IE: www.medicines.ie.

United Kingdom (GB/NI)
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Astellas Pharma Ltd. on 0800 783 5018.

Ireland
Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse reactions via: HPRA Pharmacovigilance, Website: www.hpra.ie or Astellas Pharma Co. Ltd. Tel: +353 1 467 1555, E-mail: irishdrugsafety@astellas.com.

Date of preparation: January 2023

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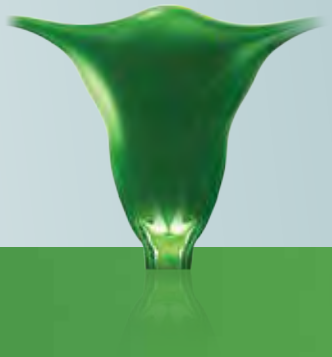

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KEYTRUDA® (pembrolizumab)
ABRIDGED PRODUCT INFORMATION KEYTRUDA® (pembrolizumab) **PRESENTATION** KEYTRUDA 25 mg/mL: One vial of 4 mL of concentrate contains 100 mg of pembrolizumab. **INDICATIONS** KEYTRUDA as monotherapy is indicated for the treatment of adults and adolescents aged 12 years and older with advanced (unresectable or metastatic) melanoma. KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults and adolescents aged 12 years and older with Stage IIB, IIC or III melanoma and who have undergone complete resection. KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with non-small cell lung carcinoma who are at high risk of recurrence following complete resection and platinum-based chemotherapy. KEYTRUDA as monotherapy is indicated for the first-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a ≥50% tumour proportion score (TPS) with no EGFR or ALK positive tumour mutations. KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of metastatic non-squamous NSCLC in adults whose tumours have no EGFR or ALK positive mutations. KEYTRUDA, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of metastatic squamous NSCLC in adults. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic NSCLC in adults whose tumours express PD-L1 with a ≥1% TPS and who have received at least one prior chemotherapy regimen. Patients with EGFR or ALK positive tumour mutations should also have received targeted therapy before receiving KEYTRUDA. KEYTRUDA as monotherapy is indicated for the treatment of adult and paediatric patients aged 3 years and older with relapsed or refractory classical Hodgkin lymphoma (cHL) who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who have received prior platinum-containing chemotherapy. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who are not eligible for cisplatin-containing chemotherapy and whose tumours express PD L1 with a combined positive score (CPS) ≥ 10. KEYTRUDA as monotherapy or in combination with platinum and 5-fluorouracil (5-FU) chemotherapy, is indicated for the first-line treatment of metastatic or unresectable recurrent head and neck squamous cell carcinoma (HNSCC) in adults whose tumours express PD-L1 with a CPS ≥ 1. KEYTRUDA as monotherapy is indicated for the treatment of recurrent or metastatic HNSCC in adults whose tumours express PD-L1 with a ≥ 50% TPS and progressing on or after platinum-containing chemotherapy. KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of advanced renal cell carcinoma (RCC) in adults. KEYTRUDA, in combination with lenvatinib, is indicated for the first line treatment of advanced renal cell carcinoma in adults. KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with renal cell carcinoma at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions. *Microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) cancers Colorectal cancer (CRC)* KEYTRUDA as monotherapy is indicated for adults with MSI-H or dMMR colorectal cancer in the following settings: - first line treatment of metastatic colorectal cancer - treatment of unresectable or metastatic colorectal cancer after previous fluoropyrimidine based combination therapy. *Non-colorectal cancers* KEYTRUDA as monotherapy is indicated for the treatment of the following MSI H or dMMR tumours in adults with (a) advanced or recurrent endometrial carcinoma, who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation, (b) unresectable or metastatic gastric, small intestine, or biliary cancer, who have disease progression on or following at least one prior therapy. KEYTRUDA, in combination with platinum and fluoropyrimidine based chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic carcinoma of the oesophagus or HER-2 negative gastroesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS ≥ 10. KEYTRUDA, in combination with chemotherapy as neoadjuvant treatment, and then continued as monotherapy as adjuvant treatment after surgery, is indicated for the treatment of adults with locally advanced, or early stage triple negative breast cancer at high risk of recurrence. KEYTRUDA, in combination with chemotherapy, is indicated for the treatment of locally recurrent unresectable or metastatic triple negative breast cancer in adults whose tumours express PD L1 with a CPS ≥ 10 and who have not received prior chemotherapy for metastatic disease. KEYTRUDA, in combination with lenvatinib, is indicated for the treatment of advanced or recurrent endometrial carcinoma in adults who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation. KEYTRUDA, in combination with chemotherapy with or without bevacizumab, is indicated for the treatment of persistent, recurrent, or metastatic cervical cancer in adults whose tumours express PD L1 with a CPS ≥ 1. KEYTRUDA, in combination with trastuzumab, fluoropyrimidine and platinum-containing chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic HER2-positive gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS ≥ 1. **DOSAGE AND ADMINISTRATION** See SmPC for full details. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer. The recommended dose of KEYTRUDA in adults is either 200 mg every 3 weeks or 400 mg every 6 weeks administered as an intravenous infusion over 30 minutes. The recommended dose of KEYTRUDA as monotherapy in paediatric patients aged 3 years and older with cHL or patients aged 12 years and older with melanoma is 2 mg/kg bodyweight (up to a maximum of 200 mg), every 3 weeks administered as an intravenous infusion over 30 minutes. For use in combination, see the Summary of Product Characteristics (SmPC) for the concomitant therapies. KEYTRUDA must not be administered as an intravenous push or bolus injection. When administering KEYTRUDA as part of a combination with intravenous chemotherapy, KEYTRUDA should be administered first. Treat patients until disease progression or unacceptable toxicity (and up to maximum duration of therapy if specified for an indication). For the adjuvant treatment of melanoma, NSCLC, or RCC, KEYTRUDA should be administered until disease recurrence, unacceptable toxicity, or for a duration of up to one year. Refer to the SmPC for dosing in neoadjuvant and adjuvant treatment of locally advanced, or early stage triple-negative breast cancer at high risk of recurrence. KEYTRUDA, as monotherapy or as combination therapy, should be permanently discontinued (a) For Grade 4 toxicity except for: endocrinopathies that are controlled with replacement hormones; or haematological toxicity, only in patients with cHL in which KEYTRUDA should be withheld until adverse reactions recover to Grade 0-1; (b) If corticosteroid dosing cannot be reduced to ≤10 mg prednisone or equivalent per day within 12 weeks; (c) If a treatment-related toxicity does not resolve to Grade 0 1 within 12 weeks after last dose of KEYTRUDA; (d) If any event occurs a second time at Grade ≥ 3 severity. Patients must be given the Patient Card and be informed about the risks of KEYTRUDA. *Special populations Elderly:* No dose adjustment necessary. *Renal impairment:* No dose adjustment needed for mild or moderate renal impairment. No studies in severe renal impairment. *Hepatic impairment:* No dose adjustment needed for mild or moderate hepatic impairment. No studies in severe hepatic impairment. *Paediatric population:* Safety and efficacy in children below 18 years of age not established except in paediatric patients with melanoma or cHL. **CONTRAINDICATIONS** Hypersensitivity to the active substance or to any excipients. **PRECAUTIONS AND WARNINGS** *Assessment of PD-L1 status* When assessing the PD-L1 status of the tumour, it is important that a well-validated and robust methodology is chosen to minimise false negative or false positive determinations. *Immune-mediated adverse reactions* Immune-mediated adverse reactions, including severe and fatal cases, have occurred in patients receiving pembrolizumab. Most immune mediated adverse reactions occurring during treatment with pembrolizumab were reversible and managed with interruptions of pembrolizumab, administration of corticosteroids and/or supportive care. Immune mediated adverse reactions have also occurred after the last dose of pembrolizumab. Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. Immune-mediated adverse reactions are immune-mediated pneumonitis, immune-mediated colitis, immune-mediated hepatitis, immune-mediated nephritis, immune-mediated endocrinopathies (including adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, diabetic ketoacidosis, hypothyroidism, and hyperthyroidism), immune-mediated skin adverse reactions (also including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)). Refer to SmPC for more information and management of immune-mediated adverse reactions. *Complications of allogeneic Haematopoietic Stem Cell Transplant (HSCT):* Cases of graft-versus-host-disease (GVHD) and hepatic veno-occlusive disease (VOD) have been observed in patients with classical Hodgkin lymphoma undergoing allogeneic HSCT after previous exposure to pembrolizumab. *Infusion-related reactions:* Grades 1, 2, 3 or 4 infusion reactions including hypersensitivity and anaphylaxis, could be seen with pembrolizumab treatment. Refer to SmPC for more information and management of infusion-related reactions. *Overdose:* There is no information on overdose with pembrolizumab. In case of overdose, monitor closely for signs or symptoms of adverse reactions and treat appropriately. **INTERACTIONS** No formal pharmacokinetic drug interaction studies have been conducted with pembrolizumab. No metabolic drug drug interactions are expected. The use of systemic corticosteroids or immunosuppressants before starting pembrolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of pembrolizumab. Corticosteroids can be used as premedication, when pembrolizumab is used in combination with chemotherapy, as antiemetic prophylaxis and/or to alleviate chemotherapy-related adverse reactions. **FERTILITY, PREGNANCY AND LACTATION** *Women of childbearing potential* Women of childbearing potential should use effective contraception during treatment with pembrolizumab and for at least 4 months after the last dose of pembrolizumab. *Pregnancy* No data on use in pregnant women. Do not use during pregnancy unless the clinical condition of the woman requires treatment with pembrolizumab. *Breast-feeding* It is unknown whether pembrolizumab is secreted in human milk. A risk to newborns/ infants cannot be excluded. *Fertility* No clinical data available. **SIDE EFFECTS** Refer to SmPC for complete information on side effects. Pembrolizumab is most commonly associated with immune-mediated adverse reactions. Most of these reactions resolved with appropriate medical treatment or withdrawal of pembrolizumab. The most serious adverse reactions were immune-mediated and infusion-related adverse reactions. When pembrolizumab is administered in combination with axitinib or lenvatinib, refer to the SmPC for axitinib or lenvatinib prior to initiation of treatment. For additional lenvatinib safety information related to advanced RCC see the SmPC for Kisplyx and for advanced EC see the SmPC for Lenvima. **Monotherapy:** *Very Common:* anaemia, hypothyroidism, decreased appetite, headache, dyspnea, cough, abdominal pain, nausea, vomiting, constipation, musculoskeletal pain, arthralgia, asthenia, oedema, pyrexia, diarrhoea, pruritus, rash, fatigue. *Common:* pneumonia, thrombocytopenia, neutropenia, lymphopenia, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, hyperthyroidism, dizziness, dysgeusia, pneumonitis, colitis, dry mouth, hepatitis, severe skin reactions, vitiligo, dry skin, eczema, alopecia, dermatitis acneiform, erythema, dermatitis, myositis, pain in extremity, arthritis, influenza like illness, chills, AST and ALT increases, increase in blood alkaline phosphatase, hypercalcaemia, blood bilirubin increased, blood creatinine increased, infusion related reaction. **In combination with chemotherapy:** *Very Common:* neutropenia, anaemia, thrombocytopenia, leukopenia, hypothyroidism, hypokalaemia, decreased appetite, insomnia, neuropathy peripheral, headache, dizziness, dyspnoea, cough, diarrhoea, nausea, vomiting, abdominal pain, constipation, alopecia, rash, pruritus, arthralgia, musculoskeletal pain, myositis, pyrexia, fatigue, asthenia, ALT increase, AST increased. *Common:* pneumonia, febrile neutropenia, lymphopenia, infusion related reaction, adrenal insufficiency, thyroiditis, hyperthyroidism, hyponatraemia, hypocalcaemia, lethargy, dysgeusia, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, pneumonitis, colitis, gastritis, dry mouth, hepatitis, severe skin reactions, erythema, dry skin, dermatitis acneiform, dermatitis, eczema, pain in extremity, arthritis, acute kidney injury, oedema, influenza-like illness, chills, blood creatinine increased, blood alkaline phosphatase increased, blood bilirubin increased, hypercalcaemia. **In combination with axitinib or lenvatinib:** *Very Common:* urinary tract infection, anaemia, hypothyroidism, decreased appetite, headache, dysgeusia, hypertension, dyspnoea, cough, diarrhoea, abdominal pain, nausea, vomiting, constipation, rash, pruritus, arthralgia, musculoskeletal pain, myositis, pain in extremity, fatigue, asthenia, oedema, pyrexia, lipase increased, alanine aminotransferase increased, aspartate aminotransferase increased, blood creatinine increased. *Common:* pneumonia, neutropenia, thrombocytopenia, lymphopenia, leukopenia, infusion-related reaction, adrenal insufficiency, hyperthyroidism, thyroiditis, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, dizziness, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), pneumonitis, colitis, pancreatitis, gastritis, dry mouth, hepatitis, severe skin reactions, dermatitis, dry skin, erythema, dermatitis acneiform, alopecia, arthritis, nephritis, influenza like illness, chills, amylase increased, blood bilirubin increased, blood alkaline phosphatase increased, hypercalcaemia. **PACKAGE QUANTITIES** KEYTRUDA 25 mg/mL: 4 mL of concentrate in a 10 mL Type I clear glass vial. **Legal Category:** POM. **Marketing Authorisation numbers** EU/1/15/1024/002 **Marketing Authorisation holder** Merck Sharp & Dohme B.V., Waarderweg 39, 2031 BN Haarlem, The Netherlands. **Date of revision:** October 2023. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin, D18 X5K7 or from www.medicines.ie. Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie. Adverse events should also be reported to MSD (Tel: 01-2998700) II121

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie.
Adverse events should also be reported to MSD (Tel: 01-2998700)

References
1. KEYTRUDA Summary of Product Characteristics, Available at www.medicines.ie. Accessed September 2023.
PDL1: Programmed death-ligand 1, CPS = combined positive score

MSD
Red Oak North, South County Business Park,
Leopardstown, Dublin D18 X5K7, Ireland.

IE-KEY-00015 Date of Preparation: January 2024

CLINICAL FOCUS: Cervical cancer

We continue to look at cervical cancer case studies in our series on female oncology, focusing on the treatment of metastatic disease

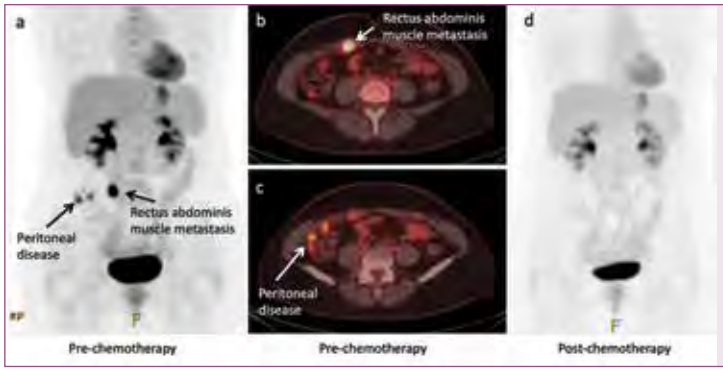
CERVICAL cancer patients with metastatic disease or advanced disease not suitable for surgery or radiation receive platinum-based chemotherapy alone as palliative intent to control rather than eradicate the disease. The current firstline treatment regimen for advanced/metastatic disease has been in place since 2009, when the GOG-204 trial established cisplatin plus paclitaxel.[1]

In 2014, the addition of bevacizumab, an antiangiogenic agent, was noted to improve overall survival by almost four months as part of the GOG-240 trial and the three compounds are now considered international gold standard.[2] Most recently, KEYNOTE-826 improved survival with carboplatin, paclitaxel and pembrolizumab with or without bevacizumab for those patients with tumours expressing a biomarker, PDL1, of 1% or above.[3] Median survival was 24 months for the intervention group and 16.5 months for the comparator arm. A proportion of advanced, metastatic cervical cancer cases have a longer than expected survival, with National Cancer Registry Ireland reporting a 15% five-year survival for stage IV disease.

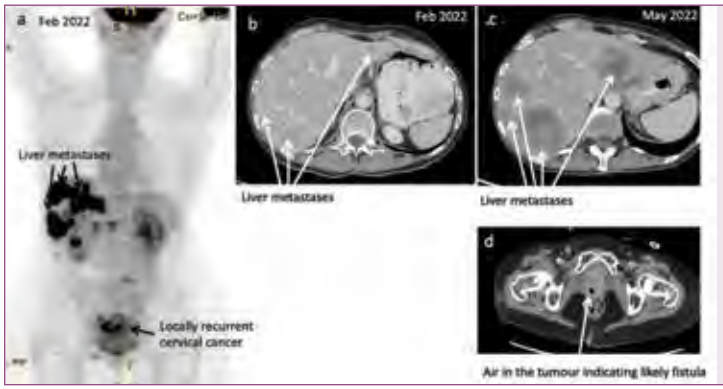
Case studies

A 32-year-old woman diagnosed with squamous cell cervical cancer with peritoneal disease noted on PET CT scan and intramuscular metastasis of the rectus sheath (*see Figure 1a, b and c*) underwent carboplatin, paclitaxel and bevacizumab followed by maintenance bevacizumab in 2017. This resulted in a complete radiological response (*see Figure 1d*). She remained disease free at last scan, beyond the five-year mark from diagnosis.

A 51-year-old woman with locally recurrent cervical cancer had a background of locally advanced cervical cancer treated with concurrent chemoradiotherapy in 2020. Unfortunately, per-vaginal bleeding resulted in investigations that led to the diagnosis of a locally recurrent cervical cancer, biopsy confirmed. PET CT scan for staging revealed multiple liver metastases.



Figures 1a, b, c, d
Prechemotherapy staging scans (a, b, c) reveal metastatic intramuscular metastasis of the rectus abdominis (1b) and intraperitoneal disease (1c)
Post-treatment scans including a PET CT (1d) revealed a complete radiological tumour response to therapy which has been maintained over five years



Figures 2a, b, c, d
PET CT scan in (a) illustrates a locally advanced cervical cancer with significant burden of liver metastatic disease. CT imaging in (b) shows the lesions prior to chemotherapy and (c) shows the increase in growth despite chemotherapy. In addition, fistulae as depicted by air in the tumour itself, as in (d) are a significant risk to this tumour subtype

She was referred to medical oncology services for palliative chemotherapy which was initiated in February 2022. The burden of liver metastases prior to cytotoxic therapy is shown above in *Figure 2a and b* and at restaging scans after three cycles of chemotherapy (*see Figure 2c*). This shows the dramatic continued increase in cancer growth in the liver predominantly (*Figures 2b and 2c*). Furthermore, imaging revealed likely fistulation between the cancer and the bowel (*Figure 2d*).

This case reflects continued disease progression despite the use of carboplatin and paclitaxel with disease unresponsive to cytotoxic therapies. While we recommend cytotoxic therapies as gold standard with or without additional biologics, for example bevacizumab, not all cervical cancer are responsive or sensitive to the treatment.

Fistulation risk factors

Fistulation of cervical cancers is not uncommon, with incidences of up to 15% reported. Risk factors for fistulation include the natural history of the cancer itself, exposure to prior radiotherapy and the use of bevacizumab. Fistulae can be challenging clinically and very symptomatic for patients, and thus need careful multidisciplinary team management. Patients deemed at high risk of fistulae should not be administered bevacizumab as this risk can be exacerbated by the use of antiangiogenic agents.

Dr Dearbhaile Collins is a consultant medical oncologist at Cork University Hospital

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FOR THE TREATMENT OF DIABETES MELLITUS IN ADULTS, ADOLESCENTS AND CHILDREN FROM THE AGE OF 6 YEARS[1]

Toujeo®
insulin glargine 300U/mL

From the start,[1] there to help your patients on their basal insulin journey[1]

- Help your patients find **balance between HbA1c reduction and hypoglycaemic risk**[1-7]
- Offers **flexibility**† (+/- 3 hours) in dosing time[1,8,9]

Toujeo® DoubleStar™ prefilled pen is recommended for patients requiring at least 20 units per day.[1]

Paediatric indication from ≥6 years

† Toujeo® is available in easy-to-use pens,[1,8,9] to be administered once daily at any time of the day, preferably at the same time every day.[1] When needed, patients can administer Toujeo® up to 3 hours before or after their usual time of administration. Flexible dosing time was evaluated in two randomised, open-label clinical studies, in patients with T2DM.[1]

Prescribing Information: Toujeo®(insulin glargine 300 units/ml) Please refer to Summary of Product Characteristics (SmPC) before prescribing. Presentation: Toujeo SoloStar and DoubleStar pre-filled pens. Each ml contains 300 units of insulin glargine. SoloStar pen contains 1.5ml (450 units) of solution for injection. DoubleStar pen contains 3ml (900 units) of solution for injection. **Indication:** Treatment of diabetes mellitus in adults, adolescents and children from the age of 6 years. **Dosage and Administration:** Toujeo is administered subcutaneously, by injection into the abdominal wall, the deltoid or the thigh, once daily, at any time of the day, preferably at the same time every day. Injection sites must be rotated within a given injection area from one injection to thé next in order to reduce the risk of lipodystrophy and cutaneous amyloidosis. The dose regimen (dose and timing) should be adjusted according to individual response. Do not administer intravenously. In type 1 diabetes mellitus, Toujeo must be combined with short-/rapidacting insulin to cover mealtime insulin requirements. In patients with type 2 diabetes mellitus, recommended daily starting dose is 0.2 units/kg followed by individual dose adjustments. Toujeo can also be given together with other anti-hyperglycaemic medicinal products. *Switch between insulin glargine 100 units/ml and Toujeo:* Insulin glargine 100 units/ml and Toujeo are not bioequivalent and are not directly interchangeable. When switching from insulin glargine 100 units/ml to Toujeo, this can be done on a unit-to-unit basis, but a higher Toujeo dose (approximately 10-18%) may be needed to achieve target ranges for plasma glucose levels. When switching from Toujeo to insulin glargine 100 units/ml, the dose should be reduced (approximately by 20%). *Switching from other basal insulins to Toujeo:* A change of dose and/or timing of the basal insulin and concomitant anti-hyperglycaemic treatment may be required. Dose adjustments may also be required if the patient's weight or lifestyle changes, the timing of insulin dose is changed, or other circumstances arise that increase susceptibility to hypo- or hyperglycaemia. Toujeo must not be mixed or diluted with any other insulin or other medicinal products. Close metabolic monitoring is recommended during a switch and in the initial weeks thereafter. SoloStar 1-80 units per single injection in steps of 1 unit and DoubleStar 2-160 units in steps of 2 units. When changing from Toujeo SoloStar to Toujeo DoubleStar, if the patient's previous dose was an odd number, then the dose must be increased or decreased by 1 unit. Toujeo DoubleStar prefilled pen is recommended for patients requiring at least 20 units per day. **Special Populations:** Insulin requirements may be diminished in the elderly or patients with renal or hepatic impairment. *Paediatric:* When switching basal insulin to Toujeo, dose reduction of basal and bolus insulin needs to be considered on an individual basis, in order to minimise the risk of hypoglycaemia. The safety and efficacy of Toujeo in children and adolescents below 6 years of age have not been established. **Contraindications:** Hypersensitivity to insulin glargine or any excipients. **Precautions and Warnings:** *Traceability:* In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Toujeo is not the insulin of choice for treatment of diabetic ketoacidosis. Patients must be instructed to perform continuous rotation of the injection site to reduce the risk of developing lipodystrophy and cutaneous amyloidosis. There is a potential risk of delayed insulin absorption and worsened glycaemic control following insulin injections at sites with these reactions. A sudden change in the injection site to an unaffected area has been reported to result in hypoglycaemia. Blood glucose monitoring is recommended after the change in the injection site, and dose adjustment of antidiabetic medications may be considered. *Hypoglycaemia:* In case of insufficient glucose control or a tendency to hyper/hypoglycaemic episodes, the patient's adherence to the prescribed treatment regimen, injection sites and proper injection technique and all other relevant factors must be reviewed before dose adjustment is considered. Particular caution should be exercised, and intensified blood glucose monitoring is advisable for patients in whom hypoglycaemic episodes might be of clinical relevance and in those where dose adjustments may be required. Warning signs of hypoglycaemia may be changed, less pronounced or absent in certain risk groups, potentially resulting in severe hypoglycaemia and loss of consciousness. Risk groups include patients in whom glycaemic control is markedly improved, hypoglycaemia develops gradually, an autonomic neuropathy is present, or who are elderly. The prolonged effect of subcutaneous insulin glargine may delay recovery from hypoglycaemia. *Intercurrent illness:* Requires intensified metabolic monitoring and often it is necessary to adjust the insulin dose. *Insulin antibodies:* administration may cause insulin antibodies to form. *Use with pioglitazone:* Cases of cardiac failure have been reported when pioglitazone was used in combination with insulin, especially in patients with risk factors for development of cardiac heart failure. If the combination is used, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. *Medication errors:* Insulin labels must always be checked before each injection to avoid errors between Toujeo and other insulins. Patients must be instructed to never use a syringe to remove Toujeo from the SoloStar or DoubleStar prefilled pen, A new sterile needle must be attached before each injection. Needles must not be re-used. *Pregnancy and lactation:* There are no data from exposed pregnancies in controlled clinical trials. However, there is a large amount of data on use of insulin glargine 100 units/ml in pregnant women indicating no specific adverse effects on pregnancy and no specific malformative nor feto/neonatal toxicity. The use of Toujeo may be considered during pregnancy, if clinically needed. Careful monitoring of glucose control is essential. It is unknown if insulin glargine is excreted in breast milk. ***Interactions:*** Substances that affect glucose metabolism may require adjustment of insulin glargine. **Adverse Reactions:** *Very common:* Hypoglycaemia. Prolonged or severe hypoglycaemia may be life-threatening. *Common:* Lipohypertrophy, injection site reactions, including redness, pain, itching, hives, swelling, or inflammation. Prescribers should consult the SmPC in relation to other adverse reactions. **Legal Category:** POM. **Marketing Authorisation Number:** SoloStar 5 pen pack: EU/1/00/133/035; DoubleStar 5 pen pack: EU/1/00/133/038. **Marketing Authorisation Holder:** Sanofi Aventis Deutschland GmbH, D-65926 Frankfurt am Main, Germany. **Further information is available from:** Medical Information, Sanofi, 18 Riverwalk, Citywest Business Campus, Dublin 24 or contact IEmedinfo@sanofi.com. **Date of preparation:** July 2022. **MAT-IE-2200355 (V1.0)**

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie; email: medsafety@hpra.ie Adverse events should also be reported to Sanofi Ireland Ltd. Tel: 01 403 5600. Alternatively, send via email to IEPharmacovigilance@sanofi.com

Intended for Healthcare Professionals in the Republic of Ireland only.

Abbreviations: HbA1c, Hemoglobin A1c; PD, Pharmacodynamics; PK, Pharmacokinetics; T1DM, Type 1 Diabetes Mellitus; T2DM, Type 2 Diabetes Mellitus.

References: 1. Toujeo® Summary of Product Characteristics July 2020. **2.** Home PD, *et al.* Diabetes Care 2015;38(12):2217-2225. **3.** Matsuhisa M, *et al.* Diabetes Obes Metab 2016;18(4):375-383. **4.** Danne T, *et al.* Diabetes Care 2020; 43(7):1512–1519. **5.** Riddle MC, *et al.* Diabetes Care 2014;37:2755-2762. **6.** Yki-Jarvinen H, *et al.* Diabetes Care 2014;37:3235-3243. **7.** Bolli GB, *et al.* Diabetes Obes Metab 2015;17:386-394. **8.** Singh R, *et al.* Eur Endocrinol 2018;14:47-51. **9.** Pohlmeier H, *et al.* J Diabetes Sci Technol 2017;11;263-269.

MAT-IE-2200486 (v1.0) | December 2022

sanofi

Glycaemic control and diabetes complications in older adults

A recent retrospective cohort study underlined Endocrine Society clinical practice guidelines for diabetes treatment in older adults

HAEMOGLOBIN A1c (HbA1c) level is an indicator of an individual's glucose control and therefore plays an important role in the treatment of type 2 diabetes. The Endocrine Society (**endocrine.org**) has outlined specific HbA1c target ranges for older adults (above 65 years of age), based on whether the individual's overall health status is categorised as being in good, intermediate or poor health.

For older adults with type 2 diabetes who are treated with insulin or sulphonylureas, the Endocrine Society guideline recommends a target HbA1c level of:

- 53mmol/mol to < 58mmol/mol (7 to < 7.5%) for those in good health
- 58mmol/mol to < 64mmol/mol (7.5 to < 8%) for those in intermediate health
- 64mmol/mol to < 69mmol/mol (8 to < 8.5%) for those in poor health.[1]

In formulating the clinical practice guidelines for the treatment of diabetes in older adults, the authors observed that diabetes, particularly type 2, is becoming more prevalent in the general population and especially in individuals over the age of 65 years.

They noted: "The underlying pathophysiology of the disease in these patients is exacerbated by the direct effects of ageing on metabolic regulation. Similarly, ageing effects interact with diabetes to accelerate the progression of many common diabetes complications. Each section in this guideline covers all aspects of the aetiology and available evidence, primarily from controlled trials, on therapeutic options and outcomes in this population. The goal is to give guidance to practising healthcare providers that will benefit patients with diabetes (both type 1 and type 2), paying particular attention to avoiding unnecessary and/or harmful adverse effects."

The guideline further recommended that in patients aged 65 years and older with newly diagnosed diabetes, an endocrinologist or diabetes care specialist should work with the primary care provider, a multidisciplinary team and the patient, in the development of individualised diabetes treatment goals.[1]

In patients aged 65 years and older with diabetes, they recommended that an endocrinologist or diabetes care specialist should be primarily responsible for diabetes care if the patient has type 1 diabetes, or requires complex hyperglycaemia treatment to achieve treatment goals, or has recurrent severe hypoglycaemia, or has multiple diabetes complications.[1]

In a retrospective cohort study conducted by Yale School of Medicine and the University of Chicago, the risk of complications for individuals based on their HbA1c levels was examined.[2] The study, which was published in autumn 2023, compared outcomes of older adults whose HbA1c fell within the recommended target range against those whose HbA1c fell outside of the range, while taking insulin or sulphonylureas – medications that can increase the risk of low blood glucose reactions.[2]

The study found that older adults who were in good health were at a higher risk of complications if their HbA1c fell outside the target range (either below or above). The researchers agreed that this finding confirmed the current target recommendations.

Those who were in poor health were found to be at a significantly higher risk of complications than those in good health and this risk did not change whether or not their HbA1c was on target or outside of the target range.

The retrospective cohort study highlighted the importance of appropriate glucose control for those in good health and suggested that stricter glycaemic control might not help to reduce the risk of complications for those in poor health.

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1. LeRoith D, Biessels GJ, Braithwaite SS et al. Treatment of diabetes in older adults: An Endocrine Society Clinical Practice Guideline. J Clin Endocrin Metabol 2019, May; 104(5):1520-74, https://doi.org/10.1210/jc.2019-00198*

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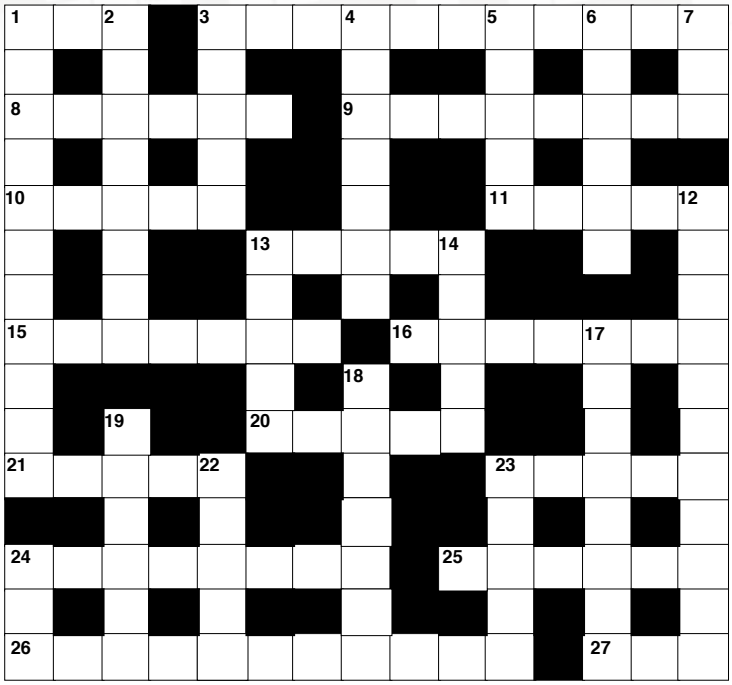
Across

1 Travel on snow or water (3)
3 The study of flags (11)
8 Replenish with what makes the umpire sick (6)
9 Might Seth fear to have what all birds have? (8)
10 See 5 down
11 Small farm, especially in Scotland (5)
13 Infer thus that it's of higher quality (5)
15 On the way to finding the one true arrangement (2,5)
16 Veered sharply (7)
20 Vestibule; foyer (5)
21 A wager or a wooden post (5)
23 Fit with glass; apply a glossy finish to food (5)
24 Vehicle with unusual air and grace (8)
25 Material made from Mayo tresses (6)
26 From which vessels to sip merlot or Chardonnay, perhaps (4,7)
27 Take part in a play and upset the cat (3)



Down

1 Vegetables made of twine? (6,5)
2 & 17d It seems poor quality Spanish bubbly from Vena goes right to the heart! (8,4,4)
3 Worth (5)
4 Intense blaze, or Hell (7)
5 & 10a The cheek of a drink dispenser to name this part of the body! (5,5)
6 US state on the Pacific coast (6)
7 Affirmative word (3)
12 Artisans won't divulge this to ordinary folk (5,6)
13 Causing death (5)
14 Boisterous (5)
17 See 2 down
18 Scabs 'es broken to show something unhealthy (7)
19 Emmanuel was elected French president in 2017 (6)
22 Looking at (5)
23 Commodities (5)
24 Animal that provides beef (3)

Name: .....

Address: .....

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You can email your entry to us at **nursing@medmedia.ie** by taking a photo of the completed crossword with your details included and putting *'Crossword Competition'* in the subject line. Closing date: **April 23, 2024.** Alternatively post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

March crossword solution

Across: 11 Eucalyptus 6 Ajar 10 Prong 11 Shake a leg 12 Beatles 15 Abyss 17 Tutu 19 Somme 21 Skydive 23 Relic 24 True 25 Rose 26 Apple 28 Sparrow 33 Hush money 34 Gaffe 35 Dude 36 Respirator

Down: 1 Espy 2 Close call 3 Light 4 Posse 5 Utah 7&30 Jolly Roger 8 Registered 9 Because 13 Leak 14 Studies 16 Approached 20&18a Marrowfat peas 21 Screams 22 Visa 27 Posed 29 Pay up 31 Knee 32 Dear

The winner of the March crossword sponsored by MedMedia is Ann Donohoe, Mater Misericordiae Hospital, Dublin

MSF project to tackle TB in children

Charity aims to improve diagnosis and treatment of condition globally

HUMANITARIAN organisation Médecins Sans Frontières (MSF) recently launched a new initiative that aims to increase the number of children diagnosed with the silent scourge of tuberculosis (TB), as well as improve their treatment and prevent new cases. The charity, also known as Doctors Without Borders, will use the new initiative to support projects in implementing the latest recommendations in the World Health Organization's (WHO) recently updated guidelines on the disease.

Focusing on more than a dozen countries in Africa and Asia, the initiative is called 'Test, Avoid, Cure Tuberculosis in Children (TACTiC)' and will contribute to several multi-region studies to assess the validity and feasibility of the new recommendations, as well as help healthcare professionals in these areas to develop better processes for diagnosing TB.

The initiative commenced last year following a finding from a UNICEF study that 96% of children who die from TB never received appropriate treatment.

MSF said this is because healthcare professionals can be reluctant to commence the lengthy treatment for TB without having established a formal diagnosis. Many currently available tests cannot detect low levels of TB-causing bacteria, which can still be enough to make a child very sick. Many tests have also been developed for adults and often rely on specimens such as sputum, which is difficult for a child to cough up.

"Recent WHO recommendations on the diagnosis of TB in children can be a game-changer to increase the number of children diagnosed and put on correct treatment," said Cathy Hewison, head of MSF's tuberculosis working group. "They provide clinicians and TB programmes with the confidence to make the decision to treat TB in children using signs and symptoms without relying on results of lab tests or x-rays if they are not available or when the test results are negative."

To read the WHO's TB recommendations, visit **www.who.int** and search for 'Global Tuberculosis Programme'.

Bon Secours Cork hosts nurse meeting

Bon Secours Hospital Cork recently hosted a conference for practice nurses and managers. More than 140 nurses attended the event, which included a line-up of expert speakers who shared their knowledge and expertise with attendees. Pictured anti-clockwise from above (l-r) practice nurses: Louise O'Callaghan, Kay Russell, Catherine Mulcahy and Geraldine Staunton, The Waterfront Medical Centre, Clonakilty; Jolita Gridziuskiene, Kinsale Medical Centre, and Elizabeth Mitchell, Avonlea Medical Centre; Anna Martinez, Danielle Desmond and Louise Kearney, Curraheen Clinic; Mandy Crowley, Ballincollig and Catherine Forde, Carragaline

Diabetes self-management app launched in Ireland

DIGIBETE, a new self-management app and video platform, has been made available to children and young people with diabetes in Ireland.

Following a pilot project in University Hospital Limerick, Diabetes Ireland and DigiBete have spent the past year training other paediatric diabetes teams in its use.

The aim of the app is to improve care for children and young people with diabetes by helping them to manage their condition more effectively, as well as to provide an easy, cost-free communication stream for paediatric diabetes teams to engage with families to provide advice and information.

The app, which is already widely used in the UK, supports children and adolescents with type 1 diabetes by giving them a place to organise their diabetes appointments and ongoing care, and receive access to relevant educational resources. The app allows access to age-appropriate diabetes information such as quizzes, videos, and food and exercise support.

Diabetes Ireland chief executive Kieran O'Leary said: "We are delighted to make DigiBete available to the families of the 3,000 children and adolescents living with type 1 diabetes in Ireland."

April

Wed 10
CPC Section meeting. 11am online

Wed 17
OHN Section meeting. 2pm online

Saturday 20
School Nurses Section meeting. 10am at The Richmond

Saturday 20
PHN Section meeting. 10.30 online

Monday 22
ED Section meeting. 11am online

Monday 22
Children's Nurses Section meeting. 1pm online

Tuesday 23
COOP Section meeting. 11am online.

Tuesday 23
ODN Section meeting. 7pm online

Wednesday 24
Telephone Triage Section meeting. 11am online

Wednesday 24
RNID Section meeting. 2.30pm online

Thursday 25
CIT Section 11am online

Thursday 25
Assistant Directors Section meeting. 2.30pm online

Thursday 25
General Practice Nurse Section meeting. 5.30pm online. See *page 20* for details and *page 16* for an interview with a practice nurse

Monday 29
Nurse/Midwife Education Section meeting 9am online

Monday 29
Advanced Practice Section meeting. 11am online

Tuesday 30
Retired Section meeting. 11am at The Richmond and online

May

Tuesday 21
Inclusion Health Section meeting. 11am online and at The Richmond. See *page 20* for further details

Thursday 23
SALO meeting. 12pm The Richmond and online

Tuesday 28
COOP Section conference, Portlaoise. See *page 20* for further details

Tuesday 28
Integrated Care Section meeting. 2pm online

Wednesday 29
Orthopaedic Nurses Section meeting. 4pm online

For further details on any listed meetings or events, contact jean.carroll@inmo.ie (unless otherwise indicated)

INMO Membership Fees 2024

A	Registered nurse/midwife *(including part-time/temporary nurses/midwives in prolonged employment)*	€299
B	Short-time/Relief *This fee applies only to nurses/midwives who provide very short term relief duties (ie. holiday or sick duty relief)*	€228
C	Private nursing homes	€228
D	Affiliate members (non-practising) *Lecturing (employed in universities & IT institutes)*	€116
E	Associate members *Not working*	€75
F	Retired associate members	€25
G	Student members	No Fee

Golf Society

❖ The Irish Nurses and Midwives Golf Society Annual Golf Classic will take place at Callan Golf Club, Co Kilkenny on Friday, May 24. The event costs €65 per person and includes tea, coffee and scones on arrival and dinner in the evening. There are fantastic prizes and a donation will be made to a local charity. Bookings open on April 1 and enquiries can be made to Kathleen at Tel: 087 2079070 or by email to: nursesgolf24@gmail.com

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

Acceptance of individual advertisements does not imply endorsement by the publishers or the Irish Nurses and Midwives Organisation

Nurse On Call

Nursing services and recruitment

Nurses, midwives, student nurses and healthcare assistants: we all want more flexibility in our work lives, and that's what **Nurse On Call** offers.

- Do you want to be able to work around family life and work when it suits you?
- Do you want to be in charge of your own work schedule?
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- Do you want to avoid a stressful work environment?
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Join Nurse On Call, an approved supplier of agency nurses, student nurses and HCAs to every HSE/HSE-funded worksite in the Republic of Ireland – we would love to have you!

For more information, email **interviewer@nurseoncall.ie** or **corkoffice@nurseoncall.ie** if you are based in the south.

**Zoom interviews Monday to Friday 8:30am-5pm.
Please text your address to **087 1437417** for an application form or download one from our website: **www.nurseoncall.ie****

Irish Nurses and Midwives Organisation Working Together

Sláintecare.

All Ireland Nursing Festival

Sláintecare

Nursing's Challenge

The Helix, DCU,
Dublin, Ireland & Online

Tuesday 11 June 2024

Register for FREE

Over 290 HCPs already registered!

Supported by: NMG narrowcastmediagroup · INMO · nsa neil stewart associates

MATERNITY & MIDWIFERY FORUM

Register for FREE

ALL-IRELAND 2024 MATERNITY & MIDWIFERY FESTIVAL

MATERNITY & MIDWIFERY FORUM

The Helix, Dublin
& live and on-demand

Tuesday 9 April 24

allireland-mmf-24.eventbrite.co.uk

Night nurses needed

The Irish Cancer Society are seeking Registered Nurses, qualified in General or Paediatric Nursing, who have some palliative care experience to deliver end-of-life care to seriously ill patients in their home.
We require 4-6 nights per month availability.
Training will be provided. Job description on **www.cancer.ie**
Email CV to **recruitment@irishcancer.ie**
Informal queries to Amanda on 01 231 0532 or **awalsh@irishcancer.ie**

Irish Cancer Society

HCI
Transforming Healthcare Quality and Safety

We are hiring nurses!

Are you interested in Quality and Safety?

HCI is looking for an enthusiastic individual, with a nursing or healthcare degree, to join our growing team as a ***Quality and Safety Specialist***.

In this role, you will have the opportunity to improve quality and safety of care across private, public and social sectors.

Job Description: hci.care/careers
CVs to: info@hci.care

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- Home Care package
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- Reliable Staff/Continuity of Care
- Flexible Self Rostering (including midweek)
- 2 x Training Shifts provided
- Weekly payroll
- Free on-site parking
- NMBI/INMO or equivalent
- Excellent Interpersonal Skills
- English Language Fluency

Expressions of interest with CV to:
recruitment@misneachhealthcare.ie

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Scan the code
to view our courses

Legal and Ethical Aspects of nursing and midwifery practice

APRIL
30
In person

NEW

This one-day course in the ethical and legal aspects of nursing and midwifery provides you with an opportunity to develop and understanding of ethical and legal issues that relate to the practice of nursing and midwifery.

It allows you to explore ethical theories and how they relate to the practice of nursing and midwifery, to understand the legal and social context that you practice within and making decisions within the parameters of the code of conduct and scope of practice. It also provides an understanding of the legislative architecture the governs nursing and midwifery, including the regulatory process and types of misconduct.

The programme will be invaluable for those who seek to frame and update their thinking about ethical and legal issues in the practice of nursing and midwifery in the context of an ever-evolving legal landscape.

Topics include;

- Values code of professional conduct
- Scope of practice framework
- Legislative framework & regulation
- Ethics – an overview
- Ethics in practice ethical issues in nursing and midwifery
- Complaints process & misconduct

Venue: The Richmond Education and Event Centre, Dublin
Time: 10am - 4pm

Early bird fee:
€75.00 (INMO members only)
(before Friday, 19 April 2024)

Normal fee:
€90.00 INMO members; €145.00 non members

For more information on the variety of topics covered

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