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WIN

World of Irish Nursing & Midwifery

INMO
Journal of the
Irish Nurses and Midwives Organisation

Latest INMO CPD education programme
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Solidarity is strength

INMO members show support for LGBTQ rights

Cover image: *INMO members pictured at the Pride event at the Richmond Education and Event Centre last month (l-r): Helen Buckley, Mary Merriman and Imelda Browne*

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Climate crisis firmly on INMO agenda

Following the recent elections, it is evident the Irish electorate is increasingly concerned about climate change. As set out in the ICTU 'Just Transition' paper, "taking action on climate change is no longer an optional policy extra for the Irish government, having signed up to and endorsed the 2015 Paris Agreement, such action now takes the form of a binding international obligation".

Worryingly, the government's recently published climate action plan 2019 confirms that Ireland will "miss the target set for the period 2013-2020 for renewables by about one-eighth and for cumulative emissions by a little under 5%. However, more worryingly is the expectation that recent growth in emissions, particularly industry, agriculture and transport will put us on a trajectory to be over 25% off target for the 2021-2030 accounting period".

Why should we worry about this 'off trajectory' prediction? Apart from the obvious climate implications there is a real cost to the exchequer and that will inevitably have a negative effect on existing underfunding of public services such as health.

The Irish Times in a recent editorial set out the issue for Ireland as follows: "The science is clear; the economic impact will be many times worse than a hard Brexit. Irish emissions are going in the wrong way, out of step with most of Europe. What's more the cost of inaction now will be considerably greater in coming years."

At this year's ADC, there were two motions on climate change seeking action from the INMO and detailing the measures expected from the HSE as an employer. These led to an informed debate and this month the INMO Executive will plan the implementation of these mandates. This process will commence at the ICTU bi-annual conference in July when the INMO will participate in the debate of a motion calling for:

- The long-awaited impact assessments on the distribution of costs and benefits of climate change and energy transition policy measures in the context of drawing up our national integrated energy and climate action plan, due to be submitted to the European Commission by the end of 2019
- The establishment of a just transition commission to ensure all voices are heard
- That any increase to carbon tax is progressive and mitigates the impact on those with lowest incomes.

A central concern for trade unions is the impact on workers employed in industries that will be affected by the transition necessary to meet our climate change objectives and obligations. The government must develop and implement policies for the creation of alternative, sustainable employment for these workers. This was emphasised by Mary Robinson in her address to the climate change conference in Dublin in 2018 when she warned that the "urgent need to end peat extraction must not undermine the rights of the communities whose lives are dependent on the bogs".

Public sector employers must also step up. In healthcare there is the opportunity to reduce plastic use and increase use of recyclables. Nurses and midwives are well placed to lead in this area in support of the motions passed at the ADC.

Policy makers in health must be aware of the health effects of climate change outlined by Canadian experts, such as higher rates of heatstroke and stress, increased allergens from prolonged pollen seasons, increased incidence of Lyme disease, increased respiratory ailments and the impact on mental health of the displacement of families due to flooding and wildfires.

Nurses and midwives can educate patients about the risks posed to human health of climate change and, together with the wider trade union movement, lead in advocacy for a just transition to a more sustainable future. There is a requirement for education seminars on the topic of the impact of climate on health.

Globally, nursing and midwifery trade unions are now seeking the inclusion of the ecological determinants of health in undergraduate education programmes. Following the motions mandated at our ADC we are now required to be involved in this debate.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Process of improvement and new-found hope

EXAMS have drawn to a close. Some students will reflect and wonder how they have done while others will be excited at the prospect of the summer and the new-found hope and freedom that this time of year brings. We have recently had European and local elections and the awakening of a green revolution, with many commentators playing down its significance and others eagerly awaiting what it will bring to Irish politics for the future.

The INMO centenary delegate conference was a lovely event, that will in the future be entered into the annals of the next 100-year history of the INMO. The business of that conference and the motions debated are to the forefront of the officers, Executive Council and union team, who have a clear focus with regard to their implementation. The Labour Court recommendations and subsequent Agreement begins the process of significant change in nursing and midwifery. Government must honour it and the INMO will insist on nothing less. As your president, I am requesting that you participate in the implementation phase. While these proposals do not solve all the issues we face, they do commence the process of improvement that we must now build on.

Nursing now

NURSING NOW meetings on May 22 and June 11 saw the production of a document outlining the aims, objectives and vision for Nursing Now in Ireland. Consideration was also given to the relationship between local and regional groups and the national Nursing Now group. Visibility is key to this initiative so social media platforms, videos and a monthly page in *WIN* will enable this process. As INMO president, I would like to extend my thanks on behalf of the membership to Edward Mathews, director of professional and regulatory services, and Steve Pitman, head of education and professional development, for their vision and work ethic in driving this initiative forward.

RCM/INMO liaison group meeting

THE third meeting of the RCM/INMO Liaison Group held on May 24 was chaired by Dave Hughes, INMO deputy general secretary. The group received an update on technology issues and a review of the use of the iLearn learning resource platform, which is available to all midwife members. It was agreed that the process needs to be stabilised. Industrial relations updates were given by all groups in attendance and the similarities of issues regarding recruitment and retention, pay and capacity were no surprise. A further meeting is planned to coincide with the RCM conference, scheduled for September 24-25 in Manchester. Information will be posted in *WIN* and on **www.inmo.ie**

Centenary celebrations

THE INMO centenary committee convened a meeting on June 18 to update the committee on its decisions and progress to date on the tapestry commissioned by the union and designed by artist Robert Ballagh. A call for needle-workers and embroiders from among the membership to become involved in the creation of the tapestry was included in *WIN* last month. The tapestry, like the one created by Robert Ballagh for the 1913 Lockout, will ensure a permanent legacy for the union as the INMO reclaims its history – one stitch at a time! Other issues discussed included the centenary symposium for the membership in November.

ICN Congress, Singapore

AN INMO delegation of five is attending the ICN biennial congress in Singapore this year. The president is being represented by Eilish Fitzgerald, second vice-president, who will travel with Edward Mathews, director of professional and regulatory services. Karen Eccles was selected from the Executive Council to attend along with INMO members Mary Tully and Kay Garvey. A full report will be forwarded to members in *WIN* September.

For further details on the above and other events see **www.inmo.ie/President_s_Corner**

Quote of the month

"What you do today, can improve all your tomorrows"

– Ralph Marston

Report from the Executive Council

THE National Executive met on June 10-11. As usual we had a packed agenda. Our key focus was on the implementation of the Labour Court recommendations. A period of grace is acceptable when implementing agreements, however in order to ameliorate the staffing and capacity crisis in the HSE this must be concluded without delay and in good faith. Various circulars are awaiting sign off which will ensure the changes to salary scales and allowances as agreed. Members are encouraged to get active in their branches in order to collectively ensure the full implementation of the proposals brokered inclusive of phase 2 – the expert review of nursing and midwifery, with its key focus on management grades.

Notification of industrial action, which was served to some 38 HSE locations by SIPTU, was also discussed. The INMO wrote, as is procedure, to the HSE director of human resources requesting the employers' contingency plan in respect of the grades in dispute and advising that our members would not be taking on the duties of the striking workers should any issue arise.

Remember, if you are working in conditions where you cannot provide safe care, please complete your disclaimer forms. This will be your only safeguard in the event of a near miss or an incident.

– Next meeting July 8-9, 2019

Get in touch

You can contact me at INMO HQ at Tel: 01 6640 600, through the president's blog on www.inmo.ie or by email to: president@inmo.ie

Tony Fitzpatrick, INMO director of industrial relations, reports on current national IR issues

NJC staff panel wins equality on bereavement leave for health sector

PUBLIC service staff in the health sector are to be granted equal bereavement leave to those working in the civil service following a key Labour Court recommendation last month.

Following extensive engagement with the employer and conciliation at the WRC the case was presented to the Labour Court. As the chair of the staff panel of the National Joint Council of Health Service trade unions (NJC), I presented the case to the Labour Court seeking an increase to bereavement leave entitlements in the health sector in line with the civil service and local government.

Revised arrangements were introduced in the civil service regarding bereavement leave by Circular 01/2017. These arrangements, which came into force in January 2017, included:

- 20 working days' leave on the death of a spouse (including a co-habiting partner), child (including adopted children and children cared for *in loco parentis*) or any person in a relationship of domestic dependency
- Five working days leave for other immediate relatives
- One day in the case of the death of an uncle, aunt, niece or nephew
- In exceptional circumstances, such as where the civil servant lived with the deceased at the time of their death, or had to take charge of funeral arrangements, the leave could be extended to five days.

In contrast HSE HR Circular 016/2012 sets out the provisions for bereavement leave applicable in the health service:

- Health employees only receive five working days in the case of a spouse, child or any person in a relationship of domestic dependency. This is compared to 20 days in the civil service. For other immediate relatives such as father, mother, brother, sister, father/mother in law it is three working days compared to five in the civil service

Unions argued that it is unfair and unjust that the provisions for bereavement leave in the health sector are at variance with the revised provisions applicable in local government and the civil service, in circumstances where there has been a government drive to standardise terms and conditions of employment across the public service in recent years. The standardisation of terms and conditions has been the subject of several agreements between employers and unions. The Public Service Agreement (PSA) 2010-2014 states: "To the greatest extent possible, there will be standardised terms and conditions of employment across the public service, with the focus initially within sectors."

Therefore, it follows that where revised provisions greatly increase the allowance of special leave which may be allowed in the event of the death of a relative, these should be consistently applied across the public service. Failure to do so would not be consistent with the PSA 2010-2014, paragraph 1.8 or with the proposition that employees deserve to be treated equally and equitably.

The INMO and staff panel of trade unions also argued that many public servants in health, civil and local authorities received cuts to pay and an adjustment of terms and conditions which included, changes to annual leave, changes to pension benefits and reduction in sick leave entitlement.

Previously, public servants enjoyed six months' full pay and six months' half pay while on sick leave, which was reduced by 50% to three months' full pay and three months' half pay. It is not fair to apply a benefit to one sector of the public service which then results in public servants in the health service having to take sick leave or annual leave as their bereavement leave is not sufficient nor reflective of that which now exists within the civil service and local government.

Furthermore, staff working in the health sector often must deal with extremely difficult situations involving assisting bereaved families. It is unfair that health service staff who have greater exposure to these situations receive less benefit to those in other sectors who do not have the same level of exposure.

Anecdotal evidence presented by unions across all grades working in the health sector indicates that significant numbers of staff take either sick leave or annual leave subsequent to the expiration of the five days bereavement leave following the death of a spouse or a child. Greater compassion is required of the employer in order to maintain staff welfare in these situations. We find that this is completely unacceptable considering the environment that these workers then return to within the health service.

Management argued that the Department of Health has engaged with the Department of Public Expenditure and Reform in relation to the unions' claim and it has been confirmed that the civil service bereavement leave arrangements do not apply to other public bodies/sectors. As outlined in DPER's correspondence, the civil service and other public bodies are separate and distinct employers. Non-pay terms and conditions are not standardised across the sectors and there is no legislative basis for standardisation. The civil service has always had different provisions in place for bereavement leave, not just since the introduction of the 2017 Circular.

Management also argued that the only non-pay terms that are standardised across the sectors is the Public Service Sick Leave Scheme which required the enactment of the Public Service Management (Sick Leave) Regulations (SI 124 of 2014) and the Public Service Management (Sick Leave) (Amendment) Regulations 2015 SI 384 of 2015.

Cost implications in amending bereavement leave entitlement was also argued by management who stated that "in the health service, the loss of any front-line staff in the majority of staff categories for a period of time generally requires substitution cover through the engagement of agency workers or other employees working additional hours/overtime. This does not generally occur in the civil service. Concession of this claim would therefore give rise to significant substitution costs

in the health sector." Management concluded that "there would be no additional funding provided if improvements in bereavement leave arrangements were to be conceded."

However, on June 13, 2019 the Labour Court recommended in favour of the staff panel in finding: "The Court having read the submissions of the parties and listened carefully to the oral submissions on the day recommends that the HSE and section 38 funded agencies bereavement policies be amended in line with the concessions referenced earlier in the civil service to allow for 20 working days for spouse/partner and child (including adopted and in *loco parentis*) and five days for an immediate relative as currently defined in the HSE and section 38's own policies.

"The Court, noting the commitments that exist in HSE HR Circular 017/2013, further recommends that the parties return to conciliation and constructively engage on the issue of the need for backfill arising from these changes, and other relevant issues, with a view to implementing the changes with effect from October 1, 2019."

Work will now commence on drafting a circular to enact these changes to the bereavement leave policy. Both parties will return to the WRC conciliation conference to negotiate the backfilling arrangement in circumstances where a bereavement has been suffered by a nurse or midwife.

More staff needed to roll out HPV vaccine to boys

HSE to revert to WRC within three weeks

THE roll-out of the HPV vaccine to boys that is due to begin in September is under threat due to inadequate staff numbers, despite full commitment from unions, the HSE and the Department of Health for extension of the programme.

In a joint statement issued last month, the INMO, the Irish Medical Organisation and Fórsa stated that they are fully committed to the rollout of the HPV vaccine to boys. In fact, they were at the forefront of seeking the extension of the vaccination to boys, as individual unions, and also as part of the Irish Congress of Trade Unions.

However, the unions warned that there is an issue in respect of adequate staff numbers to provide the extension of the vaccine without an increase in the workforce. They pointed out that there is currently a recruitment pause in place within the HSE, as well as an acute staffing shortage, while simultaneously this rollout would represent an additional workload.

The matter was the subject of a conciliation hearing on June 18, 2019 at the Workplace Relations Commission, following which the HSE requested an opportunity to reflect on the matter. Within this procedure, the unions stress that the HSE must concentrate on bringing forward realistic proposals to ensure the HPV programme can roll out to boys. The HSE was due to revert under the auspices of the WRC within three weeks (early July).

INMO general secretary Phil Ní Sheaghdha: *"This vaccine extension can certainly roll out but it requires additional staffing, rather than reductions in the workforce"*

INMO general secretary Phil Ní Sheaghdha said: "The HSE committed to a national agreement to appoint 160 public health nurses in 2019 – roles that would be central to this extension. It is now reducing this number to 98 sponsored positions, despite having received 284 applications.

"This vaccine extension certainly can roll out, but it requires additional staffing, rather than reductions in the workforce."

Dr Ann Hogan, chair of the IMO public health and community health committee, said the IMO is concerned that the resources allocated for the HPV for boys will not be sufficient for the successful roll out of this initiative. She also expressed concern at the many unfilled posts and vacancies in community health departments throughout the country.

Fórsa stated that it hopes that the HSE grasps the opportunity now to put the necessary staffing in place, across all disciplines, to properly deliver a much welcomed enhancement of public health provision.

The government is committed to extending the HPV immunisation programme to boys following a report from HIQA completed in December 2018.

Following the joint statement by the unions, Minister for Health Simon Harris stated that there would be no delay in the rollout of the HPV vaccine to boys. He said the HSE had confirmed this to him and that resources have been provided by government and will be in place for the roll-out.

Summer trolley figures now akin to mid-winter figures of five years ago

MORE than 9,000 admitted patients were forced to wait on trolleys and chairs for hospital beds in May, according to INMO trolley/ward watch analysis.

The total figure, 9,015 – of which 78 were children – represents a 114% increase on May 2006, the year INMO trolley figures began.

South Tipperary General Hospital recorded its worst ever May figures, while a number of other hospitals also experienced severe overcrowding.

The hospitals worst affected in May were:

- University Hospital Limerick – 1,102 patients
- Cork University Hospital – 824 patients
- South Tipperary General Hospital – 661 patients
- Naas General Hospital – 479 patients
- Letterkenny University Hospital – 477 patients.

INMO general secretary Phil Ní Sheaghdha said: "We're entering the milder summer months when predictable seasonal illnesses are lower yet the level of overcrowding is worsening. Overcrowding in May 2019 is now at the same level as January five years ago. Clearly this is a capacity deficit and requires immediate investment in additional hospital beds.

"Considering the evidence of this increasing activity in our public health service, it is simply unacceptable that the HSE and the Department of Health introduced a recruitment pause. We know this will simply lead to a chronic understaffing and overcrowding problems without any regard to person-centred solutions.

"Overcrowding and understaffing mean patients take longer to recover. That means worse care, higher costs and greater risks of infection. Investment in beds and safe staffing is key to resolving this ongoing crisis."

Table 1. INMO trolley and ward watch analysis (May 2006 – 2019)

Hospital	May 2006	May 2007	May 2008	May 2009	May 2010	May 2011	May 2012	May 2013	May 2014	May. 2015	May 2016	May 2017	May 2018	May 2019
Beaumont Hospital	324	559	733	601	638	622	722	453	341	782	535	269	373	312
Connolly Hospital, Blanchardstown	189	126	161	201	214	398	416	568	499	382	215	223	338	237
Mater Hospital	366	507	467	270	483	345	449	323	223	497	371	533	445	426
Naas General Hospital	218	113	75	358	215	524	116	152	218	138	218	288	329	479
St Colmcille's Hospital	59	96	22	179	226	115	189	139	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	53	79	110	139	35	151	121	190	83	258	92	176	150	229
St Vincent's University Hospital	314	552	504	340	538	599	354	462	116	427	194	188	361	224
Tallaght Hospital	293	323	352	591	527	566	223	489	363	325	337	476	532	475
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	11	1
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	29	34
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	52	36
Eastern total	**1,816**	**2,355**	**2,424**	**2,679**	**2,876**	**3,320**	**2,590**	**2,776**	**1,843**	**2,809**	**1,962**	**2,153**	**2,620**	**2,453**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	10	93	101	73
Cavan General Hospital	174	199	156	71	165	446	318	126	68	38	48	46	56	202
Cork University Hospital	434	393	341	212	629	653	444	353	400	454	397	401	826	824
Letterkenny General Hospital	204	26	33	15	22	38	56	59	334	93	38	507	310	477
Louth County Hospital	10	n/a	n/a	6	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	192	36	111	77	123	65	90	128	191	64	211	109	50	169
Mercy University Hospital, Cork	129	65	145	40	93	138	160	183	140	253	175	326	210	182
Midland Regional Hospital, Mullingar	10	7	8	23	134	171	242	389	309	435	445	341	390	201
Midland Regional Hospital, Portlaoise	35	21	31	9	11	178	33	56	212	167	307	287	284	221
Midland Regional Hospital, Tullamore	n/a	14	2	2	65	220	95	130	426	116	448	420	598	316
Mid Western Regional Hospital, Ennis	33	61	12	113	54	1	6	30	n/a	3	7	15	5	12
Monaghan General Hospital	25	35	16	7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	9	3	3	23
Our Lady of Lourdes Hospital, Drogheda	297	270	196	160	172	649	683	272	375	718	451	219	138	137
Our Lady's Hospital, Navan	17	50	9	118	17	137	25	109	23	42	50	139	127	43
Portiuncula Hospital	42	8	27	n/a	97	66	40	58	23	101	19	87	31	52
Roscommon County Hospital	9	66	46	58	48	84	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	47	76	40	n/a	152	54	237	101	162	245	180	132	377	341
South Tipperary General Hospital	40	27	45	55	75	27	184	321	161	223	448	397	472	661
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	34	23	159	77	297	159	404	356	256
University Hospital Galway	154	209	218	186	378	510	493	282	410	524	349	671	637	454
University Hospital Kerry	102	20	33	11	38	56	26	42	77	169	85	234	272	209
University Hospital Limerick	112	98	80	181	233	193	263	755	502	538	592	627	858	1,102
University Hospital Waterford	n/a	n/a	40	13	147	129	124	221	83	357	195	412	329	469
Wexford General Hospital	332	15	151	194	212	222	56	137	75	63	42	131	133	138
Country total	**2,398**	**1,696**	**1,740**	**1,551**	**2,867**	**4,071**	**3,598**	**3,911**	**4,048**	**4,904**	**4,665**	**6,001**	**6,563**	**6,562**
NATIONAL TOTAL	**4,214**	**4,051**	**4,164**	**4,230**	**5,743**	**7,391**	**6,188**	**6,687**	**5,891**	**7,713**	**6,627**	**8,154**	**9,183**	**9,015**
Of which were under 16	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	99	78

Percentage increase/decrease: 2018 compared to 2019: -2%; 2017 compared to 2019: 11%; 2016 compared to 2019: 36%; 2015 compared to 2019: 17%; 2014 compared to 2019: 53%; 2013 compared to 2019: 35%; 2012 compared to 2019: 46%; 2011 compared to 2019: 22%; 2010 compared to 2019: 57%; 2009 compared to 2019: 113%; 2008 compared to 2019: 116%; 2007 compared to 2019: 123%; 2006 compared to 2019: 114%

Key appointments in Cork/Kerry EDs

LONG-RUNNING negotiations at the Workplace Relations Commission (WRC) have now delivered designated staff to deal with overcrowding at both Mercy University Hospital, Cork and University Hospital Kerry.

A whole time equivalent CNM2 for admitted patients has now been appointed to the emergency departments of each of these hospitals. In addition, it has been agreed that the patient-flow ADON positions in the two hospitals will be provided exclusively for this role.

These positions were agreed following negotiations under the auspices of the WRC subsequent to the 2015 ED dispute.

The INMO has been highlighting the HSE's failure to provide such agreed additional staffing in several EDs at the WRC oversight meetings, which is charged to ensure the implementation of the Emergency Department Agreement of 2016.

Mercy University Hospital and University Hospital Kerry are two of five hospitals nationwide for which the INMO had secured agreement for an additional CNM2 for admitted patients in each, due to the fact that these hospitals had needed to invoke the escalation procedure due to overcrowding since 2016.

The INMO has also been ensuring at the oversight meetings that the designated ADON patient-flow posts were not merged with operational ED ADON posts, which had been found to be the case in several locations, including the Mercy and Kerry EDs.

– Mary Power, INMO IRO

WRC called in over St Patrick's Centre, Kilkenny

Unions representing staff at St Patrick's Centre in Kilkenny, have sought the intervention of the Workplace Relations Commission (WRC) to assist with ongoing industrial relations difficulties. Balloting of members on industrial action has been deferred pending developments.

The INMO, SIPTU and Fórsa are concerned that the recent announcement by the board of St Patrick's to withdraw its governance by December 1, 2019, will cause further difficulties for staffing and services.

Prior to this announcement, staff already had issues with proposed new rosters and staffing arrangements. The frustrations of staff with management's handling of staffing and rostering were raised at a meeting of all union members in May. Unions say the existing difficulties have been compounded by the recent announcement by the board to withdraw in a row over funding and governance.

These developments were discussed at a further general meeting of union members on June 10, where it was agreed to request the WRC to intervene and assist with the rostering and staffing issues. The decision was also taken to defer a ballot for industrial action until after the WRC process.

INMO IRO Liz Curran said: "Rostering and staffing difficulties have arisen as service users and staff have moved from the St Patrick's campus into community houses. A row over funding between the board of St Patrick's and the HSE, which is the centre's primary funding body, doesn't help matters and increases the uncertainty for staff and service users."

Regrading of night nurse manager posts secured

FOLLOWING a prolonged dispute over the appropriate grading of night nurse manager posts in St John's Hospital, Enniscorthy, an agreement has been reached between the INMO and the HSE-South to for these two nursing posts to be regraded as CNM3, effective from June 13, 2019, with the assistance of the Workplace Relations Commission (WRC).

The dispute centred around the INMO claim that these two posts should be graded at ADON grade for historical reasons. In the late 1980s, when Brownswood Hospital, Wexford closed, its staff were moved to St John's Hospital – a Band 4 care of the older person service. Brownswood had two appointed ADON posts on night duty, and these ADONs continued in that grade following the move to St John's. When these two ADONs retired in 2003-2004, the then INO lodged a claim that the two night manager posts should remain at ADON grade. However, HSE-South then argued that the grade of the two former Brownswood ADONs was "personal-to-holders", but the INMO claim to have their posts permanently refilled at ADON grade was successful.

A further subsequent filling of the two posts were again made on a permanent basis at ADON grade, and when they became vacant in 2012, the INMO again sought their filling at ADON grade. Agreement was reached for the HSE-South to seek approval to advertise the posts at ADON grade, but due to the recruitment moratorium, the posts were never advertised.

The current post-holders were paid at CNM3 grade for a number of years, but earlier this year management advised that the posts would revert to staff nurse grade. A meeting between the INMO and hospital management in February 2019 failed to resolve the matter, although the HSE-South offered to appoint the two members on CNM3 grade.

The INMO referred the dispute to the WRC. At conciliation on June 13, 2019 the INMO claimed the posts should be at ADON grade. Agreement was reached at the WRC that the two night nurse managers in post be at CNM3 grade "with immediate effect", with an agreement on reviewing the roles/posts in the context of the union's contention that they are historically ADON posts. This review is to take place within two years or when either post becomes vacant, whichever is earlier. The parties agreed that the outcome of such review will result in no less that the post remaining at CNM3 grade.

INMO IRO Liz Curran said: "The INMO is hopeful that this review will allow for a re-evaluation of the INMO claim for ADON grade for the posts. However, we are pleased to have ensured that our two members will not be reverted to staff nurse grade as per management's initial proposal, and that the posts are guaranteed to be filled at a minimum of CNM3 grade into the future."

Talks ongoing on structure changes in UHL wards

TALKS are ongoing on the welcome proposals by Management at University Hospital Limerick to redesignate medical wards by specialty.

Management advised the INMO on May 1, 2019 of these proposals, which the union welcomed. Indeed the idea had been proposed by the INMO a number of years ago as the grouping of patients by specialty on wards is more effective for nurses and other staff involved in the delivery of care.

Two meetings on the changes have taken place to date, on May 22 and June 6, at which the INMO raised serious concerns on the historically low levels of nursing staff at the hospital, as well as the ongoing placement of additional patients on trolleys in wards and on corridors.


Mary Fogarty, INMO IRO

Management agreed to provide the INMO with details on the proposed staffing levels for all medical wards to be reconfigured, in particular wards 3A and 4A which are to be re-designated as elderly care units.

Nurse management acknowledged at the meeting that this is needed and that an increase in nursing resources will be required in 3A and 4A.

The INMO has also raised the fact that members require clarity on the use of available beds designated for patients with cystic fibrosis, which need to be reserved and available for CF patients when in need of admission.

Since the meetings, members have further raised the non-adherence to an agreement on ward 3D regarding staffing levels, loss of nursing cardiology expertise from some areas, access to telemetry and risks arising from the layout of ward 4C. A further meeting is scheduled for July 18.

– Mary Fogarty, IRO

Maternity pay system clarified and simplified at Bon Secours, Limerick

MATTERS relating to the calculation of maternity pay top up in Bon Secours Hospital at Barringtons, Limerick have been resolved in advance of a hearing at the Workplace Relations Commission, as the INMO has received a clarification on the application of the hospital's titrated maternity pay system.

The INMO had concerns on the method of calculation of the top up payment as it is complicated. Hospital management has advised that it will review the manner in which the calculation is derived over the next 12 months in order to simplify it.

If any member is seeking details on the calculation method please contact the hospital HR department to ascertain the calculation for your maternity pay top up.

Resolution of this matter now allows agreement on the payment of monies owed to nurses/midwives entitled to location and specialist allowances who were not paid correctly during periods of leave to receive back money from January 1 to August 30, 2018. From August 30 onwards the INMO understands that these allowances were paid in the correct manner.

– Mary Fogarty, IRO

Labour Court award for delay in investigation

A member of the INMO from the mid-west has been awarded compensation of €1,500 by the Labour Court following an appeal of a previous adjudication recommendation. The INMO on behalf of the member claimed compensation for the delay in initiating an investigation under the Dignity at Work policy.

In outlining the rationale for the award the Court stated that the respondent must take some responsibility for the delays and review the lessons learned from this case. It emphasised the need to implement best practice in the respondent communications with employees who raise grievances and complaints in the future.

– Mary Fogarty, IRO

World news

Nurses and midwives in action around the world

Australia
- Nurses say FACS did not consult over staff losses in switch to group homes

Canada
- Nurses call for end to workplace violence as attacks mount
- Shortage of nurses: New Brunswick universities struggle to meet demand
- Government, nurses looking for solutions to reduce overtime

New Zealand
- Nursing central to mental health package
- Race pay end on nursing agenda
- Hospital nurses ending shifts 'in tears' as working conditions bite, union claims

Paraguay
- New mobilisation of nurses in front of the Ministry of Finance

Spain
- Nurses ask government to classify 'burnout' as a professional affliction
- EU to study nurse/patient ratio and dangerous drugs law
- No money for nursing staff summer replacements

UK
- Clinical placements to increase by 25% as part of NHS workforce plan
- Nurses priced out of homes promised to NHS workers

US
- Bill to protect nurses from workplace violence advances
- Nurses report patient safety concerns at University of Chicago Medical Center
- Florida's universities get creative to meet demand for new nurses

Position statement

A call on all healthcare employers to develop transgender-inclusive and friendly workplaces

The Irish Nurses and Midwives Organisation (INMO) is proud to stand with and support LGBTQ nurses and midwives, as well as members of the wider LGBTQ community both in Ireland and internationally. In light of Dublin LGBTQ Pride Week 2019, the INMO believes that it is important to recognise and affirm its support for transgender nurses, midwives and other healthcare workers. This support includes joining the campaign to end transphobia, including stigma, discrimination and inequality.

The Irish Equality Authority estimates that 10% of the population is lesbian, gay or bisexual. However the size of the transgender population in Ireland is unknown but expected to be significantly lower. On the May 25, 2019 the World Health Organization changed the categorisation of transgender from a 'gender identity disorder' to 'gender incongruence'. This is a significant change to the International Statistical Classification of Diseases and Related Health Problems (ICD-11). Being transgender will no longer be seen as a 'mental disorder' and will now be considered as part of 'sexual health'.

Transgender people are not a recent phenomenon; they have been evident and have contributed to society throughout human history. In more recent times the transgender community has played a key role in the struggle for LGBTQ rights and the fight to end discrimination, most notably the Cooper Do-nuts Riot (1959), the Compton's Cafeteria riot (1966) and the Stonewall rebellion (1969). The events that occurred on Christopher Street, New York on the June 28, 1969 in response to a police raid at the Stonewall Inn, are the foundation of the global LGBTQ Pride celebrations held each year in June.

Transgender people in Ireland experience discrimination and violence, causing fear and anxiety that can lead to exclusion and social isolation. The Transgender Equality Network Ireland (TENI) defines transphobia as "the fear, dislike or hatred of people who are trans or are perceived to challenge conventional gender categories or 'norms' of male or female."[1] Between 2014 and 2016, 79 incidents or crimes against transgender people were recorded. These included fifty reports of hate crimes; rape, aggravated sexual assault, assaults causing harm, threats to kill and public order offences.[2] It is likely that these figures do not show the full extent of the discrimination and violence experienced by transgender people. It is important to recognise the often insidious nature of discrimination that is manifest as everyday hostility and can include being 'fired' from employment upon 'coming out' as transgender.

It is also important to recognise that employers have a legal responsibility to support and protect transgender employees and prevent workplace harassment. This obligation is mandated by a variety of legislation including:

- Employment Equality Acts 1998 and 2015
- Equal Status Act 2000-2004
- Irish Human Rights and Equality Commission Act 2014
- Gender Recognition Act 2015.

The INMO believes in listening to the transgender community and its representative organisations in Ireland. This is fundamental to enabling societies to understand the experience and needs of transgender people. TENI is a non-profit organisation that provides a powerful voice and support for the transgender community in Ireland, and has welcomed this INMO position statement. TENI is the leading organisation that campaigns to improve conditions and advance the rights and equality of trans people and their families through support, advocacy and education. TENI provides a range of resources to help people to make positive change by creating environments and encouraging discourses that are respectful and trans-inclusive. The TENI 2017 'Supporting Transgender Inclusion in the Workplace' guidance is the most comprehensive resource for supporting employers and employees. These guidelines assist employers, co-workers and trans employees to manage and sustain an open, inclusive and diverse workplace environment. Dublin Bus, as part of its Equality, Diversity and Non-Discrimination Strategy has led the way in establishing the most comprehensive and advanced practices for supporting workers transitioning in the workplace. The leadership and experience of Dublin Bus provides a model for other organisations to follow. Dublin Bus is not alone; other organisations including Dublin City Council and the RCSI have been at the forefront of creating friendly, transgender-inclusive workplaces.

Healthcare employers in Ireland already recognise and are committed to creating inclusive, positive working environments supported by dignity at work policies. This is evident in the HSE Diversity, Equality and Inclusion Strategy 2015-2018, which has promoted and encouraged the development of 'LGBT Champions', increasing awareness and establishing a HSE LGBTI and Allies Network. This support and inclusion of LGBTQ workers is welcomed and reflects the broader positive changes in Irish society. However there remains further opportunity to build on this foundation, particularly in supporting transgender employees in the workplace.

The INMO calls on all healthcare employers, in both the public and private sectors, to develop transgender-inclusive and friendly workplaces that include clear guidance on supporting employees transitioning in the workplace

Endorsed by:

References
1. STAD: Stop Transphobia and Discrimination Report 2014-2016
2. Haynes A, Schweppe J. The Disappearing of Hate Crime in the Irish Criminal Justice Process. Critical Perspectives on Hate Crime 2017; pp17-44

Transgender Equality Network Ireland

While apathy threatens democracy in the western world, the attacks are far more severe in other parts of the globe, writes **Dave Hughes**

Democracy in crisis across the globe

THE *2019 ITUC Global Rights Index,* published last month by the International Trade Union Confederation, provides chilling examples of the deterioration of fundamental trade union, democratic and human rights across the globe and demonstrates a galloping trend of attacks on democratic and trade union rights in many regions of the world. Naming the top 10 worst countries for workers in the world, ITUC general secretary Sharan Burrow concludes that democracy is in crisis.

In the western world we are witnessing the undermining of democratic structures through apathy and disillusionment among the general populations. This is prompted largely by scandal and corruption which has left a sense of bewilderment for many and an alienation from authority and state figures.

Across western democracies the turnout for general elections or referenda barely creeps above 50% of those eligible to vote. The ultimate consequence of this is played out in front of our eyes in the election of cult figures as has happened in America. We can now see it occurring in British politics, which is highly fracture following a referendum in which Brexit was passed by only the tiniest majority. The vote represented slightly more than half of the registered voting population but the UK decided to leave Europe without a Brexit plan.

While this apathy and disillusionment threaten democracy in the western world, the attacks on democracy across other parts of the globe are far more severe.

The number of countries that exclude workers from the right to establish or join a trade union increased from 92 in 2018 to 107 in 2019. All regions in the world had an increase in exclusion of workers, with the greatest increase occurring in Europe, where 50% of the countries now exclude groups of workers from the right to join, up from 20% in 2018.

Only Ireland and New Zealand are singled out for praise in the 2019 report. In Ireland, the banning of zero-hour contracts, through the adoption of the Employment (miscellaneous provisions) Act which came into force in March 2019 is described as providing "some important guarantees to improve the security and predictability of hours of work for employees". New Zealand saw a significant repeal of regressive laws which had been introduced between 2010 and 2013 with its new government restoring rights which prohibit pay deductions for partial strikes such as low level industrial action, oblige business to enter into bargaining for multi-employer collective agreements, and extend the protections against discrimination on the basis of union membership status.

The worst regions for working people are the Middle East and North Africa. In Libya, Palestine, Syria and Yemen conflicts still rage and fundamental liberties and rights are trampled. In 53% of countries in the Middle East and North Africa workers were arrested or detained, 10 trade unionists were murdered in the Philippines in 2018 and physical violence against workers and trade unions intensified dramatically. In Pakistan a labour leader was killed after attending a meeting with a power loom factory owner in March 2018. In the Asia Pacific region 91% of countries exclude workers from the right to establish or join a trade union.

The situation of workers in the Americas worsened compared to last year. In many countries trade unionists experienced violent attacks and in Columbia 30 trade unionists were murdered.

Workers who attempted to form unions were summarily dismissed in Ecuador, when a transportation company dismissed 22 workers after they formed a union. In Trinidad and Tobago, TSTT, the state communication company, dismissed 503 workers without any justification, the majority of whom were CWU members. Some 327 workers dismissed by PROSEGUR in Paraguay were reinstated following court action but still await their return to work. They had been dismissed after the dissolution of the union in 2012, and their lockout was in retaliation against their strike action. In Peru, ABINBEV dismissed 1,500 workers and replaced them with casual employees to avoid the application of a collective bargaining agreement.

Even in Europe trade union leaders were murdered in Turkey and Italy. In Turkey Abdullah Kracan, president of the Rubber and Chemical Workers Union Lastic-IS, was shot dead by an assassin on November 13, 2018. He was visiting workers at the Goodyear Tyre Factory in Adapazarı. In Italy, Soumayla Sako, a 29-year-old agricultural worker and trade unionist from Mali, was killed in San Calogero on June 2, 2018 while collecting materials to help build a city of tents and shacks where he and his co-workers lived.

There was an erosion of collective bargaining rights in the Netherlands, Estonia and Spain.

Surprisingly the results for Europe, in spite of social protection legislation, demonstrate that 40% of countries exclude the workers from the right to establish or join a trade union, 60% of countries violated the right to strike, and 50% violated collective bargaining rights.

There is little doubt that the economic recession has added fuel to global corporations who are determined to undermine civil, human and trade union rights in relentless pursuit of profit.

Apathy and alienation from democracy assist the march of such regressive movements and we must not be complacent in our right to be trade unionists and speak freely about our demands in terms of pay, conditions of employment, and dignity in the workplace.

Perhaps it is time to wake up and smell the roses or we may, once again, return to the era where workers sing the trade union ballad 'Bread and Roses'.

Dave Hughes is deputy general secretary of the INMO

Unions must pursue social justice

President Higgins inspires at EPSU Congress

THE INMO attended the 10th Annual Congress of the European Federation of Public Service Unions (EPSU), held in the RDS on June 4-7, 2019.

The Congress, with the slogan, 'Fighting for a Future for All', was attended by over 550 trade unionists from across Europe, and focused on the need for trade unions to embrace digitalisation, to continue to fight privatisation and to work in more collaborative ways to build solidarity and power.

The first day of Congress was launched with addresses from President of Ireland Michael D Higgins and new deputy general secretary of the European Trade Union Confederation (ETUC), Esther Lynch.

President Higgins' speech, which was a highlight of the three-day event, focused on Ireland's long history of trade unionism, the role of Irish women in fighting for justice both at home and abroad, and on the future role of trade unions and public servants in fighting for climate action and for social justice.

The President said that he was delighted that the EPSU conference was taking place in Dublin, as it was a "city with a proud tradition within the trade union movement. As President, I have been privileged to be asked to speak in the past of the role of Larkin, Connolly and others, of trade unionists, and particularly of the brave and neglected women trade unionists and their importance to our history in the late 19th and early 20th century.

"While drawing strength and courage from the exemplary bravery and determination of these individuals, and indeed from more contemporary figures like Mary Manning – the shop worker from Irish grocery chain Dunnes Stores who, in 1984, refused to handle the sale of fruit from South Africa in protest at the apartheid regime – the labour movement draws its strength from its collectivity, from the hundreds of thousands of people willing to demonstrate solidarity in their workplace, towards their fellow citizens, and towards people all over the world."

Presidential matters: *President Michael D Higgins greets INMO president Martina-Harkin Kelly at the EPSU Congress in Dublin last month. Photo credit: Conor Healy, Picture It Photography*

President Higgins also pointedly underscored the global need to develop "a new ecological-social paradigm", to "simultaneously pursue both equity/social justice and sustainability/sufficiency goals within an activist innovation state, with substantial public investment and greater regulation and planning."

The President also considered the future role of the International Labour Organisation – "the only surviving international institution that was created from the ashes of World War I – which, in its constitution, refers to social justice as being essential to lasting universal peace. In our present circumstances, almost 100 years after that constitution was first proclaimed, that spirit of idealism and of vital moral purpose is more urgently required than ever, yet it is seriously undermined. This begs the question of how can the International Labour Organisation re-dedicate itself to its founding mission in the context of an ongoing assault on workers' rights?

"I believe that the founding message given expression in an achievable agenda of the International Labour Organisation must be vigorously brought to the attention of the world by all of us who believe in equity and the dignity of work. How much better it would be if the necessary elements of what constituted social cohesion formed the basis of the discourse that prevailed on the streets of the world, rather than the excluded being abandoned to become the prey of xenophobes, homophobes and racists," he said.

Speaking on climate action, the President remarked "I see the role of public servants as being transformative in acting as champions for climate action, both in terms of mitigation and adaptation.

"Public servants have the capacity, given a real opportunity, to shape and implement policies in these spheres that will reduce the impact of climate change and enable society to adapt to the most destructive effects of a changing climate which we are already beginning to witness first hand – through, for instance, the increased severity and frequency of storms and extreme weather events.

"There exists now a great opportunity to give leadership and for trade unions to play a strong role in pushing for fair, ambitious and binding international agreements on greenhouse gas emission reduction targets," he said.

On his vision for the future, the President said: "My vision is of a Europe with excellent public services at its core. Good jobs in the public sector mean quality services for citizens. Your members appreciate only too well that the services they deliver are not a cost to society, but an investment in our communities. This message must be taken to the heart of Europe."

– Beibhinn Dunne, INMO media officer

Retired Section enjoys day trip to Athlone

MEMBERS of the Retired Nurses Section enjoyed a pleasant day trip to Athlone in May. Members of the section visited Athlone town and cathedral before taking a leisurely cruise along the Shannon and having a tasty lunch at the Left Bank Bistro. *Pictured on the section's day trip to Athlone were (l-r): Ann Gee, Geraldine Sweeney, Joan Dempsey and Ann Igoe.* The Section's next social event will take place on Thursday, September 12 when attending members will take a tour of the 14 Henrietta Street museum – meeting at 11am. Make sure to book your place in advance at Tel: 01 5240383 or contact Geraldine Sweeney at Tel: 087 2794701

Focus: INMO Public Health Nurse Section

THE PHN Section of the INMO meets at least four times a year and has an AGM each January.

There are currently many areas of concern in the community and these have been highlighted at our recent meetings at INMO HQ. There is a committee of five – chair, vice chair, joint secretaries and education officer – elected at every AGM. We send two delegates and submit one motion to ADC every year.

The Section is a forum for discussion on topics of interest to all members and we disseminate news and updates through a WhatsApp group which includes CRGNs and some ADPHNs. We welcome all members to this group, which offers solidarity, support, information sharing and updates on matters of mutual interest.

We are lucky to have two of our members on Executive Council: Eilish Fitzgerald and Gráinne Walsh.

Members of the INMO PHN Section and CRGN Section, along with director of industrial relations, Tony Fitzpatrick pictured at the Richmond Education and Event Centre at the section's June meeting

June meeting

The June meeting at the Richmond was jointly held with the CRGN Section. It was well attended and a number of members participated via teleconference. INMO director of industrial relations Tony Fitzpatrick was also in attendance.

Topics on the agenda

Allowances

The discussion around allowances covered caseload allowances for CRGNs, the location allowance for PHNs and the increased specialist qualification allowance. Pay and conditions, travel expenses, loading of car insurance for carrying students, and indemnity are all contentious areas.

HPV immunisation for boys

As immunisation is a PHN/CRGN role, there is grave concern around the imminent HPV for boys, due for roll out in autumn 2019, and the capacity of the immunisation teams to cope with these increased demands, given the ongoing recruitment and retention crisis and the current recruitment pause in place *(see page 9)*.

Home help governance

This has been an area of ongoing debate over recent years and it is becoming highly charged in an era of cutbacks and cost containment.

Local budget overspend is penalised by a recruitment pause and essential home support services are put on hold indefinitely. This is detrimental to staff morale and affects the PHN's relationship with families and vulnerable patients. The PHN, as front-line staff, has to bear the brunt of families' frustrations at the negative outcome of these corporate decisions.

> ***"The PHN Section is driven by the passion of its members for their work in the community"***

The Section continues to resist pressure to assume the risks and responsibility for local service delivery given the diversity of private providers. Discussions between the INMO and the HSE are ongoing.

Weekend planned essential services

Currently, these services are delivered on an ad hoc basis and there is much work being done at section level with the director of industrial relations to clarify and standardise the conditions of these services.

Staff working weekends in areas outside the so-called Dublin Agreement are frequently in breach of the EU Working Time Directive, and it is not only untenable but illegal to have staff working 12 or more days in succession with no cover provision for time off.

The need for safe staffing levels must be addressed soon with Sláintecare as this is premised on early discharge from the acute sector to the community.

Metrics

Metrics are being standardised nationally and while generally viewed in a positive light, there is a caveat that they do not capture the full extent of the PHN's work. Child metrics are due to be rolled out in the near future, following consultation, and are expected to better capture the work and more accurately reflect the role of the PHN.

Child health records

Nationally, standardised child health records are expected to be rolled out in October 2019 but further consultation and training is needed. A number of working groups have been involved. These will not be parent-held records, as is the case in some parts of the country at present.

The Nurture Programme

This programme is focused on child health and has been subject of much discussion at national level in recent months as the programme was devised and progressed without any consultation with the INMO.

Meetings with the Nurture Programme leads, the HSE, the INMO director of industrial relations and the PHN Section were held in March, April and May and currently the programme is on hold until further notice. It had been running in some areas but the plan to nationalise its roll out was never agreed upon.

Ages and Stages

A contentious issue is the Ages and Stages questionnaire, which is funded by private philanthropic foundations. Further dialogue, piloting and evaluation are needed to reach any agreement with front line staff.

We have ongoing concerns over the workload of the PHN given the increased demands of administrative duties in the absence of any realistic clerical support.

The future

Plans for the future of the section include a national PHN conference. We are keen to expand on this and with the support of Steve Pitman and INMO Professional, it looks like it will become a reality. We have already had a number of topics proposed to us by section members.

The PHN Section is driven by the passion of its members for their work in the community and by a shared goal of achieving the best outcomes for members to enable them to deliver a high quality service to their patients.

– Catherine Rotte-Murray, PHN Section, chair

Spotlight on: Ciaran McHugh

NURSING NOW is a worldwide campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, wider society and improved economies. The overarching aim of the campaign is to improve health globally by raising the profile and status of nurses worldwide by influencing policymakers and supporting nurses to lead, learn and build a global movement.

Its other aims include:

- Greater investment in nursing
- More nurses in leadership positions
- Increasing nurses' input and impact on healthcare.

The campaign is bringing policy makers the evidence to show that nurses improve health and will make a crucial contribution to realising universal health coverage.

In a new series, *WIN* will showcase the Nursing Now Campaign and in this issue we put the spotlight on nurse Ciaran McHugh.

Mr McHugh was one of 24 young nurses who were selected by Nursing Now, in partnership with the International Council of Nurses (ICN), to attend the World Health Assembly in Geneva, in May 2019.

Mr McHugh represented the INMO and here he describes his experiences over the past few weeks and shares his ambitions for improving the status of nursing and midwifery in the future.

World Health Assembly

The World Health Assembly is an annual week-long conference where delegations representing every World Health Organization (WHO) country around the world, gather in Geneva to set out the global health agenda for the year ahead. Twenty-four young nurses and midwives were chosen to travel to Geneva, and form part of the ICN delegation attending the assembly.

The role of the ICN delegation was to:

- Represent nurses around the world
- Raise the profile of the nursing and midwifery professions
- Lobby to improve the conditions for their 20 million colleagues
- Convince key stakeholders to invest in nursing, for without us, universal health coverage cannot be achieved.

Nurse Ciaran McHugh with Elizabeth Iro, chief nursing officer at the WHO

Nurse Ciaran McHugh with Dr Tedros Adhanom, director-general of the WHO, alongside other members of the 24-strong delegation

The delegation attended meetings and high-level strategic sessions with WHO officials. In addition, they participated in discussions on global health issues at side-events during the assembly.

Mr McHugh describes how he could not, "begin to put words on a page, to describe how I felt when I met some fascinating people from incredible parts of the world on a Friday morning in Geneva. The 24 representatives and their new family of mentors spent a life-changing six days together in historical settings, carrying out a job that has been described as revolutionising modern nursing," he said.

Over the week in Geneva, the delegation met with Dr Tedros Adhanom, director general of the WHO, and Elizabeth Iro, chief nursing officer of the WHO to discuss their experiences.

Mr McHugh described how he couldn't believe how normal and welcoming they were.

"They seemed as excited to meet us, as we were to meet them. Nearly every speaker mentioned how fantastic it was to have a group of young nurses present; nurses who are currently at the start of their clinical careers, working on the front-line, delivering the services that were being discussed," he said.

As the week in Geneva drew to a close, Mr McHugh described how he knew "that this was by no means the end of our journey. Of course, we asked ourselves where do we go from here?"

Two weeks after the World Health Assembly, Mr McHugh found himself speaking at the RCSI Hospitals Group Nursing Now launch in Drogheda. He described how he felt privileged to be provided with the opportunity to present his experiences as one of Nursing Now's young nurses in Geneva.

Mr McHugh believes after his recent experience that "these are unprecedented times for the profession of nursing, and this is a once in a lifetime opportunity for young aspiring nurse leaders to break the mould and shape the way for modern nursing into the future."

Call to expand neonatal screening service in Ireland

Dear colleagues,

My name is Lynda Martin. I've been a staff nurse for 14 years, most recently in St Vincent's Private Hospital in Dublin. Almost two and a half years ago my two sons Cathal and Ciaran (Cogs and Kiwi) were diagnosed with a terminal illness called metachromatic leukodystrophy (MLD). They were aged two and a half, and 11 months at the time.

For Cathal there was no treatment as the disease was too far progressed. He was a great little boy and grew up perfectly to two years of age. He was five on May 27 and is now fully paralysed, peg fed and close to his end.

Ciaran however was still presymptomatic. Cogs had shown us the problem, so we could go for a trial gene therapy treatment in San Raphael Hospital in Milan. We stayed there for six months and have been back many times since. He is two years post therapy now and appears to be stabilising, but he has white matter on his brain, peripheral neuropathy and will be disabled. He is just about walking independently now with splints on and is attending preschool. We are hopeful for his future.

We also have a little girl Holly, aged six, who is unaffected, but has struggled through all this with us.

Through our contacts in Italy we recently learned of their expanded newborn screening programme which can detect MLD at birth. If treated close to birth a child will show no signs of the disease whatsoever.

In Ireland, we screen for eight conditions at birth. In Italy they screen for 40! Moreover, they are looking to expand the number of diseases they scan for. Italy increased its screening from just four to 40 conditions in one year across 20 test centres. In the first year running the programme they identified 350 cases across the panel of 40 conditions and treated them all. They did all this by bringing in a law. Roughly translated, it says: "Every citizen born in Italy has the human right to be screened at birth for all conditions for which there is a treatment."

Myself and my husband Les are petitioning the Irish government and the HSE to follow the Italian model on newborn screening in Ireland. Our Italian friends in their Department of Health have given us a written offer to share all their data and assist in any way possible.

They saved my son Ciaran and now they want to save a further 50 Irish children a year with this system. There is one child born every week in Ireland with one of these 40 conditions.

We are delighted with the written support we got from the INMO, and would like all of you to help us by signing our petition. We're hoping that this will start the conversation about newborn screening within the hospitals and eventually up the ladder, building pressure for change. The agony we have lived and continue to live through cannot be described in words. I want my boy Cathal to be among the last to suffer and die needlessly in this way, and now we have a way to do that.

Please help,

Lynda Martin, staff nurse and mum

Please sign the petition at: **https://my.uplift.ie/petitions/newborn-screening-expansion**

For more information see: **facebook/cogsandkiwi**

INMO members celebrating Pride in the courtyard of the Richmond Education and Event Centre

INMO members pictured ahead of the movie night

Linda Doyle and Helen Buckley

Clare Treacy, Labour Court workers' rep and Albert Murphy, IRO

Blandina Mwanyopa

An audience of INMO members

Taking pride in supporting our LGBTQ members


Dave Hughes, deputy general secretary

The INMO's recent Pride-themed movie night celebrated the diversity of the Organisation's membership and highlighted the work that still needs to be done to eliminate discrimination against the LGBTQ community

ON June 20 the Richmond Education and Event Centre hosted a pride-themed movie night, screening the 2014 British film *Pride*, which won the Queer Palm award at the Cannes Film Festival in 2014 and is based on true events.

Speaking on the night, INMO deputy general secretary Dave Hughes gave the audience some context for the film, which depicts the bitter 1984-85 British miners' strike, and the support that strikers received from the LGBTQ community, which eventually led to the London 1985 Pride parade being led by mining union lodges and their supporters.

Mr Hughes outlined how during the 1984-85 strike "the funds of the National Union of Miners were sequestrated" and how this led to funds from women's groups and LGBTQ fundraisers being distributed directly to mining communities "which in turn led to a close bond forming between the two communities".

Also addressing the audience, INMO director of professional and regulatory services, Edward Mathews said: "The INMO for a long time has been a very active supporter of LGBTQ members and also of the LGBTQ community."

He stressed the many strides made for the rights of LGBTQ people in Ireland since the 1980s, noting however that "you can still see a resistance to the rights and entitlements and the recognition of the human dignity and humanity of gay, lesbian and trans persons in this country".

Mr Mathews also spoke of the Executive Council's recent adoption of a proposal in support of trans rights, noting the many legal and social battles faced by Irish trans people to achieve recognition. He referred to the European Court of Human Rights' position that "in a modern society, a failure to recognise a person for who they are and what they fundamentally recognise themselves to be is a breach of their human rights".

Speaking about the 2017 marriage equality referendum, Mr Mathews said: "It was an extraordinary day for many people, and certainly for those of us in the LGBTQ community, it was a day of great joy, and I have to say of unparalleled joy for me in terms of my recognition of who I am and where I am in this society. But the struggle isn't over. There is still huge oppression out there in hidden ways.

"Pride remains an important part of society, as there's still a huge amount of discrimination. There's still violence towards gay people just because they are gay.

"It's in that context that we believe we have achieved a huge amount, but that there is a lot more to achieve, and we have to be actively involved in that.

"We believe Pride is an important event. Nurses, midwives and women in particular have played a huge role in supporting the LGBTQ community in Ireland, and we are a predominantly female organisation, so it is really important that as a trade union we support our LGBTQ friends, our colleagues and the people we know in society."


Edward Mathews, INMO director of professional and regulatory services

Regulation reform

The INMO has taken a firm stance on the reform of the regulation governing nursing and midwifery, writes **Edward Mathews**

THE regulation of nurses and midwives by the Nursing and Midwifery Board of Ireland (NMBI) is currently the subject of proposals for extensive legislative reform. The Regulated Professions (Health and Social Care) (Amendment) Bill 2019 was put before the Houses of the Oireachtas earlier this year. The Bill proposes substantial changes in the regulation of all health professionals, including nurses and midwives.

The Nurses and Midwives Act, which currently regulates nurses and midwives, was enacted in 2011, however in reality the new fitness to practise regime under that Act, only commenced operation in 2014. Notwithstanding the relatively recent reforms in the regulation of nurses and midwives, it is timely that further reforms are introduced.

The current process requires reform as in places it unnecessarily creates complexity and delay in the operation of the fitness to practise regime. It can also require people to undergo full fitness to practise inquiries where there are less traumatic ways to protect the public interest and the integrity of the professions of nursing and midwifery.

Voluntary removal from register

Quite a number of the reforms proposed in the 2019 Bill are welcome and are supported by the INMO. One such reform is the proposal that nurses will be able to voluntarily remove their names from the Register of Nurses and Midwives, even if there is a fitness to practise complaint against them, once it is not contrary to the public interest for them to do so. There are instances where nurses and midwives have reached the end of their career and do not wish to undergo a fitness to practise inquiry, and in that context this reform is quite welcome. Additionally, there is a small number of nurses and midwives who realise for various reasons that they do not wish to continue their nursing and midwifery career and allowing them exit the profession in a dignified manner, once this is not contrary to the public interest, is a welcome and compassionate reform.

Currently, no nurse or midwife who is the subject of a fitness to practise complaint can remove their registration voluntarily. This forces retirees and others who never wish to return to nursing and midwifery to undergo a fitness to practise inquiry.

Another welcome reform within the Bill is the removal of the role of the overall Board of the NMBI where complaints are withdrawn during the investigative phase or when being considered by the Fitness to Practise Committee. The Bill proposes, where it is regarded as appropriate to do so, that when a complaint is withdrawn while being considered or investigated by the chief executive, the Preliminary Proceedings Committee or the Fitness to Practise Committee, that any of these can decide, without the requirement of later confirmation by the Board, to dispense with consideration of the complaint because of its withdrawal.

This is a welcome reform in terms of increasing the efficiency and speed with which the Board can deal with fitness to practise matters, and it also deals with circumstances where complaints can be made which are without substance, which may have been made for ulterior motives, and a person who made the complaint decides to withdraw.

Undertaking and censure

Currently, the Fitness to Practise Committee, as a means to bring an end to fitness to practise hearings, can request a nurse or midwife to undertake not to repeat the conduct in question and/or agree to being censured – a form of written warning. In a welcome development the Fitness to Practise Committee has recently made greater use of the current provisions of the Nurses and Midwives Act, however the current status is that a complaint must proceed through the preliminary stage and must either be prepared for hearing or have been heard, prior to the Fitness to Practise Committee deciding that an undertaking and/or censure is the appropriate end to the case.

Under the proposals included in the Bill, the Preliminary Proceedings Committee of the NMBI – which deals with matters at a preliminary stage – and/or the Fitness to Practise Committee could now request a nurse or midwife to undertake not to repeat the conduct and/or to consent to being censured.

This is an extremely welcome development as there are cases that come to the attention of the Board which do require to be marked in order to protect the public interest and the integrity of the professions, however, such cases may not always require a full fitness to practise inquiry for the matter to be effectively resolved.

This proposal is being strongly supported by the INMO as is the related proposal that both the Preliminary Proceedings Committee and the Fitness to Practise Committee

can use the undertakings and/or the consent procedure without the necessity for subsequent confirmation by the NMBI, which will assist in the efficiency of the fitness to practise processes.

Cause for concern

Moving away from the welcome proposed reforms, there are two such reforms which cause us very significant concern.

In the first instance, it is proposed that all sanctions, including written warnings in the form of advice, admonishment and censure, will require to be confirmed by a judge of the High Court. Currently, only more serious sanctions require confirmation. We believe that this reform is unnecessary and in particular will expose nurses and midwives to increased publicity as the confirmation hearings take place in open court and are widely reported upon in the media.

An associated reform has provided for all sanctions, even minor sanctions, to be subject to appeal to the High Court. This is arising from certain comments made in case law regarding the potential effect of minor sanctions and the necessity that an appeal mechanism be available.

While the appeal provision is a welcome reform, it is unnecessary and unduly traumatic to expose all nurses and midwives, irrespective of how minor the sanction against them, to public court proceedings which are reported in the media.

On a related point, the Bill also proposes that all sanctions, irrespective of the level of that sanction, must be reported on by the NMBI. This is a very damaging development.

Members of the Organisation will know that we have huge concerns regarding the public nature of fitness to practise proceedings as they stand, given the extreme trauma suffered by members who are the subject of public commentary in the press and on social media. However, the current regime within the Nurses and Midwives Act, notwithstanding our criticism of it, does offer the facility for the Fitness to Practise Committee to grant a hearing in private where there is cause to render it appropriate in the circumstances.

Furthermore, the current legislative regime allows the Board to decide that it would not be in the public interest to publish a sanction in a given case. The current regime at least allows the Board to consider the very serious medical effect that fitness to practise proceedings can have on nurses and midwives, and to direct non-publication.

If the proposed reform is seen through this will mean that the Board will have no discretion to refrain from publishing the outcome of a fitness to practise hearing, including sanction, where the Fitness to Practise Committee might have decided on compelling medical evidence that the health situation of the nurse or midwife demanded that a hearing take place in private.

The combined effect of the necessity for all sanctions to be confirmed by the Court, and the requirement for the NMBI to publish all sanctions, will mean that even in circumstances where there is compelling medical evidence that a registrant's health would be seriously affected, the nurse or midwife will be the subject of public commentary in the press and social media.

These are reforms which are dangerous for nurses and midwives. They are not necessary to protect the public interest, they are not necessary to protect the integrity of the professions and they are being strongly resisted by this Organisation.

Actions

In support of the reforms that are welcome, and resisting those that are considered dangerous, we have made submissions to the health spokespersons of all political parties, submissions to the Minister for Health and submissions to the Oireachtas Health Committee. In addition, we have coalesced with other organisations representing physicians, dentists and allied health professionals in making further submissions to the Oireachtas Health Committee and Minister resisting the dangerous reforms within the Act.

Section 40 of the Nurses and Midwives Act, 2011

The Organisation recently made submissions to the NMBI regarding the proposed commencement of Section 40 of the Nurses and Midwives Act, 2011, which would require an annual declaration by midwives that they have adequate indemnity insurance in circumstances where they are attending a woman in childbirth, childbirth being understood as antenatal, perinatal and postnatal care. We have made submissions to the Board in relation to the necessity to have an efficient, user friendly and nuanced annual declaration procedure, which is designed to capture the position of all midwives.

In relation to midwives working in public hospitals and those working under a memorandum of understanding with the state, such midwives are embraced by the state clinical indemnity scheme and no issue arises for them in relation to the level of clinical indemnity insurance.

In respect of midwives working for private companies, those companies would have sufficient indemnity insurance in place, which poses no concern for the annual declaration process.

In respect of midwives working in a general practice setting, we have secured commitments from the NMBI that if those midwives are indemnified to undertake a limited range of maternity services, that a declaration of such a level of indemnity will be sufficient for the purposes of the annual declaration.

I wish to thank the midwives working in general practice who provided much insight and information in relation to their situation in advocating with the NMBI on this issue.

We have also raised with the NMBI the necessity to ensure that midwives working in general practice are embraced by the state clinical indemnity scheme to ensure that women have the maximum choice in the delivery of services to them and to ensure that the skills and competencies of those midwives are not wasted when they are available to assist women attending the general practice setting.

Finally, we have made submissions to the NMBI in relation to midwives who would not be working in practice, but would make a substantial contribution to the midwifery community, and that the annual declaration process should be sufficient to ensure that they can declare their lack of involvement in childbirth, as understood above, and as such comply with the declaration process.

Submission to HIQA in relation to the availability of pre-exposure prophylaxis

The Organisation recently made an extensive submission to HIQA, with the assistance of members working in sexual health services, on the availability of pre-exposure prophylaxis (PrEP) to the community.

We have strongly supported the availability of PrEP as a means to reduce the level of transmission of HIV within our communities. We have also advocated for substantial increases in staffing for sexual health services to ensure that those receiving PrEP can be appropriately treated, that the service can be implemented, and that appropriate service provision can include monitoring and education to assist persons receiving PrEP.

Edward Mathews is INMO director of regulation and social policy

Resolving issues the right way

INMO student and new graduate officer **Neal Donohue** looks at the steps involved in the HSE grievance procedure

INTERNSHIP students and new graduates often identify issues that affect their health, safety and welfare at work. These can include issues with the organisation of working time, issues with pay and issues with alleged bullying in the workplace. Where issues arise, it is imperative that employees are aware that there is a mechanism to resolve them.

A grievance is a complaint that an employee or a group of employees have concerning terms and conditions of employment, their working environment or working relationships. Grievances can arise for many different reasons including: allocation of work, assignment of duties, rostering arrangements, granting of all forms of leave, interpretation and application of national/local agreements including matters concerned with pay-related benefits, granting of overtime, access to courses, health and safety issues and acting-up/deputising arrangements.

The HSE has a policy on grievance and disciplinary procedure that has been agreed with health service unions. These procedures have been prepared in accordance with the Labour Relations Commission's Code of Practice on Grievance and Disciplinary Procedures.

I am frequently contacted by internship students and new graduates who are not getting access to premium hours such as Sundays; this is an example of a legitimate grievance. Since premium hours attract time-plus-time payment (ie. double time) it is in the interest of all employees to have access to these hours of work. However, occasionally junior employees, including internship students, are told they do not have a right to these days, and they are allocated to more senior staff. As an employee you should not be treated any less favourably than another employee. Duration of employment does not matter in this instance.

Reading the grievance procedure will help you to identify the steps you need to take to find a resolution to your grievance. If you are uncertain of your rights and entitlements, you may contact the INMO Information Office at Tel: 01 6640619 or 01 6640610 for further information.

As per the agreed policy, you must in the first instance raise complaints on an informal basis. This means going to your line manager and telling them about your complaint and asking them to resolve it. If you do not feel you can go to your immediate line manager, then you can go to the next in command. Some people report fear of being treated differently if they complain. However, the policy itself states that "an employee will not be penalised in any way for making a complaint in good faith, regardless of whether or not the complaint is upheld".

It is important to consider whether you are the only one affected by your complaint or if there are others experiencing the same issue. If the latter, it is a good idea to address the issue collectively. You can support one another as a group, which gives you a stronger position, and it can also help to build camaraderie.

Keep a record of the date and time you first informed your manager of your grievance. If you are concerned about not being listened to, or if you are not confident in speaking, you may write to your manager, specifying that you are writing informally to ask that they resolve your issue. This will also provide a record of your communication.

If you are unsuccessful in having your issue resolved locally through informal discussions, you may invoke the grievance procedure and make a formal complaint under stage one. At this point you would write down the details of your complaint and refer it to the appropriate level of management. A meeting would be arranged with management within seven working days. You are entitled to have your trade union representative accompany you to such a meeting.

There are four stages to the grievance procedure whereby if a resolution is not found you may progress the issue through the four stages. Under stage two, it would progress to a more senior level of management. This may be omitted in ID services, voluntary hospitals and specialist agencies. Under stage three, the grievance is referred to the HR department, and if there is still no resolution the matter may be referred to a third party under stage four, eg. the Workplace Relations Commission or Labour Court.

Your INMO rep or IRO will support you through the process to find a resolution. The majority of complaints can be resolved at local level, but it is important to know that if they are not, you may pursue the issue further.

It is not a good idea to suffer in silence. Leaving issues unresolved can lead to dissatisfaction at work and this can also affect your colleagues and create a negative work environment. Don't get stuck in a cycle of complaining.

Most importantly, learn how your union can help you through providing information, advice and representation. When you are informed you will be empowered to have a happier and healthier career.

Neal Donohue is the INMO's student and new graduate officer. If you have a question about the above article, or need support or information, you can contact him at email: neal.donohue@inmo.ie or Tel: 01 6640628

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I HAVE an enquiry regarding annual leave. I was due to go on annual leave and had booked a week off work.

However, on the weekend before the leave was due to start, I became ill and was on sick leave for that week. My question is will I be able to avail of this annual leave at a later date?

Reply

Where a nurse/midwife falls ill during a period of annual leave and submits a medical certificate from a registered medical practitioner, the period covered by the certificate is regarded as sick leave and annual leave entitlement is restored.

Therefore annual leave can be taken at a later date.

Query from member

I AM a staff nurse working in the public health service and I have used up all my normal sick leave entitlement while I was pregnant.

If I am out on sick leave with a non-pregnancy related illness when I return to work after maternity leave how is my sick leave affected?

Reply

After maternity leave if you are absent with a non-pregnancy related illness, any illness that was recorded as 'pregnancy-related' in the previous four years will be credited back to your sick leave record at half pay.

This does not include any time spent on the 'extended' period of pregnancy-related sick leave as this time is not counted in the four-year look back. Any sick leave that occurs after maternity leave has ended will not be recorded as 'pregnancy related'.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Karen McCann at
Tel: 01 664 0610/19 or
Email: catherine.hopkins@inmo.ie/
karen.mccann@inmo.ie
Mon to Thur 8.30am-5pm/Fri 8.30am-4.30pm

INMO

• Annual leave • Sick leave • Maternity leave • Parental leave
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• Pay and pensions • Public holidays • Career breaks
• Injury at work • Agency workers • Incremental credit

Quality & Safety

A column by Maureen Flynn

Introducing the 'Know, Check, Ask' medication safety campaign

THIS month our column focuses on an exciting medication safety campaign which has been developed in line with the World Health Organization (WHO) Global Patient Safety Challenge, 'Medication Without Harm'. Medication management is an integral part of nursing and midwifery practice. This column introduces the campaign and the resources provided to support your practice.

Know, Check, Ask

'Medication Without Harm' is a global improvement campaign. Its aim is to challenge health services to reduce severe avoidable medication-related harm by 50% globally over the next five years. The medication safety programme 'Safermeds' is one of the HSE National Quality Improvement Team's priority improvement programmes. The team will be supporting services to respond collectively to the challenge. As in previous WHO campaigns, such as 'Clean Care is Safer Care', which focused on hand hygiene. The public awareness message is 'Know, Check, Ask'.

The purpose of the campaign is to encourage and empower those taking medication, and their caregivers, to take an active role in managing their medication (*see poster image*).

The call for action is to:

- Know – your medicines and keep a list
- Check – you are using the 'right medicines the right way'
- Ask – your healthcare professional if you are unsure.

Why the campaign is important

Adverse drug events are the third-most common type of adverse events in the Irish healthcare system[1] with 8.8% of emergency admissions to hospital being adverse drug related.[2] Safe prescribing at transitions of care can be problematic. With traditional medication history taking, Irish research has shown that 41% of patients had at least one medication error at admission.[3] At the time of discharge 56% of patients experienced prescribing errors and miscommunication.[4]

Figure: Medication memory aid

People who use a memory aid, such as a medicines list (*see figure above*) could recall their medicines more accurately (65%) than those who did not (21%), providing a more reliable initial medication history.[5] An accurate medication history may still require verification with an additional reliable source of information as no single source is complete for everyone. Options include contacting the community pharmacy or contacting the GP practice, which have complete histories for 77% and 69% of people respectively.[5] If there are any differences, return to clarify these with the patient.

Get involved

Discuss the campaign with your colleagues and consider how nurses and midwives could promote it in your place of work. A key component of this campaign is to encourage people who take regular medicines to keep an up-to-date list of their current medication and to take this with them to all healthcare appointments. Another option is for the person to ask their pharmacist or GP to print a copy of their current medication for them.

Ask people if they have an up-to-date medicines list when discussing their medicines and refer to it with them. Share the key messages from the campaign with people you are caring for including:

- Knowing how you take your medicines and keeping a list helps you and everyone involved to make correct decisions about your care
- A list can be helpful at times when you might not be able to remember all the details of your medications, eg. in an appointment or in an emergency
- Some people find it useful to keep a photo of their medicines list on their phone.

Further Information

The campaign consists of a social media campaign and access to medication list leaflets via community pharmacies, with posters and information being distributed widely. The campaign will have two phases, in July and September 2019. Resources to support the campaign are available from: **www.safermeds.ie**

Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement Team

Acknowledgement: With special thanks to Muriel Pate and Ciara Kirke, SaferMeds Programme and members of the HSE National QI Team for sharing information and help in preparing the column

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Mapping out ways to support breastfeeding

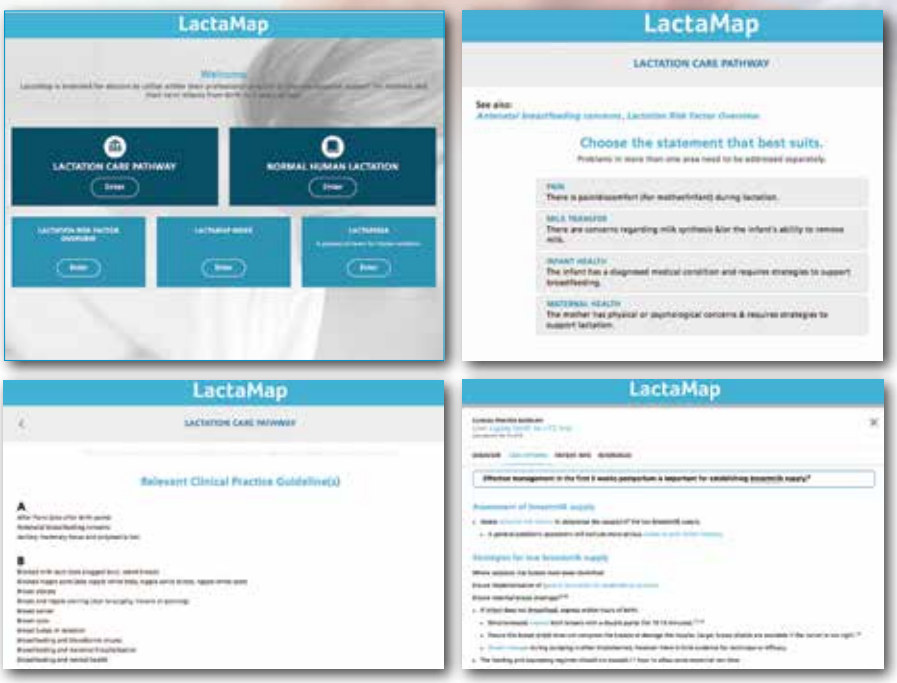
LactaMap is a new online breastfeeding and lactation care support resource for healthcare professionals. **Alison Moore** reports

"IF YOU look over the past 100 years, unlike other phases of reproduction, human lactation has declined in both initiation rates and sustained lactation rates. While we've been able to make some impact on lactation initiation, most women fail to sustain lactation for the minimum recommended durations." This was according to Melinda Boss, a senior research fellow at the University of Western Australia, who was addressing the recent Medela international breastfeeding and lactation symposium held in London.

Ms Boss is chief investigator and founder of the LactaResearch group research which aims to support effective lactation through the translation of research to practice. Her recent research achievements include LactaPedia and LactaMap. LactaPedia (**www.LactaPedia.com**) launched in August 2018 and is an internationally collaborative glossary of lactation terminology for science and medicine. LactaMap (**www.LactaMap.com**) is an online lactation care support system designed to provide evidence-based information to support doctors caring for women and infants experiencing difficulty with lactation. LactaMap launched in March 2019.

Speaking at the symposium, Ms Boss said that while we have been able to improve the rates of lactation initiation in western countries somewhat, most women fail to sustain lactation for the minimum recommended durations. She said that women who made the decision to imitate breastfeeding were "not abandoning it lightly" and as a result healthcare professionals had questions to answer. There are many reasons why this is the case. But our hypothesis is that compared to other organs in the human body, there's a comparative lack of basic research and a lack of translation of that research that is available to the medical care of problems with lactation."

She explained that over the past 10 years, a multidisciplinary group at the University of Western Australia, which she leads, has been involved in collating information to design an online tool, which has evolved into the LactaMap website.



Screenshots from LactaMap illustrating the taxonomy of the site and the many resources available

"It's an online lactation care support system. And we've designed it specifically for the use of healthcare professionals – doctors, obstetricians, paediatricians, and nurses and midwives, and indeed all healthcare professionals, many of whom are reporting that they're not receiving the education for the knowledge and skills expected of them when they're supporting problems with lactation."

This is why, explained Ms Boss, that in the first version of LactaMap, one of the first things they set out to do was define normal function, because "you can't determine what dysfunction is without an understanding of normal function".

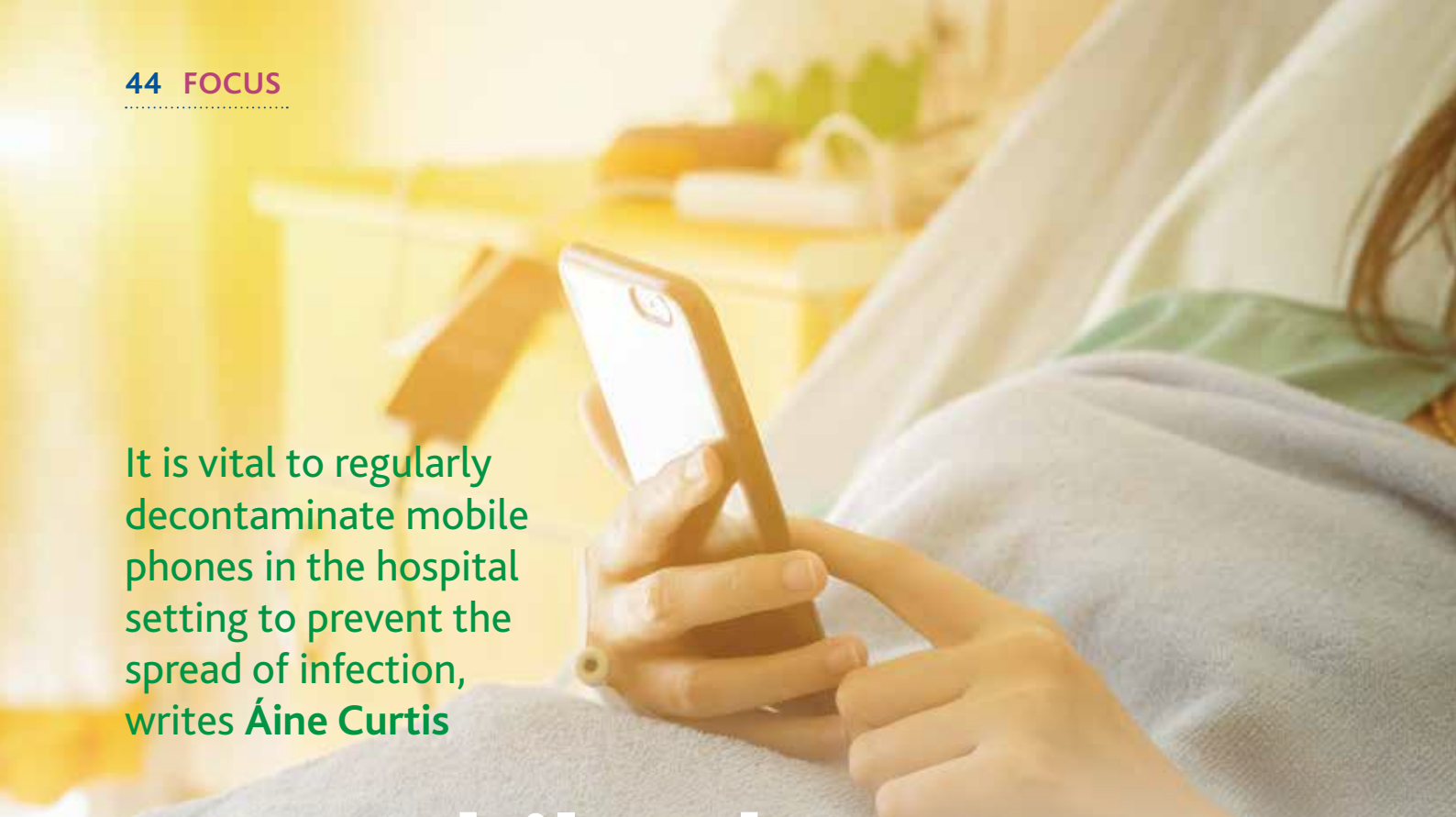
She continued: "Then we defined our scope and created content for more than 412 clinical practice guidelines to support the medical care of problems with lactation. We also have supporting information, patient information documents, and normal function articles. These are all evidence based and are supported by more than 1,000 references."

Ms Boss told those attending the symposium that because LactaMap is online, its content can be continually updated and reviewed, meaning that there is now a way to translate new research to practice soon after publication.

"The National Institute of Medicine, states that it currently takes about 17 years for research to be translated to practice. We hope that with our online format, we have developed a way to get research directly to practice.

"LactaMap is free to use and anyone can access it anywhere in the world. We really hope that by creating this tool and making this information accessible to healthcare professionals, when they're caring for those with problems with lactation, that we will be able to make some impact on sustained lactation rates," said Ms Boss.

Further information about these projects can be found in Ms Boss's research impact story available at: **https://researchimpact.uwa.edu.au/research-impact-stories/whats-a-breastfeed/**



It is vital to regularly decontaminate mobile phones in the hospital setting to prevent the spread of infection, writes **Áine Curtis**

Do mobile phones cause nosocomial infections?

CONCERNS around nosocomial infections or healthcare-associated infections in hospitals pose grave challenges in both developed and developing countries. The World Health Organization (WHO) states that a healthcare-associated infection is acknowledged where the patient acquires an infection during the period of their hospitalisation that was not present on admission.[1]

A nosocomial infection is an infection that occurs within 48 hours of admission to hospital. It can be an infection occurring three days after being discharged from hospital or an infection that is diagnosed 30 days after undergoing an operation.[2] The consequences of such infections can be very problematic; they not only lead to increased resistance of micro-organisms to antibiotics, they can also cause patients longer hospital stays. This can cause disability in the long-term. As a direct consequence, costs in the healthcare system escalate and patients suffer as a result. For instance, WHO estimated in 2010 that healthcare-associated infections indirectly cost the United States $6.5 billion and Europe €7 billion, as well as 16 million extra days of hospital stay annually.

Until recently, mobile phones were forbidden within the ICU and neonatal ICU as they were causing interference with vital medical equipment. The ban has since been lifted as such interference is no longer a problem.[3]

Staff, parents of babies and wider society are now very reliant on the use of the mobile phone. Parents often use the phone to update family members of their arrival at the unit. The phone is also most valuable to healthcare staff as important information is readily available and allows for easy access to this information.[3] We know anecdotally and from data that smartphone use is on the increase.

Systematic review

Numerous studies have investigated whether the mobile phone increases a nosocomial risk to patients. However, there are no systematic reviews examining if mobile phones cause nosocomial risk to the neonatal population. This made us question available literature and conduct a systematic review entitled *Does using a cellular mobile phone increase the risk of nosocomial infections in the neonatal intensive care unit?: A systematic review*.

In the review, a short list of inclusion criteria was derived. From this, data was obtained from articles that met the inclusion criteria. Six studies were chosen following a data extraction tool to avoid bias. From these studies, data was further extracted and quality appraised. Subsequently, data was summarised narratively and results synthesised – an independent reviewer supervised each of these steps. The findings are alarming considering that the studies found a pathogenic growth rate of bacteria or organisms on the surface of between 33.3% and 100% of mobile phones.

In five out of the six studies, coagulase-negative *Staphylococci* (CoNS) was found on between 62.9% and 72% of these.[4] CoNS is a member of the staphylococcus family. It is a normal part of the flora on the skin and thus is thought to be harmless. However, when an individual with a compromised immune system such as the neonate comes into contact with CoNS, it can cause a serious infection. Others at risk include children and adults with cancer, people with autoimmune disorders or patients who have recently undergone surgery. CoNS is the leading cause of early onset sepsis in the neonate and late onset sepsis in the developed world.[5] Other studies suggest that the CoNS species is responsible for both early and late onset causes of septicaemia in neonates. Nonetheless, it is the most common gram-positive organism.[6]

Notably and adversely, it is also a known nosocomial infection.

Impact of bacteria on the neonate

The WHO highlights that newborns are at a higher risk of healthcare-associated infections. The immune system of babies admitted to the neonatal unit is often undeveloped. This leaves them vulnerable to infections.[7] It is well known that infections can produce poor outcomes in neonates. These outcomes can vary however and deviate from a baby suffering with minor neurodevelopmental impairment, to considerable damage, or can be fatal.[8] In southeast Asia and sub-Saharan Africa, healthcare-associated infections are responsible for 75% of neonatal deaths. Recently, it has been noted that the regions of the eastern Mediterranean and southeast Asia report the highest rates of nosocomial infections.[3]

Klebsiella pneumoniae is also on the list of bacterial pathogens found on the surface of mobile phones, along with a bacterium called *Enterobacteriaceae*. One study found that *Enterobacteriaceae* colonised 53.5% of mobile phones.[9] *Klebsiella pneumoniae* and *Enterobacteriaceae* are gram-negative bacteria and both are extremely dangerous to the immunocompromised patient. The *Klebsiella* genus has been found to be the cause of many cases of late-onset sepsis in the neonate. Other pathogenic bacterial micro-organisms found on mobile phones from the studies were methicillin-sensitive and methicillin-resistant *Staphylococcus aureus* (MSSA and MRSA).

All of the above bacterial infections are known sources of nosocomial infections and are denoted as 'superbugs' due to the complexity of treating them.

Treatment options

A major difficulty with CoNS and other bacteria discussed is their treatment. CoNS for example, is traditionally treated with a strong antibiotic. For a neonate, any antibiotic treatment can affect their microbiome.[11] The microbiome of the neonate admitted to the neonatal ICU is different to that of a healthier baby. It is important to protect this microbiome as it has long lasting consequences for the baby. Each study included in the review indicated that mobile phones were contaminated with multi-drug resistant organisms. One study suggests that it is as high as 35%.[11] Antimicrobial resistance has become a considerable threat to public health. Regardless of the unit or hospital, treatment of an infection such as CoNS is especially difficult as the antimicrobials used to treat it are no longer effective. Not only is this a concern nationally,[12] it is an international crisis.[13]

Table 1: WHO's 'My five moments of hand hygiene'

The World Health Organization's 'My five moments of hand hygiene' approach recommends that healthcare workers clean their hands in the following clinical scenarios:

- Before touching a patient
- Before clean/aseptic procedures
- After body fluid exposure/risk
- After touching a patient
- After touching patient surroundings

The primary outcome of the systematic review was to establish if the use of cellular mobile phones causes increased risk of nosocomial infection to the neonatal population. Secondary outcomes questioned whether or not appropriate hand hygiene and cleaning of the mobile phone prevents transmission. All of the studies overwhelmingly stated that mobile phones can harbour and are an area for harmful bacteria, possibly nosocomial. However, it appears after extensive research, no studies were performed to investigate if these bacteria did in fact cause a nosocomial infection in the neonate.

Secondarily, all of the studies also confirmed that regular decontamination of the mobile phone does prevent transmission. However, incorrect hand hygiene and inappropriate mobile phone cleaning can also lead to transmission. All of the studies recommended the use of an effective mobile phone cleaning policy.[4] One study in particular endorses the use of a suitable mobile phone cleaning station on the unit.[14] The WHO's 'My five moments of hand hygiene' must always be considered *(see Table 1)*.[15]

Recommendations

To conclude, banning the mobile phone is difficult. Due to the speed at which information is available their presence and use is pervasive. They have also become an indispensable tool for healthcare staff. Parents want to immediately update family members as soon as they have access to the baby.

However, we know that the mobile phone is a known carrier of harmful micro-organisms, including nosocomial pathogens. The disease potential of these germs means that they are incredibly challenging to treat. When treated, they can cause long-term consequences for the neonate to overcome.

We know that cleaning mobile phones can minimise risk of transmission and effective hand hygiene can prevent transmission. As healthcare staff, the onus is on us to protect those most vulnerable in our healthcare system, such as the neonatal population. It is therefore paramount to ensure mobile phones are decontaminated regularly and that we follow the WHO's 'My five moments of hand hygiene' in the hospital setting.

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Making the right choice

Efficient and cost-effective use of home glucose monitoring equipment is an important component in diabetes management, write **Siobhan Meehan**, **Sarah Fitzpatrick** and **Caitriona Coleman**

HOME blood glucose monitoring (HBGM) equipment has been used for over 30 years and has been simplified enormously for the user during this time. It is an important component in the management of diabetes for the majority of individuals. In the late 1970s, HBGM was demonstrated to improve glycaemic control for patients with type 1 diabetes, with the first blood glucose meters marketed for home use around 1981.

After the results of the DCCT[1] trial in 1993 and the UKPDS[2] trial in 1998, self-monitoring became widely adopted as a necessary part of diabetes care. It provides immediate information on a person's glycaemic level and can be an important guide for adjusting all factors that affect glucose control on a timely basis.[3]

Diabetes management in primary care

The GP and practice nurse are the primary caregivers to people with diabetes in the community, supported by other members of the multidisciplinary care team. The role of the GP includes the diagnosis of diabetes, advice to patients regarding lifestyle changes, monitoring of blood glucose, agreeing health-related targets, commencing medication, with ongoing care and monitoring as appropriate.

In order for HBGM to be effective it must be incorporated into a self-management plan for the patient. It can be a useful tool to help the patient and healthcare professional (HCP) identify areas of glycaemic variability that may require adjustments to food choices, exercise and medication. Timing and frequency of testing are important parts of diabetes education.

Frequency of HBGM in type 2 diabetes

In 2015 the HSE spent €46.5 million on blood glucose monitoring test strips. Despite the high frequency of testing in patients with type 2 diabetes, there was very little evidence to justify its cost-effectiveness.[4] Indiscriminate testing by all patients with diabetes is not recommended.

The National Clinical Programme for Diabetes[5] issued guidelines in 2015 on the frequency of testing for patients with type 2 diabetes (*see Table 1*).

Table 1: Guide to blood glucose testing: type 2 diabetes[6]

Diabetes treatment	Guidelines for blood glucose testing
People with stable type 2 diabetes on diet alone	Do not need to self-test
People with type 2 diabetes taking: • Metformin alone, or • Metformin with any of the following diabetes medications: – a DPP-4 inhibitor, or – a GLP-1 analogue, or – a TZD, or – SGLT2 inhibitor	Test up to three times a week
People with type 2 diabetes taking sulphonylureas or glinides (such as gliclazide) on its own or taking it with any of the following diabetes medications: – a DPP-4 inhibitor, or – a GLP-1 analogue, or – a TZD, or – a SGLT2 inhibitor – metformin	Test one to two times a day • Test more often if: – driving (see driving guidelines) – doing extra physical activities such as gardening or sports, – experiencing hypoglycaemia, 'hypo' – feeling ill or stressed – consuming alcohol
People with type 2 diabetes on insulin alone or insulin with other diabetes medications	Test up to four times a day. • Test more often if you are: – driving (see driving guidelines) – doing physical activities such as gardening, sports etc – experiencing hypoglycaemia, 'hypo' – during illness – feeling stressed – consuming alcohol
People with type 2 diabetes planning a pregnancy or who are pregnant.	Test up to seven times a day. • Test more often as advised by your doctor, nurse or dietitian

Consider HBGM in the following additional situations:

- Patients with deteriorating glycaemia who may require treatment titration
- Patients with intercurrent illness
- Patients on steroids.

Frequency of HBGM in type 1 diabetes

NICE guidelines 2016[7] advise self-monitoring of blood glucose for all adults with type 1 diabetes, at least four times a day,

Table 2: Blood glucose testing strips and meters meeting ISO standards and CE marked most commonly used and available in Ireland (as of June 2017)

Company	Strip Name	GmmmG evaluation*	Meter	CE mark	ISO	Note
Roche Diagnostics	Accu-Chek Aviva Test Strips	Group 1	Accu-Chek Aviva Meter	CE0088	Compliant	
			Accu-Chek Aviva Nano Meter	CE0088		
			Accu-Chek Aviva Expert Meter	CE0088		
	Accu-Chek Mobile (test cassette)	Group 1	Accu-Chek Mobile Meter	CE0088	Compliant	
Ascenscia Diabetes Care formally Bayer Healthcare	Contour Next test strips	Group 1	Contour Next One USB	CE0088	Compliant	
			Contour XT	CE0088	Compliant	
			Contour Next Link	CE0088	Compliant	
Abbott Laboratories	FreeStyle Optium test strips	Group 1	FreeStyle Optium Neo meter	CE0086	Compliant	Can estimate both glucose and ketones
Lifescan	OneTouch Verio test strips	Group 1	OneTouch Verio IQ Meter	CE0344	Compliant	
			OneTouch Verio Flex meter	CE0344	Compliant	
			OneTouch Verio meter	CE0344	Compliant	
Menarini Diagnostics / Medicon Ireland	GlucoMen Areo Sensor test strips	Group 1	GlucoMen Areo Meter	CE0123	Compliant	
	GlucoMen LX2 Sensor strips		GlucoMen LX2			Can estimate both glucose and ketones

**GmmmG evaluation[11]: The Greater Manchester Medicines Management Group carried out a review process and scoring mechanism in order to select a preferred blood glucose testing strip for Greater Manchester offering a comprehensive and high level accuracy while being cost effective to the health economy. These blood glucose monitoring systems listed in Group 1 had independent and published evidence demonstrating ISO 15197:2013 accuracy standards as per evaluation process.*

before meals and before bed. Testing up to seven times a day may be advised in the following circumstances:

- If the desired target for blood glucose control (HbA1c level) is not achieved
- If the frequency of hypoglycaemic episodes increases
- Before driving
- During periods of illness
- Before, during and after sport
- When planning pregnancy, during pregnancy and while breastfeeding
- If awareness of hypoglycaemia is impaired
- During high-risk activities.

Regulation and quality

In February 2015 the Health Products Regulatory Authority (HPRA) published a document entitled *Safety notice: medical devices in the home*.[8] the document made a number of recommendations in relation to blood glucose monitoring aimed at those providing and using blood glucose meters.

In response to this publication, a newly established blood glucose monitoring review group advised the following best practices:

- Registration and traceability of meters
- Quality control of meters
- Training for both the patient and the healthcare professional (HCP).

Registration and traceability of meters

It is essential to register each capillary blood glucose meter with the manufacturer. This will provide:

- Replacement by the company in the event of safety concerns
- Access to information regarding the safe use of capillary blood glucose meters
- Access to support materials provided by the manufacturer.

Registration can be achieved by:

- Completing the warranty card included in the meter packaging
- Using the freephone number provided in the meter packaging
- Registering online via the manufacturer's website.

Quality control

HBGM results must be accurate and precise to ensure safety for patients. See *Table 2* for a list of meters achieving ISO standards as of June 2017. Since the data for *Table 2* was collated, the GlucoRX Nexus range (Ideal, Mini-Ultra and Voice) with Nexus test strips have also come on the market in Ireland, are CE marked and meet ISO 15197 standard.

Table 3 lists older meters, some of which do not meet ISO 15197 standards and are no longer promoted by manufacturers, but are still in use by patients. Manufacturers recommend that quality control (QC) solutions must be used to ensure the meter is producing accurate results but, in practice, the use of QC solutions is minimal.

Training and education

Formal training in capillary blood glucose monitoring and the use of meters is essential for the person with diabetes, his or her carers, and the HCP. Patients using meters require access to a HCP deemed competent in the use of the meter.

Ideally, patients should have an assessment of their blood glucose self-monitoring technique as part of their annual review visit.[9] However, elements of HBGM will form part of each consultation. This should include:

- The patient's self monitoring skills
- Frequency of blood glucose testing and circumstances including pre driving as appropriate
- Checking that the patient can interpret the blood glucose results and know what action to take
- The impact on the patient's quality of life
- The continued benefit to the patient
- The equipment used
- The accurate recording of results or downloading of results to verify blood glucose readings.

It is generally recommended by the manufacturers that all blood glucose meters are replaced every two years.

Special circumstances to consider[10]

Capillary blood glucose testing may not be appropriate for monitoring blood glucose in patients with:

- Poor peripheral perfusion
- Severe dehydration (diabetic ketoacidosis or hyperglycaemic hyperosmolar syndrome)
- Shock
- Peripheral arterial occlusive disease
- Lipaemic sample (triglycerides > 20.3mmol/L)
- Abnormally high/low haematocrit (low haematocrit < 10% may cause higher results; high haematocrit > 65% may cause lower results)
- Continuous ambulatory peritoneal dialysis (depending on dialysate type used)
- Intravenous immunoglobulin preparations containing maltose.

A venous blood sample should be obtained from these patients instead.

Choice of equipment

There are a number of blood glucose meters available. The choice of a blood glucose meter for the person with diabetes will depend on a variety of factors, including size, ease of use and the type of strip (eg. canister, individual foil wrapped strip or strip free).

Other additional features such as memory and download capability, alarms and back lights may need to be considered for some patients. Individuals with visual impairment or dexterity problems will need a meter that accommodates these issues. People with type 1 diabetes will require a meter to measure blood ketone levels, or a smart meter that assists in insulin bolus calculations. Patients using insulin pumps will require a meter that relays blood glucose levels to their pump. Thus, the choice of blood glucose meter needs to be tailored to each individual patient.

The meter and testing strips chosen must comply with the ISO 15197 standard and be CE marked to comply with performance standards specified by the manufacturer for intended purpose. It is recommended by manufacturers that meters are replaced every two years.

Current and future developments

Recent developments in blood glucose monitoring have provided us with two new systems to measure interstitial glucose: continuous glucose monitoring (CGM) and flash glucose monitoring. These systems are expensive, and are currently only recommended for people with type 1 diabetes under certain conditions and should only be provided by a specialist centre with expertise in their use.

Table 3: Older meters on the market still in use by patients

Company	Strip name	Meter
Roche Diagnostics	Accu-Chek Active test strips	Accu-Chek Active meter
	Accu-Chek Compact test strips	Accu-Chek Compact meter Compact Plus meter
	Accu-Chek Advantage Plus test strips	Accu-Chek Advantage meter
	BM Accutest strips	Accutrend meters
Ascenscia Diabetes Care	Breeze 2 disc	Breeze 2 meter
	Contour test strips	Contour Meter
		Contour Link Meter
		Contour USB Meter
Abbott Laboratories	FreeStyle Lite test strips	FreeStyle Freedom Lite meter
	FreeStyle Optium glucose test strips	FreeStyle Optium
Menarini Diagnostics/ Medicon Ireland	GlucoMen LX Sensor test strips	GlucoMen LX Plus meter
	GlucoMen Sensor	GlucoMen Glyco meter
	GlucoMen Visio Sensor	GlucoMen Visio meter
LifeScan	OneTouch Ultra test strips	OneTouch Ultra 2
		OneTouch Mini
Clonmel Healthcare	TrueResult test strips	True Result meter
		True Result Twist meter

Continuous glucose monitoring

A sensor is inserted into the subcutaneous skin around the abdomen to which a transmitter is attached. This sends data wirelessly to a display device which shows real-time glucose information including trending. Interstitial glucose correlates well with plasma glucose, with some devices having alarms for hypo and hyperglycaemic excursions, reducing the need for capillary blood glucose sampling.

Flash glucose monitoring

This method of monitoring is becoming more popular. However, it has not yet been formally evaluated by NICE on clinical and cost-effectiveness grounds. The only licensed system in Ireland is the FreeStyle Libre, which is currently being reimbursed by the primary care reimbursement system (PCRS) on a trial basis for patients with type 1 diabetes up to the age of 21.

It involves inserting a sensor, scanned with an individual patient reader or a smartphone app and replaced every 14 days, in the upper arm. When worn continuously, each scan gives the current interstitial glucose reading, a record of the last eight hours and shows which direction the glucose is trending. This is displayed numerically and in graph representation. It allows for unlimited scanning at no extra cost. This is a measurement of interstitial fluid glucose, not blood glucose and therefore there will be a discrepancy due to the known lag time of five to 10 minutes. See **www.nice.org.uk/advice/mib110** for further reading.

It is noted that this technology does not completely replace capillary blood glucose monitoring. Patients will continue to require home blood glucose monitoring in addition to flash monitoring under the following circumstances:

- Glucose reading < 4mmol/L
- Blood glucose readings > 13mmol/L
- Before driving
- If feeling unwell.

Numerous studies have demonstrated the importance of optimal blood glucose control. HBGM is an excellent educational tool that provides an immediate glucose result. Indiscriminate testing by all patients with type 2 diabetes is not recommended. Efficient and cost-effective use of blood glucose monitoring equipment is essential. With the availability of numerous methods to monitor home blood glucose it is imperative that we are mindful of the appropriate choice of equipment to suit each individual as well as ensuring that standards of care in glucose monitoring are met.

Siobhan Meehan is a clinical nurse specialist (CNS) in diabetes and primary care, in Longford/Westmeath; Sarah Fitzpatrick is a CNS in diabetes at University Hospital, Dooradoyle, Limerick; and Caitriona Coleman is a CNS in diabetes in Sligo

References on request from nursing@medmedia.ie (Quote Meehan WIN 27(6) 47-50)

WIN Vol 27 No 6 July/August 2019

Focus on: Psoriasis

Fatima Awdeh and Maureen Connolly present two case studies on different presentations of psoriasis

Case 1

A 56-YEAR-OLD woman presented with a 12-year history of psoriasis, mainly involving the palms and soles, which had been refractory to treatment.

This woman had tried multiple different potent topical corticosteroids and calcipotriene ointment. Physical examination revealed erythematous scaly and hyperkeratotic psoriatic plaques, in a symmetrical distribution involving both palms and soles (*see Figures 1, 2 and 3*).


Figure 1

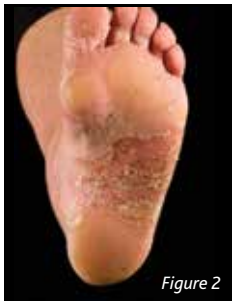


Figure 2


Figure 3

The diagnosis was palmoplantar psoriasis. First-line treatments include topical agents such as emollients, keratolytic agents, for example urea and salicylic acid containing-products, which can reduce thickened scale. Coal tar preparations on their own or used in combination with topical steroids can improve scale and inflammation and are usually applied at night time. Super-potent topical steroids such as Dermovate (clobetasol propionate) with or without occlusion can be used short-term to improve the psoriasis.

When topical treatments fail to provide adequate improvement, second-line treatments are often required to treat the condition. This patient was commenced on acitretin 30mg daily which cleared her psoriasis leading to a significant improvement in her quality of life.

An alternative treatment option is hand and foot PUVA (psoralen and ultraviolet A) in which patients soak their palms and soles for 15-30 minutes in a methoxypsoralen solution before UVA exposure. Hand and foot PUVA is usually performed twice weekly and the number of treatments required varies according to the treatment response.

Methotrexate can be used if a patient is unable to attend for hand and foot PUVA following a systemic work up. However, such patients will require regular ongoing review with blood test monitoring to avoid hepatotoxicity.

A further treatment option is apremilast which works by inhibiting an enzyme known as phosphodiesterase inhibitor (PDE4). PDE4 controls the inflammation process in the skin and so when this is reduced in patents with psoriasis their skin can improve.

Biologics (targeted therapies) may also be effective in the treatment of severe palmoplantar psoriasis. However, it should be noted that TNF-alpha inhibitors such as infliximab and adalimumab may trigger this disease which is known as paradoxical psoriasis.

Interleukin-17 inhibitors (IL-17) are also effective therapies for palmar plantar psoriasis.

Case 2

A 22-year-old woman was referred to the dermatology outpatient clinic by her general practitioner with a two-month history of a generalised rash that appeared after a sore throat. Physical examination revealed multiple small scaly plaques like 'tear-drops' that affected her chest and back (*see Figure 4*). She had a similar rash on her abdomen and limbs.

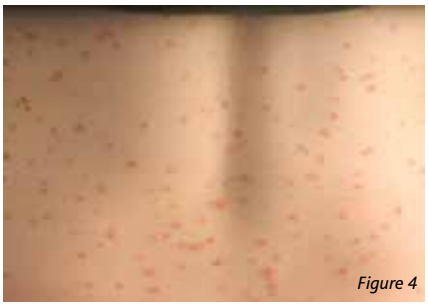


Figure 4

The diagnosis is guttate psoriasis. 'Gutta' is Latin for drop and it is called guttate psoriasis as it looks like a shower of red, scaly tear-drops that have fallen on to the skin. The diagnosis was made by the combination of history, clinical appearance of the rash, and evidence of a preceding throat infection.

A streptococcal throat infection was the most likely trigger. The rash of guttate psoriasis often comes on very quickly, usually within a couple of days of infection. It tends to affect children and young adults and has a good chance of spontaneously clearing completely. Treatments include treating the underlying streptococcal infection with antibiotics, along with topical agents for the skin that include mild to moderate topical steroids, coal tar and calcipotriol. Phototherapy is a good treatment if topical therapies alone don't clear the psoriasis.

The exact pathophysiologic mechanism is undetermined. The disease is believed to result from an immune reaction triggered by a previous streptococcal infection in a genetically susceptible host. Recent research points toward chromosome 6 as HLA-Cw*0602 allele positive patients are more prone to develop the guttate form of psoriasis.

Fatima Awdeh is a registrar in dermatology and Maureen Connolly is a consultant dermatologist, at Tallaght University Hospital, Dublin

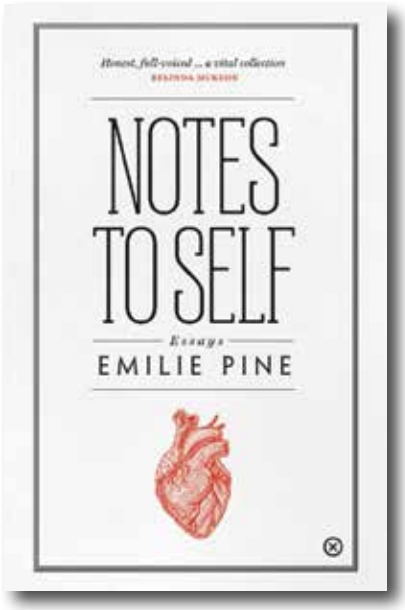
Correction to article on childhood atopic eczema published in WIN May (vol 27 issue 4, pp51-52)
Table 2 should have been titled as 'Maximum amount of topical steroids per month for chronic use'. The correct version can be accessed online at: **inmo.ie**

Heart-sore and honest

RAW, powerful, brave – these are all words that come to mind when I think of Emilie Pine's *'Notes to Self'* even months after I first read it.

"By the time we find him, he has been lying in a small pool of his own shit for several hours." The opening sentence of the first of this set of six personal essays simply tells you like it is. The author is describing finding her father in Corfu General Hospital after a journey of over 24 hours from Dublin. It is evening time when she and her sister eventually track him down in what the locals dubbed 'the dying ward', where after 5pm there is just one nurse per ward and this one has at least six rooms, each with up to six patients.

It is unlikely that the overworked and understaffed in Irish hospitals will take much solace from Pine's descriptions of how things could be so much worse. In this large hospital in a corner of the EU not many years ago the absolute basics were severely lacking. Nurses had to buy their own supplies out of their wages, basics like cotton wool and disposable gloves. There is a tragically amusing scene of Pine trying to



persuade a nurse through a language barrier to change her blood-stained gloves for a fresh pair from the box bought in the hospital shop.

When her father eventually transfers to Ireland, while nurses would automatically use fresh gloves with every patient, gaining access to a hospital bed and inpatient care in a timely fashion was another thing.

However, this is not a story about contrasting health services; it is a harrowing account of a daughter's heart-sore relationship with her alcoholic father. How she loved him yet wished him dead at times, nevertheless doing everything to keep him alive. Pine manages, in 28-pages of carefully chosen words, to tell a story many would fail to relate in a full length novel.

The remaining five essays in this short book cover a vast array of subjects, often overlapping and interweaving. Among the issues explored are: fertility (or lack there of), marriage breakdown, family, menstruation, body image, eating disorders, sexuality, sexual abuse, rape, feminism, casual sexism, internalised sexism, stress and depression.

Emilie Pine is associate professor of modern drama at UCD. This is her first collection of personal essays. It is honest, unsentimental, brave and somehow also humorous. It will draw you in.

– Tara Horan

Notes to Self by Emilie Pine is published by Tramp Press, 2018. ISBN 978-1-9997008-4-3, €15

CROSSWORD Competition

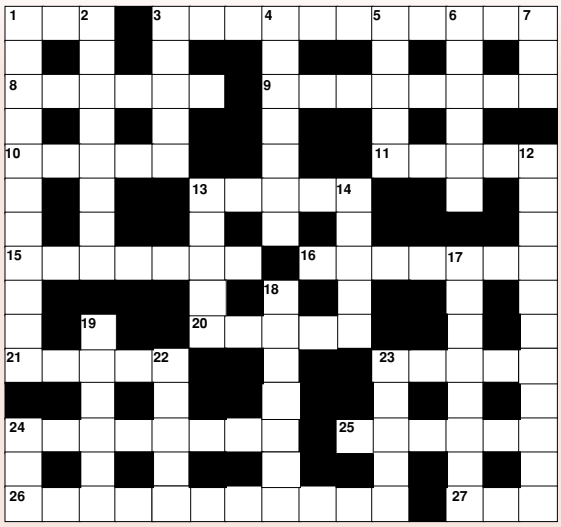
WIN a €50 gift voucher

Across

1 Attila was the most infamous one (3)
3 The Bard of Avon (11)
8 Man from Antrim? (6)
9 Outhouse for storing implements (4,4)
10 A cake's sweet covering (5)
11 Part of the body made of regurgitated wines (5)
13 & 21a Marine sports enthusiast who may have an absurd vice? (5,5)
15 Will a stone of this Cork cheese help you get the gift of the gab? (7)
16 Head under this when on the building site (4,3)
20 Used letters to name a type of wheat (5)
21 See 13 across
23 Striped predator (5)
24 Find water sources A and C not to be crimson, but this one is - good pedigree, you see! (4-4)
25 Such facts provide the stuff of quizzes (6)
26 Yam (5,6)
27 Mr Keane is seen right beside Offaly (3)

Down

1 Does it hover about, even though it doesn't know the words of the song? (7,4)
2 & 17d Is the caring profession a relict of trying to cope with that 'morning after' feeling? (7,1,8)
3 Taking legal action (5)
4 Sauce (7)
5 & 14d Incompatible description of a Warsaw separation? (5,5)
6 Feeling pain (6)
7 Terminate (3)
12 Was this twentieth century political entity about to try new games? (4,7)
13 Prophets, visionary mystics (5)
14 See 5 down
17 See 2 down
18 Green gemstone, somewhat like an emerald (7)
19 Develop gradually (6)
22 The capital of Morocco (5)
23 T, or something like it, for trunk (5)
24 The West, as it used to be (3)



June crossword solution

Across: 1 Add 3 Memorabilia 8 Cystic Fibrosis 11 Adios 13 Backs 15 Awaited 16 Mastiff 20 Knife 21 Sitar 23 Frill 24 Stallion 25 Safari 26 Bull terrier 27 Egg

Down: 1 Accumulated 2 Dyslexia 3 Maine 4 Offence 5 Burma 6 Lassie 7 Abs 12 Scaffolding 13 Bleak 14 Snake 17 Irritate 18 Vintner 19 It's all my eye 22 Relit 23 Flair 24 Sub

The winner of the June crossword is: Helen Crawford Portmarnock, Co Dublin

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Friday, August 16, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Buying your first home

MONEY MATTERS

Ivan Ahern discusses the mortgage process and gives his top tips to buying your first home

BUYING your first home can seem like a daunting process. This quick guide highlights the 10 steps to buying your first home:

1. Get your finances in order

Before you submit your mortgage application, you will need to demonstrate you can pay back the loan and you have the finances to cover the repayments. Make regular savings arrangements, pay down any outstanding credit card balances and pay off any loans you can.

2. Apply for your mortgage

There are lots of financial products and lenders to choose from when selecting your mortgage. It's important to get the right advice and find the right mortgage. Cornmarket has a handy mortgage application checklist which lists all the documents you will need to apply for a mortgage, including ID, utility bills, P60s, payslips, bank statements, loan/mortgage account statements, credit card statements etc *(see www.cornmarket.ie)*

3. Get approval in principle

Once the lender has received your documents and they are satisfied you meet the criteria for a mortgage, they will issue you with an 'approval in principle'. This means that you have been approved for a specific mortgage amount. Some sellers may ask if you have your approval in principle before accepting a bid on a property.

4. Pay a booking deposit

When you find a property you wish to buy, you pay a booking deposit for the seller. This deposit holds the property for you until the contracts and the full loan offer are in place. This booking deposit is refundable if either party decides to cancel the purchase agreement. At this point you should employ a solicitor. Your solicitor will work on your behalf and review the property deeds, contracts and so on.

5. Property valuation

When you choose your property, your mortgage provider will have it valued. The purpose of valuing the property is to confirm that the property value is appropriate to the mortgage approved.

6. Receive a full loan offer

When your mortgage provider is satisfied with the valuation on the property you have chosen, they will issue you with a full loan offer. This document confirms the mortgage amount, the term, the rate and the type of mortgage. It is also sent to your solicitor with the legal documents for your mortgage.

7. Get a structural survey completed

Although this may not be required by your mortgage provider, it is advisable that you complete a structural survey of your property. This gives peace of mind that the property you are purchasing is structurally sound and in good condition.

8. Sign your purchase contract and pay your deposit

Your solicitor will review your contract and the property deeds. Once they are satisfied with these, you will be ready to sign. When you sign your contract, you will then be required to pay the full deposit for the property (less the booking deposit paid).

9. Full loan offer conditions

Your full loan offer will contain certain conditions that you must complete before closing. These conditions will include mortgage protection cover, property insurance, direct debit etc.

10. Close the purchase

The mortgage provider transfers the mortgage amount to your solicitor, who in turn transfers it to the seller of the property on your behalf. This process is called the draw-down of your mortgage. Once these funds have been drawn-down and have been paid to the seller, you have purchased the property. Now all that is left to do is move in!

Help with your mortgage

Cornmarket's public sector mortgage experts specialise in public sector mortgages. They offer impartial advice on lenders and financial products, to find the best mortgage for you. They can assist you through the process – from preparing your application to getting the keys. Cornmarket will advise you on the mortgage amount, term and the repayments and will ensure you select a mortgage that is suitable and affordable for you. Tel: 01 4086260 for more information.

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

Gender-related barriers stifle nurses' leadership potential – ICN survey

WOMEN comprise just 25% of health system leadership roles worldwide despite accounting for 70% of the total health and social care workforce, according to a recent report.

The report, *Investing in the power of nurse leadership: what will it take?*, published by IntraHealth International, Nursing Now and pharmaceutical company Johnson and Johnson cites discrimination, bias and stereotyping as the main barriers to female nurses and midwives advancing their careers.

The report's findings and recommendations, which can be accessed online at **www.intrahealth.org**, were drawn from a survey of 2,537 nurses and midwives from 117 countries, as well as an extensive literature review and eight key informant interviews.

When asked about the factors keeping them from pursuing higher-level positions, the top responses from participating nurses and midwives were:

- Having the equipment and the other resources necessary to perform the job
- Fair salary
- Leadership training.

Other findings from the report include:

- The perception of nursing as a feminine and nurturing profession and the devaluation of work associated with women were cited as barriers to women's advancement in the profession and the status of nursing in the health workforce
- Nurses perceive the effects of a 'glass ceiling' – when female nurses are inhibited from advancing professionally, often due to domestic responsibilities – and a 'glass escalator' – when male colleagues with less experience advance more quickly due to cultural advantages
- Respondents overwhelmingly reported that challenges balancing unpaid and paid work affect female nurses more than male nurses
- Respondents cited a lack of self-confidence as a barrier to assuming leadership positions
- Nurses perceive limited decision-making authority, regardless of gender.

The World Health Organization (WHO) projects a shortfall of 18 million health workers by 2030, primarily in low- and middle-income countries, and estimates that nurses and midwives represent 50% of this projected shortage.

Speaking about the report, ICN president Annette Kennedy said: "The voices of the many nurses who contributed to this report must be heard by governments and healthcare leaders around the world. Nurses can be the answer to so many of the world's health problems – but only if there are serious, sustained efforts to remove the obstacles that are routinely put in their way.

"Give them a level playing field, remove the glass ceiling, abandon any notions of 'women's work' and nurses will change the world."

HSE launches new 'Health Passport' which aims to improve disability care

A NEW Health Passport, which aims to ensure people with intellectual disabilities in the north west receive safer, better care, has been launched by the HSE.

The Health Passport is a document that contains vital information about a person, including personal details, medical history and communication abilities. In the event that someone needs medical care, this easy-to-read document can be given to staff, allowing them to get a clearer picture of the patient.

Dr Siobhan O'Halloran, chief nursing officer with the Department of Health, said: "The Health Passport contains a number of sections that will provide information about the person. This will help healthcare staff to provide safer, better integrated care that is person-centred and compassionate."

The Health Passport was launched in Letterkenny with the screening of a short film, *Mission Possible*, which is part of a campaign to raise awareness about the passport. The movie stars Paul Gallen Jnr, a young man with Down syndrome.

Speaking at the launch, Mr Gallen said: "Being involved in the making of the movie to promote the HSE Health Passport has been a wonderful experience for me. This passport allows me to communicate my health needs to staff working in the HSE."

Speakers at the launch were (back row l-r): *Ciaran McCann, Maureen Jordan, Marie Kehoe-O'Sullivan, Shaun Doogan, Jean Kelly, Prof Owen Barr, Niamh Walsh and (front row l-r): Dr Anne Gallen, Dr Siobhan O'Halloran, Paul Gallen Jnr and John Hayes*

The Health Passport has been piloted and evaluated for people with intellectual disabilities over the past two years in Letterkenny University Hospital and Sligo University Hospital.

This work was carried out by the Nursing and Midwifery Planning and Development Unit (NMPDU) in the north west.

According to the unit director, Dr Anne Gallen, who led the work, the Health Passport "will truly enable person-centred and compassionate integrated care, as well as driving safer healthcare delivery".

The HSE Health Passport will be available to people with an intellectual disability within the Saolta University Healthcare Group and the Community Healthcare Organisation Area 1 (CHO 1).

The film can be viewed via the HSE Ireland channel on YouTube.

Irish Skin Foundation warns against reliance on self-management apps

PEOPLE with skin conditions should consult expert information before seeking help from self-management apps, according to the Irish Skin Foundation (ISF).

A recent study by the *British Journal of Dermatology* found that 34% of eczema self-management apps contain information that is not aligned with international guidelines on eczema management.

The study examined 98 individual apps in English, Spanish and Chinese and determined that only 15% contained information supported by international guidelines such as those outlined by the National Institute for Care Excellence (NICE).

Commenting to *WIN*, ISF CEO David McMahon said people who have eczema or are concerned about their skin should always speak with their GP first, to establish a diagnosis and treatment regimen.

He said: "People with or caring for eczema often search for tips and strategies online to help manage the condition and inevitably encounter apps.

"The word 'eczema' is a collective term, consisting of many sub-types. Atopic eczema is the most common form and it can be very unpredictable, difficult to manage, and individual patients have widely differing requirements and lived experiences of the condition.

"The ISF develops up-to-date, independent and carefully reviewed patient information in partnership with people living with skin conditions, their carers, specialist nurses and consultant dermatologists."

Mr McMahon says that the ISF cannot comment on or vouch for the quality of information available through smartphone apps, and instead refers people to the extensive body of expert information available through the resources page on the ISF website: **www.irishskin.ie**

Changing attitudes towards dementia

Ita Kelly, Sinead O'Reilly and Dr Emer Begley from the HSE's National Dementia Office (pictured l-r) at the Dementia: Understand Together campaign's national partner forum 2019, which took place in Kilmainham, Dublin, recently.
The HSE-led campaign, in partnership with The Alzheimer Society of Ireland and Genio, is supported by more than 40 national partners. Organisations from various sectors shared their experiences of taking action to change the culture around dementia. It is estimated that 11 people develop dementia every day in Ireland with over half a million families affected by the condition. For information on how individuals, businesses and organisations can help create communities that are supportive and inclusive of people with dementia and their families, visit: ***www.understandtogether.ie/get-involved***

September

Monday 2
National Children's Nurses Section meeting. OLCH Crumlin. Teleconferencing will be available. 11am

Wednesday 4
RNID Section 'Tools for Safe Practice' workshop followed by meeting. Cope Foundation, Montenotte, Cork. 9am-1pm

Saturday 7
Midwives Section meeting. Limerick University Maternity Hospital. 2pm

Tuesday 10
National Care of the Older Person Section annual conference. Richmond Education and Event Centre.

Saturday 14
School Nurses Section meeting. Midland Park Hotel, Portlaoise. From 10am. Education session with protocols, policies and procedures

Thursday 19
ED Section meeting. Richmond Education and Event Centre. 10.30am *See page xx* for further details

Thursday 19
Retired Nurses and Midwives Section meeting. Richmond Education and Event Centre. 11am. Educational talk on mindfulness

Tuesday 24
Telephone Triage Section conference. Richmond Education and Event Centre

October

Sunday 6
Reunion of past Meath Hospital Nurses Clayton Hotel, Burlington Road, Dublin. 5pm. Contact Mary Kelly at Tel: 087 9393801

Saturday 12
PHN Section meeting. Richmond Education and Event Centre. 11am

Saturday 12
Community RGN Section. Richmond Education and Event Centre. 11am

Saturday 12
CNM/CMM Section meeting, following the study day. Richmond Education and Event Centre. 10am.

Thursday 17
All Ireland Midwifery Conference Armagh

Thursday 17
Student Allocation Liaison Officers meeting. INMO HQ. 12pm

November

Tuesday 12
National Care of the Older Person Section meeting. INMO Cork office. From 10.30am

Thursday 21
Occupational Health Nurses Section conference. Richmond Education and Event Centre

Wednesday 27
CPC Section meeting. Richmond Education and Event Centre

Saturday 30
ODN Section conference. Richmond Education and Event Centre

Saturday 30
PHN Section meeting. Richmond Education and Event Centre

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

INMO Professional DEVELOPMENT CENTRE

Library Opening Hours

July/August
Please note that the library will be closed on the following dates: **July 1-12** and **July 31 to August 7**. Normal opening hours apply on all other summer dates

For further information on the library and its services or to make an appointment to visit, please contact
Tel: 01 6640 625/614
Fax: 01 01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2019

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

Condolences

❖ The INMO Midwives Section wishes to extend its deepest sympathies to the families, friends and colleagues of Patrick White, Roz Cashman and Bernadette Loughnane, all of whom passed away recently. Patrick White was CMM2 in the birthing suite at CUMH. He passed away on October 22 last year. Roz Cashman was CNS at CUH and formerly at CUMH. She passed away on April 20 this year. Bernadette Loughnane worked in practice development at CUMH and passed away on May 5. They will all be sorely missed. May they rest in peace.

OHN Section conference

INMO

Thursday, November 21, 2019

Richmond Education and Event Centre

Please contact **jean.carroll@inmo.ie** for details